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Differences in Narcissistic Presentation in Abused and Non-Abused Children and Adolescents

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The University of Southern Mississippi

DIFFERENCES IN NARCISSISTIC PRESENTATION IN ABUSED
AND NON-ABUSED CHILDREN AND ADOLESCENTS

by

Mallory Laine Malkin

Abstract of a Dissertation
Submitted to the Graduate School
of the University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

August 2014

ABSTRACT

DIFFERENCES IN NARCISSISTIC PRESENTATION IN ABUSED AND NON-ABUSED CHILDREN AND ADOLESCENTS

by Mallory Laine Malkin

August 2014

The present study examined whether children and adolescents who have been victims of sexual or physical abuse report higher levels of narcissistic tendencies than children and adolescents who have not been victims of abuse. In addition to narcissism, internalizing symptoms, externalizing behaviors, and risky behaviors were evaluated, as such issues have been associated with both maltreatment (Baer & Maschi, 2003) and narcissism (Barry & Malkin, 2010; Bushman & Baumeister, 1998). One-hundred fifty-six (156) children and adolescents (100 females, 56 males) ranging in age from 8 to 17 ($M = 12.90, SD = 2.66$) were recruited as participants. The vast majority of participants were African American (86.5%). Sixty-one (61) of the participants were children and adolescents referred for forensic medical evaluations resulting from reported sexual or physical abuse, and the remaining 95 participants were recruited from the community. Contrary to hypotheses, children/adolescents in the abused group demonstrated significantly lower narcissism than those in the community group. Community participants also reported somewhat higher risk-taking behaviors than the children and adolescents in the abused group. The implications of these findings for understanding narcissism and risk-taking behaviors as a function of abuse history are discussed.

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August 2014

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CHAPTER I

INTRODUCTION

Physical and sexual abuse of children is a significant issue that needs further attention as to the lasting effects on victims. Abuse can have long-term consequences on the development of a child or adolescent, as "survivors of abuse are affected physically, emotionally, cognitively, behaviorally, relationally, and spiritually, and [such] injuries in each of these areas needs to be addressed in treatment" (James, 1994; as cited in Weitzman, 2005, p. 321). Furthermore, childhood maltreatment has been associated with emotional and social difficulties, aggression, hostility, extreme passivity, and withdrawal, as well as low self-esteem and a high incidence of juvenile delinquency (Erickson & Egeland, 2002). Therefore, studying children and adolescents who have been victims of abuse can help illuminate associations with psychological difficulties, behavioral problems, and variations in coping styles that can, in turn, inform intervention efforts. Of particular interest in the present study is whether children and adolescents who had suffered abuse would exhibit higher levels of narcissistic tendencies than non-abused children and adolescents. Specifically, the present study conceptualizes narcissism as a potential coping mechanism for children/adolescents dealing with a history of sexual and/or physical abuse.

Abuse

Each state in the United States of America has a different definition of physical and sexual abuse, which may affect the reporting rate of these incidents (Kolko, 2002). Societal opinions and cultural perspectives also affect how abuse is viewed and whether it is brought forth to law enforcement or child protective services (Kolko, 2002). This

lack of consistency in definition and investigation could result in prolonged child abuse because law enforcement may be unable to press charges or remove the child from the home given the state's regulations, which is likely to have a profound effect on the child's personality development (Erickson & Egeland, 2002). Likewise, individual states have different legal definitions of what constitutes child sexual abuse (Berliner & Elliott, 2002). Prevalence rates of child sexual abuse are difficult to calculate because of the inconsistency in definition, lack of reporting, and the complication that many statistics are garnered from retrospective reports with adult clinical populations (Berliner & Elliott, 2002).

Physical abuse, sexual abuse, and neglect as defined by the Child Abuse Prevention and Treatment Act of 1974 involves

the physical or *mental injury*, sexual abuse or exploitation, *negligent treatment*, or maltreatment of a child under the age of 18, or the age specified by the child protection law of the state in question, by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby as determined in accordance with regulations. (Kolko, 2002, p. 5, italics in original)

There have been a number of identified risk factors associated with physical and sexual abuse. Children who are victimized are at increased risk of maladaptive behaviors and deteriorating mental health relative to their non-abused peers (Baer & Maschi, 2003). In addition to the problematic outcomes noted above, children who have been victims of abuse have shown greater difficulty with perspective taking and providing alternative strategies to problematic situations as well as inappropriate affective responses to

interpersonal interactions (Kolko, 2002). Baer and Maschi (2003) propose several different models of the self to understand the affective responses and general effects of trauma on children's and adolescents' thoughts and behaviors. They suggest that by utilizing Janoff-Bulman's (1992) theory of worthiness of self, one is better able to make sense of the behaviors of victims of abuse (as cited in Baer & Maschi, 2003). Under this model, as a result of being a victim of abuse, children may develop a "grandiose type of self-esteem," emphasizing the need for survival and worrying about their own individual self-care (Baer & Maschi, 2003, p. 90). This need for survival and pursuit of self-interest in conjunction with a grandiose presentation seem to parallel the presentation of narcissistic tendencies.

Narcissism and Abuse

Narcissism is typically conceptualized by grandiosity, dominance, and a sense of entitlement (Atlas & Them, 2008; Raskin, Novacek, & Hogan, 1991; Washburn, McMahon, King, Reinecke, & Silver, 2004). Grandiosity is a key characteristic of narcissism (Raskin et al., 1991) and thus may be considered an important influence on how children and adolescents with narcissistic tendencies interact with others and cope with difficult situations. Narcissistic grandiosity is associated with affective responses such as depression, rage, shame, and humiliation, all of which may not be expressed appropriately in certain contexts (Kohut & Wolf, 1986). These feelings, if expressed maladaptively, may impair interactions with others. Feelings of grandiosity may drive a need for survival and self-care, looking out for one's own needs, and disregarding others, which may help explain why traumatized children have deficits in interpersonal skills (Baer & Maschi, 2003). Interpersonal and behavioral difficulties (e.g., externalizing

behaviors such as aggressive or impulsive outbursts) may be the result of children who have experienced abuse trying to assert and acquire control over situations and people because of feelings of vulnerability, powerlessness, and helplessness.

Externalizing Responses

Raskin and colleagues (1991) suggest that narcissism is utilized as a form of self-esteem regulation which may act as a coping mechanism; therefore, a person with high levels of narcissistic tendencies may develop aggressive tendencies or a grandiose self-presentation to defend against perceived interpersonal threats to his or her self-image. As a result of attempting to gain and maintain control over their environment (Berliner & Elliott, 2002), children who have experienced abuse may present with certain behaviors such as aggression and manipulation. Some of these control-seeking behaviors and need to maintain a strong self-image are similar to narcissistic tendencies. For example, aggression is a common response by individuals with high levels of narcissism as a means of protecting themselves against interpersonal threats (e.g., Bushman & Baumeister, 1998; Thomaes, Bushman, Orobio de Castro, Cohen, & Denissen, 2009). Children and adolescents who have been victims of abuse also often react aggressively when threatened (Kolko, 2002), mirroring the same response as individuals with narcissistic tendencies (Thomaes, Bushman, Stegge, & Olthof, 2008). For individuals who have experienced maltreatment or who have high levels of narcissism, such attempts to garner control and stabilize one's self-image through aggression may be an effort toward coping with insecurity and unstable self-esteem.

Furthermore, employing a narcissistic means of self-protection to cope with experienced abuse or maltreatment may be associated with more varied maladaptive and

risky behaviors, as narcissism has been related to behaviors such as substance abuse (Zullig, Valois, Huebner, Oelmann, & Drane, 2001) and gambling (Lakey, Rose, Campbell, & Goodie, 2008) as well as other externalizing difficulties including conduct problems (Barry, Frick, & Killian, 2003), delinquency, and aggression (Barry, Grafeman, Adler, & Pickard, 2007; Barry, Pickard, & Ansel, 2009). Likewise, having experienced abuse seems to increase a child's proclivity toward risky and maladaptive behaviors (Zullig et al., 2001). Therefore, it is important to evaluate externalizing behaviors, such as risk-taking behaviors, in conjunction with narcissistic tendencies, particularly in a sample of children who have experienced abuse.

It is also the case that children and adolescents are generally more inclined to engage in risky behaviors than adults (Goldberg, Halpern-Flesher, & Millstein, 2002). Early rewarding experiences of risk-taking may lead to further engagement in such behaviors as the child matures (Goldberg et al., 2002). However, other life experiences, relevant to the present study, may also lead a child toward an increased tendency of engaging in risky behaviors. For instance, Howard and Wang (2005) found that adolescents who were forced into sexual intercourse during childhood were more likely than other youth to engage in excessive alcohol, cigarette, and cocaine use as well as risky sexual behaviors (e.g., multiple partners, unprotected sex). Females who were sexually abused were more likely to contemplate suicide, physically fight, drink, and smoke excessively, whereas males who were sexually abused were more likely to carry a weapon and attempt suicide (Howard & Wang, 2005). Howard and Wang (2005) concluded that childhood abuse has important and influential effects on adolescent and adult behavior, including a tendency to engage in risky behaviors. Baer and Maschi

(2003) further suggested that childhood victims of abuse engage in self-destructive or risky behaviors such as delinquency or later criminal behavior because they believe themselves to be unworthy and act in this manner as a way to punish themselves. For example, risk-taking (e.g., petty stealing) may escalate to more severe forms of antisocial behavior as the child matures. Means of attempting to control one's environment may be an act driven by an unstable and fragile identity. The fragility seen among individuals with narcissistic tendencies and among individuals who have experienced childhood abuse may be an important factor to consider not only in their engagement of risk-taking and externalizing behaviors but also internalizing responses (Kolko, 2002; Thomaes et al., 2008).

Internalizing Responses

Internalizing symptoms have also been associated with narcissism in adolescents (Barry & Malkin, 2010). It is believed that individuals with narcissistic tendencies tend to utilize distant and indifferent responses when interacting with others in an effort to bolster their self-image (Morf & Rhodewalt, 2001). Morf and Rhodewalt (2001) explain that these strategies may result in negative interactions with peers as well as negative emotions, such as depression, anxiety, and low self-esteem. Interpersonal deficits and associated internalizing problems, such as those seen in individuals with narcissistic characteristics, have also been observed in children who have experienced abuse. For example, child victims of sexual abuse are at increased risk of many internalizing symptoms, such as feelings of shame and guilt, depression, emotion dysregulation, and low self-esteem compared to children who have not been victims of abuse (Berliner & Elliott, 2002). Because internalizing problems are consistently related to self-esteem,

self-esteem was included in the present study as a potential control variable. Increased suicidality, self-harming behaviors, hypervigilance, and somatic complaints are also present in child sexual abuse victims (Berliner & Elliott, 2002). Interpersonal difficulties may exacerbate feelings of sadness and low self-esteem (Baer & Maschi, 2003). Being a victim of childhood abuse may also interfere with the development of appropriate interpersonal skills, evidenced by distancing or dissociating oneself from others as well as showing a lack of empathy or interest in others (Baron, Reznikoff, & Glenwick, 1992).

A lack of empathy has also been linked to aspects of narcissism (e.g., exploitativeness), that are, in turn, related to depression and anxiety (Washburn et al., 2004). In addition, the existing literature indicates that fragile self-views or unstable identities seem to characterize both victims of abuse who have difficulty valuing their own identity and self-worth (Finkelhor & Browne, 1985), as well as individuals with narcissistic tendencies (Zeigler-Hill, 2006). Therefore, because both narcissism and a history of abuse are related to internalizing symptoms, youth who have been abused who also exhibit narcissistic characteristics may have an even higher incidence of internalizing symptoms than non-abused youth or youth who have experienced abuse but do not exhibit narcissism.

Narcissism as a Potential Coping Style

Childhood abuse is thought to occur in environments that are invalidating (Miller et al., 2010), which would potentially elicit some sort of coping response to overcome feelings of worthlessness and insecurity. Coping style is an important factor related to the presentation of symptoms that may stem from abuse (Berliner & Elliott, 2002). A narcissistic coping style may initially serve a useful purpose for childhood victims of

abuse; however, maladaptive internalizing and externalizing symptoms may develop in response to such a coping style. As a result, narcissism may be initially necessary in coping with abuse, but these same tendencies may increase the child's tendency toward maladjustment (e.g., anxiety, aggression, risk-taking behaviors) that may be detrimental to his or her emotional well-being. Specifically, as mentioned previously, Baer and Maschi (2003) suggested that children who are victims of abuse have a "grandiose type of self-esteem" (p. 90), which has been associated with a need for survival and an increased tendency toward reacting with aggression to a perceived threat. Therefore, children who have been abused may continue to feel threatened and feel the need to survive, which may contribute to more impulsive and maladaptive behaviors as well as interpersonal difficulties.

The primary question addressed in the present study was whether children and adolescents who had been victims of physical or sexual abuse exhibited more narcissistic tendencies than non-abused youth. The present study was based on the theory that children and adolescents who have experienced abuse utilize narcissistic tendencies, such as asserting power, to cope with their trauma history. Individuals high on narcissistic tendencies often attempt to dominate others in an attempt to maintain their own self-image and stabilize their social identity (Raskin et al., 1991), which is congruent with findings that traumatized children emphasize their own needs over those of others as a means of survival and gaining power (Baer & Maschi, 2003). Narcissistic tendencies, a potential coping strategy for individuals who have experienced trauma, may be important to explore to help understand the varied presentations of youth who have experienced abuse. Narcissism may allow a young person to regain a sense of power and security

after feeling vulnerable and powerless. However, what may initially be protective for the child/adolescent may actually contribute to later emotional or behavioral problems, thus indicating a need to better understand narcissism among youth who have suffered abuse.

Overt and Covert Narcissism

Research has indicated that narcissism may appear overt and/or covert (Atlas & Them, 2008). The partitioning of narcissism into overt and covert forms has been supported by at least two factor analytic studies (Rathvon & Holmstrom, 1996; Wink, 1991), and these facets of narcissism appear to differentially influence individuals' behavioral responses to the world around them (see Rose, 2002). Covert and overt narcissism both include some indications of grandiosity, but covert narcissism is thought to exist on a more unconscious level and is displayed in conjunction with poor self-confidence and lack of initiative. Individuals with covert narcissism are described as "hypersensitive, anxious, timid, and insecure but on close contact surprise observers with their grandiose fantasies" (Wink, 1991, p. 591).

On the other hand, individuals with overt narcissistic characteristics tend to have higher self-esteem and are more likely to be optimistic (Rose, 2002). In addition, overt narcissism is related to low avoidance motivation; therefore, individuals with overt narcissism are not inhibited against impulsive responses to an ego threat and may even behave in ways that are self-serving to remedy any perceived threats to their self-concept (Foster & Trimm, 2008). Overt narcissism tends to be associated with high self-esteem and optimism, but covert narcissism is thought to co-occur with depressive symptoms and anxiety (Rose, 2002). Perhaps the most important distinction between these two aspects of narcissism is that individuals with overt narcissistic tendencies tend to exhibit

more externalizing symptoms, whereas individuals with covert narcissistic tendencies tend to demonstrate more internalizing symptoms (Wink, 1991). Ashby, Lee, and Duke (1979) and Serkownek (1975) described individuals with covert narcissistic tendencies as anxious and lacking confidence in themselves and their decisions. Individuals who have higher levels of covert narcissistic tendencies also tend to be sensitive to criticism and to experience high levels of negative emotional reactivity (Atlas & Them, 2008), such as anxiety and shame.

It is possible that individuals may exhibit different features of narcissism. The nature of the narcissistic tendencies may play a role in how an individual may react to threatening environments or aversive situations. Overt and covert narcissism may be related differently to emotional and behavioral difficulties, especially among children and adolescents who are victims of abuse. Additionally, physical and sexual abuse have been associated with different emotional and behavioral responses. Physical abuse victims are more likely than non-abused children to react with aggression when threatened and are more likely to view social interactions as hostile than non-abused children (Berliner & Elliot, 2002), whereas sexual abuse victims are more likely than non-abused children to display feelings of shame and guilt in response to feeling threatened (Kolko, 2002).

These differences seem to mirror similar distinctions between overt and covert narcissism. Children and adolescents who have been physically abused appear to utilize similar strategies as individuals with overt narcissistic tendencies. That is, overt narcissism has been linked to aggression in the face of threats to one's self-image (Bushman & Baumeister, 1998) as well as to hostile perceptions of peer interactions (Kernis, Grannemann, & Barclay, 1989). Similarly, some of the correlates of sexual

abuse appear to parallel the lack of self-confidence, insecurity, and negative emotional reactivity recognized in covert narcissism (Atlas & Them, 2008). Therefore, there may be differences in the presence of each form of narcissism based on the type of abuse (physical or sexual) that a young person has experienced, a possibility that was explored in the present study.

The Present Study

The present study investigated the relation between experiences of physical or sexual abuse and levels of narcissism in both an abused sample and a non-abused community sample. Specifically, this study examined whether individuals who have experienced abuse are likely to have higher narcissism than non-abused children and adolescents, presumably as a means of protecting against concerns about safety and uncertainty in interpersonal relationships. The majority of past research has discussed internalizing and externalizing difficulties, as well as other personality features, in children and adolescents who have been victims of abuse (e.g., Berliner & Elliott, 2002; Kolko, 2002). However, this study aimed to extend previous research by considering the connection between narcissism and specific internalizing (i.e., anxiety; depression; somatic) and externalizing behaviors (i.e., delinquency; aggression; risky behaviors) as a function of experienced abuse. The present study is an initial step in differentiating the relations of potential coping strategies with maladaptive emotional and behavioral responses among child victims of abuse. Investigations such as the present study could benefit treatment efforts for children and adolescents who have been victims of abuse by allowing a better understanding of potential coping strategies that may emerge after abuse

and the maladaptive emotional and behavioral responses that may also be evident in the presence of coping strategies such as narcissism.

Hypotheses

It was hypothesized that children and adolescents who were suspected to have experienced abuse would have higher levels of both overt and covert narcissism than non-abused children and adolescents (Hypothesis 1). It was also hypothesized that covert narcissism would be greater in children and adolescents who had reportedly suffered sexual abuse than in children and adolescents who had reportedly been physically abused (Hypothesis 2), but it was predicted that overt narcissism would be higher in children and adolescents who had been physically abused than in children and adolescents who had been sexually abused (Hypothesis 3). It was expected that overt narcissism would be positively related to externalizing symptoms and risk-taking behaviors independent of abuse status (Hypothesis 4). Furthermore, it was expected that abuse status (abused vs. non-abused) would moderate the relation between overt narcissism and externalizing (i.e., delinquency, aggression) and risk-taking behaviors (e.g., alcohol, drug, and tobacco use, physical fighting, use of weapons, and bullying) such that abuse status would exacerbate both externalizing behaviors and risk-taking behaviors (Hypothesis 5). It was also hypothesized that covert narcissism would be positively related to internalizing problems (i.e., anxiety; depression; somatic) independent of abuse status (Hypothesis 6). Lastly, it was expected that abuse status (abused vs. non-abused) would moderate the relation between levels of covert narcissism and internalizing problems, such that abuse status would exacerbate internalizing problems (Hypothesis 7).

CHAPTER II

METHODOLOGY

Method

Participants

One-hundred fifty-six (156) children and adolescents ranging in age from 8 to 17 ($M=12.90$, $SD =2.66$) were recruited for the present study. The majority of the overall sample was female ($n = 100$; 64.1%) and African American ($n = 135$; 86.5%). Sixty-one (61) of the participants were youth referred for forensic medical services due to allegations that they had been victims of physical abuse or sexual abuse. These participants ranged in age from 9 to 17 ($M=12.64$, $SD =2.17$), and the majority were female ($n = 52$) and African American ($n=47$). Twelve participants reported their ethnicity as Caucasian, and two reported "other" (Table 1).

The remaining participants were recruited from an after-school program and a public high school from the local community to form a community group. The students in the public school system in the area are predominantly African American. The high school students who participated in the present study were approached during their health classes by the researcher. The after-school program was on the same street as the participating public high school. The community group consisted of 95 children and adolescents ranging from 8 to 17 years of age ($M= 13.07$, $SD =2.93$). These participants were screened to ensure that none of them had ever been victims of sexual and or physical abuse. The majority of participants in the community group were female ($n = 48$) and African American ($n = 88$). Three participants reported their ethnicity as Caucasian, one reported Hispanic, and three reported "other."

Participants in the community sample were matched based on sociodemographic variables (e.g., age, gender, ethnicity, and socioeconomic status) to participants in the abused sample to test hypotheses and control for potential demographic influences on the result after analyses were conducted on the overall sample.

Materials

Demographic Information Form. Parents/guardians in both the community and abused samples completed a brief form that provided basic demographic information. If the parent/guardian was unavailable, the custodial guardian provided consent for participation, and the child/adolescent (with a research staff member's assistance) completed a brief set of demographic questions to obtain information about the participant's race, age, socioeconomic status (SES), and gender. SES was based on reported parental occupation and was calculated by means of the Duncan's Socioeconomic Index Score Method (Hauser & Featherman, 1977).

Narcissistic Personality Inventory for Children (NPIC; Barry et al., 2003). The NPIC is a self-report inventory that assesses overt narcissism in children and adolescents. The NPIC is derived from the Narcissistic Personality Inventory (NPI; Raskin & Terry, 1988), which is used widely with adults. The NPIC contains 40 items, and each item contains paired narcissistic and non-narcissistic statements. The respondent chooses one of the statements and then rates how true (e.g., *sort of true* or *really true*) the selected statement is for him or her. The NPIC was designed to assess the same features as the NPI while using developmentally appropriate language for youth. Items are scored on a scale ranging from 0 to 3; thus, total scores can range from 0 to 120. Barry and colleagues (2003) found an internal consistency coefficient of $\alpha = .82$ for the NPIC in a

sample of adolescents (Barry et al., 2007). Based on its conceptual overlap with the adult NPI, the NPIC has good content validity, has been found to have predictive utility in adolescents (Barry, Frick, Adler, & Grafeman, 2007), and is correlated with other measures of youth narcissism (Barry & Wallace, 2010). The present study yielded an internal consistency of $a = .81$ for the overall sample.

The Hypersensitive Narcissism Scale (HSNS; Wink & Cheek, 1998). The HSNS assesses covert narcissism and was developed by Wink and Cheek (1998) using items from the Murray Narcissism Scale (Murray, 1938), with additional items added to further assess covert narcissism. The measure consists of 10 items (e.g., "I can become entirely absorbed in thinking about my personal affairs, my health, my cares or my relations to others"; "My feelings are easily hurt by ridicule or the slighting remarks of others") with responses made on a 5-point Likert scale, ranging from *very uncharacteristic* to *very characteristic* (Hendin & Cheek, 1997). In a sample of college students, the internal consistency of the HSNS was $a = .87$ (Atlas & Them, 2008). The HSNS was correlated near zero with the NPI in a study of 260 undergraduate students, demonstrating good discriminant validity in delineating between overt and covert narcissism (Hendin & Cheek, 1997). The present study yielded an internal consistency of $a = .64$ for the full sample.

Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorla, 2001). The ASEBA Youth Self-Report (YSR) is a 112-item self-report measure using a 3-point Likert scale (*Not True, Somewhat True, or Very True*). The Externalizing Problems and the Internalizing Problems scales were used for the present study. Achenbach and Rescorla (2001) found a test-retest reliability of $a = .90$ for both the

Externalizing Problems and Internalizing Problems scales of the YSR. The Externalizing Problems Scale is composed of both the Rule-Breaking and Aggressive Behavior subscales (Achenbach et al., 2008). Thirty-two items comprise the Externalizing Problems Scale, including items such as "I drink alcohol without my parents' approval," "I don't feel guilty after doing something I shouldn't," and "I get in many fights" (Achenbach & Rescorla, 2001). The ASEBA YSR Externalizing Problems Scale was significantly correlated with the following scales from the Behavior Assessment for Children, 2nd edition (BASC-2), $r = .67$ (School Problems), $r = .72$ (Inattention/Hyperactivity), $r = .44$ (Sensation Seeking; Reynolds & Kamphaus, 2004).

The ASEBA YSR Internalizing Problems Scale is composed of 31 items from the Anxious/Depressed, Withdrawn Depressed, and Somatic Complaints subscales (Achenbach et al., 2008). Examples of YSR Internalizing Problem items include "I cry a lot," "I am afraid of certain animals, situations, or places other than school," and "I am unhappy, sad, or depressed" (Achenbach & Rescorla, 2001). The ASEBA YSR Internalizing Problems Scale was significantly correlated, $r = .83$, with maternal report of Internalizing Problems on the BASC-2, $r = .80$, with paternal report of Internalizing Problems on the BASC-2, $r = .75$, and with BASC-2 teacher report of Internalizing Problems (Achenbach & Rescorla, 2001). Research indicates that the YSR's Externalizing and Internalizing Problems scales provide the ability to discriminate between clinically-referred and non-referred children suggesting good criterion-related validity (Achenbach et al., 2008). The present study yielded a Cronbach's alpha coefficient of $\alpha = .91$ for the Internalizing Scale and $\alpha = .89$ for the Externalizing Scale for the overall sample.

Youth Risk Behavior Survey (YRBS; Centers for Disease Control and Prevention, 2011). The Youth Risk Behavior Survey (YRBS) was developed initially in 1999 and in its original format was composed of 50 items, with some items providing dichotomous responses (e.g., "yes" or "no") regarding whether the respondent has ever engaged in a behavior, other questions asking about the frequency of a behavior, others inquiring about the age at which the respondent engaged in a behavior, and other questions offering multiple responses, such as, for example, "During the past 30 days how did you usually get your own cigarettes?" (i.e., "I bought them in a store" or "I gave money to someone else to buy them for me"). For the present study, a participant's YRBS score for 13 dichotomous items represented the number of separate acts in which he/she reported having engaged (e.g., "Have you ever smoked a cigarette?") with a possible range of 0-13.

The YRBS addresses the following six areas: behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted infections, including human immunodeficiency virus (HIV) infection; unhealthy dietary behaviors; and physical inactivity (Brener et al., 2004). For the purposes of the present study, the scale was modified to reflect specific variables of interest and did not include questions related to sexual behavior, as well as unhealthy dietary behaviors and physical inactivity. The YRBS items pertaining to sexual intercourse were omitted due to concerns regarding use in the community sample, as well as potential confounds related to how the victims of sexual abuse perceived and defined their sexual experiences. More specifically, for the present study, the YRBS was composed of items pertaining to violence, tobacco use, and

alcohol and drug use, as children who have experienced abuse have a higher propensity toward these behaviors than non-abused children (Howard & Wang, 2005). The present study yielded an internal consistency of $a = .63$ for the 13 YRBS items to which participants responded.

Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The RSES has been widely used in the study of global self-esteem in adolescents and adults. It consists of 10 items, rated on a 4-point scale, ranging from "strongly agree" to "strongly disagree." The RSES has good psychometric properties, including with adolescents. For example, a study utilizing a sample of Canadian adolescents, ranging in age from 12 to 19 years old, demonstrated an internal consistency coefficient of $a = .86$ for the RSES (Bagley, Bolitho, & Bertrand, 1997). Self-esteem was considered as a control variable in the present study. The present study yielded an internal consistency of $a = .72$ for the RSES.

Procedure

For the participants who had allegedly been victims of abuse, parent/guardian consent was obtained at the time that the participants attended their medical appointment at the forensic medical center. Parents/guardians were approached while they were in the waiting room with their child; the researcher inquired if they would be interested in completing the present study; and if so, assent was also obtained from the child. The child had the option of completing their measures in the waiting room or in a private conference room. Parental consent was obtained prior to data collection for participants in the community group. The researcher attended the public high school's four health class periods, with the permission of the superintendent, principal, and teacher. The researcher explained the purpose of the study, answered any questions, and provided

students with consent forms and demographic forms to be completed by their parent/guardian at home. The students were given a week to have the forms completed by their parent/guardian if they were permitted to participate. They then had to return the completed forms to their health class teacher. The researcher picked up completed demographic and consent forms and returned in a week to have those students with consent complete the study's measures. Data collection at the after-school program, also located within the public school district, occurred on two separate occasions. The researcher attended the after school program during sign-in time for a week to approach parents/guardians regarding the purpose of the study. Consent and demographic forms were completed during this sign-in time. Once consent was obtained, the researcher arranged to return to have the children complete the study's measures. The researcher brought pizza for the after-school program, since the data collection was during their usual snack time. After consent from the parent or guardian, the participants in each group had the opportunity to agree or refuse to participate in the study through signing an informed assent form. Refusal to participate did not affect the adolescent's grade or standing in school.

At the forensic medical center, the measures for the present study were provided separately from the participants' medical paperwork (i.e., paperwork related to their consent for the forensic medical evaluation with regard to their reason for referral). Refusal to participate in the study did not affect the child/adolescent's medical appointment. Participants were informed of their right to refuse participation or to withdraw from participation at any time and were asked to complete several measures taking approximately 60 to 90 minutes to complete. If the child or adolescent was unable

to read the measures to him or herself, a nurse, clinic assistant, or research assistant read the instructions and items. The nurses, clinic staff, and research staff were briefed on the purpose of each measure as well as how to appropriately administer them and answer questions from the participants. The participants were asked to complete the NPIC, HSNS, ASEBA-YSR, YRBS, and RSES. Due to inconsistent accompaniment of biological parent(s) with children and adolescents brought to the forensic medical center for forensic evaluation, self-report measures and review of each participant's forensic medical file were used as the primary sources of information for the present study. Procedures were put in place such that if a child and/or adolescent in the community group were to disclose abuse on any of the provided measures or verbally disclose such information to any research staff member, the primary investigator of the study would be informed. The investigator would then follow proper ethical guidelines to evaluate whether the alleged abuse had already been reported to proper authorities or whether she was mandated to report the disclosed incident(s) to the Department of Human Services (DHS). However, no child and/or adolescent in the community group disclosed any form of possible abuse.

The consent and assent forms also requested permission to access the child/adolescent's file at the forensic medical center to confirm the type of abuse (sexual and/or physical) allegedly experienced by the child or adolescent. All such information was de-identified.

CHAPTER III

RESULTS

Demographic information for both the community group and the abused group is shown in Table 1.

Table 1

Demographic Information for Overall Sample (N = 156)

	Mean	SD	Range	Percentage	Frequency
Alleged Abuse Victim				39.1	61
Age	12.90	2.66	8-17		
Socioeconomic Status	33.56	22.46	0-92		
Gender					
Male				35.9	56
Female				64.1	100
Ethnicity					
African American				86.5	135
Caucasian				9.6	15
Hispanic				.6	1
Other				3.2	5

Note: SD (Standard Deviation); Age = years

Descriptive statistics for the main variables are shown in Table 2.

Table 2

Descriptive Statistics for the Variables of Interest (N=156)

Variable (possible range)	<i>M</i>	<i>SD</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Skewness</i>
Narcissism (0-120)	59.91	16.12	26.00	103.59	.39
Covert Narcissism (0-50)	29.82	7.31	10.00	46.00	-.19
Internalizing Symptoms (0-62)	16.58	11.13	0.00	51.00	.88
Externalizing Symptoms (0-64)	13.26	9.83	0.00	47.00	1.09
Risk taking Behaviors (0-8)	2.60	1.93	0.00	7.00	.50
Self-Esteem (0-40)	17.79	3.62	8.00	33.33	.21

A *Chi-Square* analysis with Crosstabs was used to test for differences between the groups with regard to participants' ethnicity. There was a significant difference between the abused and community groups on ethnicity (coded African American, Caucasian, Hispanic, and Other), $X^2(3) = 12.22, p = .007$, such that 88 of the 95 (92.6%) community participants were African American, and 47 of the 61 (77%) abused participants were African American. An independent samples t-test was conducted to examine mean differences in age between the abused ($M = 12.64, SD = 2.17$) and community groups ($M = 13.07, SD = 2.93$), with the results demonstrating that the groups were equivalent on average, $t(154) = -1.00, p = .32$. An independent samples t-test also revealed that the two groups did not significantly differ on average socioeconomic status, ($M_{abused} = 30.02, SD_{abused} = 22.74; M_{community} = 35.84, SD_{community} = 22.10$), $t(154) = -1.59, p = .11$. However, the groups differed on gender, $t(154) = 4.69, p < .001$, with the abused group being

predominantly female (85.2%) compared to the community group (50.5%), which was balanced with regard to gender.

Overall Sample

Correlational analyses were conducted to examine the relations among the variables of interest (i.e., overt narcissism, covert narcissism, internalizing symptoms, externalizing symptoms, and risk-taking behaviors) and potential control variables (i.e., gender, self-esteem, ethnicity, and socioeconomic status) with results shown for the full sample in Table 3.

Table 3

Correlations among Variables of Interest for Overall Sample (N = 156)

	2	3	4	5	6	7	8	9	10
1. Gender	.12	-.35***	-.05	-.12	.15	.32***	.09	-.07	-.18*
2. Age		.08	-.15	-.04	-.04	-.08	.02	.34***	.01
3. Abuse Status			.13	.22**	-.06	-.14	.03	.16*	.14
4. SES				.08	.03	-.08	-.09	-.12	-.05
5. Overt Narcissism					.23**	-.14	.23**	.08	.25**
6. Covert Narcissism						.31***	.24**	-.02	-.06
7. Internalizing Symptoms							.54***	.16*	-.21**
8. Externalizing Symptoms								.31***	.07
9. Risk-taking Behaviors									.04
10. Self-Esteem									

Note: Gender coded as 0 = male and 1 = female; Abuse Status coded as 0 = abused group and 1 = community group

* $p < .05$. ** $p < .01$. *** $p < .001$.

Overt narcissism was significantly positively related to covert narcissism, $r = .23, p = .004$, self-esteem, $r = .25, p = .002$, and externalizing symptoms, $r = .23, p = .004$. Covert narcissism was also significantly positively related to internalizing symptoms, $r = .31, p < .001$, and externalizing symptoms, $r = .24, p = .003$. In addition, internalizing symptoms were significantly positively related to gender (coded 0 for male and 1 for female), $r = .32, p < .001$, externalizing symptoms, $r = .54, p < .001$, and risk-taking behaviors, $r = .16, p = .045$, and significantly negatively related to self-esteem, $r = -.21, p = .008$. Thus, both gender and self-esteem were controlled for in subsequent moderated multiple regression analyses in which internalizing symptoms were the dependent variable. Lastly, risk-taking behaviors were significantly positively related to externalizing behaviors, $r = .31, p < .001$, and age, $r = .34, p < .001$. Therefore, age was controlled for in subsequent analyses in which risk-taking behaviors were the dependent variable. Furthermore, it should be noted that scores on the externalizing problems scale were slightly positively skewed in the overall sample (externalizingskewness = 1.09) such that scores tended to cluster toward the lower end of the scale in the overall sample (see Table 2). This trend was also evident in the abused group (externalizingskewness = 1.23) and non-abused group (externalizingskewness = 1.03).

Group differences were also examined on the dependent variables of interest.

There was not a significant difference between the abused group ($M = 12.90, SD = 9.08$) and the community group ($M = 13.49, SD = 10.32$) on externalizing symptoms, $t(154) = -.37, p = .71$. However, the abused group ($M = 2.23, SD = 1.82$) and the community group ($M = 2.84, SD = 1.96$) differed somewhat on risk-taking behaviors, $t(154) = -1.96, p = .052$, such that children and adolescents in the community group exhibited slightly more

risk-taking behaviors. A one-way ANCOVA was conducted to account for age in the relation of risk-taking between groups, $F(1, 154) = .73, p = .39$. There was no difference between the abused group ($M = 18.44, SD = 10.61$) and the community group ($M = 15.38, SD = 11.35$) on internalizing symptoms, $t(154) = 1.69, p = .09$. A one-way ANCOVA was conducted to control for self-esteem in the analysis of group differences on internalizing problems, $F(1, 154) = .90, p = .35$. Again, the two groups did not differ on internalizing problems.

Tests of Study Hypotheses

It was hypothesized that children and adolescents who were suspected to have experienced abuse would have higher levels of both overt and covert narcissism than non-abused children and adolescents (Hypothesis 1). Hypothesis 1 was examined by conducting independent samples t-tests to evaluate mean differences in overt and covert narcissism between the abused group and the community group. There was not a significant difference in covert narcissism between the abused ($M = 30.39, SD = 7.77$) and community groups ($M = 29.45, SD = 7.01$), $t(154) = .78, p = .43$. However, there was a significant difference in overt narcissism, such that individuals in the abused group ($M = 55.59, SD = 13.60$) tended to report *lower* overt narcissism than participants in the community group ($M = 62.67, SD = 17.05$), $t(154) = -2.74, p = .007$. Therefore, Hypothesis 1 was not supported.

Additionally, it was hypothesized that covert narcissism would be greater in children and adolescents who had reportedly suffered sexual abuse than in children and adolescents who had reportedly been physically abused (Hypothesis 2), but it was predicted that overt narcissism would be higher in participants who had been physically

abused than those who had been sexually abused (Hypothesis 3). It should be noted that there was a very low number of participants who had allegedly experienced physical abuse in this sample, (i.e., $n = 53$ sexual abuse, $n = 6$ physical abuse, $n = 2$ both, with those who experienced both being excluded from these analyses). An independent samples t -test was conducted, and there was not a significant difference in covert narcissism between those who allegedly had experienced sexual abuse ($M = 30.48, SD = 7.72$) and those who allegedly had been physically abused ($M = 30.83, SD = 8.77$), $t(58) = -1.1, p = .92$. Therefore, Hypothesis 2 was not supported. There was also not a significant difference in overt narcissism between those who allegedly had experienced sexual abuse ($M = 55.33, SD = 13.48$) and participants who had allegedly been physically abused ($M = 63.27, SD = 16.42$), $t(58) = -1.34, p = .19$. Therefore, Hypothesis 3 was not supported.

It was also hypothesized that overt narcissism would be positively related to externalizing symptoms independent of abuse status (Hypothesis 4). This hypothesis was examined by conducting a multiple regression analysis and evaluating the main effect of overt narcissism on externalizing symptoms, controlling for abuse status (coded as 0 = abused group; 1 = community group). In this model, there was a significant main effect for overt narcissism, $\beta = .24, p = .004, R^2 \text{ for the model} = .05$, indicating a positive association between overt narcissism and externalizing symptoms (see Table 4). There was not a significant main effect for abuse status, $\beta = -.02, p = .80$. Therefore, Hypothesis 4 was supported.

Table 4

Multiple Regressions Analyses with Overt Narcissism as a Predictor of Externalizing Behaviors and Risk Taking Behaviors within the Overall Sample (N = 156)

	Externalizing Behaviors		Risk Taking Behaviors	
	Main Effect Model	Interaction Effect Model	Main Effect Model	Interaction Effect Model
Age			.33***	.32***
Abuse Status	-.02	-.04	.12	.10
Overt Narcissism	.24**	.43**	.07	.18
Overt Narcissism X Abuse Status		-.23		-.13
<i>R² for the model</i>	.05*	.07	.13	.14
<i>Change in R²</i>		.02		.01

Note: Abuse Status coded as 0 = abused group and 1 = community group

* $p < .05$; ** $p < .01$; *** $p < .001$

Furthermore, it was expected that abuse status would moderate the relation between overt narcissism and externalizing problems and between overt narcissism and externalizing behaviors (Hypothesis 5). This hypothesis was examined utilizing multiple regression, and the results of these analyses are shown in Tables 4 and 5. The first model included abuse status and overt narcissism in the first step in the prediction of externalizing symptoms and the interaction term for overt narcissism by abuse status entered in the second step. In this model, there was not a significant main effect for abuse status, but as noted above, there was a significant main effect for overt narcissism in the first step of the model, $\beta = .24, p = .004, R^2 \text{ for the model} = .05$. However, the interaction term for overt narcissism and abuse status was not significant, $\beta = -.23, p = .13, R^2 \text{ change for the model} = .02$. Exploratory analyses were conducted to test the model predicting

externalizing symptoms from covert narcissism and abuse status. There was not a significant main effect for abuse status, but there was a significant positive main effect for covert narcissism, $f^2 = .24, p = .003$, in the first step. The addition of the interaction term in the second step of the model did not indicate a significant relation, $f^2 = -.11, p = .34, R^2 \text{ change for the model} = .01$ (see Table 4).

In the model predicting risk-taking behaviors from overt narcissism and abuse status, controlling for age, there was not a significant main effect for abuse status, $f^2 = .12, p = .14$, or for overt narcissism, $f^2 = .07, p = .38$, in step one of the model, $R^2 \text{ for the model} = .13$ (see Table 4). There was a significant main effect for age, $f^2 = .33, p < .001$. The addition of the interaction term between overt narcissism and abuse status in the second step did not yield a significant effect, $f^2 = -.13, p = .36, R^2 \text{ change for the model} = .01$. In the model predicting risk-taking behavior from covert narcissism and abuse status, controlling for age, there was not a significant main effect for abuse status, $f^2 = .13, p = .09$, or for covert narcissism, $f^2 = .003, p = .97$, in step one, $R^2 \text{ for the model} = .13$, but there again was a significant main effect for age, $f^2 = .33, p < .001$. The addition of the interaction term for covert narcissism and abuse status did not yield a significant effect, $f^2 = -.09, p = .46, R^2 \text{ change for the model} = .00$. Therefore, Hypothesis 5 was not supported for overt narcissism.

It was also hypothesized that covert narcissism would be positively related to internalizing problems (i.e., anxiety and depression) independent of abuse status (Hypothesis 6). This hypothesis was tested via a regression model that included covert narcissism and abuse status as predictors of internalizing problems, controlling for both self-esteem and gender. In this model, there was a significant main effect for covert

narcissism, $\beta = .27, p < .001$, but not for abuse status, $\beta = -.009, p = .91, R^2$ for the model = .20. Therefore, Hypothesis 6 was supported.

In addition, it was expected that abuse status would moderate the relation between covert narcissism and internalizing problems (Hypothesis 7). Because internalizing problems were significantly correlated with self-esteem and gender, self-esteem and gender were entered as control variables in the first step of the model. This hypothesis was tested by adding the interaction between covert narcissism and abuse status in step two of the regression model. The interaction term was not significant, $\beta = -.001, p = .99, R^2$ change for the model = .00 (see Table 5).

Table 5

Multiple Regressions Analyses with Covert Narcissism as a Predictor of Internalizing Symptoms within the Overall Sample (N = 156)

	Main Effect Model	Interaction Effect Model
Self-Esteem	-.15*	-.15
Gender	.25**	.25 **
Abuse Status	-.009	-.008
Covert Narcissism	.27***	.29*
Covert Narcissism X Abuse Status		-.03
<i>R² for the model</i>	.20***	.20
<i>Change in R²</i>		.00

Note: Abuse Status coded as 0 = Abused group, 1 = Community group

* $p < .05$. ** $p < .01$. *** $p < .001$.

Exploratory analyses were utilized to examine overt narcissism as a predictor in separate analyses in the prediction of internalizing symptoms. In this model, there was not a significant main effect for abuse status, $\beta = -.09, p = .25$, or for overt narcissism, $\beta = -.07, p = .39$. The addition of the interaction term of overt narcissism by abuse status did not contribute significant predictive variance to the model, $\beta = -.07, p = .62, R^2 \text{ change for the model} = .00$ (see Table 5). Therefore, Hypothesis 7 was not supported.

Post hoc correlational analyses were conducted for each group separately to further examine patterns of relations among narcissism and the dependent variables within each group. More specifically, correlational analyses were conducted to examine the relations among the variables of interest (i.e., overt narcissism, covert narcissism, internalizing symptoms, externalizing symptoms, risk-taking behaviors) and potential control variables (i.e., gender, self-esteem, ethnicity, socioeconomic status) with results shown for the abused group in Table 6 and community group in Table 7.

Table 6

Correlations among Variables of Interest in Abused group (N = 61)

	2	3	4	5	6	7	8	9
1. Gender	.21	.08	-.10	.06	.33*	.04	-.10	-.36**
2. Age		.03	.24	.06	-.11	-.07	.29*	.06
3. SES			.17	.03	.11	.03	-.01	-.10
4. Overt Narcissism				.44***	-.06	.39**	.23	.27*
5. Covert Narcissism					.32*	.38**	.09	.04
6. Internalizing Symptoms						.44***	.16	-.41**
7. Externalizing Symptoms							.19	-.02
8. Risk-taking Behaviors								-.06
9. Self-Esteem								

Note: Gender coded as 0 = male and 1 = female; Abuse Status coded as 0 = abused group and 1 = community group

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 7

Correlations among Variables of Interest in Community Group (N=95)

	1	2	3	4	5	6	7	8	9
1. Gender		.15	-.05	-.03	.18	.28**	.13	.02	-.02
2. Age			-.26*	-.18	-.08	-.05	.06	.35**	-.03
3. SES				-.01	.05	-.17	-.17	-.23*	-.04
4. Overt Narcissism					.14	-.13	.16	-.04	.21*
5. Covert Narcissism						.30**	.16	-.07	-.13
6. Internalizing Symptoms							.61***	.20*	-.05
7. Externalizing Symptoms								.38***	.12
8. Risk-taking Behaviors									.07
9. Self-Esteem									

Note: Gender coded as 0=male and 1=female; Abuse Status coded as 0=abused group and 1=community group

* $p < .05$; ** $p < .01$; *** $p < .001$

The analyses revealed that within the community sample ($n=95$), overt narcissism and covert narcissism were not significantly related to externalizing symptoms, $r = .16, p = .13$ and, $r = .16, p = .12$, respectively; however, overt narcissism and covert narcissism were positively related to externalizing behaviors in the abused group ($n=61$), $r = .39, p = .002$, and $r = .38, p = .003$, respectively (see Table 6 & 7). *Fisher's z* transformations were calculated to determine whether there were significant differences between the magnitude of the correlations between narcissism and externalizing behaviors for the two groups. The *Fisher's z* transformation converts the

Pearson's r correlation to a normally distributed variable, z , and is a determinant of significant differences between correlation coefficients between groups (Fisher, 1921). The correlations between overt narcissism and externalizing behaviors for the two groups were not significantly different, $z' = 1.52, p = .13$. In addition, the correlation between covert narcissism and externalizing behaviors between the abused and community groups were not significantly different, $z' = 1.39, p = .17$. Overt and covert narcissism were not significantly related to risk-taking behaviors in the community group, $r = .04, p = .70$, and $r = -.07, p = .48$, respectively. Likewise, overt and covert narcissism were not significantly related to risk-taking behaviors within the abused group, $r = .23, p = .08$ and $r = .09, p = .48$, respectively. The correlations between overt narcissism and internalizing symptoms between the abused, $r = -.06, p = .63$, and community groups, $r = -.13, p = .20$, were not significantly different, $z = .42, p = .67$. Covert narcissism was significantly positively related to internalizing symptoms in both the abused group, $r = .32, p = .01$, and the community group, $r = .30, p = .003$. The correlations between covert narcissism and internalizing symptoms between the abused and community groups were not significantly different, $z' = .17, p = .87$. Overt and covert narcissism were both positively correlated in both the abused group, $r = .44, p < .001$, and the community group, $r = .14, p = .16$; however, the correlations were significantly different between the groups, $z' = 1.96, p = .03$, such that the association was stronger in the abused group.

Matched Sample

. Following these analyses, the two groups were matched based on age, gender, ethnicity, and socioeconomic status to help control for potential demographic influences on the results. As a result of the matching process, 34 community participants were

excluded. As noted above and displayed in Table 1, the abused group ($n = 61$) ranged in age from 9 to 17 years old ($M = 12.64$, $sd = 2.17$) and had a socioeconomic index ranging from 0 to 72 ($M = 30.02$, $sd = 22.74$). The majority of these participants were female ($n = 52$; 85.2%) and African American ($n = 47$; 77%). The matched community group ($n = 61$) ranged in age from 8 to 17 years old ($M = 13.05$, $sd = 2.83$) and had a socioeconomic index ranging from 0 to 92 ($M = 35.69$, $sd = 21.59$). The majority of these participants were female ($n = 46$; 75%) and African American ($n = 56$; 91.8%).

A *Chi-Square* with Crosstabs was used to test for significant differences between the matched groups with regard to participants' ethnicity. There was a significant difference for ethnicity (coded African American, Caucasian, Hispanic, and Other) between the abused group and community group, $X^2(2) = 8.13$, $p = .02$, because there were fewer Caucasians ($n = 3$) available for matching in the community sample. An independent samples *t*-test was conducted to examine mean differences in age between the abused and community groups, with the results demonstrating that the groups were equivalent on average, $t(120) = -.90$, $p = .37$. An independent samples *t*-test was conducted to examine mean differences in socioeconomic status between the abused and community groups, $t(120) = -1.41$, $p = .20$. Furthermore, an independent samples *t*-test was conducted to examine differences with regard to gender between the abused and community groups, $t(120) = 1.37$, $p = .18$. These results indicated that the matched groups were similar in their gender and socioeconomic status composition.

. Consistent with the overall sample there was not a significant difference between the abused group ($M = 12.90$, $sd = 9.08$) and the community group ($M = 13.56$, $sd = 10.36$) on externalizing symptoms, $t(120) = -.37$, $p = .71$. The abused group ($M = 2.23$, $sd =$

= 1.82) and the community group ($M = 2.74, sd = 2.06$) also did not differ on risk-taking behaviors, $t(120) = -1.45, p = .15$, whereas they differed slightly on risk-taking in the overall sample. Consistent with the overall sample, there was no difference between the abused group ($M = 18.44, sd = 10.61$) and the community group ($M = 16.54, sd = 10.88$) on internalizing symptoms, $t(120) = .98, p = .33$. Results of correlational analyses for the study variables in the matched sample are shown in Table 8. Within the matched sample self-esteem was no longer significantly related to internalizing symptoms and therefore was not used as a control variable in these analyses for the matched sample.

Table 8

Correlations among Variables of Interest in Matched Sample (N = 122)

	2	3	4	5	6	7	8	9	10
1. Gender	.19*	.12	.01	.12	.11	.34***	.12	.03	.13
2. Age		.08	.08	.05	.04	.06	.12	.37***	.01
3. Abuse Status			.13	.20*	.05	.09	.03	.13	.07
4. SES				.10	.01	.01	.03	.06	.04
5. Overt Narcissism					.28**	.07	.31**	.08	.37***
6. Covert Narcissism						.37***	.29**	.06	.11
7. Internalizing Symptoms							.50***	.22'	.17
8. Externalizing Symptoms								.33***	.08
9. Risk-taking Behaviors									.04
10. Self-Esteem									

Note: Gender coded as 0 = male and 1 = female; Abuse Status coded as 0 = abused group and 1 = community group

* $p < .05$; ** $p < .01$; *** $p < .001$.

Hypothesis 1 was examined through an independent samples t -test to evaluate mean differences in overt and covert narcissism between the matched sample of participants from the abused group and the community group. There was not a significant difference in the covert narcissism between the abused group ($M = 30.39, sd = 7.77$) and the community group ($M = 29.67, SD = 8.06$); $t(120) = .50, p = .62$. As with the overall sample, there was a significant difference in overt narcissism, such that individuals in the abused group scored *lower* ($M = 55.59, SD = 13.60$) than participants in the community group ($M = 62.37, SD = 19.82$); $t(120) = -2.21, p = .03$. Therefore, Hypothesis 1 was not supported in these analyses.

The results pertaining to Hypotheses 2 and 3 are described above and did not necessitate additional testing as the group composition did not change and the abused group composition did not change in matching. Hypothesis 4 was examined through a multiple regression analysis for the matched sample with abuse status and overt narcissism as predictors of externalizing problems. In this model, there was a significant main effect for overt narcissism, $\beta = .29, p = .002, R^2 \text{ for the model} = .08$. Therefore, Hypothesis 4 was supported.

Hypothesis 5 was again examined utilizing multiple regression analysis, this time for the matched sample of participants. The results of the regression models predicting externalizing behaviors are shown in Table 9.

Table 9

Multiple Regressions Analyses with Overt Narcissism as a Predictor of Externalizing Behaviors and Risk Taking Behaviors within the Matched Sample (N=122)

	Externalizing Behaviors		Risk Taking Behaviors	
	Matched Sample Main Effect Model β	Matched Sample Interaction Effect Model β	Matched Sample Main Effect Model β	Matched Sample Interaction Effect Model β
Age			.37***	.35***
Abuse Status	-.04	-.05	.09	.08
Overt Narcissism	.29**	.44**	.05	.17
Overt Narcissism X Abuse Status		-.19		-.15
R^2 for the model	.08**	.09	.15	.16
Change in R^2		.01		.01

Note: Abuse Status coded as 0 = abused group and 1 = community group

* $p < .05$. ** $p < .01$. *** $p < .001$

In the model predicting externalizing behaviors from overt narcissism and abuse status, there was not a significant main effect for abuse status, but, as noted above, there was a significant main effect for overt narcissism, $\beta = .29, p = .002, R^2$ for the model = .08. The interaction term for overt narcissism and abuse status entered in the next step was not significant, $\beta = -.19, p = .20, R^2$ change for the model = .01. Additionally, exploratory analyses investigated the model predicting externalizing behaviors from covert narcissism and abuse status. There was not a significant main effect for abuse status, $\beta = .04, p = .67$. However, there was a significant main effect for covert narcissism, $\beta = .26,$

$p = .004$, such that higher covert narcissism was associated with higher externalizing symptoms independent of abuse status, R^2 for the model = .07. The interaction between covert narcissism and abuse status was not significant, $p = .11$, $p = .37$, R^2 change for the model = .01.

The results of the models predicting risk-taking behaviors are displayed in Table 10.

Table 10

Multiple Regressions Analyses with Covert Narcissism as a Predictor of Internalizing Symptoms within the Matched Sample (N=122)

	Matched Sample Main Effect Model p	Matched Sample Interaction Effect Model p
Self-Esteem	-.20*	-.20*
Gender	.27**	.27***
Abuse Status	-.03	-.03
Covert Narcissism	.30***	.30***
Covert Narcissism X Abuse Status		.001
R^2 for the model	.24***	.24
Change in R^2		.00

Note: Abuse Status coded as 0 = abused group and 1 = community group

* $p < .05$. ** $p < .01$. *** $p < .001$.

In the model using overt narcissism as a predictor, controlling for age, there was not a significant main effect for abuse status, $p = .09$, $p = .32$, or for overt narcissism, $p = .05$, $p = .56$, R^2 for the model = .15. There was a significant main effect for age, $p = .37$, $p <$

.001, such that being older was associated with higher risk-taking. The addition of the interaction term for overt narcissism and abuse status did not indicate a significant moderation, $\beta = -.15, p = .32, R^2 \text{ change for the model} = .01$. Removing age as a control variable did not change these findings. Additional exploratory analyses were conducted to examine the model using covert narcissism, controlling for age. There were no significant main effects for covert narcissism or abuse status. There was a significant main effect for age, $\beta = .37, p < .001$. The addition of the interaction term for covert narcissism and abuse status did not yield a significant effect, $\beta = -.07, p = .53, R^2 \text{ change for the model} = .003$.

As noted above, it was also hypothesized that covert narcissism would be positively related to internalizing problems independent of abuse status (Hypothesis 6). The results of the regression models predicting internalizing symptoms in the matched sample are shown in Table 10. In the model predicting internalizing symptoms from abuse status and covert narcissism, there was a significant main effect for covert narcissism, $\beta = .34, p < .001$, but not for abuse status, $\beta = -.08, p = .33$. Therefore, Hypothesis 6 was supported in that covert narcissism was positively related to the prediction of internalizing symptoms while controlling for abuse status. Additional exploratory analyses examined overt narcissism as a predictor in a separate model. There was not a significant main effect for overt narcissism or abuse status in the prediction of internalizing symptoms.

In addition, it was expected that abuse status would moderate the relation between covert narcissism and internalizing symptoms in children and adolescents (Hypothesis 7). In this model, abuse status, and covert narcissism were entered in step one, and the

interaction term between covert narcissism and abuse status was added in step two. There was a significant main effect for covert narcissism, $\beta = .34, p < .001, R^2 \text{ for the model} = .12$, but not for abuse status. In the subsequent step, the interaction term was not significant, $\beta = .05, p = .66, R^2 \text{ change for the model} = .00$. Additional exploratory analyses examined overt narcissism as a predictor of internalizing problems in a separate model. In this model, there was not a significant main effect for abuse status or for overt narcissism, but there was an effect for self-esteem, $\beta = -.23, p = .016$. The addition of the interaction term for overt narcissism and abuse status did not contribute significant predictive variance to the model, $\beta = -.06, p = .70, R^2 \text{ change for the model} = .001$.

CHAPTER IV

DISCUSSION

The results of the present study suggest that narcissistic tendencies may not be a response following victimization for children who have been victims of maltreatment, as participants who allegedly had not been victims of abuse actually reported higher levels of overt narcissism than those who had. The abused and community participants in the present study also differed with regard to risk-taking behaviors, such that children and adolescents in the community group reported slightly more risk-taking behaviors than those in the abused group. This difference was not evident in the matched sample. Additionally, overt and covert narcissism were significantly correlated within the maltreated, but not the community, group, yet the magnitudes of these relations were not different across the groups. Although the study's hypotheses were generally not supported, the results provided potentially important information regarding some of the possible emotional and behavioral sequelae of abuse.

Overt Narcissism and Risk-taking Behaviors

The group difference in overt narcissism was in contrast to the study's hypothesis. Children and adolescents who have been victimized may have reported lower levels of overt narcissism because their attitudes and behavior might be influenced by fear of future abuse. Pine and colleagues (2005) found that abused children have an "attention bias away from threat," such as shying away from threatening facial expressions (e.g., anger; p. 91). On the other hand, overt narcissism in general has been associated with an "aggressive interpersonal orientation" (Bushman et al., 2009, p. 429). Such an orientation seems unlikely with abused children given their tendency to withdraw from

threatening situations and may correspond to relatively lower overt narcissism. The original hypothesis proposing that overt narcissism would be higher in the abused children than the non-abused children was based on parallel literature that suggested that children can present with overt narcissistic characteristics based on their increased impulsivity and need for survival in the face of perceived threats (Foster & Trimm, 2008).

It should also be noted that the majority of participants within the abused group were victims of sexual abuse, and it had been hypothesized that victims of sexual abuse would have lower levels of overt narcissism than victims of physical abuse but not non-abused children. Kendall-Tackett, Williams, and Finkelhor (1993) found that child victims of sexual abuse experience withdrawal and other similar symptoms. Chaffm, Wherry, and Dykman (1997) noted that avoidant coping and withdrawal provided short term benefits for child victims of sexual abuse, delaying cognitive and emotional processing of their trauma. Thus, it is possible that a child or adolescent who has been a victim of sexual abuse may employ withdrawal and avoidance, rather than overt narcissistic tendencies such as exhibitionism, grandiosity, and entitlement, to protect him/herself from perceived dangerous situations. Furthermore, drawing attention to themselves, by means of grandiose displays or entitlement, may not be viewed as a viable interpersonal strategy given their experiences. Therefore, in light of previous findings, the high percentage of participants in the abused group who had been sexually abused may help explain directionality of the group difference in overt narcissism.

In addition, Alink, Cicchetti, Kim, and Rogosch (2012) found that abused children showed significantly more withdrawn behaviors and lower levels of prosocial

behaviors than non-abused children. Similarly, Anthonysamy and Zimmer-Gembeck (2007) found that children and adolescents who had been victims of maltreatment exhibited relatively lower levels of prosocial behavior and were more likely to be disliked and ignored by peers than youth who had not been maltreated. Among abused children, lower levels of prosocial behavior and strained peer relationships may contribute to a lack of social behaviors that would be developmentally appropriate for children and adolescents (e.g., starting a conversation, asserting oneself in peer interactions). Moreover, this relative withdrawal, limited self-confidence, and lack of assertiveness could contribute to lower self-reports of overt narcissism.

On the other hand, non-abused children/adolescents may more consistently engage in peer-related activities; consequently, some individuals who are highly engaged with peers may become preoccupied with presenting a positive, grandiose self-image. Such youth may endorse narcissistic tendencies such as competitiveness, being influential over others, and gaining positive appraisals from others. In summary, although the group difference on overt narcissism was in direct contrast to the study's hypothesis, some previous studies on the interpersonal behaviors of youth who have experienced abuse may help explain why they reported lower overt narcissism relative to their non-abused peers.

Although no hypotheses regarding group differences on risk-taking behaviors were predicted, participants in the community sample also reported higher levels of risk-taking behaviors than participants in the abused group. However, this effect was rather small in magnitude. It is possible that children and adolescents who have been victimized may have higher levels of supervision by family and friends following

maltreatment; therefore, they may have fewer opportunities to engage in risk-taking behaviors. Previous studies suggest that parental support and supervision following disclosure of abuse is an important predictor of negative behaviors, such that higher levels of perceived support and supervision tend to result in lower levels of risk-taking behaviors (e.g., substance abuse and externalizing behaviors; Tremblay, Hebert, & Piche, 1999). Furthermore, many risk-taking and delinquent behaviors are associated with delinquent peer affiliations, such that peer associations appear to provide a reinforcing context for risk-taking behaviors (Boyer, 2006); however, children who have been victims of abuse tend to have a deficit in interpersonal skills (Baer & Maschi, 2003) and may not experience this reinforcing context in the way that youth who have not experienced maltreatment may. That is, many children who have experienced maltreatment may have difficulty forming peer affiliations, which could, depending on the nature of those affiliations, influence their proclivity toward risky behaviors. These factors (i.e., parental supervision, peer affiliations) were not directly examined in this study, yet they deserve further attention in future research in this area.

Furthermore, although not specifically hypothesized, there was a significant main effect for age in the prediction of risk-taking behaviors, such that older children/adolescents were more likely to engage in risk-taking behaviors. This finding is consistent with previous evidence which has demonstrated that adolescents tend to engage in more frequent and varied risk-taking behavior than younger children (Steinberg, 2008). Consequently, a child's age, independent of maltreatment history, is one factor in his/her engagement in risk-taking behavior, with some evidence pointing

toward the influence of increased peer interactions that occur with age (Chein, Albert, O'Brien, Uckert, & Steinberg, 2011), particularly outside of parental supervision.

The Relation between Overt and Covert Narcissism

In contrast to research in adults (Chatham, Tibbals, & Harrington, 1993; Hendin & Cheek, 1997; Luchner, Houston, Walker, & Houston, 2011), covert and overt narcissism were significantly positively correlated in the present study. However, this effect seemed to be largely driven by participants in the abused group. In the present study, children in the abused group who endorsed low levels of overt narcissism also endorsed similar levels of low covert narcissistic tendencies. In this sense, the positive correlation between overt and covert narcissism is not surprising.

By the same token, though, abused youth who endorsed higher levels of overt narcissism also tended to report higher levels of covert narcissism. Endorsement of covert narcissism (e.g., fragile self-esteem, hypersensitivity to evaluations by others) and overt narcissism (e.g., exhibitionism, entitlement) among youth who have been abused may be indicative of a heightened concern to control their environment and manage feelings of anxiety and sensitivity to rejection. Within the abused group, both forms of narcissism were also positively correlated with externalizing problems. However, based on the nature and timing of the data collection in this study, it cannot be determined what role the endorsement of various forms of narcissism might play in terms of later and prolonged psychosocial functioning.

Externalizing and Internalizing Symptoms

In the present study, both overt and covert narcissism were also significantly positively related to externalizing symptoms across the entire sample. These findings are

consistent with previous research on overt narcissism (Barry & Malkin, 2010; Thomaes, Stegge, & Olthof, 2007; Washburn et al., 2004), but they further indicate that either form of narcissism is a risk factor for child externalizing behaviors. Miller and colleagues (2010) found that vulnerable narcissism, similar to covert narcissism in that it involves lack of self-confidence, hypersensitivity, and fragile self-esteem, was associated with externalizing behaviors such as anger and hostility. Furthermore, vulnerable narcissism was positively related to anger and hostility, particularly in threatening or provocative situations (Okada, 2010). Thus, the features of narcissism that are more closely associated with covert narcissism may only translate to aggression or other externalizing behaviors in a particular situation.

For some youth, an experience of maltreatment may provide a context in which both covert narcissism and externalizing behaviors develop, yet the findings of the present study do not support such a pattern as robust. More specifically, the interaction between abuse status and covert narcissism for predicting externalizing problems was not significant. *Post hoc* analyses within groups indicated that covert narcissism was significantly positively related to externalizing problems in the abused group but not in the community group. That is, among children who have experienced maltreatment, covert narcissism could be a risk factor for externalizing behaviors. However, because the magnitude of correlation between covert narcissism and externalizing behaviors was not different across groups, a specific interpretation regarding abuse in this relation should be made cautiously. Although it is unknown due to the cross-sectional nature of this study, covert narcissism and associated externalizing behaviors may be a response to the child's abuse experience. Future research is warranted in determining the extent to

which covert narcissism is a response to maltreatment and how this may play a role in future behaviors demonstrated by victims.

Covert narcissism also demonstrated a significant positive main effect in predicting internalizing symptoms, independent of abuse status. The connection between covert narcissism and internalizing symptoms is consistent with previous research (Malkin, Barry, & Zeigler-Hill, 2011; Wink, 1991). It appears that adolescents with covert narcissistic tendencies (e.g., vulnerability, sensitivity, fragile self-esteem) may present an outward appearance of self-assuredness while actually suffering from feelings of anxiety, sadness, or shame. It should be noted that gender was controlled for in this analysis given its significant correlation with internalizing symptoms, consistent with previous research (e.g., Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993). Overall, based on the findings from the present study, both externalizing and internalizing issues may deserve further empirical and clinical attention as they relate to covert narcissism in youth.

The Influence of Sample Characteristics

According to staff at the forensic medical center, most referred children and adolescents experienced abuse within a month of being referred for a forensic medical evaluation. It may be only after a certain period of time that narcissistic tendencies fully develop following the victim's experience of abuse. For example, Briere and Elliott (1994) found that sexually abused children may appear asymptomatic for up to two years following the abuse. Furthermore, they reported that "children who were initially asymptomatic had more problems at an 18-month follow-up than did children who were initially highly symptomatic" (p. 63). Therefore, it may be appropriate for future studies

to assess symptoms immediately following disclosure of the abuse and then again later so that changes in symptom presentation or coping responses can be examined.

Briere and Elliott (1994) also suggest that there is a period of depersonalization (i.e., a distorted feeling of self-awareness) immediately following victimization. It could be that the abused children and adolescents who participated in the present study were in such a period of depersonalization in which they distanced and detached themselves from their recent abuse and had not yet developed a consistent means of coping. Kerig, Bennett, Thompson, and Becker (2012) suggest that emotional detachment, similar to depersonalization, is a potential coping strategy for children/adolescents who have been victims of abuse as a result of their post-traumatic symptoms of emotional numbing and avoidance. Depersonalization was not directly measured in the present study; therefore, future studies in this area may incorporate a measure of depersonalization (e.g., Adolescent Dissociative Experiences Scale; Armstrong, Putnam, Carlson, Libero, & Smith, 1997) to determine the potential presence of such a response to maltreatment.

Finally, it should also be noted that the ethnic composition of the abused group in the present study was predominantly African American. There may be cultural, ethnic, or racial variables that influence the time frame and manner in which adaptive and maladaptive strategies develop as a form of coping with abuse. For example, Clear, Vincent, and Harris (2006) found that African American females had higher levels of post-trauma avoidant symptoms (e.g., avoidance of coping with the trauma) than Hispanics. Additionally, they noted that African Americans, as an ethnic minority, may have experienced negative and adverse experiences with social service, legal, and government agencies. Reports of dehumanization and lack of belief in claims reported

are believed to contribute to a greater distrust toward these types of agencies for African American individuals (Clear et al., 2006). Even in instances in which reports are made, this distrust may translate to reluctance in discussing victimization and a delay in disclosing the extent of the abuse or developing a consistent approach to coping with the incident. Future studies should consider these factors, as well as information regarding when the abuse was disclosed to the immediate family or other sources of support and when the information was brought to law enforcement. Such efforts may aid in more complete understanding of the relative timing of responses to maltreatment among victims who come from a variety of backgrounds or who have experienced a variety of issues with disclosing the maltreatment.

Limitations

There are several important limitations that should be considered in interpreting the findings of the present study. First, the sample was recruited from both a large city and a mid-sized city in the southern United States, and as noted above, the abused group was mainly composed of African American females. Therefore, the results may not be generalizable to the general child/adolescent population, including the general population of youth who have experienced abuse. In addition, the study relied on self-report measures, thus resulting in source invariance for the constructs of interest and the potential for socially desirable response sets. However, self-report measures were integral because of the nature of data collection. Parental reports may provide an inaccurate estimate of internalizing symptoms for older children and adolescents, and many parents/guardians may be unaware of risk-taking or externalizing behaviors in which their child/adolescent engages (Frick, Barry, & Kamphaus, 2010). In addition,

self-perception (i.e., narcissism) was thought to be best evaluated through self-reports. Inconsistent parental/guardian accompaniment at the forensic medical center and the use of an after-school program for means of data collection also made the use of parent report less feasible for the present study.

Furthermore, risk-taking was measured by self-report, in which the child/adolescent endorsed whether he/she had ever engaged in each risky behavior. The present study only used a portion of the full measure's questions, and the measure's items were reduced to only dichotomized items because only the relative presence or absence of risk-taking behavior was necessary to test the hypotheses. As a result, the risk-taking variable in the present study did not incorporate frequency of behavior or age of onset. In addition, the scope of risky behaviors for the present study was limited to violence as well as substance and alcohol use. Information regarding risky sexual behaviors was not collected from participants, as youth who have experienced sexual abuse may interpret the items differently than intended based on their experiences.

In addition, due to the small sample size of the abused group ($n = 61$) and the very low frequency of individuals who had reportedly only experienced physical abuse, it was difficult to make comparisons within this group based on type of abuse. Furthermore, the majority of participants in the present study were relatively young in comparison with those in most studies of narcissism in children and adolescents. Lapsley (1993) notes that the adolescent's increased ability to self-reflect is related to the emergence of egocentrism. Certain patterns of egocentrism (e.g., imaginary audience) in adolescence elicit a multitude of emotional reactions, including concern with shame, embarrassment, and feelings of being constantly evaluated and judged (Lapsley, 1993). The presence of

egocentric traits, which mirror some elements of narcissism, may not have yet emerged in some participants due to their young age and limited capacity for self-reflection.

However, that issue would not explain the relative lack of group differences or interactions involving abuse status in the present study, as the groups were equivalent on age, or the lack of correlation between age and narcissism.

Future Directions

Future studies should attempt to address some of these limitations by obtaining data from larger and more diverse samples, additional sources (e.g., parent report), and different geographic regions. In addition, it may be informative for studies to be conducted in a longitudinal fashion at initial evaluation and then again several months to a year after suspected maltreatment. Doing so may help account for the possibility that it may take a child or adolescent time to develop consistent coping strategies (e.g., narcissistic tendencies), exhibit problem behaviors or symptoms related to abuse, or recognize and be able to identify reactions to their abuse.

Future work might also examine the relationship of the perpetrator to the victim as a factor in a young person's response to abuse. Such work could also examine perceived parental support and supervision as an influence on externalizing and risk-taking behaviors among youth who have experienced maltreatment. In addition, the inclusion of children/adolescents who have been victims of neglect may illuminate how different types of maltreatment play a role in the later development of narcissism or problem behaviors.

Longitudinal research would help delineate the developmental relations between narcissistic tendencies and persistent internalizing symptoms, externalizing behaviors,

and risk-taking behaviors. For instance, children/adolescents who were victims of abuse and who present with high levels of narcissistic tendencies or risk-taking behaviors may be inclined to escalate in the seriousness of their risk-taking behaviors as they get older. It would also be important to examine the influence of narcissism on subsequent interpersonal relationships with peers and relatives among youth who have experienced maltreatment.

The present study may be a stepping stone in the examination and clarification of narcissism as a potential coping mechanism for children who have been victims of abuse. Although the present study did not find support for many of the expected relations among constructs, it particularly highlighted that elevated narcissism may not be evident immediately following abuse and that research should focus on how children/adolescents respond to abuse immediately following disclosure of maltreatment in addition to the coping strategies that may emerge later. It should be noted that the nature of research on children who experience maltreatment may preclude the examination of baseline functioning or personality development prior to maltreatment. Thus, from cross-sectional designs, it is unknown whether abused and non-abused youth differ on narcissism prior to the abused children's experience of abuse or whether the presence of narcissism follows a particular developmental trajectory as a function of maltreatment. Based on the variety of symptoms that may be present following child maltreatment, continued efforts to address these issues and to better understand the potential presence of internalizing symptoms, externalizing behaviors, and risk-taking behaviors for abused children are needed. Ultimately, further empirical investigations should better inform clinical intervention efforts targeting these varied responses.

APPENDIX A

USM IRB APPROVAL LETTER

It
 THE UNIVERSITY OF
 WISCONSIN MISSISSIPPI

INSTITUTIONAL REVIEW BOARD
 118 College Drive #5147 | Hattiesburg, MS 39406-0001
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NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months. Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 12011901

PROJECT TITLE: Differences in Narcissistic Presentation in Abused and Non-Abused Children and Adolescents

PROJECT TYPE: Dissertation

RESEARCHER/S: Mallory Laine Malkin

COLLEGE/DIVISION: College of Education & Psychology

DEPARTMENT: Clinical Psychology

FUNDING AGENCY: N/A

IRB COMMITTEE ACTION: Expedited Review Approval

PERIOD OF PROJECT APPROVAL: 01/19/2012 to 01/18/2013

Lawrence A. Hosman, Ph.D.

Institutional Review Board Chair

APPENDIX B

UMC IRB APPROVAL LETTER

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

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Institutional Review Board

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IRB I Registration

#00000061

IRB 2 Registration

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Approval Notice

Initial Application

12/12/2011

T. David Elkin, Ph.D.

Psychiatry and Human Behavior

University of Mississippi Medical Center

2500 North State Street

Jackson, MS 392164505

RE: IRB File #2011-0215

Differences innarcissistic presentation inabused and non-abused children and adolescents

Your Initial Application was reviewed and approved by the Expedited Review process on 12/12/2011. You may begin this research.

Please note the following information about your approved research protocol:

Protocol Approval Period: 12/12/2011 - 12/10/2012

Approved Enrollment #: 60

Participant Population: K-12 Students

Performance Sites: University Physicians Specialty Clinics Jackson Medical Mall

Expedited Review Category(ies): (I0) Minimal risk, but does not meet categories 1-9 for expedited review;

Documents /Materials:

Type	Description	Version #	Date
Document	Consent 10.17.11.docx	■	12/12/2011
Document	Assent 10.17.11.docx	■	12/12/2011

Document	Final October 10th 2011 Full University of Mississippi Medical Center IRB Mallory Malkin.docx	1	10/18/2011
Other Consent/Assent Document	USM Consent/Assent	1	11/29/2011
Other Material	Questionnaires	1	12/07/2011

Review History:

Date	Type	Decision
10/26/2011	Administrative Review	Revisions Required
11/28/2011	Expedited Review	Revisions Required
12/06/2011	Expedited Review	Revisions Required
12/07/2011	Expedited Review	Revisions Required
12/12/2011	Expedited Review	Approved

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