

THE RELATIONSHIP OF MALE SOCIALIZATION AND  
PERSONALITY PATHOLOGY IN MALE BATTERER SUBTYPES

A Dissertation

by

LEE SHEFFERMAN

Submitted to the Office of Graduate Studies of  
Texas A&M University  
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2006

Major Subject: Counseling Psychology

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## ABSTRACT

The Relationship of Male Socialization and Personality Pathology in Male  
Batterer Subtypes. (May 2006)

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This study examined the role that rigid sex-role stereotyping and male socialization played in differentiating the three typologies of male batterers. The first purpose was to utilize a cluster analysis to determine whether the three male batterer clusters (Family Only (FO), Borderline-Dysphoric (BD) and Generally Violent-Antisocial (GVA)) theorized by Holtzworth-Munroe and Stuart (1994) could be reproduced using the MMPI-2. 101 adult court referred males on probation for domestic violence were given the MMPI-2, and three distinct batterer typologies emerged. Once the clusters were established, this study attempted to determine if the theoretical model proposed by Jennings and Murphy (2000), which emphasized male socialization and its potential effect on male-female interactions within intimate relationships, is influential in creating differentiation among the cluster typologies. Specifically, an emphasis was placed on examining how the FO male batterer cluster differed from the BD and GVA clusters. Four variables were theorized to best represent Jennings and Murphy's (2000) model, including: the Masculine –Feminine (MF) clinical scale, Social Introversion (Si) clinical scale, Gender-Masculine (GM) supplementary scale and Low Self-Esteem (LSE)

content scale. A MANOVA was utilized to see if the three batterer typologies differed on the variables (MF, Si, GM, and LSE) that encompass the male socialization construct. Results indicated that statistically significant differentiation did exist between the three clusters. Furthermore, there was indication that the FO men adhered more closely to rigid traditional male roles and displayed higher self-esteem. Discussion focused on the importance of matching treatment to batterer typology and the importance of incorporating discussion of male socialization into group therapy treatment.

## DEDICATION

I would like to dedicate this dissertation to my Mother, Brother, Merdy and in memory of my Father.

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## CHAPTER I

### INTRODUCTION

Marital violence is a severe issue in the United States as indicated by data from the 1985 National Family Violence Survey (Holtzworth-Munroe & Stuart, 1994). The survey showed that during the year of the study, 1.8 million wives were beaten by their husbands, and one out of eight husbands inflicted at least one violent act upon their wives. The 1985 survey focused on married women only and did not account for other women who are abused by their partners. More recently, the National Institute of Justice and the Centers for Disease Control and Prevention sponsored The National Violence against Women Survey (Tjaden & Thoennes, 1998). This study, conducted from November 1995 through May of 1996, indicated that about 1.5 million women were victims of intimate violence (Tjaden & Thoennes, 1998). Straus et al. (1980) reported that in the United States, one out of six American couples engage in violent outbursts at least once a year. Furthermore, data from a national survey tells the story that on a yearly basis married men will be physically aggressive towards their spouses and nearly two million women will be severely assaulted by their male partners (Gelles, 1992). It should be noted that men are not the only ones to engage in intimate partner violence. Rather, research has suggested that women are as likely, or slightly more likely (Anderson, 2002; Straus, Gelles, & Steinmetz, 1980) to commit low-level acts of

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This dissertation follows the style of the *Journal of Consulting and Clinical Psychology*.

aggression (i.e., hitting, slapping, pushing, etc.) than men (Frieze, 2005). Even though this evidence indicates that women engage in violence towards men in intimate relationships, it has been consistently found that women are more likely to suffer from severe injuries and depression (O'Leary, 2000; Currie, 1998; Johnson, 1995; Stark & Flitcraft, 1996; Yllo, 1993; Straus & Gelles, 1990). Furthermore, Bachman and Saltzman (1995) indicate that whereas the vast majority of assaults on men tend to be perpetrated by strangers and acquaintances, women are most likely to be victimized (raped, beaten, stalked or killed) by intimate partners than strangers or any other type of perpetrator.

The influence of the women's movement in the 1970's prompted the justice system to prosecute men who assaulted their wives/partners, even though wife assault was illegal by the end of the 1800s (Lawson et al., 2003). Gelles (1992) remarked that even though prosecution of wife abusers has increased, it usually occurred as the result of a severe injury or death. As public awareness and interest in domestic violence increased, so did the interest in research to understand the cause of family violence (Hale, Duckworth, Zimostad, & Nicholas, 1988).

Holtzworth-Munroe and Stuart (1994) suggested that in trying to understand husband to wife violence it is the male "that is the most productive line of inquiry" (p. 2). In efforts to study married men who are violent there had been a tendency to group all batterers into one homogeneous group. In turn, men had been categorized as either batterers or non-batterers. However, merely separating violent men from non-violent men and lumping all batterers into one group by averaging the mean scores on variables

of interest discounts some important variables that could yield valuable information on how each type of violent man differs from one another. For example, averaging of mean scores may consequently discount the potential of important variables, including attitudes towards women, anger, depression, severity of violence, etc. (Holtzworth-Munroe & Stuart, 1994).

In an effort to understand how male batterers differ, a number of researchers have proposed typologies of battering men. Gottman, Jacobson, Rushe, Shortt, Babcock, La Taillade, and Waltz (1995) discussed two typologies of male batterers based on heart rate reactivity during interaction with their partners. Gottman et al. (1995) delineated two typologies: *Type 1*, characterized by deceleration of heart rate during conflict; and *Type 2*, distinguished by acceleration of heart rate during conflict. Additionally, according to Shields, McCall and Hanneke (1998), historical accounts of batterer typologies have placed batterers into two major groups. These groups included men who battered inside the home and men who battered elsewhere.

Men who use violence with their partners are alike neither in patterns of violence employed nor in their intention for using violence. Although several profiles of male perpetrators of intimate violence exist, researchers have tentatively identified a tripartite typology for male partner abuse (Holtzworth-Munroe & Stuart, 1994; Tweed & Dutton, 1998). These three types differ on: (a) the severity and frequency of violence within the relationship, (b) the extent of violence in and outside the home, and (c) psychopathology and personality characteristics. The three abuse types suggested in the literature include: (a) Generally Violent–Antisocial (GVA), (b) Borderline-Dysphoric (BD), and (c) Family

Only (FO) violence (Holtzworth-Munroe & Stuart, 1994). Although these three empirically identified abuser types have been delineated across studies, the importance of these distinctions has not yet been fully realized in mainstream treatment approaches.

Holtzworth-Munroe et al. (2000) described and delineated three male batterer typologies. Family Only (FO) men display the lowest amount of aggressive behavior and could easily be mistaken for men who experience marital distress but do not engage in spousal or partner abuse. The authors suggest that FO men tend to demonstrate low levels of psychopathology, a positive attitude towards women, and a negative attitude toward violence, which possibly results in these men feeling remorse that prevents further aggression or damage. The Borderline-Dysphoric (BD) are hypothesized to come from a background of parental abuse and rejection resulting in their difficulty in establishing a stable and trusting relationship with a partner (Holtzworth-Munroe et al, 2000). Consequently, they may appear quite jealous and dependent on their wives, while at the same time being fearful of losing them. The Generally Violent–Antisocial (GVA) men are characterized as experiencing high levels of family violence and are associated with a deviant peer group. They are characterized as being impulsive, having poor attitudes towards women, lacking relational skills, and accepting of violence and violent acts (Holtzworth-Munroe et al, 2000).

In identifying and formulating the three male batterer subgroups, research has utilized standardized tests (MCMI, MMPI and MMPI-2) to indicate the batterer typologies (Holtzworth-Munroe & Stuart, 1994; Lawson et al., 2003). Holtzworth-Munroe and Stuart (1994) explain that the three major dimensions (severity of violence,

generality of violence and psychopathology/personality disorders) are descriptive in explaining subtypes.

Clinicians face many challenges in working with male perpetrators of intimate violence. One of these challenges is providing effective treatment for at least three different types of batterers: Generally Violent-Antisocial, Borderline-Dysphoric, and Family Only perpetrators. Currently, most batterer treatment programs employ cognitive-behavioral and short-term psychoeducational models of treatment regardless of the type of batterer (Carden, 1994; Gondolf, 1997; Feldman & Ridley, 1995; Holtzworth-Munroe & Meehan, 2004). Although treatment is more effective than no treatment, of those who completed treatment, recidivism rates ranged from 24% to 40% within 6 to 24 months following termination (Gondolf, 1997). Some hold that current data on current cognitive-behavioral treatment models fail to indicate notable treatment success in reducing either psychological or physical abuse (Holtzworth-Munroe, Beatty & Anglin, 1995; Holtzworth-Munroe & Stuart, 1994). As a result, limited research has shown that different types of batterers responded more favorably to different kinds of treatment (Saunders, 1996). However, little appears in the domestic violence literature pertaining to a rationale for differential treatment based on batterer typology.

Holtzworth-Munroe and Meehan (2004) argue for the need for matching batterer typologies with differential treatment programs:

Our understanding of husband violence may be enhanced by drawing attention to these differences, rather than ignoring them. Comparing various types of violent men to each other, and understanding how each type differs from nonviolent men, may allow us to identify different underlying processes resulting in violence. Such efforts might also improve the effectiveness of batterer intervention programs, by identifying which types of men benefit from available



treatments and designing interventions to address the relevant clinical issues of each type (p. 1370).

Additionally, Gondolf (1988) suggests that batterer differentiation may be essential for treatment to address the range of batterer types. He addresses the need to differentiate batterer types and suggests that there may be situations where clinicians may separate or circumvent treatment for sociopathic and antisocial batterers. Specifically, the author stated, “Consequently, batterer programs may do better to reject these men from counseling, in order to avoid presenting another “false hope” to women with men who are beyond the scope of conventional treatment. In other words, there are some batterers whom counseling programs should not accept, despite financial and programmatic pressures” (Gondolf, 1988, p. 200).

Rather than continuing to rely upon one type of treatment for all batterers despite evidence suggesting its ineffectiveness, matching batterer typologies with differential treatment could be quite significant in the field of domestic violence. Holtzworth – Munroe and Stuart (1994) support the notion that differential treatment matching would increase therapeutic effectiveness. Specifically the authors state, “Many current treatment programs for batterers are standardized and uniformly applied to all violent men seeking help. However, one treatment may be better suited for one subtype of violent men than for another. Tailoring treatments to meet the needs of each subtype of violent men might improve therapy efficacy (Gondolf, 1988; Saunders, 1992)” (Holtzworth-Munroe & Stuart, 1994, p. 49).

Drawing upon the previous literature and from clinical observations working with male batterer groups, this author hypothesizes that there are concrete differences

between batterers. Specifically, in keeping with the terminology of Holtzworth-Munroe and Stuart (1994), there appear to be significant clinical differences between the FO, BD, and the GVA male batterers. The present author points to the work by Jennings and Murphy (2000) who propose that domestic violence may stem from male to male relational issues, which could have implication for treatment with the FO male batterer.

Jennings and Murphy (2000) state that the field of domestic violence has largely focused its research, theories and treatment approaches on the male-female dimensions, which refers to the interactions between males and females. While it is important to pay attention to the interactions between males and females, the authors suggest that socialization of male to male interactions also plays an essential role in the understanding and conceptualization of the male batterer. Jennings and Murphy (2000) infer that boys have been socialized to be strong, independent, and emotionally invulnerable, which likely contributes to a lack of intimacy or vulnerability between men. Without this model of intimacy, men may face challenges in forming healthy relationships with other men, as well as in establishing healthy intimate relationships with females. Consequently, these men may grow up without the ability to establish an adequate support system, thus ultimately relying on the female partner to be "...his lover, mother, best friend, confidante, social group, buddy and sometimes even surrogate father – all rolled up into one" (Jennings & Murphy, 2000, p. 26).

Jennings and Murphy (2000) contend that traditional male socialization and the unbending sex role stereotypes impact emotional and behavioral responses in the male to female relationship. Thus, male issues, independent of the male to female dimension,

may play a crucial role in the field of domestic violence, which in turn could have significant implications for differing treatment approaches.

### *Purpose of Study*

A major purpose of this study would be to test empirically whether the three batterer subtypes (FO, BD, and GVA) developed by Holtzworth-Munroe and Stuart (1994) can be reproduced using the Minnesota Multiphasic Personality Inventory-Second Edition (MMPI-2), a widely-used and psychometrically sound measure of personality.

The second major purpose of this study is to lend support to Jennings and Murphy's (2000) view that male socialization is an important factor to consider when working with male batterers. Specifically, we seek to incorporate the ideas of Jennings and Murphy (2000) to determine whether the non-clinical (FO) men who have abused their wives or partners adhere more strongly to the socialized traditional male roles. MMPI-2 variables selected based on the present author's theorizing will be used to examine potential differences between batterer groups, and possible treatment implications will be discussed.

The understanding of male to male relationships and the strong adherence to rigid sex roles may provide future treatment implications for addressing specific subtypes of male batterers described by Holtzworth-Munroe and Stuart (1994). If certain subtypes of male batterers (i.e., the FO men) are more likely to rigidly adhere to the male gender role, then this may lend credence to the idea that cognitive behavioral and short-term psychoeducational techniques may not be the sole or most effective

therapeutic intervention for treating male batterers. Specifically, such a finding may provide further evidence for the need to tailor treatment approaches based on batterer subtype and to consider incorporating male to male relationships and male socialization into the treatment of domestically violent men.

## CHAPTER II

### LITERATURE REVIEW

Intimate partner violence is a significant issue in the United States, and has been throughout its history. Although violence in general has been studied for centuries, violence within the context of the family had previously been viewed as a separate issue, and was therefore not studied extensively until somewhat recently (Lawson et al, 2003). According to Lawson et al. (2003), “This has been due in part to the historical position of the culture and legal system to view violence within the family as noncriminal (Pleck, 1989). Intimate violence was considered private, thus, outside interference was viewed as intrusive (Dutton, 1995)” (p.259). Despite the fact that wife assault was illegal by the end of the 1800s, it was not until the influence of the women’s movement in the 1960’s and 1970’s that the justice system was prompted to prosecute men who assaulted their wives/partners (Lawson, et al. 2003). Furthermore, Gelles (1992) remarked that even though prosecution of wife abusers increased, it usually occurred only as the result of a severe injury or death. Jennings (1987) eloquently described the historical context from which the recognition of male battering behavior commenced:

The history of the treatment of battering males begins, of course, with the entrenched patriarchal power imbalance in our culture (Dobash & Dobash, 1979). On one hand, our common heritage of patriarchy has legitimized male domination and violence as an acceptable response to frustration. On the other hand, it has debilitated men’s natural capacity for intimacy, emotional expressivity, and feeling experience (Watts & Courtois, 1981). Currently, it is broadly accepted that domestic violence is a direct manifestation of socially learned sex-role behaviors. However, this is a very recent recognition that

slowly emerged in the wake of the civil rights and women's movements of the 1960s. Previously, in the 1930s and 1940s, the related problems of wife battering, child abuse, and sexual violence were attributed to circumscribed deviant acts by "crazy sex fiends" or "lust-murderers" (Taubmann, 1986). Offenders were viewed as horribly disturbed individuals suffering from incurable brain damage, psychiatric illness, profound childhood trauma, or hereditary flaws of moral character (p.195).

As public awareness and interest in domestic violence increased in the wake of the women's movement, so did the interest in research to understand the cause and treatment of family violence (Hale et al, 1988).

As a result of the feminist movement which recognized the sociocultural crisis of gender violence, shelters for battered women quickly emerged. The first shelter for battered women was established in London in 1971 (Jennings, 1987), and the United States soon followed suit. Between the years of 1973 to 1980, the number of shelters for women jumped from two to 600 (Roberts, 1984). Treatment initially focused solely on working with the woman to establish safety in the immediate aftermath of the domestic violence. However, relatively few programs included treatment of the male partner; in fact, only two such programs existed in 1975 (Roberts, 1984). The recognition for the vital importance of working with the male partner increased slowly, as evidenced by the fact that 80 such programs were established by 1981 (Roberts, 1984). This number increased again to 148 in 1982 (Pirog-Good & Stets-Kealey, 1985).

### *Male Battering Typologies*

Given the recognition for the need to treat the partners of battered women, increasing interest arose in studying maritally violent men. In such efforts there has been a tendency to group all batterers into one homogeneous group. Accordingly, men

have been categorized as either batterers or non-batterers (Holtzworth-Munroe & Stuart, 1994; Holtzworth-Monroe & Meehan, 2004). Specifically, Gondolf (1988) stated:

In many of the accounts from abused women, batterers appear as sadistic psychopaths with little or no humanity (for example, see Walker, 1979). In the clinical reports of men in batterer programs, batterers are often presented as victims of parental abuse or neglect (for example, see Gondolf, 1985). The prevailing clinical profiles of batterers as traditional males, with impulse and communication deficiencies and alcohol and anger problems, may oversimplify the diversity of batterers being referred to treatment (see Dutton, 1988) (p.187).

However, merely separating violent men from non violent men and lumping all batterers into one group by averaging the mean scores across variables of interest discounts some important variables that would yield valuable information on how each type of violent man differs from one another and from nonbattering men (Holtzworth-Munroe & Stuart, 1994). For example, some researchers have not been able to distinguish battering from nonbattering men on measures of attitudes towards women (Holtzworth-Munroe & Stuart, 1994; Neidig, Collins, & Freedman, 1986; Saunders, 1992). Thus, simply assuming that all male batters hold devaluing attitudes towards women is misleading. Additionally, averaging of mean scores may consequently discount the potential of important variables such as anger, depression, severity of violence, substance abuse, etc. (Holtzworth-Munroe & Stuart, 1994).

Therefore, much research has been dedicated to describing characteristics of men who batter and to developing typologies that incorporate distinct types of male batterers (Saunders, 1992). Holtzworth-Munroe and Stuart (1994) point out,

...a reliable and valid typology of male batterers would yield valuable information. Comparing the various subtypes of violent husbands with each other, and pinpointing how each type of violent man differs from nonviolent men, could increase the understanding of marital violence and help in identifying

different underlying processes resulting in violence... Moreover, such a typology could lead to increases in therapy effectiveness, eventually resulting in patient-treatment matching. Many current treatment programs for batterers are standardized and uniformly applied to all violent men seeking help. However, one treatment may be better suited for one subtype of violent men than for another (pp. 477-478).

Thus, when conducting research into the nature of men who abuse their partners, it is necessary to consider the different subtypes of men who engage in such behavior.

### *Rational-Deductive Typologies*

The earlier attempts at developing typologies of male batterers were based upon a rational/deductive strategy, which encompassed clinical observations and theoretical speculation (Holtzworth-Munroe & Stuart, 1994). An early example of such a rational/deductive strategy is Elbow's (1977) paper delineating four abuse syndromes developed from patterns of behavior, family characteristics, emotional needs, and personality attributes that were observed in clinical settings. The four abuse syndromes included: the controller, the defender, the approval-seeker, and the incorporator.

The Controller is characterized by a need to control others by using persuasive abilities, threats, or force (Elbow, 1977). He appears to closely resemble the diagnostic criteria defined by Antisocial Personality Disorder; he is overly confident, is never deserving of blame, believes that he is deserving of all he desires, appears smooth and in control, and is lacking in empathy and emotional connectedness. The Controller tends to neglect the needs of his partner, and seeks to control her activities and relationships. Violence tends to occur when the Controller feels his authority is questioned or disrespected, or when he feels that he is no longer in control of his partner (Elbow,



1977). The Controller has been characterized by a high level of psychological and physical abuse (Holtzworth-Munroe & Stuart, 1994).

The Defender is similar to the Controller, in that he experiences a sense of grandiosity and seeks a partner who he can control. However, the Defender's self-esteem is dependent upon his partner's reverence and dependence, and he is more interested in "saving" or protecting his partner than in controlling her (Elbow, 1977). He is the "giver" in the relationship, and feels threatened when he feels unneeded or as though his protectiveness is no longer wanted.

The third abusive syndrome, the Approval Seeker, can best be summarized as one who is dependent on others' approval and acceptance (Elbow, 1977). His self-esteem is fragile and needs to be constantly reinforced by his partner. The Approval Seeker's abuse pattern seems to be contingent on his self-image and whether or not he feels accepted by his partner. For example, when his self-image is low, he may expect rejecting reactions from his partner, which triggers verbal attacks that may escalate into physical violence. According to Elbow (1977), "The physical attack is shocking to the abuser and he usually stops immediately; weapons are seldom used" (p.522).

The final type as described by Elbow (1977) is the Incorporator. The Incorporator is primarily characterized by feelings of desperation and the need to cling to his mate to preserve his self-worth. Elbow (1977) describes that the Incorporator's identity is defined by his relationships, and that he has a tendency to erupt into explosive anger, deep depression, and suicidal ideation. Such a description appears to mirror the

characteristics observed in the Borderline Personality Disorder. The Incorporator and the Controller have been described as the two most violent types of batterers.

Another example of a rationally-derived typology was conducted by Shields, McCall, and Hanneke (1988). In keeping to the rational-deductive approach, the authors utilized the social-cultural and social-structural theory of violence, in asserting that interpersonal violence is learned in the family and in social groups and is transmitted intergenerationally. After interviewing 85 violent husbands, these authors proposed three categories of male violence: family only, nonfamily only, and generally violent. According to the Shields et al. (1988), “It appears that the ‘family only’ group uses violence primarily as a means of dealing with stress and conflict within the marital relationship, whereas the ‘generally’ violent men seem to rely on violence as a general interpersonal strategy” (p.93). The nonfamily only group is unusual, in that they engage in violence only outside of the context of their family and do not engage in domestic violence. The authors attempted to account for this category by suggesting that these men may be at “an earlier stage of their violent ‘careers’ and will later become ‘generally’ violent” (Shields et al, 1988, p.93).

Other rational/deductive typologies have focused on severity of abuse. For example, Mott-McDonald (1979) divided abusive men into two categories: hitters and batterers. Hitters were characterized as more accountable for their behavior and as more remorseful. On the other hand, the batterer type was seen as more violent in both frequency and severity, and did not take responsibility for their abusive behavior (Saunders, 1992). Additionally, Sweeney and Key (1982) devised a similar typology to

that of Mott-McDonald (1979), but incorporated personality characteristics with the severity of violence. Specifically, they distinguished between a “frequent” and “infrequent” batterer. The “frequent” batterer exhibited a higher level of violence, with very little ability to inhibit their anger when feeling frustrated. The “infrequent” batterer had a lower level of violence, but tended to be more “rigidly inhibited” (Saunders, 1992, p.265).

Upon examination, these rational/deductive studies appear to be broken down into three dimensions: (1) severity of violence, (2) generality of violence, and (3) batterer psychopathology or presence of personality disorder (Holtzworth-Munroe & Stuart, 1994). The severity of violence dimension considers both severity and frequency of marital violence. This category was utilized in the typologies of Mott-McDonald (1979) and Sweeney and Key (1982). The generality of violence dimension refers to whether the batterer is abusive solely in the home or whether it extends beyond the family environment. Shields et al. (1988) provides an example of utilizing this dimension in their typology. The third dimension, psychopathology or personality disorder, incorporated the degree of Axis I and II psychopathology into their batterer typologies. Elbow (1977) and Sweeney and Key (1982) both included this dimension in their typologies.

#### *Empirical/Inductive Typologies*

Building upon the theoretically and clinically derived (Rational/Deductive studies), the evolution of batterer typologies led to Empirical/Inductive studies, which utilized more advanced statistical procedures, such as cluster analysis and factor

analysis. One of the earlier Empirical/Inductive studies was conducted by Hamberger & Hastings (1986), which factor analyzed results from the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983) to categorize male batterers. Their results led to the creation of three categories: (1) Schizoid/Borderline, (2) Narcissistic/Antisocial, and (3) Dependent/Compulsive. The Schizoid/Borderline is described as, "... a withdrawn and asocial individual... Such individuals are often described by others as highly volatile and over-reactive to trivial interpersonal friction... in colloquial terms, a 'Jekyll & Hyde' personality" (Hamberger & Hastings, 1986, p.329). The Narcissistic/Antisocial type is described as selfish and self-centered, and is characterized by a sense of entitlement and a disregard for the rights and feelings of others. The Dependent/Compulsive type is descriptive of an individual who is rigidly anxious, and has low self-esteem and a strong need for the approval and attention of others (Hamberger & Hastings, 1986).

Another example of an Empirical/Inductive study was designed by Hale, Duckworth, Zimostad, and Nicholas (1988) who argued that previous research focusing on male batterers was based too heavily on clinical impressions. Rather, they recommended using objective evidence as a way to formulate conclusions regarding battering behavior. The study looked at 67 MMPI profiles of males who were currently participating or had finished a treatment program for male batterers. The validity and clinical scales were analyzed in the study, and as a result three homogenous clusters were revealed (Hale et al., 1988). Cluster one, representative of 10% of the sample, was composed of individuals who were either "faking bad" or were seriously psychologically

disturbed, as indicated by the high F score and elevations on nearly every clinical scale. Cluster two, which represented approximately 15% of the sample, was characterized by an absence of significant elevation on any of the clinical scales. The remaining seventy-five percent of the sample fell into Cluster three, which can best be described by a 2-4/4-2 profile on the MMPI, indicating elevations on the Depression and Psychopathy scales (Hale et al, 1988). The authors indicate that the 2-4/4-2 MMPI code-type parallels their clinical observations of male batterers. According to Hale et al. (1988), “Some of the characteristics we have observed include (a) impulsiveness, (b) lack of respect for social standards, (c) frequent difficulties with the law and with their families, (d) situational depression, (e) feelings of inadequacy or low self-esteem or both, and (f) the tendency toward substance abuse” (p.222). Clinicians have noted that it is also common for individuals with this code type to lay blame on others, avoid taking responsibility, and to justify their behaviors (Sonkin & Durphy, 1982; Walker, 1979). Thus, the 2/4-4/2 code type closely resembles the diagnostic criteria of the Antisocial Personality Disorder.

In a similar study, Flournoy and Wilson (1991) worked with 56 adult male batterers who were court-mandated for treatment. Similar to Hale et al. (1988), Flournoy and Wilson (1991) cluster analyzed the results of MMPI profiles to determine batterer typologies using the three validity scales and ten clinical scales. Two profiles were revealed by the study: a normal profile and an elevated 4-2 profile. Fifty-six percent of the sample fell into the normal profile group, while 44% exhibited profiles with elevated scores on scale four (psychopathy) and scale two (depression). As

previously described, the elevated 4-2 profile is indicative of an Antisocial Personality Disorder.

Additionally, Saunders (1992) collected data from 165 male batterers and utilized cluster analysis on six self-report variables (including depression, anger, generalized violence, severity of marital violence, attitudes toward women, and alcohol use during violent incidents) to highlight three clusters of male batterers. The three clusters that emerged were (1) family-only aggressors (52% of sample), (2) generally violent aggressors (29% of sample), and (3) emotionally volatile aggressors (19% of sample) (Holtzworth-Munroe & Stewart, 1995; Saunders, 1992).

The family-only aggressors, termed Type I by Saunders (1992), can best be described as individuals with low levels of anger, depression, and jealousy. However, these men also demonstrated the highest scores on social desirability bias, which can be interpreted as allowing oneself very little display of emotion or vulnerability. Saunders (1992) described, “They are the least likely to have been severely abused as children and to be violent outside of the home. They reported the most satisfaction in the relationship, the least marital conflict, and being the least psychologically abusive. These reports were maintained even with adjustment for response bias” (p.270).

The Type-II males, labeled as generally violent, were described by Saunders (1992) as the most likely to engage in violence outside of the home. According to Saunders (1992),

The majority had been severely abused as children, yet they reported relatively low or moderate levels of depression and anger. Their violence was usually associated with alcohol use, and they reported the most frequent use of severe violence. Their attitudes about sex roles were more rigid than those of Type I

men, and their reports of marital satisfaction and conflict were moderate compared with the other types. Their reports of alcohol use and severe violence were reflected in their relatively high rates of arrest for drunk driving and violence (p.270).

Type-III men, who were labeled by Saunders (1992) as emotionally volatile aggressors, had the highest levels of anger, depression, and jealousy of the three groups. Despite the fact that these men had engaged in severe violence less frequently than the generally violent aggressors, they were the most likely to be psychologically abusive. Of the three groups, they were also the least satisfied in their marital relationships (Saunders, 1992).

Furthermore, Gondolf (1988) examined self-reports of 6000 battered women from each of the 50 shelters in the state of Texas. The author utilized cluster analysis to examine the six self-report variables, which included: the amount of physical abuse, amount of verbal abuse, the use of blame or remorse following the abuse, substance abuse, use of violence outside of the home, and previous arrest record (Gondolf, 1988; Holtzworth-Munroe & Stuart, 1994). The cluster analysis revealed three clusters, two of which were characterized as severely abusive and displaying antisocial behaviors, and one of which was described as less severely violent. Type I, the sociopathic batterer, was described by Gondolf (1988) as, "...extremely abusive of his wife and children. His abuse is, in fact, very likely to include the use of a weapon. This batterer is very likely to have been abusive sexually, as well. His response to abuse is extremely diverse and unpredictable; it includes blame, threats, or sexual demands of the victim... He is the most likely to have been previously arrested for property, violent, and drug-or alcohol-related crime" (p.197). Type-II, labeled the antisocial batterer, is highly physically and

verbally abusive. However, Gondolf (1988) differentiates this group from the sociopathic batterer by their less extensive criminal record. Type-III, called the typical batterers, were less verbally and physically abusive than the antisocial and sociopathic types, and were less likely to use weapons. The typical batterers also had smaller arrest records and were less likely to engage in violence outside of the home. According to Gondolf (1988), “His verbal abuse, sexual abuse, and child abuse is also less extensive and less severe than the antisocial batterer. Moreover, this batterer is more likely to be apologetic after abusive incidents- that is, he approximates the ‘honeymoon phase’ of the cycle of violence (Walker, 1979)...Consequently, his victim is more likely to return to him” (p.197).

#### *The Holtzworth-Munroe & Stuart (1994) Typology*

Possibly the most prolific researchers on this topic have been Holtzworth-Munroe and colleagues. After reviewing the previous literature classifying subtypes of male batterers, including both inductive and deductive studies, Holtzworth-Munroe and Stuart (1994) observed that three descriptive dimensions could best classify the various subtypes. These included: severity of marital violence, generality of violence, and psychopathology/personality disorders (Holtzworth-Munroe & Stuart, 1994). Holtzworth-Munroe & Stuart (1994) then utilized these three dimensions in order to propose their own typology of three distinct types of male batterers, which included the Family Only (FO) type, the Borderline-Dysphoric (BD) type, and the Generally Violent-Antisocial (GVA) type.



FO men were hypothesized to display the smallest amount of aggressive behavior and could easily be mistaken for men who experience marital distress but do not engage in spousal or partner abuse. The authors suggest that FO men tend to demonstrate low levels of psychopathology, a positive attitude towards women, and a negative attitude toward violence, which results in feelings of remorse that prevent further aggression or violence (Holtzworth-Munroe & Stuart, 1994). The FO batterers were suggested to engage in the least severe marital violence and the smallest amount of violence outside of the home. According to Holtzworth-Munroe, Meehan, Herron, Rehman, and Stuart (2000),

Holtzworth-Munroe and Stuart (1994) proposed that the violence of FO men results from a combination of stress (personal or marital) and low-level risk factors (e.g., childhood exposure to marital violence, limited relational skills), such that on occasion, during escalating marital conflicts, these men engage in physical aggression. Following such incidents, however, their low levels of psychopathology and problems (e.g., impulsivity, attachment dysfunction), combined with their positive attitudes toward women and negative attitudes toward violence, lead to remorse and help prevent their violence from escalating (p.1004).

The BD batterers are more likely to have come from a background of parental abuse and rejection, which may have predisposed them to have difficulty in establishing stable and trusting relationships with a partner. Consequently, they may appear quite jealous of and dependent on their wives, as well as fearful of losing their partners (Holtzworth-Munroe & Stuart, 1994). Holtzworth-Munroe et al. (2000) emphasize, “They lack adequate marital relationship skills, have hostile attitudes toward women, and have attitudes moderately supportive of violence. This group resembles batterers studied by Dutton (1995), who has suggested that their early traumatic experiences lead

to borderline personality organization, anger, and insecure attachment, which when frustrated, result in violence against the adult attachment figure (i.e., the wife)” (p.1004).

The GVA men are characterized as experiencing high levels of family violence and tend to be associated with a deviant peer group. They are characterized as being impulsive, having negative attitudes towards women, lacking in relational skills, and accepting of violence and violent acts (Holtzworth-Munroe et al, 2000). Holtzworth-Munroe et al. (2000) point out, “The GVA batterers were predicted to resemble other antisocial, aggressive groups... Their marital violence is conceptualized as part of their general use of aggression and engagement in antisocial behavior” (p.1004).

The typology developed by Holtzworth-Munroe and Stuart (1994) has found substantial empirical support (i.e., Hamberger et al, 1996; Holtzworth-Munroe et al, 2000; Jacobson & Gottman, 1998; Langhinrichsen-Rohling et al, 2000; Tweed & Dutton, 1998). For example, although Gottman, Jacobson, Rushe, Shortt, Babcock, La Taillade, and Waltz (1995) identified only two clusters of batterers, the two clusters that did emerge resembled the Family Only and Generally Violent-Antisocial types identified by Holtzworth-Munroe & Stuart (1994). Specifically, Gottman et al. (1995) identified their two groups of male batterers based on heart rate reactivity during interaction with their partners. Type 1 batterers were characterized by hyporeactivity, or a deceleration of heart rate during conflict, and Type 2 batterers were distinguished by acceleration of heart rate during conflict. More specifically, men identified as Type 1 were diagnosed by the MCMI-II as psychopathic, or as having “antisocial and aggressive-sadistic personality disorders...” at higher rates than Type 2 men. Gottman et al. (1995)

suggested that batterers who were more hyporeactive displayed characteristics of an antisocial individual (i.e., an outwardly calm demeanor which is incongruent with the psychological and physiological process they are experiencing). Walker (1995) added that while Type 1 men seemed outwardly calm, Type 2 men presented as emotionally needy and hot-tempered. Thus, the Type 1 batterer appears to be similar to Holtzworth-Munroe and Stuart's (1994) Generally Violent-Antisocial male, while the Type 2 batterer appears to be reflective of the FO batterer.

Another study that offered support for Holtzworth-Munroe and Stuart's (1994) findings was Langhinrichsen-Rohling et al's (2000) study, which compared empirically and theoretically derived typologies of male batterers. The authors stated, "Family Only (T1), Generally Violent/Antisocial (T2), and Dysphoric/Borderline (T3) batterers were distinguished by a history of suicidal ideation, likeability as judged by their therapist, perceived ability to tolerate frustration and control their violence at the end of therapy, estimated probability of being violence free in six months, and their rates of completing the program" (p.51). Thus, clinicians were able to distinguish male batterers based upon the three dimensions (i.e., severity and generality of violence, and psychopathology) set forth by Holtzworth-Munroe and Stuart (1994).

Chase, O'Leary, and Heyman (2001) also provided support for Holtzworth-Munroe and Stuart's (1994) typology. They categorized partner-violent men into either reactive or proactive aggressor categories, and found that the two groups differed significantly on affectivity, personality, and violence in the family of origin. In drawing

comparisons to the Holtzworth-Munroe and Stuart (1994) typology, Chase et al. (2001)

assert:

The affectively and personality findings generally support the proposition that reactives appear similar to the impulsive, Type 2, BD, and FO groups, whereas the proactives appear similar to the instrumental, Type 1, and GVA groups (Gottman et al., 1995; Holtzworth-Munroe & Stuart, 1994; Tweed & Dutton, 1998). Specifically, reactives were more likely than proactives to be angry while discussing a conflictual topic with their partner and to have a dependent personality disorder; whereas proactives were more likely than reactives to dominate a conflictual topic discussion with their partner and to have antisocial, aggressive-sadistic, and psychopathic personality disorders and/or elevated traits (p.570).

Finally, Holtzworth-Munroe, Meehan, Herron, Rehman, and Stuart (2000)

conducted an empirical study utilizing scores on the MCMI to test the Holtzworth-Munroe and Start (1994) batterer typology. The authors recruited 102 maritally violent men and their wives from the community, as well as two control groups of nonviolent men, who were divided into martially distressed and nondistressed. The variables they utilized to categorize the batterers included: severity/frequency of marital violence, generality of violence, and psychopathology/personality disorder. As a result, all three groups (i.e., FO, BD, and GVA types) did emerge as predicted by Holtzworth-Munroe and Stuart (1994). Additionally and unexpectedly, Holtzworth-Munroe et al. (2000) discovered a fourth group, which they labeled low-level antisocial (LLA). The LLA group fell between the FO and GVA groups on many of the variables measured, yet Holtzworth-Munroe et al. (2000) believed the LLA group was akin to the less violent FO group. They attributed this unexpected factor to the fact that they utilized a community sample rather than a clinical sample, and thus believed that their FO group was somewhat different than those examined in previous studies. Specifically, the authors

stated: “In contrast, given that the present sample was recruited from the community, we believe that the FO group in the present study has probably not been studied in previous batterer typologies...we hope that our new, four cluster typology will help bridge a recognized gap in this research area- a gap between research done on generally low levels of violence among community samples” (p.28). Thus, this study provided strong empirical evidence supporting their proposed typology, as well as introducing the notion that the FO group may be more diverse than originally conceived.

#### *Tailoring Treatment Based on Typology*

While these typologies have certainly been useful in developing an understanding of battering behavior, researchers have also suggested that these typologies may prove valuable in tailoring treatment to different battering subtypes.

Specifically, Holtzworth-Munroe et al (2000) emphasized,

The present results suggest that researchers should examine how various subtypes of violent men respond to different treatment programs.... Along with others (e.g., Saunders, 1992), we have suggested that treatment outcome might be improved by matching interventions to batterer subtypes. For example, in a post-hoc analysis of data from a study comparing cognitive-behavioral-feminist treatment to a new process- psychodynamic treatment designed to help men examine the traumas they have experienced, Saunders (1996) found that batterers scoring high on an antisocial measure did better in the structured cognitive-behavioral intervention, whereas batterers scoring high on a measure of dependency did better in the new intervention (p. 29).

Thus, given that it has been suggested that different subgroups of batterers have different needs and reasons for engaging in violence, it appears that using one type of treatment for all martially violent men would be ineffective. For example, given that the FO group appears to differ greatly from the GVA and BD groups, it appears that these groups would respond differently to treatment. In support of this notion of tailoring

treatment to the differing battering subtypes, it is also important to consider another factor that is hypothesized to differentiate the three types of male batterers and may, therefore, influence the effectiveness of treatment: the male socialization process.

### *The Role of Male Socialization in Battering*

The field of domestic violence has focused much of its theories, research and treatment from the perspective that a problem exists between the male to female relationship. However, Jennings and Murphy (2000) suggest that rigid sex role stereotyping and male socialization can lead to a disruption in the male-to-male dimension, which in turn can have “emotional and behavioral consequences placed on the female to male relationship” (p. 21). Specifically, the authors assert:

Domestic violence is seen, first and foremost, as a disruption or an aberration in male relationships with females. The salience and horror of battering thrusts it forward as the most obvious display of male dominance, exploitation, and abuse of women. It appears so obvious, so self-evident, that it could hardly be seen as anything else. On closer examination, however, domestic violence can be motivated by other concerns. We argue that male – female battering is also a disruption in male – male relatedness borne out of the disappointments of traditional male socialization and gender role training. Thus, the core pathology of male–female battering involves fundamental disruptions in male–male relations as well as male–female ones. By analyzing domestic violence from the perspective of intermale relations and male identity issues we show that this theory can enhance current understanding of the phenomenon (Jennings & Murphy, 2000, p. 21).

According to Jennings and Murphy (2000), conceptualizing and treating perpetrators of intimate violence from a perspective of male identity issues and male to male relationships will help understand the phenomenon of violence between males and female intimates. As might be expected, most male partner abusers hold to rigid traditional male roles (Jennings & Murphy, 2000). Traditional male roles have been

outlined by David and Brannon (1976) as follows: earning respect for successful achievement is of utmost importance to men; display of any weakness is unacceptable; the display of any feminine-like qualities is considered shameful; and the need for risk-taking and adventure (including acts of violence, if necessary) is acceptable.

Furthermore, Levant et al. (1992) created seven dimensions to outline the traditional male role: avoidance of feminine qualities; restriction of emotions; exhibiting toughness and aggression; self-reliance; achieving status in life; lack of intimate relationships; objectification of sexuality; and fear and disdain of homosexuality.

Levant and Pollack (1995) suggest that men maintain a “code of masculinity” that requires them to avoid all things, actions, and emotions that are potentially characterized as female traits (i.e., passivity, emotionality, and dependence). Lisak (1998) explains that masculine socialization is similar to pre-basic training of soldiers. Males who have been socialized to adhere to strict rigid male sex roles have internalized certain values, which essentially dictate their core value as human beings. These men have been socialized to believe that intense forms of shame result from inward or outward displays of non-masculine behavior. Masculinity has become the core aspect of identity, resulting in a loss of self and eventual “psychic death” (Lisak, 1998, p.218). Lisak (1998) also draws an analogy between masculinity and being a soldier in the trenches during combat by stating, “...the realest men in the trench are those who feel no fear; the next realest men are those who feel it but do not show it; the failures are those who show it; those who show it and act on it get shot by their officers” (p. 218).

Schwalbe (1996) asserts that many men avoid disclosing feelings and live in constant fear of becoming emotionally vulnerable to their competitors- other men. Blazina and Watkins (2000) postulate that the restrictive nature of traditional male gender role and the subsequent psychological strain results in maladaptive psychological outcomes, including rejection and fear of feminine qualities. Significant relationship issues, including difficulty establishing trust, bonding, and differentiation arise for men experiencing gender role strain (Blazina & Watkins, 2000). Ultimately, problems related to separation/individuation and attachment are demonstrated within interpersonal relationships. Jennings and Murphy (2000) suggest that the development of rigid sex role stereotyping have emotional and behavioral consequences that are displaced on male-female relationships. They hold that a lack of nurturing relationships between males places greater pressure on males' relationships with females, which may in turn contribute to dependency, jealousy, mistrust, and, ultimately, violence.

Jennings and Murphy (2000) reviewed other theories that have provided insight to men's issues in regards to domestic violence and ultimately shaped their own theory of battering typologies. One approach Jennings and Murphy (2000) discuss is the "trait-psychopathology" (p. 22) approach, which has attempted to identify specific innate character traits and personality profiles (i.e., borderline, dependent, antisocial, etc.) in order to distinguish male batterers from other men (Hale, Zimostad, Duckworth, & Nicholas, 1992; Hamberger & Hastings, 1986; Holtzworth-Munroe & Stuart, 1994; Saunders, 1992).



Another approach mentioned by Jennings and Murphy (2000) was the feminist approach. The feminist approach rejected the trait-psychopathology approach because they believed that attributing violence to innate personality traits would absolve men from their abusive behaviors. Additionally, the feminist theorists disagreed with the trait-psychopathology approach because it ignored the sociocultural context in which marital violence exists. The feminist approach maintains that “male domination at the social level is the most crucial factor” (Bograd, 1988, p.14). Furthermore, according to Jennings & Murphy’s (2000) account of the feminist perspective, “Battering is seen as the undisguised expression of implicit cultural sanctions that allow men to use violence and intimidation to control women (Bograd, 1988; Dobash & Dobash, 1979; Jennings, 1987; Lisak, 1991)” (p.22).

The third theory mentioned, which appears to have been heavily incorporated into Jennings and Murphy’s (2000) approach, was shame theory. Shame theorists implicated shame at the core of male battering (Retzinger, 1991; Tangney, Wagner, Fletcher, & Gramzow, 1992). Those who adhere to shame theory advocate that men who engage in battering behavior subscribe to traditional male stereotypes. The rigid male stereotype is held by men who avoid feelings of vulnerability, emotion and dependency which are associated with shame. Instead, such men would prefer to portray themselves as strong, void of emotions and independent (Goldberg, 1976; Kaufman, 1989; O’Leary & Wright, 1986). Specifically, Jennings and Murphy (2000) state:

Consequently, the traditionally socialized male feels shame in situations that may expose his dependency needs, threaten his masculine self-concept, reveal the limits of his power, or elicit vulnerable emotions (Wallace & Nosko, 1993)...Stated most simply, battering men are shame-based individuals

desperately afraid of abandonment by their mates (Reitzinger, 1991; Wallace & Nosko, 1993) (p.23).

Jennings and Murphy (2000) utilized the three previously described theories (i.e. trait-psychopathology, feminist approach, and shame theory) of battering behavior as an introduction to their theoretical perspective. They primarily used shame theory as a starting point for the incorporation of humiliation in understanding battering behavior. They focus on the term humiliation as a “potent and pervasive social mechanism that dominates male psychology, causing multiple problems in male self-esteem and interpersonal relations” (p. 21). The term humiliation is best described as a public form of shaming. Shame and humiliation were differentiated by Jennings and Murphy (2000) as:

Shame is a self-induced, privately felt experience that is rooted in weak self-esteem and, theoretically, is concerned with saving the relationship in order to bolster inadequate self-esteem through attachment. Humiliation is experienced as being publicly lowered in esteem (whether one’s self-esteem is weak or strong) and is concerned with ‘saving face.’ Humiliation is the shame of perceived or anticipated negative social evaluation (p.23).

Jennings and Murphy (2000) theorize that masculinity is learned in two ways: through interactions with women and through interactions with men. Though men’s interactions with females tend to be significantly less shame-inducing than their interactions with other males, the primary mode of learned masculinity is through relationships with other boys (Jennings & Murphy, 2000). As one might observe on the playground, children tend to be highly gender segregated, with boys spending the greatest amount of time with other boys (Maccoby, 1990). When boys interact with other boys during the formative childhood years, the range of acceptable emotional

displays is significantly restricted, giving way to humiliation as a powerful socialization tool. As Jennings and Murphy (2000) point out, “In the very male domain of boyhood, the contingencies of social humiliation are sharp and piercing, and the need for male peer acceptance is keen. In craving acceptance, the fear of negative social evaluation by other males is pre-eminent” (p.23).

Thus, boys learn from a very young age to escape humiliation by restricting their emotional range, keeping their feelings to themselves, preventing crying at all costs, avoiding being laughed at or embarrassed, and acting tough. While these traditionally male behaviors may be successful in warding off painful humiliation, they also prevent the healthy expression of emotion and intimacy and disallow healthy interpersonal connectedness with other men (Jennings & Murphy, 2000). This lack of connected, intimate relationships with other males leads some men to seek fulfillment of all of their emotional and social needs through a single female partner. As Jennings and Murphy (2000) summarize:

To the degree that he depends on his female partner to meet all these needs, her loss would be truly catastrophic. Therefore, holding onto her becomes absolutely paramount and calls for the most drastic (and ultimately self-defeating tactics). This helps to account for the characteristic aggressiveness, violence, intimidation, and controlling behaviors used by abusive men... In short, battering may be explained as forcible behavior (by shame-based esteem-deficient men) to directly maintain attachment with a female loved one-but is also a desperate act (by humiliation-avoidant men) to indirectly maintain the woman who functions as his surrogate “male” buddy, confidante, father, and affirming peer group (p.26).

Thus, the purpose of this study is to empirically test the utility of incorporating Jennings and Murphy’s (2000) theoretical perspective to support the continued argument for the need to differentiate male batterers. Taking into consideration Jennings and

Murphy's (2000) theory on the development of male battering behavior, we are seeking to explore certain MMPI-2 variables to determine whether this theoretical perspective may be useful in differentiating the three categories of male batterers originally set forth by Holtzworth-Munroe and Stuart (2000).

#### *Variables Selected for the Study*

Because no previous empirical studies have explored the relationship between male relatedness and battering typologies, this study is primarily exploratory and theoretical in nature. This author chose to look at four scales that would theoretically best fit the perspective put forth by Jennings and Murphy (2000). These four scales include the following: Masculinity-Femininity clinical scale (MF; Scale 5); Social Introversion clinical scale (Si; Scale 0); Gender Role-Masculine supplementary scale (GM); and Low Self-Esteem content scale (LSE).

The author theorizes that this male socialization perspective can be depicted on the MMPI-2 by looking first at the Masculinity-Femininity (MF) scale. The MF scale measures the extent to which men behave in traditionally masculine ways and reject traditionally feminine traits and interests. In other words, the MF scale can be used to identify men on the continuum of masculinity. As previously described, Jennings and Murphy postulate that humiliation lies at the core of the male socialization process, causing boys to act in traditionally masculine ways in order to ward off ridicule or social shaming. Therefore, the MF scale appeared a natural choice in tapping into these constructs of shame, humiliation, and adherence to a strict code of masculinity. Whereas a low MF scale (i.e., a T-score less than 45) indicates a strong adherence to traditional

masculine values and a rigid sex role, a high MF scale score indicates a more flexible sex role orientation and an interest in more stereotypically feminine interests such as involvement in artistic interests, housekeeping and participating in child-rearing practices (Graham, 2000; Greene, 2000; Peterson & Dahlstrom, 1992).

According to Jennings and Murphy (2000), abuse can occur when the batterer experiences a disruption or threat to his rigid sex role type. The FO men, who tend to evidence little psychopathology and rarely engage in violence outside of the home (Holtzworth-Munroe & Stuart, 1994), are hypothesized to engage in violence primarily to protect their sense of masculinity. These men would, therefore, be expected to exhibit lower MF scale scores. This lies in contrast to the Generally Violent-Antisocial (GVA) or Borderline-Dysphoric (BD) male batterer, who might tend to engage in violence primarily because of personality dysfunction or other psychopathology. The MF scale would be hypothesized to be higher for the GVA male batterer because they fundamentally do not adhere to societal norms (Holtzworth-Munroe & Stuart, 1994), and would therefore not experience as much pressure to conform to rigidly defined norms of masculinity. It may also be hypothesized that the BD men would not adhere as strongly to stereotypical male behaviors. Borderline individuals by nature tend to be highly needy, fearful of abandonment and emotionally unstable (American Psychiatric Association, 1994). These characteristics of the BD men lie in stark contrast to the stoic and independent masculine role. Therefore, both the GVA and BD men may be less influenced by social norms, whereas the non-clinical male might be more likely to

succumb to the socialized pressures to adhere to the “Marlboro Man” persona (Shay & Maltas, 1998).

Similar to the MF scale, the GM (Gender role – Masculine) supplementary scale was used to identify a stereotypical portrayal of men on the continuum of masculinity (Greene, 2000; Graham, 2000). Items on the GM scale indicate stereotypical masculine type traits, specifically the denial/absence of emotionality and fear (Greene, 2000). The content of the items on the MMPI-2 for the GM scale include: absence or denial of fears, anxieties, and somatic complaints (Graham, 2000). In addition, a number of items pertain to stereotypical masculine interests (i.e., reading adventure stories) and a denial of stereotypical feminine occupations (i.e., nursing). The scale also includes items that focus on a denial of excessive emotionality, and the appearance of self as independent and self-confident (Graham, 2000). As a result, similar to the MF scale, the Gender Role-Masculine (GM) supplementary scale appeared to also be a natural choice in tapping into the constructs of shame, humiliation, and adherence to a strict code of masculinity. A high raw GM score (i.e., T-score greater than 65) indicates stereotypical masculinity whereas a low GM score would be viewed as someone who acknowledges fear, experiences emotional distress, and may have little interest in masculine activities (Greene, 2000; Graham, 2000; Peterson & Dahlstrom, 1992). The FO men, who tend to evidence little psychopathology and rarely engage in violence outside of the home (Holtzworth-Munroe & Stuart, 1994), are hypothesized to engage in violence primarily to protect their sense of masculinity. These men would, therefore, be expected to exhibit

higher GM scale scores. Since the FO men evidence little psychopathology, they may be more likely to batter due to their need to preserve the masculine role.

Jennings and Murphy (2000) indicate that when a disturbance or threat occurs to the traditional male role, self-esteem may be affected. “In the absence of effective male bonds and mentoring, traditional male socialization and rigid sex role definitions can create severe deficits in self-esteem, emotional development, and social relatedness for battering men, which are then displaced onto the male-female relations” (p. 32).

Therefore, we would expect to observe a relationship between a low score on the Masculinity-Femininity (MF) clinical scale and a high score on the Low Self-Esteem (LSE) content scale of the MMPI-2. The LSE content scale items are designed to measure an individual’s admission of feelings of ineffectiveness, inferiority, and low confidence (Green, 2000). A high LSE score ( $T > 65$ ) indicates persons who may be passive in relationships, are sensitive to being rejected or criticized, have a poor self concept, often view themselves as failures, and have many worries and fears (Graham, 2000). Additionally, Graham et al. (1997) suggests that low raw scores (below 40) on the LSE scale may be indicative of individuals who are better adjusted with fewer problems than those that fall within the average range. As a result, a rigid adherence to the socialized male sex role type (as indicated by a low MF score), coupled with one’s low self-esteem (as indicated by a high LSE score) would lend credence to Jennings and Murphy’s (2000) theory that male batterers face a significant degree of stress due to their masculine role strain, which in turn may affect their self-esteem. Once again it would

be theorized that the FO men may have lower self esteem than the other two groups due to their adherence to the stereotypically masculine persona.

Jennings and Murphy (2000) pointed out that shame, humiliation, and adherence to a strict code of masculinity result in a sense of social isolation. Isolation and social withdrawal are protective mechanisms that are used to shield oneself from humiliation (Jennings & Murphy, 2000). Men may also engage in isolation and withdrawal to hide their inadequacies. Jennings and Murphy (2000) write, “Even though men need male acceptance and connectedness with other men, they avoid it because it is humiliating to reveal such longings. At worst, expressing a desire for closeness with another male hints of the dreaded idea, ‘What if he thinks I’m gay!’”(p.26). Developing intimate relationships with men by disclosing one’s weakness and dependency on others puts men at risk for painful rejection (Jennings & Murphy, 2000). The MMPI-2 variable that theoretically fits Jennings and Murphy’s (2000) perspective on social isolation is the Social Introversion (Si) clinical scale. The Social Introversion (Si) scale was designed to assess discomfort in social interactions and the tendency to withdraw from social situations. These individuals may present with limited social skills or may yearn to be simply left alone (Greene, 2000). A high score on the Si scale ( $T > 65$ ) is indicative of someone who presents as shy, introverted and insecure in social settings. Conversely, a low score on the Si scale ( $T < 44$ ) indicates a tendency towards social extroversion and gregariousness (Greene, 2000). Due to our prediction that FO men tend to be more preoccupied with the avoidance of shame and humiliation, we would further expect these



men to exhibit greater social isolation, and therefore have higher Si scores than the other two groups.

Once again it is important to note that this is an exploratory study in pursuit of examining differences between the three typologies of male batterers, specifically in how the FO men differ from the other two groups. The variables chosen may provide additional information to reinforce Jennings and Murphy's (2000) theory asserting that male socialization and the rigid sex role type is an essential aspect of male battering behavior that may prove useful in differentiating and treating groups of male batterers.

In summary, a restatement of the hypotheses is included below:

- The FO men are expected to exhibit a low MF scale score (i.e., a T-score less than 45) indicating a stricter adherence to traditional masculine values than the BD and GVA men.
- The FO men are expected to exhibit higher GM scale scores than the BD and GVA men.
- The FO men would be theorized to have lower self esteem than the BD and GVA men. Thus, the FO men are expected to exhibit a higher LSE scale score than the other two groups.
- The FO men are expected to exhibit greater social isolation than the BD and GVA men. Thus, the FO men are expected to have a higher Si scale score than the other two groups.

## CHAPTER III

### METHODOLOGY

#### *Participants*

Participants were composed of 101 adult males on probation for engaging in domestic violence. The initial data set consisted of 126 subjects; however, twenty-five subjects were omitted from the original data set because they were charged with assault rather than domestic violence. The participants ( $n=101$ ) ranged in age from 19 to 58 ( $M = 31.4$ ,  $SD = 8.61$ ). Subjects' self-reported ethnicity was as follows: 35.6% ( $n = 36$ ) Caucasian; 34.7% ( $n = 35$ ) African-American; and 29.7% ( $n = 30$ ) Hispanic/Latino. Years of education ranged from 5 to 18 years ( $M = 11.38$ ,  $SD = 2.07$ ), indicating a range from the fifth grade level through graduate/professional degrees. The participants reported their marital status as: 29 (28.7%) single; 45 (44.6%) married; 10 (9.9%) separated; 17 (16.8%) divorced.

#### *Instruments*

*Minnesota Multiphasic Personality Inventory – 2 (MMPI-2)*: The 567-item MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemner, 1989) was used to assess the subjects' patterns of psychological and emotional functioning. The MMPI-2 represents a restandardization of the original MMPI. The restandardization was conducted to update the norms of the inventory, to provide a larger normative sample, and provide a more appropriate representation of ethnic minorities, and to update the content of items (Greene, 2000). In an effort to clarify its items, the MMPI-2 reworded

141 of the original 550 items. Sixteen repeated items were dropped, and 13 items from the validity and clinical scales were eliminated. Another 77 items were dropped from the remaining 167 items. Additionally, 89 items were added that constituted the content scales. Thus, the MMPI-2 includes a total of 567 items (Green, 2000).

The three validity scales, Lie (L), Infrequency (F), and Correction (K) are used primarily to assess test-taking attitudes (Graham, 2000) and to determine the utility or validity of a profile. The L scale identifies individuals who deliberately portray themselves in a favorable manner. According to Green (2000), “The scale assesses attitudes and practices that are culturally laudable but actually found only in the most conscientious persons” (p.90). The F scale detects atypical or deviant responses to test items. Individuals who endorse items that constitute the F scale may be characterized as either those who purposely portray themselves in an overly negative or pathological light (i.e., those calling out for help or “faking bad”) or those who are truly pathological. The K scale measures test defensiveness, or a tendency to deny personal faults or difficulties (Green, 2000).

In addition to the three validity scales, the MMPI-2 also consists of ten clinical scales that were incorporated into this study. Scale 1, Hypochondriosis (Hs) detects somatic complaints and a preoccupation with bodily functioning and physical illness. Scale 2, Depression (D), indicates depression, as characterized by low morale, hopelessness, low energy, lack of enjoyment in pleasurable activities, trouble sleeping and eating, suicidal thoughts, and a feeling of general dissatisfaction with life. Scale 3, Hysteria (Hy), consists of two subsets of items: somatic symptoms and denial

symptoms. According to Greene (2000), “Although these two categories of items are either unrelated or negatively correlated in normal individuals, they are closely associated in persons whose personality revolves around histrionic dynamics” (p.139). Such individuals tend to develop conversion-like symptoms when experiencing extreme stress or conflict (Green, 2000). Scale 4, Psychopathic Deviate (Pd) is a measure of sociopathy or rebelliousness. As scores increase, the rebelliousness manifests itself in more criminal, antisocial ways. High scores also indicate conflict with authority figures, troubled family relationships, tendency to blame others, lack of accountability for actions, impulsivity, limited frustration tolerance, little patience, an absence of deep emotional response, a general disregard for social mores, and a tendency to be selfish and egocentric. Scale 5, Masculinity-Femininity (MF), measures the propensity towards masculine or feminine interests. Originally, scale 5 was developed to identify “homosexual invert males” (Hathaway, 1956; Graham, 2000). However, it was discovered that only a few accurately differentiated homosexuality and heterosexuality in men. Additionally, Green (2000) wrote that, “The 56 items comprising Scale 5 are very heterosexual in content” (p. 151). Thus, additional items were added to differentiate between men and women. The items assess professional and personal interests, aesthetic preferences, activity-passivity, and personal sensitivity (Green, 2000). The scale also indicates sexual conflicts and gender confusion. Once raw scores are obtained, T score conversions are reversed so that a low T-score for a male indicates an adherence to traditionally male interests, while a high T-score for a female indicates an adherence to traditionally feminine interests. For men, a greater number of endorsed

items signifies stereotypically feminine qualities (passivity, enjoyment of the arts, music, drama), whereas a low T-score indicates a strong adherence to traditional masculine qualities (i.e., interest in hunting, fishing, and mechanics; tendency to be independent and inflexible). Scale 6, Paranoia (Pa), is a measure of paranoid symptomatology. Items assess feelings of persecution, interpersonal sensitivity, suspiciousness, and extravagant concepts of self. On a continuum of T- scores, a low score on scale 6 suggests a personality type that is thick skinned and not bothered by much. Moderate T-score elevations are indicative of interpersonal sensitivity, while high T-scores are indicative of frank paranoia and suspiciousness of others. Scale 7, Psychasthenia (Pt), is a measure of anxiety and obsessive-compulsiveness. It assesses one's fears, phobias, and worries. Although the diagnostic label of psychasthenia is not used widely today, the diagnosis that most closely resembles this label is obsessive-compulsive disorder (Graham, 2000). Low scores on scale 7 indicate one who does not have many worries, while high T-scores are suggestive of someone who would be best characterized as always worrying and waiting for impending doom. Scale 8, Schizophrenia (Sc), measures, "a wide variety of content areas, including bizarre thought processes and peculiar perceptions, social alienation, poor familial relationships, difficulties in concentration and impulse control, lack of deep interests, disturbing questions of self-worth and self-identity, and sexual difficulties" (Green, 2000, p.163). Scale 9, Hypomania (Ma), may best be described as a scale that assesses one's level of energy. The scale identifies hypomanic symptoms, such as accelerated speech, overactivity, irritability, excitability, grandiosity, and elevated mood. Scale 10, Social Introversion (Si), examines individuals' propensity

to isolate and withdraw from social situations and responsibilities. Test-retest reliability scores for each of the validity and clinical scales may be found in Table 1.

Table 1  
*Test-Retest Reliability Coefficients for the MMPI-2 for Male Subjects in Normative Samples (One Week Interval)*

Scale and Abbreviation	Male (N=82)
<b>Validity Scales</b>	
L (Lie)	.77
F (Infrequency)	.78
K (Defensiveness)	.84
<b>Clinical Scales</b>	
1 Hs (Hypochondriasis)	.85
2 D (Depression)	.75
3 Hy (Hysteria)	.72
4 Pd (Psychopathic-Deviate)	.81
5 Mf (Masculinity-Femininity)	.82
6 Pa (Paranoia)	.67
7 Pt (Psychasthenia)	.89
8 Sc (Schizophrenia)	.87
9 Ma (Hypomania)	.83
0 Si (Social Introversion)	.92

Source: Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for Administration and Scoring by J.N. Butcher, W.G. Dahlstrom, J.R. Graham, A. Tellegen, & B. Kaemmer, 1989, Minneapolis: University of Minnesota Press.

As previously mentioned, in addition to the validity and clinical scales used in this study, the Gender Role-Masculine (GM) supplementary scale and the Low Self-Esteem (LSE) content scale were utilized. The GM identifies a stereotypical portrayal of men on a continuum of masculinity. The LSE content scale was designed to measure the extent to which an individual exhibits a devalued view of the self.

*Procedure*

Participants were court-referred males who were on probation for an assault-related offense against a female partner. A completion of a 24-week domestic violence group, which later was changed to a 15-week group with weekly sessions, was required as part of their probation contract. Although the participants were required by the Community Supervisions and Correction Department, their participation in the research study was completely voluntary and there was no deception or coercion used in the study. The groups were run by doctoral students as part of an ongoing research team project at Texas A&M University. The ongoing research team was headed by David Lawson, Ph.D., and was designed to provide an opportunity for doctoral students to acquire insight into working with the criminal population as well as gain experience running therapy groups.

The participants tested in groups of 20 to 30 men. All participants initially read and signed an informed consent form and completed a demographic form. Demographic information was collected via an individual interview and police/probation reports. The participants completed two questionnaires, which included the Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996); and the MMPI-2 (Butcher, Dahlstrom, Graham, Tellegren, & Kaemner, 1989). The MMPI-2, which was completed by the participants before any psychological treatment, was used for the present study. The consent form and the MMPI-2 questions were read to those participants who did not have the necessary reading level to individually read and understand the materials.

## CHAPTER IV

### RESULTS

The first purpose of this study was to test empirically whether the three batterer subtypes (Family Only, Borderline-Dysphoric, and Generally Violent-Antisocial) developed by Holtzworth-Munroe and Stuart (1994) can be reproduced using the MMPI-2, a widely-used and psychometrically sound measure of personality. In order to test empirically whether the three batterer subtypes could be reproduced in the present study, a cluster analysis was used to fulfill the first purpose of the study. The MMPI-2 validity and clinical scales were used to obtain the clusters.

A cluster analysis is a statistical procedure in which people, objects, variables or items are grouped according to their similarity. It is an exploratory data analysis tool which aims to sort different objects into groups such that the degree of association between two objects is greatest when they belong to the same group (Heppner, Kivlighan, & Wampold, 1999). In this study the method of *K-means* clustering was utilized to determine the applicability of the three cluster solution (Family Only, Borderline-Dysphoric, and Generally Violent-Antisocial) theorized by Holtzworth-Munroe and Stuart (1994). Because the goal was to match the results of the cluster analysis to those hypothesized by Holtzworth-Munroe and Stuart (1994), rather than to determine the “correct” number of clusters, three clusters were produced and the output was descriptively compared for consistency to what Holtzworth-Munroe and Stuart (1994) hypothesized.



Table 2 presents the means and standard deviations of the clinical scales and validity scales of the MMPI-2 across the entire sample. More importantly, Table 3 provides final means for the three cluster groups. Additionally, Figure 1 pictorially represents the three cluster profiles. The first cluster is comprised of data from 51 participants (50.4%) and is consistent with the FO group theorized by Holtzworth-Munroe and Stuart (1994). Individuals on the first cluster can be categorized as non-clinical due to cluster means falling within the normal limits on the MMPI-2 (see Table 3).

Table 2  
*Means and Standard Deviations of Male Batterers' Scores on the Validity and Clinical Scales (n = 101)*

Variable	<i>M</i>	<i>SD</i>
Validity Scales		
Lie (L)	57.15	10.27
Frequency (F)	58.12	13.85
Correction (K)	48.49	9.95
Clinical Scales		
Hypochondriasis	54.70	10.35
Depression	51.97	11.52
Hysteria	49.67	11.28
Psychopathic	59.71	11.10
Masculinity/Femininity	44.58	8.19
Paranoia	57.14	13.78
Psychoasthenia	53.45	11.69
Schizophrenia	55.51	12.34
Mania	60.86	12.72
Social Introversion	50.94	8.96

Table 3  
*Initial Cluster Means for Male Batterers*

	Non-Pathological (n=51)	Borderline/Dysphoric (n=24)	Antisocial (n=26)
<b>Validity Scales</b>			
Lie (L)	58.24	50.04	61.58
Infrequency (F)	48.80	71.54	64.00
Correction (K)	51.57	40.67	49.65
<b>Clinical Scales</b>			
Hypochondriasis (HS)	50.49	51.96	65.50
Depression (D)	46.06	51.54	63.96
Hysteria (Hy)	46.88	43.96	60.42
Psychopathic Deviant (Pd)	55.31	60.92	67.23
Masculinity-Femininity (MF)	42.61	45.92	47.23
Paranoia (Pa)	49.63	71.50	58.62
Psychasthenia (Pt)	45.36	60.50	62.81
Schizophrenia (Sc)	45.86	66.25	64.54
Hypomania (Ma)	56.00	72.96	59.23
Social Introversion (Si)	45.96	53.04	58.77

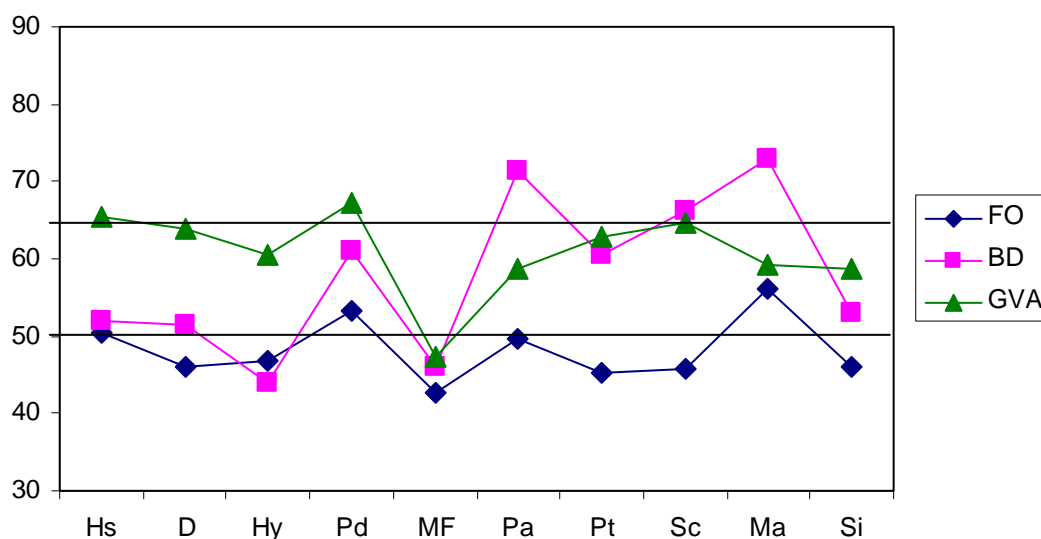


Figure 1. FO, BD, and GVA cluster profiles across the Minnesota Multiphasic Personality Inventory – 2 (MMPI-2) clinical scales.

The second cluster accounted for 24 of the 101 participants (23.8%). The validity configuration for these participants suggests that they are experiencing moderate to severe personal and emotional distress characterized by agitation, tension and excitement. They may also admit to personal difficulties and request help because they are unsure how to tap into the resources available to them in order to handle their problems (Greene, 2000; Lawson et al. 2003). “In an inpatient setting clients with this Validity scale configuration are likely to evidence poorer impulse control and a greater frequency of inappropriate and destructive behavior than clients with other types of validity scale configurations (Post & Gasparikova-Krasnec, 1979)” (Greene, 2000, p. 117). The elevated F score (T = 71.54) indicates that severe distress and extensive psychopathology is probably present (see Table 3). Furthermore, along with the elevated F scale score, there would be an expectation that many of the clinical scales would be elevated, especially scales 6 (Paranoia), 8 (Schizophrenia), and 9 (Hypomania) (Greene, 2000; Lawson et. al., 2003). This pattern was found in the present sample: Scale 6 (T=71.5), Scale 8 (T=62.25), Scale 9 (T=72.96).

The second cluster was a well defined 2 point code with a Ma/Pa (9-6/6-9 Spike) configuration along with an elevated, clinically significant Sc (Schizophrenia) score. Individuals with this profile report mild dysphoria and general anhedonia (Greene, 2000). These individuals may have difficulty expressing their emotions and have a tendency to fluctuate between over-and under-controlling their emotions. They are easily impatient with others and are characterized as irritable, grouchy and hot headed

(Greene, 2000). Additionally, Gynther, Altman and Warbin (1973) analyzed 6-9/9-6 psychiatric inpatients from two state hospitals and characterized them as likely to be excited, hostile, loud, grandiose, and circumstantial.

Individuals with a 6-9/9-6 profile also may exhibit a pattern of poor impulse control and greater frequency of destructive behavior than individuals with other MMPI-2 profiles (Greene, 2000). They might demonstrate a difficult time concentrating and thinking due to their occasional states of excitement or agitation. They exhibit poor judgment, despite their belief that their judgment is sound and good. They may exhibit strange and unusual thoughts, which is supported by the elevated Sc scale in the current study ( $T = 66.25$ ). These strange thoughts are believed to be more likely due to a mood disorder or personality disorder than a thought disorder (Greene, 2000). Due to the clinically relevant Scale 8 (Sc) these individuals may also have difficulty conforming to societal mores (Greene, 2000).

The Ma/Pa (6-9/9-6) profile also indicates that the prognosis for treatment is generally poor due to the individual's limited concerns about his behavior (Greene, 2000). In conclusion, the Cluster 2 sample would be theorized as similar to the Borderline/Dysphoric group theorized by Holtworth-Munroe and Stuart (1994).

Cluster 3 accounted for 26 participants (25.7%). The validity configuration for cluster 3 suggests that these individuals display minimal emotional distress, as evidenced by the high F score ( $T=64$ ), but might experience a sense of dissatisfaction about not living the "right kind of life" (Greene, 2000, p.341). Thus, these individuals are likely

experiencing an underlying chronic dysphoria that might be unrecognizable to others due to a lack of emotional expression.

The cluster can be interpreted as a 4/1/8 profile. However, given only the small differentiation between scale 1 (Hs; Hypochondriasis) and scale 8 (Sc; Schizophrenia), the code is not considered well-defined but still is interpretable (Graham, 2000). The highest scale for this cluster was the scale 4 (Pd; Psychopathic Deviate). Given the slight difference between scales 1 and 8, it is scale 4 that best distinguishes this profile. The elevated scale 4 is characterized by individuals who may exhibit "...low tolerance for frustration, and this quality combined with poorly controlled anger and poor self-control often result in outbursts of physical aggression" (Greene, 2000, p.341). These individuals are likely to lack insight into their actions, perceive themselves as better than others, and expect change from others rather than themselves, leading to poor treatment prognosis. The elevated scale 4 indicates that these individuals portray a high level of confidence that may be a façade covering up feelings of insecurity, inadequacy, and dependency (Greene, 2000). These individuals likely make good first impressions, but the impressions do not last long because their interpersonal relationships are often shallow and superficial (Lawson et al, 2002, Greene, 2003). The elevated scale 1 (Hypochondriasis) additionally indicates a presence of discomfort and somatic symptoms that may be chronic in nature. The elevated scale 8 (Schizophrenia) supports the indication of violent behavior (Lawson et al. 2003, Greene, 2000) The moderate elevation of scale 2 (Depression) along with an elevated scale 4 (Psychopathic Deviate) is similar to that of a psychopath, who is characterized as one who is easily provoked to

violence (Meyer & Deitsch, 1996; Lawson et al., 2003). Psychopaths are found to experience low levels of anxiety, while looking for elevated sensation-seeking behaviors. They are also characterized as resistant to social control standards (Hare, Hart, & Harpur, 1991).

Once the three clusters were established, a one-way multivariate analysis of variance (MANOVA) was conducted to test whether the three male battering typologies resulted in different scores on the bundle of variables that encompass the socialization of male to male interactions. These variables were selected from those MMPI-2 clinical, content and supplementary scales that were felt to best represent Jennings and Murphy's (2000) theoretical perspective of male battering behavior. Specifically, these variables were the Masculinity-Femininity (MF) clinical scale, Gender Role-Masculine (GM) supplementary scale, Low Self-Esteem (LSE) content scale, and Social Introversion (Si) clinical scale. Because we were primarily interested in testing whether FO individuals would be different from BD and GVA individuals, we used Helmert contrasts to distinguish between-group differences.

We were concerned that the cluster analysis and the MANOVA both contained the MF and Si scales, making results difficult to interpret. Thus, before conducting the MANOVA, we ran an additional cluster analysis, after removing the MF and Si scales. Results of the revised cluster analysis are presented in Table 4 and are substantively similar to the previous results. Three distinct clusters still emerged, representing the Family Only group, the Borderline-Dysphoric group, and the Generally Violent-Antisocial group. Cluster membership remained the same with one exception. The

initial cluster membership included: FO (n=51), BD (n=24), GVA (n=26). The revised cluster membership resulted in the following: FO (n=51), BD (n=25), GVA (n=25).

Table 4  
*Revised Cluster Means without the MF and Si Scales*

	Family Only (n=51)	Borderline/Dysphoric (n=24)	Antisocial (n=26)
Validity Scales			
Lie (L)	58.76	50.12	60.88
Infrequency (F)	49.18	73.68	60.80
Correction (K)	50.96	41.24	50.68
Clinical Scales			
Hypochondriasis (Hs)	50.65	53.32	64.36
Depression (D)	46.00	53.00	63.12
Hysteria (Hy)	46.41	44.72	61.28
Psychopathic Deviant (Pd)	55.24	62.40	66.16
Paranoia (Pa)	49.82	70.64	58.56
Psychasthenia (Pt)	45.16	61.16	62.64
Schizophrenia (Sc)	45.67	68.04	63.08
Hypomania (Ma)	56.12	73.24	63.08

The omnibus test of the MANOVA was significant, Pillais  $V = .71$ ,  $F(8, 192) = 13.18$ ,  $p < .001$ , indicating that a significant amount of the variance in the dependent variables is explained by the three battering typologies. The effect size of .35 indicates that nearly a third of the variance in the dependent variables can be explained by the bundle of dependent variables (see Table 5).

Table 5  
*Omnibus MANOVA Differentiating the Three Clusters in the Male Socialization Variables*

	<i>Value</i>	<i>F</i>	<i>P</i>	<i>Partial Eta Squared</i>
Pillai's Trace	.709	13.175	<.001	.354
Wilks' Lambda	.399	13.835	<.001	.368
Hotelling's Trace	1.234	14.496	<.001	.382

More importantly, the first Helmert contrast (see Table 6), comparing FO individuals to BD and GVA individuals was significant, Pillais  $V = .46$ ,  $F(4,95) = 20.34$ ,  $p < .001$ . Thus, 46% of the variance in the dependent variables is attributable to the difference between the FO and the other two typologies. Analysis of standardized discriminant function coefficients reveals that the LSE contributes most to the differentiation of FO than the other typologies, followed by GM. Si and MF made the smallest contributions. Means on these variables reveal that FO individuals ( $M = 44.63$ ) had lower LSE scores than the BD and GVA males ( $M = 57.74$ ). On the GM scale, FO individuals ( $M = 51.61$ ) had higher scores than the BD and GVA males ( $M = 40.38$ ).

Table 6  
*1<sup>st</sup> Helmert Contrast (FO vs. BD and GVA)*

	<i>Value</i>	<i>F</i>	<i>P</i>
Pillai's Trace	.461	20.344	<.001
Wilks' Lambda	.539	20.344	<.001



Table 7  
 2<sup>nd</sup> Helmert Contrast (BD vs. GVA)

	Value	F	P
Pillai's Trace	.274	8.956	<.001
Wilks' Lambda	.726	8.956	<.001

Table 8  
 DF coefficients for 1<sup>st</sup> and 2<sup>nd</sup> Helmert Contrasts

Variable	Helmert 1	Helmert 2
Mf	-.075	-.176
Gm	.298	-.361
Lse	-.679	-1.245
Si	-.170	-.720

The second Helmert contrast (see Table 7), comparing BD individuals to Anti-Social individuals was also significant, Pillais V = .27,  $F(4,95) = 8.96$ ,  $p < .001$ . Thus, 27% of the variance in the dependent variables is attributable to the difference between the BD and GVA typologies. Analysis of standardized discriminant function coefficients (see Table 8) reveals that the LSE contributes most to the differentiation of these two typologies, with a higher mean in the BD ( $M = 61.96$ ) than the Anti-Social group ( $M = 53.52$ ) (see Table 9). The next highest contributor was Si with higher scores in the GVA ( $M = 57.32$ ) than the BD ( $M = 53.72$ ) group. GM and MF contributed less to the differentiation between the groups.

Table 9

*Means for Each Cluster on the Dependent Variables Used in the MANOVA*

	Family Only (n=51)	Borderline/Dysphoric (n=25)	Antisocial (n=25)
Masculinity-Femininity (MF)	43.16	45.44	46.64
Gender Masculine (GM)	51.61	40.04	40.72
Low Self-Esteem (LSE)	44.63	61.96	53.52
Social Introversion (Si)	46.45	53.72	57.32

Table 10

*Means for FO versus BD/GVA Clusters on the Dependent Variables Used in the MANOVA.*

	FO (n=51)	BD/AS (n=50)
Masculinity-Femininity (MF)	43.16	46.04
Gender Masculine (GM)	51.61	40.38
Low Self Esteem (LSE)	44.63	57.74
Social Introversion (Si)	46.45	55.52

Thus, results confirmed our first hypothesis, that it is possible to differentiate the three male batterer typologies theorized by Holtzworth-Munroe and Stuart (2000). The results indicated that there is differentiation between the three groups as well as differentiation between the FO from the BD and GVA groups. Results from the MANOVA suggest that male socialization is an important distinguishing characteristic between the three clusters, as theorized by Jennings and Murphy (2000). Specifically, when looking at Table 10 the cluster scores for the dependent variables on the MANOVA show that the FO men scored lower on MF, higher on GM, lower on LSE and lower on Si than the BD and GVA groups. Implications for these findings will be discussed further in the conclusion section.

## CHAPTER V

### DISCUSSION AND CONCLUSIONS

This chapter has been structured into several sections, which include the interpretations of the findings, a discussion of treatment implications, limitations of this study, and directions for future research. In addition, this chapter will focus on future considerations of male batterer treatment based on typology and the incorporation of male socialization into the treatment of male batterers.

Before delving into discussion and results, the purposes for this study will be restated. The study was essentially broken up into two parts, with the first major purpose necessary in order to examine the second major purpose. The first purpose of this study was to test empirically whether the three batterer subtypes (Family Only, Borderline-Dysphoric, and Generally Violent-Antisocial) developed by Holtzworth-Munroe and Stuart (1994) could be reproduced using the Minnesota Multiphasic Personality Inventory- Second Edition (MMPI-2). The second major purpose of this study was to lend support to Jennings and Murphy's (2000) view that male socialization is an important factor to consider when conceptualizing and working with male batterers. Specifically, we sought to incorporate the ideas of Jennings and Murphy to determine whether the Family Only (FO) men adhere more strongly to the socialized traditional male roles than did the Borderline-Dysphoric (BD) and Generally Violent-Antisocial (GVA) men.

We were able to reproduce Holtzworth-Munroe and Stuart's (1994) theoretical model proposing three distinct batterer typologies by examining psychopathology as measured by the MMPI-2. The three clusters were shown to be distinct in nature. The first cluster, which we labeled "Family Only," did not exhibit any significant psychopathology, as evidenced by all ten clinical scales falling within the normal range. The second cluster displayed a well defined 9-6 profile with an elevated scale 8, a profile suggestive of a borderline personality disorder. The third cluster was the only typology with an elevated scale 4, indicating the presence of antisocial attitudes. Our findings not only lend credence to Holtzworth-Munroe and Stuart's (1994) model, but they also support the findings set forth by a number of other authors on the topic who found similar distinct typologies (Hamberger et al, 1996; Holtzworth-Munroe et al, 2000; Jacobson & Gottman, 1998; Langhinrichsen-Rohling et al, 2000; Tweed & Dutton, 1998). This first step of establishing the three distinct clusters based upon psychopathology was important because it demonstrated the need for separating these men into distinct groups rather than assuming that batterers may be lumped into one homogenous group. The cluster analysis clearly demonstrated that there are distinct types of batterers with different levels of pathology and psychological concerns. This distinction between battering clusters lays the groundwork for the second part of the study, in which we sought to explore whether differences in male socialization and rigid sex role stereotype played a role in further distinguishing these men.

Once the three clusters were established we sought to explore how Jennings and Murphy's (2000) theory of male socialization might play a role in understanding male

battering behavior. As mentioned earlier, Jennings and Murphy (2000) asserted that men who batter their female partners may do so as a result of their strong adherence to a rigid male sex role stereotype that forbids men from engaging in deep intimate friendships with other men in order to avoid painful humiliation. Specifically, Jennings and Murphy (2000) stated: “In the absence of effective male bonds and mentoring, traditional male socialization and rigid sex role definitions can create severe deficits in self-esteem, emotional development, and social relatedness for battering men, which are then displaced onto male-female relations” (p.28). With this theory laying the groundwork for the present study, we looked to see how male socialization affected the differences between the three clusters. The author sought to compare the FO men to the BD and GVA men in order to provide further support for separating groups of male batterers and to shed light on possible interventions that could be used to treat these separate groups. Specifically, this author seeks to introduce the idea of integrating process-oriented group therapy with a focus on male socialization issues with traditionally established modes of group therapy (i.e., cognitive-behavioral and psychoeducational groups). These forms of therapy will be addressed in the Treatment Implications section of this paper.

The overall MANOVA illustrated that there is a statistically significant difference between the three clusters of male batterers. The four variables that were selected to best represent Jennings and Murphy’s (2000) theoretical perspective were the Masculinity-Femininity (MF) and Social Introversion (Si) clinical scales, the Low Self-Esteem content scale (LSE) and the Gender Role-Masculine (GM) supplementary scale.

Of these four variables, the MF scale was the least effective in differentiating the Family Only (FO) group from the Borderline-Dysphoric (BD) and Generally Violent-Antisocial (GVA) groups. The MF scale assesses interests in stereotypically masculine and feminine vocations and hobbies, aesthetic preferences, activity and passivity, and personal sensitivity (Green, 2000). The finding that the MF scale played the smallest role in differentiating the groups initially ran contrary to our hypothesis. The hypothesis stated that the FO men would display stronger adherence to the masculine sex role stereotype. It was initially believed that the FO men, in the absence of psychopathology and personality deficiencies, would engage in battering behavior primarily to protect themselves from feeling emasculated and humiliated. Although the MF scale did not strongly differentiate the groups in the MANOVA/Helmert Contrasts, upon closer examination of the mean cluster scores, we observed that the FO group was the only group to meet the MMPI-2 cutoff ( $T < 45$ ) for interpretation of this scale as men who identify very strongly and inflexibly with the masculine role (Green, 2000). Thus, although there was little statistical differentiation among the groups, these cluster means on the MF scale may be interpretable according to the MMPI-2 manual, which may have clinical relevance for treatment.

Notably, the Gender Role-Masculine (GM) supplementary scale score, which is similar to the MF scale in interpretation, showed greater differentiation among the groups than did the MF scale. The GM scale reflects stereotypically masculine behavior consisting of the absence of fear and other negative emotions (Green, 2000) while the MF scale focuses on activities and hobbies. Thus, it appears that the GM focuses more

on the internal depth of masculinity and may be understood as a slightly different interpretation of masculinity than the MF scale. Upon looking at the MMPI-2 mean scores across the GM scale, all three clusters fell within the normal range. However, the FO group had a mean score that was statistically higher than the BD and GVA groups, indicating that the FO group could be interpreted as having greater stereotypically masculine behavior (i.e., fear of negative emotional expression, such as crying and displaying fear).

The Social Introversion scale (Si) provided little differentiation between the FO group and the BD and GVA groups. The Si scale was designed to assess discomfort in social interactions and the tendency to withdraw from social situations. Individuals with high Si scores may present with limited social skills or may yearn to be simply left alone (Greene, 2000). Upon further examination of the mean cluster scores for this particular scale it appears that the FO men may be slightly less likely to withdraw from social situations and have better social skills than the BD and GVA groups. However, little conclusion can be made because all three groups' cluster means fell within the normal range. The finding may suggest that the FO men are slightly more comfortable in social situations which, therefore, may have implications for treatment that will be addressed below.

The variable that played the greatest role in differentiating the FO group from the BD and GVA groups was the Low Self Esteem (LSE) content scale. The LSE scale indicates whether individuals are able to admit their personal shortcomings and are able to adapt and meet the demands of their surroundings (Green, 2000) The LSE content

scale items are also designed to measure an individual's admission of feelings of ineffectiveness, inferiority, and low confidence (Green, 2000). Initially, the FO men were theorized to have the lowest self-esteem of the three clusters due to their hypothesized masculine role strain. Although the FO men were found to experience the greatest adherence to traditional masculinity according to the MF and GM mean cluster scores, the opposite of what was predicted was discovered regarding their self-esteem. In fact, the FO men were shown to have the highest self-esteem of the three groups. One possible interpretation for the higher self-esteem of the FO men could be that, due to their relative lack of psychopathology, they are better equipped to meet the demands of their surroundings than are the GVA group and the BD group. Thus, it appears that lack of psychopathology may be a better predictor of self-esteem than male socialization or rigid sex role stereotyping. Although our findings did not support our initial predictions, these results do have significant implications for treatment, which will be addressed later in this chapter.

As previously mentioned, the primary focus of this study was to reproduce the clusters and examine how the FO men differed from the other two groups on male socialization and rigid sex role stereotyping. The special emphasis placed on the FO group stemmed from the author's own clinical and observational experiences. Thus, less attention was paid towards explaining how the BD and the GVA groups differ. However, it is important to briefly note that differences did exist. The Low Self Esteem (LSE) content scale provided the greatest differentiation among the two groups, with the BD group exhibiting lower self-esteem than the GVA group. The second greatest



differentiation between the two groups was provided by the Social Introversion (Si) scale, with the GVA group displaying greater social introversion than the BD group. No a-priori hypotheses were developed to explain these group differences. However, the observation that these groups differed on self-esteem and social isolation provides further support for the idea of separating typologies and matching them with appropriate treatment groups.

### *Limitations*

The limitations that restrict generalizability and future clinical considerations are important to be noted. First, the participants used in this study were on probation for domestic violence charges and thus are less representative of abusive men in the community who have not been formally charged with domestic violence. However, it should be noted that Holtzworth-Munroe and Stuart (1994) asserted that the Family Only (FO) sample are often missing in probation samples. Given that the FO group represents the largest group in our sample, this limitation may also be a strength of the present study.

The second limitation may be the sole use of the MF and GM scales of the MMPI-2 as a basis for determining levels of masculinity. Perhaps a multi-method approach involving additional self-report measures of masculinity, as well as observation and collateral partner interviews may have been more appropriate for assessing the constructs of masculinity and male socialization. Though the use of the MF scale might be limiting in determining masculinity, given our reliance on archival data, it at least

provides a starting point for examining male socialization and rigid sex role stereotyping as a variable to determine differentiation among male battering groups.

### *Implications for Treatment*

The finding that the FO men have higher self-esteem is relevant, as it opens the door for the possibility of incorporating process-oriented therapy. An interpersonal process group uses an unstructured format that encourages its members to re-enact the very relational problems that initially brought them to group therapy (Yalom, 1995). This form of group therapy rests on the assumption that the group is a living workshop, or a social microcosm (Yalom, 1995) of how individuals relate in the outside world. Yalom (1995) emphasizes, “They will interact with the group members as they interact with others in their social sphere, will create in the group the same interpersonal universe they have always inhabited. There is no need for them to describe or give a detailed history of their pathology: *they will sooner or later enact it before the group members’ eyes*” (p.28).

Thus, the group provides an opportunity for clients to practice new relational behaviors in a safe environment. For example, an individual who struggles with managing his anger when threatened by others would be encouraged in a process-oriented group to confront a challenging group member without using his regular pattern of conflict management (i.e., violence). Instead, with the facilitation of a group therapist and other group members, this member would be encouraged to deal with his anger in the moment in a healthy way (i.e., talking out his feelings of anger).

This form of group therapy also fosters the development of close relationships among group members, as members are able to see firsthand that they are not alone in their struggles. The group also provides a forum for individuals to discuss difficult topics that they might not otherwise feel comfortable sharing in other contexts. For example, the present author has utilized this type of group format with male batterers to encourage them to share their experiences, feelings, and vulnerabilities, with the goal of helping them learn to build deeper relationships with other men. This mode of therapy is very different from a structured cognitive-behavioral group (i.e., identifying the triggers that potentially precipitate violent behavior; learning relaxation techniques, etc.) or psychoeducational group (i.e., learning the definitions of abuse, learning the precipitants and effects of abuse, etc.), in which the focus is symptom reduction versus relationship building, and interventions are aimed at learning versus experiencing. According to Yalom (1995), "...groups resting *solely* on other assumptions, such as psycho-educational or cognitive-behavioral principles, fail to reap the full therapeutic harvest of group therapy. Each of these forms of group therapy can, in my view, be made even more effective by incorporating a focus on interpersonal process" (p. xiv).

The greatest predictor of group therapy success is that of group cohesiveness (Yalom, 1995). Group cohesiveness refers to a situation in which group members feel a sense of acceptance, warmth, and belongingness. Yalom (1995) asserts that,

To be accepted by others brings into question the patient's belief that he or she is basically repugnant, unacceptable, or unlovable. The group will accept an individual, provided that the individual adheres to the group's procedural norms, regardless of his or her past life experiences, transgressions, or social failings. Deviant lifestyles, history of prostitution, sexual perversion, heinous criminal

offenses- all can be accepted by the therapy group, so long as norms of nonjudgmental acceptance and inclusiveness are established in the group (p.49).

A closely related concept to self-esteem is that of self-acceptance. According to Yalom (1995), self acceptance is an important element in establishing group cohesiveness, as there is a significant correlation between one's self acceptance and one's acceptance of others (Rubin, 1967). Thus, because of their higher self-esteem, the FO men may be more likely to succeed in a process-oriented group due to their greater likelihood of connecting with and accepting other group members.

Furthermore, the finding that the FO men are slightly more comfortable in social situations may suggest that this group is more appropriate and ready for a process-oriented group versus a structured group. However, such tentative findings would need additional empirical support before being implemented in a clinical setting.

#### *Suggestions for Future Research*

In addressing the limitations described above, future research should incorporate the inclusion of additional, multi-modal measures of masculinity and include samples of men from the community who have not been formally charged with domestic violence. Additionally, it would be highly useful to conduct controlled outcome studies comparing traditional group therapy formats (i.e., cognitive-behavioral and psychoeducational groups) with groups that combined these traditional methods with a process-oriented approach incorporating men's issues as they relate to domestic violence. This type of research would further shed light on the role masculinity plays in battering behavior among non-pathological men. Additionally, in support of the extensive research suggesting the importance of matching group treatment to batterer types, it would be

useful to run outcome studies that compare recidivism rates among FO men-only groups to mixed typology groups.

### *Conclusion*

Although the results of this study did not support some initial hypotheses, the findings did reveal implications for addressing the bigger picture of understanding and treating male batterers. Previous literature has long suggested that current battering treatments are insufficient and ineffective (Gondolf, 1991; Rosenfeld, 1992; Holtzworth-Munroe et al, 2000). The recidivism rate for male batterers is high; in fact, several studies have found recidivism rates around 40% (Eisikovits & Edelson, 1989; Gondolf, 1991; Rosenfeld, 1992, Tolman & Bennett, 1990; Tolman & Edelson, 1995). According to Eddington and Shuman (2005), “Most uncontrolled studies report small but statistically significant effects for batterer programs. The few controlled studies undertaken reveal ambiguous results and methodological concerns, in turn, conclusions regarding batterer programs effectiveness remains an open question” (pg. 16).

Our first finding that three distinct typologies of male batterers exist supports the previous literature and provided evidence to recommend the use of differentiation of group treatment. Thus, the findings support the importance of matching treatment to typology (Lawson et al. 2003). In fact, as suggested by Hale, Duckworth, Zimostrad and Nicholas (1998), the use of the MMPI-2 appears to be quite useful in screening the men into one of three typologies and subsequently matching them for particular treatment.

Due to the author’s clinical experience as well as the findings suggested by the current study, it appears that the Family Only (FO) men would be better served by

receiving treatment separate from the Borderline-Dysphoric and Generally Violent-Antisocial groups. The Borderline-Dysphoric and Antisocial groups were reported to have the poorest outcomes for men completing domestic violence treatment programs (Dutton, Bodnarchuk, Kropp, Hart & Ogloff, 1997; Holtzworth-Munroe et al, 2000). Furthermore, Langhinrichesen-Rohling, Huss, and Ramsey (2000) found that the GVA group was the least likely as rated by their therapist to remain violent-free six months after receiving treatment. The needs and characteristics of each of these groups are quite different and grouping them together for joint treatment is likely to be distracting and ineffective.

Violent men with greater levels of psychopathology, such as the Borderline-Dysphoric and Generally Violent-Antisocial men, are less likely to be successful in therapy and it is suggested that they benefit most from short term behavioral and psychoeducational interventions (Lawson et al, 2003; Saunders, 1996). The borderline/dysphoric men are characterized by emotional dysregulation, poor impulse control, low self esteem, and insecure attachments. These findings were confirmed by the MMPI-2 profiles observed in the present study. In addition to interventions that include psychoeducational and short term behavioral techniques, it has been proposed that the borderline/dysphoric group would also benefit from incorporating dialectical behavioral therapy (Linehan, 1993) and schema-focused therapy (Young, 1999).

The Generally Violent-Antisocial men (GVA), also referred to as primary psychopaths, are said to be even more challenging in treatment (Garrido, Esteban, & Molero, 1996; Hare, 1993; Serin, 1995; Whitely, 1994; Lawson et al, 2003). These men

are thought to be the most violent outside of the home and have the most extensive history of criminal involvement (Holtzworth-Munroe & Stuart, 1994). This group is considered to be the most manipulative and it is believed that, in some cases, group therapy can actually prove to be counterproductive as it facilitates the development of a more manipulative psychopath (Lawson et al, 2003; Meyer & Deitsch, 1996).

Additionally, Yalom (1995) characterizes the antisocial male as potentially being quite destructive in the group therapy context. Though the antisocial male may appear initially as an active member with important status within the group, through time his inability to relate to others will manifest and cause problems within the group.

Specifically, the antisocial male's tendency to dominate group conversations, failure to adhere to group norms, and inability to empathize with other members can threaten the safety and proper functioning of the therapy group. (Yalom, 1995).

Although the results of our study did not strongly support the differentiation of male battering groups based on the male socialization variable, our study did emphasize that all three male battering groups adhere to rigidly defined norms of masculinity. However, the FO group appeared to have the strongest adherence to these norms, a finding that, given the other characteristics of this group, has significant treatment implications. All three groups would likely benefit from the inclusion of discussion around male socialization (i.e., issues around shame, emasculation, what it means to be a man, etc.) and how it relates to domestic violence into group therapy; however, some of the other findings from our research suggest that the FO men would be the best match for this type of treatment. Specifically, the author's clinical observations and the

findings from the MMPI-2 indicate that the FO group exhibits little or no psychopathology and they tend to have higher self-esteem. These qualities make the FO group more appropriate for an interpersonal process-type (Yalom, 1995) group incorporating the processing of men's issues.

Given the findings from the current study and what has been written about the link between domestic violence and male socialization/rigid sex role stereotyping (Jennings & Murphy, 2000), it seems that incorporating these issues with traditional cognitive-behavioral, and psychoeducational (i.e., anger-management) group therapy interventions could prove highly beneficial. Jennings and Murphy (2000) theorize that male socialization and the adherence of rigid male sex roles contributes to a lack of intimacy and vulnerability between men. As a result, men face many challenges in creating healthy relationships with other men, which consequently jeopardizes the establishment of healthy intimate relationships with women.

To incorporate these ideas into developing a group therapy treatment, we suggest a starting place would be to consider the ideas set forth by Brooks (1993) in working with what he refers to as "working class men" (Pollack & Levant, 1998). It is important to note that his model is not geared towards working with domestically violent men, but his ideas shed light on the value of incorporating men's issues into the group therapy forum. Pollack and Levant (1998) summarize Brooks' ideas by asserting:

Group therapy can be especially helpful to men when it emphasizes the following key elements: (a) offering noble ascriptions for traditional male behavior; (b) accommodating men's communication styles; (c) framing men's problems in a larger gender context; (d) decreasing men's isolation from other men, and promoting the universality of their experiences; (e) instilling hope; (f) evoking



and catharting men's psychological pain; (g) generating self-disclosure; and (h) lessening overdependence on women (p. 5).

Thus, the idea of incorporating men's issues into domestic violence groups would be geared towards debunking the myth of rigid masculinity, learning how to be in relationships with other men, discussing how to be vulnerable without losing one's manhood, and expanding the definitions of what it means to be "a man." To cite Jennings and Murphy (2000), "...group therapy is the treatment of choice for battering men. In fact, it is even more crucial, because the treatment group becomes a living workshop for addressing, challenging, and (re)building male-male relations and masculine identity" (p.28). There is power in offering a safe environment where men are able to learn that sharing, opening up, and being vulnerable are also ways of being a man.

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