

Personality Correlates of Men Who Abuse Their Partners: A Cross-Validation Study¹

L. Kevin Hamberger² and James E. Hastings³

The present study was designed to replicate a previous investigation of personality profiles of men who abused their partners. The initial study found personality profiles reflecting general categories related to schizoid/borderline, narcissistic/anti-social, and dependent/compulsive personality disorders. Cross-validation revealed a nearly identical replication of the initial findings. Further, as with the initial study, only about 12% of the subjects in the present effort showed no discernable psychopathology. It was concluded that (1) there is no unitary "batterer profile," (2) the vast majority of batterers examined evidenced personality disordered profiles, and (3) personality and psychopathological processes must be considered as part of the constellation of psychosocial factors related to spouse abuse.

KEY WORDS: spouse abuse; personality disorder; abusive males, abuser characteristics.

INTRODUCTION

The issue of male-to-female spousal violence has received serious attention by social scientists within the past 15 years. Sociological aspects of spouse abuse have been carefully elucidated (Gelles, 1974, 1977, 1980; Straus, 1976, 1977). Such factors include unequal sex roles at home and in the workforce, as well as historical and religious traditions which subordinate women and trap them in violent relationships.

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²Department of Family Practice, Medical College of Wisconsin, Southeastern Family Practice Center, P.O. Box 598, Tallent Hall, Kenosha, Wisconsin 53141.

³Cardiopulmonary Rehabilitation Center, Zablocki V. A. Medical Center.

In general, psychological characteristics of persons in violent relationships (especially abusers) have not been widely studied. Indeed, some authorities consider psychological factors unimportant in understanding spouse abuse (e.g., Gelles and Straus, 1979; Straus *et al.*, 1980). Several investigations describing abuser characteristics report data gathered indirectly from the victim (e.g., Appleton, 1980; Rosenbaum and O'Leary, 1981a,b). Several non-data-based reports have provided rich, descriptive information about spouse abusers (Elbow, 1977; Gondolf, 1985; Symonds, 1978). Such reports describe abusers as having difficulty with control issues, either out of fear of domination or out of an antisocial need to use others (Elbow, 1977; Symonds, 1978). Hence, on the basis of clinical observational reports, as well as data gathered indirectly from the victim, there appears to be at least preliminary evidence suggesting that spouse abusers exhibit personality characteristics which predispose them to difficulties in coping with the stress of intimate relationships. Further, Gondolf (1985) pointed out that many of the abusers in his study were clinically depressed. Indeed, as noted in the Diagnostic and Statistical Manual, Third Edition (DSM-III; American Psychiatric Association, 1980), personality disorders typically involve depression as a complicating factor.

Two studies have published data on abuser characteristics gathered directly from the abuser. Stewart and deBlois (1981) conducted structured interviews with the parents of children attending a child psychiatry clinic. The interview assessed, among other things, personal problems and spousal violence. A separate rater who was not blind to the differential history of spouse abuse, provided psychological diagnoses of the male spouses. Results indicated more psychopathology in abusers relative to nonabusers, particularly in the area of personality disorder and alcohol abuse. Faulk (1974) interviewed 23 abusers taken into custody. Approximately 61% of the abusers were found to have a psychiatric disorder. The most prevalent problems observed were depression and delusional jealousy. The other disorders included anxiety state, personality disorder, dementia, and post head injury syndrome. These data suggest considerable psychopathology among batterers. However, the small sample size limits the generalizability of this conclusion.

More recently, a study by Hamberger and Hastings (1985a) assessed personality profiles of 105 men participating in court-mandated programing for violence abatement. Factor analysis of subscale scores on the Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1983) revealed three major personality factors: Schizoid/borderline, Narcissistic/antisocial, and Passive dependent/compulsive personality. Average MCMI profiles were calculated for subjects in each profile (10-15). Only one profile type evidenced no discernable psychopathology, comprising 15% of the total

sample. Moreover, among the pathological personality profiles, considerable dysphoria was noted.

Methodological issues preclude acceptance of the investigations reviewed above as *prima facie* evidence for the existence of disordered personality processes or other psychopathology in batterers. In the studies by Faulk (1974) and Hamberger and Hastings (1985a), control groups were not used. It is not known from the latter two studies, therefore, if batterers exhibit personality profiles that are different from nonbatterers. The latter issue is particularly true of the Faulk study in which diagnostic criteria were not specified and standardized instruments were not employed so that comparisons between batterer data and normative samples were not possible. In the Hamberger and Hastings (1985a) study, standardized instruments with established norms were used. Therefore, at least batterer data could be compared to normative data.

The issue of whether batterers differ from non-batterer controls may be of less importance to the clinician working with a specific population such as batterers. For theory development, however, such knowledge would be important. The study by Stewart and deBlois (1981) did compare batterers versus nonbatterers. They found greater psychopathology in the form of personality disorder and alcohol problems among batterers compared to non-batterers. They used data gathered from either partner, but did not specify the gender of the reporter. Further, victim-perpetrator differences in report were not provided. Finally, the rater providing the diagnosis for the male partner was not blind to history of abuse. Such prior knowledge could have influenced diagnostic outcome.

In addition to the lack of control groups in two of the three studies reviewed above, none of them provided replication data. Such a strategy would be a particularly important step in determining the reliability and validity of findings in the single-group studies; particularly those with relatively small sample sizes (e.g., Faulk, 1974; Stewart and deBlois, 1981).

Despite the methodological shortcomings of the studies reviewed above (Faulk, 1974; Hamberger and Hastings, 1985a; Stewart and deBlois, 1981), when taken together, as well as with reports of clinical observation, batterers appear, as a group, to evidence considerable disorder in basic personality processes. Such disorder is not unitary, as evidenced by the numerous profiles elucidated among the themes of schizoid/borderline, narcissistic/antisocial and passive dependent/compulsive tendencies. It remains to be seen, however, if such findings are replicable within any given sample population. Should initial findings prove to be replicable, then confidence can be placed in their reliability—a major precondition for determining validity, or uniqueness, from a control condition. The purpose of the present study was to replicate the findings of the preliminary investiga-

tion reported by Hamberger and Hastings (1985a). As in the initial study, it was hypothesized that the preponderance of batterers would evidence personality disorders, and a confluence of personality disorders centering around schizoid/borderline, narcissistic/antisocial, and dependency/compulsive disorders would be observed. Consequently, it was hypothesized that the factor structure of the "Basic Eight" personality subscales on the MCMI in the initial study would be replicated in the present study. Finally, it was hypothesized that the pattern of dysphoria observed in the initial sample would be replicated in the present study. Specifically, it was hypothesized that profiles exhibiting schizoid/borderline characteristics, particularly in combination with helpless and passive-dependent characteristics, would tend to exhibit more depression and anger-proneness than other profiles.

METHOD

Subjects

Participants in the replication study were 99 men who attended a domestic violence abatement program conducted by the first author (LKH) between August 1984 and February 1985.

Procedure

All participants were administered the test battery (described below) as a routine part of their involvement in the treatment program. They were provided an information sheet explaining the purpose and procedures of the study, and were asked for permission to anonymously use their test results. Those agreeing each signed an informed consent form.

Tests Administered

In addition to a demographic data form, each participant completed the Millon Clinical Multitaxial Inventory (MCMI; Millon, 1983), the Novaco Anger Scale (NAS; Novaco, 1975), and the Beck Depression Inventory (BDI; Beck *et al.*, 1961).

The MCMI (Millon, 1983) is a 175-item personality inventory. The respondent reads each item and answers in true-false format. The test yields 20 clinical scales and two validity scales. The first eight subscales (the "Basic Eight") describe basic personality patterns. The next three scales relate to

pathological personality disorders (i.e., schizoid, cycloid, and paranoid). Together, these 11 scales provide a detailed description of personality disturbances, corresponding closely to those identified in the third edition of the Diagnostic and Statistical Manual (DSM-III). The remaining subscales provide data on anxiety, hysteria, mania, depression, alcohol and other drug abuse, and psychotic processes.

The Novaco Anger Scale (Novaco, 1975) is comprised of 80 situational vignettes. The respondent rates his degree of anger arousal to each scenario, using a 5-point Likert-type scale. Novaco (1975) has shown the NAS to differentiate persons with anger control problems from control subjects.

The Beck Depression Inventory (Beck *et al.*, 1961) is composed of 21 items. Each item describes four levels of depressive symptoms, in order of increasing severity. The respondent selects from each item set the description which best characterizes his feelings in the past week. The BDI has been shown to validly identify depressed subjects (Schaefer *et al.*, 1985).

RESULTS

A summary of the demographic data gathered from this sample appears in Table I. Demographic characteristics are described in detail in a separate report (Hamberger and Hastings, 1985b), and will not be elaborated upon here. It can be noted that the present sample does not differ greatly from the initial sample.

Valid MCMI protocols were collected on 99 men in the study. The standard 20 clinical scales (and two response bias scales) were computed for each test. A factor analysis was computed on the first eight (the "Basic Eight") MCMI scales, using a varimax rotation. Three orthogonal factors with eigen values greater than 1.0 were identified, accounting for 44%, 25%, and 11% of the factor variance, respectively. The loadings of the Basic Eight scales on these three factors appear in Table II. For purposes of comparison, factor loadings from the initial sample are also included in Table II. As can be seen from visual inspection of the table, the three factors derived in the present study, together with their respective loadings, are virtually identical to those derived in the initial study. Factor I was labeled "schizoidal/borderline," Factor II was labeled "narcissistic/antisocial," and Factor III was labeled "passive dependent/compulsive."

As in the initial study, factor scores for each of the three factors were derived for all subjects in the present investigation. Using all possible combinations of these factor scores (High I, Low II and III; High II, Low I and III etc.), each subject was assigned to one of the eight possible subgroups. The groups were of roughly equivalent size (from 10 to 16 subjects per

Table I. Demographic Characteristics of Batterers ($N = 99$)

Demographic Category	Initial Sample (%)	Replication Sample (%)
(1) Race		
Caucasian	83.8	85.9
Black	13.1	7.7
Hispanic	1.9	3.8
N.A.	1.0	2.6
(2) Marital Status		
Married	25.7	38.5
Separated	41.0	29.5
Divorced	14.3	12.8
Never Married	19.0	19.2
(3) Employment		
Employed	77.7	69.2
Unemployed	22.3	30.8
(4) Alcohol		
No Problem	70.2	66.7
Problem	29.8	33.3
(5) Education		
H.S.	24.3	21.8
H.S. Grad	49.5	56.4
Some College	24.3	19.2
Post-Grad	1.0	1.3
(6) Religious Preference		
Protestant	44.6	33.3
Catholic	33.7	42.3
None	19.8	21.8
(7) Abuse History		
None	63.8	84.6
Emotional	9.5	3.8
Physical	11.4	2.6
Both	7.6	9.0
(8) Witness Abuse		
Yes	26.5	29.5
No	73.5	70.5
(9) Volunteer Phase II		
Yes	31.4	23.1
No	68.6	76.9
(10) Follow Through		
Yes	17.8	15.4
No	82.2	84.6
(11) Age		
Range 19-64 $\bar{X} = 31.94$ -Range 19-54 $\bar{X} = 32.31$		

Table II. “Basic Eight” Scale Loadings on the Three Factors for the Initial (Group 1) and Replication (Group 2) Samples

MCMI Subscale	Factor Loadings					
	Factor 1		Factor 2		Factor 3	
	Gp. 1	Gp. 2	Gp. 1	Gp. 2	Gp. 1	Gp. 2
Asocial	0.69	0.59	-0.52	-0.64	0.09	0.10
Avoidant	0.86	0.75	-0.39	-0.49	0.17	0.28
Submissive	0.20	0.26	0.05	-0.15	0.91	0.81
Gregarious	-0.05	-0.03	0.93	0.90	0.04	-0.18
Narcissistic	-0.11	-0.04	0.82	0.70	-0.29	-0.49
Aggressive	0.29	0.15	0.37	0.23	-0.78	-0.87
Conforming	-0.86	-0.82	-0.29	-0.29	0.14	0.08
Negativistic	0.93	0.90	-0.08	-0.15	-0.02	0.04

group), a finding also highly similar to that of the initial study. Mean MCMI profiles were calculated for each of the eight factor score groups. These data appear in Figures 1-8, in comparison to profiles reported in the initial study. Visual inspection of each of the eight figures depicting the factor groupings reveals a high degree of replication of the personality profiles of Group 1 and Group 2. To confirm the intuitions of visual inspection, multivariate ANOVA's were completed on each of the eight derived factor groups. In each case, the independent variable was Group (first vs. second sample) and the variates were the 20 MCMI scales. No profile pairs differed significantly. There were four significant univariate *F*'s (among the 160 comparisons generated); however, in the absence of significant overall multivariate *F*'s, it is inappropriate to consider these as meaningful differences. (Eight significant univariate *F*'s would have been anticipated by random chance, using $p = 0.05$ as a cut-off.)

In the interest of brevity, only the first three sub-group mean profiles will be discussed in detail. The first sub-group consisted of 10 individuals who scored high on Factor I, and low on Factors II and III. The mean profile appears in Fig. 1. This profile describes a withdrawn and asocial individual who is moody and hypersensitive to interpersonal slights. Such individuals often are described by others as highly volatile and over-reactive to trivial interpersonal friction. They may seem relatively calm and controlled one moment, and extremely angry and oppressive the next—in colloquial terms, a “Jeekyll and Hyde” personality. The DSM-III diagnosis associated with this profile is “Borderline Personality.” The men in this group demonstrate extremely high levels of anxiety and depression, as well as the likelihood of alcohol problems on the other MCMI scales and by self-report. The BDI scores showed high levels of depression, and the NAS confirmed very high levels of anger proneness. Clearly, these are individuals who would experience (and produce) high levels of strife in interpersonal relationships.

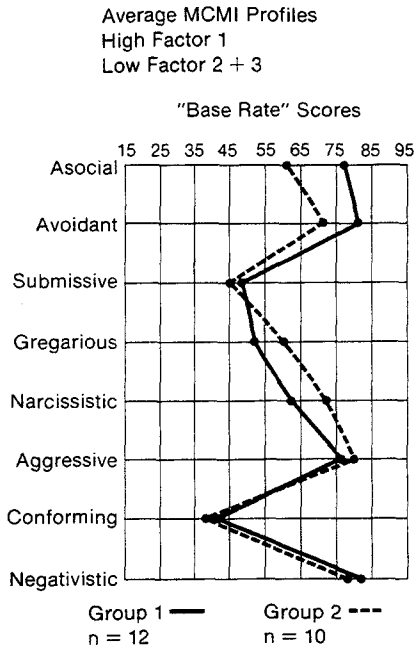


Fig. 1. Average MCMJ "Basic Eight" profiles for initial (Group 1) and replication (Group 2) samples, High Factor I, Low Factors II and III.

The second group is comprised of 13 individuals who scored high on Factor II, and Low on Factors I and III. The mean profile appears in Fig. 2. This profile describes an individual who has a very self-centered approach to life, rigidly insisting that his perceptions, values, and rules be accepted by others. He uses others to meet his own needs, and only reciprocates when it works to his advantage. His self-perception leads him to feel entitled to be treated well by others according to his own standards. Hesitation or refusal by others to respond to his demands invites threats and aggression. The 14 men in this group reported low levels of dysphoria, a high energy level, and marginal tendencies to alcohol and drug problems. BDI scores were very low, and despite the high aggression score on the MCMJ, they reported very low scores on the NAS. The DSM-III classification for these individuals is Narcissistic or Antisocial personality disorder.

The third group is composed of 16 individuals who scored high on Factor III and low on Factors I and II. The average profile appears in Fig. 3. Such a profile describes a tense, rigid person who may characteristically behave in a weak, passive, or ingratiating way. Self-esteem is lacking, and there is a strong sense of "need" for one or a few significant others. Failure

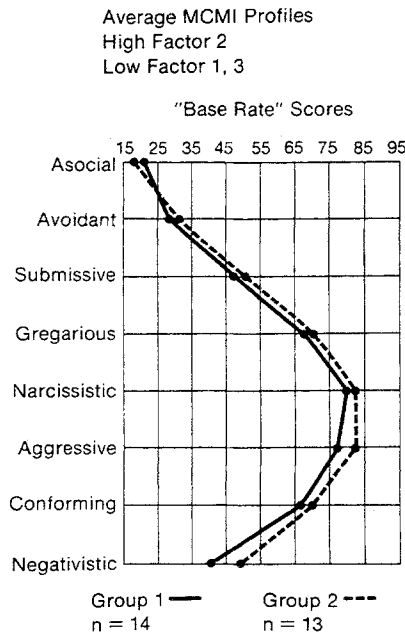


Fig. 2. Average MCMII "Basic Eight" profiles for initial (Group 1) and replication (Group 2) samples, High Factor II, Low Factors I and II.

to meet these needs may occasionally result in a breakthrough of rebellious hostile feelings. The men in this group reported only mild dysphoria on the MCMI although self-reported energy level was extremely low, and BDI scores were moderately high. Despite a slightly elevated MCMI self-report of aggressiveness, the NAS revealed very low levels of anger proneness. These individuals would likely be diagnosed as "Dependent" or "Compulsive" personality in the DSM-III.

The remaining High Factor score combination groups seem to combine the negative features of the first three "pure" factor groups. For example, Group 4, composed of 12 men scoring high on both Factors I and II, and displayed in Fig. 4, combines the angry, sullen, volatile qualities of Group I with the aggressive, narcissistic qualities of Group 2, to produce an extremely aggressive, unpredictable sort of antisocial (or, classically, "psychopathic") personality. Group 5, which includes 14 men scoring high on Factors I and III, combines the sullen, moody, avoidant properties of Group I with the intense dependency needs of Group 3 to create an intensely conflicted, *extremely* frustrated and dysphoric borderline syndrome. There

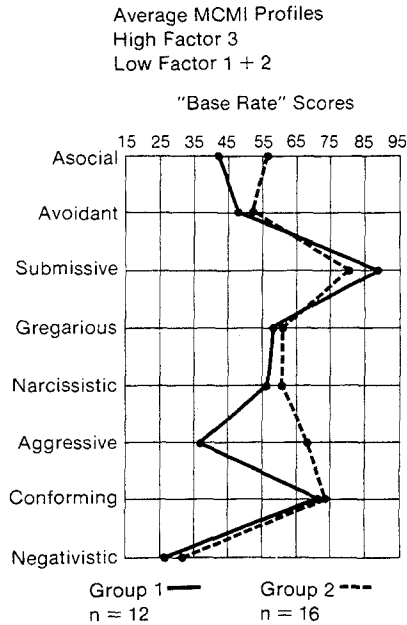


Fig. 3. Average MCMJ "Basic Eight" profiles for initial (Group 1) and replication samples, High Factor III, Low Factors I and II.

is also evidence of pronounced mood swings and periodic psychotic adjustment (see Fig. 5).

Group 6 is composed of 11 men who scored high on Factors II and III, and low on Factor I. The resultant profile is one which suggests a combination of the narcissistic and manipulative qualities of Group 2 with the dependent qualities of Group 3. Such individuals are described as gregarious, superficially charming, and self-dramatizing as a way of gaining the attention, admiration and support of others. They are also alert to signs of potential rejection. Further, when their dependency security seems seriously threatened they may react with sudden, brief, disorganized hostility (see Fig. 6).

Group 7 represents high scores on all three major factors. Marked dependency needs in these 11 patients create periods of anxious bids for support and fears of separation and loss, alternating with periods of moodiness, futility, and dejection and occasional impulsive angry outbursts.

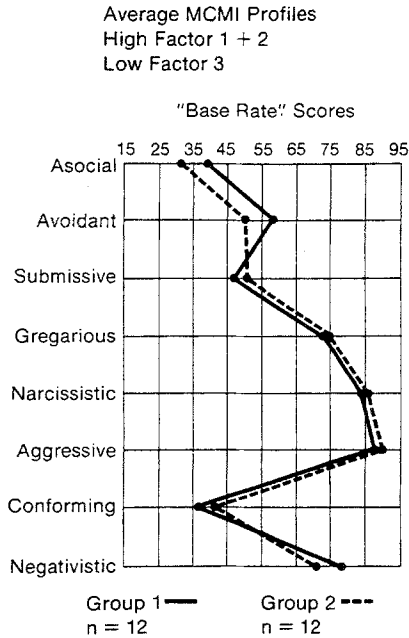


Fig. 4. Average MCMI "Basic Eight" profiles for initial (Group) and replication (Group 2) samples, High Factors I and II, Low Factor III.

Dysphoria is considerable and persistent, as reflected in the remaining MCMI mood scales, BDI, and Novaco (see Fig. 7).

Finally, Group 8 shown in Fig. 8 consists of 12 men who scored low on all three factors. The mean Basic-8 profile shows no scales above the cut-off base-rate score of 75. These men would not be construed as suffering from any clear pathology. The mean profile suggests a self-confident, assertive, but largely appropriate and rule-governed adjustment. Dysphoria as measured by MCMI, BDI, and Novaco is negligible.

One-way analyses of variance were conducted to determine whether the factor groups differed in actual degree of depression, as measured by the BDI and anger proneness, measured by the NAS. The first ANOVA examined BDI scores. Mean BDI scores for each factor group are presented in Table III. Overall analysis revealed a significant effect ($F(7, 89) = 5.40 p < 0.001$). Post hoc analysis used the modified, least significant differences test with a criterion of $p < 0.05$. Group 6 (high Factor II and III, low I) showed

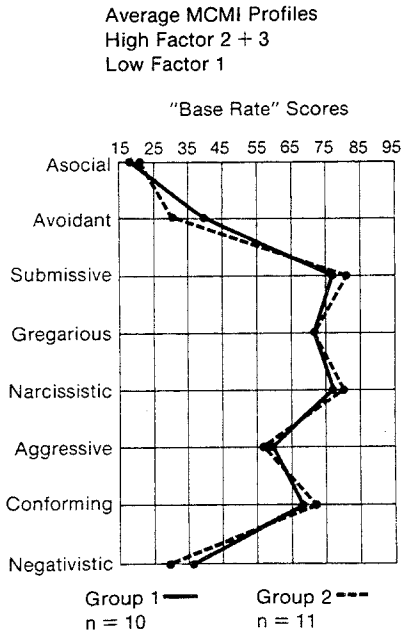


Fig. 6. Average MCMII "Basic Eight" profiles for initial (Group 1) and replication (Group 2) samples, High Factors II and III, Low Factor I.

A one-way ANOVA was also conducted for the NAS scores. Mean NAS scores for each group also are presented in Table III. Results of the ANOVA showed a significant effect ($F(7, 90) = 3.02, p < 0.007$). Subsequent analysis, using the modified least significant differences test with cut-off criterion of $p < 0.05$ revealed that Group 3 (high Factor III) was significantly less anger prone than Groups 5 (high Factors I and III, low II) and 4 (high Factors I and II, low III). The latter two groups exhibited the greatest anger proneness and did not differ statistically from each other. As with the BDI data, these results are fairly similar to those observed in the initial study (see Fig. 10 for a comparison).

For each of the eight factor groups, one-way ANOVA's were used to compare the scores of sample 1 vs. Sample 2 subjects on the Beck Depression Inventory and the Novaco Anger Scale. The only significant difference which emerged was on the NAS scores for Factor Group 3. Subjects in sample 2 scored significantly lower on the NAS than subjects in sample 1. ($F(1,198) = 3.86, p < 0.05$). Here again, the loss of "alpha protection" associated with multiple tests discourages interpretive speculation. It should

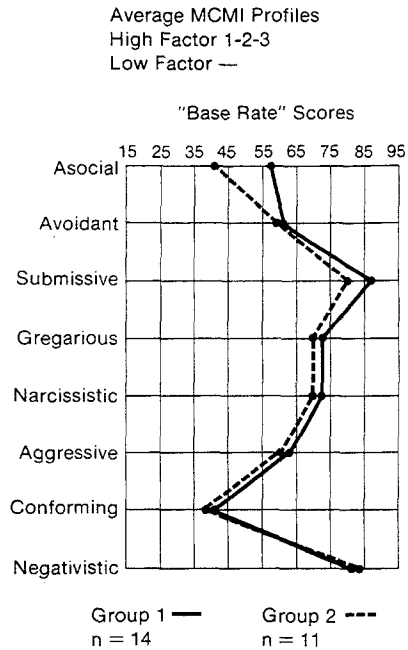


Fig. 7. Average MCMI "Basic Eight" profiles for initial (Group 1) and replication (Group 2) samples, High Factors I, II, and III.

be noted, however, that significant differences were found on the MCMI aggression scale for this group, too. Paradoxically, these differences were in the opposite direction (i.e., sample 2 subjects scored *higher* on aggression). In view of the statistical impropriety of pursuing these results, they are best understood as interesting anomalies in need of replication. In general, then, the pattern of dysphoria, as measured by the BDI and NAS, observed in the initial study was largely replicated in the present investigation. Specifically, those personality profile groupings showing the greatest dysphoria include those with a high Factor I component (Groups I and 4) and a combination of high Factor I and III (Groups 5 and 7).

DISCUSSION

The present study was conducted to replicate an initial investigation that was carried out to determine personality characteristics of men iden-

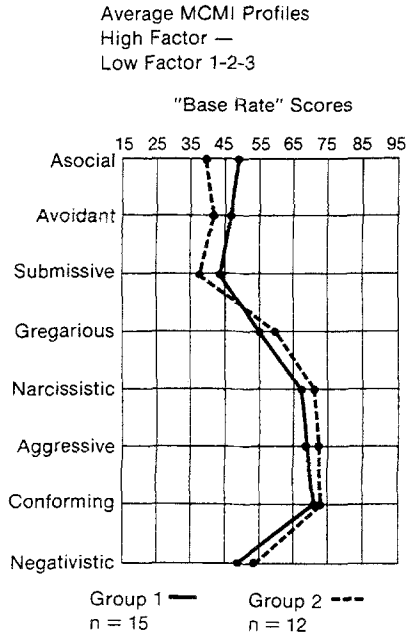


Fig. 8. Average MCMJ "Basic Eight" profiles for the initial (Group 1) and replication (Group 2) samples, Low Factors I, II, and III.

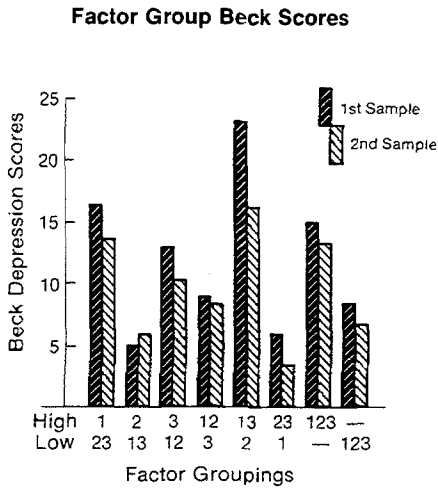


Fig. 9. Average BDI scores for initial and replication samples on factor score groupings.

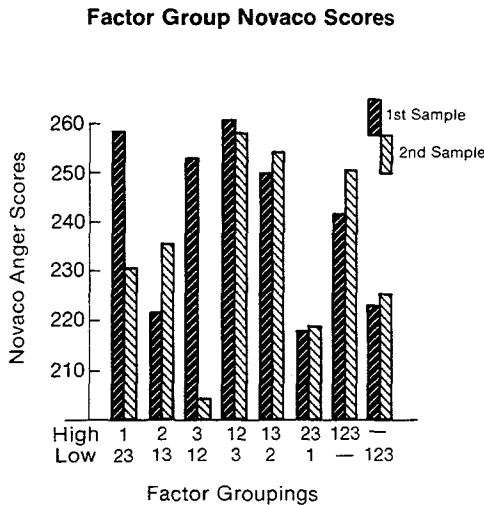


Fig. 10. Average NAS scores for initial and replication samples based on factor score groupings.

tified as having committed acts of violence against their partners. Demographic data indicated considerable consistency across both studies, and with that reported in other studies of spouse abuse. Specifically, compared to the community as a whole, unemployment and alcohol problems had a higher prevalence among batterers. Further, approximately 40% of the present sample reported having grown up in a family in which abusive violence of some type was experienced. Hence, the present paper appears to be based on subjects who are demographically similar to those generally reported in the literature.

It is clear that the second study replicated the findings of the preliminary effort. In fact, the authors were surprised by the high degree of similarity between the two independent samples. Personality profile as measured by the MCMI supported the hypothesis that the preponderance of subjects would exhibit evidence of personality disorder. Indeed, only 12 participants out of 99 for whom data were available showed no evidence of personality disorder or other psychopathology. Further, as predicted, no single "abuser personality" was found. Therefore, Hypothesis 1 was confirmed. Moreover, factor analysis also confirmed three major personality categories observed in Study 1. These categories are consistent with diagnoses of schizoid/borderline personality disorder, narcissistic/antisocial personality disorder and passive dependent/compulsive personality disorder. Consequently, Hypothesis 2 was also confirmed.

When average MCMI profiles were calculated for individuals scoring high and low on the various combinations of the three main factors, a total of seven different profiles, all reflecting the various themes of the three main factors were revealed. The eighth profile, reflecting low scores on all three factors, was observed with no MCMI subscale in the pathological range. These eight profiles were nearly identical to those observed in Study 1.

As in the initial study, when scores on the three personality factors were examined in relation to measures of dysphoria (anger proneness and depression), Factor I subjects evidenced the greatest amounts. In the initial investigation, three out of four possible factor combinations involving Factor I subjects were above the group mean of the BDI. In the present study, the pattern was virtually identical. Therefore, Hypothesis 3 was also confirmed. Further, the depression already associated with high Factor I scores appears to be intensified by the passivity associated with Factor III. Such individuals not only experience internal and interpersonal conflict and tension, but an even greater sense of defeat and helplessness at being unable to do anything about their problems.

An interesting finding with the anger-proneness data is that "pure" Factor III (passive dependent) subjects scored the lowest of all groups on the NAS, and significantly lower than "pure" Factor I and high Factor I and II subjects. The low NAS scores for Group 3 subjects is theoretically and clinically significant. The placative, submissive behavior designed to smooth over conflicts would suggest low levels of anger proneness. The present finding is in some contrast to the findings of anger proneness and high Factor III subjects. In the previous study, high Factor III subjects showed considerable anger proneness but little propensity to act more than occasionally on the anger. It appears that further research will be necessary to reconcile this apparent discrepancy.

Another interesting finding with the anger-proneness data is the relatively moderate scores for subjects in Group 2, characterized by narcissism and antisocial tendencies. The high degree of interpersonal aggressiveness, characterized by high Factor II scores would intuitively suggest high levels of anger proneness. It should be noted, however, that the NAS asks the subject about anger arousal, not anger *expression*. Hence, the finding that Group 2 subjects do not tend to see themselves as prone to anger arousal may not be inconsistent with their interpersonal aggressive tendencies. Indeed, individuals with such profiles may prefer the "Don't get mad, get even" philosophy even when that involves aggression.

One potential limiting factor of the present study is the source of subject selection. Subjects consisted of individuals who had been arrested and ordered to assessment. As a result, the findings are based on those who were

“caught” and may not represent abusers who go undetected. Two features in the present study, as with the initial endeavor, mitigate the latter limitation somewhat. *First*, in recent years, the locale in which the data were collected has instituted a “pro-arrest” policy with respect to domestic violence. Consequently, when police receive a call and have any evidence of domestic violence, an arrest is routinely made regardless of other factors. Of course, a certain segment of the abuser population continues to remain unreported and undetected. Nevertheless, the current sample of participants probably represents a wider spectrum of abusers due to the higher frequency of arrests and convictions brought about by the pro-arrest policy.

The second feature supports the first in that the present sample does not consist entirely of men volunteering for clinical treatment. In fact, only about 7% of those ordered to an initial assessment volunteered for subsequent treatment when given the option, even for no fee. Therefore, the present sample consists not only of individuals in treatment, but also of that segment of the population which would otherwise be considered undetected because of their lack of treatment participation.

In general, the high degree of replication between studies provides evidence supporting the notion that psychopathology is demonstrable in spouse abusers. Rather than define psychopathology narrowly as consisting primarily of psychotic processes, however, the present investigation focused primarily on ascertaining personality profiles and their aberrant, disordered qualities. Such a broad-based approach allowed for the determination that abusers, as a group, exhibit not only a preponderance of personality disorders, but several discrete “types.” Although preliminary and uncontrolled, the fact that the findings were so highly replicable provides support for placing confidence in their validity. Abnormal or maladaptive personality characteristics must be considered as part of the constellation of factors constituting the final common pathway leading to spousal abuse. Further, as treatment programs for batterers increase in number, scope, and sophistication, direct knowledge of the target clientele will be necessary for development of realistic intervention strategies and program goals for the various individual persons who are served.

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