

Personality Correlates of Men Who Batter and Nonviolent Men: Some Continuities and Discontinuities¹

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The present study investigated personality and family-of-origin differences among three groups of domestically violent men and a nonviolent comparison group, matched for age and education. The domestic violence groups consisted of male batterers referred for treatment (agency identified batterers) who were alcoholic (n=38) or nonalcoholic (n=61), and a third group who were identified through community sampling as maritally violent (n=28 community batterers). Multivariate analyses of variance of the Millon Clinical Multiaxial Inventory (MCMI) showed that, compared to nonviolent controls, alcoholic and nonalcoholic batterers showed higher levels of borderline characteristics. Furthermore, alcoholic batterers showed the highest MCMI elevations, followed by nonalcoholic batterers. Community-identified batterers showed no predicted significant differences from the nonviolent controls. On measures of family-of-origin pathology and disruption, only alcoholic batterers differed significantly from nonbatterers on report of both experienced and witnessed abuse victimization.

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

INTRODUCTION

Research on characteristics of men who have battered their partners has been unable to reveal a unitary "batterer profile" in terms of personality, psychopathology, or demographics. In fact, batterers have been

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found to be a heterogeneous group, as indicated by empirical studies of batterer typologies (Gondolf, 1988; Hamberger and Hastings, 1986; Saunders, 1987). Indeed, many authorities have concluded that battering males are no different than men who do not batter (e.g., Mederos, 1987, Pagelow, 1988). The political implications of viewing batterers as no different than nonbatterers have been described (e.g., Edelson *et al.*, 1985; Mederos, 1987). There is concern that workers in the field of spouse abuse focus on the *social* causes and interventions to end spouse abuse. In a review of controlled research on batterer characteristics, however, Hotaling and Sugarman (1986) suggested that the issue of personality disorder and "psychiatric risk markers" in batterers warranted research. Other workers (e.g., Hastings and Hamberger, 1988; Hamberger and Lohr, 1989; Maiuro and Wood, 1988; Saunders, 1987) have also suggested that it is timely to examine batterer characteristics to understand better and develop psychological intervention strategies. Hastings and Hamberger (1988) have also argued that psychological conceptualizations of batterers are not incompatible with those that are sociopolitical. A recent review of clinical characteristics of male batterers by Hamberger and Hastings (1988), furthermore, suggested that the preponderance of identified male batterers showed evidence of personality disorder. In an early cross-validation study, Hamberger and Hastings (1986) found only about 14% of the total sample to show no evidence of psychopathology, as measured by the Millon Clinical Multiaxial Inventory (Millon, 1983). In another study of male batterers, Gondolf (1988) identified four subgroups, two of which were personality disordered. The studies above, however, do not represent controlled comparison research.

Several controlled studies have compared male batterers with non-violent maritally discordant or satisfied males. Rosenbaum and O'Leary (1981) and Dutton and Strachen (1987) found male batterers to exhibit greater assertive deficits and higher power needs than nonviolent males. Goldstein and Rosenbaum (1985) found batterers to exhibit lower self-esteem and to feel more easily threatened than either maritally distressed or satisfied nonviolent males. Van Hasselt *et al.*, (1985) found batterers to exhibit more alcohol abuse-related problems compared to nonviolent control. Rosenbaum and O'Leary (1981) also reported greater alcohol abuse among treatment-refusing batterers compared to nonviolent controls. Caesar (1988) found that, compared to nonviolent men in therapy, batterers reported more direct abuse victimization in the family of origin. Batterers also reported having witnessed more marital violence in the family of origin than did nonviolent men. Hastings and Hamberger (1988) found that compared to age-matched nonviolent males, batterers showed higher levels of dysphoria, anxiety, and somatic complaints. Batterers were more alienated,

moody, emotionally labile, and passive aggressive. Alcoholic batterers showed the highest levels of pathology, with non-alcohol-abusive batterers intermediate between the latter group and nonbatterers. Demographic variables followed a similar pattern, with both batterer subgroups showing greater disadvantage (i.e., higher unemployment, lower education and higher rates of reported experienced and witnessed violence victimization in the family of origin). Hershorn and Rosenbaum (1985) found parental marital discord and violence related to behavior problems in children. Studies of parental alcohol abuse and parental divorce among adult batterers have not been reported.

A limitation of the Hastings and Hamberger (1988) study was that the control subjects were from a higher socioeconomic level, measured both by educational attainment and by employment status, than the batterers. It could be argued that the batterer and nonbatterer groups represented extremes on a continuum of social functioning. In fact, Hastings and Hamberger called for further study, using larger samples to enable controlling for more variables.

The present paper extends the Hastings and Hamberger (1988) study, increasing the batterer data base from 205 to 372, and the nonbatterer data base from 43 to 73. This allowed matching of subjects in the two general groups on both age and educational attainment. The present study compares groups of domestically violent males with age and education-matched nonviolent males on a number of demographic and psychological variables. It was hypothesized that:

1. MCMI subscales differentiating batterers from nonbatterers would be the Asocial, Avoidant, Negativistic, and Borderline, with greater elevations among batterers, and lower scores for batterer groups on the Submissive and Conforming subscales.

2. Alcohol-abusive batterers would show the highest MCMI elevations, followed in order by the non-alcohol-abusive batterers, the community identified batterers, and the nonviolent controls.

3. Battering males would report more abuse victimization and witnessing of abuse in the family of origin and other evidence of family of origin disruption, such as parental alcohol abuse and divorce, than would nonviolent males.

METHOD

Subjects

Participants were: (A) nonbattering males (NVC) recruited from local marriage and family therapy and medicine clinics, and marital adjustment

seminars sponsored by local churches and organizations. Nonmarried men were accepted for participation if they had been in a committed relationship for a minimum of 6 months. Inclusion was based on a score on the Conflict Tactics Scale (CTS; Straus, 1979) indicating no violence in the past 2 years as reported by both partners, following *independent* administration of the instrument. This method yielded a sample of 73 nonviolent males, 9 of whom admitted to alcohol abuse problems. Because this constituted an insufficient sample for separate analysis, those 9 subjects were deleted from further analysis. The remaining 64 nonviolent males were subdivided into the maritally discordant group ($n=31$) and the maritally satisfied group ($n=33$), using a cutting score of 100 on the Locke-Wallace Marital Adjustment Scale (Locke and Wallace, 1957). Participants scoring 100 or more on the Locke-Wallace scale constituted the maritally satisfied group.

(B) the recruitment described above yielded another subset of subjects. This group consisted of men for whom the maximum CTS score suggested a history of violence within the past 2 years, minimally at the level of a shove. Of 33 men initially included in this "community violent" (CB) sample, 5 men also admitted alcohol-abuse problems. These subjects were also removed from further analysis leaving a sample of 28 community violent subjects. This serendipitous group constituted a substantial sample of men reported to be violent, who were not detected through the usual official channels of referral for assessment and treatment. Hence, the CB group represented an "intermediate" sample for comparison between their officially identified violent counterparts and their nonviolent demographically similar counterparts. The two community samples were recruited over the same time period as the batterer groups, described below.

(C) Men who attended, minimally, the initial evaluation portion of a 16-week violence abatement program between August 1984 and December 1987, comprised the batterer group. Batterers were identified through court referral or self-referral and independent, corroborative interviews and CTS administration to the man and his partner. The treatment program in which the present study took place was originally developed and continues to function as both a clinical and a research program. Therefore, no battering males have been excluded from possible participation by the treatment program. At the criminal justice level, however, men convicted of felony-level domestic assaults have systematically been denied access to the treatment program. Hence, the population of court-ordered men in the present program consists of those convicted of (legally) less injurious forms of violence. All identified batterers admitted to at least pushing/shoving their partners.

Subject Matching

Identified batterers were selected from the sample ($n=372$) to match the community sample for age. The criterion for the age variable was to consider it a match if pairs of subjects' ages were within 1 year.

Results of previous studies of alcoholic and nonalcoholic batterers (Hamberger and Hastings, 1987, 1988) showed several important differences between groups. Hence, identified batterers in the present study were divided into alcohol abusing batterers (AA-B, $n=38$) and non-alcohol-abusing batterers (NA-B, $n=61$). The selection criterion was a self-report of alcohol problems at the time of assessment derived from the demographic data form. Self-report has been found by the authors to correlate moderately ($r = 0.36$) with the Alcohol subscale of the MCMI in this population.

Participants were also matched on education. Categories included: less than high school, high school graduate, some college, college graduate. A chi-square analysis to check the adequacy of the match indicated no significant group differences. ($\chi^2 = 7.29, p < 0.29$). These data and other demographic comparisons are summarized in Table I.

Tests Administered

In addition to a demographic data form, each participant completed the Millon (1983) Clinical Multiaxial Inventory (MCMI). The MCMI is a 175-item personality inventory, answered in a true/false format. Raw scores are transformed into "baserate" (BR) scores that are based on known prevalence data for each diagnostic category and syndrome. Baserate scores at or above 75 indicate presence of syndrome symptom features. Baserate scores at or above 85 indicate presence of the syndrome. The test yields 20 clinical scales and 2 validity scales. The first 8 subscales describe basic personality style. The next 3 subscales assess presence and severity of more marked personality pathology, such as schizotypal, borderline, and paranoid personality. Taken together, the 11 subscales provide a detailed description of personality and, when present, personality disorder. The remaining subscales provide data on anxiety, hysteria, hypomania, depression, alcohol and other drug abuse, and psychotic processes.

When disorders are observed, they correspond to those identified in the third edition of the Diagnostic and Statistical Manual (DSM-III). Numerous studies relating MCMI scales with personality diagnoses are reviewed in the manual. Dutton (1988), in reviewing research from this laboratory, cited Widiger *et al.* (1985) as providing evidence that the MCMI may overclassify subjects into DSM-III categories. In response, Millon

(1985) has offered cogent arguments and preliminary evidence that the MCMI provides a good assessment of DSM-III personality disorders. Nevertheless, results of the present study should probably be interpreted cautiously until the question of over-classification is settled.

Men recruited from the community were also administered the Locke-Wallace Marital Adjustment Scale (Locke and Wallace, 1957), and the Conflict Tactics Scale (Straus, 1979). These instruments were used for assignment to appropriate groups.

All participants completed a demographic data form. In addition to asking about history of alcohol abuse, other information gathered includes educational level, occupational status, parental divorce, history of direct abuse, victimization, and history of having witnessed parental violence. With respect to direct and witnessed abuse history, participants were asked directly to respond "yes" or "no" to the following inquiries: "Were you ever abused as a child? If yes, please specify—emotional (name calling, yelling, etc.), physical (hitting, kicking, etc.)." For history of witnessing abuse: "Did you ever witness one of your parents being abused? If yes, which parent usually received the abuse?" To assess parental alcohol abuse, participants checked all members of their family (i.e., brother, sister, mother, father) who had difficulties with alcohol abuse."

Procedure

Identified batterers were administered the test packet as part of the treatment program. They were provided an information sheet explaining the study and were asked for permission to use their test results, anonymously, for the study. All participants were assured that participation in the study was entirely voluntary. For those who were court-referred it was stressed that no information about their decision to participate in research would be provided to the courts. Virtually all agreed and each signed an informed consent form.

Community subjects were provided an information sheet and an informed consent form explaining the procedures of the study. Participants signed the consent form and were then administered the test battery. Participants were then debriefed, and any remaining questions were answered. As part of the debriefing for the community samples, which took place prior to selection into the two groups (NVC and CB), information was provided to both partners about local laws and available resources for coping with domestic violence, including contacting the first author for further assistance.

Table I. Demographic Comparisons of NA-B, AA-B, and CB Versus Matched NVC Subjects

Group	1 Non- violent controls (NVC)	2 Non- violent Batterers (CB)	3 Alcohol Abusive Batterers (AA-B)	4 Non- alcohol Batterers (NA-B)
n	64	28	38	61
Age	35.1	34.0	35.0	34.5
Education				
<High school	2	0	1	1
Some college	27	11	17	20
College grad	17	6	5	6
Race				
Caucasian	56	25	36	50
Black	2	0	1	6
Hispanic	2	0	1	2
Other	0	0	0	2
Employment				
Employed	61	26	35	45
Unemployed	3	1	3	16
Witness abuse				
Yes	6	3	18	12
No	57	23	19	46
Abused				
Yes	5	1	19	14
No	58	25	19	46
Parental divorce				
Yes	7	2	10	20
No	43	26	20	42
Parental alcohol Abuse				
Yes	4	7	9	14
No	36	21	22	48

RESULTS

Marital Satisfaction/Discord in Nonbatterers

Hastings and Hamberger (1988) found no differences between maritally discordant and satisfied males on any measure used. Therefore, to determine whether marital satisfaction was importantly related to any of the variables in the present study, a similar comparison was made with the expanded nonviolent group prior to comparison with the violent groups. As with the previous study, chi-square tests evaluated group differences on demographic variables including race, educational level, employment status,

Table II. MCMI Test Data, Mean (SD) for Na-B, AA-B, CB Versus Matched NVC Subjects

n	1 NVC 62	2 CB 27	3 AA-B 38	4 NA-B 61	Significant Differences
MCMI					
Asocial	10.2(3.7)	9.6(3.6)	12.2(4.5)	10.2(3.4)	
Avoidant	7.1(4.8)	6.7(5.6)	11.1(5.8)	8.1(4.8)	214-3
Submissive	12.2(3.7)	11.8(3.7)	11.0(4.1)	12.7(3.7)	
Gregarious	14.2(4.1)	16.3(3.7)	15.1(2.8)	15.3(3.4)	
Narcissistic	21.4(5.1)	23.4(5.8)	23.7(5.0)	23.9(4.7)	
Aggressive	15.2(4.2)	17.0(3.8)	18.9(4.6)	16.6(4.4)	1-3
Conforming	28.5(5.7)	25.4(4.4)	21.6(4.8)	26.6(6.8)	14-3
Negativistic	6.2(3.7)	7.9(5.0)	13.2(5.0)	9.1(5.5)	124-3
					1-4
Anxiety	4.8(3.7)	6.7(7.2)	9.6(7.2)	8.0(6.2)	1-34
Hysteria	7.7(3.8)	9.1(5.4)	11.7(6.2)	10.7(5.4)	1-34
Hypomania	15.8(6.4)	19.1(5.9)	21.8(6.8)	18.5(6.3)	1-3
Depression	4.8(3.3)	6.0(6.8)	9.9(6.6)	7.6(5.7)	12-3
Alcohol	8.5(3.2)	10.6(3.3)	15.6(5.6)	12.4(3.9)	124-3
					1-4
Drugs	13.8(5.2)	16.4(4.2)	20.5(5.2)	17.9(5.4)	12-3
					1-4
Schizoid	6.5(5.2)	6.4(5.9)	9.8(6.6)	6.9(5.0)	
Borderline	4.8(4.2)	6.6(7.9)	12.8(8.4)	9.4(7.2)	12-3
					1-4
Paranoid11.1(5.5)	11.9(5.1)	14.9(6.3)	13.4(5.5)		
Psy. thinking	4.4(3.5)	4.4(3.7)	8.1(5.2)	5.8(3.6)	124-3
Psy. depression	2.7(2.4)	3.6(3.7)	7.2(5.0)	5.0(3.9)	124-3
					1-4

history of being abused, and history of witnessing abuse. None of the chi-square results differentiated the two groups. Analysis of variance on the MCMI subscales also did not yield any significant group differences. Therefore, it was concluded that the two nonviolent groups were not significantly different in terms of the measures used in the present study. The two groups were then combined into a single nonviolent control (NVC) group for comparison with the batterer groups.

Demographic Comparisons

Demographic characteristics of the sample studied are summarized in Table I.

Since multiple, *à posteriori* comparisons were being made, only statistics that achieved $p < 0.007$ were accepted as being significant (i.e., 0.05 divided by the number of comparisons, 7). There were no group differen-

ces in racial composition. More NA-B subjects were employed than participants in the other groups, which did not differ from each other ($\chi^2 = 17.17$, $df = 3$, $p < 0.0007$). The groups differed in reported history of having witnessed parental violence ($\chi^2 = 26.07$, $df = 3$, $p < 0.002$). This difference is accounted for by the higher proportion of AA-B participants reporting the witnessing of violence ($\chi^2 = 23.05$, $df = 1$, $p < 0.001$). The NA-B group did not differ significantly from the NVC and CB groups on this variable. With respect to history of direct abuse victimization, alcoholic batterers reported higher levels of victimization than the NVC and CB groups ($\chi^2 = 11.83$, $df = 1$, $p < 0.001$). Nonalcoholic batterers were slightly more likely to have been victimized, compared to the NVC and CB groups, but this effect did not achieve statistical significance. There were no significant differences on report of parental divorce or parental alcohol abuse.

Personality Comparison

Means and standard deviations of MCMI scores are summarized in Table II.

Analyses of variance were used to evaluate group differences on the MCMI. Given that there were numerous comparisons to be made (a total of 20 MCMI scales), an effort was made to protect against Type-I error. First, multivariate analyses of variance (MANOVA's) were computed on subsets of conceptually similar scales, and no subsequent univariate F tests were considered unless the overall multivariate statistic achieved a " p " value of at least 0.001. Second, F tests were considered significant for subsequent comparisons if they achieve a " p " value of 0.0025 (i.e., the traditional 0.05 divided by the number of comparisons, 20).

The multivariate analysis of variance conducted on the MCMI "Basic-8" yielded a strong group effect ($\Lambda = 0.664$); equivalent $F_{25,514} = 3.23$, $p < 0.0001$). Univariate F tests, ($df = 3,184$) indicated significant group differences for the Avoidant scale ($F = 5.92$, $p < 0.001$), the Aggressive scale, ($F = 6.05$, $p < 0.001$), the Conforming scale ($F = 11.26$, $p < 0.0001$), and the Negativism scale ($F = 5.72$, $p < 0.0001$). Modified LSD tests ($df = 3,184$) are summarized in Table II. There are several significant differences. On the Avoidant scale, AA-B subjects scored higher than all other groups. Group AA-B scored higher than the NVC group on the Aggressive scale. On the Conforming scale, NVC and NA-B subjects scored higher than the AA-B subjects. And on the Negativistic scale, the AA-B group was higher than all other groups. Group NA-B also scored higher than the NVC group.

Table III. Number of Subjects (and Percentage) with BR >75 for MCMI Personality Subscales

Group	NVC	CB	AA-B	NA-B	<i>p</i>
MCMI Subscale					
Asocial	5(8)	2(7)	7(18)	3(5)	ns
Avoidant	5(8)	3(11)	8(21)	8(13)	ns
Submissive	11(19)	4(15)	6(17)	14(24)	ns
Gregarious	7(11)	5(18)	2(5)	7(12)	ns
Narcissistic	12(19)	11(41)	17(45)	21(34)	ns
Aggressive	11(18)	7(26)	21(55)	13(21)	0.003
Conforming	5(8)	0(0)	9(0)	5(8)	ns
Negativistic	2(3)	2(7)	17(45)	12(20)	0.0001
Schizoid	1(2)	0(0)	2(5)	0(0)	ns
Borderline	0(0)	2(7)	6(16)	6(10)	ns
Paranoid	6(10)	4(15)	10(26)	12(20)	ns

Overall group differences were also observed on the six mood-symptom scales ($\Lambda = 0.604$, equivalent $F_{18,507} = 5.47$, $p < 0.0001$). Univariate F tests ($df = 3,184$) yielded strongly significant group differences on all six scales ($p < 0.0001$). The modified LSD tests are summarized in Table II. In general, identified batterers (AA-B and NA-B) showed the highest levels of pathology. Both groups scored significantly higher than the NVC subjects on Anxiety, Hysteria, and Neurotic Depression. On the Neurotic Depression scale, AA-B subjects scored higher than CB subjects. On the Hypomanic scale, AA-B subjects scored significantly higher than the NVC subjects. Finally, on the Alcohol and Drug scales, the two identified batterer groups scored significantly higher than the NVC group, with the AA-B subjects scoring higher than the CB group as well.

The MANOVA for severe psychopathology scales revealed significant overall differences ($\Lambda = 0.697$, equivalent $F_{18,507} = 3.82$, $p < 0.0001$). Univariate F tests ($df = 3,184$) also revealed significant group differences for several scales: Borderline ($F = 12.17$, $p < 0.001$), Psychotic Thinking ($F = 7.90$, $p < 0.0001$), Psychotic Depression ($F = 12.37$, $p < 0.0001$). Subsequent modified LSD tests showed both identified batterer groups to exhibit the highest elevations, with AA-B group scoring significantly higher than the NVC group on the Borderline scale. On the Borderline subscale, AA-B participants were significantly higher than CB subjects, and NA-B subjects were significantly higher than NVC participants. On the Psychotic Thinking and Psychotic Depression scales AA-B subjects scored significantly higher than all other subgroups. The NA-B subjects scored significantly higher than the NVC group on the Psychotic Depression scale. These data are summarized in Table II.

Pathological Scale Scores

The means reported above reflect group averages which give the appearance of nonpathological profiles for all groups due to the averaging of heterogeneous profiles. Subsequent chi-square analyses determined whether batterer groups were more likely to score in the pathological range (BR = 75) on the MCMI personality and personality disorder scales. The data are summarized in Table III.

Only comparisons that achieved a "*p*" value of 0.0045 were accepted as significant (i.e., 05/11) significantly more alcoholic batterers scored in the pathological range of the Aggressive scale than participants in the other three groups ($\chi^2 = 18.70$, $df = 3$, $p < 0.0003$). On the Negativism scale, identified batterers were over-represented in the pathological range, compared to CB and NVC subjects ($\chi^2 = 30.31$, $df = 3$, $p < 0.0001$).

In summary, the above analyses indicate that batterers (especially identified batterers) not only tend to score higher on the MCMI than non-violent men, but more often have scores in the pathological range on scales relating to aggressiveness and passive-aggressive qualities.

DISCUSSION

The purpose of this study was to extend previous research investigating differences between domestically violent and nonviolent men. Age, alcohol abuse, and educational attainment were controlled experimentally or statistically. An additional group of domestically violent men was included that had not been identified through "official channels."

Two important factors urge caution in the interpretation of the results. First, while the overall sample sizes were adequate, the community batterer (CB) sample was relatively small, and therefore generalization is somewhat limited. Replication is needed from other laboratories. The second caveat pertains to the primary instrument used in the present study, the MCMI. Dutton (1988) cited evidence presented by Widiger *et al.* (1985) that the MCMI may overclassify subjects into DSM-III categories. Millon (1985), however, offered cogent arguments and evidence that the MCMI does *not* overclassify. In the present study, classification (defined by base rate scores =75) was not uniform for batterer and nonbatterer groups, and occurred largely in the predicted pattern. Replication with other assessment devices would add strength to these findings.

In general, all three hypotheses studied received support. Support for Hypothesis 1 is qualified in that the predicted differences for the Avoidant, Negativistic, and Borderline subscales were observed strongly for alcoholic

batterers and only moderately for the nonalcoholic batterers. Community-identified batterers were not significantly different than nonviolent controls on any of those four subscales. No group differences were observed on the Submissive subscale. On the Conforming subscale, however, alcoholic batterers did score significantly lower than nonbatterers, although nonalcoholic batterers did not.

Hypothesis 2, that Alcoholic batterers would exhibit the highest elevations of all four groups, was well supported. Alcoholic batterers scored higher than all groups on thirteen of eighteen scales for which such predictions were made. On the Conforming subscale, Alcoholic batterers scored the lowest, as predicted. There were no significant differences between NA-B and NVC subjects on the Conforming subscale. This finding was not expected and may represent attempts by nonalcoholic batterers to appear conventional, and socially acceptable. In further support of Hypothesis 2, ordering of groups from highest subscale elevation to lowest occurred as predicted (AA-B, NA-B, CB, NVC) on 7 of 18 subscales for which such predictions were made. Significant differences tended to be between the extreme groups only (AA-B vs NVC), and to a lesser extent NA-B vs NVC on 8 of 18 subscales). The predicted pattern of greater MCMI subscale elevations for the CB group, relative to NVC participants, however, was not supported.

Finally, Hypothesis 3, that batterers would report having experienced greater disruption in the family of origin was also partially supported. Alcoholic batterers were more likely to report having witnessed parental violence and having been abused than nonviolent controls. Nonalcoholic batterers were also slightly more likely (though not significantly) to have experienced abuse than were nonviolent men, and community batterers did not differ from their nonviolent counterparts on report of family of origin violence. The overall rates of direct and witnessed abuse are somewhat lower than generally reported in the literature, albeit in the same direction. It may be that the straightforward manner of inquiry resulted in lower reported rates than had we asked about the use of different types of aggression in the family-of-origin. However in designing the questionnaire, the decision was made that it would be more advantageous to allow the participant to decide if he had experienced or witnessed abuse rather than for the researcher to make such an inference based on interpretation of report of use of various forms of aggression.

No differences were noted between groups on reported rates of parental alcohol abuse or rates of parental divorce.

Based on analysis of the specific predictions made in the present study, alcoholic batterers and to a lesser extent, nonalcoholic batterers, appear to be the least similar to nonbatterers, primarily on those per-

sonality dimensions found by Hamberger and Hastings (1986) to comprise borderline and mixed borderline/antisocial features. Alcoholic batterers tend to exhibit the most severe psychopathology (i.e., highest test score elevations) and family of origin disruption relative to nonviolent controls. Scales on which alcoholic batterers comprised the *only* group to differ significantly from nonviolent men included the Avoidant, Aggressive, Conforming, Hypomania, and Psychotic Thinking subscales. The picture presented by these pure group differences is consistent with observations of Hastings and Hamberger that alcoholic batterers appear to be extremely distressed and dysphoric. They exhibit characteristics related to alienation, unpredictable moodiness, and volatile over-responsiveness to interpersonal slights. If threatened or "slighted" sufficiently, the alcoholic batterer responds with vindictive, punitive aggression, often to violent proportions.

Nonalcoholic batterers showed no "pure" group differences from the nonviolent group. The NA-B group did however, differ from controls on the following subscales: Negativistic, Borderline, Anxiety, Hysteria, Neurotic Depression, Alcohol, Drugs, and Psychotic Depression. The picture that emerges is similar to the AA-B group, except that the NA-B subjects do not share the propensity of AA-B subjects to interpersonal ambivalence and alienation characterized by extreme fear of and sensitivity to rejection versus hostile, vindictive, and punitive rejection. Instead, nonalcoholic batterers appear to be struggling with lack of personal integration of their own negative impulses and feelings versus their need to "do right" and "be alright." This latter interpretation is further supported by the unexpected finding of the higher rule governance among NA-B, compared to AA-B participants, noted earlier. Hence, as with alcoholic batterers, nonalcoholic batterers may appear moody and volatile, but with less hostility and fewer personalized perceptual distortions.

The Community-identified batterers appear quite dissimilar to the two agency-identified batterer groups, and very similar to the nonviolent controls. This was true for the MCMI scales as well as family of origin disruption indices. CB subjects also appear to have greater socioeconomic advantages (i.e., employment) than the identified batterer groups. Hence, there are some clear differences observed between agency-identified batterers and those who have not yet been detected in the community. Furthermore, between CB and NVC groups, the similarities were striking.

This pattern of findings provides support for the notion that, as a group, batterers are heterogeneous and fail to conform to a unified "batterer profile." Not all batterers look alike, and the question of how bat-

terers differ from the nonbatterers must be restated to ask how various groups of batterers differ from other groups of batterers and from non-violent men. Three important questions follow: (1) What factors account for the differences among batterer and nonbatterer groups? (2) What treatment implications can be inferred from these findings?' and (3) What are the methodological implications of these findings?

With regard to the first question, one very important variable appears to be alcohol abuse. It appears, however, to be highly related to psychopathology and report of witnessing and experiencing abuse in the family of origin. Considerable clarification is needed before the role of alcohol abuse in battering is understood.

Clear differences were also noted between identified batterers (AA-B and NA-B) and those who have not yet been "officially" identified (CB). These differences were most pronounced in the area of personality characteristics and family-of-origin disruption, and CB subjects were more likely to be employed. Identified batterers may have been identified because the intensity of their psychopathology, in addition to their violence, is intolerable to the victim, prompting use of services. Analysis of the maximum level of violence on the CTS for each group indicated higher average levels of violence for AA-B subjects (Hit or tried to hit her with an object), and NA-B subjects (Threw her bodily), compared to CB subjects (Threw something at her) and NVC subjects (Made threats to leave the relationship) $F_{3,142} = 32.35, p < 0.001$. It is also known that law enforcement and shelter options are more heavily used by those in lower socioeconomic levels, unable to afford less visible options and services. It will be necessary to develop methods that clarify the interactive effects of psychological factors and socioeconomic variables in understanding domestic violence. The present study did control for age and education range. However, some group differences were observed for employment status, another index of socioeconomic status. Subsequent research should control for this and other such effects.

Several recent studies have found that traumatization in early childhood (Bryer *et al.*, 1987; Burgess *et al.*, 1987; Herman *et al.*, 1989) and early adulthood (Resnick *et al.*, 1988) is related to adult personality disorder and deviant social behavior. It may be useful to examine the role of trauma victimization in the etiology of battering.

Results of the present study also have implications for treatment of male batterers. In all treatment of male batterers, the primary goal is cessation of violence in all of its forms (i.e., physical, sexual, psychological and property/pet destruction). It is also important to educate batterers in the destructive effect of their violence, not only in terms of the immediate impact, but in the perpetuation of an oppressive

patriarchal social system (cf. Martin, 1987). Given the heterogeneity among batterers, however, it is also timely to begin conducting assessments for the purpose of tailoring specific treatments to different subgroups. For example, time-limited skills training for managing interpersonal conflict and personal arousal levels may be sufficient for those batterers who present with minimal psychopathology and minimal histories of family violence. Alcoholic and borderline disordered batterers, in contrast, may require more intensive treatment. Substance abuse problems will require formal intervention. Depression, thought disorder, and paranoia often approach proportions requiring evaluation for adjunctive pharmacotherapy and occasional hospitalization. Men who have experienced (vicariously or directly) extreme and chronic levels of violence in the family-of-origin may require interventions not unlike those for post traumatic stress disorder. Such interventions might best be accomplished in specialized groups or individually rather than in the more typical batterer groups.

Results of the present study also suggest some important methodological implications. Officially identified batterers and violent men recruited from community sources appear, as noted above, to represent different segments of the population of domestically violent men. Therefore, in any given study, the types of conclusions drawn about batterer characteristics may be partially determined by the recruitment source. If the men are recruited from the general community it could be concluded that batterers are essentially no different from nonbatterers. If the study was based on a clinical population of male batterers it might be concluded that psychopathology is an important theoretical and etiological part of the total picture of battery. Research reports in this area must convey clear descriptions of the samples and recruitment sources under study.

The present study extended previous research from this and the other laboratories on characteristics of male batterers. Considerable progress is being made in identifying various characteristics. Much more work remains, however, in determining the theoretical and clinical significance of these characteristics.

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