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Emotional, Cognitive, and Behavioural Boundaries in Survivors of Narcissistic Abuse: A Correlational Study Between the Empowerment & Boundaries Assessment (EBA) and Obsessive-Compulsive Behavioural Tendencies (MOCS)

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Abstract

Narcissistic abuse is associated with profound impairments in emotional regulation, personal boundaries, and cognitive autonomy. Survivors often exhibit heightened reassurance-seeking, compulsive guilt, and perfectionistic control features that may resemble obsessive-compulsive behavioural tendencies. The present study examined the relationship between boundary empowerment and obsessive-compulsive behavioural patterns in individuals identifying as victims of narcissistic abuse. A sample of 30 adults (ages 24–52) completed the Empowerment & Boundaries Assessment (EBA), while clinicians independently rated participants using the Malhotra Obsessive-Compulsive Scan (MOCS/MOCREST). Pearson correlational analyses revealed significant negative correlations between total EBA scores and MOCS scores, indicating that weaker boundaries were strongly associated with higher obsessive-compulsive behavioural indicators. Findings underscore the role of boundary collapse in the development of compulsive reassurance, control, and cognitive rigidity among survivors of narcissistic abuse.

Keywords: Narcissistic Abuse; Boundaries; Empowerment; Obsessive-Compulsive Traits; Gaslighting; Reassurance-Seeking; Cognitive Rigidity; Trauma Psychology

1. Introduction

Narcissistic abuse is a form of chronic relational trauma characterized by persistent patterns of gaslighting, emotional invalidation, blame-shifting, psychological manipulation, and coercive interpersonal control. Unlike discrete traumatic events, narcissistic abuse operates through prolonged exposure to relational domination, identity erosion, and conditional attachment, leading to complex trauma responses in survivors (Herman, 1992). The DSM-5-TR recognizes the psychological sequelae of chronic interpersonal trauma, including maladaptive coping patterns, heightened threat perception, and compulsive regulatory behaviours aimed at restoring a sense of safety and control (American Psychiatric Association, 2022).

Over time, victims of narcissistic abuse internalize the abuser's distorted narratives, self-blaming attributions, and pathological relational expectations. This internalization results in progressive weakening of emotional, behavioural, cognitive, and relational boundaries. Survivors often struggle to differentiate personal needs from perceived external demands, leading to excessive compliance, self-monitoring, and hypervigilance within interpersonal contexts. Empirical and clinical work using the Narcissistic Personality Pattern Test (NPPT) has demonstrated how narcissistic relational

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dynamics foster boundary diffusion, trauma bonding, and compulsive appeasement patterns in victims (Puri & Bhatt, 2024; Bhatt & Puri, 2025).

Clinical observations increasingly indicate that survivors of narcissistic abuse frequently present with subtle obsessive–compulsive–like behavioural patterns. These include excessive reassurance-seeking, over-apologizing accompanied by pervasive guilt, perfectionistic hesitation, cognitive over-monitoring, and heightened environmental or interpersonal control behaviours. While these manifestations may phenomenologically resemble obsessive–compulsive symptomatology, they often do not meet criteria for primary Obsessive–Compulsive Disorder as defined in DSM-5-TR. Instead, they reflect trauma-driven adaptive strategies developed to anticipate threat, prevent conflict, and maintain relational safety (American Psychiatric Association, 2022; Herman, 1992).

The Malhotra Obsessive–Compulsive Scan (MOCS) offers a nuanced framework for assessing such trauma-embedded compulsive patterns, particularly those emerging within relational and interpersonal domains rather than classical contamination or checking compulsions (Malhotra & Puri, 2025). Preliminary clinical applications of the MOCS suggest that compulsive interpersonal regulation such as control, compliance, and reassurance-seeking—may serve as a compensatory response to boundary erosion rather than as an expression of ego-dystonic obsessionally.

Given this conceptual overlap between boundary impairment, narcissistic abuse, and trauma-based compulsive adaptations, the present study seeks to empirically examine whether boundary empowerment inversely correlates with compulsive behavioural patterns as measured by the MOCS. By integrating trauma theory, boundary psychology, and contemporary assessment tools, this research aims to differentiate trauma-based compulsivity from primary obsessive–compulsive pathology and contribute to more precise diagnostic and therapeutic formulations for survivors of narcissistic abuse.

Objectives

- To assess levels of emotional, behavioural, cognitive, and social boundaries using the EBA.
- To evaluate obsessive-compulsive behavioural tendencies using MOCS/MOCREST.
- To examine correlations between boundary strength and obsessive-compulsive behavioural indicators.

1.1. Hypotheses

- H1: Total EBA scores will be significantly negatively correlated with total MOCS scores.
- H2: Lower emotional and cognitive boundary scores will show stronger correlations with reassurance-seeking and cognitive rigidity domains of MOCS.
- H3: Social and relational boundary deficits will be significantly associated with elevated interpersonal control and compliance behaviours on the MOCS. This indicates that relational boundary erosion predicts trauma-driven compulsive interpersonal regulation.

2. Methodology

2.1. Research Design

The present study adopts a quantitative, correlational, cross-sectional research design to systematically examine the relationships between narcissistic abuse–related boundary deficits and trauma-driven compulsive behavioural patterns. A quantitative approach was selected to enable objective measurement, statistical analysis, and empirical validation of psychological constructs such as boundary empowerment, interpersonal control, compliance behaviours, and obsessive–compulsive like symptomatology. This approach is particularly suited to the study's aim of identifying measurable associations between trauma-related relational variables and compulsive behavioural adaptations.

A correlational design was employed to assess the direction and strength of relationships among key study variables without manipulating them. Given the ethical and practical limitations of experimental manipulation in trauma research, correlational analysis allows for the examination of naturally occurring psychological patterns within survivors of narcissistic abuse. Specifically, the design facilitates investigation into whether deficits in emotional, cognitive, behavioural, and relational boundaries are significantly associated with elevated interpersonal control, reassurance-seeking, compliance, and hyper-monitoring behaviours as assessed through standardized psychometric tools, including the Malhotra Obsessive-Compulsive Scan (MOCS) and the Narcissistic Personality Pattern Test (NPPT). This design supports hypothesis testing related to trauma-based compulsive adaptations while preserving clinical realism.

The cross-sectional nature of the study involves collecting data at a single point in time, providing a snapshot of the participants' psychological functioning and relational experiences. This approach is appropriate for identifying prevalent patterns of boundary erosion and compulsive behavioural responses among individuals with a history of narcissistic abuse. While causal inferences cannot be drawn, the cross-sectional design enables efficient assessment of associations across a diverse sample, offering valuable insights into the co-occurrence of trauma exposure and compulsive interpersonal regulation.

Overall, this research design aligns with contemporary trauma-informed psychological research by balancing methodological rigor with ethical sensitivity. The findings derived from this design are intended to contribute to differential diagnostic clarity by distinguishing trauma-driven compulsive behaviours from primary obsessive–compulsive pathology and to inform targeted clinical interventions focused on boundary empowerment and relational healing.

2.2. Participants

N = 30

Adults (24–52 years)

Self-identified survivors of narcissistic abuse in intimate relationships

Exclusion: diagnosed psychotic disorders or active substance dependence

2.3. Measures

- Empowerment & Boundaries Assessment (EBA)

A 25-item self-report scale assessing four domains:

- Emotional Boundaries (6 items)
- Behavioural Boundaries (6 items)
- Cognitive Boundaries (6 items)
- Social/Relational Boundaries (7 items)
- Scored on a 5-point Likert scale (25–125 total score).

2.4. Malhotra Obsessive-Compulsive Scan (MOCS / MOCREST)

A clinician-rated observational tool measuring subtle obsessive-compulsive behavioural indicators across:

- Reassurance & validation dependence
- Control & order orientation
- Cognitive rigidity & perfectionism
- Total score range: 0–30
- MOCS Assessment Tool

2.4.1. Procedure

The study procedure was designed in accordance with ethical standards for trauma-informed psychological research, with particular sensitivity to participants' histories of narcissistic abuse and relational trauma. Following initial screening and eligibility confirmation, participants were provided with a detailed explanation of the study's purpose, procedures, potential risks, and benefits. Informed consent was obtained digitally prior to participation, ensuring voluntary involvement and the right to withdraw at any stage without consequence. All ethical and confidentiality protocols were strictly adhered to in compliance with professional psychological research guidelines.

Participants first completed the Empowerment and Boundary Assessment (EBA) through a secure digital platform. The digital administration was selected to enhance accessibility, reduce participant burden, and provide a psychologically safe environment for disclosure, particularly for individuals who may experience distress in face-to-face settings. Clear instructions were provided, and participants were encouraged to respond honestly based on their lived relational experiences rather than idealized self-perceptions. The EBA assessed emotional, cognitive, behavioural, and relational boundary functioning, with higher scores reflecting greater boundary empowerment.

Subsequently, structured clinical sessions were conducted by trained clinicians who were blinded to the participants' EBA scores. During these sessions, clinicians independently rated obsessive–compulsive–related interpersonal behaviours using the Malhotra Obsessive-Compulsive Scan (MOCS). Particular attention was given to trauma-linked behavioural manifestations such as excessive reassurance-seeking, interpersonal compliance, hyper-responsibility, environmental control, and relational monitoring. Standardized session formats and scoring guidelines were followed to minimize rater bias and enhance inter-rater reliability.

Throughout the study, participant confidentiality was maintained through anonymized identification codes, encrypted data storage, and restricted access to records. Any psychological discomfort arising during assessment was addressed through immediate clinical support and appropriate referrals when necessary. This multi-method procedural approach, combining self-reported boundary assessment with clinician-rated behavioural observation, strengthened the validity of findings by integrating subjective experience with objective clinical evaluation while maintaining ethical rigor and participant safety.

2.5. Statistical Analysis

- Descriptive statistics (Mean, SD)
- Pearson's correlation coefficient ®
- Significance set at $p < .05$

Data were analysed using standard quantitative statistical procedures to examine the relationships between boundary empowerment and trauma-driven compulsive behavioural patterns. Descriptive statistics, including means and standard deviations, were calculated for all study variables to summarize central tendencies and variability within the sample. This provided an overview of participants' levels of boundary functioning and the distribution of MOCS-related interpersonal behaviours, facilitating interpretation of subsequent analyses.

To test the study hypotheses, Pearson's product–moment correlation coefficient ® was employed to assess the strength and direction of linear relationships between boundary empowerment scores and compulsive interpersonal behaviours as measured by clinician-rated MOCS indices. Pearson's correlation was selected due to the continuous nature of the variables and the study's aim of identifying associative patterns rather than causal effects. Prior to analysis, assumptions of normality and linearity were examined to ensure appropriateness of the statistical test.

All statistical tests were two-tailed, and the level of statistical significance was set at $p < .05$. This threshold was used to determine whether observed correlations were unlikely to have occurred by chance. Effect sizes were interpreted in accordance with conventional guidelines to evaluate the clinical and practical relevance of the findings. The analytical approach was aligned with the study's correlational, cross-sectional design and supported empirical examination of trauma-related boundary deficits and compulsive interpersonal regulation.

3. Results

3.1. Descriptive Statistics

Descriptive analysis revealed moderate to high variability in both boundary empowerment and compulsive behavioural patterns among participants. The EBA Total Score demonstrated a mean of 71.4 (SD = 12.6), indicating a generally moderate level of boundary empowerment within the sample, with notable individual differences in emotional, cognitive, behavioural, and relational boundary functioning. This variability is consistent with clinical populations exposed to chronic relational trauma, where boundary development is often uneven and context-dependent.

The MOCS Total Score yielded a mean of 18.9 (SD = 4.3), reflecting the presence of clinically meaningful obsessive–compulsive–related interpersonal behaviours. While these scores do not necessarily indicate a primary diagnosis of obsessive–compulsive disorder, they suggest elevated trauma-linked compulsive adaptations, particularly within interpersonal and cognitive domains. The relatively smaller standard deviation indicates a more clustered distribution of compulsive behavioural patterns across participants.

Table 1 Descriptive analysis table 1.1

Measure	Mean	SD
EBA Total Score	71.4	12.6
MOCS Total Score	18.9	4.3

3.2. Correlational Findings

Pearson's correlation analyses revealed a strong and statistically significant inverse relationship between overall boundary empowerment and compulsive interpersonal behaviours. The correlation between EBA Total Score and MOCS Total Score was $r = –0.68$ ($p < .001$), indicating that lower levels of boundary empowerment were associated with higher levels of trauma-driven compulsive behaviours. This finding supports the study's central hypothesis that boundary erosion plays a significant role in the emergence of compulsive interpersonal regulation.

At the domain level, emotional boundary deficits demonstrated a particularly strong negative association with the reassurance-seeking domain of the MOCS ($r = –0.72$, $p < .001$). This suggests that impaired emotional boundaries are closely linked to excessive reassurance-seeking and fear-driven dependency, commonly observed in survivors of narcissistic abuse.

Similarly, cognitive boundary impairment was significantly associated with cognitive rigidity and over-monitoring ($r = –0.65$, $p < .01$), indicating that blurred cognitive boundaries contribute to intrusive self-surveillance and rigid thinking patterns aimed at preventing relational threat. Behavioural boundary deficits were also significantly correlated with heightened control-oriented behaviours ($r = –0.59$, $p < .01$), reflecting compensatory attempts to regain safety through environmental or interpersonal control.

Collectively, these findings underscore the role of boundary dysfunction as a central mechanism underlying trauma-based compulsive behaviours, reinforcing the conceptualization of these patterns as adaptive responses to chronic narcissistic abuse rather than manifestations of primary obsessive–compulsive pathology.

Table 2 Pearson's correlation analyses 1.2

Variables	r	Significance
EBA Total × MOCS Total	–0.68	$p < .001$
Emotional Boundaries × Reassurance Domain	–0.72	$p < .001$
Cognitive Boundaries × Cognitive Rigidity	–0.65	$p < .01$
Behavioural Boundaries × Control Orientation	–0.59	$p < .01$

4. Discussion

The findings of the present study provide robust empirical support for a strong inverse relationship between boundary empowerment and obsessive–compulsive–like behavioural tendencies among survivors of narcissistic abuse. Individuals exhibiting weaker emotional, cognitive, and behavioural boundaries demonstrated significantly elevated levels of reassurance-seeking, perfectionistic hesitation, cognitive rigidity, and interpersonal control. These results reinforce the study's central premise that such behaviours are best understood as trauma-adaptive strategies rather than manifestations of primary obsessive–compulsive psychopathology.

Within the context of narcissistic abuse, chronic exposure to gaslighting systematically undermines cognitive autonomy and reality testing. Survivors are repeatedly invalidated, blamed, or contradicted, leading to persistent self-doubt and erosion of trust in one's own perceptions. The observed association between impaired cognitive boundaries and heightened cognitive rigidity and over-monitoring suggests that excessive checking, rumination, and mental rehearsal function as compensatory mechanisms aimed at restoring certainty and preventing further relational harm. These behaviours reflect attempts to externally regulate an internal environment destabilized by prolonged psychological manipulation.

Similarly, chronic criticism and conditional approval hallmarks of narcissistic relational dynamics appear to foster guilt-based over-compliance and perfectionistic hesitation. Survivors learn that mistakes, autonomy, or emotional expression are met with withdrawal, ridicule, or retaliation. Consequently, excessive apologizing, indecision, and fear of error emerge as protective strategies designed to minimize conflict and preserve attachment. The strong relationship between emotional boundary deficits and reassurance-seeking underscores the role of attachment insecurity in sustaining compulsive interpersonal dependence.

Furthermore, the link between behavioural boundary erosion and control-oriented behaviours highlights how emotional unpredictability within abusive relationships drives attempts to regain safety through environmental or interpersonal control. In contexts where emotional safety is inconsistent or contingent, survivors may adopt rigid routines, hyper-responsibility, or relational micromanagement as means of reducing perceived threat. While these behaviours may mimic obsessive–compulsive symptomatology, their function is fundamentally relational and trauma-based.

Taken together, these findings align with trauma theory and boundary psychology, emphasizing the need for differential diagnostic clarity. Conceptualizing these patterns as trauma-driven adaptations rather than primary disorders has important clinical implications. Interventions focused on boundary restoration, cognitive autonomy, and relational safety may be more effective than symptom-focused compulsive reduction alone. This study thus contributes to a growing body of evidence advocating for trauma-informed, boundary-centered therapeutic frameworks when working with survivors of narcissistic abuse.

4.1. Clinical Implications

- Obsessive-compulsive traits in narcissistic abuse survivors should be trauma-contextualized.
- Boundary restoration must be a primary therapeutic goal.
- Interventions such as CBT, trauma-informed therapy, and Subconscious Energy Healing Therapy (SEHT) may facilitate boundary repair and reduction of compulsive patterns.

Limitations

- Small sample size
- Cross-sectional design
- Reliance on self-identified abuse history
- Future research should employ longitudinal designs and larger clinical samples.

5. Conclusion

The present study highlights boundary collapse as a core psychological injury resulting from prolonged exposure to narcissistic abuse and establishes its strong association with obsessive–compulsive–like behavioural manifestations. The findings demonstrate that erosion of emotional, cognitive, behavioural, and relational boundaries is not merely a secondary consequence of abuse but a central mechanism through which trauma-driven compulsive patterns emerge. Survivors with diminished boundary empowerment consistently exhibited heightened reassurance-seeking, excessive compliance, perfectionistic hesitation, cognitive rigidity, and interpersonal or environmental control behaviours.

Importantly, the results indicate that strengthening boundaries serves a protective and restorative function. Higher levels of emotional and cognitive boundary empowerment were associated with significant reductions in compulsive reassurance-seeking and mental over-monitoring, while improved behavioural and relational boundaries corresponded with decreased control-oriented and compliance-driven behaviours. These outcomes support the conceptualization of such compulsive manifestations as adaptive responses to chronic relational threat rather than indicators of primary obsessive–compulsive pathology. When survivors regain autonomy over thoughts, emotions, and actions, the perceived need for compulsive regulation diminishes.

The integrated use of the Empowerment and Boundary Assessment (EBA) and the Malhotra Obsessive-Compulsive Scan (MOCS) emerged as a clinically valuable dual-lens framework. Together, these tools enable clinicians to simultaneously assess the depth of boundary erosion and the functional expression of trauma-based compulsive behaviours. This combined approach enhances diagnostic clarity, informs individualized intervention planning, and allows for systematic evaluation of therapeutic outcomes over time.

Overall, this study underscores the importance of trauma-informed, boundary-focused assessment and intervention models in work with survivors of narcissistic abuse. By shifting the clinical focus from symptom suppression to boundary restoration and empowerment, mental health professionals can foster sustainable recovery, relational resilience, and psychological autonomy. The findings contribute to a growing body of evidence advocating for integrative frameworks that recognize the complex interplay between trauma, boundaries, and compulsive behavioural adaptations.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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