

**The Application of Personality Patterns to Assessment and
Treatment of Male Intimate Partner Violence**

Dissertation submitted by
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Declaration

I declare that this thesis is my own account of my research and contains as its main content work that has not previously been submitted for a degree at any tertiary institution.

Peter Robert Gibbons

NB: Study 1 was published in 2011, under the title: ‘How Useful are Indices of Personality Pathology when Assessing Domestic Violence Perpetrators?’

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Abstract

This thesis sought to understand the nature and role of personality pathology in male perpetrators of intimate partner violence (IPV) who had been referred to a group intervention program in Western Australia. The research was undertaken with a sample of 181 men, across four studies that demonstrated the diversity of personality pathology in breadth, complexity and severity among this sample of men, along with a number of associated characteristics. Study 1 used the Millon Clinical Multiaxial Inventory—Third Edition (MCMI-III) to measure personality pathology in this sample of men, who were both court-referred and self-referred to the program. The results indicated that 54% of these men reported personality profiles on the MCMI-III consistent with a personality disorder, that these men had quite diverse personality profiles, and that response bias was a significant factor. Study 2 explored whether there were differences in personality pathology, response bias or reported abuse behaviours based on whether the men had been court-referred or self-referred. The results indicated few significant differences between these two groups. Study 3 parsed the men's MCMI-III scores to ascertain whether there were any cohesive groupings, and applied principal components analysis. This procedure demonstrated five clear and coherent factors in the group, with significant differences in personality profiles within each cluster. The study then explored differential ways to work with these five groups of men in an IPV intervention program. Study 4 examined the correlates of the five clusters using measures of interpersonal problems, self-compassion and emotional empathy. Some logical relationships were found among these variables, with the men in clusters higher in personality pathology being more likely to report higher interpersonal problem scores and lower self-compassion scores, along with higher abuse scores. This study then explored in detail the implications of these findings for assessment, treatment and policy.

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List of Abbreviations

ABI	Abusive Behaviour Inventory
ANOVA	Analysis of Variance
BEES	Balanced Emotional Empathy Scale
BPD	Borderline Personality Disorder
BR	Base Rate
CBT	Cognitive Behavioural Therapy
CCO	Community Corrections Officer
DBT	Dialectical Behaviour Therapy
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition
DSM-V	Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition
DV	Domestic Violence
IIP	Inventory of Interpersonal Problems
IPV	Intimate Partner Violence
MCMI	Millon Clinical Multiaxial Inventory
MMPI	Minnesota Multiphasic Personality Inventory
NEO	Neuroticism-Extraversion-Openness
PCA	Principal Components Analysis
PDM	Psychodynamic Diagnostic Manual
PTSD	Post-traumatic Stress Disorder
SCS	Self-Compassion Scale
SD	Standard Deviation
US	United States
WHO	World Health Organization
WL	Wilks's Lambda

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Chapter 1: The Issue of Intimate Partner Violence

1.1 Introduction

Domestic violence or ‘intimate partner violence’ (IPV)—as it is now often termed in relation to adult relationship partners—is a major social problem locally and internationally. Epidemiological research worldwide (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2006) indicates that between one in four and one in three female intimate partners will be physically assaulted over the course of their adult relationships. However, the World Health Organization (WHO; Garcia-Moreno, et al., 2006) data, although extremely comprehensive and with very high response rates, excludes developed countries. Locally, the Australian Bureau of Statistics (2013) gives prevalence rates of IPV as one in five for women and one in 20 for men. However, this is based on a fairly narrow definition, namely:

Violence is defined as any incident involving the occurrence, attempt or threat of either physical or sexual assault experienced by a person since the age of 15. Physical violence includes physical assault and/or physical threat. Sexual violence includes sexual assault and/or sexual threat. (Phillips & Vandenbroek, 2014, p. 4)

Under the *Family Law Act of Australia (1975)*, a broader definition is given: ‘violent, threatening or other behaviour by a person that coerces or controls a member of the person’s family (the family member), or causes the family member to be fearful’ (Section 4AB, as cited in Ryan, Collier & Stevenson, et al., 2012, p. 4). Application of this definition would increase the estimates of prevalence of IPV considerably, according to some authorities (RA Domestic Violence Online Survey, 2015). This suggestion is supported by the Dunedin Multidisciplinary Health Study (Magdol et al., 1998) in which an unselected birth cohort from Dunedin, New Zealand, was followed with comprehensive assessment of IPV and high levels of confidentiality. Prevalence rates for IPV in this sample were recorded as 37% for women and 22% for men, with 9% reporting severe violence (defined as injury, hospitalisation or police involvement). This Dunedin sample is representative of Western urban populations, and, given the similarity of cultures in Australia and New Zealand, it may well be representative of the prevalence of IPV in Australia.

The starting point for the current body of research was the scientific evaluation of the nature of male personality pathology, as identified during assessment for group intervention programs for IPV. This addresses an objective of the WHO, which declared in 1996 (World Health Assembly resolution 49.25) that violence is a priority in public health (cited in Dixon & Browne, 2003). Then, in 2000, the WHO Task Force on Violence and Health adopted a science-based agenda to address this issue, with its third objective being ‘to identify best practice and evaluate interventions aimed at preventing violence’ (Dixon & Browne, 2003, p. 108).

While there has been continuous and vigorous debate in the community around the gendered nature of IPV (Allen, 2011; Dobash & Dobash, 2004; Dobash, Dobash, Wilson & Daly, 1992; Dutton & Corvo, 2006; Ross & Babcock, 2010), this important issue will not be explored in this thesis. Instead, our purpose is a practical one—namely, to explore the current paradigms for treating male perpetrators of IPV, since the male gender typically volunteers or is mandated to attend such programs. Male domestic violence perpetration has been defined as ‘both abusive and violent acts carried out by persons in a marital, sexual (i.e., cohabitation) ... role toward others in reciprocal roles’ (Stith & Rosen, as cited in Feldman & Ridley, 1995, p. 317).

1.2 Current State of Group Interventions for Male IPV Perpetrators

The term ‘IPV’ will be generally used from this point, since this is the focus of this research. A number of reviews on the state of intervention programs for male perpetrators of IPV have been published in recent years, with mixed conclusions (Babcock, Green & Robie, 2004; Corvo & Johnson, 2013; Dixon, Archer & Graham-Kevan, 2012; Dixon & Browne, 2003; Edleson, 2012; Gondolf & Jones, 2001; Stith, McCollum, Amanor-Boadu & Smith, 2012; Stover, Meadows & Kaufman, 2009). The majority of reviews concluded that ‘batterer’ (a common term for men perpetrating IPV) intervention programs produce positive outcomes; however, this was usually qualified with statements about small effect sizes and poor quality research. The research commentary on effectiveness ranges from outcomes little better than arrest alone (Stover et al., 2009) to moderate and enduring effectiveness over four years (Gondolf,

2002). There is consensus that there remain many unanswered questions in this field of research, especially regarding which ingredients may be required to obtain effective outcomes. There are also many contradictory findings. For example, Edleson (2012) regarded personality pathology as a non-discriminant factor in effective outcomes, whereas Corvo and Johnson (2013) essentially came to the opposite conclusion.

Many reviews have focused on arguments related to gender and IPV, with its implications of distribution or attribution of responsibility. However, sound theory and effectiveness in interventions are often lacking (Babcock et al., 2004; Dixon & Browne, 2003). Corvo and Johnson (2013) presented a simple analysis of what they considered the three major theoretical positions for understanding IPV perpetration:

1. patriarchy: the use of male power and domination in society, which inherently justifies abusive or repressive male behaviour towards female partners
2. social learning theory: suggests that exposure to or observation of violence in the family of origin creates beliefs and models about the use of violence and intimidation in intimate relationships
3. psycho/neuropathological: the current psychological state of the perpetrator of IPV (for example, the male partner has an antisocial personality and is prone to using coercive and aggressive tactics to maintain control over his partner).

Corvo and Johnson (2013) dismissed patriarchy as an inadequate explanation, arguing that patriarchy is essentially ideological and cannot discriminate among abusive and non-abusive men who are all brought up in the same culture (see also Dutton, 1994). Further, they argued that patriarchy produces no testable hypotheses for research. They stated that the social learning paradigm produces small effect sizes and is often too distal to the behaviour in question. They referred to Capaldi, Knoble, Shortt and Kim (2012), whose research suggested that observing parental violence or being the victim of childhood abuse is only a low to moderate risk factor for adult perpetration, and is mediated by proximal variables, such as antisocial behaviour or poor adult adjustment. According to Corvo and Johnson (2013), the psychopathology or neuropathology paradigm does produce proximate and testable hypotheses regarding who does and does not perpetrate IPV. This is important because it has been shown that:

domestically violent men ... differ from their non-violent counterparts on important psychological variables that are related to their violent behaviour.

Understanding the connections between those variables and violence toward intimate partners yields the most parsimonious and elegant explanations (i.e. those explanations with the fewest assumptions, steps, or speculations) of domestic violence perpetration. (Corvo & Johnson, 2013, p. 177)

There have been many attempts to subtype IPV perpetration. An example of this is found in Ross and Babcock's (2010) recent comments on Langhinrichsen-Rohling's (2010) review of major controversies in IPV research, in which she proposed a bidirectional subtyping of perpetration built around different types of IPV. Ross and Babcock viewed the dyadic approach as fruitful, yet criticised Langhinrichsen-Rohling for not incorporating unidirectional perpetration in her model. Capaldi and her colleagues (Capaldi, et al., 2012; Capaldi, Kim & Shortt, 2007; Langhinrichsen-Rohling & Capaldi, 2012) also espoused the dyadic approach to understand and treat IPV, based on a series of longitudinal studies with adolescents and young adults. Langhinrichsen-Rohling and Capaldi (2012) suggested that affecting change for the female partner would reduce IPV in the relationship. Based on their research, they stated 'these results were certainly supportive of the notion that violence in relationships can be impacted by changing the dyadic relationship behavior of *either* partner' (emphasis added) (Langhinrichsen-Rohling & Capaldi, 2012, p. 411). They were dismissive of dealing with IPV as a unidirectional behaviour, and were critical of typological research. However, they failed to address the pragmatic issues in this work.

The reality is that most people directed to IPV group interventions—either by courts or other agencies and individuals in the community—are men. Further, many men come to IPV group interventions without a partner, or with a partner or ex-partner who has no desire to be involved in assessment or treatment processes (Gibbons, Collins & Reid, 2011). In addition, most jurisdictions and agencies that engage in IPV intervention work insist on separation between the sexes for safety reasons (Anglicare WA, 2005; Domestic Violence Prevention Unit—Women's Policy Office, 2000). This is not to say that the partner who is deemed to be the victim of IPV is not interviewed or directed in the safest manner to meet her needs in the situation, but rather that the female partner does not need to be involved in the intervention and thus be 'made' to feel responsible for the male perpetrator's 'loss of control' (Cavanagh, Dobash, Dobash & Lewis, 2001). For these reasons, in pragmatic terms, the opportunity to affect IPV in relationships is most likely to lie with interventions for the male perpetrator, given that he is the more

available person, and such interventions have been shown to change men's dyadic behaviour over an extended period in many cases (Jones, Heckert, Gondolf, Zhang & Ip, 2010).

For our current purposes, it is important to note that the following are still widely practised at both a policy and intervention level:

1. practices that treat male perpetrators as the principal or sole perpetrators in domestic relationships
2. practices that reject male perpetrators being treated on the basis of their psychological characteristics.

Therefore, this thesis explores and addresses the needs of the group practitioner—or, in some cases, the individual practitioner—who has the task of dealing with a range of male perpetrators and a range of types of IPV in the same group and with the same intervention paradigm.

The first step in this process is to review the field of IPV research from an aetiological and historic perspective in order to provide an overview of what is known, what is not known, and what may be the goodness-of-fit between what is known and current treatment approaches. This forms the basis of Chapter 2. Moving beyond this, Chapter 3 explores the use of personality pathology in IPV interventions. Chapter 4 examines the measurement of personality and its problems in IPV research and interventions. Chapter 5 documents Study 1, which explores the breadth and severity of personality pathology among men entering an IPV program, using our research sample. Chapter 6 reports the personality pathology differences between self-referred and court-referred men from our research database (Study 2). Chapter 7 analyses our research sample with statistical clustering techniques of the men's personality pathology profiles (Study 3). Chapter 8 considers the correlates of abuse behaviour, self-compassion and empathy, and interpersonal problem scores to the clusters of personality pathology profiles in our research (Study 4). Chapter 9 considers how the findings of the research in this series may assist with the practical treatment of men in intervention groups for IPV. Finally, Chapter 10 discusses the implications of these findings for policy and practice in the IPV field.

The author of this thesis has extensive experience in delivering IPV programs, and with assessment and preparation of participants for IPV groups. He is also an endorsed/certified clinical psychologist, registered with the Australian Health Practitioners Registration Agency. This experience underpins the clinical application and understanding of the findings from the research undertaken in this thesis.

Chapter 2: Updating the Prevailing Paradigm in IPV Treatment—A Paradigm Shift

2.1 A Review of the Aetiological and Historical Perspective of IPV Research—The Patriarchal Paradigm in Interventions

Initial IPV work was brought to public policy attention through the feminist movement and women's shelters (Walker, 1989). There has been a long debate since the 1980's about the theoretical basis for IPV interventions with male perpetrators as a result of this initial work (Dobash & Dobash, 1979). Feminist theoreticians argued that patriarchy—or male domination of women through power and control—was the underlying socially accepted attitude that led to IPV (Dobash & Dobash, 1981; Pence & Dasgupta, 2006). This theory has become a common and well-established policy in programs designed to treat men who have perpetrated IPV (Dutton & Nicholls, 2005; Walker, 1989). One of the most prevalent models from this perspective is the Duluth Model, from which was developed the popular 'Power and Control Wheel' (Pence & Paymar, 1993; Pope & Ferraro, 2006). The underlying philosophy for the Power and Control Wheel was summarised as 'rooted in an analysis of power and gendered-relations' (Pope & Ferraro, 2006, p. 1).

There has been strong criticism of this model, partly due to the accumulating research evidence that is unsupportive of patriarchy as a causal explanation (Cantos & O'Leary, 2014; Corvo & Johnson, 2013; Dixon et al., 2012; Dutton & Nicholls, 2005; Taft & Murphy, 2007). Given that the paradigm was essentially political and claimed policy and legal attention, this approach discounted psychological variables, framing them as a justification and minimisation of male responsibility for perpetration of IPV (Dobash, Dobash, Wilson & Daly, 1992; Pagelow, 1992; Pence, 1989). However, the feminist paradigm was not without thoughtful critiques of the methodology and measurement of the abusive behaviours in question. Hence, Shepard and Campbell (1992) developed an Abusive Behaviour Inventory (ABI) modelled on the Power and Control Wheel (Pence & Paymar, 1993), which was designed to capture the context of abusive power, rather than just discreet behaviours. Despite Dutton's general opposition to the Duluth Model

(Dutton & Corvo, 2006) in one study, he found strong positive correlations between Tolman's (1989) Psychological Maltreatment of Women Inventory and every segment of the Power and Control Wheel, except the 'Using Children' segment (Dutton & Starzomski, 1997). He also found strong positive correlations between his Propensity for Abuse Scale (Dutton, Landolt, Starzomski & Bodnarchuk, 2001) and the octants of the Power and Control Wheel. Two important conclusions may be drawn from this study. First, the ABI may capture the scope and nature of IPV more effectively than measures such as the Conflict Tactics Scale (Straus, 1979). Second, psychological characteristics (referred to as 'borderline personality organisation', Dutton & Starzomski, 1993), especially going back to childhood development, were implicated in the power and control system when adequately contextualised.

Activists in the legal and policy arena were also concerned that psychopathology attributed to male perpetrators of IPV might be used as a mitigating circumstance for criminal behaviour. As Pence and Dasgupta (2006) explained, the terms 'batterer' and 'battering' were not coined simply to describe physical violence, but to name a system of oppression and control that women experienced at the hands of intimate partners. However, it is difficult to imagine how the term can be used to denote anything other than violence. 'Batterer' has also become a general term, as evidenced by Gondolf's (1999) research (see also Pagelow [1992] and Gondolf's (2002) book title: '*Batterer Intervention Systems*' (emphasis added), and still emphasises males as responsible for deliberate brutalisation and control of female partners. This tendency to aggregate male perpetrators as a group of calculating and controlling oppressors of women, and emphasising the need to deal with them as a homogenous group, may have obscured the large disparities among such men. Pence and Dasgupta (2006) acknowledged that the term 'battering' should not be used for all male perpetrators of IPV. In their subtyping of IPV perpetration, they listed 'battering' as only one form of IPV and reported other types, including resistive/reactive violence, situational violence, pathological violence (that is, substance abuse or neurological impairment triggers) and antisocial violence. However, the emphasis was still very much on the unpredictable dangerousness of male IPV perpetration for female victims. The implication is that all types of IPV are potentially, if not equally, highly dangerous.

2.2 Articulating a Different Understanding of ‘Power and Control’

Donald Dutton (1998), one of the longest term researchers and a prolific writer on the issue of IPV, presented a comprehensive exposition of the various causal factors for IPV in his book *The Abusive Personality: Violence and Control in Intimate Relationships*. In this work, he not only traced the history of IPV theorising and work, but also gave considered credence to and criticism of the various approaches to understanding IPV. He described and assessed the work and theories of psychiatry, biological pathology, social biology (genetics), social patriarchy, social learning and psychological patterns.

Dutton (1998) accepted various aspects of all the models he described. For example, he cited a large-scale study by Falk in the 1970s, in which antisocial personality, depression and alcohol use were risk markers for an 80% to 90% identification of those males who had perpetrated IPV. However, he critiqued Falk’s research on the grounds that there was no explanation for choosing certain variables, nor explanation of their specific relationships to IPV. He favourably cited a psychiatrist named Rounsaville, who undertook in-depth interviews with women to explore whether their male partner’s violence was an expression of normal violence, or an expression of psychopathology within a particular sociological context. In his interviews with couples in which IPV was severe, Rounsaville (as cited in Dutton, 1998, p. 5) found ‘pathological conflicts over dependency and autonomy’ that were expressed in morbid jealousy, controlling behaviour and poor impulse control, exacerbated by substance abuse. In Rounsaville’s findings, this was more important than sociological conditions, which he argued were ‘hardly specific enough to provide an explanation’ (Dutton, 1998, p. 5) for the non-universality of IPV. This evidences Dutton’s exploration of the value of a multifactorial approach. He observed that an approach like Rounsaville’s was swept away on a ‘sociological tide that would emphasize gender dominance and power relations’ (Dutton, 1998, p. 5).

At times, Dutton also spoke with approval of the feminist perspective. For example, he approved of the critique of abusive behaviours measured merely by an aggregation of certain violent actions. He accepted that lack of context does not help understandings of IPV. However, he was highly critical of the pursuit to answer the question: ‘Why do

men beat their wives?’ (Dutton, 1998, p. 26). He referred to this as an ‘ecological fallacy’ (Dutton, 1994, p. 170) because it presupposes in advance where the answer to the question lies—namely, ‘men in general use physical force against their partners’ (Bograd, as cited in Dutton, 1998, p. 26). As stated by Corvo and Johnson (2013), this is a metaphysical explanation, rather than an evidence-based one—it is ‘logic based on the meaning of human terms ... rather than tied to observations in the real world’ (p. 176). Dutton argued that it does not address the question: ‘Why do some men become domineering and abusive while others do not?’ (Dutton, 1998, p. 30).

Ultimately, Dutton (1998) was interested in answering the latter question. His research (and that of his colleagues) explored the psychology of the cycle of violence and noted the cyclic or phasic shifts that occur in male perpetrators, for which there are few personality profile explanations from static personality theory. Earlier, Dutton (1998) had found evidence for at least three different types of personality among men who assaulted their wives, only one of which was a ‘tyrannical, personality-disordered type of wife assaulter’ (p. 5) that would fit the coercive power and control model familiar to refuge workers. Other personality types were of dependent and non-assertive styles. Dutton was already impressed by the relationship between violent reactive male perpetrators and past trauma, and pursued this avenue by using attachment insecurity as a framework. The result was a focus on the construct of ‘borderline personality organisation’, which he found to be related to past trauma on the one hand, and present cyclic abuse in intimate relationships on the other (Dutton & Starzomski, 1993). This research did not examine violence and control in intimate relationships generally, but only insofar as it applied to men with borderline personality organisation, which was highly correlated with borderline personality disorder (BPD). It did not focus on what was occurring for other male IPV perpetrators who might be disordered in other ways. However, the cyclic nature of abuse and violence by some men in intimate relationships highlighted the traumatic childhood experiences of some men who fit the IPV experience.

Other research over several decades has also recognised a number of different types of IPV (as distinct from different types of offender). The most prominent researcher associated with this development is Johnson (1995, 2008), who originally proposed different types of IPV as a way of explaining the discrepancies in IPV reports between

refuge and general population samples. Beginning with a distinction between ‘intimate terrorists’ (later referred to as ‘coercive and controlling’) and ‘common couple violence’ (later referred to as ‘situational violence’), the major distinction was found in the former being abusively controlling, and the latter being situational, with no perceived discrepancy in power between the partners. This later evolved into a differentiation of five types of IPV:

- coercive and controlling: the typical aggressive, intimidating, threatening male partner, and/or using physical violence to subjugate the partner
- situational couple violence: only provoked at times of situational crisis, but balanced in power
- violent resistance: a partner’s use of violence in reaction to or resistance against IPV
- separation-instigated violence: violence associated with reactions to actual separation, not necessarily occurring in another context
- mutual violent control: the mutual use of coercive-controlling violence (Johnson, 2008; Johnson & Ferraro, 2000).

There are other typologies of IPV perpetration, such as the one based on the instrumental–reactive dichotomy (Gottman, et al., 1995; Tweed & Dutton, 1998), which has some empirical support (Melloy, 2006; Tweed & Dutton, 1998). This is usually related to antisocial personality pathology (instrumental), as opposed to borderline personality pathology (reactive), although research has not always distinctly differentiated between these two types (Meehan, Holtzworth-Munroe & Herron, 2001). From a sociological viewpoint, Emery (2011) argued for five types of IPV based on the structure of the intimate relationship and norms of power and its use. This analysis does focus on the power and control paradigm, but modifies it according to contextual patterns. To a degree, it relates well to the Johnson (2008) model. However, for our purposes, Emery (2011) highlighted the failure of Johnson (2008) to consider *intended* control versus *achieved* control, which he viewed as confusing and masking the real issue—the actual use of power. This is important in terms of personality pathology because an antisocial-aggressive personality is far more likely to achieve control over a partner, while a passive-aggressive personality may only fantasise about having control

over a partner—hence the importance of knowing the specific types of personality pathology with which one is working.

It is important to note from a practical perspective that reservations have been expressed about the utility of differentiating forms of IPV. For example, Pence and Dasgupta (2006) sought to emphasise the possible lethal danger of most forms of IPV—a theme recently assumed by Wangmann (2011). However, if we were to go behind the presentation of IPV type to the psychological milieu of the perpetrator (Corvo & Johnson, 2013), we might find these different types of IPV additionally useful because we may see how different types of IPV relate to different types of perpetrator. For example, the two-factor model strongly suggests discriminating between borderline and antisocial personality as differentially associated with reactive and instrumental types of IPV, respectively (Holtzworth-Munroe & Stuart, 1994). We now turn to recent research in neuroscience that casts light not only on Dutton’s findings, but also on IPV research more generally.

2.3 Understanding Domestic Violence as Non-conscious Reactivity

The policy principles espoused by the women’s movement and incorporated into programs such as the Duluth Model have established a paradigm of accountability in both policy and practice that defies much recent neuropsychological research (Bograd & Yllo, 1988). This arguably limits any possible successful rehabilitation of IPV perpetrators because it refuses to seriously consider personality pathology during interventions. Dutton and Corvo (2006) summarised this problematic position by quoting from Pence and Paymar (1993): ‘To attach a clinical diagnosis to the “batterers” use of violence provides a rationalization for behaviour that may not be accurate’ (p. 23). In addition, a New York State Health Counselling Presentation (as cited in Corvo & Johnson, 2003, p. 276) stated that ‘Battering is never out of control ... Men batter because they can, and it serves as a means to an end’. This position assumes conscious cognition of all behaviour and negates any utility of psychopathology as a factor in understanding and treating IPV.

However, when we seriously consider the issues of domestically violent men from a neuropsychological perspective, we find evidence to support the views often expressed by the men themselves and, in some cases, their female partners. Many men will say that they find their own behaviour mystifying and/or reprehensible, and quite contrary to their espoused value system. The following quotations are from a qualitative study by Morgan and O'Neil (2001) that highlight the confusion and bewilderment of many men in relation to their IPV perpetration:

I just looped out, snapped out; just you know went blank just for I don't know, however long it was ... I wasn't really conscious of what I was doing, it just happened, and then when I sort of did come clear I sort of stopped straight away in horror, and went oh no ... I just looped out, snapped out. (Mike)

I've got a bad temper. I've always had a bad temper ... I've got a problem ... That's the type of person I am. I'm the one that's dishing out the violence ... I can certainly do without it as part of my character. It's a part of my life that I don't want. (Peter)

I've got a short temper and when I get angry I just get physically violent ... I get violently angry. I always knew I had a bit of a problem with it ... I'd like to be able to change that. (Paul)

Men (that this author interviewed) also recognised the completely contradictory nature of their behaviour:

I have always felt I was not good enough for her, and have been worried that she might leave me: now I've gone and done this and made it far more likely that she will leave me: how stupid is that? (Anecdotal quotation from the thesis author's work with men being assessed for IPV programs)

It is important to highlight here that this type of information would never be forthcoming from a male IPV perpetrator unless his personal experience was seriously explored, rather than imposing an *a priori* judgement on him that prevents him from serious self-examination and disclosure (Sonkin & Dutton, 2003; Taft & Murphy, 2007).

One of the areas of reassessment of the IPV problem involves neuroscience findings from the 1990s to the present day. Much of this research directly or indirectly challenges the model of IPV that assumes IPV behaviour is a deliberately chosen strategy of male intent to dominate women. For example, early developing effective myelination of the prefrontal cortex has been found to be enhanced by being allowed to cope with mild stress (Katz et al., 2009), whereas exposure to unnecessarily high levels of interpersonal stress, such as domestic violence, can cause poor regulation of negative

affect in children (Raver, Blair & Garrett-Peters, 2015). For the developing social-emotional brain of the child, this can lead to a relative failure of the prefrontal orbital cortex to modulate the feedback of the amygdala to the hypothalamus and the periaqueductal grey, which triggers the sympathetic nervous system's 'fight and flight' responses (Schore, 2003), and the brain's 'emotional motor system' (Benarroch, 2012, p. 210). This is linked to both personality disorders and abusive behaviour in adult life (Golan, Lee & Coccaro, 2005; Porges, 2011; Siegel, 2012). This complex cognitive-affective-behavioural system is significantly distorted unconsciously by abusive early childhood development (Schore, 2012).

In summary, numerous researchers have highlighted the non-conscious reactivity of much human behaviour (Cozolino, 2002; Fonagy, Gergely, Jurist & Target, 2002; Golan et al., 2005; Porges, 2011; Schore, 2003, 2012; Siegel, 2012). In turn, variability in the experience of non-conscious reactivity has been well established, based on early childhood studies of attachment and mentalisation (Beebe, Jaffe, Markese, ... et al., 2010; Bowlby, 1988; Critchley et al., 2000; Fan et al., 2014; Fonagy, 2004; Panksepp, 2001; Schore, 1997; Trevarthen, 2001).

2.4 Relational Attachments as Unconscious Reactivity Causing Behavioural Disruption

As early as John Bowlby (1969), we find observations that unite attachment theory, personality development and the fundamental components of domestically violent behaviour. Bowlby (1969) referred to a study of World War II children separated from their mothers and undergoing either 'intense clinging' or 'a rejection of the mother as a love object'. He stated that:

Thus we reached the conclusion that loss of mother-figure, either by itself or in combination with other variables ... is capable of generating responses and processes that are of great interest to psychopathology. Not only so, but these responses and processes, we concluded, are the very same as are known to be active in older individuals who are still disturbed by separations that they suffered in early life. Amongst these responses and processes and amongst forms of disturbance are, on the one hand, *a tendency to make excessive demands on others and to be anxious and angry when they are not met*, such as is present in dependent and hysterical personalities; and on the other, *a blockage in the capacity to make deep relationships such as is present in*

affectionless and psychopathic personalities (emphasis added, Bowlby, 1969, p. xxix).

Bowlby (1969, p. 165) expanded this theme with special reference to animal studies, citing Mason's (1965) research of the development of male sexual behaviour in primates, whereby males who had not developed normally with mothers and playmates before adolescence often displayed serious problems of aggression that effectively compromised mating patterns. He stated that this was due to an inability to learn inhibition of anger and aggression, which became profoundly dysfunctional in relation to female mating partners and young offspring. In his last book, *A Secure Base: Parent-Child Attachment and Healthy Human Development*, Bowlby (1988) specifically addressed the issue of family violence, commenting that psychoanalysis had been 'appallingly slow' to recognise both the prevalence and severity of psychiatric disorders attending such violence. He maintained that:

a great deal of the maladaptive violence met with in families can be understood as the distorted and exaggerated versions of behaviour that is potentially functional, especially attachment behaviour on the one hand and care giving behaviour on the other (Bowlby, 1988, p. 81).

He pointed out that such behaviour is elicited by experiences of pain, fear and fatigue, and moderated by the inaccessibility (or appearance of inaccessibility) of the caregiver. He noted that much of this behaviour is inexplicable to the person acting it out—that is, it is relatively unconscious behaviour at the point of reactive panic to attachment threat. This has clear parallels in IPV cases.

Beginning with researchers such as Schore (1994, 1999, 2003, 2007), new discoveries in subcortical brain development, especially in the right hemisphere, have begun to highlight the power of non-conscious affect to promote and mediate destructive behaviour—particularly in attachment relationships. Such non-conscious affective reactivity has been extensively studied by Jaak Panksepp via animal research, and applied to human behaviour (Panksepp & Biven, 2011). Panksepp (2005) referred to primary affects that generate 'instinctual emotional behaviours' (p. 30) embedded in the periaqueductal grey region of the diencephalon. These include such fundamental responses to the environment as RAGE, FEAR, PANIC, LUST, CARE, SEEKING and PLAY (note: these neurobiological subsystems were capitalised by Panksepp [1998] in order to discriminate primary affects from secondary emotions). These responses are generated outside of immediate conscious awareness via the amygdala, hypothalamus

and vagus complex (Porges, 1995, 2014). Tronick and Weinberg (1997, as cited in Schore, 2002) stated:

While infants are not in homeostatic balance or are emotionally dysregulated (e.g. they are distressed), they are at the mercy of these states. Until these states are brought under control, infants must devote all their regulatory resources to reorganizing them. While infants are doing that, they can do nothing else. (p. 15)

It is also worthy of note that Davis and Panksepp (2011) identified these primary affect functions as the substrate for personality and its development, noting the factor analytic correspondences with the Five-Factor Personality model (Costa & Widiger, 2002), which suggest some concordance with Millon's (1999) evolutionary model of personality. That is, Millon (1999, 2011) and Millon and Davis (1996) premised their understanding of personality on the adaptations of the human organism to the need for life-preservation and life-enhancement, ecological-accommodation and ecological-modification, and reproductive-individuation and reproductive-nurturance, which have many parallels with Panksepp's (1998) neurobiological basis for personality development.

The mother, or primary caregiver, is the 'other' who, under normal circumstances, assists the infant to regulate distressed states (Schore, 2003) and over time enables the child to internalise calm states of mind and a sense of the other's mind as well (Fonagy, 2004). However, as much research now indicates, when abuse and/or neglect is the developing child's basic experience, attachment security suffers, as does the ability to 'mentalise'—that is, to reflect on the difference between one's own and others' perceptions—effectively bringing sequelae of mental and emotional distortions to relational processes (Beebe, et al., 2010; Lyons-Ruth, 2008; Schore, 2003). Such early experiences frequently place a person on a trajectory for adult relational instability that is often characterised by aggressive behaviour towards oneself and others (Streeck-Fischer & van der Kolk, 2000).

Fonagy (2004) made a telling case for violence being innate, rather than learnt (a product of the SEEKING, RAGE and PLAY systems of the brainstem's hardwiring), pointing to a failure of socialisation processes to curb naturally inherent aggressive tendencies. This view was reinforced by Panksepp and Biven's (2011) findings on

primary affect as a ‘hard-wired’ function to mobilise defences against external threats. This view was also supported by the findings of attachment research, particularly of the disorganised category, where a child begins to exert greater ‘power and control’ over a mother by age four to six years, as a function of that disorganisation (Lyons-Ruth, 2008). The notion of a non-conscious response to threat was also reinforced by some qualitative outcome research with men who had undergone a program to treat IPV (Morgan & O’Neil, 2001). Although these men tended to acknowledge their personal responsibility for their abusive behaviour post-intervention, they continued to observe an issue of a strong ‘inner tension’ regarding their abuse, which transcended rational accountability.

Numerous writers and researchers have highlighted and brought together early childhood attachment relationships and the development of personality (Benjamin, 1996; Fonagy et al., 2002; Panksepp & Biven, 2011; Porges, 2011; Schore, 2003; Siegel, 2012; Tretharven, 2001; Williams, 1994), with particular emphasis on the relationship between adaptation to disrupted familial experiences. The biopsychosocial framework for personality traits and disorders lies at the core of Millon’s long study on personality pathology (Millon, 1999, 2011; Millon & Davis, 1996). Tretharven (2001) made an important contribution from extensive research with newborn babies, infants and toddlers by elaborating on the meaning-making and intentionality of children from birth onwards. He argued that human infants are clearly equipped to be acculturated meaning-makers, who internalise not just ‘internal representations’ of caregivers, but also develop somatic, procedural and affective models of their earliest companionable interactions, and the physiological and melodic rhythms that accompany that interpersonal subjectivity. Thus, very young children develop those nuances of self–other and self–other–object, and create unique patterns of personal experience that lead to settled and habitual ways of managing themselves in the world. These are the roots of personality development (Davis & Panksepp, 2011; Millon, 2011; Schore, 2003, 2012; Siegel, 2001). Alongside this is the discovery that personality pathology and IPV appear to be highly correlated in terms of severity (Dutton & Starzomski, 1993; Ehrensaft, Cohen & Johnson, 2006; Hamberger & Hastings, 1991; Hart, Dutton & Newlove, 1993; Holtzworth-Munroe et al., 2000). Therefore, the following chapter specifically addresses the issue of personality pathology in IPV research.

Chapter 3: Personality Pathology in IPV Work

3.1 Personality Profiles and Human Functioning

Personality disorders are defined in the *Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition* (DSM-5, 2013) as:

an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. (p. 645)

The *Psychodynamic Diagnostic Manual* (PDM, 2006) defines personality as 'relatively stable ways of thinking, feeling, behaving, and relating to others' (p. 17). Later, it adds: 'If they repeatedly cause pain to ourselves or to others, or become preoccupying or conspicuous, they may constitute a personality "disorder"' (PDM, 2006, p. 18).

Regarding personality, Millon (2011) stated:

Styles, types, and disorders of personality are not medical entities; nor should they be seen as human perversities either. Viewed from an ecological and evolutionary perspective, we conceive them as problematic styles of human adaptation. They represent unique individuals whose constitutional makeup and early life experiences have not only misdirected their development, but have also constructed an unsatisfying sense of self, a problematic way of expressing thoughts and feelings, as well as a troublesome manner of behaving and relating to others. Each of the 'classical' personalities, as well as their subvarieties, demonstrate for us the many complex structures and styles in which we become the persons we are. (p. x)

Millon and Davis (1996, p. 7) stated some important principles of definition that are worth citing here:

1. personality disorders are not diseases
2. personality disorders are internally differentiated functional and structural systems, not internally homogeneous entities
3. personality disorders are dynamic systems, not static, lifeless entities
4. personality exists on a continuum—no sharp division exists between normality and pathology.

Millon (1999) was reluctant to define the term 'personality disorder' more definitively, preferring a dynamic, dimensional approach, whereby personality disorder may be

assessed, but not definitively diagnosed. This is because he took a systemic, clinical perspective, acknowledging substantial limitations on the current functioning of particular individuals, yet with a view to remediate or remove those limitations. One factor is very clear in his work—he regarded personality as the context for distress and disorder. In addition, Axis I disorders (i.e. clinical syndromes) are seen as consequences of Axis II dysfunction (i.e. personality disorders; DSM-IV; Millon & Davis, 1996). This aligns well with the updated classification in the DSM-V (2013), which shifts towards dimensionality in addressing personality pathology (Widiger, 2004). The focus of DSM-V on identity, self-direction, empathy and intimacy combined with the domains of negative affectivity versus emotional stability, detachment versus extraversion, antagonism versus agreeableness, disinhibition versus conscientiousness, and psychoticism versus lucidity make for a complex matrix of presentation that cannot be captured by a simplistic diagnosis, but involves complex profiles in individuals.

At first sight, the notion that personality patterns can be adapted sounds contradictory, until we reflect that personality patterns, or pathologies, are considered adaptations to life—to developmental processes—and thus are an individual’s best attempt to cope with the stress of the environment (Schoore, 2003; Siegel, 2012). Neural plasticity holds great hope for remediation and further adaptation of what we have characterised as personality disorders. Only a few years ago, borderline personality disorder (BPD) was considered very difficult to remediate. However, Marsha Linehan (1993a) demonstrated empirically that BPD could be ameliorated with dialectical behaviour therapy (DBT). Since that time, great progress has been made therapeutically to manage personality disorders (Dimaggio, Semerari, Carcione, Nicolo & Procacci, 2007; Fonagy & Bateman, 2006; Livesley, 2008). Millon (1999, 2011) also developed what he termed ‘personality-guided therapy’ to address comprehensively the various components of human functioning that contribute to psychopathology. His argument was that assessing and understanding the particular behavioural, cognitive, affective, and interpersonal dynamics of different personality disorders would enable more effective choice of intervention.

Given the interrelationships of IPV perpetration to personality pathology (White & Gondolf, 2000), neuroscience findings (Siegel, 2013), emotion regulation and

attachment (Bowlby, 1988; Schore, 2012) as discussed in Chapter 2, the following principles are significant for working with IPV during interventions:

- IPV is an expression of dysfunctional coping strategies in intimate attachment relationships
- much IPV behaviour is irrational to the male perpetrator, as well as his partner
- acts of IPV are often reactive, rather than consciously chosen, behaviours
- acts of IPV are frequently symptomatic of disturbed social/emotional processing going back to early childhood development
- assessing personality patterns is a useful way of getting in touch with that disturbed social/emotional processing.

To address the core elements of IPV triggers, we chose these principles for the following reasons. Millon (1999) and Millon and Davis (1996) made it clear that personality pathology involves problematic processing at multiple levels: behavioural, phenomenological, intrapsychic and biophysical. This complex dysfunctioning leads to compromised cognitive representations of what transpires in intimate relationships (Berns, Jacobson & Gottman, 1999; Covel, Hus & Langhinrichsen-Rohling, 2007; Holtzworth-Munroe & Hutchinson, 1993). It also involves compromised attachment relationships (Dutton et al., 1994; Hesse & Main, 2000; Lyons-Ruth & Jacobvitz, 1999) that involve reactive protest behaviour. As previously discussed, male IPV perpetrators struggle to understand their own behaviour (Morgan & O’Neil, 2001), thereby suggesting non-conscious behavioural acting out. The use of a tool such as the Millon Clinical Multiaxial Inventory (MCMI) enables us to summarise and assess some of these diverse aspects of IPV perpetrators functioning with personality profiles.

3.2 Historical Exploration of IPV Personality Pathology

Prioritising personality pathology in IPV research has been a contentious issue from the beginning of modern IPV investigation, with researchers and activists disputing the value of this variable. Gondolf (2002) argued that it is not important—even titling one of his articles on the subject: ‘MCMI-III Results for Batterer Program Participants in Four Cities: Less “Pathological” than Expected’ (Gondolf, 1999). Pagelow (1992) went so far as to refer to ‘the myth of psychopathology’ (p. 108) in criticising the shift away

from viewing IPV as a social issue rooted in gender politics to an individualist discourse that she and other authors saw as seeking to nullify the feminist position and excuse male perpetrators. However, Hamberger (1993) stated that Pagelow (1992) had no references whatsoever for her section on psychopathology and the assertions she made about that subject, and cited empirical research to the contrary (Hamberger & Hastings, 1986). Namely, this research stated that there were clear personality correlates of IPV perpetration that suggested significant interrelationships, and that these relationships required exploratory research to identify them for clinical purposes. Corvo and Johnson (2013) similarly argued that psychopathology is at the core of understanding IPV perpetration.

In the psychological research community, there was an early attempt to assess male IPV perpetrators with a view to uncovering psychological disorders, as these disorders were anticipated as being likely to arise with domestically violent behaviour towards intimates. In other words, the search had begun to discern the psychological differences between domestically violent and non-domestically violent men (Dutton, 1988; Hastings & Hamberger, 1988). Dutton (1988) gave an excellent summary of the variety of different views and approaches to this topic, whereby different sampling confused the issue—an issues that has continued as a point of contention to this day. Dutton observed that in the melange of research, there seemed to be three clear types of serious IPV perpetrators. Hamberger and Hastings (1986) identified at least 3 different types of personality pathology from factor analysed MCMI scores ($N = 105$): schizoid/borderline, narcissistic/antisocial, and passive-dependent/compulsive.

Hamberger and Hastings (1986) also noted that men who had perpetrated IPV had significantly higher mean scores on these personality pathology variables than their non-violent counterparts. However, there was also a group in the Hamberger, Lohr, Bonge and Tolin (1996) research with no trace of any of the aforementioned personality pathology issues—at least not in terms of significantly high *mean* personality pattern scores on the MCMI. Regarding this last finding, some researchers have argued that the use of mean scores has clouded the issue because the MCMI was not intended to be used in this manner to assess groups (White & Gondolf, 2000). Rather, when looking for the presence of personality pathology, the critical index is a percentage of individual profiles above significance (Millon, Davis & Millon, 1997). Dutton also considered

Saunders's (1987) research, which identified three subgroups: one that involved general violence and alcohol abuse; one that involved high levels of depression, jealousy and anger; and one that involved moderate levels of depression and anger that were denied, alongside family-only violence. Despite the lack of measurement of personality pathology in Saunders's (1987) model, there could be some relationship between the Saunders (1987) and Hamberger and Hastings (1986) models. For example, general violence and alcohol abuse have often been associated with antisocial personality characteristics (Gondolf, 1988), while high levels of depression, jealousy and anger have been associated with borderline personality characteristics (Dutton & Starzomski, 1993). Moderate levels of depression and anger that are denied, alongside family-only violence, could be associated with a category referred to variously as 'no pathology' or 'low pathology' (Hamberger & Hastings, 1991; Saunders, 1992).

These categories have been picked up in subsequent research, delineating either three or four groupings of IPV perpetrators involving different forms of personality pathology (Hamberger et al., 1996; Holtzworth-Munroe & Stuart, 1994). Hamberger et al. (1996) aligned their three main clusters with Holtzworth-Munroe and Stuart's (1994) model of three types: generally-violent-antisocial, borderline-dysphoric and family-only abusers with low psychopathology. This has become almost the standard typology for IPV perpetrators—with the exception of a fourth low-level antisocial group of perpetrator identified in the same research group's model testing (Holtzworth-Munroe, Meehan, Herron, Rehman & Stuart, 2000). These researchers also tested the stability of these groupings over time (Holtzworth-Munroe, Meehan, Herron, Rehman & Stuart, 2003), with the general finding that the generally-violent-antisocial, borderline-dysphoric and low-level antisocial groups perpetrated significantly more IPV over a three-year period than the family-only group.

Curiously, despite this relative consensus around IPV typology, it is noteworthy that these subtypes have not figured largely in actual intervention programs for men who have perpetrated IPV (they were mentioned in the STOP program, but not used) (Saunders, 2008; Wexler, 2013). This is perhaps because the Holtzworth-Munroe and Stuart (1994) model has been criticised for confounding psychopathology and violence (Dixon & Browne, 2003). Once again, we can observe that the most popular models of IPV typology are still more interested in attempting to establish the most dangerous IPV

groupings, without looking more comprehensively at personality pathology. In fact, Holtzworth-Munroe et al. (2000) did not find any significant differences in levels of IPV between the generally-violent-antisocial and borderline-dysphoric groups of men, nor significant differences in ‘anti-sociality’ among their generally-violent-antisocial, borderline-dysphoric and low-level antisocial groups. This highlights the paucity of personality pathology measured in this model, and leaves the therapy field without a reliable and functionally meaningful differentiating point for treatment design in relation to such personality pathology characteristics.

3.3 Diversity of Personality Pathology

A far greater multiplicity of personality pathology appears in the research findings from Gondolf’s (1999) multisite study in the United States (US). In a large sample of male perpetrators ($N = 828$), Gondolf found significant elevations on every personality pattern scale of the MCMI-III. Here, it is important to point out that Gondolf (1999) was using the MCMI as intended, focusing on the percentages of individual personality pathology scales above significance (Millon et al., 1997). From these results, Gondolf (2002) believed that the personality pathology of men perpetrating IPV was not as pronounced as expected. Yet others have argued for relatively high levels of personality pathology among IPV men (Dutton, 1988; Hamberger & Hastings, 1986; Hamberger et al., 1996). Dutton (2003) provided some perspective to Gondolf’s (1999) differential finding in highlighting that 51% of the men in that study also recorded significantly elevated ‘desirability’ scale scores, which are suggestive of ‘faking good’, minimisation or unconscious denial (Choca, 2004), and conversely would have considerably reduced the percentage of significant personality pathology. As an addendum to Gondolf’s (1999) research, it is also important to note that he was analysing individual personality pathology *scales*, rather than *profiles*, which was the ultimate purpose of the MCMI (Millon, 1999, 2011). This indicates that personality profile patterns may be more instructive than just singular scale elevations that are aggregated. The current thesis and associated research is largely an explication of that proposition.

Given the confusion and uncertainty that surrounds the use of personality pathology in IPV intervention the question remains whether the exploration of personality pathology

with perpetrators is a priority. In answering, it is important to consider how potential diversity of personality pathology profiles among a sample of male IPV perpetrators might inform intervention strategies. Saunders's (1992, 1996) research provides an answer to this question. In 1992, he reported significant differences among batterers mandated to IPV intervention, including personality differences. In 1996, he applied a controlled experiment to IPV perpetrators with either antisocial or borderline personality, randomly allocating them to either cognitive behavioural therapy (CBT) ($n = 91$) or psychodynamic ($n = 87$) group intervention programs. The men with antisocial personality had better outcomes in the CBT intervention, while the men with borderline personality had better outcomes in the psychodynamic intervention. Such findings support the view that considering personality pathology is important for IPV intervention programs to have more effective outcomes. One size may not fit all—or even most, as Gondolf (2002) asserted.

In recent times, many IPV researchers have argued for a more therapeutic approach to this issue (Brown & O'Leary, 2000; Slabber, 2012; Taft & Murphy, 2007; Taft, Murphy, Musser & Remington, 2004), which would presumably involve taking a more differentiated approach to assessing and using personality pathology. The importance of personality pathology and profiles in therapeutic intervention is now being specifically espoused by the DSM-V (2013), with its emphasis on the dimensionality of personality patterns and their use for understanding an individual's functioning:

knowing the level of an individual's personality functioning and his or her pathological *trait profile* also provides the clinician with a rich base of information and is valuable in treatment planning and in predicting the course and outcome of many mental disorders in addition to personality disorders. *Therefore assessment of personality functioning and pathological personality traits may be relevant whether an individual has a personality disorder or not.* (emphasis added; p. 774)

Interestingly, in further support of the importance of personality profile use in interventions, White and Gondolf (2000) worked with a subsample of the same perpetrator group of Gondolf's 1999 multisite study ($N = 100$) and stated:

Case examples are used to illustrate the personality profiles and their treatment implications. The profile analysis suggests six major personality groupings ... However, the majority of batterers exhibit narcissistic and avoidant traits that are well suited for the prevailing cognitive-behavioral group treatment approach. (p. 467)

The view of this thesis is that White and Gondolf's (2000) research represents the positive and the not-so-positive aspects of current interventions with men for IPV. The positive is found in White and Gondolf's (2000) commitment to incorporating into group treatment these men's personality differences. The not-so-positive is seen in the commitment to fit these differences all into the CBT framework, which White and Gondolf (2000) described as an approach that 'confronts men with the consequences of their behavior, holds them responsible for their abuse, confronts rationalizations and excuses, and teaches alternative reactions and behaviors' (p. 468). In working with different personality profiles, even in this article by White and Gondolf (2000), the contradictory nature of this approach is evident. Confrontation of men who are already highly defensive in interpersonal style is likely to create even further resistance, 'shut down', drop out (Sonkin & Dutton, 2003; Wexler, 1999) or 'pseudo-success' (Scalia, 1994). That is, the group participants may conform to an understanding of possessing 'faulty thinking styles' without necessarily owning the deeper emotional-relational nuances (Morgan & O'Neil, 2001).

3.4 Understanding Personality Pathology as the Context for Individual Behaviour

Taking a recent and relatively sophisticated IPV intervention program as an example of current work, some interesting issues related to personality pathology and personality profiles are noteworthy. Wexler's (2013) revised version of the STOP Domestic Violence Program operates on a 26- to 52-week program (tailored to either length) and cites some popular typological research—namely, Johnson (Johnson, 2008; Johnson & Ferraro, 2000) and Holtzworth-Munroe et al. (2000)—in its introduction. The program covers many issues, including anger, the cycle of abuse, trauma, mindfulness, self-talk, masculinity, jealousy, substance abuse, accountability, shame, handling criticism, empathy and intimacy. However, Wexler does not explain how the personality pathology typology might differentially be used in the STOP program. It appears that group intervention programs are still generally applied to participants without accounting for potentially major differences in personality profiles, thereby restricting their effectiveness.

Millon (2011) highlighted important conceptual and pragmatic directions for intervention design, quoting Beutler and Clarkin: ‘the characteristics that the patient brings to the treatment experience are the single most powerful sources of influence on the benefit to be achieved by treatment’ (p. 181). Just as treating other therapy clients as being generally the same would be considered unethical, so treating men in IPV programs as being generally the same should arguably be considered inadvisable if we really believe we can assist them.

If this is the case, then men who are domestically violent need to be ‘treated’ in somewhat similar ways to any client with a serious functional problem. Thoughtful and well-trained clinicians do not just treat depression or anxiety *per se*—they treat the constellation of causes, beliefs and perpetuating factors. To treat such men as essentially ‘the same’ is to defy good clinical wisdom when they are in a ‘treatment’ program, according to some authors (Taft & Murphy, 2007). This makes it much more likely that practitioners will have limited success working with them (see Saunders’s [2007] comprehensive review) or, at best, ‘pseudo-success’ (Scalia, 1994) because some will do their best to comply with a ‘good’ outcome in order to progress through the program and gain their certification.

Millon (2011) made a comprehensive case for what he called ‘personalogic therapy’. He positively cited the work of Marsha Linehan: ‘If each personality disorder and clinical syndrome were approached therapeutically in the manner in which Linehan approached the borderline, treatment for all disorders and syndromes would likely be greatly improved’ (Millon, 2011, pp. 186–187). In other words, personality patterns become the context and matrix in which symptomatology is developed and manifested, and thus can be better understood and treated (PDM Task Force, 2006). As Millon (1999) stated, personality (Axis II, DSM-IV) is similar to the immune system in the sense that it mediates between environmental psychosocial stressors (Axis IV) and clinical syndromes or symptoms (Axis I)—or, as Millon and Davis (1996) stated: ‘Transactions between Axis II and Axis IV’ factors ‘produce Axis I’ (p. 180; see Figure 1). If we do not respond appropriately to the mediating pattern, we are unlikely to assist in the effective and long-term reduction or resolution of symptomatology. Millon (2011) referred to the personality pattern as ‘the mind’s equivalent of the body’s immune

system: that structure and style of psychic processes that represents our overall capacity to perceive and cope with our psychosocial world' (p. 194).

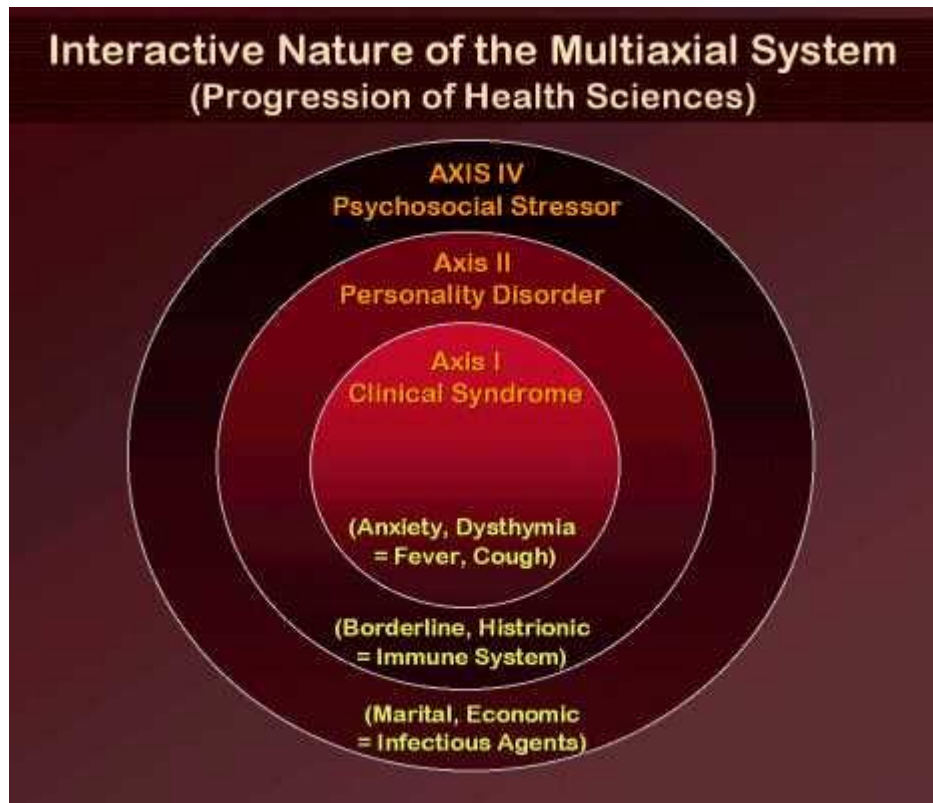


Figure 1: Interactive Nature of the Multiaxial System (Millon & Davis, 1996)

While other authors have also viewed personality patterns as the fundamental context for understanding Axis I disorders (Benjamin, 1996, 2003; Dimaggio et al., 2007; McWilliams, 1994) and as especially advantageous to systematic treatment planning, Millon has been the most substantive, thorough and systematic from a theoretical biopsychosocial perspective through to pragmatic application (Millon, 1999, 2011; Millon & Davis, 1996). His 'personologic therapy' (Millon, 1999, 2011; Millon & Grossman, 2007) is essentially dimensional and individualised around personality profiles, rather than being categorical and general. In essence, he argued that such careful assessment makes intervention far quicker because it is targeted to the client's needs (Millon, 2011).

Millon's argument, and the one explored in the research of this thesis, is that IPV is symptomatic of an inability to cope with environmental stressors—intimate relationships in particular—and that personality profiles are the proximate moderating

intrapsychic context in the triggering and expression of IPV because they shape strategies for the interpersonal context. This also helps explain why, given the culturally gendered context in which many men live (Dobash et al., 1998), IPV is likely to be manifested in power and control tactics—that is, the attempt to regain a sense of control over one’s interpersonal environment (Wexler, 1999).

Millon (1999) argued for an evolutionary-based framework to understand a person’s personality development—namely, the polarities of:

1. life-enhancement versus life-preservation—the pleasure/pain polarity
2. propagation versus nurturance—the self/other polarity
3. accommodation versus modification—the passive/active polarity.

Along these three dimensions of survival, replication and adaptation, Millon sought to locate various types of personality structure. Importantly, there is a certain approximation to the seven non-conscious neurobiological subsystems of the human brain that Panksepp (2005) and Panksepp and Biven (2011) elucidated as fundamental in personality development, and therefore prone to action, before intention to act. The foundation of attachment, primary affective regulation; and a core sense of self, are dependent on intimate others and are open to serious disruption through abuse and neglect (Panksepp, 2001; Schore, 1997, 2002, 2012). While many of these factors are highly interwoven and complex, it does seem relatively clear that developmental processes that involve attachment and inter-subjectivity are generally highly affected by intimate relationships, and subsequently exert major influences over what we term ‘personality’ (Gormley, 2006; Hofer, 2006; Rosenstein & Horowitz, 1996). These factors in turn are found to be significantly expressed in personality disorders and IPV (Fonagy, 2004; Dutton & Starzomski, 1993). These factors can be traced developmentally (Magdol, Moffitt, Caspi & Silva, 1998), specifically in relation to psychopathology (Ehrensaft, Moffitt & Caspi, 2004).

Table 1: Millon’s Chart of Theory Derived Personality Disorders (Millon & Davis, 1996)

	Existential Aim		Replication Strategy		
	Life Enhancement vs. Life Preservation		Propagation vs. Nurturance		
Polarity	Pleasure versus Pain		Self versus Other		
Deficiency, Imbalance, or Conflict	Pleasure (low) Pain (low or high)	Pleasure-Pain Reversal	Self (low) Other (high)	Self (high) Other (low)	Self-Other Reversal
	Personality Disorder				
Passive: Accommodation	Schizoid	Masochistic	Dependent	Narcissistic	Compulsive
	Melancholic				
Active: Modification	Avoidant	Sadistic	Histrionic Hypomanic	Antisocial	Negativistic
Structural Pathology	Schizotypal	Borderline Paranoid	Borderline	Paranoid	Borderline Paranoid

Millon (2011) has since developed a scheme that incorporates the dimensional development of personality patterns from normal through trait types to disordered types within each dimension. For example, in what he termed the ‘DAD spectrum’ (interpersonally imbalanced), he refers to ‘deferential styles’, ‘attached types’ and ‘dependent disorders’, based on increasing levels of dysfunctionality in dependent personality. The therapeutic value of this lies in the ability to assess different levels of severity within particular personality patterns, and then optimally target intervention strategies that will produce better outcomes for those clients (Millon & Grossman, 2007).

3.5 General Aims of the Current Research

The current series of studies began from the premise that context is essential to understand IPV. To this end, this research began by examining whether men who perpetrate IPV are homogeneous in personality patterns and/or psychopathology. If they are not homogeneous, then they are unlikely to be effectively treated with an identical treatment program (Cantos & O’Leary, 2014; Saunders, 1996; Taft et al., 2004). This thesis proposes that personality pathology is reflective of the context in which IPV occurs, since the men who perpetrate such behaviour are reacting to a developmental complex of experiences. Thus, the current series of studies sought to:

1. Assess the breadth and severity of personality pathology among a large group of men referred to a group intervention program for IPV. This is addressed in Chapter 5. The research also examines whether personality pathology is significantly related to response bias, given prior research suggesting this may be the case (Gondolf, 1999).
2. Assess the effect of the referral source on men presenting for treatment in a group setting, by comparing personality pathology and abuse scores among men who are self-referred or court-referred to the program. This is addressed in Chapter 6.
3. Cluster personality pathology with the study sample in a manner that may simplify the task of therapists and facilitators in working with men involved in IPV. This is addressed in Chapter 7.
4. Assess the effect and value of other variables correlated with personality pathology, including abuse scores, interpersonal problem scores, emotional empathy scores and self-compassion scores. This is addressed in Chapter 8.

The intention of the current body of research is to explore these issues in depth with one large sample of IPV perpetrators who have presented for treatment in order to allow exploration of the relative and interactive influence of each of these factors. The methodological issues associated with measuring personality pathology in this group will be discussed first, in the next chapter.

Chapter 4: Measurement of Personality and its Problems in IPV Research

4.1 Introduction

According to the personality model of IPV, if a man is referred to a group intervention, we need to know what kind of IPV he has perpetrated, how recently, with whom, and the safety issues involved. However, it is likely that his IPV behaviour will also be expressed differently to other men as a result of his particular personality and pathology, the way he views himself in relationships, the manner of his regulation of emotional experience and expression, his ability to tolerate distress and arousal, and his typical strategies for engaging in relationships and addressing conflict. IPV researchers have demonstrated that male IPV perpetrators—in contrast to non-violent male partners—commonly suffer empathy deficits (Covell, Hus, & Langhinrichsen-Rohling, 2007), have attachment disorganisation (George & West, 1999), lack competence in relational problem solving (Anglin & Holtzworth-Munroe, 1997), experience higher levels of negative emotion and greater demand and withdraw characteristics in intimate relationships (Berns, et al., 1999), and are more likely to attribute negative intent to their partners (Holtzworth-Munroe & Hutchinson, 1993).

It is helpful to determine which of these aspects of IPV men's behaviour in intimate relationships may be effectively addressed during treatment, and this may largely depend on the underlying habituated patterns of regulation that these men have developed prior to intervention. For example, a man with 'discouraged borderline' personality characteristics (dependent, depressive and avoidant personality patterns comorbid with borderline; Millon, 1999) is likely to be much more anxious and depressive, and liable to look to the facilitator or therapist for support and sympathy, while also being wary of abandonment. In contrast, a man with 'impulsive borderline' personality characteristics (antisocial and histrionic personality patterns comorbid with borderline) is likely to be much more demanding and to 'turn on' the facilitator or therapist if they do not live up to certain expectations. He may even pre-empt abandonment by rejecting the facilitator before the facilitator can reject him (Millon,

1999). Such patterns will only be readily apparent during intake to an IPV program if the participants are adequately assessed in their complexity with an instrument that measures personality pathology in terms of the participants' current coping strategies, as opposed to their long-term traits, such as extroversion or neuroticism.

4.2 Personality and the MCMI

Context and experience underlie the development of particular personality profiles—that is, the unique ways in which fundamental dimensions of lived experience are expressed. Millon (1999; Davis, 1999) refers to these as 'evolutionary'—namely, existential aims, adaptation modes and replication strategies (section 3.4 above). These three dimensions can produce six polar opposites in personality development. The complex developmental learning around these dimensions explains the unique expression of object representation, morphological organisation, regulatory mechanisms, self-image, mood, expressive behaviour and interpersonal conduct. For Millon (1999), these complex intrapsychic and interpersonal processes form and explicate personality development and function, and were the underlying set of principles behind his development of the MCMI to measure and assess personality (Millon et al., 1997). There have been criticisms of the MCMI on the grounds that many of the scales have relatively high inter-correlations (Widiger, 1999); however, Millon's intent was to develop a tool to measure relatively complex patterns or profiles that reflect the realistic overlap of many personal strategies, both adaptive and maladaptive (Choca, 2004; Millon, 2011).

The third edition of the MCMI (MCMI-III; Millon et al., 1997) was selected for this research because it is a widely used and relatively brief measure of personality pathology, and is appropriate for assessing IPV perpetrators in a clinical setting. Normed on 600 clinical subjects, with a cross-validation sample of 398 clinical subjects, the MCMI-III was constructed from a theoretical-evolutionary model, and includes much of the personality disorder criteria from the DSM—Fourth Edition (DSM-IV)¹ (American Psychiatric Association, 1994).

¹ Of relevance, the current body of research was conducted prior to the publication of DSM-V, when the DSV-IV was still in use.

The MCMI-III has produced alpha coefficients ranging from 0.66 to 0.9, with 20 of its 26 scales exceeding 0.8 with various test sample scores. Test–retest reliabilities for samples have produced alpha coefficients on its scale scores ranging from 0.82 to 0.96. Factor analysis of MCMI scores has generally supported Millon’s circumplex conceptualisation of psychopathology (Strack, Choca & Gurtman, 2001), while correlations with sample scores on related instruments (such as the Beck Depression Inventory, Symptom Checklist 90 and Minnesota Multiphasic Personality Inventory) have generally lent support to the convergent and discriminant validity of specific MCMI-III sample scores (Groth-Marnat, 1997).

From this theoretical and clinical work, Millon and Davis (1996) developed a measure of personality with 14 different, yet overlapping, presentations that they termed ‘personality syndromes’. These syndromes encompass 11 basic patterns, termed schizoid, avoidant, depressive, dependent, histrionic, narcissistic, antisocial, aggressive, compulsive, negativistic and self-defeating personality syndromes. Millon et al. (1997) termed three severe personality syndromes as schizotypal, borderline and paranoid. They referred to these three severe patterns as ‘structural’ disorders of personality, arguing that they are more extreme and more difficult to treat. Millon et al. (1997) also viewed the three severe patterns as more ‘defective’ forms of basic patterns, with schizoid related to the schizotypal pattern, histrionic related to the borderline pattern, and narcissistic related to the paranoid pattern. However, they also argued that other basic patterns could morph into the three severe personality syndromes. Millon et al. (1997) developed these patterns of personality pathology statistically from clinical samples based on the clusters of symptoms and adaptive strategies. However, there is considerable overlap among many of these patterns.

Millon based the scoring of the different personality and clinical syndromes on ‘the prevalence of a particular trait or disorder in the psychiatric population’ (Choca, 2004, p. 21). Thus, a base rate (BR) of 60 anchors the median prevalence in the psychiatric population, a BR of 75 anchors the presence of the trait in an individual, and a BR of 85 denotes a predominant characteristic or disorder. However, for the three severe personality patterns in Millon’s theory (schizotypal, borderline and paranoid; Millon & Davis, 1996), profile scores of BR 75 or more are interpreted as reflective of a personality dysfunction (Choca, 2004):

reflecting an insidious and slow deterioration of the personality structure, these differ from the basic personality disorders by several criteria, notably, deficits in social competence and frequent (but usually reversible) psychotic episodes. Less integrated in terms of personality organization and less effective in coping than their milder counterparts, they are especially vulnerable to the everyday strains of life. (Millon & Davis, 1996, p. 15)

However, Millon emphasised that these cut-offs were somewhat arbitrary, and that the nature of an individual's experience and report of these syndromes is complex and multifaceted. Thus, he highlighted that these categories should not be clinically applied in an absolute manner:

As clinical scientists, we are wedded to representational systems, including classifications, so wedded that the abandonment of all representational schemas would be an abandonment of knowledge itself. In the best of all possible worlds, we would have *both* the experience of true clinical knowledge *and* a representational system by which to articulate it. (Millon, 2011, p. 235)

DSM-V (2013, p. 646) maintains the DSM-IV (1994) categories of Clusters A, B and C for certain personality disorders, according to their eccentric, emotionally labile or anxious and fearful types of presentation, respectively. In the revised version of the DSM (DSM-V), an Alternative Model for Personality Disorders (p. 761) is based on more dimensional traits and functioning, and related to the so-called 'big five' personality traits (Costa & Widiger, 2002). However, it is important to note that the current research took the view—as Millon (1999, 2011) himself argued—that the MCMI-III should not be used for categorisation, but rather to cluster individual profiles of greater complexity.

In its various editions, the MCMI has been used extensively to measure personality pathology in IPV work (Beasley & Stoltenberg, 1992; Craig, 2003; Hamberger & Hastings, 1986; Hamberger et al., 1996; Johnson et al., 2006; White & Gondolf, 2000) for a variety of reasons. It relates personality pathology to clinical syndromes and the DSM taxonomy, and is brief enough to be useful for screening and assessing men being treated for IPV. As a clinical instrument, it has the advantage of being a useful 'before and after' measure of changes, since both stability and change in personality is probable (Caspi, Roberts & Shiner, 2005). Through Millon's (1999) cohesive approach to personality pathology, the MCMI-III has also enabled effective extrapolation to appropriate treatments (Dorr, 1999), while other empirical work has demonstrated the

coherence between the personality patterns and clinical syndromes of the MCMI-III in a large psychiatric sample (Haddy, Strack & Choca, 2005).

The MCMI-III has the advantage that it includes three modifying indices to assess response bias: disclosure, desirability and debasement indices (Millon et al., 1997). A number of studies have been designed to assess the effectiveness of the MCMI to detect both malingering and social desirability responding (Choca, 2004; Daubert & Metzler, 2000; Schoenberg, Dorr & Morgan, 2003; Schoenberg, Dorr, Morgan & Burke, 2004). While the net result of these studies suggested that the MCMI modifying indices' detection of 'faking good' or 'faking bad' were not particularly accurate, it nevertheless enables rough estimates of respondents' openness and closedness, as well as trends to exaggerate in either direction. This is considered particularly important in IPV research and treatment, given the propensity for such respondents to minimise their behaviour (Dutton & Hemphill, 1992; Henning, Jones & Holdford, 2005).

Gondolf's (1999) research presents a clear example of both the values and pitfalls of using a self-report instrument such as the MCMI-III. Gondolf studied a large sample of men treated for IPV across four sites in the US. In reporting his findings, Gondolf commented on the low levels of personality pathology. However, Dutton (2003) critiqued this finding because Gondolf's sample had significant returned social desirability responses on the MCMI-III—double the clinically normed responses (see Millon et al., 1997), which almost certainly minimised the levels of personality pathology. Gondolf's (2004) response to this criticism appealed to the MCMI-III's scoring program—adjusting individual scores for particular levels of modifying index scores—hence the term 'modifying'. However, Gondolf (1999, 2004) overlooked the comments by both Millon et al. (1997) and Choca (2004) that the computerised adjustments are inadequate for final assessment purposes, and that the levels of disclosure, desirability and debasement still need to be taken into account when attempting to interpret the results. In short, the modifying indices on the MCMI-III are a guide, but are not definitive in relation to minimisation or exaggeration of psychopathology.

4.3 Minimising and Exaggerating Psychopathology

Craig (2003) was critical in his meta-analysis of seven studies using the MCMI because he found only one study that specifically reported response patterns. As previously noted, this omission is particularly relevant with male perpetrators of domestic abuse, who are prone to minimise and deny responsibility for such behaviours (Henning et al., 2005; Smith, 2007). This may lead to underestimation of their personality pathology (Smith, 2007). This is something to be explored, rather than assumed, because response biases associated with exaggeration and malingering may have influence, given that these biases are characteristic of some domestically violent men when using self-report instruments (Heinze, 1999). This thesis incorporates research on applying response patterns to the MCMI-III that enable assessment of whether estimates of personality pathology in domestically violent men are confounded by response biases.

If personality pathology is a guide to behaviour, it is feasible that men with predominantly conforming and externalising personality styles (narcissistic, histrionic and compulsive patterns) might be likely to minimise their behaviour and pathology, while others with dependent or borderline personality patterns might exaggerate their psychopathology, since they are often highly anxious and keen to make clear that they are in distress of some kind. Narcissistic/conforming patterns of personality pathology here refer to those men who are not generally antisocial and aggressive, but are still self-absorbed. Millon and Grossman (2007) referred to these men as ‘expressively haughty’ and ‘interpersonally exploitive’ (p. 133). They are men who feel entitled and confident in their ‘admirable self-image’ (Millon & Grossman, 2007, p. 133). They tend to rationalise most contradictions in their experience and are ‘cognitively expansive’—that is, they like to talk about themselves and especially about their ‘immature, and self-glorifying fantasies of success’ (Millon & Grossman, 2007, p. 133). It is not especially difficult to see how or why a man with this type of personality style might minimise his abusive relationship behaviour. It is also easy to see how such a man might minimise his psychopathology, with Millon and Grossman (2007) referring to this man’s intrapsychic level as a ‘spurious organization (... creating an inner world in which conflicts are dismissed, failures are quickly redeemed, and self-pride is effortlessly reasserted’. p. 133). One could readily imagine that, if a man with this kind of

personality organisation perpetrates IPV, it would most likely be in relation to having his pride damaged by an intimate partner, and his admirable self-image seriously endangered or challenged.

In contrast, a man who is being treated for IPV and has a needy/dependent pattern of personality (Millon & Grossman, 2007) is likely to display ‘interpersonally dependent’ and ‘expressively incompetent’ behaviour (p. 57). His self-image is likely to be ‘inept’ or inadequate, desiring to rely on a stronger ‘other’ and often acting helplessly (Millon & Grossman, 2007, p. 57). We might expect such a man to exaggerate his neediness and subsequently score relatively high on the disclosure and debasement scales, but considerably lower on the desirability scale. This could be a ‘fake bad’ profile in an extreme case. Given that dependent people fear being alone and unsupported, they may become uncharacteristically desperate at certain times during close relationships, accounting for suicidal proclivities and ‘clingy’ behaviours that might end in an IPV incident (Millon, 1999).

4.4 MCMI Modifying Indices

Social desirability responses are an important issue when working with men who perpetrate IPV (Heckert & Gondolf, 2000; Jenkins, 1997), and psychometric assessment of these responses is extremely helpful, compared with clinical interview. The MCMI has been revised over time, and the third edition is now equipped with three modifying indices, as well as three validity statements. The modifying disclosure index assesses for openness and, at a higher level, distress versus lack of distress and/or closed response style. The desirability index assesses for levels of thinking well of oneself or portraying oneself in a positive manner (Choca, 2004). The debasement index seeks to measure self-depreciation by a test-taker, and high scores are associated with significant psychopathology. Those who are minimising their psychopathology, either consciously or unconsciously, might be expected to produce an inverted V-shape from their three modifying index scores—namely, low disclosure, high desirability and low debasement. In contrast, if a client is exaggerating his psychopathology, we would expect to see a V-shaped set of modifying index scores—namely, high disclosure, low desirability and

high debasement. Clearly, there may be other combinations of modifying index scores that would match different profiles and presentations.

The current study's use of the MCMI-III followed Daubert and Metzler's (2000) recommendations regarding the use of response bias indices. To this end, it was concluded that it would be important to assess the number of 'fake good' (minimised) and 'fake bad' (exaggerated) profiles, where a disclosure index score above 84 BR points denotes an exaggeration of psychopathology, and a debasement index score less than 36 BR points is regarded a reflection of the minimisation of psychopathology. The exaggerated and minimised profiles were not removed from the profiles procedure because White and Gondolf's (2000) use of the MCMI was deemed to be best practice use of this test's profiling. Only invalid profiles were removed because there are important clinical reasons for retaining minimised or exaggerated profiles. Setting cut-off scores for such profiles are not as predictively accurate as we would like, and screening them out may involve too many false-positive identifications (Schoenberg et al., 2003). Further, minimisation and self-justification are such important factors in domestic violence work, (and possibly the reverse, viz. exaggerating), that these extreme responses are clinically worthy of retention in any analysis (Heckert & Gondolf, 2000). For these reasons, it was also decided to assess response style by dividing the modifying index scores into profiles above and below the clinically significant BR score of 75, so that we could compare the prevalence of significant modifying indices across levels of severity of personality pathology.

In Gondolf's (1999) research sample, in which 51% of the men recorded significant desirability responses on the MCMI-III, it is important to note that there were considerable differences with this variable due to referral status. Fifty-five per cent of court-referred men, yet only 35% of self-referred men, recorded such elevations on the desirability scale of the MCMI. This suggests possible differences in psychopathology for IPV men based on referral status. Gondolf (2002) stated that his 1999 findings indicated that the self-referred men were higher in psychopathology than the court-referred men, although the higher desirability responses may have masked this for the court-referred men (Dutton, 2003; Gibbons et al., 2011). Some research has found indications of higher psychopathology among self-referred men (avoidant, compulsive and borderline MCMI scales; Dutton & Starzomski, 1994), while other research has

suggested the reverse (Dixon & Browne, 2003). Thus, the current research assesses this dimension.

4.5 Abuse Scores

When measuring abuse scores generated from responses on psychometric measures completed by the sample of men and their partners, we were cognisant of the criticisms raised regarding the Conflict Tactics Scale (Dobash et al., 1992; Morse, 1995), which aggregates specific behaviours, rather than assessing the significance of abuse in context. Instead, Shephard and Campbell (1992) chose to develop an Abuse Behavior Inventory (ABI) based on the Duluth Model's Power and Control Wheel, which considers various relational and social behaviours that frame abusive relationships. This ABI is a 30-item self-report inventory developed to capture the frequency of occurrence of different facets of 'power and control' employed by male IPV perpetrators against their partners.

The ABI was chosen as the instrument to measure abuse in the current research due to its range of both physical and psychological abuse behaviours sampled. The ABI includes items such as:

- 'Checked up on you (examples: listened to your phone calls, checked the mileage on your car, called you repeatedly at work)' (psychological item 16)
- 'Called you a name or criticized you' (psychological item 1)
- 'Threatened to hit or throw something at you' (physical item 6)
- 'Choked or strangled you' (physical item 29) (Shepard & Campbell, 1992, p. 304).

This inventory was developed using several samples of known abusive males and their female partners. Their responses were compared with known non-abusive males and their partners. The reliability coefficients for these samples ranged from 0.7 to 0.92 (standard error of the mean = 0.04 to 0.12). The criterion validity assessed through comparative results showed that the scores for abusive relationships were more than 25% higher than those for non-abusive relationships. The construct validity assessed via correlations between the scale and known correlates of abuse (such as other measures of physical and psychological abuse versus age and household size) was deemed

satisfactory for both discriminant and convergent validity measures ($r = 0.5$ for the former and 0.05 for the latter; Shepard & Campbell, 1992). Factor analysis also supported the structural validity of the physical and psychological abuse subscales (Shepard & Campbell, 1992). More recent assessment of the ABI (Zink, Klesges, Levin & Putnam, 2007) with a large-scale sample provided support for its validity and reliability. Another advantage of the ABI for the current study is that it has both male and female forms for comparison checks because male perpetrators are renowned for minimising their reports of abuse.

Placed together, we aimed to determine the relationships between personality patterns, response biases, clinical syndromes and abuse scores. Since IPV is now seen as multifactorial in aetiology, and personality is considered dimensional, rather than categorical, there is important scope for developing Millon's (1999, 2011) contextualisation of psychopathology and its treatment through examining these differential patterns as they manifest in men who perpetrate IPV.

4.6 Other Variables of Interest

When this project first began (in 2003), interpersonal problems for men presenting for IPV treatment were of particular interest, as IPV is relational. Self-compassion and its relationship with empathy was also of considerable interest because various researchers had argued that this personal characteristic was at the core of IPV perpetration (Fonagy, 2004; Stosny, 1993), and enabled positive shifts from fear-inducing control to identification with another's pain (Gilbert, 2009). These variables are described more fully in Chapter 8 as a post-hoc analysis of the validity of the original hypothesis regarding personality patterns and psychopathology.

In summary, interventions for men who perpetrate IPV have suffered from problems regarding the conceptualisation of IPV (Corvo & Johnson, 2013), poor outcomes (Stover et al., 2009) and high attrition rates (Day, Chung, O'Leary & Carson, 2009). Perhaps most importantly, they have failed to adequately account for differences among the men being treated (Dixon & Browne, 2003), so that treatments have not been matched to participant characteristics (Slabber, 2012), but have had a singular focus on

the behaviour in question—usually defined simply as ‘battering’, with its overtones of gross violence (White & Gondolf, 2000). Although the research cited has frequently identified differences among these men (Holtzworth-Munroe et al., 2000) and suggested attending to those differences, both ideological and pragmatic considerations have typically prevented such differential treatments from being applied (Vlais, 2014).

Previous research has identified important differences among men attending IPV programs based on personality pathology (Dutton, 1988; Ehrensaft, Cohen, & Johnson, 2006). While sound research has suggested a multifactorial aetiology for IPV (Slabber, 2012), the above review has highlighted the importance of personality pathology embodying many of those multiple factors at the intrapsychic and interpersonal level. Further, the literature has located the most effective therapeutic interventions and outcomes in the arena of personality patterns being considered in a relational manner (Millon, 2011; Norcross, 2002; Taft, Murphy, King, Musser & De Deyn, 2003; Wexler, 1999) both generally and specifically in work with clients being treated for IPV. It has also been noted that consistent research findings regarding broad differences in types of IPV (Johnson & Ferraro, 2000; Kelly & Johnson, 2008) make singular policies and interventions most likely ineffectual (Miller, 2006), and that different types of IPV are likely to be more commonly associated with different types and severities of personality pathology. Thus, designing assessment and treatment evaluation protocols requires careful consideration of these critical factors to facilitate treatment design and accountability. Measures must be selected that adequately assess personality and related contextual issues. The preliminary work required is a comprehensive profile of IPV perpetrators.

In the current study, with a sample of men entering an IPV treatment program, the study hypotheses are as follows:

1. We hypothesise that we will find a range of personality pathologies, including some severe personality pathologies (Hamberger et al., 1996; Holtzworth-Munroe et al., 2000; Johnson et al., 2006; Saunders, 1996). Study 1 will address this hypothesis.
2. Based on the findings of Dixon and Browne (2003) and Gondolf (1999), we hypothesise that court-referred men will differ in terms of severity of personality

pathology. Study 2 will test this hypothesis and the direction of differences by comparing the MCMI profile scores of court-referred versus self-referred men.

3. We hypothesise higher levels of abusive behaviours to be associated with higher levels of psychopathology. Study 3 will specifically assess this relationship.
4. We hypothesise higher levels of personality pathology to be associated with lower levels of self-compassion and empathy, and higher levels of interpersonal problems. Study 4 will assess the relationship between personality pathology clusters and these other variables.

Studies 1 and 2 will also assess the relationship between personality pathology diversity and response bias via the modifying indices of the men's MCMI profiles.

Chapter 5: Exploring the Breadth and Severity of Personality Pathology in IPV—Study 1

5.1 Introduction

This first study used the MCMI-III to assess the severity and diversity of personality pattern pathology and response bias with a sample of men who were IPV perpetrators being assessed for a treatment program ($N = 181$).² There has been considerable debate about profiling personality pathology when assessing and treating male perpetrators of IPV. Using the interpretive guidelines of White and Gondolf (2000), 54% of profiles in our sample fell into categories indicative of a personality disorder, with 37% of the total sample providing profiles indicative of severe personality pathology. These percentages were higher than White and Gondolf's (1999) findings, but lower than some others. There was also considerable diversity of personality pathology, supporting the contention that there is no one male IPV perpetrator profile. Due to debate concerning the manner of responding on self-report instruments, we devoted special attention to response biases in our sample. Twenty-six per cent of our sample exaggerated (12%) or minimised (14%) their responses. We also found that response biases on the MCMI-III modifying indices were related to self-reported severity of psychopathology. This suggests that assessing the severity of psychopathology is inadequate without reference to such biases. This chapter discusses the importance of these findings for clinical assessment and intervention.

5.2 The Case for Careful Psychometric Profiling

IPV perpetrator programs have generally targeted male participants without reference to their differentiating characteristics (Barnett, Miller-Perrin & Perrin, 1997). However, some researchers have argued that this is unhelpful, since domestic violence perpetrators are not a homogeneous group (e.g. Hamberger et al., 1996; Holtzworth-

² The research in this chapter was published in 2011 in the journal *Psychological Assessment* (volume 23, pages 164 to 173) under the title: 'How Useful are Indices of Personality Pathology When Assessing Domestic Violence Perpetrators?' (Gibbons et al., 2011). It is reprinted here largely as it appears in that publication.

Munroe & Stuart, 1994; Johnson et al., 2006; Saunders, 1996). They have further argued that assumptions about ‘sameness’ prevent operation of an effective treatment program, with consequent waste of resources and endangering of intimates with whom the perpetrator comes into contact (Rosenbaum & Leisring, 2003). Some men are premeditated in their violence, while others are affectively violent (Meloy, 2006). The former are more likely to have antisocial or sadistic personality, while the latter are more likely to display characteristics consistent with BPD (Dutton & Starzomski, 1993; Holtzworth-Munroe et al., 2000; Tweed & Dutton, 1998). Such differences suggest a likely diversity among IPV perpetrators that needs to be considered during intervention programs.

Numerous researchers have argued that assessment of personality pathology is an important basis upon which to tailor interventions to suit different client groups (Benjamin, 1996; Dimaggio et al., 2007; McWilliams, 1994; Millon & Davis, 1996; PDM Task Force, 2006; Reich, 2005; Sperry, 2003). Empirical evidence from IPV treatment studies also supports this view. For example, Saunders (1996) randomly assigned 218 men with a history of partner abuse to either feminist-cognitive-behavioural or process-psychodynamic group treatments, and then assessed the effectiveness of these treatments as a function of personality pathology. Of the 136 participants who completed the program, 79% of their partners gave reports of the men’s behaviour after an average of two years post-treatment. Men with borderline-dependent traits who experienced the psychodynamic treatment had lower recidivism rates than did their counterparts in the cognitive behavioural intervention. In the cognitive behavioural intervention, men with antisocial traits had lower recidivism rates than did men with the same personality pathology who were in the psychodynamic treatment group. These findings suggest that accurate assessment of personality pathology can be of considerable utility in tailoring interventions and improving treatment efficacy for domestically violent men with different personality pathology.

However, there have been discrepant estimates of the prevalence of personality pathology among IPV men. In a mandated group of 56 perpetrators, Flournoy and Wilson (1991) found that 63% showed evidence of personality pathology, as measured by the Minnesota Multiphasic Personality Inventory (MMPI), with 44% exhibiting a 24/42 code type consistent with antisocial personality (Graham, 2000). Hale,

Duckworth, Zimostad and Nicholas (1988) found personality pathology on the MMPI in 85% of a voluntary treatment sample, with clinical elevations of the 24/42 type also prominent. However, Langhinrichsen-Rohling, Huss and Ramsey (2000), who also used the MMPI-2, found personality pathology in only 49% of their community treatment sample. Other studies that have used the MCMI—a popular measure of personality pathology—have found a high proportion of IPV perpetrators exhibit personality pathology. For example, both Hamberger and Hastings (1986) and Johnson et al. (2006) reported that 88% of perpetrators in their samples exhibited significant personality pathology. Similarly, Dutton, Saunders, Starzomski and Bartholomew (1994) found that 79% of court-referred and self-referred perpetrators to an IPV program had a personality disorder when tested with the MCMI-II.

Hence, personality pathology has consistently been found in a substantial proportion of domestically violent men—usually in the order of more than 50%, although estimates of the prevalence of such pathology vary greatly. These variations may stem at least partly from using somewhat diverse methods of defining personality pathology, as well as using different instruments and cut-off scores. Adopting group means when deriving these estimates, rather than employing significantly elevated profile patterns, is another methodological issue that may account for some of this variability. Elevated scales have more clinical importance than mean scores, and were designed as the basis for interpretation on these instruments (Choca, 2004). Combinations of elevated scales on an individual profile also need to be assessed for clinical importance, and not just individual scale elevations (Millon et al., 1997). Further, mean scores are affected by scores that are below significance, which reduces the visibility of clinically elevated profiles. However, many studies examining personality pathology among domestically violent men have failed to interpret their responses in a manner consistent with these clinical considerations (e.g. Beasley & Stoltenberg, 1992; Dutton & Starzomski, 1994; Hamberger et al., 1996).

White and Gondolf (2000) partially addressed these issues when they used the MCMI-III as their primary instrument to assess psychopathology. They adopted a significant profile approach, rather than a group mean score, to cluster male ‘batterers’ into personality pathology groups because they argued that this was how the instrument was intended to be applied. Using this approach, White and Gondolf (2000) found severe

personality disorder in only 15% of their sample, with 9% indicative of paranoid personality disorder, 4% of BPD and 2% of atypical personality disorder. These estimates are considerably lower than previous estimates of personality pathology in IPV men. White and Gondolf (2000) also noted that more than half of the men in their sample had elevated narcissistic tendencies (a score above the clinical median for the psychiatric sample). Thus, they concluded that narcissism was the predominant personality pattern in their sample. Gondolf (1999) also compared percentages of significant personality scales in his total sample of 840 perpetrators with the MCMI-III normative sample of 600 psychiatric patients classified by clinical diagnosis. He observed that, on many of the scales, psychopathology among the IPV men was considerably lower than the psychiatric sample. Based on these findings, Gondolf (1999, 2002) concluded that there is less psychopathology than first thought among domestically violent men. Therefore, he argued that a ‘one size fits all’ approach (or at least ‘most’) is suitable for most participants in IPV treatment programs, with the exception of those with serious psychiatric disorders or psychopathic tendencies. In his opinion, current CBT group treatment approaches are adequate options for intervention.

However, others have been critical of using group CBT programs to treat perpetrators of domestic violence (e.g. Cantos & O’Leary, 2014; Dutton & Corvo, 2006; Gadd, 2004; Taft & Murphy, 2007). Given that only 25% of the MCMI’s clinically normed group had significantly elevated desirability index scores (Millon et al., 1997), Gondolf’s (1999) considerably higher rate suggests that a high percentage of the men in his sample may have minimised their reports of personality pathology. If so, personality pathology is likely to be higher than Gondolf’s (1999) estimates.

In view of the unresolved question of the prevalence of personality pathology among IPV men, the current study examined psychopathology patterns in a group of domestically violent men. The MCMI-III was used to assess the severity and diversity of personality pathology among these men. Like White and Gondolf (2000), we used a focused profile approach to group the sample because this aligns with the MCMI-III’s normal usage (Millon et al., 1997) and permits assessment of personality pathology across the scope of the instrument. In doing so, we considered personality pathology more broadly than singular categories such as antisocial or borderline personality characteristics, as has been the case in some other research of IPV men (e.g.

Holtzworth-Munroe & Stuart, 1994). In addition, we avoided a narrow focus on abusive or narcissistic personalities (see Dutton, 2006; White & Gondolf, 2000).

This study also evaluated the importance of response bias in measuring personality pathology among domestically violent men. Chapter 4 discussed the importance of devoting particular attention to response bias. In doing so, we were able to ascertain whether estimates of personality pathology among domestically violent men are confounded by such response biases. In summary, this study addressed some issues that remain outstanding in this field of research, especially in relation to the use of detailed case profiling that assesses interpretation of clinical Base Rates, and response bias.

5.3 Method

5.3.1 Participants

Participants were 181 men who were either self-referred ($n = 115$) or court-referred ($n = 66$) to complete an IPV group intervention program between 2003 to 2007 at a social service agency (Anglicare WA) in Perth, Western Australia. The mean age of this group was 37.8 years (standard deviation [SD] 9.2), with ages ranging from 18 to 64 years. All participants were assessed prior to commencing the 18-week group program, which entailed a composite psychoeducational/CBT type intervention, although Stosny's (1995) HEALS treatment technique which was at the core of the intervention is a psychodynamic treatment.

The court-referred men came to the agency for assessment via the Department of Corrective Services, and were monitored by a Community Corrections Officer (CCO) during the program. Self-referred clients generally presented for 'anger management' (the clients' term), and were frequently encouraged to attend the program by female partners, relatives, friends and community workers, such as general practitioners.

All men were initially given several assessment and preparation sessions prior to induction into the group program, with four sessions for self-referred men and two sessions for court-referred men. The difference in the number of induction sessions related to the costing measures of the Department of Corrective Services in their

contract with the agency (Anglicare WA). During these assessment sessions, the clients completed the measures for the current research project. Wherever possible, information was obtained from the men to contact their female partners in order to assess the women's safety on an ongoing basis.

A small percentage of men were screened out due to severe drug and alcohol abuse, severe mental health disorders (such as psychosis) and intense suicidal ideation that prevented them having sufficient stability to function in a group setting. These men were referred elsewhere.

5.3.2 Measures

Following the acquisition of demographic data, all men entering the IPV group program completed the MCMI-III (Millon et al., 1997). This instrument was selected because its various editions have been widely used to assess psychopathology in men attending domestic violence treatment programs (Hamberger & Hastings, 1986; Johnson et al., 2006; White & Gondolf, 2000). Other information pertaining to the MCMI-III was given in Chapter 4 and will not be repeated here.

5.3.3 Analysis Strategy

All profiles were interpreted in accordance with Millon's system of Base Rate (BR) scores (further explication of this approach is found in Chapter 4). As advocated by both Millon et al. (1997) and Choca (2004), this study undertook profile analysis for the sample, based on the interpretation of two- or three-point high personality patterns. Significant elevations are considered the strongest aspect of the individual's personality style or personality disorder (Choca, 2004). These profiles were grouped based on the severity of personality dysfunction, following White and Gondolf (2000). First, profiles with significantly elevated severe personality pattern scores on the schizotypal, borderline or paranoid scales were placed into the level of severe personality dysfunction. The remaining profiles were grouped based on their elevations on the basic clinical personality patterns (schizoid, avoidant, depressive, dependent, histrionic, narcissistic, antisocial, aggressive, compulsive, passive-aggressive and self-defeating scales). Men with scale scores above BR 84 on any of these scales were assigned to a

moderate personality dysfunction level (denoting a personality disorder other than the three severe disorders). Men with all scales below BR 85 were assigned to a low personality dysfunction level. However, as scores above BR 74 on the basic personality scales are regarded by Millon et al. (1997) as ‘clinically significant personality traits’ (p. 120), we split the low personality dysfunction level into profiles above BR 74 (trait personality patterns) and below BR 74 (sub-trait personality patterns). Consistent with guidelines on interpreting profiles (see Millon et al., 1997) any profile with elevations between BR 61 and BR 74 was relegated to the sub-trait personality level, while profiles without any personality pattern elevations above BR 60 were treated as uninterpretable. Finally, we computed the proportion of significantly elevated ($BR \geq 75$) MCMI-III Axis I clinical syndromes (anxiety, dysthymia, major depression and so forth) falling within each of the personality pathology levels (severe, moderate, trait and sub-trait levels).

Finally, we formulated personality pattern characteristics within levels of severity of personality pathology based on the typical interpersonal behaviour associated with three subtypes:

1. antisocial/aggressive
2. passive/withdrawn/dependent (schizoid, avoidant, dependent and depressive characteristics)
3. narcissistic/conforming (histrionic, narcissistic and compulsive scale elevations), as long as neither of the other two types were present.

Any case profile that failed to match these three interpretive subtypes was relegated an ‘atypical’ status. This grouping of data within levels of personality pathology severity is similar to White and Gondolf’s (2000) approach, with the exception that they grouped cases only on the basis of Millon’s personality patterns that are matched by personality types listed in the DSM-IV, whereas we included all personality scale types on the MCMI-III.

Consistent with Daubert and Metzler’s (2000) recommendations, we also carefully examined the response bias indices. To this end, we counted the number of ‘fake good’ (minimised) and ‘fake bad’ (exaggerated) profiles, where a disclosure index score above 84 BR points denoted an exaggeration of psychopathology, and a debasement index score of less than 36 BR points was regarded as a reflection of the minimisation of psychopathology. The ‘exaggerated’ and ‘minimised’ profiles were not removed from

the profiles procedure because in White and Gondolf's (2000) research, only 'invalid' profiles were removed, not minimised or exaggerated profiles, as there are important clinical reasons for leaving them in. As mentioned in Chapter 4, minimisation and self-justification are such important factors in domestic violence work, and possibly exaggeration as well, that these extreme responses are clinically worthy of retention in any analysis (Heckert & Gondolf, 2000). We also assessed response style by dividing modifying indices scores into profiles above and below the clinically significant BR score of 75 and above, and compared the prevalence of significant modifying indices across severity levels of personality pathology.

SPSS crosstabs two-by-two chi-square was used for statistical comparisons. Frequency of personality pathology and clinical syndrome scales above or below the BR cut-off scores were the dependent variables, and the different levels of personality pathology were the independent variables. Where expected cell counts were less than five, we used Fisher's Exact Test for significance comparisons.

As a further cross check on response bias, we also compared mean modifying index continuous scores across levels of severity of personality pathology, since Daubert and Metzler (2000) regarded the MCMI modifying indices as 'bimodal indicators of faking' (p. 22). That is, while high disclosure and debasement scores are indicative of 'fake bad' (exaggerated) responding, low scores on these scales are indicative of 'fake good' (minimised) responding. Further, a high desirability score is indicative of 'fake good' responding, while a low score is indicative of 'fake bad' responding. Non-parametric independent samples tests were used on these scores as the modifying index scores were not all normally distributed.

5.4 Results

Four profiles that were invalid according to the MCMI-III manual scoring system were eliminated from the analysis (profiles with disclosure scores above a raw score of 178 or below a raw score of 34; see Millon et al., 1997). The remaining 177 MCMI-III personality pattern scales and profiles were statistically analysed.

5.4.1 Clinically Significant Scales

Table 2 presents the relative percentages of men in our sample with clinically significant MCMI-III scales. For comparison, we included the corresponding percentages in Gondolf's sample (1999) and the Millon Psychiatric Test sample ($N = 600$; Millon, 1994). As can be seen in Table 2, relative to the corresponding psychiatric sample diagnoses, our sample had higher rates of significant avoidant, antisocial, aggressive and passive-aggressive personality patterns, as well as significant alcohol dependence and drug dependence clinical syndromes, and equivalent rates to the psychiatric sample on significant schizoid, depressive and borderline personality patterns, as well as significant anxiety, dysthymia and post-traumatic stress disorder (PTSD) clinical syndromes. In contrast, on most scales, our sample had a higher proportion of clinically significant personality patterns and clinical syndrome rates than did Gondolf's (1999) sample, with the exception of narcissistic and compulsive personality patterns.

Table 2: Percentages of Significant Scales (BR > 74) on the MCMI-III—Three Samples

Personality patterns and clinical syndromes	Gondolf (1999) ($n = 840$)	Millon clinical ($n = 600$)	Our sample ($n = 177$)
Axis II clinical personality patterns	Schizoid	15	19
	Avoidant	17	27
	Depressive	19	36
	Dependent	17	48
	Histrionic	5	21
	Narcissistic	25	21
	Antisocial	19	17
	Aggressive	9	4
	Compulsive	10	21
	Passive-aggressive	24	27
	Self-defeating	10	30
	Schizotypal	3	13
	Borderline	7	28
	Paranoid	10	13
Axis I clinical syndromes	Anxiety	39	62
	Somatoform	1	16
	Bipolar-manic	-	-
	Dysthymia	13	36
	Alcohol dependence	26	12
	Drug dependence	7	8
	PTSD	4	9
	Thought disorder	4	9
	Major depression	11	22
Delusional disorder	5	3	

Gondolf (2002) reported that more than half of the men in his sample displayed above-average scores ($BR \geq 60$) on the narcissistic personality scale. This was not the case in the current study. However, we found numerous other elevations. We had reservations about Gondolf's use of $BR \geq 60$ as the cut-off, since BR 60 is simply the median score for the profile in a psychiatric population (Choca, 2004). Millon et al. (1997) regarded scores in the sixties on some scales as indicative of psychological health—particularly the histrionic, narcissistic and compulsive scales, which they described as 'curvilinear in shape' (p. 125). In our study, only 27% of men had elevations above the clinical median ($BR > 60$) on the narcissism scale, while more than 50% scored above the median on the schizoid, avoidant, depressive, dependent, antisocial, aggressive, passive-aggressive, self-defeating, schizotypal, borderline and paranoid scales. Hence, narcissistic personality profiles were not the predominant pattern in our sample; rather, the trend was towards a much more diverse presentation of personality pathology.

We also grouped the men in our sample on the basis of their Millon profiles. As seen in Table 3, 54% of all participants in our sample had significant severe (37%) or moderate (17%) personality pathology elevations. According to the Millon system, such elevations are indicative of a personality disorder. Of the 37% whose responses fell into the level indicative of severe personality pathology, the majority (71%) reported borderline personality as their predominant pattern, while 9% reported a schizotypal personality, 14% reported a paranoid personality, and 6% reported atypical mixtures of these three severe pathological patterns.

Of the 17% of the total sample who fell into the moderate personality pathology level, 43% of these profiles were characterised by histrionic, narcissistic or compulsive personality disorders (i.e. $BR > 84$). The remainder of the moderate personality pathology level were split into withdrawn/dependent personality disorders with no aggressive component (20%) and antisocial/aggressive personality disorders (37%).

Thirty per cent of the sample gave responses consistent with trait personality pathology, which is defined as having at least one personality scale between BR 75 and BR 84 (excluding the schizotypal, borderline and paranoid scales). Just over half of the men in the trait personality group (51%) had profiles that were predominantly withdrawn/dependent personality patterns, and approximately one third (34%) had

profiles that were predominantly antisocial/aggressive personality patterns. There were only small numbers of narcissistic/conforming and atypical cases at this level.

The sub-trait level of personality pathology comprised the final 16% of the total sample. All except one of the 29 men in this group reported at least one personality pattern score above the clinical median of 60 BR points, and below 75 BR points. This sub-trait level group consisted of even numbers of antisocial/aggressive patterns (31%) and histrionic/narcissistic/compulsive personality patterns (31%). A further 21% exhibited withdrawn/depressive patterns, and the remainder were atypical.

Overall, a significantly higher proportion of antisocial/aggressive style profiles were found at the severe personality level than at the other three levels of personality pathology ($\chi^2 = 29.22$ [$N = 177$], $df3$, $p < 0.001$). These were in conjunction with at least one of the severe personality pattern scales. In contrast, withdrawn/depressive/dependent personality profiles were significantly more likely to be found at the trait personality pathology level than at the other three levels (51%; $\chi^2 = 15.01$ [$N = 177$], $df3$, $p < 0.01$). Histrionic/narcissistic/compulsive styles of personality profiles were significantly more likely to be found in the moderate personality pathology and sub-trait personality levels than at the trait level of personality function (43%, $\chi^2 = 12.96$ [$n = 112$], $df1$, $p < 0.001$ and 31%, $\chi^2 = 6.18$ [$n = 112$], $df1$, $p < 0.05$, respectively, versus 9% at the trait level), but did not significantly differ between the moderate and sub-trait levels. Thus, both diverse levels of severity and type of profile were evident.

Table 3: Percentages of Personality Pathology Profiles by Severity Level
(*N* in Brackets)

Personality level	Personality description (within levels)	Significant clinical syndromes (within levels)	Totals
Severe Millon personality pathology level (> BR 74)	1. Borderline disorder—71 (46) 2. Paranoid disorder—14 (9) 3. Schizotypal disorder—9 (6) 4. Atypical/mixed disorders—6 (4)	1. Anxiety—89 (58) ^a 2. Dysthymia—66 (43) ^a 3. Alcohol dependence—59 (38) ^a 4. Drug dependence—28 (18) ^a 5. PTSD—19 (12) ^a 6. Thought disorder—12 (8) ^a 7. Major depression—26 (17) ^a	37 (65)
Moderate Millon personality pathology level (> BR 84)	1. Histrionic, narcissistic and compulsive disorders—43 (13) 2. Withdrawn type (avoidant, depressive disorders)—20 (6) 3. Aggressive, antisocial disorders—37 (11) 4. Atypical disorders—0	1. Anxiety—43 (13) ^b 2. Dysthymia—27 (8) ^b 3. Alcohol dependence—40 (12) ^{ab} 4. Drug dependence—17 (5) ^{ab} 5. PTSD—7 (2) ^{ab} 6. Thought disorder—0 (0) ^b 7. Major depression—3 (1) ^b	17 (30)
Low Millon personality pathology level trait (moderate patterns < BR 85 and > BR 74)	1. Withdrawn type (avoidant, depressive pattern)—51 (27) 2. Aggressive, antisocial pattern—34 (18) 3. Histrionic, narcissistic and compulsive pattern—9 (5) 4. Atypical—6 (3)	1. Anxiety—53 (28) ^b 2. Dysthymia—25 (13) ^b 3. Alcohol dependence—26 (14) ^b 4. Drug dependence—4 (2) ^{bc} 5. PTSD—2 (1) ^b 6. Thought disorder—0 (0) ^b 7. Major depression—0 (0) ^b	30 (53)
Low Millon personality pathology level sub-trait (moderate patterns < BR 75)	1. Withdrawn type (avoidant, depressive pattern)—21 (6) 2. Aggressive, antisocial pattern—31 (9) 3. Histrionic, narcissistic and compulsive pattern—31 (9) 4. Atypical—14 (4)	1. Anxiety—17 (5) ^c 2. Dysthymia—3 (1) ^c 3. Alcohol dependence—17 (5) ^b 4. Drug dependence—0 (0) ^c 5. PTSD—0 (0) ^b 6. Thought disorder—0 (0) ^b 7. Major depression—0 (0) ^b	16 (29)
			100 (177)

Superscript: a > b > c = significant difference at $p < 0.05$; same letter = no significant difference.

Chi-square analysis also showed that the frequency of significant Axis I clinical syndromes was highest for the men in the severe personality pathology level and lowest for the men in the sub-trait personality pathology level (Table 3). Relative to the other three levels, the men in the severe level had profiles reflecting the highest rates above BR 74 of reported anxiety ($\chi^2 = 49.25$ [$N = 177$], $df3$, $p < 0.001$), dysthymia ($\chi^2 = 42.74$ [$N = 177$], $df3$, $p < 0.001$), thought disorder ($\chi^2 = 14.48$ [$N = 177$], $df3$, $p < 0.01$) and major depression syndromes ($\chi^2 = 29.00$ [$N = 177$], $df3$, $p < 0.001$). There was no difference between the proportion of significant Axis I clinical syndromes in the profiles of men falling into the moderate and trait personality levels. The men in the sub-trait personality pathology level produced fewer cases of significantly elevated anxiety ($\chi^2 = 47.02$ [$N = 177$], $df1$, $p < 0.001$; $\chi^2 = 4.74$ [$N = 177$], $df1$, $p < 0.05$; and $\chi^2 = 9.87$ [$N = 177$], $df1$, $p < 0.01$) and dysthymia syndromes ($\chi^2 = 31.67$ [$N = 177$], $df1$, $p < 0.001$; χ^2

= 6.15 [$N = 177$], $df1$, $p < 0.05$; and $\chi^2 = 5.88$ [$N = 177$], $df1$, $p < 0.05$) relative to levels one, two and three of personality pathology severity. The severe and sub-trait personality pathology levels were clearly differentiated in terms of the rates of significant clinical syndromes. Only the sub-trait level of profile severity appeared to be relatively free from psychopathology.

5.4.2 Response Style

We then looked at the response style of this group of IPV perpetrators, using the MCMI-III modifying indices of disclosure, desirability and debasement. Our total valid sample ($N = 177$) produced 43 profiles (24%) above BR 74 on the desirability index, which is almost exactly what the MCMI-III manual (Millon et al., 1997) specified for its clinical population. Significant disclosure and debasement scores were evident in 25% and 18% of our sample, respectively. Thus, our sample disclosed socially desirable responding at about the same rate as Millon et al.'s (1997) psychiatric sample, but was self-depreciating at a slightly lower rate. Overall, 24 profiles (13% of the sample) reflected minimised responses according to Daubert and Metzler's (2000) criterion, and 21 (12%) produced exaggerated profiles. As can be seen in Table 4, exaggerated profiles in our sample were more likely to occur in the severe personality pathology level ($\chi^2 = 26.71$ [$N = 177$], $df3$, $p < 0.001$). There was also a significant difference in the distribution of minimised profiles ($\chi^2 = 35.38$ [$N = 177$], $df3$, $p < 0.001$), with most being found in the moderate and sub-trait levels of personality pathology, which were not significantly different from one another ($\chi^2 = 1.42$ [$N = 59$], $df1$, $p = 0.23$).

Table 4: Percentages of 'Exaggerated' and 'Minimised' Profiles as a Function of Level of Personality Pathology Severity (N in Brackets)

	Severe personality pathology	Moderate personality pathology	Trait personality pathology	Sub-trait personality	Total in sample
Exaggerated	28 (18) ^a	10 (3) ^b	0 (0) ^c	0 (0) ^{bc}	12 (21)
Minimised	0 (0) ^c	27 (8) ^a	8 (4) ^b	41 (12) ^a	14 (24)
Total	10 (18)	6 (11)	2 (4)	7 (12)	26 (45)

Superscript: a > b > c = significant difference at $p < 0.05$; same letter = no significant difference.

Table 5 displays the percentage prevalence of elevated modifying indices in each of the four levels of personality pathology after applying the $BR > 74$ criterion. In our sample, level of personality pathology was clearly associated with response patterns on the modifying indices. Relative to the other three levels, the men in the severe personality pathology level had the highest proportion of elevated disclosure scores ($\chi^2 = 10.16$ [$N = 177$], $df1, p < 0.01$; $\chi^2 = 45.70$ [$N = 177$], $df1, p < 0.001$; and $\chi^2 = 28.46$ [$N = 177$], $df1, p < 0.001$) and debasement scores ($\chi^2 = 8.13$ [$N = 177$], $df1, p < 0.01$; $\chi^2 = 29.93$ [$N = 177$], $df1, p < 0.001$; and $\chi^2 = 17.79$ [$N = 177$], $df1, p < 0.001$), as well as the lowest rate of elevated desirability scores ($\chi^2 = 14.58$ [$N = 177$], $df1, p < 0.001$; $\chi^2 = 8.81$ [$N = 177$], $df1, p < 0.01$; and $\chi^2 = 12.98$ [$N = 177$], $df1, p < 0.001$). Conversely, relative to the severe and moderate levels, the trait and sub-trait levels of personality pathology had significantly lower rates of elevated disclosure ($\chi^2 = 13.51$ [$N = 177$], $df1, p < 0.001$ and $\chi^2 = 7.68$ [$N = 177$], $df1, p < 0.05$). Rates of debasement scores above BR 74 were lower for the trait level ($\chi^2 = 7.42$ [$N = 177$], $df1, p < 0.05$) with the sub-trait level being marginally lower ($\chi^2 = 4.15$ [$N = 177$], $df1, p = 0.06$) in relation to the other clusters.

Table 5: Percentages of MCMI-III Profiles with Modifying Indices above BR 74 as a Function of Level of Personality Pathology Severity (N in Brackets)

	Disclosure	Desirability	Debasement
Severe ($n = 65$)	59 (38) ^a	8 (5) ^b	43 (28) ^a
Moderate ($n = 30$)	23 (7) ^b	40 (12) ^a	13 (4) ^b
Trait ($n = 53$)	0 (0) ^c	28 (15) ^a	0 (0) ^c
Sub-trait ($n = 29$)	0 (0) ^c	38 (11) ^a	0 (0) ^{bc}
Total	25 (25)	24 (43)	18 (32)
χ^2	65.44	17.16	45.98
P	< .001	< .01	< .001
MCMI-III: Normative sample ($N = 998$)	28	26	31

Superscript: a > b > c = significant difference at $p < 0.05$; same letter = no significant difference.

The moderate personality pathology level had intermediate levels of elevated disclosure and debasement relative to the severe, trait and sub-trait personality pathology levels. These results clearly illustrate associations between the type of response bias and the profiles of self-reported psychopathology among these men. This was confirmed further by comparing the mean scores of the modifying indices across levels of personality pathology severity (Table 6).

Table 6: Means and SDs of MCMI-III Modifying Indices as a Function of Level of Personality Pathology Severity

	Disclosure	Desirability	Debasement
Severe (<i>n</i> = 65)	78.03 (13.20) ^a	49.45 (20.44) ^b	73.85 (10.22) ^a
Moderate (<i>n</i> = 30)	59.40 (18.93) ^b	66.80 (20.75) ^a	48.97 (26.26) ^b
Trait (<i>n</i> = 53)	55.15 (7.51) ^b	66.47 (14.69) ^a	53.38 (10.62) ^b
Sub-trait (<i>n</i> = 29)	35.97 (12.64) ^c	71.38 (12.11) ^a	36.24 (21.19) ^c
Total	61.13 (19.64)	61.08 (19.79)	57.34 (21.14)

Superscript: a > b > c = significant difference at $p < 0.05$; same letter = non-significant.

5.5 Discussion

Our findings indicate that the prevalence of reported personality pathology among the IPV men in our sample was higher than that reported in Gondolf (1999), White and Gondolf (2000) and Langhinrichsen-Rohling et al.'s (2000) samples, yet lower than the rates of personality pathology reported in other studies using the MCMI (e.g. Dutton & Starzomski, 1993; Hamberger & Hastings, 1986; Johnson et al., 2006) and several studies employing the MMPI-2 (Hale et al., 1988; Flournoy & Wilson, 1991). However, in our sample, the prevalence of significant personality pathology and significant clinical syndromes was more consonant with the prevalence of pathology diagnosed in the Millon psychiatric normative sample. We believe the discrepancies in the percentages of personality pathology across the studies reviewed here may be explained by two factors. First, studies that reported very high percentages may have been affected by the use of instruments that over-report personality disorders (Choca, 2004) and the use of group mean scores, rather than elevated profiles (Hamberger & Hastings, 1986; Johnson et al., 2006). Mean scores in the research just cited were typically lower than BR 75 on the MCMI-III, which is not the recommended cut-off for personality pathology, thereby inflating percentages of personality pathology. Second, lower percentages—such as in Gondolf's (1999) research—suffered from high social desirability responses, which probably reflected suppressed personality pathology findings (Dutton, 2003).

Regarding severity, 37% of men in our sample reported severe personality pathology, mostly of the borderline type. Three quarters of the severe personality level also had significant elevations on antisocial, aggressive and passive-aggressive personality patterns, reflecting a comorbid personality disorder, which, according to some researchers, is not uncommon (Clarkin, 2008; Livesley, 2008). This group with severe

levels of personality pathology also scored the highest percentages on a number of Axis I clinical syndrome scales, thereby suggesting they are an important, yet difficult, group with which to work in treatment programs. Hence the ‘one size fits all’ CBT group treatment approach may be inadequate, as argued by Saunders (1996) and others (Dutton & Corvo, 2006; Gadd, 2004; Stosny, 1995).

A further 17% of the overall sample—the moderate level of severity—reported profiles consistent with less severe, but quite diverse, personality disorders: histrionic, narcissistic and compulsive; antisocial, aggressive and passive-aggressive; and schizoid, avoidant, depressive, dependent and self-defeating personality patterns. Our study’s findings support the contention of Dutton (2006) and Craig (2003) that such a diversity of personality disorders in intervention groups increases the demand for facilitation of effective assessment and treatment.

While the remaining 46% of our sample did not report personality pathology consistent with a disorder, our subdivision of the low pathology level into trait and sub-trait levels of severity indicated that another 30% of the overall sample exhibited the presence of clinically important personality pattern characteristics. As Saunders (1996) indicated, the presence of even a predominant characteristic personality pattern will interact with IPV issues to affect the way treatment is received. Therefore, knowledge of the diversity of different personality pattern presentations will be important to guide treatment approaches for the large majority of male IPV perpetrators (Choca, 2004).

The findings of the current study also show that there is considerable diversity of personality pathology among male IPV perpetrators. While the focus in previous research has been on antisocial/aggressive and borderline personality pathology (Dutton et al., 1994; Hamberger et al., 1996; Holtzworth-Munroe et al., 2000), we note again that these studies used group mean scores from the MCMI, rather than individual profile analysis. Although we also found many antisocial/aggressive profiles in our sample, in the severe level of MCMI pathology, they were combined with borderline and paranoid personality disorders. However, antisocial/aggressive profiles were distributed right across the different levels of personality pathology severity. Further, at the moderate, trait and sub-trait levels of personality pathology, they were matched by narcissistic/histrionic/compulsive patterns and withdrawn/depressive/dependent

patterns. This supports the meta-analytic assessment of Craig (2003) that there is no one MCMI 'abuse profile'—male IPV perpetrators are a diverse group in terms of personality pathology. Like Craig, we found men in our sample who ranged from highly distressed and making no attempt to conceal this, to men who significantly minimised their responses to the personality pathology self-report.

We also found response bias to be a very important consideration in assessing the prevalence of personality pathology, since this may skew prevalence estimates of this dimension of male IPV perpetrators (Daubert & Metzler, 2000). In our sample, the overall rates of significant disclosure, desirability and debasement scores were close to the figures for Millon's et al.'s (1997) clinical sample. This suggests that our sample was not over-represented by men with response patterns associated with either minimisation or exaggeration of personality pathology. This gives us more confidence in concluding that, when assessed according to the Millon criteria, a reasonably accurate picture of personality pathology may be established prior to interventions, and used to inform interventions. In the current study, we also considered scores on the MCMI-III modifying indices more generally when evaluating the prevalence of psychopathology in our sample (Daubert & Metzler, 2000). It is inadequate to suggest that personality pathology is low simply because it has been self-reported to be low.

While, overall, our results showed rates of elevated modifying indices to be consistent with the mean scores for the Millon psychiatric sample (Table 4), the men in the severe personality pathology group had the highest proportion of significant disclosure and debasement scores, and the lowest percentage of significant desirability scores, relative to the lower levels of personality pathology. According to practitioners in the field (e.g. Dutton, 2006; Stosny, 1995; Taft & Murphy, 2007), severe personality-disordered IPV men are likely to be the most distressed and reactive. In contrast, the group with the lowest personality pathology, the sub-trait level, displayed the lowest mean percentage of disclosure and debasement scores, compared with the other three levels of personality pathology, and 41% of these men had minimised profiles. This suggests that the men in this sample who gave responses classified in the lowest level of severity in personality pathology may have either consciously or unconsciously denied their pathology (see Choca, 2004; Smith, 2007). Moderate and trait levels of personality pathology were similar, with both having rates of significant modifying index scores close to the

percentages found in the MCMI-III clinical sample (see Table 4) and no significant differences between the two levels. This might suggest that the moderate and trait levels of personality pathology are relatively reliable reports—free from exaggerated and minimised responses. However, this was actually true of the trait level because the moderate level showed greater variance on the modifying indices, since it incorporated both exaggerated and minimised profiles, which counterbalanced response bias.

To summarise the response bias findings: the modifying index scores showed that the moderate and trait level groups generally self-reported a reasonable reflection of their personality pathology, with the proviso that the moderate personality pathology level had a greater diversity of profiles, as explained above. The severe level of personality pathology needs to be treated with more caution due to the higher levels of distress and exaggerated responses. However, even though some of these men may have over-reported distress, underlying psychopathology is quite likely (Choca, 2004). The sub-trait level should also be treated with caution since membership to this group entails having no significant personality scale elevations and, as Choca (2004) highlighted, ‘most individuals taking the MCMI will have an elevation in at least one of the personality scales’ (p. 100). Since this IPV sample scored more like a psychiatric sample than a normal sample, it is highly unlikely that participants would register no personality scale elevations without minimising their psychopathology. Thus, these men would require considerable therapeutic work to disarm their defences against being aware of and taking responsibility for their abusive behaviour (Smith, 2007).

5.6 Study Limitations

While the use of a single self-report measure was a limitation of this study (despite being a very comprehensive and psychometrically established measure), we have shown that a profile approach can effectively illuminate the differences of severity level and type of personality pathology, alongside checking how exaggerated or minimised those responses may be. Other research has been based on population samples (Holtzworth-Munroe et al., 2000); men actually convicted of an IPV offence (Johnson et al., 2006); men already in a treatment program (Beasley & Stoltenberg, 1992); and men mandated for treatment, but yet to commence (Hamberger et al., 1996). These may differ in some

respects from our sample, which was comprised of men being assessed at the point of entry to an IPV treatment program. Further, our sample was a mixture of self-referred and court-referred men, and we recognise that there may be differences between these two groups that will require further elucidation.

5.7 Concluding Remarks

In conclusion, for a male IPV sample, this study found levels of personality pathology higher than those suggested by Gondolf (2002). The prevalence rate was intermediate between Gondolf's research and much other research of personality pathology (e.g. Dutton & Starzomski, 1994; Johnson et al., 2006), with 54% of our participants producing personality profiles indicative of disordered personality. This study also demonstrated that there was considerable diversity of personality pathology among the IPV men, especially when the modifying indices were used with a careful assessment of the effects of response biases to control against over- and under-reporting. This study supports the view that careful individual profile assessment needs to be employed in groups of domestically violent men in order to tailor treatments that will more effectively target differing personality pathologies to ensure optimal outcomes.

Chapter 6: Comparing Self- and Court-referred Men with IPV on Personality Pathology and Response Bias—Study 2

6.1 Introduction

In Study 1 (Gibbons et al., 2011), we found that 54% of a mixed group of male IPV perpetrators had MCMI-III profiles indicative of a personality disorder when applying White and Gondolf's (2000) criteria. The diversity of personality pathology in this group of men was considerable. This is important to consider in developing treatment options, if different personality pathologies warrant different treatment approaches, as Millon (1999) and others have argued (e.g. Benjamin, 2003; McWilliams, 1994). Indeed, our 2011 Study 1 findings suggest that treatment interventions for male IPV perpetrators may need to be more diverse and flexible. The findings also raise questions about the homogeneity of court-referred and self-referred perpetrators on personality pathology dimensions. If the referral route brings men with different personality pathologies and problems, then differently tailored interventions may be warranted.

Personality pathology has been of interest in research with IPV men for some years (Hamberger & Hastings, 1986; Hart et al., 1993; Holtzworth-Munroe et al., 2000); however, it remains unclear whether there are personality pathology differences between men who are court-referred (mandated to attend a program in relation to domestic violence) or self-referred. Studies of male IPV perpetration have often used population samples (Holtzworth-Munroe et al., 2000; Waltz, Babcock, Jacobson & Gottmann, 2000) or exclusively court-referred samples (Feder & Wilson, 2005; Hamberger et al., 1996). This means that men in perpetrator treatment groups are often treated as homogeneous, even though some participants have not joined these groups through the criminal justice system (Gondolf, 1999; Rosenbaum & Leisring, 2003).

The little research that has compared the personality pathology of court-referred and self-referred male perpetrators of IPV has suggested that there may be some important differences between these two groups (Dutton & Starzomski, 1994; Gondolf, 1999). For example, in a meta-review, Dixon and Browne (2003) compared typological groupings

across studies using the popular Holtzworth-Munroe and Stuart (1994) three-category typology. This typology found that around 50% of IPV perpetrators in a population sample had low or little personality pathology, low levels of domestic violence, and no use of violence outside the home (Holtzworth-Munroe et al., 2000). They called these perpetrators the ‘family-only’ abuser group. The other 50% of men fell into equal groups—one of which they called the ‘borderline-dysphoric’ group because that reflected their psychopathology. This group had much more severe levels of domestic violence, but little or no general violence. The last group was called the ‘generally-violent-antisocial’ group, as the participants exhibited serious levels of IPV and general instrumental violence, alongside antisocial personality pathology. Dixon and Browne (2003) found that there were less court-referred men in the family-only abuser group, and suggested, based on their findings, that self-referred men were probably less pathological as a group than men who were court-referred for treatment of IPV.

However, the largest study to compare court-referred and self-referred IPV perpetrators on personality pathology scales did not support Dixon and Browne’s (2003) proposition. Gondolf’s (1999) multisite study in the US assessed more than 800 perpetrators (679 court-referred and 149 self-referred men) using the MCMI-III, and generally found higher levels of personality pathology among self-referred perpetrators. In this study, self-referred men reported significantly higher percentages of clinical elevations on passive-aggressive, antisocial, depressive, aggressive and borderline personality scales than did the court-referred men. In contrast, the court-referred men reported significantly higher percentages of clinical elevations on the narcissistic and compulsive personality scales. This would suggest that self-referred and court-referred men’s personality pathology is distinctly different, with self-referred men exhibiting greater distress and generally more serious pathology, such as borderline personality organisation and major depression.

As aforementioned, before drawing such conclusions on the relative personality pathology in self-referred and court-referred perpetrators, it is important to consider the response bias in Gondolf’s (1999) participant sample, which may at least partly account for the differences. As Dutton (2003) argued, Gondolf’s finding of ‘lower than expected’ personality pathology among domestically violent men may reflect differences in response bias on the MCMI-III because more of the court-referred men

had clinical elevations on the desirability index than did their self-referred counterparts (55% v. 35%). In addition, significantly more elevations on the narcissistic and compulsive personality scales were present in Gondolf's court-referred group than in the self-referred group. Elevations on the desirability index of the MCMI and narcissistic and compulsive personality scales are associated with denial or minimisation of problems (Choca, 2004). In other words, closer perusal of response bias indicates that the court-referred men in Gondolf's sample were significantly more likely to portray themselves in a positive light and minimise their problem behaviours, thereby minimising their personality pathology in comparison to the self-referred men. Hence, to ascertain whether there are differences in the personality pathology of self-referred and court-referred perpetrators, response bias must be considered, particularly because this also has implications for treatment.

Further, in exploring personality pathology among court-referred and self-referred IPV men, it would be helpful to consider personality pathology more broadly than the three categories used by Holtzworth-Munroe and Stuart (1994), which restricted their assessment to antisocial and borderline personality—the family-only group having little significant personality pathology of the antisocial or borderline type. Indeed, Dutton and Starzomski (1994) took a broader scope in a study that compared court- and self-referred 'wife assaulters' on a range of psychological variables. On the MCMI-II, 40 self-referred men entering an IPV program in Canada produced significantly higher mean scores on avoidant, compulsive, self-defeating and borderline personality scales, and anxiety, dysthymia and major depression clinical syndromes than did 40 matched court-referred men. Thus, Dutton and Starzomski (1994) argued that the self-referred men were more distressed overall than the court-referred men. They suggested that this distress is an important motivator for attending treatment, and might be related to saving their relationship—in contrast to the court-referred IPV men, who were compelled to attend treatment. Consistent with this argument, they noted that the self-referred men had significantly higher debasement scores on the MCMI, which is indicative of self-depreciation, distress and a cry for help.

Hence, the aim of the current study—an extension of the earlier study described in Chapter 5—was to compare psychopathology patterns in a mixed group of self-referred and court-referred IPV men who presented for treatment in a program for IPV

perpetrators. Based on the findings of Gondolf (1999) and Dutton and Starzomski (1994), we would expect to find a higher proportion of histrionic, narcissistic and compulsive personality pathologies among the court-referred men than among their self-referred counterparts. Further, we would expect the self-referred men to demonstrate significantly more elevated scores on the borderline scales than court-referred men, along with higher levels of self-depreciation, anxiety and depression (Dutton & Starzomski, 1994; Gondolf, 1999).

6.2 Method

6.2.1 Participants

Participants were 181 men (the same group as for Study 1) who were either self-referred ($n = 115$) or court-referred ($n = 66$) to complete an IPV group intervention program between 2003 to 2007 at a non-government social service agency (Anglicare WA) in Perth, Western Australia. All participants completed the MCMI-III prior to attending the 18-week group program. The mean age of this group was 37.8 years (SD 9.2), ranging in age from 18 to 64 years. Demographic data are reported in Table 7.

Socioeconomic status clearly differed across the two groups, with the self-referred men being significantly better educated, more likely to be employed, older, and paid a higher wage. The self-referred men were also more likely to report that they had been sexually abused when younger. Unsurprisingly, the court-referred men were more likely to have been served with restraining orders and have criminal convictions, including more violent criminal convictions. (Some court-referred men evidently did not acknowledge their criminal records during the assessment interview, as the reported percentages for this group are less than 100%.)

**Table 7: Demographic Information by Referral Status, Expressed as Percentages
(*n* in Brackets)**

	Self-referred	Court-referred	Total
Employed	81 (101)***	53 (62)	71 (163)
Annual income above \$20,000	81 (42)**	44 (54)	60 (96)
Education above Grade 10	63 (106)*	39 (63)	54 (169)
Marital status (i.e. living with partner)	53 (107)	40 (57)	51 (164)
Physical abuse in family of origin	75 (111)	66 (48)	73 (159)
Psychological abuse in family of origin	60 (111)	60 (48)	60 (159)
Observed abuse in family of origin	66 (109)	66 (47)	66 (156)
Assaulted a parent in family of origin	32 (107)	26 (46)	30 (153)
Sexual abuse victim	16 (107)*	2 (46)	12 (153)
Violence as a child or adolescent	50 (106)	50 (46)	50 (152)
Reported injuries to partner	54 (111)	56 (52)	55 (162)
Reported separation from partner	81 (112)	94 (51)*	85 (163)
Violence restraining order	17 (107)	75 (51)***	35 (158)
Report of suicide attempt	17 (93)	20 (35)	17 (128)
Criminal record	50 (106)	97 (59)***	67 (165)
Violent criminal record	19 (106)	83 (59)***	42 (165)

P < 0.05*; < 0.01**; < 0.001***

6.2.2 Measures

6.2.2.1 MCMI-III

The MCMI-III (Millon et al., 1997) was used in this study to assess personality pathology and clinical syndromes. See the information regarding the MCMI-III in Chapter 4.

6.2.2.2 ABI

The ABI (Shepard & Campbell, 1992) is a 30-item self-report inventory developed to capture the frequency of occurrence of different facets of ‘power and control’ employed by male IPV perpetrators against their partners. Detailed information regarding the ABI’s reliability and validity may be found in Chapter 4.

6.2.3 Analysis Strategy

Initially, this study undertook a comparison of the proportion of significantly elevated personality pattern scales and clinical syndrome scales on the MCMI-III for the court-referred and self-referred men in order to directly compare our sample with Gondolf’s (1999) sample. To this end, we used a grouping procedure based on Millon’s levels of personality pathology profile severity, since this aligns best with the way the MCMI

was designed to be used, and better elucidates the treatment implications. As advocated by Millon et al. (1997) and Choca (2004), profile analysis was undertaken for the sample, based on the interpretation of two- or three-point high personality patterns. (Further explication of the levels of personality pathology severity and types of profiles across levels was presented in the statistical analysis strategy in Study 1 in Chapter 5.) We also compared the number of ‘fake good’ (minimised) and ‘fake bad’ (exaggerated) profiles (Daubert & Metzler, 2000), as explained in Study 1. The differences in the percentages of court-referred and self-referred profiles with these different styles were compared at each level of personality pathology severity, using chi-square analysis.

We also compared the results of abusive behaviours as reported by the men in this study against their partners in the last six months of their cohabitation. Their female partners (if they had a partner who could be contacted) also completed the ABI (the victim form of the same set of 30 behaviours), and mean scores were compared across referral status groups.

6.3 Results

Four profiles that were invalid according to the MCMI-III manual scoring system were eliminated from analysis (profiles with disclosure scores above a raw score of 178 or below a raw score of 34—see Millon et al. [1997] for an explanation). Table 8 shows the percentages of significant scale scores across the court-referred and self-referred participants. Only two scales on the MCMI-III differed significantly as a function of referral status, with 19% of court-referred men producing significant severe clinical personality scale scores on paranoid personality, relative to 2% of self-referred men ($\chi^2 = 12.96$ [$N = 177$], $df1$, $p < 0.001$). The other significant difference was that 35% of the self-referred men produced significant dependent personality scale scores, compared with 19% of the court-referred men ($\chi^2 = 5.53$ [$N = 177$], $df1$, $p = 0.019$). There were no other significant differences in clinically significant scale elevations between groups. This is noteworthy because the court- and self-referred men did not differ significantly on the percentages of significant modifying indices, which suggests that the groups responded in a similar manner. They also displayed no significant differences in proportions of significantly elevated Axis I scales.

Table 8: Percentage of Significant Scores MCMI-III (BR > 74) by Referral Status

MCMI-III Scales	Self-referred (<i>n</i> = 113)	Court-referred (<i>n</i> = 64)	Total (<i>n</i> = 177)	Chi-sq.	<i>P</i>
Disclosure	27	22	25	.67	.42
Desirability	20	31	24	2.64	.10
Debasement	20	16	18	.41	.52
Schizoid	17	22	19	.69	.41
Avoidant	35	31	33	.20	.66
Depressive	39	36	38	.16	.69
Dependent	35	19	29	5.46	.02*
Histrionic	4	6	5	.70	.40
Narcissistic	9	14	11	1.16	.28
Antisocial	29	27	28	.14	.71
Aggressive	29	19	25	2.36	.13
Compulsive	3	3	3	.03	.86
Passive-aggressive	43	44	43	.03	.87
Self-defeating	27	17	23	2.01	.16
Schizotypal	4	6	5	.70	.40
Borderline	34	22	29	2.72	.10
Paranoid	2	19	8	16.17	.00**
Anxiety	61	55	59	.69	.41
Somatoform	3	5	3	.52	.47
Bipolar-manic	7	5	6	.40	.53
Dysthymia	41	30	37	2.14	.14
Alcohol dependence	36	44	39	.96	.33
Drug dependence	12	17	14	.78	.38
PTSD	6	13	9	2.10	.15
Thought disorder	4	5	5	.01	.94
Major depression	12	8	10	.61	.44
Delusional disorder	2	5	3	1.27	.26

P < 0.05*; < 0.01**

Table 9 shows the referral status differences across four levels of severity of personality pathology, according to White and Gondolf's (2000) classification criteria. The self-referred participants (64% of the sample) and court-referred participants (36% of the sample) were evenly distributed across the four levels of personality pathology severity—that is, severe, moderately severe, trait and sub-trait levels ($\chi^2 = 0.35$ [$N = 177$], $df=3$, $p = 0.95$). In other words, the court-referred and self-referred men displayed similar proportions of personality pathology severity.

Table 9: Percentages of Self-referred and Court-referred Perpetrators across Different Levels of Personality Pathology Severity

	Self-referred	Court-referred	Total	χ^2	df	Sig.
Severe	23 (41)	14 (23)	37 (64)	.35	3	.95
Moderately severe	10 (18)	7 (12)	17 (30)			
Trait	20 (35)	10 (18)	30 (53)			
Sub-trait	11 (19)	5 (10)	16 (29)			
Total	64 (113)	36 (64)	100 (177)			

Table 10 shows the individual profiles of the court-referred and self-referred men—in contrast to individual scales—across four levels of personality pathology severity. Again, very few significant differences emerged. For those whose profiles fell into the severe level of personality pathology ($n = 65$), the self-referred men were more likely to have a predominantly borderline personality disorder profile ($\chi^2 = 11.44$ [$n = 65$], $df1$, $p = 0.001$), whereas more court-referred men had a predominantly paranoid personality disorder profile ($\chi^2 = 18.94$ [$n = 65$], $df1$, $p < 0.001$).

Among the 30 men who reported moderately severe personality pathology—the second level of severity—there were no significant differences in the profiles for court-referred and self-referred groups (see Table 9), although there was considerable diversity. Similarly, when these profiles were grouped based on the type of profile (aggressive/antisocial, withdrawn/depressive/avoidant and histrionic/narcissistic/compulsive-conforming patterns, there were no significant differences in the percentages of these personality pattern styles between the court- and self-referred men.

Table 10: Personality Pathology Categories Grouped According to Severity in Self- and Court-referred Men (Percentage of Profiles in Each Category and *n* in Brackets)

Personality dysfunction	Personality description(within levels)	Self-referred (<i>n</i> = 113)	Court-referred (<i>n</i> = 64)	Totals (<i>n</i> = 177)
Severe Millon personality pathology	1. Borderline disorder	85 (35)***	42 (10)	69 (45)
	2. Paranoid disorder	2 (1)	33 (8)**	14 (9)
	3. Schizotypal disorder	10 (4)	8 (2)	9 (6)
	4. Atypical/mixed disorders	2 (1)	17 (4)	8 (5)
		37 (41)	38 (24)	37 (65)
Moderate Millon personality pathology	1. Angry/aggressive disorders	17 (3)	33 (4)	23 (7)
	2. Depressive/withdrawn/dependent disorders	33 (6)	17 (2)	27 (8)
	3. Narcissistic/conforming disorders	50 (9)	50 (6)	50 (15)
		16 (18)	18 (12)	16 (30)
Low-level Millon trait personality pathology	1. Angry/aggressive	34 (12)	33 (6)	34 (18)
	2. Depressive/withdrawn/dependent	57 (20)	39 (7)	51 (27)
	3. Narcissistic/conforming	3 (1)	22 (4)*	9 (5)
	4. Atypical	6 (2)	6 (1)	6 (3)
		66 (35)	34 (18)	30 (53)
Low-level Millon sub-trait personality pathology	1. Angry/aggressive	47 (9)	10 (1)	34 (10)
	2. Depressive/withdrawn/dependent	16 (3)	30 (3)	20 (6)
	3. Narcissistic/conforming	16 (3)	60 (6)*	31 (9)
	4. Atypical	21 (4)	0 (0)	14 (4)
		17 (19)	16 (10)	15 (29)
		64 (113)	36 (64)	100 (177)

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

Fifty-three men produced profiles that fit the trait personality pathology grouping (at least one personality scale > BR 74, but < BR 85). Again, the personality pathology profiles were quite varied across these 50 men (see Table 10), but only one significant difference emerged for referral status: the court-referred men were significantly more likely to have histrionic/narcissistic/compulsive-conforming trait profiles than their self-referred counterparts ($\chi^2 = 5.22$ [*n* = 53], *df*1, *p* = 0.04: FET)—although this only amounted to five profiles in all.

There was also one significant difference in the percentage groupings of personality style profiles at the sub-trait level of severity (no personality pattern scales > BR 74; see Table 10). Again the court-referred men were more likely to report histrionic/narcissistic/compulsive-conforming profile styles than their self-referred counterparts ($\chi^2 = 5.98$ [*n* = 29], *df*1, *p* = 0.032: FET). It is important to note that the differences in the histrionic/narcissistic/compulsive-conforming styles of personality profile involved

such a small number of actual profiles that this significant result cannot be assumed to mean a great deal clinically.

In terms of response bias (refer to Table 8), there were no significant differences between the court-referred and self-referred men in the percentages of significant modifying index scores, nor in the percentages of significant exaggerated and minimised profiles. In overall terms, the MCMI-III was designed to produce approximately 25% of profiles in the significant range in any given ‘clinical’ sample, from which our groups did not differ to any large degree.

Table 11 reports the differences in the ABI scores on the basis of referral status. Only one significant difference emerged, with the court-referred men producing significantly higher extreme violence scores than the self-referred men. This refers to five questions out of a total of 30 that pertain to severe and dangerous acts of violence, such as ‘Used a gun, knife or other weapon against you’. While the mean difference on this subscale was significant, the behaviours were relatively few; however, this does not make them any less important clinically, given that it only takes one act of extreme violence to cause serious injury or death.

Table 11: Means and SDs for Male and Female ABI Scores as a Function of Referral Status

Male (<i>N</i> = 177)	Self-referred	Court-referred	T	<i>df</i>	<i>P</i>
Total abuse	49.77(10.14)	47.37 (10.88)	1.70	1175	.09
Psychological abuse	30.93 (7.26)	28.98 (7.24)	1.92	1175	.06
Physical abuse	18.71 (4.62)	18.39 (4.68)	0.92	1175	.36
Extreme violence	6.15 (3.44)	6.40 (1.72)	-0.65	1175	.52
Female (<i>N</i> = 123)	Self-referred	Court-referred	Z		<i>P</i>
Total abuse	66.47 (17.37)	71.39 (28.40)	-0.32		.75
Psychological abuse	43.45 (12.42)	44.39 (18.51)	-0.05		.96
Physical abuse	23.00 (7.38)	27.00 (11.94)	1.76	1121	0.19
Extreme violence	7.22 (2.65)	9.50 (4.53)	7.57	1121	.007**

6.4 Discussion

Surprisingly, few differences in personality pathology were found between the court-referred and self-referred IPV men in the current study. The two groups had similar proportions of personality pathology, whatever the level of severity. Further, our results showed that the response biases of the men were comparable to those found in clinical

samples, with no significant differences between the self-referred and court-referred groups. This gave us confidence that the relative paucity of significant personality pathology differences between our groups, as a function of referral status, was a reasonably accurate representation of their pathology in relation to one another. Overall, these results were surprising given Gondolf's (1999) finding of many significant differences in elevated MCMI personality scale scores for court- and self-referred men. Thus, it is important to take into account the indicators of under-reporting in Gondolf's court-referred group. This contrasts with the current study, where response biases were not significantly different between the two groups.

Demographically, there were some significant differences in our sample between the two referral groups. In comparison to the men who self-referred for a group IPV treatment program, on average, the court-referred men were younger, less well educated, more likely to be unemployed, and earning lower incomes. Involvement in the criminal justice system may partly account for the court-referred men being less likely to be employed and to have lower incomes than the self-referred men, and to be in trouble with the law prior to their IPV gaining the attention of authorities. Self-referred men typically enter domestic violence intervention groups because of relationship issues, such as separation or threats of separation (Dutton & Starzomski, 1994), and this was also the case for our group. Could such differences have affected our personality pathology results? We do not think so, given that crime (other than IPV) and IPV have been shown to be distinct constructs with only moderate overlap, with personality pathology being more predictive of IPV than either socioeconomic status or criminality (Moffitt, Kreuger, Caspi & Fagan, 2000).

The current study found only two significant differences in the proportions of elevated Millon personality *scales* as a function of referral group:

1. the court-referred men were more likely than the self-referred men to produce significant elevations on the paranoid personality scale
2. the self-referred men were more likely to produce significant elevations on the dependent personality scale.

These differences make intuitive sense to someone who has worked therapeutically with these men. That is, most court-referred men have criminal convictions and a sizeable proportion have been in prison, which is an environment where it is adaptive to be

suspicious of the motives of others, and it is not adaptive to be dependent. This view has also been expressed by Rotter, Way, Steinbacher, Sawyer and Smith (2002), who found paranoia to be a common characteristic among men in prison populations. In contrast, self-referred men have been found to be overly dependent on their intimate relationships, and prone to neediness (Dutton, 2006).

In our sample, these scale differences also translated into several significant differences in personality pattern *profiles* (the highest two- to three-point scale scores) between the self-referred and court-referred men. A significantly higher percentage of self-referred men reported borderline profiles than did the court-referred men (85% v. 42% at the severe level of personality pathology). This involved various combinations of clinically elevated borderline personality scales, alongside clinically elevated avoidant, depressive, dependent, antisocial, aggressive, passive-aggressive and self-defeating scales, thereby forming a variety of subtypes of BPD referred to by Millon and Davis (1996) as discouraged, petulant, impulsive and self-destructive borderline. This may mean that a higher proportion of the self-referred men were of the ‘anxious-reactive’ IPV type, who are fearful of abandonment by an intimate partner, and in many cases display a comorbidity with dependent personality scale elevations. Numerous researchers have reported this type of personality pathology pattern among domestically violent men (e.g. Dutton et al., 1994; Dutton & Starzomski, 1994; Hamberger et al., 1996; Holtzworth-Munroe et al., 2000; Saunders, 1992).

A significantly higher percentage of court-referred men than self-referred men reported a predominantly paranoid personality pattern profile (33% v. 2% at the severe level of personality pathology). Alongside a clinically elevated paranoid personality scale, these men produced profiles with various combinations of clinically elevated narcissistic, negativistic, avoidant and aggressive personality scales—referred to by Millon and Davis (1996) as fanatic, querulous, insular and malignant subtypes of paranoid personality disorder. Due to these differences across referral status and the fact that 37% of the total sample displayed these severe personality patterns, it is important to recognise the challenges involved in these men’s treatment in IPV group work.

The results indicate that more than a third of the men reported severe personality pattern disorders, with a number of pathology subtypes in the Millon typology, including:

- discouraged borderline (with avoidant, dependent and melancholic characteristics)
- petulant borderline (with negativistic characteristics)
- impulsive borderline (with antisocial characteristics)
- self-destructive borderline (with melancholic and masochistic characteristics)
- fanatic paranoid (with narcissistic characteristics)
- querulous paranoid (with negativistic characteristics)
- insular paranoid (with avoidant characteristics)
- malignant paranoid (with aggressive characteristics).

It is worth quoting Millon (Millon & Davis, 1996) on the significance of these differences for intervention purposes:

it is well to remember that borderlines, despite their common defining characteristics, are frequently more severe variants of other personality disorders, notably the negativistic, depressive, histrionic, avoidant, and compulsive. As a result they are even less homogeneous a classification than are other personality disorder categories. Some are well compensated; most are not. Despite symptom commonalities, *these differences in the clinical picture must be attended to closely for effective remedial intervention.* (emphasis added; pp. 683–684)

With regard to paranoid personality, Millon (1999) remarked: ‘The Paranoid Personality may be viewed as a more structurally defective and dysfunctional variant of the antisocial, sadistic, compulsive, and narcissistic patterns, with each sharing a preoccupation with matters of adequacy, power, and prestige’ (p. 678).

Clearly, some knowledge and skills in treating people with different personality disorder characteristics would be valuable for working with such individuals. Clients with BPD are probably more amenable to change than clients with paranoid personality disorder, according to Millon (1999) and others (Dimaggio et al., 2007; McWilliams, 1994); however, their high lability, fear of abandonment, and erratic and threatening behaviours are difficult for the therapist (Millon & Davis, 1996), who must be alert for self-harming behaviours and inordinate transference in attachment behaviours (Semerari & Fiore, 2007). In contrast, those with paranoid presentations are prone to be mistrustful, resentful and intimidating, which, alongside their characteristic inflexibility, places enormous pressure on the therapist to remain alert and resourceful, without burning out (Nicolo & Nobile, 2007). Clearly, neither of these severe personality disorder patterns could be considered more pathological than the other—they are simply

different in presentation and symptomatology. Further, because there were no significant differences in the percentages of elevated Axis I clinical syndromes between the two referral groups, it is not possible to argue that one is more pathological or distressed than the other. We should add that acts of extreme violence—as reported on the ABI—are very important to identify in IPV, and we would speculate that the more serious the personality pathology, the more likely that individuals will perpetrate such abusive behaviours. This issue requires further exploration.

Despite the limited number of differences by referral status in the current study, considerable variation was observed in the types of personality across the whole sample—far more than just antisocial and borderline presentations (Holtzworth-Munroe & Stuart, 1994). With regard to the conforming type personality pathologies (histrionic, narcissistic and compulsive), 15% of the total sample shared this style, with more than half of these severe enough to be at personality disorder level—although, at this level, there was also no difference by referral status. Depressive/withdrawn/dependent personality styles accounted for 31% of our sample overall, with two thirds of these in the personality disorder range, and many being comorbid with severe level personality pattern profiles. Antisocial, aggressive and passive-aggressive profiles accounted for 50% of all profiles in our sample, with 33% in the personality disorder range (and 22% of these being comorbid with severe personality patterns, as previously described). Diversity was more pronounced than similarity of personality pathology.

Combining schizoid, avoidant, dependent, depressive and self-defeating profiles into a single grouping does not necessarily imply that they can all be managed in the same manner; however, there are commonalities that set them apart from the antisocial/aggressive and narcissistic/conforming groups. Millon and Davis (1996) regarded the prognosis as poor for the depressive/withdrawn/dependent group of clients unless a strong and trusting therapeutic relationship can be formed. They cited ‘corrective emotional experience’ in interpersonal settings as an important mechanism of healing. Shared experience, rather than tackling clients’ problems, is an essential first step (Procacci, Popolo, Petrilli & Dimaggio, 2007). A group program that is supportive, rather than confrontational, would seem to have most benefit for these men—as, for example, Sonkin and Dutton (2003) outlined in their attachment therapy for IPV men.

People with histrionic personalities rarely seek therapy, according to Millon (1999), because they are externally preoccupied, repressed and seek to avoid introspection and responsible thinking. People with compulsive personalities are typically very well defended and focused away from the psychological nature of their distress, while those with narcissistic personalities are demanding and easily offended (Millon, 1999; Nicolo & Nobile, 2007). In short, such men do appear in IPV interventions, but are not highly motivated to change and not particularly easy to work with, requiring a considerably different approach to that of the borderline-dysphoric type of perpetrator. According to Millon (1999, 2011), among the narcissistic/histrionic/compulsive-conforming participants, a mixture of CBT and psychodynamic methods may be required.

The antisocial, aggressive and passive-aggressive personalities that we placed together as one of our personality pattern styles are also not entirely homogeneous. Millon and Davis (1996) referred to them as the ‘aggrandising’, ‘abusive’ and ‘vacillating’ patterns of personality, and do not see the prognosis as highly positive for these personality types. Frequently, these personalities seek help through pressure or are mandated by the criminal justice system, and often represent the more stereotypical domestically violent pattern of perpetrator (Holtzworth-Munroe et al., 2000). These men require very clear boundaries and sanctions, and need to be motivated by reality-checking their behaviour and its outcome. This is an acceptance and commitment therapy, and a CBT area of intervention (Hayes, Strosahl & Wilson, 1999; Saunders, 1996), practical and behavioural.

The need for a closer match between therapist/facilitator and offender in IPV treatment has been highlighted in recent literature in terms of client characteristics (Bowen & Gilchrist, 2004), motivation (Scott, King, McGinn & Hosseini, 2011) and therapeutic alliance (Taft & Murphy, 2007). That need is further highlighted in this study by the personality pathology differences among these men, which demand considerable flexibility if effective treatment is to occur. Contrary to popular views, not all domestically violent men are minimisers, nor are they all antisocial and aggressive. Some are highly distressed and even self-deprecating, some are apparently in denial, and some might be termed arrogant and belligerent, while others are simply anxious and trying to avoid trouble. Regardless, the diversity is evident and referral status generally does not appear to be as important as the personality pathology diversity itself.

6.5 Study Limitations

The limitations in this study are evident. Only a single instrument was used to assess these men's personality pathology, albeit a very comprehensive and psychometrically established measure. This group of men came from a single assessment process for a particular IPV program in Western Australia, and may not be comparable to men who are surveyed or recruited from the community nationally or internationally. There are no comparison groups, and it would be valuable to compare this sample with men who attend other programs in this country, both court- and self-referred. However, it is still remarkable that we found so few differences between the court- and self-referred men within the context of such major diversity in personality pathology.

6.6 Concluding Remarks

In summary, we found considerable diversity in the levels and types of personality pathology in a sample of male domestic violence perpetrators who were self-referred or court-referred for the same IPV program. There were few differences between the self- and court-referred groups; however, the most important difference was that the self-referred men were more likely to have a borderline personality disorder profile than the court-referred men, whereas the court-referred men were more likely to display a paranoid personality disorder profile than the self-referred men. Differences in response bias were non-significant overall, suggesting that, while a small percentage of men were exaggerating or minimising their psychopathology, this did not differentiate the referral status groups.

Given that one of the major aims of IPV interventions is for men is to reduce the likelihood of abuse and violence towards their intimate partners, we compared the abusive behaviour scores between the two groups. Generally, we noted the non-significant comparisons with ABI scores—that is, the court-referred men did not report significantly higher total scores, psychological abuse scores or physical abuse scores, including extreme abuse scores. Instead, their female partners' reports identified significantly higher extreme violence scores for the court-referred men *vis-à-vis* the

self-referred men. However, statistically, the partial eta squared for this difference was only 0.06, suggesting that clinical significance was not great. Further, the SD for this variable was much greater for the court-referred men than for the self-referred men, which suggested some extreme scores. However, any extreme violence or threat of extreme violence in an intimate relationship is clearly serious, and needs to be addressed immediately and effectively wherever possible.

Overall, our general conclusion was that the court-referred male domestic violence perpetrators were not more pathological than the self-referred men in this Australian sample. There was no case for a 'good guys/bad guys' differentiation between these two groups. Further, we concluded that more flexible and diverse approaches are required during the treatment of domestically violent men, especially approaches that target personality pathology for optimal change.

Chapter 7: Parsing Personality Profiles of Men for IPV—

Study 3

7.1 Summarising the Research to this Point

In Studies 1 and 2, we observed the following:

- Fifty four percent of profiles were consistent with a personality disorder.
- Profiles were minimised or exaggerated in similar proportions, and together accounted for 25% of all profiles, which is consistent with the MCMI-III norms for a clinical population.
- The diversity of personality profiles was very broad, with all MCMI-III personality patterns being reflected in the IPV sample.
- The court-referred and self-referred men showed few personality pathology differences, with no significant differences in response style on the MCMI-III.

Given these findings, we decided to ‘parse’ the men’s personality profiles to determine whether naturally-occurring groupings might emerge in order to assist in tailoring interventions that would be more effective, in line with Millon’s (2011) ‘personologic’ therapy model. This formed the basis of Study 3.

7.2 Introduction to Study 3

The WHO Task Force on Violence and Health (2000, as cited in Dixon & Browne, 2003) set as its first objective to define the heterogeneity of domestically violent men in order to understand the various forms and consequences of violence. Their second objective was ‘a classification system that would aid treatment evaluation and encourage the development of “best practice” interventions that would be more effective in preventing further victimization’ (Dixon & Browne, 2003, p. 127). While knowledge of the severity of IPV and generality of violence are necessary for risk assessment and management, they may not be as important as personality pathology when choosing and applying effective treatment interventions, as illustrated in the research presented in the current thesis.

Recent research by Ross (2011) found that men (and women) attending court for IPV perpetration cited ‘emotion dysregulation’ as a more important reason for their abuse than power and control issues, and that this dysregulation related strongly to their reports of personality pathology characteristics. Further, based on empirical research, Corvo and Johnson (2013) argued that male IPV perpetration is better explained by psychological and neuropsychological factors than either social learning or gender-biased cultural domination. Once again, this indicates that targeting personality pathology may be the most useful approach to developing best practice interventions and treatment.

The research undertaken in Studies 1 and 2, as well as previous research (Beasley & Stoltenberg, 1992; Dutton et al., 1994; Gibbons et al., 2011; Hamberger et al., 1996; Johnson et al., 2006), provide evidence that IPV men have quite high levels of varied personality pathology. Indeed, it has been argued that this personality pathology should be addressed in IPV treatment groups (Dutton, 2006; Saunders, 1996). However, there has been a tendency to develop interventions that are applied to all participants in a ‘one size fits all’ (or ‘most’) manner (e.g. Cavanaugh & Gelles, 2005; Gondolf, 2002). This is partly a result of the politico-sociological understanding of IPV, which has attempted to attribute IPV to a simplistic causal paradigm (Cantos & O’Leary, 2014; Dixon et al., 2011; Dutton & Nicholls, 2005). Reviews of the empirical evidence refute such a position and suggest that personality pathology has a larger proximal effect on IPV than such factors as patriarchy or intergenerational transmission of domestic violence (Corvo & Johnson, 2013; Kelly & Johnson, 2008; Wexler, 1999). Another way to summarise the prevailing paradigm in IPV work is to say that *the focus is on IPV, not on the characteristics that perpetrators bring to the enactment of IPV*. This is remarkably short sighted, given that research over the last 15 to 20 years has consistently suggested that there are different types of IPV and different types of perpetrator.

Research has indeed shown that male IPV perpetrators are a diverse population (Dixon & Browne, 2003; Eckhardt, Holtzworth-Munroe, Norlander, Sibley & Cahill, 2008; Gondolf, 2002; Hamberger et al., 1996; Holtzworth-Munroe et al., 2000). However, these typologies have been based on a mixture of limited personality pathologies (only borderline and antisocial, or neither of these), levels of IPV and the extent of

generalised use of violence—rather than the full range of personality pathology. As elucidated earlier in this thesis, research has indicated that there is a wider range of personality pathology among IPV perpetrators. For example, using statistical clustering techniques with a very large sample of mandated IPV perpetrators, Hamberger et al. (1996) found at least six different groupings. Three small clusters (accounting for about 11% of the sample) were ignored in further analysis. Of the other three clusters, significant mean dependent/negativistic scores characterised the first cluster, histrionic/antisocial scores characterised the second cluster, and no significant mean scores (below BR 75 on the MCMI) marked the third cluster, which the authors characterised as ‘low pathology’. As already noted, using mean scores—especially without analysing response bias (Gibbons et al., 2011)—may mask the presence of certain profiles that are significant in IPV work. Gondolf’s (1999) large multisite study sample found various percentages of the IPV men he tested to exhibit personality disorder or trait pathology on every single MCMI-III personality pattern, despite a considerable amount of denial and minimisation. However, he did not cluster these results into subtypes. Such a diversity of personality pathology indicates the need for closer study for both practical and empirical purposes.

The issue of personality pathology in IPV perpetrators is relevant to treatment intervention because different personality pathologies are likely to require very different treatment approaches—according to Millon (1999) and many authors and researchers working with personality disorders (Benjamin, 1996; Dimaggio et al., 2007; DSM-V, 2013; McWilliams, 1994). On the basis of using personality patterns and/or disorders to understand IPV perpetration, the popular three-cluster model of Holtzworth-Munroe and Stuart (1994) can be said to only inform interventions for antisocial disorders and borderline disorders or traits. The severity of IPV and generality of violence may not be as important for informing the treatment approach as the variability in personality pathology. Studies 1 and 2 in the current dissertation demonstrated that the personality pathology of men in IPV programs has a much wider spectrum, consistent with Gondolf’s (1999) findings. In Gondolf’s (1999) large multisite study, he identified borderline, paranoid, antisocial, schizotypal, schizoid, avoidant, depressive, dependent, narcissistic, histrionic, compulsive, passive-aggressive, aggressive, melancholic and masochistic disorders on the MCMI-III, frequently in comorbid combinations (White & Gondolf, 2000).

Importantly, a long history of clinical practice and research has demonstrated that diverse personality pathology is differentially influenced by the type of intervention adopted (Dimaggio et al., 2007; Millon, 1999, 2011; McWilliams, 1994). As Beutler and Clarkin (1990) observed, ‘the characteristics that the patient brings to the treatment experience are the single most powerful sources of influence on the benefit to be achieved by treatment’ (p. 31) Paying attention to these characteristics is essential in developing best practice treatment intervention.

Research on the therapeutic alliance has also recently demonstrated better outcomes with IPV men when the therapeutic alliance was incorporated, as opposed to the typical confrontational style of many intervention programs (Brown & O’Leary, 2000; Taft & Murphy, 2007; Taft et al., 2003; Taft et al., 2004). This finding suggests the importance of employing greater use of the personal emotion regulation context—that is, considering and working with personality pathology—than has typically been the case in this field of intervention.

Given the diversity of personality pathology that we (and others) have found among IPV men, and the demonstrated value of incorporating that pathology in interventions, we propose that practitioners could benefit from guidance concerning what works best with different personality patterns in this group of men. In this study, to ascertain the most fundamental characteristics of personality pathology that might differentiate male perpetrators of IPV, we chose to factor analyse the personality pattern and clinical syndrome scores on the MCMI-III, as well as their attendant modifying indices, in order to identify characteristic groupings (Choca, 2004), before clustering and examining case profiles. Since current emphasis in the personality field is on dimensionality, rather than categories (Trull & Widiger, 2013; Widiger, 2004), we concluded that factor analysis of the continuous scores on the MCMI-III would be the best first step to classifying profiles. The work of Ding and He (2004) has shown that principal components are the continuous solutions to the discrete cluster membership indicated by K-means clustering, thus overcoming some of the mathematical and conceptual shortcomings inherent in clustering analyses. Mirkin (2005) noted striking similarities between principal components analysis and clustering in terms of data recovery models. We chose to include the modifying index scores as well, since they also assist in modifying

scores in accordance with client presentation—whether the client is distressed or not, openly disclosing or denying, and wanting to look good or not. The clinical syndrome scales were also included because, according to Millon (1999) and Millon et al. (1997), all the scales contribute to an accurate understanding of the complexity of individual dimensions of coping.

Part of our purpose in discriminating male IPV perpetrators based on personality pathology was to assess the relative levels of dangerous behaviour among these men towards their female partners, since intervention groups are largely about lowering the risk for intimates in such relationships. That is, we were interested in the relationship between personality pathology and the different types of IPV mentioned above. To this end, we chose to include the scoring of abuse behaviour reports from both the male participants in an intervention program and their female partners in order to enable comparison.

7.3 Method

7.3.1 Participants

The participants were the 181 men previously described in Studies 1 and 2 (Chapters 5 and 6).

7.3.2 Measures

7.3.2.1 MCMI-III

Following the acquisition of demographic data, all men entering the IPV group program completed the MCMI-III (Millon et al., 1997). Information regarding the use of this instrument was detailed in Studies 1 and 2 (Chapters 5 and 6).

7.3.2.2 ABI

See details for the ABI in Study 2 (Chapter 6).

7.3.3 Analysis Strategy

All valid MCMI-III personality pattern, clinical syndrome BR and modifying indices scores were entered into a principal components analysis (PCA), using oblimin rotation (Delta -0.4) in the SPSS statistical program 11.5 (Brief Guide, 2002). The modifying indices scores were included as both Choca (2004) and Millon et al. (1997) observed, that while these indices help modify the actual scale scores, such adjustments cannot account for the full range of exaggeration or minimisation of reported psychopathology. Thus, including these modifying indices is likely to help differentiate between clusters. We used oblimin rotation because many MCMI-III scales are highly correlated with one another. The use of PCA with a sample of 177 was justified on the basis that: (i) this is an exploratory procedure and (ii) according to Tabachnik and Fidel (1996), using PCA on a sample this size is acceptable when there are high correlations among the variables.

An examination of the scree plot showed a clear change of slope after the fifth factor, with the first five factors having eigenvalues of 13.59, 2.62, 1.92, 1.49 and 1.15, respectively, and accounting for 76.92% of the data. The first factor accounted for 50.32% of the variance, and loaded highly and distinctively on the somatoform, major depression, dysthymia, debasement, thought disorder and PTSD scales. The second factor accounted for 9.71% of the variance and loaded highly and distinctively on the antisocial and aggressive personality scales, and the alcohol and drug dependence clinical syndrome scales. The third factor accounted for 7.11% of the variance and loaded highly and distinctively on the narcissistic and histrionic personality scales. The fourth factor accounted for 5.51% of the variance and loaded highly and distinctively on the paranoid personality and delusional disorder syndrome scales. The fifth factor accounted for 4.27% of the variance and loaded (negatively) highly and distinctively on the dependent personality scale. The rotated factor solution demonstrated five clear patterns as follows: high clinical distress, antisocial factors, narcissistic/histrionic factors, paranoid factors and dependent factors.

We then entered the five-factor regression scores into a K-means cluster analysis, assessing three, four and five clusters with a view to the most diverse, yet coherent, differentiation among groups. Five clusters was clearly the best choice in terms of coherence and differentiation. For statistical robustness, a discriminant function analysis

was used to assess the accuracy of clustering, with 96.6% of originally grouped cases correctly classified, and 94.9% of cross-validated grouped cases correctly classified by four discriminant functions:

- function 1: eigenvalue 4.76, 66.9% of variance, $r = 0.91$, Wilks's lambda (WL) = 0.03, $\chi^2 = 587.35$, df_{20} , $p < 0.001$
- function 2: 1.16, 16.3% of variance, $r = 0.73$, WL = 0.19, $\chi^2 = 288.06$, df_{12} , $p < 0.001$
- function 3: 0.82, 11.6% of variance, $r = 0.67$, WL = 0.40, $\chi^2 = 156.62$, df_6 , $p < 0.001$
- function 4: 0.37, 5.2% of variance, $r = 0.52$, WL = 0.73, $\chi^2 = 54.00$, df_2 , $p < 0.001$
- Box's M = 95.00, $F = 1.48$, $df_1: 60$, $df_2: 33485.38$, $p = 0.009$.

A probability of cluster membership above 0.7 applied to 86.4% of cases, while 6.8% of cases had probabilities in the 0.6 to 0.7 range, 5.1% had cases in the 0.5 to 0.6 range, and 0.6% (one case) had cluster membership probability below 0.5—a probability no greater than chance of falling into one of at least two different clusters.

All profiles were interpreted in accordance with Millon's system of BR scores, as previously described in Studies 1 and 2. We also sorted the sample profiles (as described in Studies 1 and 2) based on these two- or three-point high personality patterns into typical types of presentation. Thus, profiles with predominant antisocial, aggressive and passive-aggressive patterns were labelled 'angry-aggressive'; profiles with predominant avoidant, schizoid, dependent and depressive profiles were termed 'withdrawn or dependent'; and profiles with predominant histrionic, compulsive or narcissistic patterns (without antisocial/aggressive influence) were labelled 'histrionic/narcissistic/compulsive-conforming' (see White & Gondolf, 2000). Any profiles that could not be interpreted within this scheme were labelled 'atypical'.

Due to the importance of personality pathology for domestic violence, we also subdivided the 'antisocial/aggressive/passive-aggressive' grouping into:

1. profiles high on both antisocial and aggressive scores
2. profiles high on one, but not the other

3. profiles high in passive-aggressive, but not necessarily high in either antisocial or aggressive. We considered this distinction valuable because people high in both antisocial and aggressive could be considered potentially more dangerous than the others. Passive-aggressive-only profiles are potentially the least dangerous of these three types (Millon, 1999) due to the association between antisocial and aggressive characteristics with the coercive and controlling form of IPV (Tweed & Dutton, 1998).

The ABI scores were continuous and assessed using analysis of variance (ANOVA), where the ABI total, psychological and physical abuse scale scores—as reported by both men and their partners—were the dependent variables, and the factor was the five personality pathology clusters.

7.4 Results

The percentage distribution of men’s profiles across five clusters is shown in Figure 2. These five clusters were later termed the passive-anxious, borderline-dysphoric, minimising-conforming, low-level antisocial, and narcissistic-aggressive clusters.

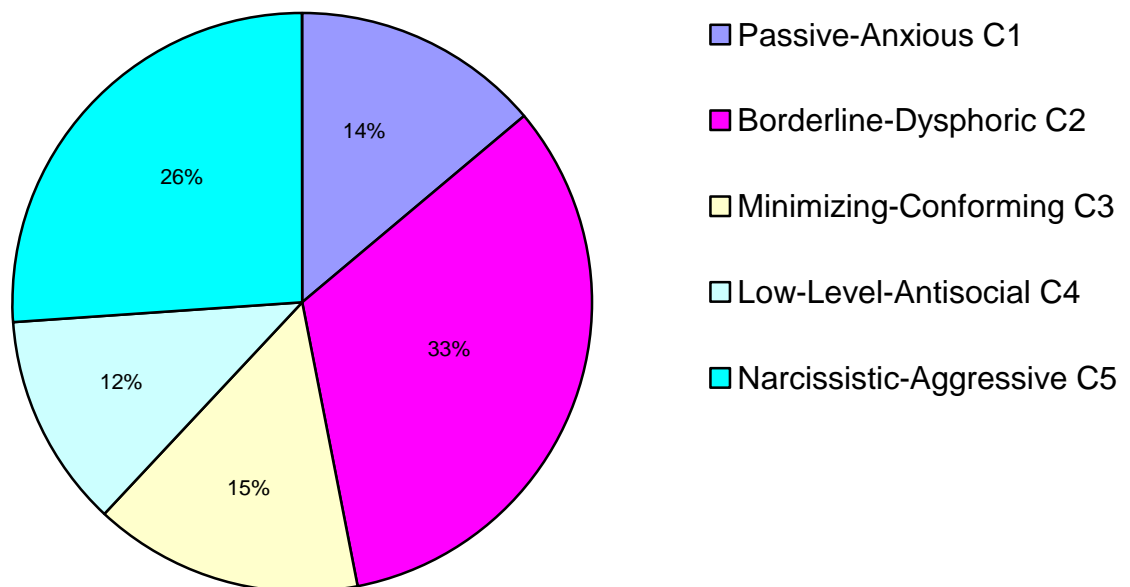


Figure 2: Percentage of Five Clusters of Personality Pathology

These clusters of men displayed some significant differences in the distribution of court- and self-referred men in the sample. The court-referred men (36% of the total sample) accounted for 44%, 28%, 50%, 18% and 44%, respectively, of the five clusters ($\chi^2 = 8.82$, $df_4 [N = 177]$, $p = 0.07$; std residual range -1.4 to +1.4). Cluster 4 (C4) had significantly less court-referred men than Cluster 3 (C3) ($\chi^2 = 5.27$, $df_1 [n = 48]$, $p = 0.02$) and Cluster 5 (C5) ($\chi^2 = 4.17$, $df_1 [n = 68]$, $p = 0.04$).

Our data also displayed some significant demographic differences across clusters, which are shown in Table 12. Some of these cluster differences were not highly distinctive. The differences that stood out were:

1. The borderline-dysphoric men (Cluster 2 [C2]) were more likely to report being sexually abused (26%) than the passive-anxious cluster (Cluster 1 [C1]), the low-level antisocial cluster (C4) or the narcissistic-aggressive cluster (C5) men, but not the narcissistic/histrionic/compulsive-conforming group—that is, the ‘minimising-conforming’ cluster (C3: 9%).
2. The borderline-dysphoric men (C2) were also more likely than the minimising-conforming men (C3) or low-level antisocial men (C4) to report a suicide attempt (33% versus 0%), but not more likely to report suicide attempts than the passive-anxious men (C1) or narcissistic-aggressive (C5) men (17% and 21% respectively).
3. The narcissistic-aggressive cluster (C5) and low-level antisocial cluster (C4) men were more likely to report violent child or adolescent behaviour (59% and 58%, respectively) than either the passive-anxious cluster (C1) or minimising-conforming cluster (C3: 30% and 24% respectively), but not more so than the borderline-dysphoric cluster (C2) men (51%).
4. However, the borderline-dysphoric cluster men did not report significantly higher percentages of violent child or adolescent behaviour than did the passive-anxious cluster (C1).
5. The low-level antisocial men (C4) were less likely than any other cluster to report a violence restraining order—9% compared with 54% for the narcissistic-aggressive cluster (C5), 38% for the minimising-conforming cluster (C3) and 34% for the borderline-dysphoric cluster (C2). However, on average, the low-level antisocial men (C4) were older than the men in any other cluster (46 years

versus 35, 37, 38 and 39 for C1, C2, C3 and C5, respectively), and, as previously noted, were more likely to be self-referred.

Table 12: Percentages, Means and SDs for Demographic Variables by Five Clusters of Men's Personality Patterns (*n* in brackets)*

	C1	C2	C3	C4	C5	<i>P</i>
Employed	68 ^{ab} (22)	58 ^b (50)	91 ^a (23)	94 ^a (16)	72 ^{ab} (40)	.011
Annual income above \$20K	42 ^b (12)	50 ^b (30)	88 ^a (16)	83 ^{ab} (6)	64 ^{ab} (28)	.048
Sexual abuse victim	5 ^b (20)	26 ^a (43)	9 ^{ab} (21)	0 ^b (21)	8 ^b (37)	.018
Violence as a child or adolescent	30 ^{bc} (20)	51 ^{ab} (43)	24 ^c (21)	59 ^a (22)	58 ^a (36)	.036
Violence restraining order	33 ^{ab} (21)	34 ^a (47)	38 ^a (21)	9 ^b (21)	54 ^a (37)	.019
Report of suicide attempt	17 ^{ab} (18)	33 ^a (40)	0 ^c (21)	0 ^{bc} (14)	21 ^{ab} (28)	.010
Age (in years)	C1 (24)	C2 (55)	C3 (23)	C4 (19)	C5 (45)	<i>F</i> =5.63 (df4,161)
	37.70 ^b (8.57)	36.95 ^b (8.09)	38.61 ^b (6.49)	46.21 ^a (9.57)	35.09 ^b (10.21)	.000

a > b > c, *p* < 0.05; * NB: there were variations in the numbers of participants through missing data or non-response on some items.

A comparison of significant MCMI-III scale elevations (BR > 74) is shown in Table 13. As seen in this table, the passive-anxious cluster men (C1; 14% of the sample) displayed modifying index scores in the average range for a clinical population, with three quarters of profiles in the 'trait' personality range (BR > 74 and < 85; Figure 3). There was nothing highly distinctive about this group other than half of the profiles being significant for avoidant personality, and two thirds being significant for anxiety. Whether significant or not, most profiles in this cluster were of the avoidant, dependent, schizoid, negativistic and depressive type. We labelled this cluster the 'passive-anxious' cluster because most of the men with these profiles were not stridently active in the pursuit of their own needs. The men in this cluster reported less total abuse and psychological abuse than the borderline-dysphoric C2 men (Table 15) (*F* [4, 172] = 10.20, *p* < 0.001; *F* [4, 172] = 11.15, *p* < 0.001) and more abuse on both scales than the minimising-conforming C3 men. As Table 14 indicates, this group was more likely than any other cluster to display a withdrawn/dependent type of profile, irrespective of severity of psychopathology ($\chi^2 = 15.04$ [*N* = 177] df 4, *p* < 0.01). This cluster also displayed some pure negativistic or passive-aggressive profiles, but none that were antisocial or psychopathic in style.

The borderline-dysphoric C2 men (33% of the sample) displayed the significantly highest mean disclosure and debasement scores (Table 14: $F [4, 172] = 76.39, p < 0.001$; $F [4, 172] = 96.57, p < 0.001$), and the significantly lowest mean desirability scores ($F [4, 172] = 56.61, p < 0.001$) in relation to the other four clusters. This is a classic distress pattern on the modifying indices of the MCMI and was evidenced by the percentages of elevated personality pattern scales and clinical syndrome scales (Table 13).

Table 13: Percentage of Significant MCMI-III Scores (BR > 74) by Cluster (*n* in Brackets) from Two-step Cluster Analysis of PCA Regression Scores of MCMI-III Scale Scores

	C1	C2	C3	C4	C5
MCMI scales	14 (25)	33 (58)	15 (26)	12 (22)	26 (46)
Schizoid	36 (9) ^a	29 (17) ^a	4 (1) ^b	5 (1) ^b	11 (5) ^b
Avoidant	48 (12) ^a	60 (35) ^a	4 (1) ^b	18 (4) ^b	15 (7) ^b
Depressive	24 (6) ^{bc}	83 (48) ^a	0 (0) ^d	5 (1) ^{cd}	26 (12) ^b
Dependent	28 (7) ^b	60 (35) ^a	4 (1) ^c	5 (1) ^c	17 (8) ^{bc}
Histrionic	0 (0) ^b	0 (0) ^b	23 (6) ^a	5 (1) ^{ab}	1 (1) ^b
Narcissistic	4 (1) ^b	2 (1) ^b	0 (0) ^b	5 (1) ^b	35 (16) ^a
Antisocial	0 (0) ^b	43 (25) ^a	0 (0) ^b	23 (5) ^a	44 (20) ^a
Aggressive	4 (1) ^b	35 (20) ^a	0 (0) ^b	23 (5) ^{ab}	41 (19) ^a
Compulsive	4 (1) ^{ab}	0 (0) ^b	15 (4) ^a	0 (0) ^{ab}	0 (0) ^b
Passive-aggressive	32 (8) ^{bc}	71 (41) ^a	0 (0) ^d	9 (2) ^{cd}	54 (25) ^{ab}
Self-defeating	16 (4) ^b	47 (27) ^a	0 (0) ^c	5 (1) ^b	20 (9) ^b
Schizotypal	4 (1)	10 (6)	0 (0)	0 (0)	2 (1)
Borderline	4 (1) ^c	67 (39) ^a	0 (0) ^c	0 (0) ^c	26 (12) ^b
Paranoid	0 (0) ^b	12 (7) ^{ab}	0 (0) ^b	0 (0) ^{ab}	15 (7) ^a
Anxiety	64 (16) ^b	95 (55) ^a	8 (2) ^d	9 (2) ^d	63 (29) ^b
Somatoform	0 (0)	9 (5)	0 (0)	0 (0)	2 (1)
Bipolar-manic	9 (0)	12 (7)	0 (0)	0 (0)	9 (4)
Dysthymia	28 (7) ^b	74 (43) ^a	0 (0) ^c	5 (1) ^c	30 (14) ^b
Alcohol dependence	8 (2) ^b	52 (30) ^a	8 (2) ^b	46 (10) ^a	54 (25) ^a
Drug dependence	0 (0) ^c	22 (13) ^{ab}	0 (0) ^c	5 (1) ^{bc}	24 (11) ^{ab}
PTSD	4 (1) ^{ab}	19 (11) ^a	0 (0) ^b	0 (0) ^b	7 (3) ^{ab}
Thought disorder	0 (0)	12 (7)	0 (0)	0(0)	2 (1)
Major depression	0 (0) ^b	29 (17) ^a	0 (0) ^b	0 (0) ^b	2 (1) ^b
Delusional disorder	0 (0)	5 (3)	0 (0)	0 (0) ^b	4 (2)

Superscript: a > b > c; $\chi^2 < 0.05$.

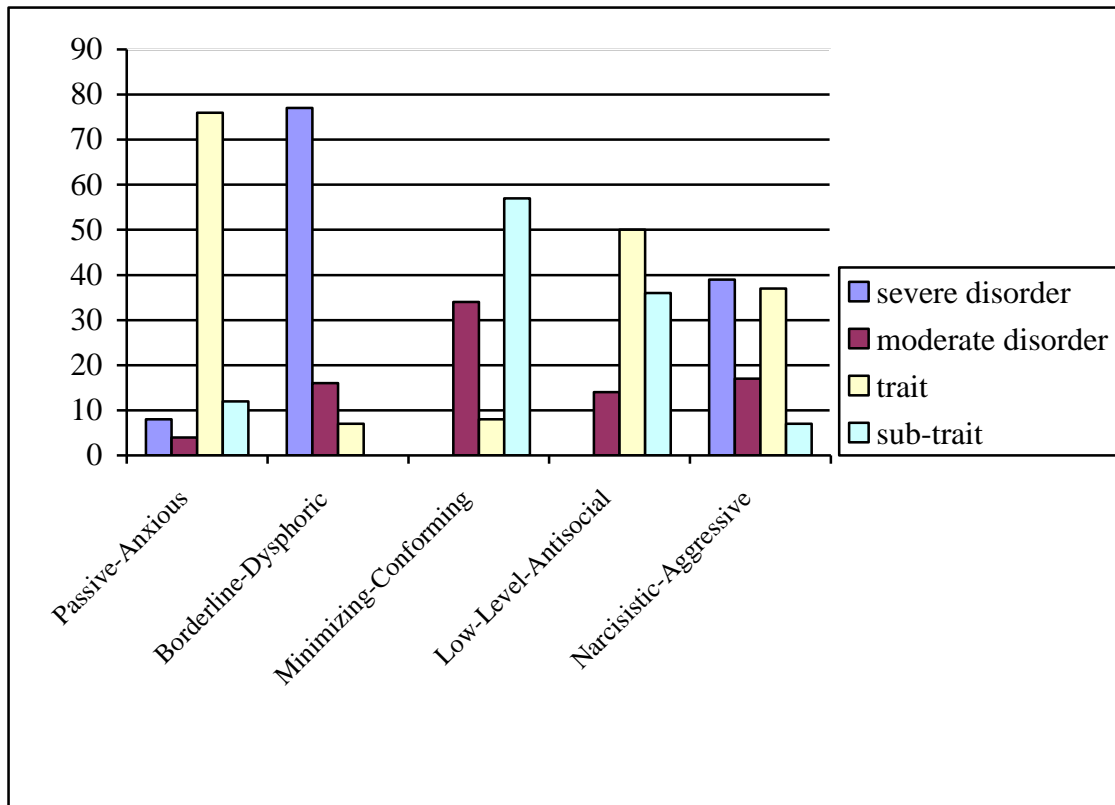


Figure 3: Percentage Severity of Personality Pathology by Five Clusters

C2 had significantly higher percentages of significantly elevated scales than did all other clusters on the following personality patterns:

- depressive ($\chi^2 = 80.68$, $df4$ [$N = 177$], $p < 0.001$)
- dependent ($\chi^2 = 44.72$, $df4$ [$N = 177$], $p < 0.001$)
- self-defeating ($\chi^2 = 31.00$, $df4$ [$N = 177$], $p < 0.001$)
- borderline ($\chi^2 = 68.05$, $df4$ [$N = 177$], $p < 0.001$)

and the following clinical syndromes:

- anxiety ($\chi^2 = 82.14$, $df4$ [$N = 177$], $p < 0.001$)
- dysthymia ($\chi^2 = 61.43$, $df4$ [$N = 177$], $p < 0.001$)
- major depression ($\chi^2 = 13.55$, $df4$ [$N = 177$], $p < 0.01$).

In C2, 93% of profiles met the MCMI-III criteria for personality disorders, with 78% being severe—especially borderline (Figure 3; Table 13). This was significantly higher than any other cluster ($\chi^2 = 78.53$, $df4$ [$n = 177$], $p < 0.001$).

The borderline profiles exhibited significantly greater percentages of the discouraged subtype compared with the borderline profiles in the narcissistic-aggressive cluster

(C5), which were predominantly impulsive ($\chi^2 = 7.06$, $df1 [n = 50]$, $p < 0.01$). The other personality disorders were largely dysphoric in nature—depressive, avoidant, dependent and self-defeating. We labelled this cluster the ‘borderline-dysphoric’ cluster. The C2 men reported perpetrating significantly higher psychological abuse than any other cluster (Table 16), and significantly higher total abuse than any other cluster, except the narcissistic-aggressive cluster men. They also reported significantly higher physical abuse scores than the minimising-conforming cluster men, but did not differ on this measure from any of the other clusters. In terms of style, C2 displayed a lower percentage of psychopathic style profiles than the narcissistic-aggressive cluster men (C5: $\chi^2 = 8.60$, $df1 [n = 104]$, $p < 0.01$), did not significantly differ from the low-level antisocial men (C4), and was only significantly greater than the passive-anxious cluster men (C1: $\chi^2 = 4.90$, $df1 [n = 83]$, $p < 0.05$). C2 shared overall higher percentages of significant angry-aggressive profiles with the low-level antisocial men (C4) and narcissistic-aggressive men (C5).

The C3 men (minimising-conforming; 15% of the sample) displayed mean disclosure and debasement scores that were significantly lower than all other clusters (Table 14), while the mean desirability score was significantly higher than all the other clusters. Such a high mean desirability score coupled with low disclosure and debasement often suggests some form of denial among the respondents (Choca, 2004). Thirty-five per cent of the profiles in this cluster would meet the criteria for a personality disorder (Figure 3) and all were of the histrionic or compulsive variety. The majority of all men in this cluster displayed histrionic, narcissistic or compulsive-conforming profiles—a significantly greater percentage than any other cluster ($\chi^2 = 81.47$, $df4 [N = 177]$, $p < 0.001$). Thus, we labelled C3 the ‘minimising-conforming’ cluster. As noted earlier, 50% were court-referred men—a significantly larger percentage than the court-referred men in the low-level antisocial cluster (C4), but not compared to any other cluster. C3 displayed significantly lower reports of total and psychological abuse than all other clusters (Table 15), and lower physical abuse scores than the borderline-dysphoric cluster (C2) and narcissistic-aggressive cluster. C3 also displayed significantly lower percentages of ‘angry-aggressive’ profiles than any other cluster ($\chi^2 = 78.82$, $df1 [N = 177]$, $p < 0.001$).

Table 14: Means and SDs for MCMI-III Modifying Indices by Five Clusters

	Disclosure	Desirability	Debasement
C1	54.72 (9.64) ^c	62.64 (12.19) ^c	57.16 (10.72) ^b
C2	78.16 (13.47) ^a	41.21 (15.87) ^d	75.22 (10.01) ^a
C3	32.92 (11.00) ^d	79.23 (11.24) ^a	22.16 (19.06) ^d
C4	47.64 (11.88) ^c	63.50 (12.49) ^c	45.36 (9.35) ^c
C5	65.54 (11.39) ^b	73.87 (10.97) ^b	60.52 (9.40) ^b
Eta sq.	0.64	0.57	0.69
Power	1.00	1.00	1.00

Superscript: a > b > c; same letter = no significant difference.

The response style showed that the low-level antisocial cluster men (C4: 12% of sample; Figure 2) displayed average desirability, but lower than average disclosure and debasement scores for a clinical population (Table 14). They also reported very little severe pathology, with most profiles being in the trait or sub-trait range of severity (Figure 3). However, nearly half had significant alcohol dependence scores, and a total of 59% of this group displayed angry-aggressive and/or antisocial characteristics.

A significantly greater percentage of these men were self-referred (as opposed to court-referred) than the men in the minimising-conforming cluster (C3), but not compared to any other cluster. Their abuse behaviour reports demonstrated significantly greater total and psychological abuse than the minimising-conforming men (C3; Table 16), but lower scores than the borderline-dysphoric men (C2). They did not differ from the passive-anxious (C1) and narcissistic-aggressive (C5) men on these variables, nor did they differ from any other cluster on the physical abuse measure.

Table 15: Percentages of Types of MCMI-III Profiles by Five Clusters

	C1	C2	C3	C4	C5
Psychopathic	0 (0) ^d	17 (10) ^{bc}	4 (1) ^{cd}	36 (8) ^{ab}	44 (20) ^a
Antisocial only	0 (0) ^c	35 (20) ^a	4 (1) ^{bc}	9 (2) ^{bc}	17 (8) ^{ab}
Passive-aggressive	36 (9) ^a	21 (12) ^{ab}	4 (1) ^c	14 (3) ^{abc}	15 (7) ^{bc}
Comb. Aggressive	36 (9) ^b	72 (42) ^a	12 (3) ^c	59 (13) ^{ab}	76 (35) ^a
Withdrawn	48 (12) ^a	26 (15) ^b	12 (3) ^b	14 (3) ^b	13 (6) ^b
Conforming	4 (1) ^{bc}	0 (0) ^c	73 (19) ^a	9 (2) ^{bc}	11 (5) ^b

Superscript: a > b > c; same letter = no significant difference.

The narcissistic-aggressive cluster (C5) was noteworthy for having the highest percentage of significantly elevated narcissistic personality profiles (35%; Table 13) ($\chi^2 = 37.87$, df4 [$N = 177$], $p < 0.001$, std res. 5.0) and the second-highest percentage of severe personality patterns after the borderline-dysphoric cluster (C2; 39%; Figure 3) ($\chi^2 = 138.14$, df4 [$N = 177$], $p < 0.001$, std res. 0.3). While more than half of the profiles

in this cluster were consistent with a personality disorder, the mean scores on desirability were the second-highest of any cluster, while the disclosure and debasement mean scores were average for a clinical population (Table 14).

This suggests a measure of distress and malfunctioning that is held together by what Baumeister, Smart and Boden (1996) referred to as ‘unrealistic high self-esteem’. The narcissistic-aggressive cluster (C5) was also characterised by sharing with the borderline-dysphoric cluster (C2) and (in some cases) the low-level antisocial cluster (C4) the highest levels of significantly elevated antisocial, aggressive and passive-aggressive personality patterns, and alcohol and drug dependence clinical syndrome scores. The profiles ranged through paranoid and borderline (especially of an impulsive or antisocial nature) severe patterns, alongside aggressive, narcissistic and negativistic patterns. This cluster was labelled the ‘narcissistic-aggressive’ cluster. This cluster of men also reported significantly higher total, psychological and physical abuse scores than the minimising-conforming cluster (C3), but lower psychological abuse scores than the borderline-dysphoric cluster (C2). However, these men did not differ from the passive-anxious men (C1) or the low-level antisocial men (C4) on these measures.

Table 16: Means and SDs for Male and Female ABI Scores as a Function of Five Clusters of Male Personality Pathology

	C1	C2	C3	C4	C5	<i>F</i> df4,172	η^2 1- β
Male total	46.68 ^b (11.26)	54.49 ^a (12.59)	40.46 ^c (6.56)	45.64 ^b (8.28)	49.61 ^{ab} (7.43)	10.20 <i>p</i> < .00	.200 1.00
Male psychol.	28.40 ^b (6.87)	34.26 ^a (8.42)	24.3 ^c (4.56)	28.14 ^b (6.10)	30.54 ^b (5.55)	11.15 <i>p</i> < .00	.204 1.00
Male physical	18.28 ^{ab} (5.99)	19.81 ^a (6.13)	16.15 ^b (3.03)	17.41 ^{ab} (4.23)	18.56 ^a (4.96)	20.92 <i>p</i> < .001	
						<i>F</i> df 4,119	
Female total	72.41 (15.50)	68.35 (21.47)	68.56 (24.06)	63.05 (13.25)	67.94 (23.34)	0.49ns	
Female psychol.	46.18 (11.15)	43.93 (13.54)	45.50 (17.77)	40.45 (11.48)	43.55 (15.19)	0.47ns	
Female physical	26.24 (9.13)	24.38 (9.72)	23.06 (8.27)	22.60 (6.00)	24.39 (9.57)	0.45ns	

a > b > c; *p* < 0.05.

In terms of profile style, 76% of the Narcissistic- Aggressive cluster were of the angry-aggressive antisocial type, displaying a significantly higher percentage of ‘psychopathic’ profiles than the borderline-dysphoric cluster (C2) (but not C4), which

was partly accounted for by a significantly higher percentage of impulsive borderline profiles than in C2 ($\chi^2 = 5.51$, $df1 [n = 50]$, $p < 0.05$).

The relationship to abuse scores, as reported by the male participants and their female partners, was both helpful and surprising (see Table 16). The scores were helpful because they made logical sense in the context of the different personality pathology the men reported, and surprising because there were no significant differences between the five clusters in terms of the female partner reports of abuse. However, the female mean scores were 1.15 SDs higher than the male mean scores of abuse.

7.5 Discussion

These results indicate that domestically violent men assessed for an IPV treatment program can be categorised coherently into at least five distinct groups of personality pathology. Severe personality pathology with attendant severe levels of clinical syndromes characterised one cluster in this sample, and accounted for 33% of these men. We labelled this cluster ‘borderline-dysphoric’ (C2) because Millon’s (1999) subcategory of discouraged borderline was highly prominent, alongside high levels of anxiety and dysthymia. This group was perhaps similar in personality pathology to Holtzworth-Munroe and Stuart’s (1994) grouping of the same name. More than three quarters of this cluster reported severe personality pathology—higher than any other cluster in the sample (see Figure 3). Like Holtzworth-Munroe et al.’s (2000) findings, our borderline-dysphoric grouping reported the highest levels of abusive behaviour, which they shared with the narcissistic-aggressive group in ABI total and physical abuse scores, and they had the significantly highest ABI psychological abuse reports of any of the clusters. This makes sense because emotional reactivity is especially prominent in such profiles (Millon, 1999).

This also makes the borderline-dysphoric group quite dangerous from a reactive violence perspective. Fear of abandonment may lead to highly aroused protest behaviours directed at a significant attachment figure, as in the MCMI-III item that reads: ‘I’ll do something desperate to prevent a person I love from abandoning me’ (Item #120; Millon, 1994). It may also lead to suicidal behaviours designed to ‘end it

all' and/or manipulate the one loved. These behaviours indicate the importance of considering these transference issues with the borderline-dysphoric cluster (Benjamin, 1993). Apart from careful attendance to risk factors, the borderline-dysphoric cluster also requires considerable focus on distress tolerance skills and emotion regulation strategies if these men are to be kept in a treatment group and assisted to reduce the reactive factors that clearly contribute to abusive behaviours in their intimate relationships. Interestingly, DBT has been successfully trialled with domestically violent men because it concentrates on these skills (Cavanaugh, Solomon & Gelles, 2011; Fruzzetti & Levensky, 2000).

A second cluster of men—26% of the current sample (C5)—exhibited the second-highest level of severe personality pathology, but also the highest percentage of narcissistic personality elevations, and many antisocial, aggressive and passive-aggressive profiles. However, unlike the borderline-dysphoric cluster (C2), few had avoidant or dependent profiles. The C5 men were also quite distinct to the C2 men in displaying highly elevated desirability scores, and could be deemed similar to Holtzworth-Munroe and Stuart's (1994) model of the generally-violent-antisocial perpetrator group—at least in terms of personality pathology. However, as we had no data to assess general violence in this study, we labelled C5 the 'narcissistic-aggressive' cluster. This cluster, along with C2, reported the highest level of total abusive behaviour, which agrees with Holtzworth-Munroe et al.'s (2000) findings of their borderline-dysphoric and generally-violent-antisocial groupings. Clinically, the narcissistic-aggressive cluster is likely to display low empathy, self-centred control and unmodulated attacks on those who 'cross' them (Benjamin, 1993). This leads to a need for this group to be managed in a strong, clear and consequential manner, so that power and control is not exerted over the group, and these men learn that such tactics will not result in their desired outcomes. Coercive and controlling IPV is likely to be most commonly employed by these men, but in a more instrumental manner than that employed by the reactive C2 men.

The low-level antisocial group identified in Holtzworth-Munroe et al.'s (2000) research was paralleled by our C4, which evinced almost no profiles that would be deemed personality disordered. However, significant alcohol dependence, antisocial and aggressive profiles were evident. This suggests some resemblance with Holtzworth-

Munroe et al.'s (2000) low-level antisocial group. This cluster had a surprisingly high percentage of angry, aggressive and antisocial profiles, albeit at lower levels of personality dysfunction than the narcissistic-aggressive cluster. Men in this cluster may be intermediate in terms of abuse behaviours to the borderline-dysphoric men (C2) and narcissistic-aggressive men (C5) on the one hand, and the minimising-conforming men (C3) on the other. Their mean psychological abuse scores were lower than the borderline-dysphoric cluster and higher than the minimising cluster, while their physical abuse scores were marginally lower than the borderline-dysphoric cluster and narcissistic-aggressive cluster (the more severely pathological clusters), but higher than the minimising-conforming cluster (C3). While more similar to the passive-anxious men, they exhibited a 'colder' mood—not highly anxious. Interventions may require some firm boundaries, but probably with a lower threat/risk level than with the borderline-dysphoric and narcissistic-aggressive clusters (C2 and C5), given their lower levels of psychopathology on the MCMI-III.

The 'low pathology' group identified by Holtzworth-Munroe and Stuart (1994) and Holtzworth-Munroe et al. (2000) was not clearly paralleled in our sample. The minimising-conforming cluster could not meet this description because it had 35% histrionic and compulsive profiles at disorder levels, and exhibited high levels of denial (as indicated by the modifying index scores), despite having the lowest reports of abuse. Thus, it is likely that the psychopathology was minimised to some degree—consciously or unconsciously—and the abuse scores may have been minimised as well. Men in this cluster displayed significantly lower abuse scores than any other cluster (at least in terms of total abuse and psychological abuse) and significantly lower physical abuse scores than the two severe clusters (C2 and C5). Working with this group of men would be problematic due to their high levels of denial or simply lack of awareness of their inner experience. Considerable reality testing is often necessary to help men with these types of profiles (Millon, 1999). This cluster was labelled the 'minimising-conforming' cluster.

C1—the passive-anxious group—was most likely to meet the criteria for low pathology, since there were almost no profiles that would meet the criteria for a personality disorder. These were largely anxious/avoidant or dependent men, who would experience some social inhibition and difficulty with self-assertion (Millon, 1999). They exhibited

the significantly highest levels of withdrawn or dependent types of personality profile, but also elevated levels of passive-aggressive profiles compared with the other clusters (apart from C2—the borderline-dysphoric cluster). From a clinical perspective, these men need a group environment and approach in which mastering anxiety is taught before work with IPV behaviour can be successful. They are easily shamed into withdrawal and shutting down (Millon, 1999).

Unsurprisingly, there seemed to be a relationship between the clusters' reports of psychopathology and abusive behaviour (controlling for social desirability) in our findings. That is, the higher the psychopathology, the higher the abuse scores reported by the men. While there were positive correlations among all the male and female abuse scales in this sample, the large mean difference between the male and female reported scores quantifying the amount of abuse suggests that we cannot rely on male reports to understand the absolute amount of violence. While some reports have suggested approximate equivalence between male and female partner reports (Ehrensaft et al., 2004), this was in a research protocol, not the general findings in intervention studies (Heckert & Gondolf, 2000; Henning & Holdford, 2006; Henning, Jones & Holdford, 2005; Jouriles & O'Leary, 1985), which indicate significant minimisation by perpetrators. Further, the longitudinal Dunedin health study cohort (Moffitt et al., 1997) using long-term confidential research protocols still found a statistically significant bias by perpetrators towards under-reporting. Heckert and Gondolf (2000) also found an element of minimisation by female victims. They believed this to be an attempt to maintain the relationship, although it may also be either a shame or safety factor. However, this raises the possibility that female reports are also skewed by some form of desirability response. There is clearly a need to identify more effectively how realistic abuse reports are. Therefore, we argue that relating the intervention to personality pathology characteristics is likely to be more useful than simply working with reported levels of abuse.

7.6 Limitations

As in Studies 1 and 2, the findings of this study are limited by their reliance on self-report and a single instrument for assessment of personality pathology. However, the

diversity and clustering was based not purely on clinical perception or pre-existing categories, but on statistical analysis, which pointed to clear personality differences in terms of both severity and type, while controlling for response bias. As noted in the statistical analysis section, we cross-validated the reliability of our profiles through the discriminant function analysis method of split group reliability comparison. Further, it is important to remember that personality profiles were used as practical tools to understand each man's coping patterns in MCMI-III terms, not as a mechanism for diagnosis *per se*.

7.7 Concluding Remarks

Thus, what is the value of parsing this group of IPV perpetrators based on personality pathology? We argue that we are seeking the most effective and parsimonious basis on which to treat men who perpetrate IPV and personality profile assessments and interventions (Corvo & Johnson, 2013) hold hope for this approach. It has been argued that more contextual information is especially relevant for the treatment of male IPV perpetrators (Capaldi et al., 2007, 2012). In the intervention programs in which these men were participants, these personality profiles were applied to inform and guide treatment. Informally, this was found to be useful in working with these men (see Chapter 9). As already noted in the methodology, there were a number of assessment and preparation sessions for participants in each of the treatment groups, and an extensive intake questionnaire was used and discussed with the men in order to understand how personality profiles interfaced with contextual factors.

Such a personality profile parsing helps explain some of the non-significant outcomes in studies that have been averaged across treatment groups (Arias, Dankwort, Douglas, Dutton & Stein, 2002; Dunford, 2000; Feder & Wilson, 2005; Stover et al., 2009). It shows a distinct need for different approaches to these different psychological profiles of men if progress is to be made in their treatment. More than 10 years ago, Saunders (2001) asserted, 'The best intervention outcomes for men who batter may be obtained when the type of offender is matched to the type of treatment' (p. 237), yet there has been little progress in this regard. Millon (2011) argued that 'personality serves as a distinct context ... that gives meaning and character to whatever clinical disorders may

also be present in the individual' (p. x). Further, appropriately addressing such pathology greatly enhances the direction and successful outcome of interventions (Millon, 1999). Thus, types of offenders can be adduced from the personality typology derived in the current study, which would assist greatly in working with different profiles to maximise treatment outcomes. This thesis emphasises the importance of formulating a template for assessment and intervention for male IPV perpetrators to assist group facilitators (or individual practitioners) to intervene more successfully with these men. We provide this template in Table 17. We concur with Wexler's comment that, 'While insisting that men take full responsibility for their abusive behavior, treatment approaches can still be most effective by addressing inherent psychological issues' (Wexler, 1999, p.140).

Table 17: Personality Pattern Grid for IPV Men’s Cluster Information

	Areas of attention		
	Primary pathology	Probable IPV modes	Treatment modes
C1: Anxious-avoidant	Moderate distress; High percentage of anxious, avoidant, depressive and dependent personality.	Often situational IPV, especially in ‘pursue–avoid’ relationships.	Gentle and encouraging approach; Strategies to reduce anxiety and avoidance; Understanding own and partner’s needs; Negotiating.
C2: Borderline-dysphoric	Highest levels of psychopathology; High levels of distress; Significant borderline, depressive, dependent personality; Significant anxiety, dysthymia and depression.	Reactive IPV, especially when abandonment is experienced; Can be emotionally coercive and controlling and thus quite dangerous at moments of perceived abandonment; Watch for suicidal and homicidal reactivity.	Need for safety planning for client and partner; Reductions in anxiety; Distress tolerance skills essential; Teaching empathy and self-compassion without allowing attachment idealisation to develop.
C3: Minimisers	Low levels of distress; High levels of social desirability and denial, unaware often; High levels of histrionic, narcissistic and compulsive-conforming personality	Lowest levels of IPV: often situational, but may exhibit almost any form of IPV if circumstances are particularly challenging; Tend to deny and project resentment and frustration.	Clear boundaries; Reality testing and motivational interviewing; Beware of colluding with denial and reinforcing attitudes; Later challenges to taking responsibility.
C4: Low-level aggressive	Moderate distress and social desirability; Moderate personality pathology—antisocial, aggressive and passive-aggressive.	Moderate to high levels of IPV; Prone to instrumental IPV—coercive and controlling—usually not as dangerous as C2 and C5.	A need for firm parameters; Motivational interviewing; Avoid early challenging.
C5: Narcissistic-aggressive	High levels of social desirability; High distress; High levels of narcissism, antisocial and aggressive personality; Some severe borderline and paranoid; High levels of alcohol and drug dependence.	Can be extremely dangerous: tend to use coercive or controlling IPV in a cold and calculating manner.	Good safety planning required regarding homicidal intent; Set clear boundaries; Make client responsible for his own treatment compliance or non-compliance; Be tough, but avoid personal confrontation; ‘Boot camp’ an option.

Chapter 8: Other Components of the Five-cluster Model of IPV Men—Study 4

8.1 Introduction

Having parsed men entering an IPV program for differential personality pathology, and having found five distinct groups, our clinical observations suggested that we should also assess certain other variables to further refine and inform treatment needs. When this project was first begun (2003), the interpersonal problems of men presenting for IPV treatment was of particular interest. To this end, the Inventory of Interpersonal Problems (IIP-64) was administered during these men's intake assessment. Self-compassion and its relationship with empathy were also of particular importance in this research, as various researchers have argued that this personal characteristic is at the core of IPV perpetration (Fonagy, 2004; Stosny, 1993). A better understanding of the place of self-compassion and empathy in the psychology of male perpetration of IPV, as well as its application in interventions, might enable positive shifts from fear-inducing control to identification with others' pain (Gilbert, 2009). This is explored further below.

8.2 Self-compassion: An Underrated Characteristic

In his book *Treating Attachment Abuse*, Steven Stosny (1995) argued that IPV men suffer from feelings of powerlessness because of poor attachment relationships in their family of origin, and seek to compensate for this by exercising control over their partners. In *The Powerful Self*, Stosny (1995) argued that, 'We see the world through the lens of self-concept' (p. 2) and because boys who grow up in abusive families lack a sense of positive self-concept, they internalise 'core hurts', such as feeling rejected, disregarded, powerless, unlovable and inadequate. In order to deal with this significant psychic pain, these men compensate, rather than regulate emotionally. Hence, defences such as entitlement, revenge, people-pleasing and self-pity develop, which are 'weak modes' of self, and entail angry ruminations and reactions that arise from feelings of helplessness, dependence, depressiveness and destructiveness.

Stosny (1995) grouped compassion with competence, creativity, growth, healing and nurturing as one of the ‘power modes’ of self. He described compassion as that which ‘converts an experience of self-destructive pain and shame into one of understanding and validation of the hurt that causes the destructive symptom’ (Stosny, 1995, p. 7). However, he did not expressly define compassion, nor attempt to measure it—unless we accept his notion that compassion is that which enables us to feel for and act positively on behalf of a frightened child. He viewed this ability or action as being at the heart of the change process, whereby a male IPV perpetrator begins to have a positive response to his own internal pain, and then extends that feeling and action to his partner. Stosny (1995) referred to this compassion towards the self and the other as a ‘core value’.

Others have defined and measured self-compassion. We used the work of Neff (2003a, 2003b) and Barnard and Curry (2011) to understand and measure this construct among a group of IPV men presenting for treatment programs. Neff (2003a) stated that compassion in Western thought tends to relate to active concern for those in need, rather than for oneself. She applied Eastern religious and philosophical notions of self-compassion to the Western world in seminal work that included developing and validating a self-report instrument (Neff, 2003b) and researching self-compassion’s relationship with positive psychological functioning and personality (Neff, Rude & Kirkpatrick, 2007), psychological resilience (Neff & McGehee, 2010), romantic relationships (Neff & Beretvas, 2013), and achievement goals and coping with failure (Neff, Hsieh & Dejjitterat, 2005). The multifaceted nature of her Self-Compassion Scale (SCS) lends itself well to understanding IPV men’s intrapsychic emotionality because Neff’s validation of the SCS presents six clear facets in the construct, with positive and negative orthogonal components. These are self-kindness and self-judgement, common humanity and isolation, and mindfulness and over-identification with emotions.

Neff and Beretvas’s (2013) study is particularly relevant, given that IPV is about adult romantic relationships. They found that self-compassion was positively correlated with caring and supportive relationships, as opposed to controlling and verbally abusive relationships, in a general population sample of 104 couples recruited from an online survey. Specifically, those higher in self-compassion were described by their partners as warmer, more considerate, more accepting of the partner and more prepared to grant

their partner autonomy than those with lower self-compassion. Thus, self-compassion appears to be a predictor of and buffer to abusive behaviour in intimate relationships. Leary, Tate, Adams, Allen and Hancock (2007) conducted a series of experiments with 117 university students that demonstrated the value of self-reported self-compassion for reducing reactivity to negative events. Once again, the outcomes demonstrated the likely moderating effect of self-compassion on abuse in intimate relationships. A further study by Neff, Kirkpatrick and Rude (2007) found that participants with higher self-compassion scores demonstrated more resilient psychological functioning when experiencing an experimentally induced 'ego threat' compared to those with low self-compassion scores. This is particularly relevant for IPV perpetrators who appear to have their defences easily mobilised by such threats.

This is an important area of study, given that much policy and opinion regarding male perpetrators of IPV has argued that such questions are largely irrelevant because IPV men are seen as addicted to 'power and control' and exhibit the visible male expression of a patriarchal society. Others have argued that power and control is a non-discriminatory factor, given that all people endeavour to and do exert some form of control over their lives (Corvo & Johnson, 2013; Dutton, 2006). The real question is how such power and control becomes abusive. Some researchers have argued that, from a social learning model, male IPV perpetrators have learnt to exercise power and control by observing and experiencing it from adult males in the family of origin and the wider male community generally (Gondolf, 2002).

Given this background and the importance of self-compassion for developing more effective intervention programs for IPV, the aim of Study 4 was to compare the patterns of self-compassion, brief emotional empathy and interpersonal problems across different clusters of personality pathology in order to assess possible deficits in self-compassion and/or empathy that might affect how IPV perpetrators deal with intimate relationship problems.

8.3 Method

8.3.1 Participants

The participants were a subset of the total sample of 177 men. This was due to the project being relatively drawn out and some ancillary measures being used in the later part of the research (and not the earlier part), but not continuously for practical reasons of time and space. The Inventory of Interpersonal Problems (IIP) sample comprised 73 men, the SCS sample comprised 96 men, and the Balanced Emotional Empathy Scale (BEES) sample comprised 84 men. All cases were measured in conjunction with the MCMI-III and ABI, and were measured at differing times—in many cases overlapping one another. Otherwise, the measurement was random in the sense that the men were coming into assessment for the service on a continuous basis for a certain period, and it was mandatory for them to complete the assessment measures.

8.3.2 Measures

8.3.2.1 The IIP

The IIP (Horowitz, Alden, Wiggins & Pincus, 2000) was developed by Horowitz, Rosenberg, Baer, Ureno and Villasenor (1988) to assess interpersonal issues, as opposed to intrapsychic issues, and changes wrought through psychotherapy in interpersonal issues. The IIP was chosen for this study for two reasons. First, Bartholomew and Horowitz (1991) used it to profile the interpersonal problems peculiar to different personality pathologies, and the relationship between personality pathology and interpersonal behaviour might be enhanced by this measure. Second, interpersonal problem behaviours are critical to IPV perpetration in particular since IPV is about interpersonal behaviour (Holtzworth-Munroe & Stuart, 1994; Rosenbaum & Leisring, 2003).

The IIP-64 was specifically designed to assess interpersonal problems along the dimensions of affiliation and dominance, which has obvious relevance to the problems encountered in IPV, where dominance often appears to be quite high, while affiliation is low. The instrument was normed on 800 cases representative of the US population in the 18 to 89 age range. Reliability coefficients ranged from 0.76 to 0.88 for the

subscales, with a full-scale alpha of 0.96. Test–retest reliabilities ranged from 0.56 to 0.78 for the subscales (Horowitz et al., 2000). The authors attributed these lower correlations to the normative sample being non-clinical and prone to low scores and low variability. Convergent validity was demonstrated through moderate scale correlations with the Beck Depression Inventory, Beck Anxiety Inventory and Social Adjustment Scale—Self Report, and moderate to large correlations with the Symptom Checklist 90, Brief Symptom Inventory, and Behaviour and Symptom Identification Scale. Factor analysis demonstrated the circumplex arrangement of the eight subscales with affiliation–dominance as orthogonal (Horowitz et al., 2000). The IIP’s 64 items assess things that a person ‘finds hard to do’ or ‘does too much of’ in close relationships. Clinical cut-off scores for the IIP were a t-score greater than 60 indicating an above-average score, and a t-score greater than 70 indicating ‘significant difficulty’.

8.3.2.2 *The SCS*

The SCS is a 26-item self-report inventory, with five self-kindness and five self-judgement items, and four items each for common humanity and isolation, and mindfulness and over-identification with emotions. A total score is obtained by summing the subscale scores after reversing the scores for self-judgement, isolation and over-identification. The instrument was developed with 391 undergraduate participants through factor analytic techniques, and cross-validated with a second sample of 232 undergraduate participants, who were further compared with a sample of 43 Buddhist practitioners of mindfulness. The SCS demonstrated internal reliability of 0.92, with test–retest reliability of 0.93 overall, and with all subscales above 0.80 in these samples. This instrument showed sound psychometric properties and theoretically valid associations with other measures—namely, high self-compassion was positively correlated with mental health, and did not display the strong associations that high self-esteem has with both narcissism and social desirability.

The instrument has since been re-examined in a short 12-item version (Raes, Pommier, Neff & Van Gucht, 2010) that demonstrated a near perfect correlation with the longer 26-item scale. The same single higher-order factor and six second-order factors corresponding to the six subscales of the SCS were in evidence using confirmatory factor analysis. The SCS has not been normed. Neff (2009) gave the following guidance

on a five-point scoring of the SCS: 1 to 2.5 = low; 2.5 to 3.5 = moderate; and 3.5 to 5.0 = high self-compassion. However, we also noted the full-scale scores from Neff's original samples, where a mean of 18.96 (SD 3.64) was recorded for the male sample.

8.3.2.3 *The BEES*

Mehrabian (2000) developed the 30-item BEES to describe 'individual differences in the tendency to feel and vicariously experience the emotional experiences of others' (p. 2)—that is, a person's ability to identify with another's experience at an emotional level. For our purposes, this scale significantly correlated -0.50 with Mehrabian's (1997) Risk of Eruptive Violence Scale, and -0.31 with Maiuro, Vitaliano and Cahn's (1987) Aggression Scale, while correlating positively with Mehrabian's (1998) Optimism Scale, thereby suggesting that higher emotional empathy may be associated with lower abuse scores.

Mehrabian (1994, 1997) also argued that the validity of his original Emotional Empathy Scale (Mehrabian & Epstein, 1972) applies to the BEES, which together share high correlations. Specifically, he found that participants high in emotional empathy were characterised by more empathy, interpersonal positivity, affiliativeness and emotional intelligence. This was evidenced by the significant positive trait pleasure and trait arousability components that emotional empathy shared with affiliative tendencies. Mehrabian (2000) normed his test on a (male) mean of 29 (SD 28), with conversion to Z scores and percentiles for comparison.

8.3.3 Analysis Strategy

First, we divided the full five-cluster sample of 177 men into those who had and had not completed these three measures, and then tested for any differences in participants using independent samples t-tests, where the independent variables were the groups who had and had not completed the measures, and the dependent variables were continuous MCMI-III personality scales and ABI continuous total scores.

Next, we used the continuous scores on the IIP, SCS and BEES as the dependent variables, and the five clusters of personality pathology from the MCMI-III (see Study

3, Chapter 7) as the independent variables in a post-hoc univariate ANOVA, using a Bonferroni correction for multiple comparisons.

8.4 Results

The results of the independent sample t-tests comparing those who had and had not completed the IIP, SCS and BEES showed only one significant result—namely for the MCMI-III narcissistic personality scale, which applied to all three variables in predictable ways. Those who had completed the SCS and BEES measures exhibited significantly higher mean narcissistic scale scores than those who had not completed them (SCS: $t = -3.99$, $df = 175$, $p < 0.0001$ [SE: 2.62]; BEES: $t = -3.26$, $df = 175$, $p < 0.001$ [SE: 2.66]), while those who had completed the IIP exhibited significantly lower narcissistic scale scores than those who had not completed it (IIP: $t = 3.99$, $df = 175$, $p < 0.0001$ [SE: 2.65]). Thus, it appears that narcissistic personality scores inflated the SCS and BEES scores, and correspondingly deflated the IIP scores. Therefore, the MCMI-III continuous narcissistic scale score was used as a covariate in the ANOVA to correct for bias in the cluster comparisons.

Table 18 presents the results of the ANOVA comparisons between the IIP, SCS and BEES scores for the five clusters. The IIP scale scores were complex, but discriminated moderately between clusters. For example, the borderline-dysphoric cluster (C2) had the highest mean scores on every scale, though it often lacked statistical significance in relation to at least one other cluster mean. C2 was also the only cluster that displayed mean total scores in excess of a t-score of 60, which is above average on the IIP norms. This might suggest that, apart from C2, most of the men in our sample did not report ‘abnormal’ interpersonal problem behaviour. However, it might also be indicative of minimising or a lack of awareness of interpersonal problem behaviour. The borderline-dysphoric cluster shared the highest mean total score with the narcissistic-aggressive cluster (C5), but not with any other cluster. The borderline-dysphoric, narcissistic-aggressive and low-level antisocial clusters had significantly higher mean domineering and controlling scores than did the passive-anxious and minimised-conforming clusters.

The borderline-dysphoric cluster (C2) was also significantly higher in socially-inhibited interpersonal problem scores than any cluster, apart from the passive-anxious cluster (C1), which makes intuitive sense, since both these clusters of men had high anxiety scores. However, the borderline-dysphoric cluster also shared significantly higher intrusive and needy interpersonal problem scores with the narcissistic-aggressive cluster (C5) when compared with the other three clusters. This is not so easily understandable, unless the C5 scores relate more to the ‘intrusive’ aspect than the ‘needy’ aspect of that scale.

C3 (the narcissistic, histrionic and compulsive-conforming cluster—the ‘minimisers’) reported the lowest scores on all scales, although they were not exclusively low in relation to all other clusters. However, as a group, they tended to report being less controlling, vindictive, cold, socially-inhibited, non-assertive, overly-accommodating, self-sacrificing, intrusive and needy.

The BEES was noteworthy because there were no significant differences between the cluster means, and the variability in the cluster scores was extremely large, thereby suggesting that expressive emotion was not a discriminating factor in this sample of IPV men. Compared with Mehrabian’s (2000) norms, all cluster means apart from C5 (the narcissistic-aggressive cluster) were well above average for these men. Having said that, we noted that C3 (the minimising cluster) produced the highest mean scores on the BEES, and C5 produced the lowest. The SCS scores were discriminating at certain points. The minimising cluster (C3) produced the highest overall score for self-compassion, although this was not significantly higher than the low-level antisocial cluster (C4). In contrast, the borderline-dysphoric group (C2) produced the lowest overall self-compassion score, although this was not significantly lower than the narcissistic-aggressive cluster (C5). The borderline-dysphoric cluster also produced higher ‘isolation’ subscale scores than any other cluster, except C5. The borderline-dysphoric cluster also shared higher over-identification with emotions subscale scores with the passive-anxious (C1) and narcissistic-aggressive (C5) clusters when compared to the minimising (C3) and low-level antisocial (C4) clusters. As a Z score, this means that the borderline-dysphoric cluster men were 1.2 SDs below the male mean for the Neff (2003) test construction sample, while C3 (the minimised cluster) had a mean score of 1.13 SDs above that mean.

Table 18: Mean Score Comparisons of IIP, SCS and BEES across Five Clusters of MCMI-III Personality Pathology

	C1	C2	C3	C4	C5	<i>F</i> (4,69)	<i>P</i>
Domineering and controlling	49.2 ^b (7.4)	64.2 ^a (12.1)	44.8 ^b (6.4)	54.4 ^{ab} (8.7)	63.3 ^a (12.2)	8.75	.000
Vindictive and self-centred	51.6 ^{ab} (8.5)	61.4 ^a (9.8)	45.7 ^b (7.3)	53.0 ^{ab} (6.3)	57.5 ^{ab} (12.6)	5.35	.001
Cold and distant	51.3 ^{ab} (8.4)	59.8 ^a (8.7)	45.2 ^b (9.1)	51.7 ^{ab} (7.4)	58.5 ^a (14.9)	4.42	.003
Socially-inhibited	57.6 ^{ab} (9.2)	68.0 ^a (10.8)	48.6 ^b (11.2)	55.6 ^b (8.3)	53.3 ^b (10.6)	7.70	.000
Non-assertive	54.5 ^{ab} (7.3)	65.7 ^a (12.5)	47.0 ^b (9.0)	56.1 ^{ab} (8.1)	56.2 ^{ab} (11.8)	5.91	.000
Overly-accommodating	53.4 ^{ab} (6.5)	62.8 ^a (11.7)	50.0 ^b (10.0)	52.9 ^b (10.1)	56.1 ^{ab} (9.9)	3.83	.007
Self-sacrificing	53.9 ^{ab} (9.0)	63.0 ^{ab} (9.9)	48.1 ^b (8.0)	51.3 ^b (7.5)	59.4 ^{ab} (11.1)	6.19	.000
Intrusive and needy	47.0 ^b (7.4)	61.4 ^a (12.8)	45.2 ^b (9.6)	49.2 ^b (5.5)	59.9 ^{ab} (14.0)	6.77	.000
Total	52.9 ^b (4.2)	66.36 ^a (8.6)	46.1 ^b (8.2)	53.5 ^b (6.6)	60.1 ^{ab} (10.6)	12.75	.000
	C1	C2	C3	C4	C5	<i>F</i> (4,92)	<i>P</i>
Self-kindness	3.4 ^a (1.1)	2.5 ^b (.79)	3.6 ^a (.63)	2.9 ^{ab} (.51)	2.9 ^{ab} (.71)	6.34	.000
Self-judgement	2.6 ^{ab} (.62)	3.0 ^a (.57)	1.6 ^b (.69)	2.0 ^{bc} (.76)	2.9 ^a (.49)	18.13	.000
Common humanity	3.7 ^{ab} (.79)	3.1 ^b (.96)	3.9 ^a (.59)	3.0 ^{ab} (.87)	3.3 ^{ab} (.79)	3.70	.000
Isolation	2.3 ^{bc} (.74)	2.97 ^a (.65)	1.5 ^d (.70)	1.5 ^{cd} (.76)	2.4 ^b (.63)	15.59	.000
Mindfulness	3.9 ^b (.77)	3.1 ^c (.85)	4.18 ^{ab} (.42)	3.4 ^{bc} (.64)	3.42 ^{bc} (.62)	7.32	.000
Over-identification	2.3 ^{ab} (1.1)	2.8 ^a (.75)	1.1 ^c (.52)	1.7 ^{bc} (.73)	2.7 ^a (.66)	18.03	.000
Total	18.6 ^b (3.1)	15.0 ^c (3.1)	22.5 ^a (2.6)	19.5 ^{ab} (1.9)	16.9 ^{bc} (2.7)	20.57	.000
BEES	38.1(27.1)	37.8(30.7)	48.5(23.0)	37.8(34.2)	26.9(20.8)	1.62	.171

Superscripts: a > b > c at significance level; $p < 0.05$ Bonferroni adjusted.

8.5 Discussion

Statistical parsing of the MCMI-III personality pattern scores from the IPV group under investigation showed five distinct factors that could be clustered into five groups that made some coherent sense out of the data. By analysing a sub-group of this sample on three other relevant instruments (IIP-64, SCS and BEES), we found that some of these characteristics helped not only in partial validation of our clustering, but would also assist in the measurement and intervention of the treatment of men presenting with IPV. That is, self-compassion is a more discriminating factor than balanced emotional empathy, and tends to show an inverse relationship with higher interpersonal problem scores. Stosny (1995) argued that self-compassion was lacking in IPV men due to attachment abuse, and that a compassionate intervention would assist them. Having assessed a group of men in a program for IPV with meaningful psychometric tools, (namely SCS, BEES and IIP) we concluded that:

- Not all men in this sample were suffering from low self-compassion. This was especially true of the minimising cluster (C3; 1.13 SD above the normative sample mean), while the low-level antisocial cluster (C4) and passive-anxious cluster (C1) exhibited similar mean scores to those produced by university student populations (the normative sample participants).
- High psychopathology was associated with lower self-compassion scores. The borderline-dysphoric cluster (C2) and narcissistic-aggressive cluster (C5) in the current sample were the men least likely to be self-compassionate, displaying scores below the mean (-1.2 SD and -0.65 SD, respectively *vis-à-vis* the normative group) for males. Further, the borderline-dysphoric group were more likely than any other cluster to report feeling ‘isolation’—out of touch with a sense of ‘common humanity’. This may be an expression of the borderline characteristics that Millon (1999) referred to as ‘discouraged’ and ‘self-destructive’, since they are constantly apprehensive of being abandoned—a factor that Bowlby (1988) associated with angry protest behaviour towards intimates. This aspect of men with IPV issues was also noted and highlighted in terms of attachment by Dutton and Starzomski (1993).
- High psychopathology was also associated with higher interpersonal problem scores; thus, once again, we saw the borderline-dysphoric (C2) and narcissistic-aggressive (C5) clusters displaying above-average (t-score > 60) domineering and controlling behaviours—by their own self-report. The borderline-dysphoric group had above-average scores on every interpersonal problem scale, with the exception of cold and distant, which is consistent with their propensity towards borderline personality pathology of an anxious, depressive, enmeshed and masochistic kind. As Benjamin (1996) indicated, the major ‘*exclusionary* condition’ for BPD is ‘tolerance of long-term aloneness’ (p. 389) (see also Dimaggio et al., 2007). It is also possible that the borderline-dysphoric cluster men were so anxious that they over-reported their psychopathology, and were far less stable as a group on behaviour—hence their above-average scores on nearly all IIP scales. The MCMI-III response indices seemed to suggest this was the case. Conversely, it may be that the men in the borderline-dysphoric group were less capable socially than the men in the other groups, even though some of the scales appeared to be contradictory. They may, as a group, be struggling with

anxiety regarding affiliation, and their preferred style for maintaining affiliation is often dominance and coercion.

- In this sample, there was no meaningful relationship between psychopathology groupings and emotional empathy scores. The emotional empathy mean scores for all five clusters failed to produce any significant differences, although the means were generally average or higher than average for Mehrabian's norms. However, the SDs were large, thereby suggesting great variability within clusters. This may mean that many IPV men can identify emotionally with partners—that is, they may be enmeshed—but are not necessarily compassionate towards them precisely because they may be low in self-compassion.

8.6 Concluding Remarks

Given the significant effect that self-compassion has on dealing more effectively with relationships, stress, negative thinking, reactive anger and psychological disorders, we would expect to see significant changes in the behaviour of men in IPV treatment when this variable is targeted for intervention through therapeutic relationships and skills training. It remains to be seen which types of personality pathology will respond best to such interventions, or how such interventions can best target different kinds of personality patterns. Stosny (1995) randomised men in an IPV group intervention to either the 'Compassion–Power' model or standard CBT models, which involved didactic skills training and active confrontation of anger and abuse. The Compassion–Power model intervention focused on techniques that identified 'core hurts' and elicited compassionate responses for intrapsychic pain. There were numerous significant advantages of the Compassion–Power model over the standard CBT model at the conclusion of the 12-week intervention, including significantly higher rates of reduced violence and verbal aggression, and higher rates of responsibility for the men's own behaviour and greater compassion for their female partners.

Neff and Beretvas (2013) demonstrated the positive relationship between self-compassion and intimate relationship satisfaction with 104 couples recruited from the community. Their research explored measures of control and dominance in the

relationship, as well as the Conflict Tactics Scale (Strauss, 1979) and was thus well suited to assessing relationships with possible IPV, and power and control issues.

Emotion regulation has been identified as an important problem among men perpetrating IPV (Fruzzetti & Levensky, 2000; Tweed & Dutton, 1998). The pragmatics of working with IPV as criminal behaviour and the need for violence to be reduced as quickly as possible have led to high confrontational strategies and high attrition rates in treatment groups (Fruzzetti & Levensky, 2000). The use of DBT for IPV men has developed from such assessments of the problems associated with standard treatments (Waltz, 2003), as described above. DBT programs involve important aspects of the Compassion–Power model, particularly mindfulness. This refers to the ability to participate in one’s experience without over-identification with emotions, and with self-kindness, rather than self-judgement. This is the heart of self-compassion as we measured it with Neff’s (2003b) SCS. The DBT approach has been trialled with IPV men with significant success *vis-à-vis* an anger management intervention, in a controlled pilot study (Cavanaugh et al., 2011). These researchers cited, among other variables, the importance of self-acceptance and recognition of one’s own emotional processes, which amounts to self-compassion.

Neff et al. (2006) also demonstrated that their SCS is negatively correlated with neuroticism on the Neuroticism-Extraversion-Openness (NEO) Five-Factor Index of personality, which reinforces their research that negatively associated the SCS with anxiety, and positively associated it with psychological wellbeing (Neff et al., 2006). The SCS was also positively correlated with extroversion, agreeableness and conscientiousness on the NEO Five-Factor Index. Such research suggests that self-compassion may be a mediator between behaviour and personality style.

Self-compassion has not been thoroughly researched in relation to IPV. However, as this thesis has demonstrated, among the men researched here, the higher their psychopathology, the less self-compassion they reported, and the more likely they were to be abusive towards their partners. Thus, there is likely to be increases in self-compassion, better emotion regulation and less abusive relationships with the amelioration of personality pathology, given that these variables appear to be intimately related to differential personality pathology patterns.

Chapter 9: Applying Personality Profiles to the Treatment of Men in IPV Intervention

9.1 Overview of the Argument in this Dissertation

Our research has shown important personality pathology differences among men who perpetrate IPV, which could usefully inform treatment. While, in some respects, we could argue for working with men on an individual basis, as Millon (1999, 2011) suggested, we are cognisant of the economic and access limitations imposed on those who work in this field, especially where the preferred option is group work. However, it may still be the case that, when an individual counsellor or therapist works with an individual male perpetrator of IPV, Millon's personalised therapy approach (Millon & Grossman, 2007) can be used to elucidate the particularly unique personality style of a specific individual.

Having said that, we contend that, at a more modest and affordable level of intervention, we can facilitate a more effective treatment using a five-cluster approach. In the body of research presented in this dissertation, five basic clusters of men have been identified based on personality pathology, with two of the clusters exhibiting significant psychopathology, higher levels of reported IPV and interpersonal problem behaviours, and lower reported levels of self-compassion. The other three clusters did not have as pronounced personality pathology and were all uniquely different in presentation. Thus, this chapter considers the goodness-of-fit between these personality clusters and treatment options. It is important to highlight that the author of this thesis is an experienced clinician with this group of clients, and that research evidence from the literature is combined here with clinical insights from first-hand experience.

9.2 The Borderline-Dysphoric Cluster (C2)

The men in our borderline-dysphoric cluster comprised 33% of the total sample and thus will be considered first. Two thirds of these men exhibited borderline personality at levels characteristic of a personality disorder, and nearly all (95%) reported significant

anxiety syndromes. The men in this cluster were uniquely significant for depressive (83%), dependent (60%) and self-defeating (47%) personalities, as well as anxiety, dysthymia and major depression clinical syndromes. Comorbidity tends to be the rule, rather than the exception, in significant personality pathology (Clarkin, 2008; DSM-V, 2013), as this group demonstrated. There was also a high percentage of men with significant negativistic personality (71%) and many significant antisocial (43%) and aggressive (35%) personality scale elevations. These were shared with C5 (the narcissistic-aggressive cluster) and, to a lesser degree, C4 (the low-level antisocial cluster). However, the profile patterns in the borderline-dysphoric cluster tended to be of the dependent, depressive variety; thus, ‘discouraged borderline’ (depressive, avoidant), ‘self-destructive borderline’ (depressive, self-defeating) and, to a lesser degree, ‘petulant borderline’ (negativistic) were evident. The dominating factors here seemed to be the presence of anxiety and dependent/depressive patterns. This preponderance of self-doubt and negativity was demonstrated by the modifying index scores of this group of men, which demonstrated significantly higher levels of distress (disclosure) and self-debasement, and significantly lower levels of social desirability than any of the other four clusters.

We note that the borderline-dysphoric group was less ‘psychopathic’ in style than C5 (narcissistic-aggressive), but with a higher percentage of severe personality profiles (78% v. 39%). The borderline-dysphoric men also reported the highest percentage of childhood sexual abuse, although this was not significantly higher than the minimising cluster (which was somewhat strange, unless the IPV men in the latter group were simply highly repressed). This cluster also had a high percentage of men who reported suicide attempts, although this was not significantly higher than the passive-anxious or narcissistic-aggressive clusters. Millon (2011) referred to borderline personality by the name ‘cyclophrenic disorder’ (p. 917), which was chosen to ‘focus on the essential features found in these patients—their psychic ambivalence, and their vacillation in mood, thought and behaviour’ (p. 923). Paradoxical interpersonal conduct, labile mood, uncertain self-image, capricious cognitive style, spasmodic expressive behaviour and regressive defences, undergirded by a ‘split’ morphological organisation and incompatible object representations of significant others, are all characteristic of borderline disorders (Millon, 2011, p. 911). Expressions of hostility tend to be exhibited impulsively, rather than in a planned manner, due to fear of rejection and loss.

This leads to a rough generalisation concerning the borderline-dysphoric cluster men—fear of abandonment and emotional instability/reactivity require interventions that prioritise containment (McWilliams, 1994; Semerari & Fiore, 2007). According to this formulation, any individual working with this cluster of men—either one-on-one or in a group—must prioritise managing their distress (Liotti, 2004; Sonkin & Dutton, 2003). It has been argued that, for men with these characteristics, the following points need to be considered:

1. Suicidal behaviours need to be thoroughly assessed:
 - a. This can be checked with several MCMI-III items or on the Danger Assessment Scale (Campbell, 2003), which was routinely used with both perpetrators and victims in this research protocol, as suicidal threats can also be a form of power and control.
2. Emotion regulation and distress tolerance skills are limited and will need to be taught as soon as possible (Linehan, 1993) to alleviate over-aroused distress:
 - a. Safety planning is required for the man and his partner (if available), preferably in the intake sessions before the group even begins.
 - b. A clear set of steps may give the man some sense of control and safety, and makes it less likely that he will ‘act out’.
 - c. Reactive violence of the ‘coercive and controlling’ variety (Johnson, 2008) is likely to be common in this group due to fears of abandonment and general emotional instability.
 - d. A family of origin exploration is indicated and a family systems theory approach can prove useful (such as Adult Attachment Interview questions) (George, Kaplan & Main, 1985) to assist the client to understand from where his unregulated fears derive in order to ‘vaccinate’ (Stosny, 1995) against negative ‘core hurts’, such as abandonment, rejection, unloveability, worthlessness and powerlessness.
 - e. Using techniques such as ‘HEALS’—an acronym for:
 - visualising the word ‘heals’ – in order to self-soothe
 - explaining and experiencing the core hurts briefly
 - applying self-compassion
 - loving the self and others through radical acceptance

- solving the problem—at least the emotional problem (Stosny, 1995).
- f. The goal is to soothe those feelings/attitudes and mechanisms in order to become more reflective or develop more of an ‘observing ego’ (McWilliams, 1994), as opposed to reacting.
3. Through HEALS and DBT skills training, and in the transference relationship with the facilitator/counsellor, develop self-compassion and compassion for others.
 4. Trauma experiences should be assessed and consideration given to individual work and group work to address these issues. Apart from the MCMI-III PTSD scale, in individual cases, the Impact of Event Scale (Horowitz, Wilner & Alvarez, 1979) might be used to assess the severity of trauma:
 - a. Undertake graduated exposure to traumatic past events.
 - b. Eye movement desensitisation and reprocessing might be used in individual sessions to desensitise the man to a more regulated emotional state.
 - c. DBT skills might be taught in a group and/or individually in order to assist in distress tolerance, emotion regulation and mindfulness (Fruzzetti & Levensky, 2000; Waltz, 2003). DBT has been trialled with male domestic violence perpetrators with positive outcomes (Cavanaugh et al., 2011), as previously noted.

Work with personality disorders usually requires at least 12 months of treatment (Linehan, 1993a, 1993b; McWilliams, 2004), which is important, given our findings that more than 50% of our sample reported MCMI scores consistent with a personality disorder, and BPD predominated in our borderline-dysphoric cluster. Many IPV programs are becoming longer (six to 12 months), and Linehan’s model (1993a) has proven effective over 12 months, in which weekly group work is supplemented by weekly individual sessions. This may be more labour-intensive and expensive than current IPV group work, but it is likely to pay dividends in improved outcomes for male participants and their partners and families in terms of reduced rates of recidivism (Jones, D’Agostino, Gondolf & Heckert, 2004; Saunders, 2007).

9.3 Narcissistic-Aggressive Cluster (C5)

The second-most pathological cluster in the current large sample was C5, which comprised 26% of our total sample and we termed the narcissistic-aggressive cluster. This cluster was unique in having the highest percentages of significant narcissistic personality patterns, and having a quite different mean response style to C2 (the borderline-dysphoric cluster). Namely, C5 had the second-highest levels of disclosure and debasement modifying index scores, along with the second-highest desirability scale scores. This ‘unrealistic high self-esteem’ (Baumeister et al., 1996) is fairly typical of significantly elevated narcissistic and antisocial scales.

The narcissistic-aggressive cluster also displayed a higher percentage (44%) of what we termed ‘psychopathic’ profiles (combined antisocial and aggressive scale elevations) than the borderline-dysphoric cluster. Personality disorder characteristics were recorded by 54% of the men in this cluster, with 39% severe—a mixture of borderline and paranoid elevations. These profiles were largely of the impulsive (antisocial) borderline subtype (a significantly higher percentage than the borderline-dysphoric cluster). Paranoid profiles were evenly spread between C2 and C5, and the major difference between them was that the C2 profiles were mainly comorbid with borderline personality, while the C5 paranoid profiles were mostly stand-alone severe patterns (although often comorbid with narcissistic and antisocial patterns).

Millon (2011) pointed out that dealing with paranoid, narcissistic, antisocial and aggressive/sadistic personality profile men will undoubtedly be one of the more difficult tasks for a facilitator or therapist. Most of the paranoid personality men in the current sample were court-referred and thus largely unwilling ‘starters’ in the IPV treatment. According to Millon (1999), one needs to be aware of several important factors regarding men with these types of personality profile. Paranoid personality patterns are more dysfunctional variants of other personality patterns, such as antisocial, narcissistic and sadistic, and such men are likely to be preoccupied with issues of ‘adequacy, power, and prestige’ (Millon, 1999, p. 678). These men also tend to be quite rigid and inflexible regarding social interaction and cognitive, affective awareness and change; they are suspicious and use projection as a defence. Due to their need for self-assertion, they can

be quite guarded, and may express considerable hostility towards others if challenged or pressured. Antisocial personality patterns are displayed through autonomy, impulsivity, irresponsibility, callousness and acting out (see Millon, 1999, p. 468). Narcissistic personalities tend to express themselves in a boastful manner, acting in exploitive ways, while rationalising their unrealistic self-image. Combinations of these personality patterns are difficult to work with. When combined with borderline personality elevations, these men are inclined to be even more reactive and more at risk for self-harm.

Many of these men would fall into the coercive-controlling type of IPV abuse, and some would probably be more calculated in their control than others—such as the men with profiles in the paranoid, antisocial, aggressive and narcissistic range. Gottman and colleagues argued from their research that men with these types of personality profiles are likely to be coldly calculating in their control of partners and prone to striking suddenly and unexpectedly in order to maintain their control (Jacobson & Gottman, 1998; Jacobson, Gottman, Conner, Berns & Shortt, 1996; Jacobson, Gottman, Waltz, Rushe, Babcock & Holtzworth-Munroe, 1994). They suggested that priorities are to:

1. Screen carefully for safety issues. Some C5 men will be screened out at assessment due to:
 - a. serious concerns about possible homicidal behaviour
 - b. occasionally suicidal behaviour—safety must come first
 - c. inordinate substance abuse (a referral to drug and alcohol rehabilitation may be more appropriate).
2. Make the man aware that facilitators will be keeping in touch with partners for safety reasons:
 - a. planning this carefully with both male and female partners is a very important element in the initial intake sessions
 - b. liaise with CCOs around these issues, as the perpetrator will be seen by their CCO on a regular basis
 - c. be clear that police will be involved if criminal behaviour occurs (physical assault or threats to life are important here).
3. Ensure that the group or therapy contract is firm and clear:
 - a. there will be consequences if they do not behave appropriately, such as being removed from the program and asked to re-consult their CCO

- b. participants will not be allowed to attend group if clearly under the influence of alcohol or drugs
 - c. no certificate of attendance will be given without complete (or near complete) attendance
 - d. in some cases, security guards may need to be employed for safety reasons, but should keep a low profile so as not to provoke reactions.
4. Deal with the men in a matter-of-fact manner:
- a. empathising should be used sparingly in initial group stages, as it is seen as weakness by many of this personality style (Benjamin, 1996; Millon, 1999)
 - b. most of these men should not be focused on too directly to begin with, apart from the contracting parameters, otherwise power struggles or opportunities to vaunt themselves may arise
 - c. reality testing—especially in a non-direct manner, such as motivational interviewing—via facilitator interactions with other group members may help here.

As Saunders (1996) demonstrated, antisocial personalities functioned better in an IPV group that used a CBT approach, rather than a psychodynamic approach. This confirms the matter-of-fact reality testing approach, which appeals to practical needs, such as retaining a job or relationship, or staying out of prison. The power of the therapeutic relationship in individual or group settings should not be underestimated. Many men in C5 will experience change if the group process is sufficiently long and the facilitator/therapist genuinely models pro-social behaviour and encourages a ‘tough love’ stance.

9.4 Minimising-Conforming Cluster (C3)

The minimising-conforming cluster comprised 15% of the current sample, and was noteworthy for demonstrating the highest levels of social desirability (MCMI desirability modifying index) and lowest levels of disclosure and debasement compared to the other four clusters. These men produced the lowest levels of aggressive profiles and highest percentage of conforming profiles—narcissistic, histrionic, compulsive or a profile that was sub-trait (no scale > BR74), and were highly minimising on the

modifying indices. The men in this group reported the lowest abuse scores and highest self-compassion scores (though not greater than C4 on SCS). Apart from the remarkably high desirability scores, this group was noteworthy for having 35% of its profiles in the personality disorder range—all of a histrionic or compulsive nature. (The conforming narcissistic profile men were different from the narcissistic-aggressive cluster men in that they showed no elevations in antisocial, aggressive or paranoid patterns.) Although the men in C3 had high employment and no reports of suicide, 38% had received violence restraining orders, half had a violent criminal record, and one third had assaulted a parent. We suspect that there is need for closer examination of this group of men in an IPV context, given their high levels of minimisation.

This group of men does not seem to have been considered much in the research literature, as they appear to be relatively low in psychopathology and abuse. Thus, IPV perpetrated by this group of men may be of the ‘situational couple violence’ or ‘separation initiated violence’ (Johnson, 2008)—only occurring at the point of separation—and neither of these forms are considered controlling and coercive. Alternatively these men may show coercive-controlling abuse of a more psychological nature – less obvious in form. As demonstrated in Study 1, these profiles are likely to be men who are consciously or unconsciously out of touch with their true psychopathology, and thus unable to report it (Choca, 2004).

Millon (2011) categorised both histrionic and narcissistic personality patterns into what he called ‘interpersonally imbalanced spectra’, while he placed compulsive personality patterns into the ‘intrapsychically conflicted spectra’. While narcissists over-value themselves, histrionics are typically highly sociable ‘closet’ dependents, and compulsives tend to be over-controlled emotionally, orderly, conscientious and moralistic. Factors in common among these three personality patterns are: (i) an external focus—either to win admiration, acceptance or a sense of worth, and (ii) a lack of awareness of inner emotional processes. In terms of working with C3 men, according to the clinicians who work with them, the following points need to be considered (Benjamin, 1996; Dimaggio et al., 2007; Millon, 1999):

1. Screening for safety issues for partners is particularly important, as this group of men are not only out of touch with their own internal processes, but will

typically focus on what their partner needs to do, rather than what *they* need to do:

- a. Explore the partner's experience of the IPV situations to see how serious they have been.
 - b. Explore in detail IPV incidents—earliest, latest and most serious—to assess seriousness and any reflective capacity that may be appealed to.
 - c. Highlight the man's tendency to focus on his partner's behaviour, rather than his own—a prescription for increasing frustration and denial, rather than self-responsibility.
2. Explore any family of origin experiences carefully with a view to helping the man recognise and identify core hurts, rather than projecting blame onto others.
 3. When teaching HEALS, pay particular attention to the man's desire to alter the focus from internal experience to other forms of blame.
 4. Undertake some reality-checking with these men. They will tend to present themselves as:
 - a. admirable partners (narcissistic)
 - b. positive, outgoing partners (histrionic)
 - c. organised—doing the necessary thinking and planning that their partner is incapable of doing without them (compulsive).
 5. Teach these men through the use of HEALS and mindfulness skills to get in touch with their body and emotional reactions to relational issues. This is most important if men in this cluster are to benefit from the intervention, rather than 'going along for the ride'. Some of the DBT skills of mindfulness have been successfully tested in pilot studies with men in IPV treatments (Cavanaugh et al., 2011).
 6. Beware the following ploys related to this group of men believing they should not really be undertaking the treatment at all:
 - a. The narcissistic minimising-conforming participant who wants to spend time relating his goodness and accomplishments as a partner—at his female partner's expense:
 - It is necessary to point out that they are not here to discuss the partner, but their own experiences of and reactions to their partner.
 - Avoid the 'rational' discussions of this man's performance as a partner.

- Do not allow this participant to dominate the group or he will disaffect others, as he usually sounds superficially plausible.
- b. The histrionic minimising-conforming participant who wants to charm or amuse the group:
 - Such men can often be a lot of fun and quite entertaining, but will distract from the serious, personal side of the endeavour.
 - They are often attention-seeking and want to be everyone's friend, but will dissociate from real interpersonal and psychic pain.
 - This may need to be addressed directly, but kindly.
 - c. The compulsive minimising-conforming participant may want to 'help' or thinks he can do a better job than the facilitator, and may indirectly criticise the facilitation process:
 - Be prepared to acknowledge his desires to help, but remind him that he needs his energy to focus on his own processes—that is what the group is for.
 - Again, beware the critical spirit that will set himself up as a 'good person' who simply has an 'undisciplined' partner.
7. There is a constant need to return to HEALS (Stosny, 1995) to focus these men on:
 - a. their own internal processing of thoughts and feelings, and their likely avoidance of doing so
 - b. the need to honour the attachment relationship needs, rather than rupturing them
 - c. the need to understand the family of origin dynamics of experiencing oneself and others, which is fundamentally at work in these IPV situations
 - d. the place for psycho-education, where personality patterns as patterns of defence may be seen and understood as habituated mechanisms for protecting the self against the internal pain of devaluation.

9.5 Low-level Antisocial Cluster (C4)

The C4 men—the low-level antisocial cluster—comprised 12% of the total sample, and were characterised by a response style that displayed average desirability, but lower

than average disclosure and debasement scores than a clinical population. They also reported very little severe pathology, with most profiles being in the trait or sub-trait range of severity. However, nearly half had significant alcohol dependence scores, and 59% displayed angry/aggressive and/or antisocial characteristics. We termed this cluster the 'low-level antisocial/aggressive' cluster. A significantly greater percentage of these men were self-referred than court-referred in comparison with the minimising-conforming cluster, but not with any other cluster. Their abuse behaviour reports demonstrated significantly greater total and psychological abuse than the minimising-conforming cluster, but lower scores than the borderline-dysphoric cluster. They did not differ from the passive-anxious and narcissistic-aggressive cluster on these variables, nor did they differ from any other cluster on the physical abuse measure. Given their antisocial/aggressive personality style, we might consider this group's likely IPV style to be of the controlling-coercive type, although situational couple violence cannot be ruled out. What we can say is that perpetration by these men is less likely to be reactive than calculated, since they displayed very few anxiety and dysthymia elevations. Alcohol abuse was relatively high in this cluster, and is likely to be a significant problem.

The low-level antisocial cluster men are likely to require strict boundaries regarding their participation in group and adherence to group contract and rules, as with the narcissistic-aggressive (C5) men (Stosny, 1995; Wexler, 2013). However, unlike the C5 men, their distress levels were quite low, and the group was significantly older than the men in other clusters, which may mean that they are more settled in their way of operating in the relationship context. They were also unusual in that they reported no sexual abuse as children, and no suicide attempts, thereby suggesting considerable stability. However, they still reported comparable levels of other forms of abuse in their upbringing. Exactly 50% of this group reported having a criminal record, while 28% reported having a violent criminal record.

The following guidelines are recommended for working with this group of men:

1. Screen carefully for safety issues (as with the narcissistic-aggressive men) (Stosny, 1995; Wexler, 2013):
 - a. It is less likely that serious concerns will be encountered, such as suicidal/homicidal behaviour.

- b. Inordinate substance abuse may still be a problem.
 - c. Make the man aware that facilitators will be keeping in touch with partners for safety reasons, and that abusive behaviour during the program will not be tolerated.
 - d. Where possible, ongoing work/contact with the female partner is invaluable in reducing the incidence of abuse.
 - e. In the event of the C4 man being court-referred, liaise with the CCO around these issues, as the perpetrator will be seen by their CCO on a regular basis.
2. The group or therapy contract must be firm and clear:
 - a. Clarify that there will be consequences, such as being removed from the program, for poor attendance, substance abuse or general non-compliance with program involvement—so that these men are compelled to participate fully.
 - b. Clear, contingent consequences are very important for these men, who have become quite adept at manipulating the system.
 3. Manage C4 men in a matter-of-fact manner. Due to the strong antisocial traits in this cluster, empathising should be used carefully in initial group stages as it may be seen as weakness by many of this group, as with the narcissistic-aggressive cluster men.
 4. Power struggles or opportunities to ‘show off’ as ‘tough guys’ should be avoided.
 5. Reality testing and practical, instrumental skills to achieve goals of a more equitable relationship need to be taught, but from a perspective that focuses on how compassion empowers men to make their relationships work.
 6. HEALS can be taught, but initially as a ‘useful tool’ for coping.
 7. Challenging men in this group will be essential, but needs to be done from the perspective of what works – practically helpful. As Saunders (1996) demonstrated, antisocial personalities function better in an IPV group that uses a CBT approach, rather than a psychodynamic approach. This confirms the ‘matter-of-fact’ reality testing approach, which appeals to practical needs, such as retaining a job or relationship, or staying out of prison.

As with the narcissistic-aggressive cluster men, for the low-level antisocial men, the power of the therapeutic relationship in individual or group settings should not be

underestimated. Many men in the low-level antisocial cluster will experience change if the group process is sufficiently long and the facilitator/therapist genuinely models pro-social behaviour and encourages a ‘tough love’ stance.

9.6 The Passive-Anxious Cluster (C1)

The passive-anxious group of men comprised 14% of the total sample, and were accounted for on the MCMI-III by trait elevated schizoid, avoidant, depressive, dependent, negativistic and self-defeating personality patterns, accompanied by many significant anxiety (and dysthymic) clinical syndrome scores. They were noteworthy for having a higher percentage of withdrawn profiles than any other cluster. By withdrawn, we refer to schizoid, avoidant, dependent, melancholic, self-defeating and negativistic type patterns, without more serious pathology.

According to Millon (1999), schizoid personalities are unengaged, apathetic and impassive, often using intellectualisation as a refuge from emotional engagement, and having ‘meagre’ object representations of significant others (p. 287). Avoidant personalities are alienated in their sense of self, aversive in interpersonal conduct, often anguished in mood, and fragile in their personality structure—clearly creating difficulties for engaging therapeutically. By distinction from the schizoid personality, they are ‘vexatious’ around object representations of significant others (Millon, 1999, p. 311). In other words, creating safety and motivation to engage with a therapist or group will be challenging, not from an ‘acting out’ perspective (as with C2 and C5), but from a withdrawal defence.

Depressive personality style men are pessimistic, depleted and sometimes inconsolable and defenceless (Millon, 1999, p. 342), with ‘forsaken’ object representations of significant others. At times, they may also be suicidal. Dependent personality men are likely to be inept and needy, seeking ‘rescue’ from the facilitator or therapist (or group), and dreading really exploring personal competencies (Millon, 1999, p. 372). Negativistic (or passive-aggressive) personality men are likely to present as discontented, resentful and contrary (Millon, 1999, p. 562); to engage in ‘displacement’ of their core hurts; and to be vacillating (‘being both seductive and rejecting’) (Millon,

1999, p. 563) with the therapist/facilitator, as this is typical of their object representational experience of significant others. It should be highlighted that the negativistic profile men in C1 were of the ‘circuitous’ (dependent) type, and the ‘discontented’ (depressive) type, rather than the more borderline or aggressive types. Finally, the few masochistic (or self-defeating) profiles that were found in this group of men involved—according to Millon (1999, p. 592)—an ‘undeserving’ self-image, ‘dysphoric’ mood, ‘deferential’ interpersonal conduct, ‘discredited’ object representations (internalised contempt) and ‘inverted’ morphological structure—that is, a ‘repetitive undoing of intention and affect’ (p. 595).

It is not difficult to discern the need to engage C1 men who suffer from these particular trait personality patterns (or combination of patterns) with a good deal of care, clarity, motivation and wisdom, given that many will be involved in IPV as a result of their personality pattern weaknesses, rather than from a deliberate coercive-controlling brand of IPV. As there has been little discrimination between personality pathology types in IPV treatment, our observations from working with this group inform our suggestions. Given that most of these men are anxious and inclined to be somewhat passive, we recommend the following for working with this group:

1. encouragement
2. self-soothing techniques
3. a strengths-based approach
4. unconditional positive regard
5. skills training
6. group supportiveness
7. exploration of core hurts and applying self-compassion in a personally responsible manner
8. rejecting and re-channelling self-blame and other blame to restore a sense of responsibility and authenticity, and encouraging appropriate pride in that
9. learning to empathise with one’s partner after beginning to heal one’s own core pain—as Stosny (1995) stated, ‘Self-regulation develops self-knowledge, and self-knowledge equals personal power’ (p. 47).

9.7 Summarising the Model

As suggested at the end of Study 3, it would be helpful to use the information gained from parsing the MCMI-III profiles of the men in this research to develop guidelines for therapists and facilitators who need to work with these men. Personality pathology is a proven method for working with clients more effectively and in a more targeted manner (Millon & Grossman, 2007). There is no reason why this should not be the case with men who have perpetrated IPV, since their abusive behaviour is symptomatic of the complex personality—and, in many cases, psychopathology—that the person brings to the relationship and the events that we focus on (Fonagy, 2004; Lyons-Ruth & Jacobvitz, 1999; Sonkin & Dutton, 2003). In other words, instead of trying to answer the question, ‘Why do men abuse their female partners?’ we are seeking to answer the question, ‘What is the best way to help men who are abusive towards their female partner to recover?’

While, in an ideal world, we would want to give each individual a completely individualised approach (Millon, 2011), the realities of limited resources—both financial and human—indicate that we need to do the best we can within a limiting framework (Gondolf, 2007). To this end, we have constructed a Personality Pattern Grid for therapists and facilitators to refer to, alongside individual profiles from the assessment process (see Table 17, Study 3). The grid shows the five-cluster model with information regarding primary pathology, probable IPV modes and treatment modes for each cluster. We believe that, with appropriate training and supervision, facilitators of IPV groups will be able to be more discriminating in the way they work with different group members, and hopefully more effective in the outcomes they achieve.

Our next goal is to trial this model in the field in order to help further the contention of Wexler that: ‘While insisting that men take full responsibility for their abusive behavior, treatment approaches can still be most effective by addressing inherent psychological issues’ Wexler, 1999, p.140).

Chapter 10: Conclusions and Implications for IPV Policy and Practice

10.1 Introduction

The argument of this thesis has been that intervention for men referred for IPV would be more effective if based on an understanding of the type of personality profile/pathology these men bring to that treatment. We have seen that, contrary to popular policy and procedure, sound research has elucidated both the diversity of IPV (Johnson, 2008; Wangmann, 2011) and the diversity of personality pathology associated with it (Corvo & Johnson, 2013; Ehrensaft et al., 2006; Hamberger et al., 1996; Holtzworth-Munroe et al., 2000). However, the personality pathology attributed to these men has seemingly stagnated around BPD and antisocial personality disorder (Dutton & Starzomski, 1993; Holtzworth-Munroe et al., 2000) in IPV research and practice. In contrast, the research by Ehrensaft et al. (2006) was noteworthy for examining a wider range of personality disorders—Clusters A, B and C from the DSM-IV—and for undertaking this in a prospective longitudinal manner. This is one of the few research articles to evaluate a greater diversity of personality pathology among men presenting with IPV.

The use of personality pathology profiles in the field of psychotherapy assessment and intervention has been extensive and focused (Benjamin, 1996, 2003; McWilliams, 1994, 2004; Millon, 1999, 2011). However, in IPV work specifically (Holtzworth-Munroe & Stuart, 1994; Saunders, 1996; Taft et al., 2004), personality pathology has been highlighted but under-utilized in developing intervention programs. There are significant policy reasons associated with this—namely, the fear that focusing on personality pathology will allow men perpetrating IPV to excuse their behaviour, similar to what they may have done with alcohol and drug misuse (Jenkins, 1997; Pence & Dasgupta, 2006; Wangmann, 2011). Further, the use of ‘therapy’ as a description of IPV treatments is seen as focusing back on childhood attachment issues that may enable male perpetrators to take on the ‘victim’ role, and may ‘take too long if it is viewed as an essential component of change—those affected by his use of violence can’t wait for

the years of healing to occur before there is a significant reduction in risk’ (Vlais, 2014, p. 5).

This thesis has explored the proposition that more effective intervention work with men presenting for IPV programs might be undertaken by focusing on their personality pathology profiles as a context for treatment, and by focusing on the differential approach required, rather than simply on the singular entity of IPV. Paying attention to some forms of personality pathology is not uncommon in research around IPV (Beasley & Stoltenberg, 1992; Dutton & Starzomski, 1993; Ehrensaft et al., 2006; Hamberger et al., 1996; Holtzworth-Munroe et al., 2000; Saunders, 1996), although this has often been truncated in focusing primarily on borderline and antisocial personality characteristics, and has been confounded with violence itself (Dixon & Browne, 2003). Further, it frequently has not progressed beyond typologies to serious application in the approach to intervention, except in rare cases (Saunders, 1996).

10.2 Making Mileage out of Personality Profiles

One response from a journal reviewer to the paper in Study 3 was that it was ‘additive’, rather than a ‘quantum leap’, which misses the point. IPV typologies based on personality pathology are not new, but what is new is that:

1. the whole spectrum of personality pathology from a profiles perspective has not received sufficient attention
2. IPV work has not been undertaken from a personality pathology profile framework.

Instead, the field still labours under the notion that it is sufficient to identify IPV and then deal with all participants using the same material, with guidelines that imply that these men are simply ‘birds of a feather’ and therefore ‘one size fits all’ (Gondolf, 2002). We contend that men in different groups with different profiles are likely to benefit most by being worked with in distinctive ways—not only because this has proven to be the case in long therapeutic experience elsewhere (Benjamin, 1996, 2003; Dimaggio et al., 2007; McWilliams, 1994, 2004), but also because it has been used on rare occasions specifically with men in IPV intervention (Saunders, 1996).

Saunders (1996) demonstrated that men in IPV treatments displaying antisocial personality pathology are more likely to benefit from a CBT type approach, rather than a psychodynamic approach. In this CBT approach, ‘each session included a didactic section on communication and cognitive skills, relaxation/desensitization training, consciousness-raising about sex roles and violence against women, and behavioral or cognitive rehearsal’ (Saunders, 1996, p. 398). In contrast, men in IPV treatments displaying dependent personality traits were more likely to benefit from the Process-Psychodynamic Treatment model. This model assumed that violence was caused primarily by childhood traumas experienced by the men (such as witnessing abuse of a loved one and/or being abused), and that the latter displace anger about these traumas onto their adult relationships. The facilitators of this approach try to create a supportive environment in which the men can re-experience childhood traumas, grieve their losses, relinquish control over others and learn to empathise with others (Saunders, 1996).

The ‘success’ was based on recidivism rates, which, for dependent personalities, was 54% in the CBT treatment, but only 33% in the Process-Psychodynamic Treatment. The reverse was found for antisocial personalities in the CBT treatment. Otherwise, the differences were non-significant between the two groups, which must still be a concern, since a one-in-three recidivism rate versus a one-in-two rate is not highly reassuring for victims.

Given that our research has indicated considerably more diverse patterns of personality pathology than those discussed by Saunders (1996), our contention is that being more comprehensive in terms of differentiating personality pathology in assessment, and implementing more personality-confluent responses in a group treatment, could be more effective. Further, we propose that facilitators and therapists engage with the men in ways that consider their interpersonal style, rather than simply which kinds of treatment techniques are used.

A real-world example is taken from this author’s experience with two group facilitators in debrief, following a group session. The facilitators were reflecting on a group member who had (in their words) ‘hijacked’ the group during that particular session by engaging in a running debate about his positive attributes in his relationship, which he said his partner did not appreciate. The facilitators—one male and one female—had

sought to demonstrate the female's perspective, and the inconsistencies and cognitive distortions in the male participant's perspective. They reported being frustrated by the man's flimsy and unrealistic rationalisations of his views and reported behaviours. On enquiry, it was ascertained that the participant's MCMI-III profile was principally of the narcissistic pattern. In the debrief, it was suggested that attempting a rational discussion with a participant of narcissistic personality was unlikely to progress positively. Rather, it was suggested that some empathic truth-telling might be in order—that is, in relation to his partner: 'You have been trying so hard to make things work well, and you feel devastated to hear that they are not going as perfectly as you thought' (Benjamin, 1996; Millon, 2011). Such a response is supportive, but not collusive, because it checks reality and encourages the participant to begin contemplating his internal process in a non-judgemental manner. As suggested in Table 17 regarding the minimising-conforming cluster, treatment modes require:

- setting clear boundaries
- reality testing the participant's perceptions
- motivational interviewing to promote responsibility-taking behaviour.

It is important to beware of colluding with denial and thereby reinforcing the 'good guy' attitudes that are characteristic of conforming personalities. Later, greater challenges to taking responsibility can be engaged, along with encouragement to self-reflect.

We recognise that Table 17 has only brief comments for therapeutic guidance, but would suggest that good, regular supervision is especially important under this model. This has normally been an important recommendation for successful IPV intervention work, and simply requires supervisors who have some skill with personality pathology, not just with IPV characteristics and work (Domestic Violence Prevention Unit—Women's Policy Office, 2000; Mandel, 2009).

10.3 Validity and Remaining Tasks

This model of personality pathology profiles needs to be replicated with other samples, since the group we researched had no controls—although, as we noted, the MCMI-III has norms with which we were able to compare this particular group of men. As a result, we noted their great similarity to a clinical sample with regard to both response

style and scale elevations. Further, the men assessed for this program all entered the assessment process, and thus completed the appropriate documentation and psychometric tests—this was a mandatory process that was not open to self-selection. We further note that the program for which the men were assessed was operated by Anglicare WA—a social service agency that is funded by and operates under government ‘best practice’ guidelines. Thus, the types of men—both self-referred and court-referred—are unlikely to be radically different to those who attend other social service agencies throughout Australia, which undertake the bulk of this kind of work. Thus, internal validity of the clustering may not appear very different in our other groups, although we recognise that this remains to be tested.

Further, our clustering strategy was a statistical one, not based on an *a priori* mode of clustering. While using PCA means that factor solutions are open to different interpretations, this was exploratory and the coherent nature of our factors and high probabilities of cluster membership gave us more confidence in our model, along with the plausibility of the associated instrument scores, which were hardly transparent to the participants. External validity must await cross-program comparisons—not only of MCMI-III profiles, but also participant characteristics.

If this personality profile change in assessment and treatment paradigm were to be implemented more broadly, it would be important to train and supervise facilitators and counsellors in the use of the Personality Pattern Grid (Table 17, Chapter 7) derived in the current research. A preliminary step remains—to assess the outcomes of some group programs that use this approach—before we can confidently say that it is a more effective way of working with IPV men. That is, we must establish the ecological validity of this tool. Given that our research in this thesis mainly used a ‘fixed design’ (we determined to research personality pathology using the MCMI-III and associate that with other measures; Robson, 2002), we were unable to consider all the human factors that are complex in IPV research.

In fact, we could be accused of bypassing one of Millon’s (1999) major points—that therapy works best for individuals when the complexity of their individual profile is considered. However, we know that all programs and the workers who operate them in this field are seriously limited by time, resources and the pressure to protect women and

children, rather than being over-focused on healing men who perpetrate IPV. This is the point Gondolf (2007) stressed in his response to Dutton and Corvo (2006) when he defended the Duluth Model against what he regarded an ‘over-simplistic’ attack. We agree with him that practicalities make individual assessment and treatment difficult. However, we argue that we are proposing a model that has much greater face validity, and is now more data driven than what is currently undertaken, while still attempting to make it sufficiently economical to be practicable.

10.4 Policy Changes are Required

Ultimately, we hope to use this research to argue for changes in policy around intervention programs for men referred for IPV treatment. Pence and Dasgupta (2006)—arguably two of the more pro-feminist writers in the IPV field—stated: ‘It has become increasingly apparent to advocates and practitioners in the domestic violence field that to treat everyone exactly alike can ultimately do more harm than good’ (p. 5). This is a very important admission, even though these authors were referring to different types of IPV, rather than different types of personality pathology. Remarkably, Pence (1999) reflected on the ‘power and control’ paradigm in the following manner:

By determining that the need or desire for power was the motivating force behind battering, we created a conceptual framework that, in fact, did not fit the lived experience of many of the men and women we were working with. The DAIP [Domestic Abuse Intervention Project] staff ... remained undaunted by the difference in our theory and the actual experiences of those we were working with ... It was the cases themselves that created the chink in each of our theoretical suits of armour. Speaking for myself, I found that many of the men I interviewed did not seem to articulate a desire for power over their partner. Although I relentlessly took every opportunity to point out to men in the groups that they were so motivated and merely in denial, the fact that few men ever articulated such a desire went unnoticed by me and many of my co-workers. Eventually, we realized that we were finding what we had already predetermined to find. (pp. 29–30)

We have already seen that Ross (2011) has found that issues of emotion regulation were far more important to both male and female perpetrators of IPV than power and control and this factor was related to personality characteristics. As previously mentioned, researchers have explored the value of working with IPV men from a therapeutic stance that considers what the individual brings to the treatment (Brown & O’Leary, 2000; Taft & Murphy, 2007; Taft et al., 2003; Taft et al., 2004). However, since policy has

developed from a pro-victim position, where the perpetrator (male) has been defined as consciously and deliberately seeking power and control under all circumstances (Dobash & Dobash, 1981; Pence, 1999), it has been difficult to view the use of personality pathology profiles in treatment as anything other than at best misleading or at worst an excuse for their behaviour—or even as one of the mythologies of IPV work, as Pagelow (1992) stated.

Interestingly, the tendency to avoid viewing treatment of IPV men as ‘therapy’ continues to this day (Murphy & Baxter, 1997; Vlasis, 2014). As Corvo and Johnson (2003) observed, the commitment to this particular position has not only proven ineffective in terms of program outcomes (Bowen, Gilchrist & Beech, 2005), but may also constitute a ‘self-fulfilling prophecy’ (Corvo & Johnson, 2003, p. 272) that has led to further blaming of male perpetrators: the problem lies with them (they are recalcitrant), not with the programs or the theory that undergirds them. As Stosny (1995) commented, ‘By demonizing the batterer, it makes him more isolated’ (p. 82). The therapist has a unique role to play attitudinally in working with men in IPV, since he or she occupies a unique position of influence in the outcomes (Baldwin, Wampold & Imel, 2007).

The value of working collaboratively and constructively with IPV men should not be underestimated, and both therapy research generally and therapeutic alliances with IPV men specifically suggest that this is the better way forward (Baldwin et al., 2007; Norcross, 2002; Siegel, 2013). That is, to treat these men humanely—as real people with a significant need to understand and regulate themselves both intrapsychically and interpersonally. In this manner, their cooperation may be harnessed through best use of their personality profiles—that is, their specific way of experiencing themselves in the world. In this way, they can be helped to change from a core position, rather than from either a ‘pretend to be good’ or resistance position—overt or covert.

The Western Australian Government’s (now defunct) ‘Freedom from Fear Campaign’ (Gibbons & Paterson, 2000) is a telling example of how to use a therapeutic approach. Those who designed this 10-year community education strategy actually interviewed IPV men and determined what would work for them in terms of changing their behaviour. They also recognised that, ‘The domestic violence Sector in Western

Australia is very much victim (and therefore female) oriented’ (Gibbons & Paterson, 2000, p. 3), and it was important to explain clearly to the domestic violence sector how this would assist in the long-term safety of women and children who were the victims of IPV.

From their research, Gibbons and Paterson (2000) dismissed as counterproductive a focus on: (i) criminal sanctions, (ii) community intervention and (iii) social disapproval. However they found that IPV men responded well to three factors: (i) recognising the problem of IPV, (ii) the need to protect their children and (iii) the fact that help was available. While these factors would only work for a certain percentage of men, it is noteworthy that ‘approach goals’, as opposed to ‘avoidance goals’, were favoured. The men researched generally felt ‘under siege’, and preferred an approach that sought to help them.

The argument of this thesis is similar—that identifying personality pathology patterns and working with IPV men in a constructive manner is infinitely preferable to alienating them. Alienation leads to high attrition rates and more covert behaviour in treatment, which perpetuates the problems and fails to ameliorate the symptomatology of IPV (Murphy & Baxter, 1997) or get to the core of the issue (Siegel, 2013). In contrast, Vlasis (2014) has argued against implementing extra time and resources to working with IPV men beyond educational means, with the express focus of reducing danger to intimates and their children as quickly as possible. In regard to treating personality-disordered male perpetrators of IPV, Vlasis (2014) stated that it takes ‘too long’ and would involve ‘years’ of work (p. 5). However, we argue that, if we are going to do this work at all, we need to do it more successfully, and this may not involve the ‘years’ to which Vlasis (2014) refers (see Linehan, 1993a).

While Vlasis (2014) was understandably focused on the safety of the women and children involved, he was silent about the sizeable percentage of relationships and families who continue living together, whether the man completes a shorter or longer program for IPV. The data from our studies indicated that approximately 50% of men were still living with partners upon intake for the program, and this percentage remained fairly stable when men went through to completion. Thus, it would seem important to assist those men who have long-term treatment needs.

Based on our data, we argue that ignoring men's real therapeutic needs in an IPV treatment program is short-sighted and probably counterproductive because core issues affect these men's ability to recover easily, as evidenced by extensive psychotherapy research (Aldao, Nolen-Hoeksema & Schweizer, 2010). For many men, the core issues of IPV may well be the 'broken image' of the primary caregiver that they hope to restore (Cogan & Porcerelli, 2003; Wexler, 1999). In a large international study, Hines (2008) indicated that borderline personality characteristics are highly predictive of IPV, which once again suggests the need to work with personality factors in treatment programs. If we settle for less, we run the risk of many cases of 'pseudo-success' caused by compliance (Scalia, 1994), which is different to the usual attrition and deep resistance common in so-called 'behaviour-change' programs (Taft et al., 2003). Siegel's (2013) article makes a strong case for going deeper than psycho-education in IPV work to focus on emotional regulation, attuning to the participants in IPV work, and validating experience that enables self-reflection and owning responsibility. As indicated by the body of research presented in the current dissertation, including personality pattern profiles can be of immense value for both understanding and working more effectively with these men.

10.5 Beyond the Ultimate Collusion

The desire to protect women and children from the worst depredations of male perpetrators of IPV—that is, the coercive-controlling type of IPV—have led the women's movement and policymakers to frame this behaviour as deliberate and calculated power and control, which does not deserve therapy, but criminal sanctions (Cavanagh et al., 2001; Dobash & Dobash, 1981, 2004; Pope & Ferraro, 2007). However, some supporters of this policy position have struggled to come to terms with the inherent contradictions in this position (Pence & Dasgupta, 2006; Vlasis, 2014). The net result has arguably been categorising the 'batterer' as recalcitrant and irremediable, so that he has sometimes been treated as a category, rather than a human being in need of understanding and help. Schmidt (as cited in Corvo & Johnson, 2003) eloquently framed this 'immense challenge to dissolve the enemy mentality and defense structures we wage against ourselves and others' (p. 259). 'The "vilification of the batterer"—the

popular policy and “scientific” legitimization of the *dismissive and degrading categorization of perpetrators*—has greatly influenced research, policy, and intervention in the field of domestic violence’ (emphasis added; Corvo & Johnson, 2003, p. 260). This has undeniably affected treatment options for these men:

there is a major problem with the view that men form most of the perpetrators; even if it were correct, it cannot be used to argue against researching or providing aid for male victims, without engaging in a form of discrimination that would not be acceptable, or even considered, in any other context. (Dixon et al., 2012, p. 203)

While the above quotation refers to male victims of IPV, the principle is still relevant in that male perpetrators are ‘victims’ of their own abusiveness, and are often extremely defensive because they feel victimised over their behaviour, which they may not fully understand due to the often implicit nature of their perceptions of interpersonal safety (Eckhardt, Samper, Suhr & Holtzworth-Munroe, 2012).

‘Collusion’ is a term often cited in domestic violence/IPV work to avoid providing justification or excuses to male perpetrators for their abusive behaviour (Pence & Paymar, 1993). However, as numerous researchers and clinicians in the field have shown (Corvo & Johnson, 2003; Dutton, 1994; Murphy & Baxter, 1997; Wexler, 1999), categorising these men in a way that reduces the possibility of them recovering and overcoming abusive behaviour may be the ‘ultimate collusion’ in IPV work. Our research has aimed to move beyond this ultimate collusion to provide a way to approach therapeutic intervention with these men, that is evidence based and ecologically sound. This intervention seeks to maximise the most clinically sound context for treatment—namely, personality profiles. Our hope is that this practical, exploratory research may both assist men to recover from IPV perpetration, and ultimately lead to policy changes in the intervention field.

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