

THE RELATIONSHIP BETWEEN NARCISSISM AND POSTTRAUMATIC SYMPTOMS IN  
ADJUDICATED YOUTH: AN EXPLORATORY STUDY

by

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(Under the Direction of Brian Glaser)

ABSTRACT

Much of the current literature on trauma and narcissism has conceptualized trauma as the catalyst for the development of narcissism. However, more recent research has begun to explore how narcissism can impact one's experience of trauma and the development of posttraumatic symptoms. This research has largely been conducted using adult samples, meaning the relationship between narcissism and trauma in adolescent populations, particularly juvenile offenders, is less understood. Therefore, the current study utilized a sample of 12–17-year-olds who were referred for mental health treatment and assessment, secondary to their adjudication by the Georgia Department of Juvenile Justice, to explore the relationship between narcissism and posttraumatic symptoms. Particular attention was given to the differences in adaptive vs. maladaptive narcissism. Regressions and correlational techniques were used to analyze participants' scores on the Narcissistic Personality Inventory-Juvenile Offender (NPI-JO) and Child Report of Posttraumatic Symptoms (CROPS).

Results suggested adaptive narcissism, and some of the factors which comprise adaptive narcissism (i.e., self-sufficiency, authority, superiority), may perform a protective function

against the development of posttraumatic symptoms. Results also indicated maladaptive narcissism may have less impact on one's experience of and recovery from trauma. In fact, only one aspect of maladaptive narcissism, entitlement, was shown to be a risk factor for the development of posttraumatic symptoms. These findings have implications for the development of innovative and effective assessment and treatment for juvenile offenders, which is relevant to preventing future delinquency, improving mental health outcomes, and maintaining the safety of youth and staff in juvenile facilities.

INDEX WORDS: Adaptive narcissism, maladaptive narcissism, narcissism, trauma, posttraumatic symptoms, juvenile offending, juvenile mental health treatment.

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A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial  
Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

2024

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August 2024

## DEDICATION

This work is dedicated to my family. To my parents, who instilled in me a love of learning, a curiosity about the world, and a tender heart that always considers others. They provided me with the opportunity to pursue my dreams, believing in me every step of the way and trusting me to find the right path for myself, even if it is not what they might have chosen for me. To the rest of my huge, loving, supportive family, thank you for your constant encouragement in the pursuit of my education, even when it meant missing more than ten years of family events, birthdays, and all the small moments in between. I am the person I am today only because I have the best family in the world.

To my fiancé, Jordan, thank you for the sacrifices you have made so that I could pursue my dream career. You never hesitate to tackle the next phase of the PhD journey with me, even when that means moving halfway across the country. I am thankful to have had your patience, understanding, and support during the difficult days of this program.

Finally, this work is also dedicated to my loyal and loving canine companion, Louie. His unconditional love and enthusiasm for everyday life are contagious. His excitement every time I came home were comforting and uplifting. My educational pursuits led me to live in several new places, away from my support systems, where he was, at times, my only source of comfort and companionship. He makes the good days great and the bad days bearable. It has been my greatest joy having Louie by my side.

## ACKNOWLEDGEMENTS

There are many people, without whom a completed dissertation would not have been possible. To my dissertation chair, Dr. Glaser, you have provided constant support, guidance, and encouragement throughout this process. Through the low points of my journey, when my faith in myself was dwindling, your enthusiasm and belief in my ability to succeed never wavered. Thank you for making this process as enjoyable as possible. I will miss our weekly meetings that always involved just as much laughing as working.

To my committee, Dr. Phelps and Dr. Stewart, I have appreciated your guidance and your enthusiasm for this project. The new and exciting perspectives you both contributed to the development of this study, and to the interpretation of its findings, strengthened my research skills and expanded the impact of the results immensely.

To my unofficial committee, Dr. Langan and Dr. Pierson, I will never be able to thank you enough. We have grown and adapted together over the last 5 years, and I am so appreciative to you both. I look forward to many more years of “consultations.” I am a better psychologist by having you in my corner. We did it!

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## CHAPTER 1

### “THE RELATIONSHIP BETWEEN NARCISSISM AND POSTTRAUMATIC SYMPTOMS IN ADJUDICATED YOUTH: AN EXPLORATORY STUDY”

#### **Introduction**

##### **Statement of the Problem**

The literature on trauma and narcissism has demonstrated a strong relationship between the two. However, most of those studies are conducted with the researchers viewing trauma as the etiological basis for narcissism (Campbell et al., 2004; Clemens et al., 2022; Kauten et al., 2013). Few have explored how possessing narcissistic traits may impact an individual's response to traumatic experiences (Levi & Bachar, 2019; Montoro et al., 2022). Additionally, studies of narcissism and trauma in the juvenile offender population tend to occur after the young person has been exposed to one or more traumas and has found themselves in legal trouble, making it difficult to be confident about the direction of this relationship. Juveniles who come into contact with the legal system are significantly more likely to have experienced trauma than youth in the general population (Abram et al., 2013; Young et al., 2017), and experiencing arrest and adjudication has been viewed as traumatic, as well (Hargons et al., 2022; Jackson et al., 2019; Pickett et al., 2022). It is estimated that between 60 and 90% of juvenile offenders experience a traumatic event in their childhood (Abram et al., 2013; Young et al., 2017). It is also common for juveniles who are legally detained either before or after adjudication to experience further victimization within the legal system (Yoder et al., 2019). Therefore, assessing for the prevalence of narcissism and other personality constructs in juvenile offenders tends to occur after one or more traumatic experiences have already occurred.

Narcissism has frequently been linked to delinquency and recidivism in incarcerated populations (Barry et al., 2009; Calhoun et al., 2000; Herrington et al., 2014). However, much of the current research on narcissism utilizes data from adult populations (Barry et al., 2007a), meaning the relationship between narcissism and trauma in adolescent populations, particularly juvenile offenders, is less understood. More specifically, the research on adaptive and maladaptive narcissism in juvenile offenders is lacking (Barry et al., 2007a). However, there is evidence that the presence of narcissism has an impact on juvenile offenders and their experiences with the legal system. Juvenile offenders with narcissistic traits, primarily those high in maladaptive narcissism, are more likely to receive disciplinary citations, demonstrate aggression, and experience emotional problems (Barry & Wallace, 2010; Calhoun et al., 2000; Herrington et al., 2014; Washburn et al., 2004). The DSM-5-TR (APA, 2022) explains that, for individuals high in narcissism, experiencing an exceptionally upsetting, challenging, or traumatic event, sometimes referred to as an "ego threat," can exacerbate mental health symptoms to the point of clinical significance. Arrest and incarceration, especially for a young person, can be upsetting or traumatic.

It is important to consider the impact of being involved with the legal system on juvenile mental health. Some research suggests that exposure to the juvenile justice system, in the form of police stops, arrests, detainment, and adjudication, can exacerbate mental health problems (Hargons et al., 2022; Jackson et al., 2019; Pickett et al., 2022). These experiences can also lead to the development of posttraumatic symptoms, which can present long-term mental health difficulties. However, in the short term, posttraumatic symptoms can become problematic for individuals upon their placement in juvenile residential facilities. Symptoms associated with trauma exposure include recurring nightmares, intrusive thoughts or images, anxiety or

nervousness, avoidance, emotional dysregulation, dissociation, increased arousal, and hypervigilance, leading to irritability and angry outbursts (SAMHSA, 2014). Hypervigilance can lead an individual to believe they are in danger when, in fact, they are not. Youths with these symptoms, in addition to disrupted impulse control, are more likely to receive disciplinary referrals for violent and non-violent behavior problems (Hirst et al., 2017). Treatment programs that adequately assess for and treat trauma and posttraumatic symptoms have been shown to successfully reduce trauma symptoms, disciplinary referrals, and instances of violence, as well as communication between juvenile offenders and facility staff (Baetz et al., 2021; Zettler, 2021).

The high prevalence of trauma in juvenile offenders, as well as the similarity in how posttraumatic symptoms and narcissistic tendencies manifest in secure facilities, makes it difficult to determine their exact relationship. Specifically, it is difficult to know if the narcissistic features prevalent in the juvenile offender population are a result of traumatic experiences, as well as what the prevalence of narcissism might be in this population without the high level of exposure to trauma. Additionally, we know very little about how trauma may be experienced and navigated differently in individuals who are high in narcissism.

After a thorough search of the literature, only two studies appeared to have looked at the relationship between the presence of narcissistic traits and individuals' posttraumatic symptoms (Levi & Bachar, 2019; Montoro et al., 2022). Both studies utilized adult participants and had somewhat conflicting results. The former found that narcissism moderated the relationship between posttraumatic growth and posttraumatic symptoms, with those high in narcissism showing a positive correlation between the two (Levi & Bachar, 2019). The authors suggest this is a result of individuals high in narcissism using more maladaptive methods of achieving posttraumatic growth, leading to the experience of posttraumatic symptoms, as well. The latter,

Montoro et al. (2022), found that some aspects of narcissism, like self-sufficiency and vanity, could negatively predict the frequency and severity of posttraumatic symptoms. They also found that even those high in grandiose narcissism had positive emotional outcomes in the presence of positive affect and resilience. In this study, the aspect of narcissism that led to the worst posttraumatic outcomes was entitlement (Montoro et al., 2022). Despite inconsistent results, both studies agree that narcissism can alter one's perception of and response to stress, such as that associated with traumatic events.

### **Purpose of the Study**

Much of the current literature on trauma and narcissism has hypothesized and argued that trauma is an etiological basis for the development of narcissistic traits (Campbell et al., 2004; Clemens et al., 2022; Kauten et al., 2013). However, more recent research has begun to explore how possessing narcissistic traits at the time of the traumatic event can impact the development of posttraumatic symptoms (Levi & Bachar, 2019; Montoro et al., 2022). This study aims to take a step back and explore the relationship between narcissism and posttraumatic symptoms in juvenile offenders, with particular attention to the differences in posttraumatic symptoms for those with adaptive vs. maladaptive narcissism.

Narcissism has traditionally been associated with adverse mental, emotional, and interpersonal outcomes. However, some aspects of narcissism in adolescence have been shown to promote the healthy development of one's sense of self (Barry & Wallace, 2010). This study could help clarify the benefits that some narcissistic traits may have on mental health outcomes, including the potential that adaptive narcissism could function as a protective factor against the development of posttraumatic symptoms.

Finally, utilizing this data is essential, as the goal of the Juvenile Counseling and Assessment Program (JCAP) was to improve mental health access and outcomes for juvenile offenders. JCAP collected data from juvenile offenders over 25 years as the juvenile justice system was rapidly evolving. Therefore, it can capture these constructs over time. This research will allow us to better understand the way trauma and narcissism can be assessed and treated in juvenile offenders, as well as how intervention of this nature may improve mental health outcomes in this population.

### **Definition of Terms**

#### ***Juvenile offender***

In this study, a juvenile offender is an individual under the age of 18 who has been convicted of a status or criminal offense. Juvenile offender and adjudicated youth will be used interchangeably.

#### ***Adjudication***

Adjudication is the final legal ruling or judgement reached at the close of a case, in which the judge has made a decision that resolves an issue between two parties. In this study, adjudicated youth refers to a juvenile offender who has been sentenced by a judge.

#### ***Adaptive narcissism***

Adaptive narcissism typically refers to the healthy aspects of narcissism, including high confidence, assertiveness, self-sufficiency, as well as methods of self-enhancement (e.g., successful self-exhibitionism, self-aggrandizement) that are socially acceptable (Cai & Luo, 2018).

#### ***Maladaptive narcissism***

Maladaptive narcissism describes a more traditional view of narcissism, including defensiveness, aggression, egotism, and socially unacceptable methods of self-enhancement (e.g., exploitation of others, lack of empathy; Cai & Luo, 2018).

### ***Trauma***

Trauma refers to both experiencing a traumatic event and the symptoms that occur as a result of experiencing a traumatic event. The term trauma does not indicate the presence of a diagnosable disorder. Trauma that results in symptomology meeting diagnostic criteria for posttraumatic stress disorder (PTSD) will be referred to as PTSD.

### ***Posttraumatic symptoms***

Posttraumatic symptoms can include avoidance of people, places, things, and thoughts related to the trauma, as well as emotional dysregulation, increased anxiety and arousal, sleep disruption, nightmares, and hypervigilance (SAMHSA, 2014). Individuals may experience posttraumatic symptoms that warrant clinical attention with or without a diagnosis of PTSD.

### **Research Questions**

1. What is the relationship between narcissism and self-reported posttraumatic symptoms in a sample of juvenile offenders?
2. What is the relationship between maladaptive narcissism and posttraumatic symptoms in a sample of juvenile offenders?
  - a. Is there a relationship between any of the individual scales of maladaptive narcissism (Exploitativeness, Entitlement, Exhibitionism) and posttraumatic symptoms in a sample of juvenile offenders?
3. What is the relationship between adaptive narcissism and posttraumatic symptoms in a sample of juvenile offenders?

- a. Is there a relationship between any of the individual scales of adaptive narcissism (Vanity, Authority, Superiority, Self-Sufficiency) and posttraumatic symptoms in a sample of juvenile offenders?
4. What is the relationship between narcissism and clinical significance on the Child Report of Posttraumatic Symptoms (CROPS)?

## CHAPTER 2

### **Review of Relevant Literature**

The Office of Juvenile Justice and Delinquency Prevention (OJJDP; Ryan & La Vigne, 2022) reports that juvenile arrests have decreased by 84% since peaking in 1996, when over 2.5 million juveniles were arrested in a single year. In 2019, fewer than 500,000 juvenile arrests were made, with 1 in 10 (about 50,000) youth experiencing detainment in detention centers, jails, or prisons (Jones & Scherer, 2021). With the unprecedented number of juveniles who were incarcerated in the late 1990s and early 2000s, great strides were made to improve access to mental health services for youth who come into contact with the legal system, including the creation of programs such as JCAP. These efforts resulted in findings that community-based alternatives to incarceration resulted in lower rates of re-offending, even for youths who had committed severe offenses (Underwood & Washington, 2016).

Since then, a greater reliance on the legal system to facilitate mental health treatment has developed. Juvenile mental health courts have expanded and connected youth with mental health services in the community under close supervision by a judge (Gardner, 2011). However, as of 2004, this problem had not been entirely resolved, with a congressional study finding that nearly 2,000 juveniles were being detained on any given day simply due to the lack of community mental health alternatives to which they could be referred (Gardner, 2011). Over half of states in the U.S. can hold a juvenile in a detention center based solely on mental health reasons, which, combined with a lack of resources, is impeding rehabilitative efforts. Additionally, it has shifted the burden onto the juvenile justice system to provide adequate mental health services to this vulnerable population (Underwood & Washington, 2016).

## **Mental Health in the Juvenile Offender Population**

Mental health problems are highly prevalent among juvenile offenders, with researchers estimating that between 50 and 75% of adolescents who come into contact with the legal system meet diagnostic criteria for some mental health disorder (Underwood & Washington, 2016; Vincent et al., 2008). These data are in stark contrast to the 14% of youth in the general public who reported experiencing a mental health issue (World Health Organization, 2021). Teplin et al. (2002) conducted one of the most comprehensive studies of mental health concerns in detained juvenile offenders, finding a similar six-month prevalence rate of 66.3% for boys and 73.8% for girls who met diagnostic criteria for at least one mental health disorder as outlined in the Diagnostic and Statistical Manual of Mental Disorders, 3<sup>rd</sup> edition (DSM-III; APA, 1980). These prevalence rates remained largely consistent, 60.9% and 70%, respectively, when the researchers controlled for conduct disorder, a common diagnosis among juvenile offenders. A longitudinal study called the Pathways to Desistance surveyed more than 1,300 juvenile offenders for seven years after their involvement with the legal system, tracking their mental health (Schubert et al., 2011; Schubert & Mulvey, 2014). This study found that 39% of youths with legal system involvement met the criteria for more than one mental health diagnosis, with substance use being the most common mental health concern (76%). Other mental health issues, like anxiety (33%), attention-deficit/hyperactivity disorder (ADHD; 14%), depression (12%), posttraumatic stress disorder (PTSD; 12%), and mania (7%) were also reported in this sample.

Although this relationship is not causal, the significant correlations between mental health and juvenile offending support the idea that mental health problems are common precipitants of juvenile offending (OJJDP, 2017). Specifically, the presence of externalizing disorders, such as conduct disorders, oppositional defiant disorders, antisocial traits, and

substance use disorders, was significantly related to juvenile recidivism (Baglivio et al., 2014; Wibbelink et al., 2017). The risk factors for developing mental health concerns and behavioral problems are similar. For example, exposure to violence and abusive/neglectful parenting have been identified as risk factors that can increase the likelihood of youth developing both mental health problems and behavioral issues (Finkelhor et al., 2009; Zeanah & Humphreys, 2018). Additionally, more than 90% of youths detained in the legal system report experiencing at least one traumatic event, with approximately 84% reporting more than one traumatic experience (Abram et al., 2013).

It is also important to consider how exposure to the juvenile justice system can exacerbate mental health problems (OJJDP, 2017). Jackson and colleagues (2019) conducted a study looking at the impact of police contact with nearly 1,000 at-risk youth on the mental health outcomes of those youth, finding that more frequent contact with police led to increases in emotional distress and posttraumatic symptoms after each encounter. Youths who were stopped by school officers or arrested from school reported the highest levels of emotional distress due to the added social stigmatization of police contact. They also found that officer behavior during these encounter(s) was especially predictive of mental health impact, with behaviors such as frisks/pat downs, use of harsh language, use of racial slurs, and threats or use of physical force leading to significant increases in emotional distress and posttraumatic symptoms (Jackson et al., 2019).

Additionally, the frequent instances of police brutality against people of color, particularly Black men and boys, and their widespread media coverage have led to a fear of being stopped by police in many communities (Graham et al., 2020; Hargons et al., 2022; Ouss & Rappaport, 2020; Pickett et al., 2022). Black Americans are also more likely to be harassed by

police and treated as suspicious during routine stops (Jones, 2014). The American Psychological Association released a resolution on police use of force in August 2022, calling for "police reforms aimed at curbing use[s] of force and protecting marginalized populations." Juveniles are not exempt from the experience of police brutality. In 2021, the Associated Press released data from 25 police departments in 17 states on their use of force against children under 16. The data revealed approximately 3,000 instances of force over 11 years, with the most common types of force being takedowns, strikes, and muscling, followed by firearms being pointed at or used on children (Wieffering et al., 2021). Half of these instances involved Black children. For juveniles in communities of color who have not experienced being stopped by police, this knowledge of the legal system is still present through defensive legal socialization, or "the talk" that Black families report having with their children (Gonzalez, 2019; Harris & Amutah-Onukagha, 2019). These conversations serve to communicate a distrust of uniformed officers, ways of avoiding police contact, and how to best avoid getting hurt in the event of police contact. The experiences of brutality and legal socialization have a lasting impact on how communities of color view the police and can further exacerbate the adverse mental health outcomes associated with police contact for Black children and adolescents (Pickett et al., 2022).

The negative impact of the legal system on mental health does not end when police contact ends; this impact carries over into the correctional facilities, as well. While many people romanticize the legal system as being rehabilitative, there are consistent data, Department of Justice (DOJ) reports, news stories, and anecdotes from incarcerated persons that conflict with the idea that rehabilitation is occurring in our correctional facilities (O'Brien & Foussard, 2019). In fact, incarcerated individuals are experiencing the extreme opposite: further exposure to, and normalization of, aggression and abuse. Incarcerated individuals of all ages can experience

legally sanctioned uses of force within facilities, such as solitary confinement, chemical munitions, and physical restraints, which has been shown to worsen mental health problems (O'Brien & Foussard, 2019; OJJDP, 2017). In juvenile facilities, there have been reports of “violence at the hands of the adults in positions of authority, including physical, psychological, and sexual violence by police, security officers, prison wardens, and various criminal justice actors including prosecutors and judges” (O'Brien & Foussard, 2019). Additionally, violence perpetrated by other detained adults or juveniles is not uncommon (Bureau of Justice Statistics, 2023; Vivian et al., 2007). Finally, detention of juvenile offenders can have adverse effects on mental health due to overcrowding, lack of treatment options, and disconnection from supportive family and friends (OJJDP, 2017).

### ***Mental Health Treatment for Juvenile Offenders***

Mental health needs often go unmet in the juvenile offender population (Young et al., 2017). In 2016, 99% of facilities reported evaluating some youth for mental health issues; however, only 60% reported evaluating all youth, regardless of any indication of the need for services (Hockenberry et al., 2016). Further, screening for mental health problems does not necessarily mean referral to treatment or availability of treatment options. Studies in Tennessee and southern California (Breda, 2003 and Rogers et al., 2001, respectively) found that only 4-6% of youths were referred to mental health services, despite research estimating that, on average, 70% of juvenile offenders meet criteria for at least one mental health disorder. The Northwestern Juvenile Project found that only 15% of juveniles diagnosed with a mental health disorder received treatment while detained (Teplin et al., 2013). The United States Department of Justice (USDJ) reported that the availability of mental health services for justice-involved youth is frequently inadequate or non-existent (USDJ, 2011). Perceived barriers to treatment can also

impact youths receiving the help they need. Abram and colleagues (2015) surveyed detained juveniles with substance use problems and mental health disorders. They found that the most frequent barriers to treatment were the perceptions that their problems would go away without intervention, the uncertainty of whom to contact or where to go for help, and the perception that getting help was too difficult.

There are also racial and gender influences impacting the treatment disparities in the juvenile offender population. In general, youth of color are less likely to receive mental health or substance use treatment (Dalton et al., 2009; Spinney et al., 2016) and are more likely to be diverted to the legal system (Cauffman et al., 2005; Pope, 2019). Shelton (2005) found that nearly 50% of White youths who had a diagnosable mental health condition received services, while only 11.9% of Black youths with a diagnosable mental health disorder received those same services. Additionally, research has found that girls are more likely to be referred to treatment than incarcerated when compared to boys (Daurio, 2009). However, some studies hypothesize this is due to girls being more likely to report mental health symptoms.

When it is available and utilized, mental health treatment, including cognitive behavioral therapy (CBT) and multisystemic therapy, has been shown to reduce aggression, rearrests, recidivism, and total number of days incarcerated for juveniles more than other common interventions, like intensive supervision and juvenile offending awareness programs (e.g., Scared Straight; Hoogsteder et al., 2015; Petrosino et al., 2004; Timmons-Mitchell et al., 2006; Underwood & Washington, 2016). Unfortunately, justice-involved youths most often receive mental health treatment while being detained in detention centers, prisons, or jails (Underwood et al., 2014). This treatment includes addressing trauma, mood and anxiety disorders, self-harm, and criminogenic concerns (Young et al., 2017). However, upon their release, it is up to the

youth, their family, or their probation officer (if applicable) to facilitate mental health treatment with, in some cases, few community resources (Gardner, 2011).

### **Trauma in the Juvenile Offender Population**

Traumatic experiences are often the precursor to mental health symptoms and legal system involvement in children and adolescents (Abram et al., 2013; Zettler, 2021). In the Northwestern Juvenile Project conducted by Abram and colleagues (2013), 92.5% of detained juvenile participants reported experiencing at least one traumatic event, and 84% reported experiencing more than one. In a review of juvenile delinquency and therapeutic interventions, Young and colleagues (2017) estimate that 20 to 30% of the juvenile offender population meet the criteria for PTSD. To put these numbers into perspective, the general adult population has a 12-month prevalence rate of 3.5% for a diagnosis of PTSD, with the American Psychiatric Association (APA) reporting an even lower prevalence rate in children and adolescents (APA, 2022). Young and colleagues (2017) also found gender differences, with the rates of trauma for girls being more than double that of boys in the legal system. Additionally, they found that 62% of juvenile offenders experienced a traumatic event within the first five years of life, and 93% will have experienced a traumatic event before adulthood (Young et al., 2017).

Other research suggests that 5% of justice-involved youth ages 10-17 have experienced polyvictimization, with an average of 5 types of traumatic victimization. Poly-victimization occurs when individuals experience multiple types of victimization (e.g., physical abuse, sexual abuse, neglect, witnessing violence). Poly-victimization is not to be confused with repeated victimization, which occurs when an individual experiences multiple exposures to the same type of victimization (e.g., years of physical abuse by a parent; Yoder et al., 2019). Individuals may also fall into both of these categories, and both can lead to the development of PTSD or

posttraumatic symptoms. The traumas experienced by juvenile offenders include disproportionate rates of neglect, sexual abuse, exposure to substance use, and family violence (O'Brien & Foussard, 2019), making it no surprise that trauma is a focus of treatment for many juveniles within the legal system.

One of the most common ways clinicians and researchers evaluate for trauma in children and adolescents is through assessing for adverse childhood experiences (ACEs). The term ACEs comes from a 1998 study conducted by Felitti and colleagues looking at the effects of childhood trauma on long-term health outcomes. ACEs include traditional traumas (e.g., physical abuse, sexual abuse, witnessing violence), as well as experiences that may not be considered traumatic outside of childhood, like being left at home alone for multiple days, having a parent who is incarcerated, not having enough food to eat in the home, or having parents who are too drunk or high to care for a child's wellbeing. Felitti et al. (1998) found a direct dose-response relationship between the number of ACEs and adverse physical and mental health outcomes, meaning more exposures to traumatic events lead to more negative outcomes. Youth who have experienced four or more ACEs are up to 12 times as likely to experience chronic medical issues, such as heart disease, cancer, and lung diseases, and are significantly more likely to exhibit depression, suicidality, and violent behaviors (Felitti et al., 1998). As children develop, they learn different skills at different ages (e.g., how to talk ~1 year old, form relationships ~3-4 years old, do simple math ~7 years old). Experiencing a trauma during any of these stages can impact the development of those skills, causing additional impairment in functioning (Fox et al., 2015).

Perez and colleagues (2018) found that experiencing ACEs led to significant increases in aggression and impulsivity in juveniles, a dangerous combination that can lead to contact with the criminal justice system. Individuals who have experienced multiple ACEs, especially four or

more, also face the mental and physical health issues that arise from complex trauma. When trauma is not addressed through therapy or other interventions, the individual has a greater likelihood of being incarcerated, dropping out of school, experiencing housing and food insecurity, engaging in deviant behavior, or having an unstable family life, which can lead to additional traumatic experiences (Fox et al., 2015).

Baglivio and Epps (2016) provided a comprehensive discussion of the relationship between ACEs and juvenile offending using a sample of 64,329 juveniles who 1) had an arrest history in Florida and 2) turned 18 between 2007-2012, meaning they aged out of the juvenile justice system and had a "final" juvenile offense record. The researchers looked at the prevalence of ACEs and types of maltreatment across varying genders and ethnic groups. Consistent with other trauma research, their study found individuals in the legal system to have a higher number of ACEs than the general population. Additionally, they found females in the juvenile justice system to have a higher prevalence of ACEs than males, and their data suggest that the types of ACEs experienced differ by gender and ethnicity (Baglivio & Epps, 2016). The least prevalent ACE was family mental illness (9%), and the most prevalent was family violence (82%). Only 3% of males and 2% of females in this sample of high-risk youth reported no ACE exposures. Equal proportions of Black and White youth reported exposure to four or more ACEs (50%), while 40% of Hispanic youth and 39% of "Other" youth reported the same level of exposure. At 22%, a higher percentage of White youth experienced six or more ACEs than any other group.

In a small study of youth on probation in Chicago, 93% of the sample reported exposure to at least one traumatic event, and 12% met the full criteria for a diagnosis of posttraumatic stress disorder (PTSD) (Wilson et al., 2013). The most prevalent traumatic events reported by this sample were related to witnessing or some other exposure to violence. For this sample, being

involved with delinquent activities and other justice-involved youth made individuals far more likely to experience violence and victimization in their community (Wilson et al., 2013). As previously mentioned, it is this exposure to violence, either within their family or the community, that makes up the majority of traumatic experiences for youth in the legal system. Wilson and colleagues discovered that of the youth in this sample, 53% reported experiencing physical assault in their community, 77% reported seeing a physical assault in their community, 74% reported hearing about the violent death or severe injury of a loved one, and 38% reported seeing a dead body. Additionally, their results suggested that being exposed to traumatic events was positively correlated with both internalizing and externalizing comorbid mental health symptoms (Wilson et al., 2013). Specifically, the number of traumatic events led to problems with mood, increased anxiety, and conduct issues.

Racial trauma, a result of experiencing racism, discrimination, or other race-related stressors, has historically been left out of the literature surrounding trauma in children and adolescents. Part of this is due to the prolific use of the ACEs measure in child and adolescent trauma research, which does not ask about racial trauma or race-related stress. However, the institutional racism present in the educational and legal systems, as well as racism present in society and law enforcement agencies, has a direct impact on the experiences of trauma and the development of posttraumatic symptoms in youth of color, who are overrepresented at all stages of the legal system (Alexander, 2010; Johnson, 2018; Lacey, 2013). Additionally, the externalization of mental health symptoms in youth of color, resulting in behavioral problems in school or the community, is often overcriminalized (Johnson, 2018). In 2010, youth of color accounted for 71% of the United States's detained juvenile population (Lacey, 2013). The racial disparities in how youth enter into and process through the legal system, as well as the

experience of race-related stress as a result of negative law enforcement interactions with people of color, make it imperative to account for racial trauma and race-related stress in our assessment and treatment of trauma. If not, we risk missing a key factor relevant to the traumatic experiences of the majority of youth receiving services in our legal system.

As previously mentioned, youth who are detained rather than released on probation are likely to be further victimized within the system, as well. Using a sample of 7,073 incarcerated juveniles, Yoder and colleagues (2019) explored "both composite and cumulative effects of childhood victimization" on future victimization within correctional facilities. They included experiences of sexual and physical abuse within the facility and robbery. They also attempted to assess the mediating role of trauma symptoms. Findings reinforced the idea that early victimization was predictive of subsequent victimization within the facility and exacerbation of trauma symptoms. Youths with a poly-victimization history were 2.5 times more likely to experience sexual assault within the facility. Additionally, trauma symptoms fully mediated the relationship between cumulative victimization and future facility revictimization, and this revictimization exacerbated trauma symptoms. This finding provides important information, as youths within secure facilities reported experiencing 12-20 traumatic stressors, including witnessing, experiencing, or being threatened with physical or sexual assault. Yoder and colleagues (2019) posit that this within-system victimization (as well as revictimization in society) is more likely to happen if the individual has experienced poly-victimization prior to incarceration. It is hypothesized that experiencing multiple forms of victimization can create vulnerabilities, often in the form of trauma symptoms, that make an individual more at risk for facing subsequent trauma.

### *Addressing Trauma and Posttraumatic Symptoms in Treatment*

**Assessment of Trauma.** As evidenced, trauma is a widespread problem for youth who are involved with the legal system. There has been a push for officers and authorities in the legal system to learn trauma-informed practices for engaging with youth in ways that do not cause trauma or additional trauma, as well as helping them overcome the trauma they have experienced (Lacey, 2013; Zettler, 2021). Proper screening and assessment provide a better understanding of each individual's presenting concerns and are necessary for effectively treating youths' trauma and posttraumatic symptoms (Baetz et al., 2021). The National Child Traumatic Stress Network recommends assessing for a wide range of traumatic events and ascertaining when they occurred over time so they may be linked to the developmental stages.

Some of the most commonly used assessments of traumatic experiences are the ACEs measure (Felitti et al., 1998), the UCLA Child/Adolescent PTSD Reaction Index (Kaplow et al., 2020), the Brief Trauma Questionnaire (BTQ; Schnurr et al., 1999), and the Life Events Checklist for DSM-5 (modified for children; Weathers et al., 2013). Some of the most widely used assessments of posttraumatic symptoms are the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), the Child Report of Posttraumatic Symptoms (CROPS; Greenwald & Rubin, 1999), and the Child Posttraumatic Symptom Scale for DSM-5 (CPSS-5; Foa et al., 2017). Other assessments, like the Structured Trauma-Related Experiences and Symptoms Screener (STRESS; Grasso et al., 2019), can assess for both traumatic events and resulting posttraumatic symptomology.

Symptoms associated with trauma and ACE exposure include recurring nightmares (leading to lack of sleep and lowered conscious awareness), intrusive thoughts or images, anxiety or nervousness, avoidance of thoughts, people, places, and things, emotional dysregulation,

dissociation, and increased arousal, leading to angry outbursts and hypervigilance (SAMHSA, 2014). Treating youths' trauma symptoms may also be beneficial for the legal system because youth with trauma histories are more likely to receive disciplinary referrals for violent and non-violent acting out (Hirst et al., 2017), and trauma treatment has been shown to reduce these instances of juvenile violence (Baetz et al., 2021). Traumatized youths often act out due to hypervigilance and disrupted impulse control. Hypervigilance can lead individuals to believe they are in danger when they are not (Hirst et al., 2017). This reaction can occur in situations that resemble that of the trauma or in novel, seemingly dangerous situations. The individual prepares to "fight or flight," both inappropriate (although adaptive) responses within a secure facility.

**Treatment of Trauma in Juvenile Offenders.** The overwhelming evidence of trauma and posttraumatic symptoms in this population has led to the development of several trauma-informed treatments and programs for use with juvenile offenders. Zettler (2021) provided a review of trauma-informed treatments used with juvenile offenders. This review identified CBT, as well as several CBT-based programs, as being frequently used by therapists in correctional settings. CBT has been shown to effectively reduce symptoms of posttraumatic stress, depression, and anxiety, as well as violence, recidivism, and other problem behaviors (Zettler, 2021). CBT-based trauma treatment programs include Seeking Safety; Structured Sensory Interventions for Traumatized Children, Adolescents, and Parents (SITCAP); Cognitive Behavioral Interventions for Trauma in Schools; Trauma and Grief Component Therapy for Adolescents; Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT); and others (Zettler, 2021). Rhoden et al. (2019) reviewed articles looking at the effect sizes found when using specific trauma treatments and interventions, finding the largest effect sizes for Imagery Rehearsal Therapy (IRT) and Cognitive Processing Therapy (CPT).

A review of these programs found similar rates of symptom reduction across studies, suggesting treatment itself is effective in reducing posttraumatic symptoms for this population. Notably, TF-CBT had the strongest empirical support of any program (Zettler, 2021). In general, treatment programs that adequately assess for trauma symptoms, consider the juvenile from a holistic perspective, use evidence-based practices, and provide practical skills for navigating probation or incarceration have been shown to be successful in reducing trauma symptoms, disciplinary referrals, and instances of violence, as well as improving communication between the juvenile and facility staff (Zettler, 2021).

### **Narcissism in Juvenile Offender Population**

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR; American Psychiatric Association, 2022) describes narcissistic personalities as including patterns of pervasive grandiosity, need for admiration, and lack of empathy for others that appear before early adulthood. This pattern can manifest behaviorally as grandiose behaviors or fantasies, arrogance, a sense of entitlement and "specialness," or a willingness to exploit others to achieve one's own goals (APA, 2022). The prevalence of narcissism has not been well-established in adult or adolescent populations due to challenges in accurate assessment (Mitra & Fluyau, 2020). However, most research has attempted to determine the prevalence of narcissism in adult community and clinical samples. This research estimates prevalence rates of narcissism in adults ranging from 0.5% to 5% in community samples and 1% to 15% in clinical samples (Mitra & Fluyau, 2020). The DSM-5-TR describes a median prevalence of 1.6% in adult populations (APA, 2022).

An epidemiological study on alcohol and related conditions interviewed 34,653 adults, finding a lifetime prevalence rate for narcissistic personality disorder (NPD) of 6.2%, with

significantly higher rates found in men (Stinson et al., 2008). With regard to racial differences, several studies have shown Black American men and women and Hispanic women to have significantly higher odds of receiving an NPD diagnosis (Stinson et al., 2008; Wetzel et al., 2017). Additionally, White Americans scored higher on narcissism measures than Asian Americans (Wetzel et al., 2017). In adults, individuals aged 20-29 had higher rates of narcissism than any other age group, with prevalence rates decreasing as age increased (Stinson et al., 2008). NPD is most often comorbid with depressive disorders and substance use concerns (APA, 2022). The etiology of narcissism is also not well understood, with many studies linking parenting styles and traumatic experiences to the development of narcissism and other etiological factors being inconsistently supported (Clemens et al., 2022).

Traditionally, narcissism has been viewed negatively and associated with poor behavioral, emotional, and interpersonal outcomes (Coleman et al., 2022). In adolescents, narcissism has been found to be a predictor of behavioral and emotional problems, specifically conduct problems, aggression, and internalizing symptoms (Barry & Wallace, 2010; Washburn et al., 2004). It has been linked to adolescent entitlement, a sense of superiority, boastfulness, and a willingness to exploit others (Herrington et al., 2014). Youth narcissism has also shown strong relationships with drug use, risk-taking, recidivism, and juvenile offending, particularly violent offending (Calhoun et al., 2000; Herrington et al., 2014). However, narcissism has also been conceptualized by researchers as early as Kohut (1977) as a normative, healthy dimension of personality that aids in the development of an adolescent's sense of self and allows them to confidently tackle new situations and problems (Barry & Wallace, 2010). Even today, researchers have suggested narcissism was prematurely labeled as entirely negative or

maladaptive, guaranteed to lead to poor outcomes (Barry et al., 2009), leading modern researchers to attempt to distinguish adaptive from maladaptive aspects of narcissism.

Today, adaptive narcissism includes traits like a sense of authority, leadership, self-sufficiency, superiority, and vanity (Barry et al., 2007a). The more unhealthy and pathological side of narcissism, which includes an overly inflated and unstable sense of self and the need for approval and acknowledgment from others to maintain a positive self-image, is referred to as maladaptive narcissism. It includes constructs like exploitation of others, exhibitionism (i.e., engaging in behaviors intended to draw attention to the self), and a sense of entitlement (Barry et al., 2007a). Some researchers identify adaptive and maladaptive narcissism as separate constructs that warrant unique attention and suggest it may be meaningful to distinguish between the two, particularly in youth who are in crucial stages of identity development (Barry et al., 2007a). Maladaptive and adaptive narcissism are correlated with one another but have different relationships with other variables (Frick et al., 2010; Golmaryami & Barry, 2010). For example, adaptive narcissism in adolescents is highly correlated with self-esteem and social skills, and maladaptive narcissism is not. Maladaptive narcissism in adolescence is highly correlated with psychopathy-linked narcissism, as measured by the Antisocial Process Screening Device (APSD; Frick & Hare, 2001), and had a strong negative relationship with self-reliance, whereas adaptive narcissism did not (Barry et al., 2010). Additionally, although maladaptive narcissism has been consistently related to delinquency, adaptive narcissism was unrelated to delinquency (Barry et al., 2007a).

The social-personality conceptualization of narcissism posits that it is a normative dimension of personality. From this perspective, some researchers argue that adaptive and maladaptive narcissism coexist at two ends of the same spectrum, with the maturity of one's self-

regulation skills determining on which end of the spectrum one falls (Roche et al., 2013). Kohut (1977) also suggested self-regulation is crucial to distinguishing adaptive and maladaptive narcissism, with adaptive narcissism allowing individuals' narcissistic goals (i.e., admiration, acknowledgment, self-enhancement) to be met through more appropriate, less impulsive means. However, Kohut's (1997) research posited that parenting factors were most relevant to determining which self-regulation strategies would be developed, with supportive and empathic parenting facilitating a more adaptive form of narcissism. Conversely, maladaptive narcissism has been positively correlated with both child and parent reports of harmful parenting practices (Barry et al., 2007a). Regardless of the theoretical basis, adaptive and maladaptive narcissism have been shown to directly impact behavioral, psychological, and interpersonal outcomes in children and adolescents.

### ***Maladaptive Narcissism***

As discussed previously, maladaptive narcissism has been linked to poor social adjustment, as well as behavior problems and delinquency in children and adolescents, even when controlling for other risk factors (Barry & Wallace, 2010; Barry et al., 2007a). It is also negatively associated with self-esteem, and self-esteem has been shown to mediate the role between maladaptive narcissism and various adverse outcomes, like aggression, exploitation of others, anxiety, and depression (Lau et al., 2011). These outcomes also suggest that maladaptive narcissism can lead to both internalizing and externalizing mental health symptoms. Within residential settings, maladaptive narcissism was more predictive of disciplinary citations than youths' self-reported history of behavior problems and delinquency (Herrington et al., 2014). Specifically, in adolescents, the exploitativeness aspect of maladaptive narcissism has been associated with aggression, and exhibitionism (i.e., the need for admiration, acknowledgment, or

attention) has been associated with internalizing symptoms (Washburn et al., 2004). As measured by the Narcissistic Personality Inventory (NPI), maladaptive narcissism consists of exploitativeness, entitlement, and exhibitionism (Raskin & Terry, 1988).

### ***Adaptive Narcissism***

Adaptive narcissism has not shown a similar relationship with delinquency, aggression, or behavior problems. Adaptive narcissism tends to be positively correlated with self-esteem, confidence, assertiveness, and social skills (Barry et al., 2009; Herrington et al., 2014) and negatively correlated with most common mental health concerns, like anxiety and depression, as well as goal-instability and external control (Calhoun et al., 2000; Lapsley & Aalsma, 2006). Particularly in more individualistic societies, such as in the United States, aspects of adaptive narcissism may even be encouraged by parents, teachers, sports coaches, and other role models in the child's life (Barry et al., 2009). Those with adaptive narcissism can use social skills like self-promotion, confidence, charisma, and leadership to meet their needs through social interactions and publicized achievements/successes (Campbell et al., 2006). Other studies have found adaptive narcissism to be related to resilience (Sedikides et al., 2004). As measured by the Narcissistic Personality Inventory (NPI), adaptive narcissism consists of authority, superiority, self-sufficiency, and vanity (Raskin & Terry, 1988).

### ***Addressing Narcissism in Treatment***

Carlson and Gjerde (2009) found predictors of future narcissism that can be identified in early childhood and adolescence. Narcissism may be particularly relevant in adolescence as the individual tries to form a self-concept that is impervious to the criticism and social pressures associated with adolescence (Barry et al., 2009). Additionally, narcissism is positively correlated with invulnerability (i.e., perceived immunity from emotional or physical injury), which is also a

common trait in adolescence (Aalsma et al., 2006). With extensive research showing narcissism is prevalent in adolescence, and the adverse outcomes associated with maladaptive narcissism in adulthood (Montoro et al., 2022), it is surprising that this aspect of personality is rarely assessed or addressed in treatment.

Part of the hesitation to address narcissism in treatment, particularly in adolescents, may be due to the apparent issues that come with assigning the label of "narcissist" to a child or adolescent, particularly given that one's sense of self in childhood and adolescence is unstable and almost guaranteed to change (Barry & Wallace, 2010). Additionally, research suggests there are elements and traits of narcissism present in most children and adolescents, serving useful functions for development (Kauten & Barry, 2016). However, the assessment and treatment of narcissistic traits, without diagnosing or pathologizing, can be beneficial. Particularly for juvenile offenders, assessing for narcissism, specifically maladaptive narcissism, may be useful in predicting and understanding adolescent functioning within secure facilities.

**Assessment of Narcissism.** The Narcissistic Personality Inventory (NPI; Raskin & Terry, 1988) has been the most widely used measure in narcissism research over the last 35 years. The NPI was created to measure the behavioral criteria of narcissistic personality disorder (NPD) as it was defined in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III; American Psychiatric Association, 1980). Its popularity in research has led to derivatives of the measure being created for younger populations, including the Narcissistic Personality Inventory – Children (NPI-C; Barry et al., 2003) and the Narcissistic Personality Inventory – Juvenile Offender (NPI-JO; Calhoun et al., 2000). The use of the NPI in research has helped in defining adaptive and maladaptive narcissistic traits. However, we are still unsure to what extent narcissistic traits are typical in children and adolescents, how these traits are utilized adaptively

to face social and other developmental challenges, and whether youth personality traits remain stable into adulthood (Barry & Wallace, 2010). The NPI is also congruent with the social-personality theory of narcissism, as it assesses adaptive narcissism as a normative dimension of personality characterized by mature self-regulation strategies (Roche et al., 2013). Notably, the NPI does not assess for the distress caused by the reported narcissistic traits.

Other assessments of narcissism include a narcissism scale on the youth version of the Antisocial Process Screening Device (APSD; Frick & Hare, 2001). The APSD is primarily a measure of psychopathy, however, it measures narcissism as an aspect of psychopathy. The narcissism scale on the APSD has been predictive of aggression and antisocial behaviors in children and adolescents (Barry et al., 2007b), and it has been significantly correlated with parent reports of conduct problems (Barry et al., 2010). This scale is behaviorally focused and does not tap into the adaptive aspects of narcissism as much as others. The Child Narcissism Scale (CNS; Thomaes et al., 2008) is a relatively newer measure with strong internal reliability and consistency. Narcissism measures are commonly criticized as being too closely related to measures of self-esteem. Studies done by the authors of the CNS suggest it is unrelated to measures of self-esteem, as well as positively related to superiority and aggression after a threat to one's ego and negatively related to empathic concern for others (Thomaes et al., 2008). Finally, the Pathological Narcissism Inventory (PNI; Pincus et al., 2009) was developed to map onto clinical theories and presentations of narcissism in practice settings. The PNI primarily assesses for maladaptive self-enhancement strategies and how the individual responds to narcissistic injuries (i.e., ego threat).

**Treatment of Narcissism in Juvenile Offenders.** There is little research on how narcissism is addressed in treatment, and there are no standardized, evidence-based

psychological or pharmacological treatments for NPD (Dimaggio, 2021; Mitra & Fluyau, 2020). This paucity of research is particularly evident in the juvenile offender literature. The lack of research poses a challenge for therapists at a time when providing validated and empirically supported treatment has been deemed an ethical obligation (Knapp et al., 2024). However, there is evidence suggesting it is beneficial to address narcissism in treatment with adolescents, as narcissistic traits are associated with the healthy development of one's sense of self (Barry & Wallace, 2010). Additionally, narcissistic tendencies can become exacerbated and reach clinical significance amid extremely upsetting or challenging events or crises (APA, 2022), making it salient during adolescent contact with the legal system.

Some adaptations to existing treatments have shown promising results and empirical support. Most treatments for NPD and pathological narcissism stem from psychoanalytic theory and focus on transference and interpersonal processes within therapy (Kernberg, 1975; Kohut, 1971). A review of treatments for NPD and pathological narcissism by Dimaggio (2021) included treatments such as Mentalization Based Treatment (Drozek & Unruh, 2020); Transference Focused Therapy (Diamond & Hersh, 2020); CBT (Beck et al., 2015); Schema Therapy (Young et al., 2003); Metacognitive Interpersonal Therapy (Dimaggio & Attinà, 2012); Dialectical Behavior Therapy (Linehan, 2015; Reed-Knight & Fisher, 2011); and Clarification Oriented Psychotherapy (COP; Sachse, 2020). None of these therapies have been tested in a randomized controlled trial to assess their effectiveness in treating narcissism.

With this lack of research in mind, Dimaggio (2021) attempted to provide pragmatic, helpful solutions for therapists in treating clients with pathological narcissism, including strategies for "increasing self-reflection and reducing intellectualizing, reducing the impact of maladaptive thought processes and forming healthier and more flexible ideas about self and

others, supporting agency, counteracting maladaptive coping and promoting healthier ways of dealing with suffering, and promoting theory of mind and empathy." Literature from the social-personality research on narcissism could also help inform treatment, as it conceptualizes pathological narcissism as a set of primitive, immature self-regulation strategies for meeting needs and gaining recognition (Roche et al., 2013), which has direct implications for treatment.

### **Relationship Between Narcissism and Trauma**

Much of the literature on narcissism and trauma posits that childhood traumatic experiences are causal factors in the development of narcissistic features (Clemens et al., 2022; Kauten et al., 2013; Montoro et al., 2022). These traumatic experiences can include traditional traumas, such as physical and sexual abuse or neglect, or other experiences like emotional and psychological abuse, cold and uncaring parental figures, or overly critical parents (Mosquera & Gonzalez, 2011). In adults, one study showed that living close to a war zone was positively associated with the development of PTSD only for civilians high in narcissism (Besser et al., 2013) and PTSD has been positively associated with narcissism in samples of survivors of terrorism, car accidents, and workplace injury (Bachar et al., 2005; Levi & Bachar, 2019). These authors argued that the traumatic experiences "shattered the [narcissistic persons'] belief of omnipotent invulnerability," resulting in a narcissistic injury (Levi & Bachar, 2019). Trauma impacts one's sense of self, which can be compensated for by the development and utilization of narcissistic traits. The development of a grandiose sense of self or tactics that elicit praise, admiration, acknowledgment, and recognition from others can help individuals compensate for the lack of warmth, support, encouragement, or safety found during and after traumatic experiences (Clemens et al., 2022; Mosquera & Gonzalez, 2011). Some studies have also looked at biological factors related to narcissism, such as the level of autonomic arousal in response to

stress. Those high in narcissism report experiencing more frequent and varied stressors, making them more vulnerable to chronic stress (Coleman et al., 2019). These studies have produced inconsistent results but agree that narcissism can alter one's perception of and response to stress (Montoro et al., 2022).

Levi and Bachar (2019) looked at how narcissism may moderate the relationship between posttraumatic growth (i.e., positive psychological change as a result of experiencing trauma) and PTSD symptoms. Posttraumatic growth has been demonstrated in response to a multitude of traumatic experiences and includes things like having greater esteem for oneself and one's ability to survive and adapt, increased appreciation for close relationships, and reevaluating belief systems (Tedeschi & Calhoun, 2004). Levi and Bachar's (2019) results suggest narcissism does, in fact, moderate the relationship between posttraumatic growth and posttraumatic symptoms, with individuals high in narcissism showing a positive correlation between the two. The authors propose this may mean individuals high in narcissism are using more maladaptive means to achieve their posttraumatic growth, like self-deception and illusory defenses, and therefore also experience posttraumatic symptoms.

Recent research by Montoro and colleagues (2022) suggests that some of the underlying vulnerability to posttraumatic stress may be a result of narcissistic traits or NPD. Using the NPI as a measure of both adaptive and maladaptive/grandiose narcissism, they found that the frequency and severity of posttraumatic symptoms in those high in grandiose narcissism could be mediated by positive affect and resilience. Additionally, some aspects of grandiose narcissism were found to be strongly related to adaptive emotional outcomes, and positive affect and resilience were positively associated with most narcissism dimensions. Looking at individual scales on the NPI, they found self-sufficiency negatively predicted the frequency and severity of

posttraumatic symptoms, and vanity negatively predicted the frequency of these symptoms but not the severity. Further, the frequency of posttraumatic symptoms was positively related to entitlement. Entitlement was consistently associated with the worst posttraumatic outcomes. Montoro and colleagues (2022) suggest their findings could demonstrate that some narcissistic traits may be helpful in coping with traumatic experiences and could help clinicians develop a personalized approach to treatment. Other studies have supported the idea that assessing for and addressing narcissism during trauma treatment may lead to more effective mental health treatment following a traumatic event in childhood or adolescence (Clemens et al., 2022).

### **Present Study**

Given the inconsistent findings in the studies discussed above, as well as the focus on adult samples, further research is needed to determine the exact dynamic between narcissism and posttraumatic symptoms. Using a sample of juvenile offenders, this study aimed to explore the relationship between narcissism, both adaptive and maladaptive, and the presence of posttraumatic symptoms in adolescents involved in the legal system. The goal of this study was not to hypothesize the etiology of posttraumatic symptoms with respect to narcissism or, as has been done more commonly, hypothesize the etiology of narcissism with respect to traumatic experiences. Because the relationship between these constructs in this population is largely understudied, exploratory analyses were utilized with the hope of clarifying how narcissistic traits and posttraumatic symptoms are related in this sample.

## CHAPTER 3

### Method

#### Description of the Sample

Participants for the study were chosen retroactively from the Juvenile Counseling and Assessment Program (JCAP) database at the University of Georgia in the Department of Education. JCAP is comprised of faculty, masters-level, and doctoral-level students who provide individual, group, and family therapy, as well as psychological evaluations (conducted by doctoral-level clinicians), for youth involved in the juvenile justice system of Georgia. The purpose of this long-running program is to provide juvenile offenders with access to mental health services, psychoeducation, and knowledge regarding possible resources, which will ultimately lead to a decrease in delinquent behavior (Kadish et al., 1999). Procedures for the study were approved by The Internal Review Board at the University of Georgia.

Participants consisted of adolescents who were court-referred to JCAP for clinical services by the Georgia Department of Juvenile Justice (GA DJJ) following adjudication of delinquency or were detained in a regional youth detention center. Inclusion in this database is contingent on consent given by the parent on behalf of the juvenile and informed assent given by the juvenile themselves. Masters- and doctoral-level graduate clinicians collected the data for the study at the time of the participant's intake for JCAP services. Clinicians informed the participants that their decision to engage in JCAP research was voluntary and they would receive no direct gains or incentives for participation. Additionally, they were told that no identifiable information would be included in the research, and they could choose to leave the study at any point without consequence.

The sample ( $n=102$ ) was comprised of juvenile offenders who were seen for an intake interview for participation in JCAP between 2012 and 2017 and who completed both the Narcissistic Personality Inventory – Juvenile Offender (NPI-JO; Calhoun et al., 2000) and the Child Report of Posttraumatic Symptoms (CROPS; Greenwald & Rubin, 1999). Participants included in the sample were between 12 and 17 years of age. The sample consisted of cisgender female (58.8%) and male (41.2%) youth who were predominately African American/Black (67.6%). Table 3.1 depicts more detailed demographic characteristics of the sample.

**Table 3.1**

*Demographic Information*

Categorical Variables	Total (N = 102)	
	N	%
<b>Gender</b>		
Cisgender boy	42	41.2
Cisgender girl	60	58.8
<b>Ethnicity</b>		
African American/Black	69	68.3
Caucasian/White	14	13.9
Hispanic/Latinx	10	9.9
Multiracial/Other	8	7.9
<b>Continuous Variables</b>		
Age	<i>M</i> 14.9	<i>SD</i> 1.3
Grade Level	9.0	1.2

**Instruments**

*Narcissistic Personality Inventory – Juvenile Offender*

The Narcissistic Personality Inventory – Juvenile Offender (NPI-JO; Calhoun et al., 2000) was utilized as a measure of general narcissism, as well as maladaptive and adaptive forms of narcissism. The NPI-JO is a 40-item self-report measure designed to assess narcissism in

juvenile offenders (see Appendix A). It is a slightly revised version of the Narcissistic Personality Inventory (NPI), a research measure created by Raskin and Terry (1998) to assess for narcissism based on established DSM criteria. This measure was made applicable to juvenile offenders by changing the wording and reading level of the items. The items of the NPI-JO are at a third-grade reading level. Each item contains two statements, and participants are asked to choose which of the two statements describes them most accurately. If the participant endorses the more narcissistic statement, the item is scored as a "1". The item is scored as a "0" if the participant endorses the non-narcissistic statement. A total NPI-JO score is the sum of all the endorsed narcissistic statements.

The NPI-JO also provides seven subscale or factor scores, as well as total scores for Maladaptive Narcissism and Adaptive Narcissism. The seven subscales/factors include Vanity, Authority, Superiority, and Self-Sufficiency, which combine to form the Adaptive Narcissism total score, and Exploitativeness, Entitlement, and Exhibitionism, which combine to form the Maladaptive Narcissism total score. These seven factors are consistent with those from the original NPI developed by Raskin and Terry (1998).

### ***Child Report of Posttraumatic Symptoms***

The Child Report of Posttraumatic Symptoms (CROPS; Greenwald & Rubin, 1999) was utilized as the outcome measure, providing data on the trauma symptom presentation of the participants. The CROPS is a 26-item measure that has demonstrated validity and reliability in assessing a broad range of posttraumatic symptoms in children ages 7-17 (see Appendix B). This measure has been utilized in a variety of clinical settings internationally. The CROPS is beneficial in screening for posttraumatic symptoms with or without an identified trauma. This measure assesses a broad range of symptoms indicated in Fletcher's (1993) meta-analysis of the

literature on childhood trauma, including somatic symptoms, dysphoric symptoms, avoidance, and intrusive thoughts. The response format for the measure is a 3-point Likert scale, and youth are asked to report the severity of their symptoms within the last week (0=None, 1=Some, 2=Lots). The total score is calculated by summing the responses. CROPS scores above 19 suggest clinical significance/concern (Greenwald & Rubin, 1999).

Several studies have demonstrated the validity and reliability of the CROPS in various settings and languages, with a Cronbach's alpha of .9 (Greenwald & Rubin, 1999; Greenwald, 2008; Bocknek et al., 2009). Internal consistency was found for the CROPS with juveniles in a detention setting (Greenwald, 2002). Concurrent validity was found between the CROPS and the Lifetime Incidence of Traumatic Events Scale (Greenwald & Rubin, 1999). CROPS scores have also been found to correlate with the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) ( $r=.7$ ; Greenwald et al., 2001). The CROPS is responsive to changes in symptoms across settings, which gives it great clinical utility (Greenwald, 2002).

### **Data Collection and Procedure**

JCAP researchers collected data during the intake interview process for new admissions to the program. Interviews took place in a conference room at a Department of Juvenile Justice office building in northeast Georgia. Their parent or guardian typically accompanied them for the interview; however, they were asked to sit at opposite ends of a conference room table while completing self-report measures. Participants were asked to put away and silence any electronic devices or possessions that may be distracting. Measures completed by new participants were hand-scored by the clinician-researcher who completed the intake and then entered into the JCAP database in the Statistical Package for the Social Sciences (SPSS). Participants who had

completed both the NPI-JO and the CROPS were selected and entered into a separate database for this study.

Upon review of the database for the present study, participants who completed both measures of interest were removed if they had more than five missing responses. No participants had missing responses on the CROPS; however, approximately 15 had missing responses on the NPI-JO. For participants with five or fewer missing responses, single-item imputation was used to replace the missing data point with the participant's mean response on the corresponding scale. For example, if participant A did not answer Item 32 on the NPI-JO, which loads onto the Superiority subscale, their mean response on the Superiority subscale would be inputted as their response to Item 32.

### **Limitations**

The current study is limited due to its reliance on self-reported information provided by juveniles. These juvenile offenders were often mandated to receive treatment by the court, which could have limited their buy-in and, subsequently, their willingness to respond truthfully and with good effort. The generalizability and diversity of the sample may be limited because it consists only of juveniles who were court-referred for services by the Georgia Department of Juvenile Justice, making it not representative of the general population. Further, this sample is also not consistent with the typical demographic makeup of the juvenile justice system, of which boys make up approximately 90%, and Black youth make up approximately 40% of juveniles detained in facilities. The sample for the current study was comprised primarily of girls (58.8%) and Black/African American youth (68.3%). While it is encouraging that a large number of adolescents of color were receiving these services, as they are less likely to receive mental health or substance use treatment (Dalton et al., 2009; Spinney et al., 2016), it is unfortunate that

receiving such treatment required diversion into the legal system. These data highlight the continued racial inequities that lead to an overrepresentation of youth of color at all stages of the legal system (Alexander, 2010; Johnson, 2018; Lacey, 2013).

While the NPI-JO was normed using a JCAP sample, the generalizability of the findings may be limited due to the demographic differences in the norming samples of the CROPS. Finally, the data were collected over five years (2012-2017), approximately 7-12 years ago. Therefore, it does not account for how the COVID-19 pandemic may have impacted juveniles currently entering the system, including the trauma associated with the shared experience of surviving a pandemic and the differences in court processes post-pandemic.

### **Assumptions**

It is assumed that all participants answered truthfully and honestly on each of the instruments administered to them by JCAP student researchers. The administered instruments are also assumed to be valid, and any invalid measures have been removed from the sample. Finally, the student researchers are assumed to have correctly scored and entered the instruments into the dataset.

### **Hypotheses**

Hypothesis 1: Adaptive narcissism will be associated with lesser report of posttraumatic symptoms (i.e., lower scores on the CROPS).

Hypothesis 2: Of the adaptive narcissism subscales (Superiority, Authority, Vanity, Self-Sufficiency), self-sufficiency will be most negatively associated with the development of posttraumatic symptoms.

Hypothesis 3: Maladaptive narcissism will be associated with greater report of posttraumatic symptoms (i.e., higher scores on the CROPS).

Hypothesis 4: Of the maladaptive narcissism subscales (Exploitativeness, Entitlement, Exhibitionism), entitlement will be most positively associated with the development of posttraumatic symptoms.

Hypothesis 5: Maladaptive narcissism will be predictive of clinical significance on the CROPS, and adaptive narcissism will be predictive of clinically insignificant scores on the CROPS.

### **Statistical Treatment**

The goal of this study was to conduct exploratory analyses to determine the extent of the relationship between narcissism and symptoms of posttraumatic stress in juvenile offenders. Binomial logistic regression techniques were used to determine whether a predictive relationship exists between participants' NPI-JO total and subscale scores and clinically significant scores on the CROPS. The regression techniques were believed to be more advantageous than other approaches, as they would provide odds ratios and allow for controlling confounding variables, if necessary. Correlational techniques were used to examine the relationship between NPI-JO total and subscale scores and CROPS total scores. Descriptive statistics, including means, standard deviations, and score ranges, were used to examine the nature and makeup of the sample. Pearson correlations, chi-square analyses, and a two-way ANOVA were used to determine if there were significant differences in instrument scores based on demographic factors such as age, gender, ethnicity, and grade level. The results of these analyses are presented in Chapter 4.

## CHAPTER 4

### Results

#### Preliminary Analyses

Chi-square tests were run to determine if there were significant differences in clinically significant scores on the CROPS based on gender or ethnicity. There was a significant difference in CROPS scores by gender,  $\chi^2(1) = 14.934, p < .001$ , with girls being significantly more likely to score in the clinically significant range. Fifty-one percent of girls had a clinically significant score on the CROPS, compared to only 14.3% of boys. No significant differences were found for ethnicity,  $\chi^2(3) = .922, p = .820$ . Pearson's correlations were used to determine if significant differences existed in NPI-JO or CROPS total scores by age or grade level. No significant differences were found for age [CROPS ( $r = -.001, p = .990$ ); NPI-JO ( $r = -.070, p = .487$ )] or grade level [CROPS ( $r = -.022, p = .829$ ); NPI-JO ( $r = -.100, p = .318$ )] on either measure. A two-way ANOVA was also used to determine if there were any significant differences in NPI-JO total scores based on gender and ethnicity. There was no statistically significant interaction for gender or ethnicity,  $F(3, 93) = 2.069, p = .110$ .

The CROPS had a mean total score of 16.4 (SD = 10.5), with participants' scores ranging from 0 to 44. The NPI-JO had a mean total score of 19.12 (SD = 6.17), with participants' scores ranging from 5 to 34. The adaptive narcissism scale on the NPI-JO had a mean score of 11.4 (SD = 4.03), with participants' scores ranging from 1 to 19, and the maladaptive scale had a mean score of 7.72 (SD = 3.15), with scores ranging from 0 to 15.

## Assumptions

Binomial logistic regression techniques were used to determine whether a predictive relationship exists between participants' NPI-JO total and subscale scores and clinically significant scores on the CROPS. Correlational techniques were used to examine the relationship between NPI-JO total and subscale scores and CROPS total scores. Data were checked for normality and to determine the assumptions for each analysis were met. The data were approximately normally distributed. Hypotheses 1 through 4 were tested using correlational techniques. Hypothesis 5 and the secondary analysis were tested using binomial logistic regressions. The assumptions of both types of analyses are listed below, and a discussion of how these assumptions were tested against the data for the current study is provided.

Correlations describe the strength and direction of the relationship between two continuous variables, providing a correlation coefficient ranging from -1 (a perfect negative linear relationship) to +1 (a perfect positive linear relationship). A coefficient value of 0 indicates no linear relationship between two continuous variables. Initially, the statistical plan involved using Pearson's correlations to test Hypotheses 1 through 4. However, the data failed the assumption of linearity (i.e., a linear relationship between the two continuous variables), one of the five assumptions the data needed to "pass" to use Pearson's correlations. The independent and dependent variables were transformed to establish linearity, and the relationship between the resulting variables was monotonic but not linear. Therefore, Spearman's rank-order correlation, a non-parametric correlational technique, was used to test these hypotheses.

For Spearman's correlation, three assumptions must be met. The first assumption is that the two variables being compared are measured on a continuous or ordinal scale. Total scores, such as those provided by the NPI-JO and CROPS, are continuous; therefore, the data passed this

assumption. The second assumption states that the two variables should be paired, meaning that all participants have a value for each variable. The inclusion criteria for this study required that each participant had completed a valid NPI-JO and CROPS, meaning all participants have total and subscale scores for both measures. The third assumption states that the two variables should have a monotonic relationship. This relationship was achieved after the data were transformed using a square root transformation.

For the binomial logistic regressions, seven assumptions must be met. The first assumption requires one dependent (i.e., outcome) variable that is dichotomous (i.e., clinical significance on the CROPS, scored as 1 for "clinically significant" or 0 for "not clinically significant"). The second assumption requires one or more independent (i.e., predictor) variables measured on a nominal or continuous scale. The independent variables in this study, NPI-JO total scores and NPI-JO subscale scores, are continuous. The third assumption requires independence of observations, meaning there is no relationship between the observations in each category of the independent and dependent variables. In this study, the two categories of the dependent variable are "clinically significant" and "not clinically significant." These two categories are independent because a participant could not score in *both* the "clinically significant" and "not clinically significant" range on the CROPS. Similarly, the continuous independent variables pass this assumption because a participant cannot have multiple scores on the same measure. For example, a participant cannot score both a three and a five on the Authority subscale of the NPI-JO.

The fourth assumption requires a minimum of 15 cases per independent variable. With ten independent variables (NPI-JO total score, NPI-JO adaptive and maladaptive total scores, and seven NPI-JO subscale scores), a sample size of  $n=102$  failed this assumption. Therefore, the

independent variables were divided by adaptive, maladaptive, and total scores and then analyzed separately. The first regression included the adaptive subscales of the NPI-JO: Authority, Superiority, Vanity, and Self-Sufficiency. The second included the maladaptive subscales of the NPI-JO: Exhibitionism, Exploitativeness, and Entitlement. The third regression included the NPI-JO adaptive total and maladaptive total scores, and the fourth regression analyzed the NPI-JO overall total scores.

The fifth assumption requires a linear relationship between the continuous independent variables and the logit transformation of the dependent variable (Hilbe, 2016). The Box-Tidwell (1962) approach was used to test for linearity. This approach was initially developed for use in linear regression models. However, it has also been shown to be appropriate for logistic regression models (Fox, 2016). Natural log transformations were created for each independent variable, and then, interaction terms were created between the original independent variable and its respective natural log-transformed counterpart. Each continuous independent variable was linearly related to the logit of the dependent variable.

The sixth assumption states that the data must not show multicollinearity. Multicollinearity occurs when two or more continuous independent variables are highly correlated and can lead to difficulty in determining which constructs contribute to the variance explained by the model. Correlations were used to detect multicollinearity between scales. Because all ten independent variables were taken from one measure, there was a high degree of multicollinearity between several subscales and the total scores. However, once the scales and total scores were divided into the four groups in which they would be analyzed, there was no multicollinearity between variables. Finally, the seventh assumption of the binomial logistic

regression requires no significant outliers. Casewise diagnostics were used to check for outliers or highly influential points, and none were found.

### **Primary Analyses**

*Hypothesis 1* stated that adaptive narcissism would be associated with lesser report of posttraumatic symptoms (i.e., lower total score on the CROPS). A Spearman's correlation was run to explore this relationship, using the adaptive narcissism total score and the CROPS total score, which is assumed to be a general measure of posttraumatic symptoms. Preliminary analysis showed the relationship to be monotonic, as assessed by visual inspection of a scatterplot. Although low, there was a statistically significant negative correlation between adaptive narcissism and posttraumatic symptoms,  $r_s(100) = -.353, p < .001$ . The results should be interpreted with caution, given the weak correlational relationship. However, we can reject the null hypothesis and accept the alternative hypothesis.

*Hypothesis 2* stated that self-sufficiency would be most negatively associated with the development of posttraumatic symptoms when compared to the other adaptive narcissism scales (Superiority, Authority, and Vanity). Four Spearman's correlations were run to assess the relationship between 1) the Self-Sufficiency subscale score and the CROPS total score, 2) the Superiority subscale score and the CROPS total score, 3) the Authority subscale score and the CROPS total score, and 4) the Vanity subscale score and the CROPS total score. Preliminary analyses showed the relationships to be monotonic, as assessed by visual inspection of a scatterplot. There was a statistically significant, negative correlation between self-sufficiency and posttraumatic symptoms,  $r_s(100) = -.353, p = .002$ . There were also statistically significant correlations between authority and posttraumatic symptoms,  $r_s(100) = -.296, p = .003$ , and superiority and posttraumatic symptoms,  $r_s(100) = -.2, p = .044$ . However, the strength of these

relationships was lower when compared with self-sufficiency. Finally, there was no significant relationship between vanity and posttraumatic symptoms,  $r_s(100) = -.130, p = .193$ . The results should be interpreted with caution, given the weak correlational relationships. However, we can reject the null hypothesis and accept the alternative hypothesis.

*Hypothesis 3* stated that maladaptive narcissism would be associated with greater report of posttraumatic symptoms (i.e., higher total score on the CROPS). A Spearman's rank-order correlation was run to assess the relationship between the maladaptive narcissism total score on the NPI-JO and the total score on the CROPS. There was no statistically significant correlation between the maladaptive narcissism total score and the CROPS total score,  $r_s(100) = .148, p = .137$ . Therefore, we cannot reject the null hypothesis or accept the alternative hypothesis.

*Hypothesis 4* stated that entitlement would be most positively associated with the development of posttraumatic symptoms when compared to the other maladaptive narcissism scales (Exploitativeness and Exhibitionism). Three Spearman's correlations were run to assess the relationship between 1) the Entitlement subscale score and the CROPS total score, 2) the Exploitativeness subscale score and the CROPS total score, and 3) the Exhibitionism subscale score and the CROPS total score. Preliminary analyses showed the relationships to be monotonic, as assessed by visual inspection of a scatterplot. Although the strength of the relationship was weak, there was a statistically significant, positive correlation between entitlement and posttraumatic symptoms,  $r_s(100) = .206, p = .038$ . There was no statistically significant correlation between exploitativeness and posttraumatic symptoms,  $r_s(100) = .077, p = .439$ , or exhibitionism and posttraumatic symptoms,  $r_s(100) = .018, p = .857$ . The results should be interpreted with caution, given the weak correlational relationship. However, we can reject the null hypothesis and accept the alternative hypothesis for this sample.

**Table 4.1***Correlation Coefficients and Significance Values*

	CROPS total score	
	Correlation Coefficient	Sig. ( $p = xx$ )
Adaptive total	-.353*	<.001*
Authority	-.296*	.003*
Superiority	-.200*	.044*
Self-Sufficiency	-.308*	.002*
Vanity	-.130	.193
Maladaptive total	.148	.137
Exploitativeness	.077	.439
Entitlement	.206*	.038*
Exhibitionism	.018	.857
NPI-JO total	-.165	.098

\* Indicates significant finding

To test *Hypothesis 5*, a binary logistic regression was performed to determine the effects of adaptive and maladaptive narcissism on the likelihood that a participant would score in the clinically significant range of posttraumatic symptoms on the CROPS. The logistic regression model was statistically significant,  $\chi^2(2) = 10.71, p = .005$ . The model explained 13.7% (Nagelkerke R<sup>2</sup>) of the variance in clinical significance on the CROPS and correctly classified 63.7% of cases. Of the two predictor variables, only adaptive narcissism was statistically significant,  $\chi^2(1) = 9.19, p = .002$ . As shown in Figure 4.1, the Exp(B) value for adaptive narcissism was .295. Because this value is less than 1, it indicates decreased odds of experiencing the outcome variable for each 1-point increase in the independent variable, and it must be transformed to a number greater than 1 (Laerd Statistics, 2017). Inversion occurs by dividing one by the value (i.e.,  $1 / .295 = 3.39$ ). Therefore, for each 1-point increase in the adaptive total score, the individual was 3.39 times less likely to have a clinically significant CROPS score. Maladaptive narcissism was not significant ( $p = .254$ ).

**Figure 4.1**

*Binary Logistic Regression, Effects of Adaptive and Maladaptive Narcissism on Clinically Significant Posttraumatic Symptoms*

		Variables in the Equation							
		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
								Lower	Upper
Step 1 <sup>a</sup>	AdaptTotal_transformed	-1.222	.403	9.196	1	.002	.295	.134	.649
	MaladaptTotal_transformed	.447	.392	1.301	1	.254	1.564	.725	3.374
	Constant	2.227	1.261	3.117	1	.077	9.271		

a. Variable(s) entered on step 1: AdaptTotal\_transformed, MaladaptTotal\_transformed.

**Secondary Analyses**

A binary logistic regression was used to examine the effects of general narcissism, as measured by the NPI-JO total score, on the likelihood that a participant would score in the clinically significant range on the CROPS. The logistic regression model was statistically significant,  $\chi^2(1) = 4.45, p = .035$ . As shown in Figure 4.2, the Exp(B) value for NPI-JO total score was .553, which also required inversion (i.e.,  $1 / .553 = 1.81$ ; Laerd Statistics, 2017). The odds of having a clinically significant CROPS score were 1.81 times lower each time the NPI-JO total score increased by one point. Finally, a Spearman's correlation was performed to determine the relationship between NPI-JO and CROPS total scores, resulting in no significant relationship between the two,  $r_s(100) = -.165, p = .098$ .

**Figure 4.2**

*Binary Logistic Regression, Effects of General Narcissism on Clinically Significant Posttraumatic Symptoms*

**Variables in the Equation**

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
								Lower	Upper
Step 1 <sup>a</sup>	NPIJtotal_transformed	-.593	.288	4.235	1	.040	.553	.314	.972
	Constant	1.969	1.240	2.522	1	.112	7.160		

a. Variable(s) entered on step 1: NPIJtotal\_transformed.

## CHAPTER 5

### **Discussion**

Finding innovative and effective ways to address mental health problems in adolescents, especially juvenile offenders, is relevant to preventing future delinquency, improving developmental outcomes, and maintaining the safety of youth and staff in juvenile detention facilities. This study contributes to the body of literature on the assessment and treatment of juveniles in the legal system, with specific attention to posttraumatic stress and narcissistic personality traits.

### **Summary of the Study**

The relationship between narcissism and trauma in adolescent populations, particularly juvenile offenders, is not well understood (Barry et al., 2007a). Several factors tend to present problems in this line of research. For example, studies of narcissism and trauma tend to occur after the person has been exposed to one or more traumas, making it difficult to be certain about the direction of this relationship. Short of engaging in harmful and unethical research practices that expose human subjects to trauma, this unavoidable situation means we are unable to know what individuals' narcissistic traits looked like pre-trauma or how trauma may be experienced by people high in narcissism. Juveniles who come into contact with the legal system are significantly more likely to have experienced trauma than youth in the general population (Abram et al., 2013; Young et al., 2017). Being involved with the legal system can also have negative impacts on juvenile mental health, with police stops, arrests, detainment, and adjudication being traumatic for the young person and exacerbating mental health problems, especially for youth of color (Jackson et al., 2019; Pickett et al., 2022). It is estimated that

between 60 and 90% of juvenile offenders experience a traumatic event in their childhood (Young et al., 2017). These experiences can lead to the development of posttraumatic symptoms (e.g., hypervigilance, increased anxiety and arousal, emotion dysregulation, and disrupted impulse control), which can become problematic in juvenile residential facilities (Hirst et al., 2017). Youths with these symptoms are more likely to receive disciplinary referrals for violent and non-violent behavior problems (Hirst et al., 2017).

Narcissism has also been associated with adverse mental, emotional, and interpersonal outcomes, such as delinquency and recidivism in incarcerated populations (Barry et al., 2009; Calhoun et al., 2000; Herrington et al., 2014). However, some aspects of narcissism in adolescence have been shown to promote the healthy development of one's sense of self (Barry & Wallace, 2010). Adaptive and maladaptive narcissism in juvenile offenders is largely understudied (Barry et al., 2007a), and there is evidence that these traits have an impact on juvenile offenders and their experiences with the legal system. Juvenile offenders with narcissistic traits, specifically those high in maladaptive narcissism, are more likely to receive disciplinary citations, demonstrate aggression, and experience emotional problems (Barry & Wallace, 2010; Calhoun et al., 2000; Herrington et al., 2014; Washburn et al., 2004). The DSM-5-TR (APA, 2022) explains that an exceptionally upsetting, challenging, or traumatic event, sometimes referred to as an "ego threat," can exacerbate mental health symptoms to the point of clinical significance in individuals high in narcissism. Arrest and incarceration can be upsetting or traumatic. The similarity in how posttraumatic symptoms and narcissistic tendencies manifest in secure facilities makes it difficult to determine their exact relationship.

Little is known about how trauma may be experienced and navigated differently in individuals who are high in narcissism. Aspects of adaptive and maladaptive narcissism have

been associated with important mental health outcomes, like self-sufficiency, self-esteem, social skills, behavior problems, and anxiety and depression (Barry et al., 2009; Calhoun et al., 2000; Herrington et al., 2014; Lapsley & Aalsma, 2006). Levi and Bachar (2019) found that narcissism moderated the relationship between posttraumatic growth and posttraumatic symptoms, with those high in narcissism showing a positive correlation between the two. The authors suggest this association is a result of individuals high in narcissism using more maladaptive methods of achieving posttraumatic growth, leading to the experience of posttraumatic symptoms, as well. Montoro et al. (2022) found that some aspects of narcissism, like self-sufficiency and vanity, could negatively predict the frequency and severity of posttraumatic symptoms. In this study, the aspect of narcissism that led to the worst posttraumatic outcomes was entitlement (Montoro et al., 2022). Despite inconsistent results, both studies agreed that narcissism can alter one's perception of and response to stress, such as that associated with traumatic events.

This study aimed to explore the relationship between narcissistic traits and juvenile offenders' responses to traumatic experiences, including the development of posttraumatic symptoms. Specific attention was given to the differences in posttraumatic symptoms for those with adaptive vs. maladaptive narcissism. Participants for the study ( $N = 102$ ) included youth ages 12-17, who were chosen retroactively from the Juvenile Counseling and Assessment Program (JCAP) database at the University of Georgia. Data were collected by JCAP researchers during the intake interview process for new admissions to the program. Measures completed by new participants were hand-scored by the clinician-researcher who completed the intake and then entered it into the JCAP database. Participants who had completed both the NPI-JO and the CROPS were selected and entered into a separate database for this study. Regression and correlational techniques were utilized to analyze participants' NPI-JO total and subscale scores

with CROPS total scores and clinically significant status on the CROPS. Consistent with prior research, it was hypothesized that maladaptive narcissism would be associated with greater report of posttraumatic symptoms, with entitlement being predictive of poorest outcomes. Conversely, it was hypothesized that adaptive narcissism would be associated with lesser report of posttraumatic symptoms, with self-sufficiency being predictive of the best outcomes.

## **Conclusions**

Notably, the findings of the present study are broadly consistent with previously discussed studies using adult samples, suggesting narcissism may function similarly for juveniles in relation to posttraumatic symptoms. Results indicated a significant negative correlation between adaptive narcissism and the degree to which this sample of juvenile offenders experienced symptoms of posttraumatic stress. Adaptive narcissism was generally associated with lower scores on the CROPS, as well as scores that fell below the cutoff for clinical significance. Specifically, for each 1-point increase in the adaptive total score, the individual was 3.39 times less likely to have a clinically significant CROPS score. Self-sufficiency, authority, and superiority were the aspects of adaptive narcissism that were associated with the lowest CROPS total scores, with self-sufficiency having the strongest negative association. These findings suggest that aspects of adaptive narcissism could play a significant role in protecting against the development of posttraumatic symptoms after exposure to a traumatic event, including arrest, detention, and adjudication. Social-personality theory describes adaptive narcissism as being made up of more "mature" mechanisms for self-regulation that help the individual set and meet realistic goals for self-enhancement and positively deal with disappointments (Roche et al., 2013). Adaptive narcissism is also highly related to resilience and

self-esteem, which may mitigate some of the "ego threat" individuals experience after exposure to a traumatic event (Sedikides et al., 2004).

Adrien and colleagues (2024) describe traumatic experiences as leading to a "catastrophic loss of agency." They also hypothesized that posttraumatic symptoms may result from an individual's attempts to restore this sense of agency. In prior studies, self-sufficiency has been significantly negatively associated with both the frequency and severity of posttraumatic symptoms (Montoro et al., 2022). In his 2014 book *The Body Keeps the Score*, Dr. Bessel van der Kolk described his patients who had experienced trauma as feeling "trapped and immobilized" by the harm that had been inflicted on them. He discusses this inability to take action as thwarting their innate fight or flight response, resulting in adverse mental and emotional outcomes (van der Kolk, 2014). Therefore, a high degree of self-sufficiency may allow the individual to restore this sense of agency, and their ability to take action in the midst of or after the trauma could reduce the degree to which they experience posttraumatic symptoms (Adrien et al., 2024).

In Montoro et al. (2022), vanity was significantly negatively associated with the frequency of posttraumatic symptoms and positively associated with resilience. However, there was no significant relationship between vanity and posttraumatic symptoms in the present study. There is a paucity of research in the area of vanity and trauma, providing little information from which to draw conclusions related to this finding. However, one study from the nursing field may shed some light on the intersection of the two. Freysteinson (2020) examined the use of mirrors to view the body after a traumatic event, specifically an amputation or body disfigurement. Their findings suggested that using mirrors to view the incisions or other changes to one's body, while initially uncomfortable, resulted in the individual processing and accepting a

new body image and increasing their comfortability with reentering society. However, the patients consistently cited the stigmatization associated with vanity as keeping them from engaging in the "mirroring" exercise, resulting in prolonged discomfort and uncertainty surrounding their changed appearance (Freysteinson, 2020). While these findings do not directly translate to the present study, they highlight the stigmatization of vanity in society, which could prevent vanity from being reported accurately or serving as a protective factor post-trauma.

The results indicated that maladaptive narcissism was not significantly associated with CROPS total scores. This finding was unexpected, given prior research in which maladaptive narcissism has been linked to poor mental health outcomes, even in the absence of trauma. Barry and colleagues found maladaptive narcissism to be associated with poor social adjustment, behavior problems, and delinquency in children and adolescents, even when controlling for other risk factors (Barry & Wallace, 2010; Barry et al., 2007a). It is also negatively associated with self-esteem; self-esteem has been shown to mediate the role between maladaptive narcissism and various adverse outcomes, like aggression, exploitation of others, anxiety, and depression (Lau et al., 2011). From a statistics standpoint, this non-significant finding could be due to the limited range of possible maladaptive narcissism total scores on the NPI-JO compared to the adaptive and overall total scores. The maladaptive total scores could range from 0-18, while the adaptive and overall total scores had possible ranges of 0-22 and 0-40, respectively. Participants' average maladaptive total scores were also lower ( $M = 7.72$ ) than the adaptive total scores ( $M = 11.4$ ), even when accounting for the differences in ranges of scores.

Entitlement, one aspect of maladaptive narcissism, was significantly positively correlated with posttraumatic symptoms, as measured by the CROPS. As scores on the entitlement subscale increased, so did CROPS total scores. This finding is consistent with recent research by Montoro

and colleagues (2022), who found entitlement to be associated with the worst posttraumatic outcomes. It is also consistent with the social-personality theory, which describes maladaptive, or pathological, narcissism as being composed of "primitive" mechanisms for self-regulation, leading to the development of maladaptive and ineffective strategies for meeting one's self-enhancement needs and dealing with disappointments (Kohut, 1977; Roche et al., 2013). One possible explanation for this finding is that a traumatic experience represents an "ego threat" or a "threat to the person's self-image or self-esteem" (Leary et al., 2009). Narcissism has been associated with perceived invulnerability (i.e., immunity from emotional or physical injury; Aalsma et al., 2006). When a traumatic event highlights the individual's vulnerability, potentially to both emotional *and* physical injury, it can threaten their sense of self, particularly their perceived specialness in comparison to other people (Grubbs & Exline, 2016).

There was no statistically significant correlation between exploitativeness and posttraumatic symptoms or exhibitionism and posttraumatic symptoms. From a theoretical perspective, we would expect to see similar results for these aspects of maladaptive narcissism as were seen with entitlement. Therefore, this finding could result from a Type II error, in which the effect exists in the general population but was not found in the sample. Alternatively, these aspects of maladaptive narcissism may not be as impactful as entitlement with regard to the development of posttraumatic symptoms. Further, exploitativeness and exhibitionism are defined more behaviorally and represent external symptoms (i.e., seeking external sources of admiration and attention, manipulating or exploiting others for personal gain), while entitlement is more of a belief or internalizing symptom. The internalized nature of entitlement may cause the individual to also internalize traumatic experiences, resulting in increased posttraumatic symptoms. Similar

studies, although using adult samples, also found no significant association between exploitativeness or exhibitionism and trauma symptoms (Montoro et al., 2022).

Finally, the odds of having a clinically significant CROPS score were 1.81 times lower each time the NPI-JO total score increased by one point. This finding indicates that narcissism generally may serve as a protective factor against clinically significant posttraumatic symptoms. However, the results discussed above suggest that the majority of this protective power comes from the adaptive aspects of narcissism, making it important not to use the overall narcissism total score to predict how an individual may respond to trauma.

### **Implications**

Although the relationship is not causal, the significant correlations between mental health and juvenile offending support the idea that mental health problems are common precipitants of juvenile offending (OJJDP, 2017). Entering the juvenile justice system can also compound an individual's mental health problems, with arrest and incarceration being experienced as traumatic by some youth (Jackson et al., 2019). Further, posttraumatic symptoms (i.e., emotional dysregulation, hypervigilance, irritability) can become problematic for youth upon their placement in juvenile residential facilities. Treatment programs that adequately assess for and treat trauma and posttraumatic symptoms have been shown to successfully reduce disciplinary referrals and instances of violence, as well as improve communication between juvenile offenders and facility staff (Baetz et al., 2021; Zettler, 2021).

The results of the current study have implications for assessment, treatment, and the creation of behavioral management strategies for juvenile offenders. It is already well-established in the literature that proper screening and assessment provide a better understanding of clients' presenting concerns and are necessary for holistically treating youths' trauma and

posttraumatic symptoms (Baetz et al., 2021). This screening and assessment could include measures related to narcissism, such as the NPI-JO. Given the significant differences in how various aspects of narcissism can impact mental health outcomes, these measures must assess for and distinguish between adaptive and maladaptive narcissism. Some measures to consider are the Narcissistic Personality Inventory, as well as its many variations (e.g., NPI-JO, NPI-C), the Pathological Narcissism Inventory (PNI), and the Adaptive Narcissism Scale (ANS), which assesses constructs like self-esteem, leadership, and goal-setting behavior. Proper assessment of personality traits, specifically narcissistic traits, is not only relevant for improving intervention selection and treatment outcomes, but it is also appropriate due to the ongoing identity development occurring in adolescence (Aalsma et al., 2006).

Understanding the relationship between trauma symptoms and narcissism could help clinicians identify specific interventions for preventing the adverse outcomes associated with trauma and narcissism, resulting in a more personalized treatment approach (Barry et al., 2003; Herrington et al., 2014). Additionally, clinicians may be better equipped to intervene and prevent behavior problems before they lead to disciplinary action or further victimization and prevent maladaptive narcissistic traits from continuing into early adulthood, where they will lead to additional adverse outcomes (Barry et al., 2007a; Calhoun et al., 2000; Herrington et al., 2014). The research on narcissism, particularly adaptive narcissism, makes it seem likely that narcissistic features like self-sufficiency could perform a protective function for those who experience trauma, and the results of the present study provide additional support for that idea. Adaptive narcissism is positively associated with resilience, self-esteem, confidence, and social skills (Barry et al., 2009; Herrington et al., 2014). Those high in adaptive narcissism can meet their needs for acknowledgment, admiration, and recognition through more effective means and

deal with disappointments in more positive ways (Kohut, 1977; Roche et al., 2013). Adaptive narcissism is also negatively correlated with common mental health problems such as anxiety and depression (Calhoun et al., 2000; Lapsley & Aalsma, 2006). It stands to reason that if mental health problems often precede juvenile offending, and adaptive narcissism can protect against mental health problems, adaptive narcissism may also protect against future offending. This idea is supported by prior research, which found maladaptive narcissism to be related to delinquency and adaptive narcissism to be unrelated to delinquency (Barry et al., 2007a). This conceptualization and approach are more consistent with the intended rehabilitative nature of the juvenile justice system.

Psychological treatment post-trauma aims to minimize the detrimental emotional impacts of trauma and the likelihood of developing posttraumatic symptoms and to promote healthy posttraumatic growth, which includes outcomes like having greater esteem for oneself and one's ability to survive and adapt, increased appreciation for close relationships, and reevaluating belief systems (Tedeschi & Calhoun, 2004). Levi and Bachar's (2019) results suggest narcissism, at least partially, moderates the relationship between posttraumatic growth and posttraumatic symptoms. Therefore, evidence-based interventions that promote self-sufficiency, such as solution-focused therapies and assertiveness training, may help promote better outcomes post-trauma, including the trauma associated with the legal system. Conversely, given the current study's results that suggest entitlement may serve as a risk factor, evidence-based interventions that minimize entitlement, such as dialectical behavior therapy (e.g., interpersonal effectiveness skills), compassion-focused therapy, and interpersonal therapy (IPT), may prove helpful in reducing symptoms of posttraumatic stress. These interventions may also help provide much-

needed insight into the juvenile's impacts on others, especially when provided in a group treatment setting.

However, it is important to consider how those who are high in narcissism may (or may not) present in a treatment setting. Narcissistic patients may be hesitant to present to treatment at first. Research suggests that individuals high in narcissism often seek treatment at the recommendation of others in their lives (e.g., children, spouses, coworkers) who have become exhausted by the dysfunctional interpersonal dynamics of the relationship (McLean, 2007; Mosquera & Knipe, 2015). Sharing their perceived weaknesses or problems that require treatment may result in a greater degree of shame for the narcissistic patient (McLean, 2007).

Weinberg and Ronningstam (2020) describe a range of challenges across several domains (i.e., cognitive, emotional, interpersonal, and motivational) for therapists to be aware of when treating patients with narcissistic traits. Cognitively, narcissistic patients struggle with self-reflection, resist differing perspectives, and may not have a realistic self-appraisal, as narcissism is often associated with an overly positive self-image (Mosquera & Knipe, 2015; Weinberg & Ronningstam, 2020). This unrealistic view of the self may result in poor insight into the issues that must be addressed, leading to difficulties in receiving feedback and redirection. The patient may fear that feedback is a result of negative evaluation and judgement from the therapist. Additionally, they may have difficulty identifying and expressing emotions and experience a sense of meaninglessness (Weinberg & Ronningstam, 2020). Interpersonally, their relationships are often unstable. This instability may present in the therapy space, as well, with the patient having paranoid reactions toward the therapist. The narcissistic patient has a greater desire for affirmation, acknowledgement, and praise and is often perfectionistic. In this same vein, they may tend to externalize responsibility and be unlikely to recognize their contributions to the

problems discussed in therapy. Their motivation for change is often externally driven, crisis-generated, and mood-dependent, making it inconsistent across time. Finally, therapists can experience powerful countertransference reactions, which, if unexamined, can disrupt and even destroy the therapeutic process (Weinberg & Ronningstam, 2020).

The complex nature of narcissism may result in a lengthy treatment relationship, as the treatment process often must begin with "dismantling the dysfunctional personality structure" (Mosquera & Knipe, 2015). Kohut offered suggestions, like maintaining empathy and a non-judgmental stance throughout therapy. Weinberg and Ronningstam (2020) also offered strategies, such as focusing on concrete, realistic, and measurable treatment goals that the patient can identify as their own; encouraging a more realistic view of the self; validating challenges, threats to self-esteem, and moments of vulnerability; and foster a tolerance for uncertainty. Therapists are encouraged to be cautious in challenging the individual's self-concept, as the narcissistic patient may be vulnerable to perceived criticism and may drop out of treatment altogether. Finally, therapists need to manage their emotional reactions, as engaging in a power struggle with the patient is likely to be ineffective and damaging to the relationship. Even amid strong emotional reactions to patient behavior, demonstrating empathy is necessary for facilitating meaningful change in the patient (McLean, 2007).

### **Recommendations for Further Research**

The lack of research on the relationship between adaptive/maladaptive narcissism and posttraumatic symptoms means there are nearly unlimited possibilities for future research. There is uncertainty about the extent to which narcissistic traits are typical in children and adolescents, how these traits are utilized adaptively to face social and other developmental challenges, and whether youth personality traits remain stable into adulthood. The results of the present study

give rise to several logical next steps, several of which will be presented here. Given the non-representative sample used in this study, a nationally representative sample of juvenile offenders would allow for more generalizable results and an opportunity to see if the trends observed in the current study are consistent across samples. It is also imperative to account for racial trauma and race-related stress in our assessment and treatment of trauma. If not, we are missing a key factor relevant to the traumatic experiences of many youth receiving services in our legal system. The CROPS does not assess for racial trauma or race-related stress. A study similar to the current one could assess how adaptive and maladaptive narcissism are related to the development of symptoms after an individual experiences racial trauma.

Additionally, more gender-specific analyses may be beneficial in determining the presence of adaptive and maladaptive narcissism by gender. The present study found significant differences in the likelihood of scoring in the clinically significant range on the CROPS based on participant gender. It is unclear if these results are due to girls being more likely to report the degree to which they are experiencing posttraumatic symptoms (Daurio, 2009) or whether it is indicative of the breakdown of narcissistic tendencies by gender. For example, these findings may make sense if boys were found to be more likely to possess traits of adaptive narcissism and girls were more likely to score higher on measures of maladaptive narcissism.

As previously discussed, social-personality theories of narcissism argue that adaptive and maladaptive narcissism coexist at two ends of the same spectrum, with the maturity of one's mechanisms for meeting their needs determining on which end of the spectrum they fall (Roche et al., 2013). The present study would have greatly benefitted from a qualitative portion, which allowed the participants to discuss how they did or did not achieve posttraumatic growth, allowing for the coding of those responses as adaptive or maladaptive. Heinz Kohut, a leading

scholar in the early development of treatments for narcissistic personality disorder, suggested self-regulation is crucial to distinguishing adaptive and maladaptive narcissism, with adaptive narcissism allowing individuals' narcissistic goals (i.e., admiration, acknowledgment, self-enhancement) to be met through more appropriate, less impulsive means. The *Behavior Assessment System for Children, 3<sup>rd</sup> edition* (BASC-3) provides a measure of behavioral control, which could be a way of assessing self-regulation. Future studies could use the BASC-3 to assess how self-regulation, or behavioral control, affects the relationship between narcissism and the development of posttraumatic symptoms.

Finally, some research in this area suggests parenting factors are relevant in determining which self-regulation strategies would be developed, with supportive and empathic parenting facilitating a more adaptive form of narcissism (Kohut, 1977). This idea is also supported in more recent research, which found maladaptive narcissism to be associated with both child and parent reports of harmful parenting practices (Barry et al., 2007a). There are numerous measures that may be beneficial in this line of research. The Alabama Parenting Questionnaire (APQ) assesses positive and negative parenting practices across different domains, such as parental involvement and discipline. The Parenting Stress Index (PSI) and the Parenting Relationship Questionnaire (PRQ) assess more of the relational aspects of the parent-child dyad, such as parent-child bond, dysfunctional communication, parental distress, and parental satisfaction. A more clinical approach to this study could include participants engaging in family therapy sessions that address narcissistic tendencies, like self-sufficiency and entitlement, as they relate to posttraumatic stress.

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