The Society for Research into Empathy, Cruelty and Sociopathy

Study Report

The Lived Experiences of Individuals Subjected to Psychological Abuse

In February this year SoRECS invited individuals who had been affected by psychological abuse to tell us about their experiences and the traumas they experienced as a result of the abuse. Our intention was to gather and collate data on the topic of psychological abuse to shed more light on the extent and nature of the problem and the public health burden attached to it. We hope to use this information to inform the direction of future research as well as to help deepen professional and public understanding of the issue.

Psychological abuse, sometimes termed emotional or mental abuse is characterised as a person subjecting or exposing another to behaviour that may result in psychological trauma, including anxiety, depression, or post-traumatic stress disorder (PTSD). Such abuse is often associated with situations of power imbalance, such as abusive relationships, bullying, and abuse and harassment in the workplace. It is often covert in nature and therefore an invisible problem to those not directly affected by it.

Psychological abuse can involve gaslighting, which is a form of psychological abuse in which false information is presented in such a way as to make the target doubt his or her own memory and perception. The term originates from the 1938 play “Gas Light” (later adapted as films in 1940 and 1944), wherein a husband attempts to drive his wife crazy using a variety of tricks causing her to question her own perceptions and sanity. It is a deliberate ploy that occurs between one individual (the covert aggressor) and another (the targeted individual). The endgame is the person who is gaslighted no longer trusts their own perception of the situation. The process of gaslighting distorts an individual’s sense of reality and makes them disbelieve what they see.

The scars and injuries that result from psychological abuse can affect a person’s mental state and affect their health and wellbeing. The emotional trauma of psychological abuse, if left unchecked can lead to anxiety disorders, depression and post-traumatic stress disorder (PTSD). It has been documented for instance that chronically traumatised people, such as children who have endured abuse by a parent, sibling or other abusive family member often exhibit hyper-vigilant, anxious and agitated behaviour. They may also experience

insomnia and assorted somatic symptoms such as tension headaches, gastrointestinal disturbances, abdominal pain, back pain, tremors and nausea. Moreover, exposure to and interaction with an abuser in childhood can leave lifelong scars, including a deep mistrust of other people and anxiety in social situations. The culture we live in exacerbates the problem for often a 'blame the victim' mentality is adopted, which means those targeted by abusers must also contend with feelings of shame about the abuse.

Method

We chose a popular method of qualitative research, the case study approach, which examines in-depth "purposive samples" to better understand a phenomenon. We chose this approach in order to gather an in-depth understanding of the consequences of psychological abuse. We wanted to find out how this sort of abuse affected the lives of individuals, and in what ways. Hence, a small but focused sample is used rather than a large sample. Rather than generalise, we wanted to gain a deeper, more nuanced understanding of the traumas and difficulties encountered by individuals who had been psychologically and emotionally abused.

Participants

We sought volunteers with first-hand experience of overt and covert forms of abuse to participate in our research project about people's personal experiences of psychological abuse. We posted a request for volunteers online on the SoRECS web site and also the Facebook page The Empathy Trap book.

We had many expressions of interest from the public and sent out information to 73 individuals. This included further information about the study and an invitation to send us a narrative account of their experiences of abuse, the traumas they experienced, what hindered and what aided recovery from the experience. Of the 73 who expressed initial interest, three people declined to send material of such a confidential and personal nature, because of reported problems of email interception and cyber stalking. Ultimately, 55 of the original 73 who expressed an interest in participating in the study sent us written narrative accounts of their experiences of psychological/emotional abuse. Forty-nine (89%) of the study participants identified themselves as female. The majority of participants spoke English as a first language. We did not request data on nationality or ethnicity of the abuser or the individual themselves, since unempathic acts are found in every population and culture on the planet. We also did not ask participants their age. Whilst demographic data

might be useful we chose not to ask for personal data of this kind to protect participants' anonymity.

Only six (11%) of the 55 participants are male. In consequence the study findings need to read with caution as the findings are skewed towards women's experiences. What we have learned from this is where research on sociopathy/psychopathy is heavily reliant on a male conceptualisation of the disorder, the opposite is true in the case of research on trauma and recovery from abuse where help-seeking is more often associated with women. This gender asymmetry likely is a reflection of bias and difficulties encountered by studying complex social phenomenon where abuse is largely viewed as a male problem.

The gender difference in terms of study participation may be culturally influenced; there may be greater barriers for men with regard to being open about psychological abuse, barriers which need to be identified and explored in order to reduce the impact on their health and wellbeing, and their help-seeking behaviour. We regard this as an indication for research on the topic of gender and in relation to seeking help due to psychological abuse.

Data analysis

All names were removed from the narrative accounts to protect their identities and we have taken care not to use any personal material that could potentially expose the individual's identity. All narrative accounts were stored securely and anonymised using codes to protect individuals' identities. The narrative accounts were then analysed using thematic analysis, a common form of analysis in qualitative research. This type of analysis emphasises pinpointing, examining, and recording patterns (or "themes") within data. Themes are patterns across data sets that are important to the description of a phenomenon and are associated to a specific research question. Specifically, we wanted more understanding of the health burden of psychological abuse; thus we sought the involvement of individuals who identified themselves as having experienced psychological abuse at some stage in their life.

Outcome of our investigations

The study is qualitative in nature. This is exploratory research that is used to gain an understanding of underlying reasons, opinions, and motivations. The approach affords a way to gain insights into the problem and helps to develop ideas or hypotheses for potential quantitative research.

After in-depth analysis and theming of the material, the following themes emerged from the data sets:

Perpetrators of abuse

In 50 (91%) of the accounts of psychological abuse reported, a partner or spouse was identified as the perpetrator of abuse. However, in 40 cases (73%) there had been abuses in childhood by one or more family members. Forty-eight (87%) reported being psychologically abused by more than one person throughout their lives. Other perpetrators included former colleagues at work and former friends.

Reported Problems

All participants reported some or all of the physical and psychological health problems listed below.

All participants in the study reported feeling emotionally injured in some way. This varied from mild confusion to emotional breakdown in consequence of becoming disorientated and detached from their reality. As one participant described it:

"I questioned myself so much that I didn't know what was real, what was unreal, if I was over-reacting to things, if I was making things up in my head, or what."

(Participant 11)

Another participant explained the experience this way:

"*I experienced a 'freeze' response…It felt like my thought patterns were '*scrambled'."

(Participant 53)

Almost all participants described a sense of isolation during and after the abuse. In many cases the sense of isolation was further compounded when they sought validation and help from others people including friends and helping professionals, because their experiences were met with incredulity. One participant expressed it thus:

"*The counsellor mentioned that…she believed what I said had happened was a bit farfetched, so I must be making it up*."

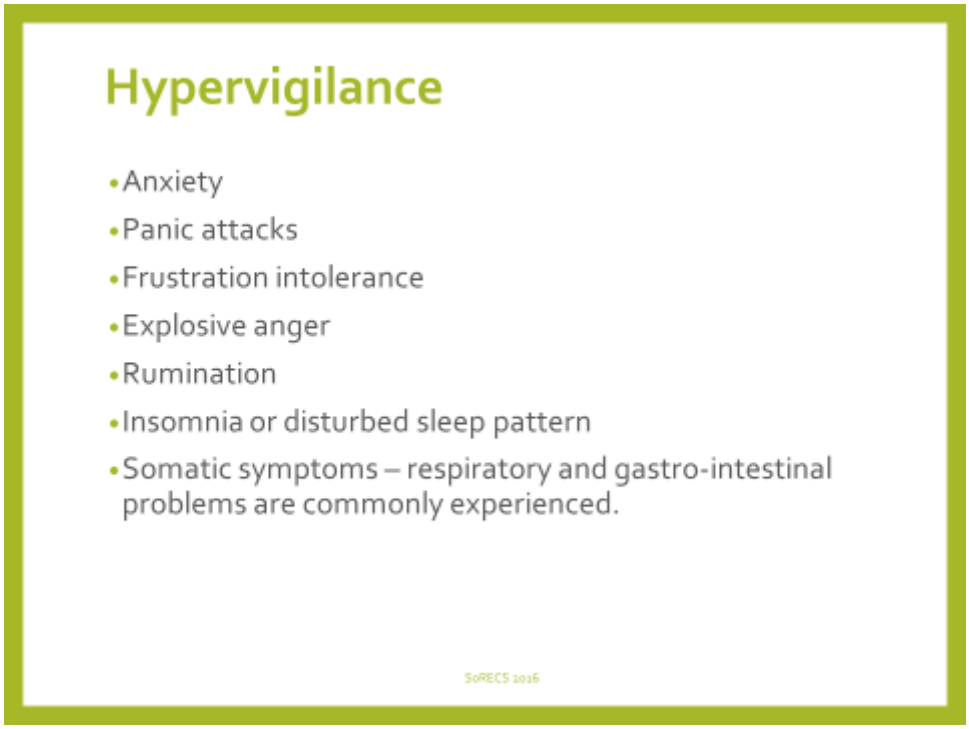
(Participant 2)

Sleep disturbance was a commonly reported problem alongside psychosomatic complaints and humiliated anger, which led to problems of explosive anger. Commonly reported psychosomatic complaints include gastro-intestinal problems, respiratory complaints and headaches. Weight loss and weight gain also were reported problems.

All participants reported symptoms associated with a heightened state of arousal, stress and anxiety for at least a short duration during and after being subjected to psychological abuse. Almost all individuals experienced a persistent state of hypervigilance; often for many months in the aftermath of abuse, and in some cases, for years (in the case of abuse in childhood and/or abuse by partner or spouse). In a bid to deal with the stress, anxiety and other post-trauma symptoms, almost half of participants reported an over-reliance on intoxicants such as alcohol and cannabis, or prescription medication including hypnotics, tranquillisers and sedatives. Several participants described becoming intoxicated as a way and means of escape from the controlling person in their lives.

Hypervigilance is a heightened state of sensory sensitivity. Symptoms usually include abnormally increased arousal, high responsiveness to stimuli, and being on the constant lookout for threats. The individual is on high alert in order to be certain danger is not near. People suffering from hypervigilance will 'overreact' to loud and unexpected noises or become agitated in highly crowded or noisy environments. They will often have a difficult time getting to sleep or staying asleep. Hypervigilance can lead to a variety of obsessive behaviour patterns, as well as producing difficulties with social interaction and

relationships. Hypervigilance is also accompanied by a state of increased anxiety which can cause exhaustion.



Many of the participants experienced a period of time where they shut down emotionally and felt numb or succumbed to trauma induced apathy. Many reported being chronically traumatised and experiencing severe anxiety and fear, even depression. Some experienced startle reactions and agitation and numerous physical symptoms. Prolonged trauma can lead to what is called the **Survivor Triad: Insomnia**, **nightmares**, **and psychosomatic complaints.** On top of that many people experience anger and rage, as a result of the humiliation that comes with abuse.

Recovery from trauma symptoms was commonly reported as a gradual process, but most people overcame the reported physical and psychological difficulties over time, with or without the aid of medical treatment. However, 27 (49%) individuals succumbed to low mood or depression. The same number were either diagnosed with post-traumatic stress disorder (PTSD); or diagnosed themselves (self-diagnosis) as having the disorder. In three cases where the symptoms were severe, suicide was attempted.

Post-traumatic stress disorder is a severe anxiety disorder that can develop after exposure to any event that results in psychological trauma. The disorder arises due to deregulation of the fear system. Fear is a necessary emotion at times of danger, and like anger is followed by a stress response — fighting, freezing, or fleeing. This survival system depends on our ability to appraise threats in order to initiate survival behaviour. Once the threat or trauma is over, the fear system normally calms down after a few days or weeks. In PTSD this system

fails to reset to normal, keeping the sufferer hyper alert, on the lookout in case the event happens again.

Many traumatic events are of time-limited duration. However, in some cases people experience chronic trauma that continues or repeats for months or years. The current PTSD diagnosis often does not fully capture the severe psychological harm that occurs with prolonged, repeated trauma. People who experience chronic trauma often report additional symptoms alongside formal PTSD symptoms, such as changes in their self-concept and the way they adapt to stressful events. On account of these additional symptoms, Dr. Judith Herman of Harvard University, suggests that a new diagnosis, Complex PTSD, is needed to describe the symptoms of long-term trauma. Symptoms often develop immediately after the traumatic event but in some (less than 15% of all sufferers) the onset of symptoms may be delayed. Many individuals who expressed the view that they suffered from PTSD did not recognise this for quite a time, until their symptoms became debilitating and severe.

"I was functioning with depression, anxiety, and PTSD for at least three years without realising it."

(Participant 24)

Dissociation was an experienced reported by six of the study participants. The term dissociation describes a wide array of experiences from mild detachment from immediate surroundings to more severe detachment from physical and emotional experience. The major characteristic of all dissociative phenomena involves a detachment from reality. It has been described as a state of emotional disconnection, where it feels as if you are looking at yourself from a distance; like looking at a stranger. The different types of dissociation. The mental health charity MIND states that there are **five types of dissociation**:

1. Amnesia - This is when you can't remember incidents or experiences that happened at a particular time, or when you can't remember important personal information.

2. Depersonalisation - A feeling that your body is unreal, changing or dissolving. It also includes out-of-body experiences, such as seeing yourself as if watching a movie.

3. Derealisation - The world around you seems unreal. You may see objects changing in shape, size or colour, or you may feel that other people are robots.

4. Identity confusion - Feeling uncertain about who you are. You may feel as if there is a struggle within to define yourself.

5. Identity alteration - This is when there is a shift in your role or identity that changes your behaviour in ways that others could notice. For instance, you may be very different at work from when you are at home.

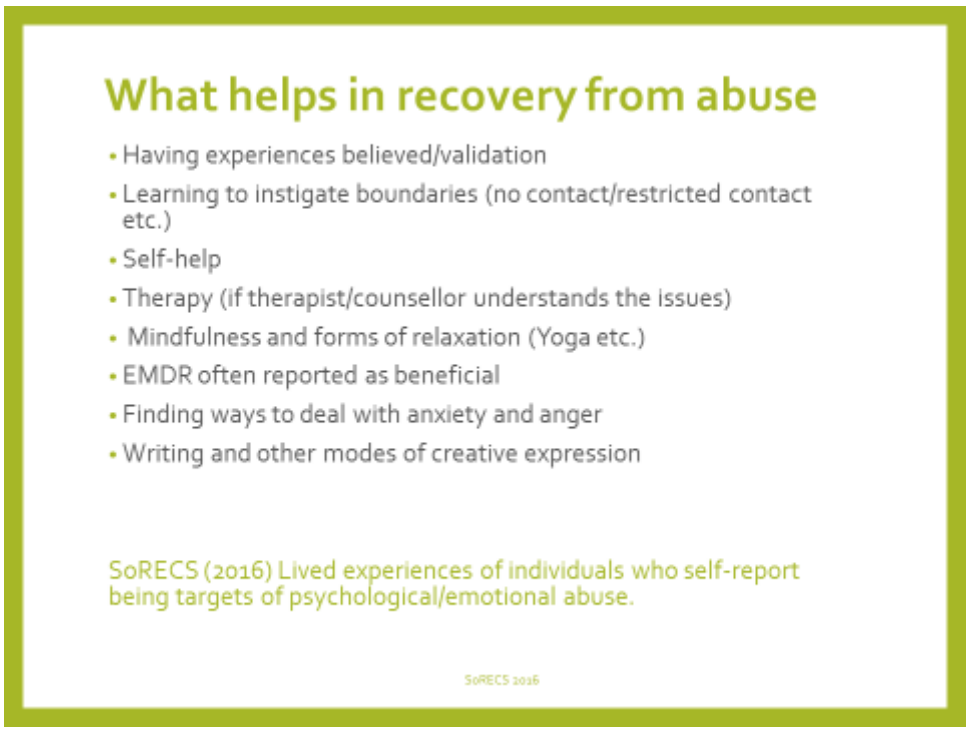
One participant described how living in this state impacted upon daily life:

"I was becoming suspicious of scenarios, and people were not as they seemed. I felt like I was living in a Horror Film…I was suspicious of everyone so I began to stop talking…I began to withdraw from society, and stay indoors as often as I could."

(Participant 47)

What helps in recovery from abuse?

For most of us, recovery from traumatic experiences in life does not occur in a neat and linear fashion; in fact, the direction of travel can be a little bit messy, with movement back and forth. Things begin to steady as the individual gains confidence in the process. Thankfully, most people recover eventually, as the study participants attest. Below is a list of things cited as helping in recovery from emotionally abusive relationships.



Validation

There was general agreement that having one's experiences and feelings validated helped initiate the process of recovery. Having one's traumatic experience acknowledged, being heard and understood, mattered most to individuals who reported being gaslighted (89% of participants). Gaslighting entails the systematic attempt by one person to erode another's reality. It is a form of psychological abuse in which false information is presented in such a way as to make the target doubt his or her own memory and perception. The syndrome gets its name from the British stage play Gas Light and subsequent film adaptations. The storyline involves a murderer who attempts to make his wife doubt her sanity. He uses a variety of tricks to convince her that she is crazy so she won't be believed when she reports the strange things that are genuinely occurring, including the dimming of the gas lamps in the house (which happens when her husband turns on the gas lamps in the attic to conduct clandestine activities there).

Gaslighting may simply involve the denial by an abuser that previous abusive incidents ever occurred, or it could be the staging of strange events intended to disorientate the target. The effect of gaslighting is to arouse such an extreme sense of anxiety and confusion in the target that the person reaches the point where they no longer trust their own judgment. The techniques are similar to those used in brainwashing, interrogation, and torture — the instruments of psychological warfare. A person exposed to it for long enough loses their sense of self. They find themselves doubting their own memory; they become depressed and withdrawn and totally dependent on the abuser for their sense of reality. The targeted person may even believe that they are going crazy. Psychologist Robin Stern describes three stages that people who have been gaslighted experience: disbelief, defense, and depression.

Study participants reported that the best way to remedy the effects of gaslighting is having one's experiences validated and one's reality (and sanity!) confirmed by other people. Though therapy and professional assistance was often sought, most people who participated in the study cited the support of friends as being the most beneficial in terms of relieving them of the symptoms of gaslighting. Self-help materials and mutual aid resources, often found on the internet and social media (Facebook groups, for example), also helped in this regard.

It can help to seek out others who have a shared goal. People recovering from a traumatic and abusive relationship often find recovery supportive friendships beneficial. Such friendships need to be natural (reciprocal), accessible to you at times of greatest need, and potentially enduring. It can also make a real difference if a positive person is around to witness your change. Author Alice Miller identifies this sort of person as an "enlightened witness," someone willing to support a harmed individual and to help them gain

understanding of their past experiences. In this context an enlightened witness is anyone who is insightful and empathetic enough to help you face up to your difficulties and regain your autonomy. The change process is often messy, so if you become engaged in peer support you may find yourself flitting between roles, from acting helpless to engaging in the act of helping others. This is entirely normal and healthy given the tentative nature of the recovery process.

Interpersonal boundaries

All participants in the study stated that instigating boundaries of communication (restricting contact or no contact at all) and space (relocating or in some cases moving into temporary accommodation or shelter), was essential in helping them recover from the experience of psychological and emotional abuse. One participant put it this way:

"I only now understand that the only practical response is to have absolutely no contact with her and any other people that she is in contact with who believe her or who could leak information to her."

(Participant 4)

Therapy and therapeutic interventions

Although it is generally accepted in many other countries that people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]), these treatments are not always available. Whilst many study participants acknowledged they received some form of therapy, only 7 out of 55 (13%) received trauma specific therapy such as EMDR or trauma-focused CBT. Some participants engaged in a variety of therapies and self-help approaches to healing including meditation, yoga and mindfulness. One participant identified the use of a 12-step group as aiding recovery. One individual found pranic healing of benefit. This is a system of healing that is based on the principles that the body is self-repairing and can heal itself.

Self-help

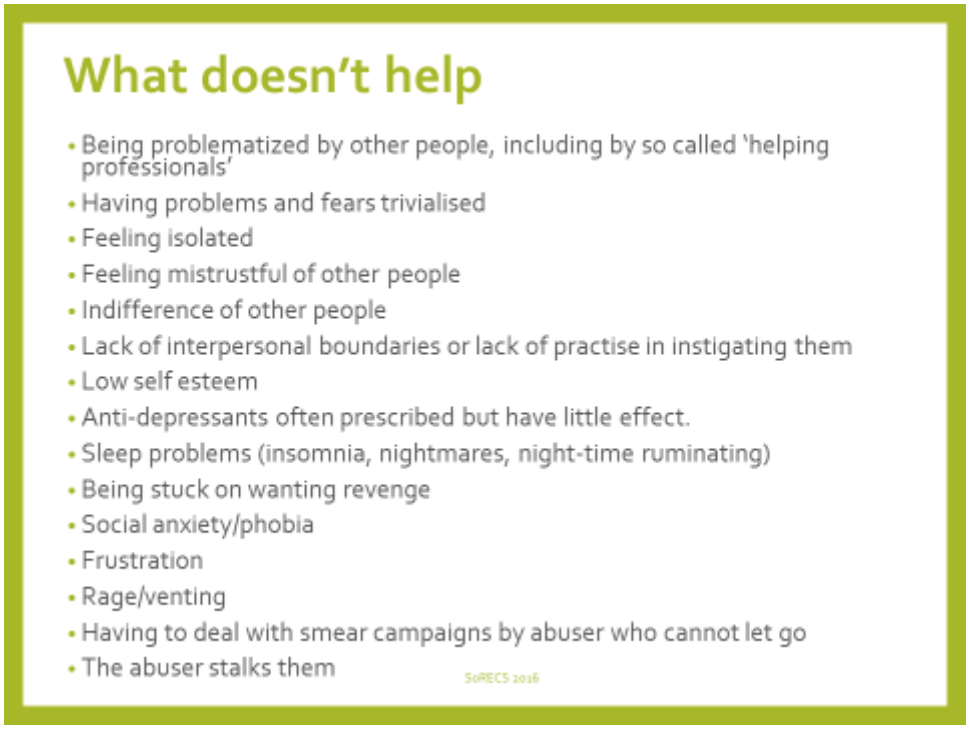
The use of one's own efforts and resources to achieve things and making use of mutual aid featured highly as a way and means that people found valuable information and support. The types of self-help material ranged from self-help books to social media support groups. Many participants cited mutual aid groups as having value and a way to establish new friendships and supportive guidance from other people who had similar or shared experience. One participant, whose view reflects the majority of participants' view about self-help had this to say on the topic.

"The counsellor had no experience of psychopathy, or whatever it was, and didn't understand what I had faced. I learnt more via the internet – I found help from web resources, and later I bought some books that helped."

(Participant 53)

What hampers recovery from abuse

The themes that emerged from the data sets are as follows:



Being problematized

A quarter of participants stated that one of the most difficult things to be confronted with during and in the aftermath of abuse is being disbelieved. For many, this is why validation from empathic others mattered so much to them and helped them in their recovery from the abuse. Unfortunately, in this regard several participants had negative experiences with professionals, including therapists. Being problematized as either 'mad' or 'bad' was a recurring theme in many of the participants' narrative accounts and many wrote about feeling they were regarded as hysterical, whilst the abuser was often able to maintain calm control. This sometimes led to detrimental advice, and most often to a loss of support, which exacerbated the abuse. This is what one participant had to say on the subject:

"As far as ask help, there is no way I would have reached out to any medical person and told my story. I would have probably been committed as delusional and paranoid."

(Participant 9)

Another concern about professional help was concern about the professional's inexperience in this area:

"I have concluded that sometimes therapy is not helpful if a therapist does not have the right experience and encourages action that is not advisable under the circumstances (e.g., trying to fight someone with a narcissistic personality disorder rather than going no contact)."

(Participant 4)

One of the largest determinants of a positive outcome is the therapist who provides treatment. Empathy is an important factor, though tends not to be focused on in the hiring and training of therapists. (Moyers & Miller, 2013). Paradoxically therapists with high empathy are vulnerable to abuse as the very empathy so necessary for their work is what makes them prized targets of covert abusers. SoRECS sees a need for specialist training for therapists and counsellors with regard to covert abuse. The charity is currently in the process of formulating a training programme for therapists and counsellors specifically for this purpose.

Apathy of bystanders and problems of enduring social anxiety

Almost all participants mentioned that at some stage other people were insensitive and/or unresponsive to their fears. Many participants expressed concern that their reality and the abuse they encountered was trivialised. In some cases, this had such a distorting effect on their own perception of the abuse that they ended up ignoring their own distress and stopped help-seeking. For many this meant the period of abuse was extended and the trauma and fallout from the abuse was intensified.

Some people are empathic and helping when it comes to showing care and compassion for other people, but have very little empathy when it comes to dealing with someone else's anger or outrage. Some close down in the face of violence and abuse, and some cut off completely from emotions they are frightened of in themselves. Whilst bystander passivity can be simply the first reaction to perceived danger and an avoidance strategy engaged in in the hope that the problem will go away, it can also be something more sinister; say when someone passively or actively connives in hostilities they witness. The reasons people join forces with aggressors are manifold: they may fear punishment if they don't go along with the scheme; they themselves may bear a grudge towards the targeted person or persons, or just feel no real connection with them and shut off from feeling concern for them because of this. Or sadder still they may go along with the situation on account of being boredom or to revel in a sense of schadenfreude! In such cases apathy becomes not just a lack of empathy but a betrayal of it.

Apathy on the part of bystanders, whether at work, the home or in the social sphere is a significant problem that perpetuates abuse. One participant expressed it thus:

"Few people can be my friends, as I do not tolerate stupidity, mediocrity, cruelty, abuse of any type, even the subtlest, I will notice and it will cause me pain, towards me or any other person or animal or living thing. This narrows it down quite a lot as we know the world is full of these people."

(Participant 1)

Humiliated anger and thoughts of revenge

Prolonged trauma at the hands of a covert emotional abuser can lead a person to experience anger and rage, as a result of the humiliation that comes with abuse. The targeted individual has been unable to express anger at the perpetrator; to do so would

have jeopardised their survival. So even when released from the perpetrator's grip, they continue to be afraid of expressing their anger. Furthermore, the individual often carries a burden of unexpressed anger against all those who remained indifferent and failed to help. Efforts to control this rage may exacerbate the person's social withdrawal and paralysis of initiative, while occasional outbursts of rage against others may further alienate him and prevent the restoration of relationships. Internalisation of rage may result in self-hatred, even thoughts of suicide.

Most participants experienced anger and rage. Many of them experienced problems in this regard; with other people remarking upon their venting or releasing pent-up feelings of anger and outrage and problematizing it. Venting is often explosive and can be an act of aggression. When people vent their anger to the person they're angry with, they often feel better immediately afterward. However, not long after that, most people report feeling guilty, ashamed, or sad for the hurt they caused another person. Originally, venting was thought to be helpful and healthy for reducing anger difficulties. However, recent evidence suggests that venting is not healthy because it increases the chances of further anger in the future. Many, if not all, participants of the study concurred that finding ways to manage their emotions and express their anger in a healthier way was an important part of the recovery process. Many stated that an improved sense of balanced awareness helped them achieve greater emotional resilience. One participant identified empathy as a way and means of moving on from revenge:

"Stay away; set firm boundaries and make empathy a way of life. It is often a brutal awakening, but beyond that, there is the ability to create a new environment around us that reflects that empathy and attracts those of the same ilk."

(Participant 55)

Enduring stress and anxiety

Enduring stress and anxiety may act as a deterrent to recovery. Poor sleep, nightmares, and anxiety-induced psychosomatic complaints and trauma-induced apathy all impede getting over the experience. Following a trauma, it is important for the person diagnosed with PTSD or enduring stress and anxiety to see a medical doctor for regular check-ups. Antidepressant medications is often viewed by the medical profession as helpful in treating the core symptoms of PTSD and C-PTSD, either alone or in combination with psychotherapy. However, participants in this study who reported that they were prescribed antidepressants commonly remarked that such medication was of little help. As previously

mentioned, individuals with PTSD can also become ill with depression. Depression can be treated either with antidepressant medication or with talking treatments — or through a combination of both medication and talk therapy. It is important when the PTSD symptoms persist, to speak about them openly with someone and get professional help. The important message to take from all this is that by reaching out for support, seeking medical advice and treatment, and developing new coping skills, individuals can at the very least learn to effectively manage the symptoms of PTSD and, better still, overcome the problem in time.

The abuser won't let go

Trying to outsmart a covert abuser or getting into arguments with them reduces you to their level, and distracts you from the task of protecting yourself. It is better to resist a showdown with an abuser of this sort at all costs. In such situations their drive to win sets in. The best way to protect yourself is to avoid them, and to refuse any kind of contact or communication. The abuser will feel no obligation to you or anyone else. To keep them in your life is therefore to put yourself at risk of harm. Nevertheless, covertly abusive behaviour is often deeply entrenched behaviour and hard for the abuser to let go of. Some abusers resort to stalking. And some resort to smear campaigns and harassment, which often cause further harm and isolation for the individual who is the target of the abuse.

Stalking is a covert aggressive act, and unwanted or obsessive attention by an individual toward another. Stalking behaviours are related to harassment and intimidation. Some of the actions that contribute to it can be legal (gathering information, phoning someone, sending gifts, emailing or text messaging) but they become illegal when they breach the legal definition of harassment. Sometimes, the abuser will refuse to let the other person leave the relationship. The abuser can't take no for an answer and will continually attempt to make contact with the target, perhaps even in violation of a restraining order. This especially seems to be a pattern among men who are domestic abusers. According to some experts, the life and physical safety of a battered woman are in the greatest danger after she has left her violent partner. This problem was experienced by the majority of participants whose abuser was an intimate partner.

"They started a smear and distortion campaign that affected every part of my life and continues to do so… [this person] spread this rumour throughout our community such that every friend I had then, were lost...I was isolated and excluded within the community."

(Participant 4)

"[The person] has smeared my name and maliciously lied about me. I'm still traumatised by it, I still think of things I experienced, that [they] did, and I'm horrified. I feel like a year and a half of my life has wasted, my reputation at work is destroyed, and I'm looking at the real possibility of leaving just to attain peace."

(Participant 53)

Conclusion

The themes that emerge from this qualitative study are not exhaustive. Further research needs to be undertaken to gain a nuanced understanding of the health impacts and burden that result from emotional abuse. Nevertheless, rich insights emerge from the data, which should help emotionally abused individuals and professionals supporting them, respond in more mindful ways. Overtime we hope to see the body of evidence grow. SoRECS will take the findings of this study forward and consider the most suitable approach (i.e. research design) and focus for future research on this important topic. As previously mentioned, SoRECS is currently in the process of formulating a training programme for therapists and counsellors specifically for the purpose of improving professional awareness of the extent and nature of the problem of psychological abuse.

References:

T. B. Moyers & W. R. Miller (2013) Is low therapist empathy toxic? Psychology of Addictive Behaviors, 27, 878-884.

Our thanks go to all those who participated in this study.

SoRECS