

Wounded Gods: Narcissistic Vulnerability and PTSD Symptomatology Following Ego-Threatening Trauma

Abstract

This proposed dissertation examines how individuals high in vulnerable narcissism respond to ego-threatening versus physically threatening traumatic memories. Vulnerable narcissism – a personality style marked by hypersensitivity, shame-proneness, and fragile self-worth – has been linked to more severe PTSD symptoms after trauma ¹ ². However, its interaction with different trauma types (e.g. social humiliation vs. physical assault) is not well understood. Using a mixed-methods design with outpatient clients, participants will complete the Pathological Narcissism Inventory (PNI) to quantify vulnerability, then be randomly prompted to recall either a profound episode of public humiliation or physical assault. Outcome measures include PTSD symptoms (via the PCL-5) ³, affect (PANAS), dissociative experiences (DES-II) ⁴, and physiological stress markers (salivary cortisol and heart rate variability). It is hypothesized that high-vulnerability individuals will exhibit greater PTSD symptom severity, negative affect, and physiological stress when recalling humiliation than assault, compared to lower-vulnerability peers. Qualitative interviews will explore personal meaning and emotion regulation. Anticipated findings would support theories that ego threats (social status losses) provoke intense shame and stress responses similar to physical danger ⁵ ⁶. Clinical implications include screening for narcissistic vulnerability in trauma survivors and tailoring interventions (e.g., shame-focused therapies, compassion-based strategies) for those with injury to self-esteem. The study will carefully integrate multicultural perspectives (e.g., varying cultural norms of honor and shame) and rigorous ethical safeguards (informed consent, emotional support) in its design and interpretation.

Introduction

Pathological narcissism comprises two interwoven themes: **grandiosity** (inflated self-views, entitlement) and **vulnerability** (fragile self-esteem, hypersensitivity to criticism) ⁷ ⁸. Traditional diagnostic criteria (DSM-5 NPD) emphasize the grandiose side, but clinical models recognize that many narcissistic patients present primarily in a vulnerable state – marked by anxiety, shame, and emotional dysregulation ⁹ ². Vulnerable narcissists may appear shy, avoidant, or depressed, but underlying these states is a fluctuating yet brittle sense of self-worth that desperately seeks validation ¹ ².

Trauma exposure is often conceptualized as an external event causing fear and helplessness, but not all traumas threaten the same goals. One important dimension is whether a trauma assaults one's **ego** or social standing (e.g., public humiliation) versus more prototypical **physical threat** (e.g., assault). Humiliation may be experienced as a direct injury to the self, evoking intense shame and anger ⁵. Social self-preservation theory posits that humans maintain a “social self” tied to esteem and status; threats to this system (such as ostracism or humiliation) activate biological stress responses (cortisol release, arousal)

similarly to threats to physical safety ⁶ . Vulnerable narcissists, with their chronic fear of losing status and pervasive shame, may be especially reactive to ego-threatening trauma.

Empirical evidence links vulnerable narcissism to greater PTSD symptoms. For example, veterans higher in vulnerable narcissistic traits report significantly more severe PTSD, whereas grandiose traits show no such effect ¹ . This suggests that the insecure, shame-prone qualities of vulnerability amplify traumatic stress. However, most research has been correlational and has not isolated trauma types or physiological reactions. The present dissertation aims to fill this gap by experimentally comparing responses to social (humiliation) versus physical trauma recall in relation to vulnerable narcissism. By integrating self-report, physiological, and narrative data, the study will yield a rich understanding of *how* narcissistic vulnerability interacts with different trauma themes.

The research questions include: *Do individuals high in narcissistic vulnerability exhibit more intense PTSD symptomatology (intrusive re-experiencing, avoidance, arousal) after ego-threatening (humiliation) trauma than after physical assault? Are negative affect and dissociative symptoms more pronounced in such cases? Do physiological stress markers (salivary cortisol, heart rate variability) show differential patterns for humiliation versus assault in vulnerable narcissists?* Answering these will elucidate psychological and neurobiological pathways linking self-concept, trauma type, and posttraumatic response.

Literature Review

Narcissistic Vulnerability

Pathological narcissism is often measured by instruments like the **Pathological Narcissism Inventory (PNI)** ⁸ . The PNI yields scales for grandiose and vulnerable features of narcissism ⁷ ⁸ . Vulnerable narcissism is characterized by fragility, hypersensitivity, and inner turmoil: individuals feel chronically insecure, anxious about others' evaluations, and prone to shame when self-esteem is threatened ¹ ² . Unlike overt grandiosity, this type of narcissism is often hidden; vulnerable individuals may oscillate between self-criticism and fleeting grandiose fantasies ⁹ . Empirical studies note that vulnerable narcissism correlates with depression, anxiety, hostility, and shame, especially following stress or perceived failure ¹ . Clinically, it manifests as unstable mood and affect dysregulation when confronted with ego threats ² .

In summary, vulnerable narcissists tend to have a **fragile self** that requires constant validation and reacts strongly to any hint of criticism or rejection ¹ ² . They may appear envious or self-pitying when thwarted, and are more likely to collapse into shame than anger. This theoretical profile suggests they could respond differently to social humiliation (targeting self-esteem) than to impersonal physical harm.

Trauma Types and Ego Threat

Traumatic events vary in their core nature. Many trauma studies differentiate **interpersonal/relational traumas** (e.g., abuse, humiliation) from **non-relational traumas** (e.g., accidents, natural disasters) because the former often entail violations of trust and self-concept. Posttraumatic **embitterment** is an example of a reaction to singular events experienced as deeply unjust or humiliating ¹⁰ . Although not officially in DSM-5, related constructs (like *betrayal trauma* or *PTSD with prominent shame*) have been discussed in the literature.

Public humiliation is a severe ego-threat: one's worst fears about worthlessness or disgrace may be realized. Neuroscience suggests that social pain (shame, rejection) uses similar neural pathways as physical pain ¹⁰. The shame meta-analysis notes that shame activates threat-related processes akin to physical pain ⁵, and that trauma-related shame predicts PTSD symptoms and avoidance behaviors ¹⁰. In comparison, **physical assault** typically triggers classic fear circuits (fight-or-flight) and elicits PTSD mainly through memories of life-threat, helplessness, or bodily harm. Both types can lead to PTSD, but humiliation may involve additional self-related attributions ("I am worthless") that uniquely drive symptoms.

Understanding how narcissistic vulnerability modulates these reactions is key. Ego-threat theory (e.g. social self-preservation) suggests that threats to one's social standing produce cortisol spikes and negative self-evaluations ⁶. Vulnerable narcissists, already on guard for ego challenges, might show especially strong stress responses to humiliation, potentially resulting in more severe posttraumatic outcomes. In contrast, they may perceive physical threat as devastating but not personally condemning, perhaps eliciting less shame-driven dysregulation relative to humiliation. The specific psychological and biological mechanisms linking these elements have not been fully tested.

PTSD Subtypes and Symptom Clusters

PTSD is heterogeneous. DSM-5 outlines symptom clusters (intrusion, avoidance, negative alterations in cognition/mood, arousal) and recognizes a *dissociative subtype* (persistent depersonalization/derealization) in some sufferers. There are also proposed distinctions like "fear-based" vs. "anhedonic" PTSD, or "externalizing" vs "internalizing" phenotypes, though these are not formal diagnoses. Social traumas often co-occur with intense shame, guilt, or anger, which may alter the symptom profile (e.g., more negative beliefs about self or others).

Dissociation is particularly relevant: a fraction of trauma survivors experience dissociative symptoms, and this can worsen prognosis. People with PTSD tend to score high on the **Dissociative Experiences Scale (DES-II)** ⁴, which captures depersonalization, derealization, and amnesic experiences. Some theories propose that dissociation is a maladaptive emotion regulation strategy; those unable to process shame/trauma may disconnect from experience to cope. Narcissistic vulnerability might predispose to dissociation: vulnerable narcissism has roots in trauma and unmet needs, possibly entwined with dissociative defenses (Howell, 2003). Though empirical work is limited, we include the DES-II in anticipation that higher dissociation will accompany intense humiliation in vulnerable narcissists, reflecting an extreme coping style ⁴.

Ego-Threat and Social Self-Preservation Theory

The **social self-preservation theory** provides a framework for understanding how ego threats induce stress responses. Dickerson and Kemeny (2004) describe a biologically-mediated "social self-preservation system" that monitors threats to social esteem or status and triggers protective responses (increased cortisol and self-conscious emotions) ⁶. For example, controlled experiments have shown that tasks involving public evaluation or rejection raise cortisol levels even when physical threat is absent. Threats to the **physical self** (survival, injury) naturally activate stress biology, but important research indicates that symbolic threats to one's social standing can engage the same HPA axis.

In non-human primates, low-status animals chronically exhibit elevated cortisol under social subordination ⁶. In humans, socially-evaluative stressors cause spikes in cortisol and negative self-reflection ⁶. Thus,

a humiliating trauma recall – especially if described as “everyone laughed at me” or “I was publicly shamed” – should provoke a strong neuroendocrine stress response. By contrast, a purely physical trauma may provoke adrenaline and fear but perhaps less targeted negative self-cognitions. We integrate this theory to predict physiological outcomes (cortisol, HRV) in our study.

Affective Dysregulation and Narcissism

Emotion regulation difficulties are well-documented in vulnerable narcissism. Research finds that higher vulnerable narcissism is associated with *greater* emotion dysregulation and maladaptive coping strategies ². For instance, individuals with high narcissistic vulnerability score higher on measures of uncontrolled anger, anxiety, and mood lability. They often externalize blame and struggle to tolerate criticism ⁹ ¹¹. Experiments indicate that vulnerable narcissists exhibit elevated negative affect when their self-view is challenged. The present study will use the **Positive and Negative Affect Schedule (PANAS)** (Watson et al., 1988) to quantify current emotional state after each recall. We expect those high in vulnerable narcissism to report more negative affect and less positive affect following humiliation than others.

Dissociation

Building on earlier points, dissociation will be assessed via the DES-II, a widely-used self-report scale ⁴. We include it for two reasons. First, trauma-related dissociation often correlates with high PTSD severity. Second, if vulnerable narcissists use dissociation to defend against intolerable shame or anger, this may be most evident after humiliation. Prior literature notes that people with PTSD score high on dissociation scales ⁴, but few studies have considered narcissistic traits in this context. Including the DES-II allows exploration of whether dissociation mediates the link between narcissistic vulnerability and PTSD symptoms, especially in ego-threatening conditions.

Methodology

Design

This mixed-methods study combines quantitative and qualitative data. The core design is a 2×2 mixed experiment: each participant is categorized by narcissistic vulnerability (high vs. low) and randomly assigned to recall either a humiliation or a physical assault trauma. Quantitative outcomes (surveys, physiological metrics) will be compared across conditions and traits. Additionally, semi-structured interviews will qualitatively explore participants’ emotional responses and meaning-making.

Participants and Recruitment

We will recruit approximately 100 adult outpatient clients (e.g., from community mental health clinics) to achieve sufficient power for medium effect sizes ($\alpha=0.05$, power=0.80) in ANOVA/regression models. Inclusion criteria: ages 18–65, fluent in English, and with a history of at least one significant ego-threatening event and one physical assault (to ensure recall feasibility). Exclusion: current psychosis or severe cognitive impairment (due to risk of distress and protocol comprehension), acute suicidality, and conditions contraindicating study procedures (e.g., steroid medications affecting cortisol). We will actively seek a diverse sample: balanced gender, various racial/ethnic backgrounds, and varied socioeconomic statuses, reflecting the clinic population.

Measures

Pathological Narcissism Inventory (PNI) – A 52-item self-report assessing grandiose and vulnerable narcissism ⁸. We will use the total vulnerable narcissism score as a continuous predictor and also create high/low groups via median split for some analyses. The PNI has demonstrated reliability ($\alpha \approx .90$) and validity for this trait ⁸.

PTSD Checklist for DSM-5 (PCL-5) – A 20-item self-report of PTSD symptoms over the past week ³. Administered after recall, the PCL-5 will capture intrusion, avoidance, negative mood, and arousal symptoms related to the recalled event. Total score (0–80) will index PTSD severity ³.

Positive and Negative Affect Schedule (PANAS) – A 20-item measure yielding positive affect and negative affect scores (Watson et al., 1988). Participants rate current mood; high reliability. We will compare negative affect (e.g., upset, ashamed) between trauma recall conditions, expecting more negative affect after humiliation in vulnerable narcissists.

Dissociative Experiences Scale-II (DES-II) – A 28-item scale of dissociative experiences ⁴. Participants indicate how frequently they experience such phenomena. We expect higher scores after trauma recall, particularly in the humiliation condition among high-vulnerability individuals ⁴.

Physiological Measures: - *Salivary Cortisol*: Collected via passive drool at baseline (pre-recall), immediately post-recall, and 30 minutes post-recall (to capture peak cortisol lag) ⁶. Samples will be assayed for cortisol concentration ($\mu\text{g/dL}$). Hypothesis: greater cortisol increase for humiliation recall in high-vulnerability group. - *Heart Rate Variability (HRV)*: Continuous ECG recorded (via chest strap) from 5 min before recall through 10 min after. HRV indices (e.g., RMSSD) will be computed. Lower HRV reflects sympathetic dominance/stress. We anticipate a larger HRV drop (stress response) during and after recall of humiliation among vulnerable narcissists.

Additional Qualitative Interviews: After quantitative assessments, participants will be interviewed using open-ended prompts about their recalled trauma, emotions, and coping. The interviews will be transcribed and analyzed thematically to contextualize the quantitative findings, exploring how narcissistic self-views shape trauma narratives.

Procedure

Participants will be scheduled for a lab session. After informed consent and baseline questionnaires (demographics, PNI), each person will rest 5 minutes (for baseline physiology), then be randomly assigned to one recall condition.

Trauma Recall Task: Using standardized instructions, participants will vividly recall and describe a personal memory of severe public humiliation or physical assault (depending on condition). This will last ~5–10 minutes and is guided to ensure relevant content. Example prompts: “Please describe an event when you felt deeply humiliated in front of others...” or “Describe a time you were physically assaulted and felt threatened.” A clinician will gently probe for details. The task aims to elicit emotional recall (without real-time social evaluation).

Immediately post-recall, self-report measures (PCL-5, PANAS, DES-II) will be completed regarding feelings about the event. Physiological monitoring continues throughout the recall and 10-minute recovery. Cortisol samples are taken pre-task, +30min post-task, as cortisol peaks roughly 20–30 min after stress ⁶ .

Data Collection Notes: Efforts will ensure minimal disruption (e.g., consistent time of day to control diurnal cortisol), and we will provide breaks between tasks. Participants will also receive a debrief and access to support resources.

Ethical Considerations

We will obtain IRB approval and follow APA ethical guidelines for trauma research. Key precautions include: (1) Thorough informed consent explaining the stress nature of tasks. (2) Exclusion of individuals for whom recall may be too destabilizing (e.g., extremely high suicide risk). (3) On-site mental health professional standby, and immediate debriefing to contain any acute distress. (4) Participants may withdraw at any point. (5) Confidentiality of sensitive trauma narratives will be protected rigorously.

Multicultural Considerations: Researchers will be trained in cultural competence. Recruitment will include diverse populations, and we will ensure that recall prompts are culturally sensitive (e.g., acknowledging that perceptions of humiliation may vary by social norms). If necessary, validated translations of measures (PNI, PCL-5, DES-II) will be used for non-English speakers. We will analyze whether race/ethnicity or cultural background moderates effects: for instance, in collectivist cultures, public shaming might carry even heavier weight. Cultural factors (gender norms, stigma around shame) will be recorded and potentially included as covariates.

Data Analysis Plan

Hypotheses: 1. *PTSD Severity:* High-vulnerability participants will have higher PTSD symptoms (PCL-5 scores) after humiliation recall than after assault, whereas low-vulnerability individuals will show a smaller difference (interaction effect). 2. *Negative Affect:* High-vulnerability × humiliation group will report highest negative affect (PANAS-NA). 3. *Dissociation:* DES-II scores will be highest in the high-vulnerability/humiliation condition. 4. *Physiology:* Cortisol increase (Δ from baseline) and HRV decrease (during recovery) will be larger in the humiliation condition for vulnerable narcissists.

Statistical Analysis: We will conduct mixed ANOVAs with trauma type (between-subjects: humiliation vs assault) and narcissism (continuous PNI scores or high/low) as factors predicting each outcome (PCL-5 total, PANAS NA, DES-II, cortisol change, HRV metrics). Regression models will test PNI scores as predictor of PTSD symptoms, with trauma type as moderator. We will correct for multiple comparisons (e.g., Bonferroni) across dependent measures. Effect sizes (η^2 , Cohen's d) will be reported. Physiological data will be examined with time-series or change scores (peak-baseline). We will also explore mediation: e.g., does negative affect or dissociation mediate the link between narcissism and PTSD in humiliation?

Qualitative Analysis: Interview transcripts will be thematically coded (by at least two raters). We anticipate themes related to self-worth, anger, and coping. For example, high-vulnerability individuals may frame humiliation as confirming negative self-beliefs (shame narrative), whereas others focus on fear during assault. These patterns will be integrated with survey data.

Anticipated Results

We hypothesize an interaction between narcissistic vulnerability and trauma type. Specifically, *vulnerability* is expected to amplify PTSD symptoms predominantly in the humiliation condition. In a mixed ANOVA, this would appear as a significant Narcissism×Trauma interaction on PCL-5 scores. Post-hoc contrasts might show that high-vulnerability participants have much higher PCL-5 after humiliation ($M_{\text{hum}} > M_{\text{assault}}$), whereas low-vulnerability participants show smaller difference or overall lower PCL-5 scores.

Parallel findings are expected for PANAS and DES-II. Vulnerable narcissists recalling humiliation will likely endorse more negative emotions (“ashamed,” “sad,” “hostile”) and higher dissociation than when recalling assault. A possible mechanism is that humiliation triggers intense shame (a highly dysregulated, self-referential emotion), whereas assault may evoke fear but not engage the fragile self-schema as deeply. We will test if PANAS-NA mediates the effect of narcissism on PTSD symptoms in the humiliation condition.

Physiologically, we anticipate that salivary cortisol will rise more sharply from baseline to 30 minutes post-task for the humiliation recall in high-vulnerability individuals ⁶. This would reflect that ego-threat activated their HPA axis robustly. HRV is expected to drop (indicating sympathetic arousal) more in the humiliation condition as well, especially during and after the recall period. We will analyze HRV change and possibly latency of recovery. If results align with theory, they would confirm that social-evaluative stressors provoke quantifiable stress responses in narcissistic individuals.

Qualitative data should enrich these findings. We expect vulnerable narcissists to express accounts heavy in self-criticism and shame, possibly struggling to verbalize anger or sadness. In contrast, narratives of assault might focus on external danger and fear. These thematic differences will help illustrate the distinct posttraumatic processes. For example, coding might reveal a theme like “shame-confirming self-view” that appears only in the humiliation/high-vulnerability group.

Statistical control for potential confounds (e.g., baseline stress levels, comorbid depression) will clarify the unique contribution of narcissism. We will also compare effect sizes to gauge practical significance. If the hypothesized effects are found (e.g., $p < .05$, $\eta^2 \sim .10$ for interactions), it would support our model. If not, alternative explanations (e.g., all trauma equally distressing for narcissists) will be considered.

Discussion

Theoretical Implications

If vulnerable narcissism interacts with trauma type as predicted, this research would extend both narcissism theory and PTSD models. It would suggest that **ego-threatening traumas** (social humiliations) are especially pathogenic for individuals with fragile self-esteem. This aligns with social self-preservation theory ⁶ and shame-centered trauma frameworks ⁵. We would also highlight that narcissistic vulnerability functions as a *trait vulnerability factor* for PTSD, not merely a consequence of trauma. This bridges personality and trauma literatures, consistent with findings in veterans ¹.

Our results could refine PTSD subtype conceptualizations. The distinction between humiliation-based vs fear-based trauma responses may inform future diagnostics: perhaps envisioning a shame-dissociative

phenotype of PTSD more likely in narcissistic vulnerability. Such a subtype might benefit from different treatment foci (e.g., self-compassion training) than fear-based PTSD.

At a psychological level, findings would underscore that traumatic stress is filtered through the lens of self-concept. Two people can endure similar trauma but experience it differently based on personality. This aligns with quotes from our precursor study: “events impact us in highly personal ways... filtered through our own way of viewing ourselves” ¹. Empirical support for this view could motivate more integrative personality assessment in trauma research.

Clinical Applications

Clinically, the study suggests that assessing vulnerable narcissism (e.g., via PNI) in trauma survivors may identify those at risk of complicated PTSD. For instance, a patient who experienced workplace embarrassment might develop more severe chronic PTSD if he has high narcissistic vulnerability. Psychotherapists could then emphasize interventions addressing shame and self-esteem (e.g. Narrative Exposure, Cognitive Restructuring of self-beliefs) alongside standard trauma processing.

Therapies that teach emotion regulation may be vital, since our data would likely show affect dysregulation as a mediator. Techniques from dialectical behavior therapy (DBT) or acceptance and commitment therapy (ACT) might help such clients tolerate the distress of ego threat. Compassion-focused therapy, in particular, could counteract chronic self-criticism and shame by building self-compassion (as [14] suggests). Additionally, recognizing dissociation as a coping mechanism could prompt grounding strategies during trauma therapy.

Our physiological findings also have implications. If salivary cortisol reliably reflects the acute distress of humiliation, therapists might use biofeedback or stress management to address the bodily aspect of shame. Heart rate patterns could inform relaxation training (e.g., HRV biofeedback) to teach clients how to engage the parasympathetic system when triggered by social threats.

Multicultural and Ethical Reflection

A strength of this work is its attention to culture. Narcissistic vulnerability may manifest differently across cultural contexts; for example, collectivist cultures emphasize social harmony, so public humiliation might even more deeply wound the social self. Conversely, in individualist cultures, personal achievement is paramount, so assault (which limits autonomy) might be felt more personally. Our study will examine cultural moderators to these patterns. Culturally adapting trauma narratives and respecting diverse shame/taboo topics are critical.

Ethically, our design acknowledges the potential harm in trauma recall. By integrating immediate support and voluntary participation, we aim to minimize risk. Data interpretation will also be sensitive: we will avoid blaming individuals for their narcissistic vulnerability or implying it “causes” PTSD in a deterministic way. Instead, we will view narcissistic traits as one factor among many that shape trauma response. We will also consider participants’ right to respectful treatment and will avoid pathologizing cultural expressions of self-esteem or shame.

Limitations and Future Directions

Several limitations deserve mention. First, the experimental recall method, while controlled, does not replicate actual trauma. Memory bias or reconstruction could influence results. Second, the mixed inpatient-outpatient sample may limit generalizability to the broader population. Third, cross-sectional measurement (before-after recall) precludes long-term outcome data. Future research should follow up to see if these acute reactions predict chronic PTSD or treatment response.

We also rely on self-report (PNI, PCL-5, DES-II), which could be influenced by defensiveness – especially in narcissistic individuals. Triangulating with clinician interviews or implicit measures would strengthen validity. Expanding beyond recall tasks, future designs could use longitudinal trauma exposure (for example, in soldiers or disaster workers) to track how narcissistic traits affect PTSD development over time.

Finally, the interplay of narcissism with other personality factors (e.g., borderline features, depression) merits exploration. Our focus on narcissism may oversimplify complex personalities; future models should include broader trait assessments.

Conclusion

This dissertation proposes to examine the nuanced interplay between **ego-related trauma** and **narcissistic vulnerability** in shaping PTSD outcomes. By combining psychological inventories, physiological markers, and personal narratives, the research aims to provide a rich, multi-layered understanding of how a fragile self-concept transforms traumatic events into profound distress. Should hypotheses be confirmed, the findings will illuminate the “wounded god” – the narcissist whose hidden pain drives pathological responses – and will suggest that trauma care must attend not only to what happened, but to the inner value system of the one who suffered.

Sources: Findings and theoretical frameworks are drawn from current literature, including recent empirical work linking narcissism and PTSD ¹ ⁷, meta-analytic reviews of shame in trauma ¹⁰ ⁵, and stress physiology research on social-evaluative threats ⁶. Instrument information is based on standard references (PNI, PCL-5, etc.) ³ ⁸. All aspects of the study design and interpretation integrate multicultural and ethical considerations as guided by best practices.

¹ **Specific narcissistic traits appear to heighten veteran PTSD risk**

<https://www.psypost.org/specific-narcissistic-traits-appear-to-heighten-veteran-ptsd-risk/>

² **Vulnerable narcissism and emotion dysregulation linked to binge-watching**

<https://www.psypost.org/vulnerable-narcissism-and-emotion-dysregulation-linked-to-binge-watching/>

³ **PTSD Checklist for DSM-5 (PCL-5) - PTSD: National Center for PTSD**

<https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

⁴ **Dissociative Experiences Scale (DES-II): Screening for Dissociative Identity Disorder and more**

<http://traumadissociation.com/des>

⁵ ¹⁰ **Association Between Shame and Posttraumatic Stress Disorder: A Meta-Analysis - PMC**

<https://pmc.ncbi.nlm.nih.gov/articles/PMC7500058/>

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