5-2017

Intervention with Intimate Partner Violence: Application of Attachment and Personality Disorders

MaryBeth Ehlert
St. Catherine University, ehle0031@stthomas.edu

Intervention with Intimate Partner Violence:

Application of Attachment and Personality Disorders

By MaryBeth K.G. Ehlert, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members
Sarah Ferguson, PhD, LSW (Chair)
Denise Morcomb, MSW, LICSW
Noya Woodrich, MSW, LISW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The goal of this study was to examine the influence attachment theory and personality disorders have on the clinical interventions currently used with individuals who have committed intimate partner violence. Qualitative interviews were conducted with four professionals currently working with IPV perpetrators in group or individual therapeutic settings. Six themes were developed: (a) Multiple Risk Factors of IPV, (b) Societal Views on Perpetration and Victimization, (c) Mental Health Informed Intervention Options for IPV, (d) Training or Educational Background Dictating Conceptual Framework, (e) Trauma and (f) Negative Connotations of Personality Disorders. The findings of this small exploratory study suggest that while mental health has become a major component of IPV intervention, more can be done to address some of the mental health underpinnings of IPV, and more research needs to be done to identify the most effective methods to support that area of focus.

Acknowledgements

First and foremost, I would like to thank my research chair, Sarah Ferguson. She challenged me when I needed to be challenged and she supported me when I needed support. There was no person better qualified to guide me through this process, and her professional knowledge and personal perspective on this topic was enormously influential on the direction of my research. Additionally, I would like to thank my committee members Denise Morcomb and Noya Woodrich. The depth and diversity of knowledge you both provided me in this process was inspiring.

I would also like to thank the participants of this study. I am so grateful to all of you for taking the time to meet with me and discuss your experiences and feelings. The insights you shared were incredible, and each of you had an amazing story to tell.

Lastly, an enormous thank you to my family and friends. Thank you all for putting up with me and helping me keep my humor intact through stressful times. Finally, to my husband, who is always willing to pick up my parenting slack on a moment's notice, and whose calm and supportive nature has kept me balanced and sane… you are an absolute superhero and I could not have done this without you.

Table of Contents

Approximately 1 in 4 women have experienced severe physical abuse at the hands of a spouse or intimate male partner (Black et. al, 2011). Far more have experienced other forms of intimate partner violence (IPV), which can be defined as any form of aggression or controlling behaviors used in the context of an intimate relationship – and can include both verbal and emotional abuse (Dixon & Graham-Kevan, 2011). Including medical and mental health care services and lost work production, IPV costs over $5.8 billion each year (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004).

While historically IPV was conceptualized as a sociological or gender-equality issue, a large volume of contemporary research shows that mental health is a crucial factor in understanding these behaviors (Dutton, 2012). If there is any hope for prevention or rehabilitation with the violent individuals who commit these forms of abuse, there must be a deep understanding of the traits or pathologies that can lead to these behaviors. Recent meta-analytic studies have suggested that current interventions may be somewhat ineffective at preventing recidivism, so this is a timely and critical need (Babcock, Green & Robie, 2004).

Research has shown that intimate partner abusers are not a homogenous population, and instead can be placed into one of many subtypes based on pathology (Ross & Babcock, 2009). Understanding these subtypes or "batterer typologies" is crucial to designing effective interventions to treat these individuals, as different subtypes may be more responsive to some treatment modalities than others (Mauricio et. al, 2007; Saunders, 1996).

Several studies suggest that a combination of insecure attachment styles and certain personality disorders are some of the primary contributing factors to IPV (Buck, Leenaars, Emmelkamp, & van Marle, 2014; Mauricio et. al, 2007; Ross & Babcock, 2009). While the body of research does suggest that personality disorders do serve as mediators between attachment and

IPV, some of the associations assumed on the basis of clinical practice theories do not hold true (Mauricio et. al, 2007). Researchers have also assessed how personality disorders contribute to violent behavior in the absence of insecure attachment (Buck et. al, 2014).

Perhaps most interesting is some of the recent research that seeks to understand motivations and interactional antecedents for violent behavior among abusive individuals with different personality disorders and attachment styles (Ross & Babcock, 2009). Work has also been done to determine the specific mechanisms or emotional deficits which may contribute to the perpetration of IPV.

The literature clearly supports the idea that attachment insecurity and personality disorders both play integral roles in IPV perpetration, but it is unclear if and how this translates to daily work done with intimately violent populations. The goal of the present study is to examine the influence attachment theory and personality disorders have on the clinical interventions currently used with individuals who have committed intimate partner violence.

Literature Review

Theoretical Perspectives on Intimate Partner Violence

Historically, intimate partner violence has been regarded as more of a sociological concern than a psychological one. Many argue that IPV is a direct result of deeply held patriarchal beliefs in modern culture, which encourage men to seek dominance over their subordinate female partners (Dixon & Graham-Kevan, 2011). This gendered perspective has been the dominant paradigm in both clinical and criminal justice settings for over two decades. Some researchers argue that this paradigm ignores other potential etiologies of abuse (Dutton, 2012).

The sociological paradigm of IPV struggles to explain the patterns of this behavior within different demographic samples. While male-to-female IPV does have a negative correlation with measures of female empowerment, some studies suggest that correlation is not as strong as traditionally suspected (Archer, 2006). In his meta-analysis of cross-cultural IPV studies, Archer (2006) points to several that suggest that gender empowerment may shift the patterns of IPV perpetration, but it does not eliminate the issue itself. IPV is prevalent across the globe, in a vast variety of societies and cultures, but it is perpetrated by what Dutton and White (2012) call the "non-normative minority" within any demographic. While some IPV risk factors such as poverty and lack of education may affect certain cultures in differing proportions, the relationship between these factors and IPV are inconsistent between cultural groups. This all suggests that additional, more personal risk factors are involved (Krahe, Bieneck & Moller, 2005).

As it seems gender inequality alone does not appear to explain IPV, many contemporary studies have aimed to uncover psychological factors that contribute to the perpetration of

violence against intimate partners, such as depression, substance abuse, previous exposure to child abuse, and personality disorders (Dutton & White, 2012).

Impacts of Personality Disorders on Relationships

Research suggests that personality disorders in one or both members of a relationship is detrimental to the quality of the relationship. In a study of couples in which the woman was diagnosed with borderline personality disorder (BPD), such couples were found to have higher instability and lower relationship satisfaction than non-borderline couples. Of even greater concern, perhaps, is that the same study found that nearly half of the male partners of the women suffering from BPD were diagnosed with a personality disorder themselves. These findings may help explain the higher levels of psychological violence in these couples (Bouchard et. al, 2009).

In addition to the decrease in relationship stability and satisfaction, research also shows a marked increase in IPV within couples where one or both partners have a personality disorder (Bouchard et. al, 2009; Mauricio et. al, 2007; Ross & Babcock, 2009). Romantic partners of men with both BPD and antisocial personality disorder (ASPD) report substantially higher rates of IPV than those without a personality disorder diagnosis (Ross & Babcock, 2009). Frequently comorbid, IPV perpetrators with both antisocial and borderline traits have a higher risk of recidivism after psychotherapeutic treatment (Romero-Martinez, Lila, & Moya-Albiol, 2016). If analyzed separately, BPD has been found to be significantly associated with both physical and psychological violence, while ASPD seems to only be associated with physical violence (Mauricio et. al, 2007).

Women are three times more likely to be diagnosed with BPD than men, and women have historically been overrepresented in the literature on BPD. Men, as some researchers suggest, are potentially overrepresented in IPV literature (Dutton, 2012). It is worth noting that,

despite the well-established link between BPD and IPV, very little has been done to resolve this disconnect (Jackson et. al, 2015).

The Complex Relationship between Attachment, Personality Disorders, and Violence

Attachment theory, which can serve as a theoretical framework to understand the origins of personality disorders themselves, has also become widely considered an important predictor of IPV (Mauricio et. al, 2007). Accordingly, several researchers have attempted to decode how exactly personality disorders and attachment fit together within the equation of IPV (Buck et. al, 2014; Mauricio et. al, 2007).

Batterer typologies. With so many potential contributing factors, it is clear that the profile of an intimate partner abuser can vary greatly (Ross & Babcock, 2009). Several typologies exist, and are believed to fall within three main subtypes: Family-Only (FO), Borderline-Dysphoric (BD), and Generally-Violent-Antisocial (GVA). FO abusers are believed to engage in the most minor abusive behaviors, have no criminal history outside of the home, and exhibit little to no psychopathology. BD abusers are more violent, but exhibit little violence outside the home and likely have borderline traits or BPD. GVA abusers are the most severely violent, are likely violent outside the home as well, and likely have antisocial traits or ASPD (Holtzworth-Munroe, Meehan, Herron, Rehman & Stuart, 2000).

One of the classic profiles frequently referenced in the body of literature is that of the ‘borderline personality with anxious attachment’ which has long been shown to be highly correlated with jealousy and abusive behaviors (Dutton, van Ginkel, & Landolt, 1996). Other typologies exist, and are often based on theoretical conceptualizations or recognized relationships. Antisocial personality disorder, for another example, is often assumed to be paired with avoidant attachment (Mauricio et. al, 2007).

Many of these typologies seem logically valid. Someone who exhibits a pathological need to control others (e.g. NPD and ASPD) would be presumed to have a different pattern of abusive behaviors than an individual with BPD who struggles with self-concept and identity (Mauricio & Lopez, 2009). However, not all of these profiles have consistent support in the body of research (Buck et. al, 2014). For instance, Mauricio and Lopez (2009) were able to find evidence indicating BPD, anxious attachment, and avoidant attachment were all positively associated with violence – but not ASPD.

Personality Disorders as mediators between attachment and violence. While personality disorders and attachment have both long been considered factors in IPV, many earlier studies failed to test whether these elements operated independently or if one mediated the other, which can have major implications on appropriate models for intervention. The literature suggests that both antisocial and borderline personality disorders significantly mediate the relationship between avoidant attachment and both physical and psychological violence, but have a much less robust effect on the relationship between anxious attachment and violent behaviors. In fact, when controlling for personality disorders, it was found that anxious attachment continued to have a direct impact on psychological violence, which was not the case with avoidant attachment (Mauricio et. al, 2007). A later study failed to find a significant mediating effect of this same nature when they introduced an additional variable of hostile dominant interpersonal problems (HDIP), but suggested that the results did not necessarily refute the prior findings. Instead, it was simply found that HDIP was a stronger mediator than the borderline features themselves (Lawson & Brossart, 2013). However, considering the significant correlation between HDIP and the primary features of BPD, there may be some overlapping concepts that have yet to be fully addressed in the research (Leichsenring, Kunst & Hoyer, 2003).

Personality Disorders still predictive in securely attached. Despite insecure attachment being an important predictor of IPV, not all perpetrators are insecurely attached, with at least one study finding 39.4% of their sample to be securely attached (Buck, Leenaars, Emmelkamp, & van Marle, 2012). In attempt to tease apart the effects of personality disorders versus those of attachment, some researchers have attempted to examine the causes behind abusive behaviors in batterers whose main attachment style is secure (Buck et. al, 2014).

Many clinicians would assume that personality disorders like ASPD and narcissistic personality disorder (NPD) would be more commonly seen in the securely attached, while BPD would only be predictive of battering when paired with insecure attachment. Instead, it appears that all three personality disorders are predictive of battering in the securely attached (Buck et. al, 2014). While the Buck study did find that ASPD was the most predictive of the three personality disorders in a securely attached population, it did not find the suspected lack of correlation with BPD and violent behavior, and in fact, did not find support for the long-assumed theory that BPD was predictive of battering among insecurely attached individuals (Buck et. al, 2014).

Motivations

The psychological motivations behind abusive behavior can vary greatly between batterer subtypes, and yet few studies have delved very deeply into the topic of motives and antecedents for abusive behavior, likely due to some of the ethical implications. In one exception Ross and Babcock used sequential analysis on interview data from abusive partnerships and analyzed the situations that preceded violent acts in the different subtypes of abusive men. The study found that batterers without a personality disorder responded most violently to partner's complaints, ASPD batterers responded most violently to acts of belligerence/dominance from their partner,

and BPD/comorbid batterers responded most violently to their partner's displays of distress, such as crying or pleading (Ross & Babcock, 2009).

Interestingly, the severely violent response to distress seen was only seen in BPD men, as ASPD and control group men were less likely to engage in any violence in response to their partner's distress. This confirmed part of their hypothesis, which was that BPD men engage in more reactive violence, whereas ASPD men primarily use it proactively, as a means to control dominant behavior from their partners (Ross & Babcock, 2009). The results from this study could be interpreted as indirectly supporting some of the common batterer typologies proposed in the other studies, particularly that of the "anxiously attached with BPD" profile. Compared to their ASPD and no-diagnosis counterparts, their most extreme acts of violence often seem to be an unplanned, uncontrollable response to abandonment fears (Ross & Babcock, 2009).

The source of these abandonment fears may be a combination of reasonable reactions to external stimuli or irrational reactions to neutral or even positive stimuli. Not all partner violence is entirely one-sided. As seen in at least one study, women's negative attachment behaviors had a stronger effect on men's physical aggression than their own attachment behaviors (Oka, Sandberg, Bradford, & Brown, 2014).

However, many acts of IPV are triggered by seemingly innocent stimuli, which suggests that perpetrators of IPV may have deficits in their ability to recognize their partners' emotions (Marshall & Holtzworth-Munroe, 2010). In fact, poor emotion recognition and low cognitive empathy has been found to moderate the relationship between high antisocial and borderline traits and the risk of recidivism among post-treatment IPV perpetrators (Romero-Martinez et. al, 2016). IPV perpetration has been found to correlate negatively with sensitivity to their partners' expressions of happiness (which may be misidentified as disgust) and fear (which may be

misidentified as neutral), and this diminished sensitivity may mediate between borderline traits and IPV (Marshall & Holtzworth-Munroe, 2010.)

Whether in reaction to real or mistakenly perceived negative stimuli, IPV men have an apparent difficulty in labeling and expressing some emotions. Presented with simulated situations involving being criticized by their partner, violent men were much more likely to express feelings of anger, compared to non-violent men, who more commonly expressed feelings of sadness (Costa & Babcock, 2008).

The Efficacy of Current IPV Intervention Methods

Meta-analysis of modern IPV intervention research shows that much of the work done with IPV perpetrators does little to reduce recidivism (Babcock, Green & Robie, 2004). While some of this inefficacy can be attributed to the high attrition rates for treatment groups, with longer/greater attendance being associated with efficacy of treatment, that association does not appear to be linear or fully predictable (Sartin, Hansen, & Huss, 2006). The issue of inefficacy is found in both Duluth model interventions (psycho-educational groups that focus primarily on gender dynamics) and more mental-health focused CBT interventions. However, as pointed out by Babcock et al., the lines between these two types of interventions are currently quite ill-defined, as modern Duluth-type interventions use many CBT methods, and most CBT interventions are likewise informed by the Duluth model (2004).

Research does suggest that certain personality types have better outcomes to certain types of intervention than others. In one study, for example, perpetrators with antisocial traits had better outcomes in group treatment more closely following the Duluth model, while perpetrators with more dependent personalities responded much more strongly to process-psychodynamic group treatment (Saunders, 1996). This seems logically consistent with research done on batterer

typologies and their specific motivations behind abusive behaviors – if one assumes an overlap between the "dependent personalities" in this study and the "anxiously attached with BPD" typology in other studies (Holtzworth-Munroe et. al, 2000; Mauricio & Lopez, 2009; Ross & Babcock, 2009)

Conclusion

With a population as heterogeneous as the one seen in perpetrators of IPV, it is clear that one-size-fits-all interventions will not be effective in this arena (Ross & Babcock, 2009). Understanding the possible profiles of abusive individuals, and how those profiles differ in terms of both etiology and current motivations or triggers, is crucial. It is also of critical importance to thoroughly test whether some of the "classic" profiles that dominate practitioners' assumptions about this population are truly accurate and significant. When addressing a problem that has social justice and safety implications far beyond that of many other mental health issues, it is of particular importance to make sure that any and all interventions being crafted will actually be effective for the population they are designed to serve.

If the motivation of a batterer with BPD or anxious attachment is to control their partner's emotional proximity, teaching them that their behaviors may create more emotional distance may be very effective for them (Mauricio & Lopez, 2009.) However, the motivations of someone exhibiting avoidant attachment or ASPD may in fact be to gain emotional distance, so those same methods may not be effective (Mauricio & Lopez, 2009.) In fact, with the incapacity for remorse and empathy seen in ASPD may make any form of clinical treatment incredibly challenging (Mauricio & Lopez, 2009.) While the entire body of research on this topic states similar clinical goals, very little research has been done throughout the course of a treatment or intervention process to see if and how they affect any change within populations of the differing

subtypes, which appears to be the next obvious progression in this field. The goal of the present study is to examine the influence attachment theory and personality disorders have on the clinical interventions currently used with individuals who have committed intimate partner violence.

Methods

The goal of the present study was to examine the influence attachment theory and personality disorders have on the clinical interventions currently used with individuals who have committed intimate partner violence. The aim of this research was to determine, via qualitative interviews, if and how clinicians in direct practice with IPV perpetrators utilize their knowledge of these risk factors.

Research Design

This study was qualitative in nature, and consisted of structured interviews with professionals working in this field. Snowball sampling was used to recruit interviewees that were asked about the conceptual framework they have regarding IPV, and how that manifests in the concrete details of their work. Responses were coded using content analysis in an attempt to synthesize their narratives into common themes.

Sample

The sample consisted of four professionals working with IPV perpetrators in a group or individual treatment setting. All participants were professionals with an educational background in mental health, such as licensed clinical social workers or psychologists. Individuals with other backgrounds were not directly excluded, as they could potentially add contrasting viewpoints, however all completed interviews were with clinical social workers and/or psychologists. The sample was selected using a snowball sampling method, wherein the researcher asked initial participants to help locate and refer additional participants (Grinnell, Williams, & Unrau, 2016).

Participants were initially recruited included by research chair, Dr. Sarah Ferguson, committee members Noya Woodrich and Denise Morcomb, as well Dr. Michael Chovanec, a fellow professor in the St. Catherine/St. Thomas social work program. Initial participants were

asked to identify and refer colleagues who may have insight on the research topic. The researcher asked participants, as the final question of the interview, “Do you have any colleagues that work in this field that might be interested in participating in this study?” If participants were comfortable providing contact information for these colleagues, they provided it, and the researcher reached out proactively. If participants preferred to ask their colleagues first, the researcher provided them contact information to have these potential participants reach out to on their own time. The initial goal in regards to sample size was 8-10 participants, but due to a low response rate and multiple scheduling conflicts, only four interviews were completed.

Protection of Human Subjects

The study was submitted to the St. Catherine University Institutional Review Board for exempt-level review and approval. Respondents were asked to sign an informed consent form detailing the specifics of their participation in the study.

Care was taken to preserve the confidentiality of all respondents. Recordings and transcripts were maintained on a private computer with password protection and deleted shortly after completion of the study. Signed consent forms were kept in a secure location separate from all recordings and transcripts. With the exception of confidentiality concerns, no major risks were identified in relation to participating in the study.

Data Collection

The interviews were in semi-structured format, guided by a set of questions that were developed by the researcher (see Appendix). An early draft was reviewed by Dr. Lance Peterson, and the final draft was reviewed by the research committee to ensure content validity. The questions were intended to be objective and open-ended wherever possible to maintain the

integrity of the research. The interviews lasted between 30 minutes to 1 hour and were recorded and fully transcribed.

The questions were developed to address some of the practical implications of the findings in the literature. The questions sought to determine the theoretical framework or personal bias of the respondent and investigate what impact that bias may have on his/her daily work with clients with a history of IPV. The initial questions addressed the respondents' perceptions regarding the causes of IPV and their perspectives on attachment and personality disorders. The next few questions addressed how their daily work/direct practice does or does not reflect their own theoretical perspective, and how that might translate to specific scenarios in their group work.

The questions have been developed as a rough guide for the conversation, but the interviews were semi-structured, allowing for discussion of other pertinent topics. Interviews primarily took place in person. One interview was done via telephone due to scheduling complications. Interviews were conducted at either the respondent's place of work, or a neutral space with as much privacy as possible.

Research Question

This study seeks to determine what influence attachment theory and personality disorders have on the clinical interventions currently used with individuals who have committed intimate partner violence. If so, the goal is to uncover some of the specific methods that arise from this kind of informed practice. To do so, specific questions were asked to determine both the theoretical framework preferred by respondents and their current methodology. These interviews were recorded and fully transcribed.

Data Analysis

Using content analysis, the interview transcripts were coded and categorized into themes (Monette, Sullivan, DeJong & Hilton, 2013). Specifically, this study utilized directed content analysis, which uses existing literature to guide the creation of codes and themes. This differs from grounded theory or more conventional content analysis, which aims to code the content with no pre-conceived notions, and is more appropriate for new and unexplored areas of research (Hsieh & Shannon, 2005). Since significant research already exists on this topic, a directed approach is more fitting.

Based on the literature and prior work done by the researcher, the predicted themes are as follows: multiple risk factors of IPV, training or educational background dictating paradigm or conceptual framework, societal views on perpetration and victimization, and mental-health-informed intervention options for IPV. The interview transcripts will first be coded using only these pre-defined themes. Salient content from the interviews that does not fit into one of these pre-defined themes were assigned new codes and considered for new themes as applicable (Hsieh & Shannon, 2005).

Strengths and Limitations

Due to the qualitative design of this study, there are several limitations. First, the sample is quite small. While we will gather a depth of information from each respondent, the breadth of responses were quite low. As a consequence, the results may not be generalizable to a greater population. In addition, as the sample was recruited in a snowball-type method, there may be some homogeneity in the training, theoretical principles, and demographics of the respondents, which can also decrease generalizability.

Content analysis as a form of measurement has some inherent limitations as well. As an individual researcher with limited external resources to assist in coding, there is a chance that the codes derived from the interviews are not the most meaningful or valid indicators of the concepts the researcher is attempting to measure (Monette et. al, 2013). Reliability can also be an issue, where codes recognized in one interview may be missed or mislabeled in others.

The nature of qualitative design is not to discover or confirm potential causal relationships, as quantitative research often attempts to. As such, the limitations noted ultimately do not diminish the significance of the potential findings of the study. The intent is to investigate new avenues for potential future research based on the clinical work of those with meaningful experience in this field. The narrative nature of qualitative design may potentially allow for insight currently lacking in the current quantitative literature on the subject at hand.

Findings

The researcher initially predicted four themes: multiple risk factors of IPV, societal views on perpetration and victimization, mental health informed intervention options for IPV, and training or educational background dictating conceptual framework. In coding the transcribed interviews, the researcher identified two additional salient themes: trauma and negative connotations of personality disorders.

Multiple risk factors of IPV

All four of the study participants expressed very clearly that they do not see IPV as a one-dimensional behavior or issue. While the respondents may have differed in their specific beliefs and focus areas, they could all ultimately be described as viewing IPV through an ecological lens. Participant A had a striking metaphor for this "I was once told that some mental health things are like cancer and vice versa... and there's not one type of cancer, there's lots of cancers. I see intimate partner violence or domestic violence similarly... while we often treat one-size-fits-all, it's not a one-size-fits-all issue."

Several mental health disorders were discussed in terms of prevalence with this population. Impulse control and conduct disorders were both mentioned by two participants, and all participants agreed that at least a minimally significant portion of their clientele have, if not officially diagnosed, at least shown symptoms or traits of personality disorders. Narcissistic personality was typically listed as the most prevalent, with responses like: "Probably narcissistic personality disorder is the most common one," (Participant C) and "frankly, for women, borderline personality disorder... for men, most often, narcissistic personality disorder and antisocial personality disorder" (Participant A). With that said, personality disorders were not a

prominent focus for any of the respondents. In the words of one participant, “If they have a personality disorder, we talk about it. If they don't talk about it, then we don't” (Participant C).

Three of the four participants spoke specifically about the circumstantial life stressors that contribute to IPV behavior. As Participant A stated it, “Sometimes it's simply an adjustment and a person is not dealing with their stressors very well...often it is severe antisocial stuff... antisocial and narcissistic... sometimes it's just somebody in a bad circumstance.” From unmet basic needs (food, shelter) to the perceived lack of agency or “manhood” from joblessness or general poverty, the majority of respondents talked about the influence of material stressors in the daily lives of perpetrators, and how without addressing some of these needs and desires, self-help and growth work might be not happen.

The importance of perpetrator’s perceptions of “manhood” and agency were echoed in this statement from a participant who sees it as the core of IPV:

> Who we are as men is made up of three pieces. One is about who we are as human beings. Second piece is about who we are as, our makeup of our experiences, both positive and negative, and those strengths, and those negative kind of elements that we've got within us. Then the third part is about who we are as a man, and what that all means, both sociologically and but also, in terms of our own... what I believe is that there are some elements about being a man that are almost innate to being a man that are, when threatened, those innate pieces, when threatened, bring... those are often what I've found from the men that who have been through the groups, and that I've worked with, a lot of times... it's a threat to one of those three areas to who it is... being a man. Then their choice to be violent becomes very... at hand, becomes the quickest way to deal with that threat. (Participant B)

Childhood experiences were also a common topic of discussion. “Usually the people we see have been abused. They're not just one identity, they hold multiple identities” (Participant C). Much of this directly related to attachment theory, such as this statement from Participant D “What was their experience with Mom or Dad growing up? How did that shape how they relate to other people? How does that shape how they relate to people now?” Even participants that very much view IPV as a conscious choice attribute quite a bit of the issue to early childhood: “Attachment, object relations is a big piece of understanding what brings about this choice to be violent” (Participant B).

One respondent expressed that they see perpetrators as belonging to two distinct groups. Batterers, in his view, are calculated and manipulative. However, he insists that the majority are people who simply “feel trapped and so they respond abusively because that's A) what they're used to from their childhood and B) it's just a strong impulsive reaction” (Participant A). This was similar in nature to a concept another respondent discussed regarding a “window of tolerance” where, for various reasons, a perpetrator lacks a certain innate ability to tolerate negative experiences and emotions (Participant C). Several factors can shorten that window even further, such as addiction. This was echoed by another respondent, who stated “alcohol is another factor to me... where does that fit in? I have a lot of people who re-offend, and the re-offense is most often due to going back to drinking or using drugs. I'm not saying alcohol or drugs are at fault, but I'm saying the person goes back to that behaviors that aren't effective for them” (Participant A).

Societal views on Perpetration and Victimization

“Frankly, most people don't want to do our work. Most people do not want to work with domestic violence perpetrators,” Participant A said of how others view his work, adding a

hypothetical interaction with a peer from another line of work: “Then they're like "Oh, do you work with women" and I'm like "Nope, I do perpetrator work" and then they assume it's just men... but then they're like "Oh, that must be so hard and you must hate that" and it's like, no, why would I do a job I hate? That would be really weird. And no, I love it” (Participant A).

There was a lot of discussion regarding wider societal views about IPV and specifically IPV perpetration, and how those impact intervention methods. These issues came up more with the participants who were veterans in the field of work, but were still present in all of the interviews to at least a small degree.

One participant does group work with both male and female perpetrators, and one of the biggest societal misconceptions they take issue with is the idea that, as he put it “well women aren't abusive and if they are, it's only under the context of being abused” (Participant A). In his work, he does not see that to be the case. He finds it troubling how little research exists on women abusers. Some of his most rewarding clients have been abusive women who do not conform to the societal image of IPV perpetrators

> I have a woman who, she didn't want to come to group, and it actually took a couple of months to get her there... because it didn't fit her schedule with her kids, because she only had them part time. But once she came to group, she's done just incredible... being open and honest about all her issues. Again, she's a person that's... she's a business woman, owns her own business; is highly successful. If you saw her, she wouldn't be somebody you'd say would be in a domestic violence group... but she has a lot of life struggles, but in many ways, she leads our group... in terms of among the group members. And her openness has really motivated the other women in that group to be open about their struggles and working on the issues they need to work on (Participant A).

Another area of concern for some is the disconnect between how society views IPV in comparison to other similar issues. “So for the last five years or so, I think in the profession, and particularly for me, it's been a struggle of so... if you go to chemical dependency programs, you say the first step is to realize you're powerless over this behavior and this life. Yet, we're saying, no... You’ve made a conscious choice” (Participant A).

The Duluth model and the impact it still has on IPV interventions is a contentious subject for those who have developed more mental health informed interventions. In describing the Duluth method, Participant B says it “was developed out of an educating, very confrontational, no-holds-barred, who cares about the feelings of this guy, who care about what he grew up with... what he needs to do now is stop doing what he was doing and now change what he was doing.” He says the intense focus on accountability, the roots of which trace back to the Duluth method, is based on societal views: “People have a hard time letting go of ‘Oh gee, if I'm not holding them accountable enough, I must be colluding with the batterer.’ And that's some of the concern that people take when they get involved in this... they don't want to show that they're colluding with the batterer, so they tend to over-compensate with that by having more accountability levels” (Participant B).

Mental Health Informed Intervention Options for IPV

Several of the theories and frameworks utilized by the study’s participants have their roots in Psychology. Whether they acted as general inspiration or took an actual concrete role in intervention varied, but the list of influences was fairly extensive between the four recipients. Psychoanalytic Psychotherapy, Sensorimotor Psychotherapy, Dialectical Behavior Therapy (DBT), Solution-Focused Brief Therapy, Cognitive-Behavioral Therapy (CBT), and Adlerian

Therapy were all mentioned… with DBT and CBT being the two most thoroughly and consistently sited.

Participant C talked at length about a theoretical framework used at her agency that uses an interplay of Sensorimotor Psychotherapy (specifically a theory about the "window of tolerance" mentioned previously) and DBT. One of her main interventions, as she describes it, is to teach perpetrators "that when you're getting out of your window of what you can tolerate, you can actually insert some skills in there so that you can bring yourself back down to a place where you're more stable and kind of in wise-mind if you're familiar with DBT, we do a lot of DBT skills... kind of pieced in there to kind of help people manage their emotions better and make better decisions" (Participant C). This overlaps with Participant D's focus, which she describes as being based more in CBT and mindfulness and includes teaching perpetrators "How do I pay attention to my thoughts as I start to get angry? How do I pay attention to my body? How do I remove myself from a situation or find a better way to handle a situation that's upsetting me than getting abusive?"

All four study participants talked to some degree about the importance of a balanced curriculum, which takes both mental health and more sociological frameworks into account. Participant B, a respected veteran in this field of work, was particularly passionate about this sense of balance between, as he described it: mental health, gender accountability, and self-help/regulation. This was echoed by another long-time practitioner, who repeatedly spoke of his disappointment with "archaic" group work curriculums that focus too heavily on accountability and ignored other aspects of the issue (Participant A). Meanwhile, Participant B was more concerned about the disappearance of accountability from the work, stating, "I'm not so sure that the best place for men to access that is through the mental health system, because there's a lot of

training we have to do with Psychologists and Clinical Social Workers and Therapists around understanding Domestic Violence, understanding what men need in these situations. And if they're willing to go there... from my stance, my opinion, if they're willing to demonstrate that they're giving out a balance of the three things that I mentioned, I'm all for them doing the treatment. But if they're just focused on the self-care piece? Well, they're not taking into account the effects on other people."

Two of the four participants do diagnostic assessments prior to working with a perpetrator. The other two specifically choose not to do such assessments, as they find them to be inconsequential to the overall process. This seems to vary greatly by agency and practitioner. In the words of Participant B, "I know (Participant A) does diagnostic assessments. And that's OK. I'm not going to do it, but that's fine if other people want to do it. I think it's good to know, it's just not the crux of the issue." For those that do assessments, they find that it helps them predict how well a person will respond to group intervention. "Really I'm looking at, are they going to be able to do group? Are they at all willing to do group? And can I be useful to this person or can our groups be useful?" (Participant B).

One of the interview questions addressed how the participants might alter their treatment if research suggested a heightened focus on the issues of personality disorders and attachment dysfunction, and the participants had several ideas on the subject. Many of them revolved around taking existing curriculum and simply adjusting it. For example, all of the respondents spoke about lessons in their group work that touch on early childhood experiences and attachment, but most of them do not explicitly discuss attachment with group participants. Only one respondent reported that they feel their current curriculum represents a best practice in terms of attachment, as it represents a large portion of his individual work with perpetrators. Participant A had several

specific ideas: “helping with empathy, and looking at treatment for trauma. Part of what I may do more of is increase, and/or make it mandatory, like DBT mandates individual therapy. Like, if you're going to be in DBT group, you need to be in individual therapy as well. So, at some point, I may increase that... where we're doing specific, maybe EMDR.”

Two participants suggested that different treatment methods may work better for different perpetrators, particularly in light of personality disorders, which echoes some of the literature. “I think it would be ideal to have different treatments for different people,” stated Participant A, going on to state that research suggests some individuals with certain personality disorders “shouldn't be in a domestic violence group, because they're just going to learn more ways to be abusive and be successful without being arrested.” Participant C echoed this sentiment “Under that model where we're going to focus more on personality disorders... I would almost think that you would want to create groups with the disorders in mind of the attendees. Right? So maybe there's a specific group where everyone in that group has borderline personality disorder, and yeah, there would be much more of a DBT component... but, I don't know what you'd do with like the antisocial personality disorder group... I would try not to be the group leader for that one.”

Training or educational background dictating conceptual framework

The interviews did reveal definite links between the training history and conceptual frameworks of the practitioners, but not in the clear-cut ways the researcher anticipated. Of the respondents, one was a Licensed Independent Clinical Social Worker, one was a PhD level Clinical Psychologist, and two were licensed mental health practitioners with MA degrees in Counseling Psychology. There was an assumed correlation, based on previous research and experience, that those with purely mental health-based educational backgrounds, such as

Psychology, might be more inclined to see things from a mental health lens. This was not the case. The participant with the most focus on mental health was the LICSW, while the Clinical Psychologist was perhaps the most resistant to the medical model mental health focus presented by the researcher.

There was a definite correlation between current and past agency affiliation and conceptual framework. Two participants had worked within the same agency at different times, and their responses often mirrored each other… with both of them commonly referring to IPV as a “learned behavior” and “conscious choice” as opposed to the less accountability-focused terms that the other participants used like “impulse” and “shortened window of tolerance”.

Two of the participants have been working in this field of work for a considerable length of time, and although they were fairly disparate in some of their views, both had much more of an unfavorable opinion of gender-based frameworks such as the Duluth Model, with Participant A calling it “archaic material”, and further adding, “not that it was wrong, just that it felt a little bit like going through the motions... but I also think that's part of the profession.”

Trauma

An unanticipated theme that arose in the study was that of the widespread occurrence and significant impact of childhood trauma in the IPV perpetrator population. Participant A was the first to bring it to the attention of the researcher. “The other piece that I would put there is trauma... and that's an enormous buzzword in the last five years related to general work in the mental health field and then domestic violence specifically.” All of the other participants echoed this sentiment very clearly, often pointing out the interconnectedness between trauma, attachment, and even personality disorders.

Participants on either the more mental-health end or more sociological end of the theoretical spectrum reported some level of complexity or even contradiction that being a trauma-informed practice entails in this work.

> Here you have a person that's been traumatized, and the most likely thing they're going to do is fight or flight... fight, they're going to get in trouble. But it's really an automatic response. And yet, what we've been teaching all along is that abusive people is learned and can be unlearned, and that it's a conscious choice. (Participant A)

Meanwhile, Participant B feels that sometimes those who are too focused on mental health also often miss out on trauma:

> Unfortunately, many psychologist who just kind of take the MMPI-2 information and just take what's presented before them and the information from that, a lot of times don't take into context the previous traumas that this guy has had... or the previous attachment issues that this guy had.

All of the participants were fairly familiar with the link between previous trauma/victimization and later perpetration of abuse. Quite simply, as Participant A stated, “The statistics show that if you've been abused, the likelihood of you being abusive is simply higher.” Participant B was even more specific, advising that “when a guy has experience 4 to 6 of those ACEs [adverse childhood experiences, a common measure of potentially traumatic experiences] he's somewhere between 4500 and 6000x more likely to be a perpetrator of abuse.” He went on to add that “their experiences with other traumas, which affects attachment, which affects the brain... so there's been a lot more, you know both connection between attachment and behavior later on, as well as brain function, brain capacity, brain development, and how it gets affected if people have had between 4 and 6 of those ACEs” (Participant B). In a lengthy discussion on the

nature of trauma, and the lasting impacts it can have on neural biochemistry, Participant B used a poignant metaphor:

> So, it's my belief that when a kid has experienced or has witnessed a violence or has been exposed to some sort of trauma to them... that it's a concussion to the soul... a concussion to the being of who that kid is... it's not just a concussion physically, but we need to see as concussing as problematic as a physical concussion to the brain. So, there's whole programs built around traumatic brain injury... and that's great... but they only focus when there's been a physical trauma of the brain. On the other hand, I'm saying, and many of us are saying more and more, is that because there's been this concussion to the soul, it has physically caused changes in the brain. We need to balance that out in terms of the importance and priority as much as the physical concussion. So, doing that, we do need to take into consideration not just those experiences that caused those concussions that lead to those physical change in the brain, we also need to look at what leads up to it.

Negative Connotations of Personality Disorders

All four respondents, regardless of whether they acknowledge personality disorders as a common issue among their clients, seemed to take some issue with the core concept of personality disorders. Many of them spoke of the negative connotation of personality disorders within the mental health profession, and the sense of hopelessness both clients and clinicians have in treating these issues. In the words of Participant A "Part of the challenge with personality disorders is that lots and lots of people would argue that there isn't really a good treatment for personality disorders."

Participant B took a pronounced stance against personality disorders because of these issues, stating "So, I think if we keep trying to focus on... if the focus is more on a personality

disorder trait... because when we're talking about personality disorders, we're talking about characterological elements... and I don't think there's a characterological element, I think it's about a choice." He also felt that personality disorders are just a checklist of symptoms and do not actually provide any direction to the cause of the behaviors. In his logic, that makes it an inadequate tool for his work.

Two of the respondents were more receptive to diagnosing and acknowledging personality disorders as a contributing factor to IPV, despite their concerns. Participant D in particular, had quite a bit to say about the complexities of the topic:

> "I guess we talk about narcissism in some ways, but we don't ever really frame it as a personality disorder, primarily because a whole... the whole concept of (my agency) is that you can change your behavior, and sometimes personality disorders can almost seem like fate, right? Like you're telling someone this is just your orientation, and this is how you think, and this is how you're always going to be... and so, that would kind of run up against the premise of (my agency) in some ways.
>
> So I think that we... we're a very person-centered and humanistic perspective on clients, like, if we have someone who has a personality disorder, whatever it is, that's not a judgment about them. And I think that's pretty common, is to be dismissive and "Oh, you're this way forever. You're never going to change". And I don't think we have that approach at all. We think even people with personality disorders can change. That's why we do the work."

Discussion

The purpose of this study was to determine what influence attachment theory and personality disorders have on the clinical interventions currently used with individuals who have committed intimate partner violence. If so, the goal is to uncover some of the specific methods that arise from this kind of informed practice. Qualitative interviews were conducted with four professionals who work with domestic violence perpetrators in group and/or individual intervention settings. The findings of this study will be discussed with regard to how the findings compare and differ from the current literature.

Comparisons to the Research

Theoretical perspectives. All four participants were more nuanced in their theoretical perspectives on IPV than the literature would suggest. While they did represent a range of opinions on the topic, with Participant A aligning most with the mental health perspective and Participant B representing the other end of the spectrum, they all ultimately considered their approach a multi-faceted, ecological one.

Because of these more nuanced viewpoints, none of the participants would go so far as to completely rule out major components of the alternate paradigm. Instead, what most clearly delineated the two sides of the debate was the language used around whether or not IPV was a choice/learned behavior, or an impulsive reaction. Those more aligned with the mental health paradigm were more inclined to see this as an unfortunate impulse, a poorly crafted adaptation to something in their environment. Those who aligned themselves more with gender-equality and sociological paradigms were quite explicit in their belief that these behaviors were ultimately a choice. While it may be a choice that they made based on flawed information from poor role

models, or a choice constricted by negative life circumstances or mental health concerns, it is still, in this paradigm, a choice.

Risk factors. Regardless of where on the theoretical spectrum each participant was, all of them spoke of the multitude of factors that contribute to IPV behavior. The same themes came up in both literature and the current research. All participants recognized both the sociological factors such as poverty and lack of education (Krahe and Moller, 2005) as well as the more personal psychological ones: depression, substance abuse, previous exposure to child abuse, and personality disorders (Dutton & White, 2012.)

Professionals of differing theoretical frameworks did seem to rank these issues in a far different manner. For instance, Participant B was very specific in the concept that mental health issues were not the "crux of the issue" in IPV. Meanwhile, Participant A, who had much more of a mental health focus, was quick to point out exceptions to the sociological rules. From telling anecdotes of perpetrators and victims that did not meet the popular image of those roles (wealthy and successful families who do not 'look the part') to expressing frustration over the lack of research or societal recognition on female abusers... he is very vocal about how his experience seems to routinely contradict the sociological paradigm.

The current interventions used by all of the participants do seem to address some of the individual behavioral deficits identified in the literature. Teaching emotion recognition and working on cognitive empathy were mentioned as part of the curriculums of all four professionals, both of which are called for when working with perpetrators with high antisocial and borderline traits (Romero-Martinez et. al, 2016). Likewise, a prominent focus of all four participants' interventions is teaching more effective ways to label and express emotions, which is another area of focus in the research (Costa & Babcock, 2008).

Batterer typologies. Participant A was the only respondent who overtly spoke about different types of IPV perpetrators. While his distinction of "batterers" versus general IPV perpetrators is considerably less complex than some of the literature from researchers like Holtzworth-Munroe and Mauricio, it still echoes some of the same core concepts. The manipulative, terroristic qualities he attributes to "batterers" harken back to the Generally-Violent-Antisocial abuser subtype in the literature (Holtzworth-Munroe, Meehan, Herron, Rehman & Stuart, 2009.)

While the other respondents did not overtly speak to the existence of different subtypes of IPV perpetrators, they were recognized in subtler ways. For instance, when speaking about best practices for more mental health informed interventions, most of the participants made at least brief mention of the fact that separate interventions may work best for different perpetrators. This fits with prior research suggesting that abusers with antisocial traits may benefit most from Duluth model group work, while those with more dependent personalities may benefit more from process-psychodynamic group treatment (Saunders, 1996.)

However, based on descriptions of current work being done by these clinicians, it seems like there is more of a one-size-fits-all approach, which is warned against in much of the research (Ross & Babcock, 2009). It seems that the clinicians who do any sort of diagnostic assessment (in this small sample, 50%) do so primarily to identify those differences that may make someone more or less receptive to group work, but it is unclear how much the curriculum might be altered based on this information.

Participant A, who does lengthy two-session assessments with all incoming clients, spoke most explicitly about how different treatment types would be best for different perpetrators, which is very much in line with the research that suggests that those who use IPV to control their

partner's emotional proximity would benefit from very different psycho-educational methods and content than those who use IPV to gain emotional distance (Mauricio & Lopez, 2009). Whether or not Participant A is using the same diagnoses or terminology to arrive at these concepts or not, his keen interest in obtaining this insight via mental health assessments would likely benefit his treatment groups.

Personality Disorders. There was a surprising amount of resistance from the participants in regards to considering personality disorders as an important contributing factor to IPV. While almost all of the participants stated that it was a more-or-less prevalent issue with their clientele, all of them expressed significant concerns. Two participants expressed that they did not believe that personality disorders were anything more than an occasionally comorbid issue, and even the two who were seemingly more receptive to the idea of a link took some degree of issue with the connotation of a diagnosed personality disorder. This seems to be in direct opposition to much of the literature.

A very common theme that arose in the study was the perceived hopelessness of a personality disorder diagnosis; the idea that a personality disorder is a permanent characterological fault impervious to treatment. This was an unexpected finding that had not featured in any of the literature on this topic. However, some of the issue might lay in semantics. Much of the literature focused on personality disorder traits, not an officially diagnosed disorder itself. An abuser with BPD traits may or may not actually have a clinical diagnosis of BPD, but that does not necessarily imply that the presence of BPD traits is not significant within the context of research. The participants seemed more averse to the diagnosis itself, so perhaps the research would have benefitted from some additional clarity on the working definition of personality disorder traits versus personality disorders.

Another interesting finding was the fact that the majority of respondents identified NPD as the most common personality disorder that they do see in the field, not ASPD or BPD which dominate the literature. Also, contrary to the suggestion in the literature that BPD is common among IPV perpetrators, the participants in this study did not identify it as one of the commonly seen disorders. Participant A did identify it as common among his female clientele, but not the male. Whether this is evidence that BPD is not common among male IPV perpetrators, or just a reflection of societal attitudes towards both BPD and IPV is difficult to tell (Dutton, 2012).

Trauma. All four respondents spoke at length about the significance of prior trauma when working with IPV perpetrators. This issue was entirely lacking in the literature, but makes perfect sense as an additional variable within the theoretical paradigm the study is focusing on. The links between trauma and attachment are well studied in other areas of mental health. Likewise, attachment is believed to be at the core of personality disorders (Mauricio et. al, 2007). As such, perhaps all of these variables are simply one interconnected concept being viewed from different lenses.

Limitations

The most notable limitation of this study was the incredibly small sample size. Qualitative research often involves smaller samples than more quantitative forms of study, so this limitation was already anticipated to some degree. However, the sample ended up being significantly smaller than the original intent of the study, which magnifies the issues inherent in a small sample. It would be impossible to generalize these findings to the social work field as a whole, or even the local area within which the study took place.

The semi-structured interview format was also slightly problematic in this particular study. Depending on where the conversation went, some topics were not addressed as clearly or

fully as intended. Given a larger sample, this likely would have balanced itself naturally over the course of the research, but with the small number of respondents, it seemed to leave some holes in the findings.

Lastly, there are many important factors inherent in both research and intervention work that were perhaps not adequately explored in the interest of simplicity and clarity of research. While not stated explicitly, the literature referenced in this study was primarily specific to heterosexual relationships, and much of it failed to take into account any distinctions or complexities for those from non-dominant cultures. The researcher would be remiss not to acknowledge this as a limitation of the current research

Implications for Social Work Practice

The findings of this study have a variety of possible implications on social work practice. While mental health issues like attachment and personality disorders clearly provide much of the theoretical framework for clinicians to understand the behaviors, explicit interventions to attend to mental health concerns are often lackluster or entirely missing from modern group work. The majority of participants agreed that more could be done to address, particularly as it relates to attachment.

Perhaps the most noteworthy finding of the study was the concept that, in order to more fully address the mental health foundations of IPV, a best practice would involve more personalized treatment options, which was echoed in the literature. This study suggests that groups should be divided by “batterer subtype” and each group would use a curriculum specifically adapted to address the needs of that specific population. Additionally, individual therapies can and should augment the existing group work structure for those perpetrators who are willing and invested in the process.

Implications for Policy

Current policy, particularly in the state of Minnesota, is somewhat vague regarding the specifics of treatment. While this can be beneficial to some programs, it also allows for a wide variety of interventions being used, some of which are not currently supported by psychological or sociological theory or modern research. Policy work needs to be done to provide a more uniform and effective treatment process for all perpetrators.

Additionally, without policy changes to provide additional resources to the counties and other organizations doing this work, none of the practice implications can be enacted. In order to assess, divide, and provide multiple groups for multiple subtypes of offenders… capital is needed. Funding for these programs is often scarce as it stands.

Implications for Future Research

First and foremost, this topic would benefit from a more thorough, large-scale qualitative study. To hear more voices of those doing this work could sharpen the focus and provide a far better picture of the current state of the work as well as identify even more future best practices.

Additionally, research needs to be done to see if specialized-by-subtype group work (if and when implemented) has any greater success than current group work practice. A study tracking recidivism rates among specialized and non-specialized groups would lend credence to what is currently an unsubstantiated hypothesis.

In conclusion, this study managed to highlight some of the same issues and concerns highlighted in the literature, and confirmed that a significant proportion of the professionals working in this field do feel that more can be done to address some of the mental health underpinnings of IPV. Further work needs to be done to identify and confirm the specifics to

ensure the treatments being provided to IPV perpetrators is sufficient to significantly reduce recidivism.

References

Archer, J. (2006). Cross-cultural differences in physical aggression between partners: A social-role analysis. *Personality & Social Psychology Review (Lawrence Erlbaum Associates), 10(2),* 133-153.

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review, 23(8),* 1023-1053. doi://dx.doi.org.ezproxy.stthomas.edu/10.1016/j.cpr.2002.07.001

Bouchard, S., Sabourin, S., Lussier, Y., & Villeneuve, E. (2009). Relationship quality and stability in couples when one partner suffers from borderline personality disorder. *Journal of Marital and Family Therapy, 35(4),* 446-455. doi:10.1111/j.1752-0606.2009.00151.x

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Buck, N. M. L., Leenaars, P. E. M., Emmelkamp, P. M. G., & van Marle, H.,Johan Carel. (2014). Personality traits are related to intimate partner violence among securely attached individuals. *Journal of Family Violence, 29*(3), 235-246. doi:10.1007/s10896-014-9584-7

Costa, D., & Babcock, J. (2008). Articulated thoughts of intimate partner abusive men during anger arousal: Correlates with personality disorder features. *Journal of Family Violence, 23*(6), 395-402. doi:10.1007/s10896-008-9163-x

Dixon, L., & Graham-Kevan, N. (2011). Understanding the nature and etiology of intimate partner violence and implications for practice and policy. *Clinical Psychology Review, 31*(7), 1145-1155. doi:10.1016/j.cpr.2011.07.001

Dutton, D. G. (2012). The case against the role of gender in intimate partner violence. *Aggression and Violent Behavior, 17*(1), 99-104. doi:10.1016/j.avb.2011.09.002

Dutton, D. G., Van Ginkel, C., & Landolt, M. A. (1996). Jealousy, intimate abusiveness, and intrusiveness. *Journal of Family Violence, 11*(4), 411-423. Retrieved from http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=9702101416&site=ehost-live

Dutton, D. G., & White, K. R. (2012). Attachment insecurity and intimate partner violence. *Aggression & Violent Behavior, 17*(5), 475-481. doi:10.1016/j.avb.2012.07.003

Grinnell, R. M. Jr., Williams, M., & Unrau, Y. A. (2016). *Research methods for social workers. An introduction* (11th ed.). Kalamazoo, MI: Pair Bond (ISBN 9780981510071).

Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. L. (2000). Testing the holtzworth-munroe and stuart (1994) batterer typology. *Journal of Consulting and Clinical Psychology, 68*(6), 1000-1019. doi:10.1037/0022-006X.68.6.1000

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. doi:10.1177/1049732305276687

Jackson, M. A., Sippel, L. M., Mota, N., Whalen, D., & Schumacher, J. A. (2015). Borderline personality disorder and related constructs as risk factors for intimate partner violence perpetration. *Aggression & Violent Behavior, 24*, 95-106. doi:10.1016/j.avb.2015.04.015

Krahe, B., Bieneck, S., & Moller, I. (2005). Understanding gender and intimate partner violence from an international perspective. *Sex Roles, 52*(11), 807-827. doi:10.1007/s11199-005-4201-0

Lawson, D. M., & Brossart, D. F. (2013). Interpersonal problems and personality features as mediators between attachment and intimate partner violence. *Violence & Victims, 28*(3), 414-428. doi:10.1891/0886-6708.VV-D-12-00031

Leenaars, E P E M, Emmelkamp, P. M. G., Buck, N. M. L., & Marle, v., H.J.C. (2012). Explaining the relationship between insecure attachment and partner abuse: The role of personality characteristics. *Journal of Interpersonal Violence, 27*(16), 3149-3170. doi:10.1177/0886260512441258

Leichsenring, F., Kunst, H., & Hoyer, J. (2003). Borderline personality organization in violent offenders: Correlations of identity diffusion and primitive defense mechanisms with antisocial features, neuroticism, and interpersonal problems. *Bulletin of the Menninger Clinic, 67*(4), 314-327.

Mauricio, A. M., & Lopez, F. G. (2009). A latent classification of male batterers. *Violence and Victims, 24*(4), 419-438. doi:10.1891/0886-6708.24.4.419

Mauricio, A. M., Jenn-Yun Tein, & Lopez, F. G. (2007). Borderline and antisocial personality scores as mediators between attachment and intimate partner violence. *Violence & Victims, 22*(2), 139-157. Retrieved from http://ezproxy.stthomas.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=24841006&site=ehost-live

Max, W., Rice, D., & Finkelstein, E. (2004). The economic toll of intimate partner violence against women in the united states. *Violence and Victims, 19*(3), 259-272. doi:10.1891/088667004780905660

Monette, D.R., Sullivan, T. J. DeJong, C.R., & Hilton, T. P. (2013). *Applied social research: Tool for the human services* (9th Ed.). Belmont, CA: Brooks/Cole (ISBN 978-128507551).

Oka, M., Sandberg, J. G., Bradford, A. B., & Brown, A. (2014). Insecure attachment behavior and partner violence: Incorporating couple perceptions of insecure attachment and relational aggression. *Journal of Marital & Family Therapy, 40*(4), 412-429. doi:10.1111/jmft.12079

Romero-Martínez, Á, Lila, M., & Moya-Albiol, L. (2016). Empathy impairments in intimate partner violence perpetrators with antisocial and borderline traits: A key factor in the risk of recidivism. *Violence & Victims, 31*(2), 347-360. doi:10.1891/0886-6708.VV-D-14-00149

Ross, J., & Babcock, J. (2009). Proactive and reactive violence among intimate partner violent men diagnosed with antisocial and borderline personality disorder. *Journal of Family Violence, 24*(8), 607-617. doi:10.1007/s10896-009-9259-y References

Sartin, R. M., Hansen, D. J., & Huss, M. T. (2006). Domestic violence treatment response and recidivism: A review and implications for the study of family violence. *Aggression & Violent Behavior, 11(5),* 425-440. doi:10.1016/j.avb.2005.12.002

Saunders, D. G. (1996). Feminist-cognitive-behavioral and process-psychodynamic treatments for men who batter: Interaction of abuser traits and treatment models. *Violence & Victims, 11(4),* 393-414.

Appendix

1. What is your theoretical perspective on IPV? Do you think of IPV as more of sociological issue, or more related to mental health? Or both?
2. Do you assess for mental health issues?
3. If you assess for mental health issues, or have access to mental health records for your participants… do you know approximately how many typically have diagnosed/diagnosable personality disorders? Attachment insecurity?
    a. If so, what are the common diagnoses that you see? Do you feel that abuse patterns differ based on their particular diagnosis?
4. Do you feel that attachment and personality disorders are commonly discussed or considered in working with abusive individuals?
    a. If yes, do you currently assess for that in your own practice? Do you know others that do?
    b. If no, why do you think that is? Are there other perspectives or paradigms that take priority?
5. What is the ultimate focus of your treatment groups? Would you say it's more informed by psychological theories, or gender/sociological themes?
6. Do you feel that the work you're currently doing is sufficient if indeed attachment and personality disorders are the root causes for IPV?
    a. If not, how would your approach differ in order to cater to that?
7. Who are you working with? Are all of your clients court-ordered or are any voluntary?