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An Examination of Psychopathology among Men who have Suspended the Use of Violence in
their Intimate Relationships

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Abstract

It is well established that personality pathology has been associated with the onset and continued perpetration of intimate partner violence, yet if and how this relates to the cessation of such behaviours remains unclear. The aim of this study was to determine whether personality pathology differentiated 37 intimate partner violent men who had suspended the use of violence against their intimates ('desisters'), 50 persisters, and 49 non-violent controls using the Millon Clinical Multiaxial Inventory-III subscales. Cluster A and Cluster B disorders at a diagnostic level were more often reported in men who had used violence against intimates compared to men in the control group. The rates and percentages of clinically meaningful traits and disorders were lower for the desisters than the persisters, with the desisters more like the controls than the persisters. The findings suggest that the initial stage of the desistance process may be related to personality pathology.

Keywords: Intimate partner violence, domestic violence, desistance, personality, MCMI-III

An Examination of Psychopathology among Men who have Suspended the Use of Violence in their Intimate Relationships

Researchers have demonstrated that men can and do stop, or desist from, using violence in relationships, but research has typically been focused on identifying whether, and the extent to which, it may occur. In its most simplistic form, desistance refers to the cessation of offending following intervention or something that happens spontaneously (Fagan, 1993). Desistance is regarded as a dynamic process that gradually unfolds over time, as opposed to a simple static one off event (see Healy, 2010; Kazemian, 2007; King, 2013; Maruna, 2001; Sampson & Laub, 2003). There is debate however regarding just how long this absence of behaviour must have occurred for in order for it to be deemed significant. Authors have highlighted 12 months as being of clinical significance (Feld & Straus, 1989). Consequently, in the present study, desisters were identified as having been violence-free for a minimum of 12 months. This might therefore be better conceptualised as a suspension of IPV, rather than a genuine indicator of desistance. Indeed, as desistance is understood as a process, defining it in this way suggests a focus has been placed on the initial stages of desistance, which has been referred to as primary desistance (Maruna, Lebel, Mitchell, & Naples, 2004). It has been suggested that there is value in studying the early stages of desistance (i.e. primary), as this can provide an insight in to how longer-term (or secondary) desistance develops and a clearer understanding of the specific areas that might be more appropriate for intervention (King, 2013). For the purpose of the current study, the terms ‘desistance’ and ‘desister’ will be used to refer to the cessation of IPV and those who have stopped using IPV, with the caveat that this relates to the suspension of these behaviours or the initial stages of the desistance process.

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In the general offending literature three major theoretical explanations have been proposed to understand offending behaviours and account for desistance: propensity (e.g., Gottfredson & Hirschi, 1990; Greenberg, 1992; Rowe, Osgood, & Nicewander, 1990); informal social control (e.g., Bersani, Laub, & Nieuwebeerta, 2009; Capaldi, Kim, & Owen, 2008; Kirk, 2012) and subjective change (Giordano, Cernkovich, & Rudolph, 2002; Maruna, 2001; Paternoster & Bushway, 2009; Weaver, 2012). Consistent with the propensity account of criminal behaviour, a number of psychological and psychopathological characteristics have been found to be associated with the onset and maintenance of IPV behaviours. This list of factors, although not exhaustive, includes psychopathology and personality (e.g., Dutton, 2006; Ehrensaft, Cohen, & Johnson, 2006; Shorey, Febres, Brasfield, & Stuart, 2012); anger/hostility (e.g., Baron et al., 2007; Oberleitner, Mandel, & Easton, 2013; Stith, Smith, Penn, Ward, & Tritt, 2004); self-esteem (e.g., Murphy, Stosny, & Morrel, 2005; Papadakaki, Tzamalouka, Chatzifotiou, & Chliaoutakis, 2009); and substance and alcohol abuse (e.g., Boles & Miotto, 2003; Fals-Stewart, 2003; Hirschel, Hutchison, & Shaw, 2010). Research regarding the potential role of such factors in desistance from IPV has yet to be conducted (for a review see Walker, Bowen, & Brown, 2013). Understanding the factors associated with desistance may offer insights into how best to develop and target intervention and improve our understanding of factors that impede desistance, in line with the responsivity principle (Andrews & Bonta, 2003; Andrews & Dowden, 2006; Andrews, Bonta, & Wormith, 2006; Polaschek, 2012). Such knowledge may be used to inform existing intervention practices in order to increase intervention effectiveness. Consequently, the present study provides the first purposeful comparison of psychological and psychopathological characteristics between men who have desisted from IPV, men who continue to engage in IPV behaviours, and a non-violent control group.

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Several researchers have reported the existence of personality pathology among those who use IPV, although the extent of this varies (e.g., Dutton & Starzomski, 1994; Fowler & Westen, 2011; Hamberger & Hastings, 1986, 1988; Langhinrichsen-Rohling, Huss, & Ramsey, 2000). For example, Hamberger and Hastings (1986) found that only 12 out of their 99 participants (12%) attending treatment (mandated and self-referred) for IPV in the USA showed no evidence of personality disorder or other psychopathology based on the MCMI (Millon, 1987), the Novaco Anger Scale (Novaco, 1975) and the Beck Depression Scale (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Likewise, several other studies have also shown high rates of personality pathology (around 80% and above). For example, using the MMPI, Hale et al. (1988) found personality pathology in 85% of their sample of men voluntarily attending community treatment programmes in the USA. Rates of pathology prevalence between 88 - 90% (Hamberger & Hastings, 1988; Hart, Dutton, & Newlove, 1993; Johnson et al., 2006) and 79% (Dutton & Starzomski, 1994) have also been found in court and self-referred men in the USA and Canada when the MCMI was used. However, Flournoy and Wilson (1991) found lower prevalence rates with 63% of court-mandated men (who attended an eight week treatment programme in the USA) evidencing pathology, and Langhinrichsen-Rohling, Huss, and Ramsey (2000) observed using the MMPI-II an even lower rate of 49% of personality pathology in a community sample in the USA. However, these variations may be in part due to the diverse methods used to define personality pathology, as different instruments and cut off scores were used and because the samples were at different stages of treatment/intervention.

A number of authors have identified that IPV offenders possess a range of distinct personality traits (e.g., Dixon, Hamilton-Giachritsis, & Browne, 2008; Ehrensaft et al., 2006; Fowler & Westen, 2011; Gondolf, 1999). Using Q-factor analysis Fowler and Westen (2011)

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identify three personality constellations among partner-violent men: psychopathic; hostile/controlling; and, borderline/dependent. Ehrensaft, Cohen and Johnson (2006) found that three clusters of personality disorders (Cluster A paranoid, schizoid and schizotypal; Cluster B, borderline, narcissistic and antisocial; and Cluster C, dependent, avoidant and obsessive/compulsive) were independently associated with IPV in a 20-year longitudinal study of community-based IPV men (residing in New York). Hale, Zimostrad, Duckworth, and Nicholas (1988) identified evidence of three distinct MMPI personality profiles in 67 men who had been abusive in their relationships: elevations on almost every clinical scale; no clinical elevations; and, profiles indicating a '24/42, 2 point' code type,¹ (e.g., feelings of inadequacy, low ego, strong tendencies to addictions and dependency tendencies). Other personality disorders associated with the need to control others (e.g., antisocial and narcissistic) and self-concept and identity (borderline) have also been proposed as being relevant in differentiating those who have and have not used IPV (e.g., Hamberger, Lohr, Bonge, & Tolin, 1996; Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; Tweed & Dutton, 1998). It has been suggested that a limitation of this research generally, however, is the absence of a control group (Gibbons, Collins, & Reid, 2011; Hamberger et al., 1996; White & Gondolf, 2000). This means that it is not clear whether IPV men have distinctly different profiles from men who have not used IPV, and it is plausible that personality pathology is related to the continuation or cessation of IPV.

Psychopathology is a defining characteristic feature of perpetrator typologies.

Holtzworth-Munroe and Stuart (1994) proposed that batterer subtypes could be classified using the man's: severity and frequency of marital violence; generality of violence; and, psychopathology or personality disorder characteristics. The resulting three subtypes are: family

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only (FO); dysphoric/borderline (DB); and, generally violent antisocial men (GVA). FO perpetrators use the lowest and least severe and frequent levels of violence and are the least likely to engage in psychological and sexual abuse. The violence of this group tends to be restricted to family members, and these individuals show little psychopathology and either no personality disorders or passive dependent personality disorder. The DB perpetrators engage in moderate to severe abuse of their partners, including psychological and sexual forms of abuse. The victims of this group are mostly family members, but there are also some extra-familial victims. This group are the most dysphoric, psychologically distressed and emotionally volatile. These individuals may show borderline schizoid personality disorders and may have abused alcohol and/or substances. The GVA perpetrators engage in moderate to severe marital violence, including psychological and sexual abuse. These individuals are more likely than the perpetrators from the other groups to use violence against non-family members, have histories of criminal activity, and abuse alcohol and drugs. Individuals in this group are the most likely to have an antisocial personality disorder. Empirical research broadly supports these three groups (e.g., Cunha & Gonçalves, 2013; Dixon et al., 2008; Langhinrichsen-Rohling et al., 2000; Mauricio & Lopez, 2009).

Holtzworth-Munroe, Meehan, Herron, Rehman, and Stuart (2003) found that this typology is also relevant to desistance. Longitudinal data were used to examine if subtypes identified at time one continued to differentiate men at 18 month and 36 month follow-up points. In this research a fourth subtype, Low Level Antisocial (LLA; Holtzworth-Monroe et al. 2000), was identified that was intermediate to the FO and the other two groups on the measures of their severity and frequency of marital violence. It was found that that 40% of the FO men and 23% of LLA men desisted, but only 14% of DB and 7% of GVA men desisted. Based on the overall

findings of Holtzworth-Munroe and colleagues, it should follow that differences in certain characteristics that are associated with each type, i.e., antisocial behaviour, attachment, impulsivity, personality traits and psychopathology, are likely also to be associated with desistance, and conversely persistence, of offending.

The MCMI-III has been used extensively to study personality pathology and the characteristics of those who use IPV, and distinct types of IPV offenders have been identified who are characterised by the following features: antisocial, narcissistic, borderline and dependent (Craig, 2003; Gibbons et al., 2011; Retzlaff, Stoner, & Kleinsasser, 2002; White & Gondolf, 2000). Typology researchers suggest that personality pathology is likely to be more evident in persisters than desisters (Holtzworth-Munroe et al., 2003), and therefore it is proposed that the scores on the subscales of the MCMI-III will be higher for the persisters than the desisters, and in turn than the controls. However, it is proposed that this will be the case for 21 of the 24 subscales. This is because for three of the subscales, (compulsive, narcissistic, and histrionic), elevations relate to personality strengths rather than pathology, as it has been suggested that in the absence of pathology these scales will be elevated (Millon et al., 2006). This therefore would suggest that the scores are likely to be higher in the controls than the desisters, and in turn than the persisters.

A strength of the MCMI is that it can be used to generate profile reports for individuals (Choca, 2004). To date these profiles have only been used in two IPV studies (Gibbons et al., 2011; White & Gondolf, 2000), in both of which high frequencies of individuals classified within a 'severe personality level' were observed. Although it is clear that there is an association between personality disorders and IPV, to date no study has been published where the personality subscales of men who have desisted from IPV are compared with those who have

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persisted and those who have never used IPV. In addition a comparison of the MCMI profiles of each of these groups has never been undertaken. Therefore, the aim of this study is to determine if there are differences between desisters, persisters, and controls within their MCMI measured psychological characteristics. Specifically it was hypothesised that:

- (1) The percentages of clinically relevant scores (i.e., personality traits and clinical syndromes with BR>74) will be significantly different between controls, desisters, and persisters, with the percentages of clinically relevant scores being more prevalent among persisters than desisters, and in turn more prevalent than in controls
- (2) There will be a significant difference between controls, desisters, and persisters in the MCMI-III personality and clinical syndrome scores. It is expected that the scores will be higher for persisters, desisters then controls for 21 of the subscales. However, for 3 of the subscales, (compulsive, narcissistic and histrionic) it is expected the scores will be higher for the controls, desisters then persisters..
- (3) There will be an association between personality level (severe, moderate, and low) and offending group (desister and persister) based on personality profiling. It is expected that persisters will be associated with the severe personality level and desisters associated with the low personality level.

Method

Design

A cross sectional between subjects design was used. Three groups, desisters, persisters, and controls were recruited and their scores on the MCMI-III were taken at one point in time. The scores of the three groups were compared in order to identify group differences in clinically

relevant scores, personality and clinical syndrome scores, and levels of personality pathology (severe, moderate, or low).

Participants

Several gate-keepers working at community treatment programmes and the Probation Service were contacted for help with recruitment of participants. Three community-based rehabilitation programmes and two Probation Trusts in England agreed that the researcher could attend IPV programmes, or initial assessments prior to programme commencement, to recruit participants to complete the questionnaires. Therefore, this was an opportunity sample of either court-mandated or self-referred male perpetrators who had engaged in IPV. They were determined as desisters or persisters based on their use of physical violence in their lifetime and the past year, as measured on The Revised Conflict Tactic Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). The control sample was an opportunity sample of men. G*Power analysis for a χ^2 analysis with a medium effect size and to achieve a power of 0.80, established that a sample size of 108 was required. A sample size of 136 was recruited and was therefore acceptable in size to detect group differences if present. By group, 49 controls (mean age 41.0, *SD* 10.4), 37 desisters (mean age 38.6, *SD* 9.5) and 50 persisters (mean age 35.0, *SD* 9.7) were recruited. There was a significant difference between the ages of the participants in each group $F(2, 133) = 4.48, p < .05$. Post hoc independent *t* tests revealed the difference between the controls and persisters was significant, $t(97) = 2.93, p = .004, d = 0.08$ (Bonferroni corrected $p \leq .01$), but that there was no significant difference in age between the controls and desisters and the persisters and desisters. The sample was predominantly White British (93.7%). For definition and grouping purposes, and based on file notes where available and applicable:

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- (i) Controls were those who self-reported on the CTS2 that they had never used physical violence in their relationships;
- (ii) Persisters were those who self-reported on the CTS2 that they had used physical violence within their lifetimes and had used physical violence within the last year; and
- (iii) Desisters were those who self-reported on the CTS2 that they had used physical violence within their lifetimes but did not report the use of physical violence within the past year.

All the desisters had completed treatment. The persisters were at various stages in the treatment process, some were waiting to start, others had just started attending treatment, and some had attended for a few months. None of the persisters had completed treatment. All the men who had been identified as having used IPV were asked to participate in the study, and were classified on completion of the questionnaires based on their scoring of physical violence only on the CTS2.

Measures

The Revised Conflict Tactic Scale (Straus et al., 1996). This is a self-report inventory that assesses how individuals choose to resolve relationship conflicts. Respondents report on the behaviors of themselves and their partners during conflict. It consists of 78 items designed to assess conflict in intimate relationships that are represented by a five-factor model: negotiation, psychological aggression; physical assault; sexual coercion; and, injury. Frequency with which the individuals have engaged in these five factors is measured on an 8-point Likert-type, where 0 means, “This has never happened,” and 6 means, “More than 20 times in the past year”; however, 7 means, “Not in the past year, but it happened before.” In the current study, group classification was based on the men’s use of physical violence, so the 12 physical assault items on the CTS2 were used. The men were therefore asked to report how many times they had used

any of the physically violent behaviours in the last year and/or in their lifetime. Validation of the scale revealed high internal consistency, $\alpha=.88$.

The Millon Clinical Multiaxial Inventory III (Millon, Millon, Davis, & Grossman, 2009). This is a self-report inventory consisting of 175 dichotomous items (true or false) to measure personality disorders. It comprises 4 validity scales; 11 Clinical Personality Patterns scales; 3 Severe Personality scales, 7 Clinical Syndromes scales, and 3 Severe Syndromes scales. Validation of the subscales revealed high internal consistency with α scores ranging from .70 to .91. Alphas exceeded .80 for 15 of the subscales.

The MCMI-III is interpreted using base-rate (BR) transformation scores, which is a distribution that utilises prevalence rates to maximise diagnostic efficiency (Gibertini, Brandenburg, & Retzlaff, 1986). A BR of 60 is the median prevalence score in a psychiatric population and BR of 35 is the median score for non-clinical populations. A BR score greater than 74 ($BR>74$) is the prevalence figure for the presence of a clinically significant trait or presence of a syndrome. A BR score greater than 84 ($BR>84$) reflects the prevalence figure for the presence of a disorder or prominence of a particular syndrome (Millon, Millon, Davis, & Grossman, 2006), which is indicative that the trait and symptoms are at the diagnostic level (Craig, 2008).

Procedure

Ethical approval was obtained from the University's Research Ethics Committee. Ethical approval was also obtained from the National Offender Management Service (NOMS) through the Integrated Research Approval System (IRAS). In order to maintain anonymity and minimise disruption for the IPV groups and controls, the questionnaires were administered through a variety of routes. The IPV groups either filled in the questionnaires during a group treatment

session, during one-to-one assessments, or following receipt of the questionnaire in the post. The researcher collected some of the questionnaires personally following completion in group sessions, while the others were sent via the post. For the controls, the questionnaires were sent and returned in the post. Informed consent was obtained from all participants.

Data analysis

Initial data screening indicated that normal distribution and homogeneity of variance were both violated for the majority of the subscales. Data transformation of this was not deemed appropriate as transformations result in different constructs being addressed to the ones originally measured (Grayson, 2004). In addition, Millon BR scores use criterion scoring not normative referencing, which is used in most psychological tests. As a normal distribution is not typical for measures based on criterion referencing, it made little sense to attempt to transform the distribution of the MCMI to normality. Non-parametric testing was therefore used and Bonferroni adjustments were made.

As the men who had used IPV were recruited from probation and non-probation treatment settings, Mann-Whitney comparisons between these two groups on the CTS2 and the MCMI-III were conducted. Overall, there were no statistically significant differences in the scores on either the CTS2 or the MCMI-III. (Data are available on request).

In order to test hypothesis 1, the percentages of clinically significant (BR>74) MCMI-III sub-scale scores were calculated and chi-square analyses were then used to examine associations between these percentages across the three groups. Due to sample size and because in some cases the expected outcome values were less than five, Fisher's exact test for significance comparisons were used and Cramer's V reported to indicate effect size.

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To test the second hypothesis, differences between the controls', desisters', and persisters' MCMI-III personality and clinical syndrome scores were examined using Kruskal-Wallis tests and Post-hoc Mann-Whitney tests.

To test the third hypothesis, the desisters and persisters were individually profiled by analysing the severity of personality dysfunction using the procedure advocated by White and Gondolf (2000), and Gibbons, Collins and Reid (2011). Firstly, individuals with significantly elevated severe personality scores ($BR > 84$) on the schizotypal, borderline, or paranoid scales were categorised as Severe Personality Dysfunction. The rest of the participants were grouped using their elevations on the 11 basic clinical personality patterns. Individuals with any BR scores greater than 84 on these 11 basic personality patterns were assigned to Moderate Personality Dysfunction level. Those with BR scores less than 85 were assigned to a Low Personality Dysfunction level. The proportions of significantly elevated ($BR > 74$) MCMI-III Axis I clinical syndromes falling in each of the pathology levels were then calculated.

To complete the profiling, data were grouped by formulating personality pattern characteristics within each of the levels' personality pathology that they were assigned to using the approach taken by White and Gondolf (2000). Those in the severe disorder group were divided into borderline disorder (borderline scale $BR > 74$) and paranoid disorder (borderline scale $BR < 75$ and paranoid scale $BR > 75$). In the moderate dysfunction level, individuals were classified in to those with: antisocial disorder (antisocial scale $BR > 84$) and narcissistic disorder (antisocial scale $BR < 84$ and narcissistic scale $BR > 84$). Participants from the low dysfunction group were classified as narcissistic/conforming if at least two of the following scales, narcissistic, compulsive, and histrionic, were among the highest scores in that participant's profile. An avoidant/depressive group was classified if the participant was not classified as

narcissistic but at least one of the following scales, avoidant, depressive, schizoid was the highest score in the profile. In the severe, moderate, and low personality pathology levels, those who could not be classified based on this formulation were assigned to the atypical group (Gibbons et al., 2011). The proportions of clinically elevated ($BR > 74$) MCMI-III Axis I clinical syndromes that fell in to each of the personality pathology levels were calculated. (These profiles are tabulated in the results section, see Table 4). As response bias could not be statistically controlled for invalid profiles were removed.

Results

Hypothesis 1

The results from the chi-square analyses are presented in Table 1.

[[Insert Table 1 here]]

As seen in Table 1, the percentages of clinically relevant scores (i.e., personality traits and clinical syndromes with $BR > 74$) were significantly different between controls, desisters, and persisters for 13 of the 24 subscales. For 12 of these (avoidant, depressive, antisocial, sadistic, masochistic, borderline, paranoid, anxiety, bipolar, dysthymia, alcohol dependence, and major depression), the clinical scores were more prevalent among persisters than desisters, and in turn more prevalent than among controls. For the compulsive subscale this was reversed, as the clinical scores were more prevalent among the controls than the desisters, and in turn more prevalent than among the persisters.

Table 1 also shows the results for the 2 x 2 chi-square post-hoc follow-up analysis that was undertaken. It was found that for: (i) controls and desisters, there were significant differences in scores for 3 (depressive, antisocial, alcohol dependence) of the 13 subscales; (ii) controls and persisters, there were significant differences in scores for all 13 of the subscales;

and, (iii) desisters and persisters, there were significant difference in scores for 6 (depressive, compulsive, borderline, anxiety, dysthymia, major depression) of the 13 subscales. To measure effect size, Cramer's V was calculated and as shown in Table 1 effect sizes generally ranged from medium to large.

Hypothesis 2:

The results from the Kruskal-Wallis and post-hoc Mann-Whitney analyses are presented in Table 2 (personality styles and dysfunctions) and Table 3 (clinical syndromes). There were significant differences in the scores of the three groups in all but one of the subscales (narcissistic). The median scores increased from controls to desisters to persisters as expected for 20 of the 21 subscales, but for the schizoid sub-scale, the desisters had the lowest scores, followed by the controls, then the persisters. In line with expectations for the two of the remaining three scales, histrionic and narcissistic scales, the median scores decreased from controls to desisters to persisters. However, this was not the case for the compulsive scores, as the median was the highest for the desisters, then the controls, with the persisters having the lowest scores.

[[Insert Tables 2 & 3 here]]

In Tables 2 and 3 for the Mann-Whitney post-hoc follow-up analyses it can be seen it was found for: (i) controls and desisters, there were significant differences in scores for 13 (depressive, antisocial, sadistic, negativistic, masochistic, borderline, paranoid, bi-polar, dysthymia, alcohol dependence, drug dependence, post-traumatic stress, thought disorder) subscales; (ii) controls and persisters, there were significant differences in scores for all 24 subscales; and (iii) desisters and persisters, there were significant differences in scores for 18 (schizoid, avoidant, depressive, dependent, histrionic, compulsive, negativistic, masochistic,

schizotypal, borderline, paranoid, anxiety, somatoform, dysthymia post-traumatic stress, thought disorder, major depression, delusional disorder) subscales. To measure effect size, Pearson's correlation coefficient, r , was calculated and, as shown in Tables 2 and 3, effect sizes generally ranged from medium to large.

Hypothesis 3:

Overall, 60% of the sample presented with personality pathology. The interpretation of all 87 MCMI-III profiles (all those who recorded using physical violence against an intimate i.e. desisters and persisters) is presented in Table 4 and revealed three levels of personality pathology referred to as severe personality dysfunction (39%), moderate personality dysfunction (21%), and low personality dysfunction (40%). In the severe group, there is evidence of Axis II disorders, i.e., borderline and paranoid, and these are also accompanied with Axis I conditions, such as thought disorder and major depression. The profiles of the moderate dysfunction men suggest fewer severe personality disorders, such as antisocial and narcissistic. However, the profiles of low dysfunction did not evidence any DSM-IV (APA, 1994) personality disorders. Of the 39% of men who fell into the severe personality level, the majority (59%) had borderline personality disorder as their predominant pattern. For the moderate and low personality level, the majority of individuals in each group evidenced atypical status (i.e. failed to match the interpretative subtypes selected), although there were still quite high proportions that did show some of the predominate patterns. This was particularly in relation to antisocial disorder and narcissistic /conforming style.

[[Insert Table 4 here]]

In order to examine the association between personality level (severe, moderate, and low) and offending group (desister and persister), a comparison of frequencies of desisters and persisters within personality levels was made including the personality descriptions within each group. Significant clinical syndromes were omitted due to smaller group sizes that were created by splitting the IPV men into desisters and persisters. As seen in Table 5, more persisters were found in the severe personality level than desisters, with the opposite being true for the low personality level. Using a Chi-Square analysis, the association between personality level and desister or persister group was examined. The hypothesis was supported in that there was a significant association between personality level and those who desisted or persisted in IPV ($\chi^2(2) = 14.23, p = .001, V = .40$), although based on standardised residuals, this association was mainly driven by group differences found in the severe personality group.

[[Insert Table 5 here]]

Post-hoc follow-up 2 x 2 chi-square analyses (three in total) were performed to determine the relationship between group (desister and persister) and each personality level (severe, medium, and low). Due to multiple testing, a significance testing level $p \leq .017$ was used in line with a Bonferroni adjustment from $p < .05$. Based on sample size, Fisher's exact test for significance comparisons was used and Cramer's V was reported to indicate effect size. In support of the hypothesis, persisters were significantly more likely to be associated with severe personality group than desisters ($\chi^2(1) = 14.14, p \leq .017, V = .40$), and desisters were significantly more likely to be associated with the low personality group than persisters ($\chi^2(1) = 7.31, p \leq .017, V = .29$). No significant association was found between group and moderate personality level ($\chi^2(1) = 1.58, p > .017, V = .13$).

Discussion

Main findings and interpretations

The aim of the current study was to compare the psychopathology of men who have stopped using IPV, those who continue to use IPV, and those who have never used IPV, and assess if there are differences in personality characteristics between these three groups based on MCMI-III subscales and profiles. The novel findings from this current study demonstrated that there are differences in the percentages of clinically relevant scores across the controls, desisters, and persisters, suggesting that such characteristics have a role in desistance. Prevalence levels were higher in the persisters than in the desisters and in turn, than the controls. In relation to the MCMI-III subscales, there were statistically significant differences between the groups on 23 of the 24 subscales (not narcissism). Follow-up analyses revealed that the desisters and controls shared more characteristics than the persisters and controls, and the desisters and persisters. Furthermore, it was also found that there was an association between levels of personality pathology (severe, moderate, low), with more persisters found in the severe group and more desisters in the low group. These findings therefore confirm that personality pathology is significantly associated with using violence in a relationship. However, it is also potentially related to desistance, or primary desistance as conceptualized in the current study (i.e., suspension of physical violence for one year), and persistence of IPV. Therefore it is concluded that personality pathology differentiates violent men who suspend the use of violence against their partners (desisters), from persisters and non-violent controls.

In support of hypothesis one, it was found that the percentage of men who had clinically significant scores ($BR > 74$) was much higher in the persister group, followed by the desister and then the control groups for the majority of the scales. Frequency scores were notably higher for persisters on depressive, antisocial, negativistic, masochistic, paranoid, anxiety, dysthymia,

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alcohol and drug dependence, and major depression subscales. In the case of anxiety, 72% of the persisters group reported symptoms associated with this disorder, and this included 32% with symptoms at a diagnostic level. In addition, 19% of the sample scored at diagnostic level for borderline personality disorder. This indicates a need to undertake individual assessment of IPV prior to treatment as personality pathology needs careful consideration when formulating the most appropriate type of treatment required. The desisters' higher frequency scores were in the histrionic, narcissistic, antisocial, anxiety, and alcohol and drug dependence subscales. For the majority of these subscales this was not at the diagnostic level, with the exception being for the alcohol dependency and antisocial subscales. This implies that a high proportion of both persisters and desisters have clinically meaningful traits and disorders across a broad range of characteristics, but the rates and percentages are lower overall for the desisters. These findings are in line with existing knowledge that IPV offenders form a heterogeneous sample (Dixon & Browne, 2003; Fowler & Westen, 2011) where personality disorders are a common feature (Cunha & Gonçalves, 2013; Hamberger & Hastings, 1991; Hamberger et al., 1996; Holtzworth-Munroe, 2000). However, it was also demonstrated that the clinically meaningful traits and syndromes were more widespread in persisters than desisters. Hence, it may be that the differences found across these characteristics are related to the continuation or cessation (or suspension) of violence against an intimate, which again supports the premise that personality pathology differentiates desisters and persisters.

The second hypothesis was also supported as it was found that there were significant group differences between the desisters, persisters, and controls on the MCMI-III subscales. A comparison of the psychopathologies of the groups suggested that the desisters and controls shared more characteristics than the persisters and controls and the desisters and persisters, with

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the persisters as a whole evidencing more pathology. The post-hoc group analysis revealed that both the desisters and the persisters reported significantly different scores than the controls on antisocial, alcohol and drug dependence subscales. However, these traits did not differentiate desisters and persisters. These findings are consistent with previous studies where it has been identified that antisocial behaviour is a risk factor for IPV (e.g., Craig, 2008; Huss, Covell, & Langhinrichsen-Rohling, 2006; Taft et al., 2010). In addition, evidence shows that IPV is linked with substance and alcohol abuse as both antecedent (Easton, Swan, & Sinha, 2000) and situational risk factors (Lipsky, Caetano, Field, & Larkin, 2005; Taft et al., 2010; Thomas & Bennett, 2009), with some suggesting that alcohol abuse is one of the most important risk markers for IPV (Bennett, Tolman, Rogalski, & Srinivasaraghavan, 1994). Although these characteristics could not distinguish persisters and desisters, the subscales are measured based on historical use of behaviours, and as these groups have both used IPV historically, this could explain such a finding, and why both groups differed from the controls.

The desisters and the persisters did, however, differ significantly in their scores on 18 of the MCMI-III subscales. On eight scales (depressive, negativistic, masochistic, borderline, dysthymia, paranoid, post-traumatic stress, and thought disorder) the desisters had significantly different scores from *both* the persisters and the controls (these scales were also significantly different between the persisters and the controls). These scores all followed the same trend (i.e., highest for the persisters, followed by the desisters and then the controls) and it may be where the groups fall on the continuum of scores that is relevant. For example, in these subscales the group base rate median scores for the desisters were typically less than 60 (the exceptions being masochistic and paranoid where BR=60), which is the median score of a clinical population (psychiatric patients). For the persisters, the group base rate median scores were all greater than

60. The raised elevations in the persisters may be risk factors associated with the continuation of IPV, and this similarity in scoring between the persisters and clinical populations may be what differentiates the persisters from the desisters. That the desisters presented with base rates less than 60 for these scales means that these traits are not currently presenting as risk factors for offending, and this may promote desistance. The significant difference in scores between the desisters and controls may, therefore, be more related to historical factors associated with previous IPV, which raised BR scores, but not to a clinical level.

There were 10 subscales for which there were significant differences between the desisters and persisters, but not between the desisters and controls, and consequently these traits and syndromes may be more relevant and important to the desistance process. With the personality traits of histrionic and compulsive, the desisters are more like the controls, but significantly different than the persisters, and these are the traits commonly elevated in non-clinical samples (Millon et al., 2006). In relation to the compulsive subscale, Craig (2008) observed that scores on the scale: (i) are rarely elevated in psychiatric patients; (ii) correlate positively with items relating to control of behaviour and emotion; and (iii) consistently correlate with measures of mental health and negatively with measures of emotional maladjustment. In addition to this the author noted that non-clinical populations, particularly males, score highest on this scale. In order to assess the relevance of elevations on the compulsive and histrionic scales, an examination of significant Axis 1 pathology and scores on severe personality pathology scales is required as this will assist in determining if the elevations reflect healthy personality or significant personality pathology (Millon et al., 2006). However, if these scales are personality strengths, it is likely that elevations on these scales will act as promotive factors that aid the desistance process.

A final observation from the comparison between the desisters and persisters was the significant differences observed on all three of the personality dysfunction scales and all three of the severe clinical syndrome scales. This is reflected in the findings from the profile analyses undertaken. Profile analyses as advocated by Millon et al. (2009) and Choca (2004) of the IPV men (i.e. the controls were excluded from this analysis) revealed that, in line with expectations and prior research (e.g., Craig, 2003; Gibbons et al., 2011; White & Gondolf, 2000), considerable diversity of personality pathology was found. A high proportion of the men met the threshold for personality pathology disorder classification as it was seen in 60% of the sample. This is consistent with Flournoy and Wilson (1991) who found that 63% of their sample evidence pathology. However, the rates are lower than reported by others (e.g., 88%; Hamberger and Hastings 1986, Johnson et al. 2006; 79%; Dutton and Starzomski 1994). These lower rates may be accounted for by the fact that in the other samples the men were all just about to enter, or were fairly new, into treatment programmes; whereas some in the current sample, had finished and had reported at least a year violence free. Nevertheless, there was still considerable personality pathology observed in the current sample: 39% of the IPV men reported severe personality type pathology, mostly of the borderline type. The majority of these men were in the persister group. This association between personality level and group suggests that personality pathology relates to the cessation of IPV, and differentiates desisters and persisters.

Theoretical Implications

From a theoretical perspective the findings link to typology research. The desisters in the current study were less pathological and therefore there is strong evidence that they reflect the FO group, who are classified as demonstrating little to no psychopathology. Although there were some significant differences in some of the scores on subscales between controls and

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desisters, indicating a difference in the levels of psychopathology, the frequencies of those of the desisters who scored base rates greater than 74 was generally fairly low on the majority of scales. However, frequencies of elevations were higher for antisocial, anxiety, alcohol and drug dependence scales. This suggests that some of the men in the desister group shared characteristics with the LLA group identified by Holtzworth-Munroe et al. (2003) and validated by Huss and Langhinrichsen-Rohling (2006). The LLA offenders were identified as having moderate scores on measures of antisociality, marital violence, and general violence, and fell intermediate to the FO and GVA groups in that FO men scored lower, and GVA men scored higher than the LLA group on these measures (Holtzworth-Munroe & Meehan, 2004). In the current study, the persisters are characterised as using severe physical and psychological violence, and displaying a range of psychopathology or personality disorders and share characteristics with both the DB and GVA subtypes. In relation to the DB group, the persisters in the present study evidenced higher levels of clinically significant characteristics in relation to depressive, dependent, avoidant, borderline, anxiety and major depression compared to the other two groups. Regarding the GVA group, persisters in the present study also reported significantly higher scores and displayed higher frequencies of clinically significant traits for antisocial, sadistic, negativistic, alcohol and drug dependence.

This theory, clearly offers a framework that identifies differences in characteristics between the desisters and persisters, however, it does not offer explanation for the differences. From a developmental perspective this could be accounted for by theorising that the origins of these differences are explained by a genetic predisposition (Anholt & Mackay, 2012) i.e., that aggressive behaviour patterns and personality are inherited and biologically based. This would then suggest that there are developmental differences between desisters and persisters who have

fundamentally different predisposed characteristics. Indeed, typology research would imply that that the different characteristics found within each group are stable. Holtzworth-Monroe et al. (2003) found that most of the characteristics of their typology were stable over 3 years, but that on certain measures some of the men became less pathological over time. However, clinically, it has been suggested that change is possible in personality pathology and that not all personality is stable over time (Lenzenweger, 2006). This would therefore suggest that while there is heterogeneity in the characteristics of partner violent men, these characteristics are malleable and change over time, and that such a change is responsible for the differences found in the current sample between the three groups. In relation to the MCMI, it is suggested that personality disorders are perhaps longstanding chronic features for individuals, but that clinical syndrome scales assess acute symptomatic features of an individual's current condition (Wetzler, 1990). It has been proposed that when doing assessments using the MCMI, following treatment, clinical scales change more than personality disorder scales (McMahon et al., 1986; Millon, 1987; Piersma 1986) suggesting that some traits do change and that treatment may have an effect. In the current study, although it was identified that there were differences in the groups in personality characteristics, the underlying mechanism responsible for the group differences remain unclear because of the cross-sectional nature of the study. In order to address this, longitudinal multi-wave studies that assess repeatedly for the progression of psychopathology in the context of treatment and non-treatment are required. This will also clarify if individuals persist due to lack of treatment and others desist due to completion as this carries heavy implications for individuals' progress through the penal system.

Limitations

The data presented here highlight the potential relevance of psychopathology to IPV desistance. However, the study findings should be interpreted within the context of the study limitations. First, the study was not conducted as a means of determining if there were discrete profiles for persisters and desisters on the MCMI-III, but to examine trends and differences between these groups. The results must be approached with caution due to the modest sample size and the large numbers of statistical comparisons that were undertaken thereby limiting generalizability. Nevertheless, the current study does identify patterns of psychopathology among the groups that are consistent with empirical evidence (e.g., Craig, 2003; Gibbons et al., 2011; Gondolf, 2004).

Second, within the sample characteristics it was found that the controls were significantly older than the persisters (although there were no significant age differences between the desisters and controls and the persisters and controls). More control over the matching of the samples used is required in future research. In addition the samples were predominantly White British, and therefore this potentially limits the generalizability to other cultures. Future research needs to be extended within different cultures and ethnic populations.

Third, group classification was made based on self-report on the CTS2, which can be problematic (Cook, 2002). There is no guarantee that the controls had not used violence in their relationships, or that the desisters had stopped using violence. However, file notes were accessed for some of the desisters, and if there had been any police call outs to the desister group this would have been known, and this was not the case. The MCMI-III was also self-report and so open to response bias. The controls presented with the highest desirability scores and the persisters were less socially aware of presenting in what would be a desirable manner. However, it has been found that the debasement scale may be elevated and desirability depressed (which is

seen for the persisters in comparison with the other groups) in people reporting numerous symptoms (Tweed & Dutton, 1998). Therefore this finding in the current results might reflect a greater number of symptoms confirmed on the questionnaire by the persisters. As response bias could not be statistically controlled for, invalid profiles were removed, but any minimised and exaggerated profiles were retained for clinical reasons; minimisation and self-justification are important factors in IPV work and it has been suggested that extreme responses are clinically worth maintaining in any analysis (Heckert & Gondolf, 2000). Arguably this diversity in response bias means that the sample used is a representative group.

Fourth, the MCMI-III findings need to be extended over time because desistance was only measured up to a year. Although this is clinically meaningful (Feld & Straus, 1989), it is not clear what stage of desistance this relates to and perhaps does not represent secondary (or permanent) desistance (Gadd, 2006; Maruna et al., 2004). It is worth reiterating that desisters in the current study were conceptualized as those who had suspended the use of physical violence in their relationships for one year, and at this stage could not be classified as individuals who had achieved permanent and long-term behaviour change. Therefore, this study needs to be extended and replicated over longer time periods. On an individual basis, a clear understanding is required of how the characteristics measured on the MCMI-III play a role in desistance and persistence. The MCMI-III findings need to be repeated longitudinally, as there is debate as to whether personality is static (Duggan, 2004) or dynamic. The role that treatment plays on this process also needs to be clarified.

Direction for future research and practice

Despite these limitations, the findings are consistent with previously published literature, and consequently there are some clear implications for future research and practice. First, the

data support the individual assessment of IPV perpetrators in order to effectively treat them. Using the MCMI-III (or a comparable tool) each individual's personality pathology should be assessed in order allow practitioners to determine if pathology is a clinical or criminogenic need. This will enable the direct targeting and tailoring of treatment, consistent with the Risk-Need-Responsivity (RNR) model of rehabilitation (Andrews & Bonta, 2003; Andrews & Dowden, 2006; Andrews et al., 2006).

Bonta, Wallace-Capretta and Rooney (2000) found in an evaluation of a treatment programme for offenders under community supervision that low risk offenders who received intensive treatment had higher recidivism rates, but that high-risk offenders who received intensive treatment showed significant decreases in recidivism compared to non-treated groups. Therefore, IPV individuals who present with minimal violence and minimal psychopathology may need more simplistic / basic intervention than IPV individuals who present with high levels of violence and psychopathology. This will enable perpetrators to develop more self-awareness and better communication skills to aid them with their desistance. These individuals may benefit from treatment targets that deal with managing interpersonal conflict and day-to-day skills, as well as relationship skills that can promote healthy and balanced partnerships. However, those with more severe disorders such as borderline, paranoid, or major depression may need more intensive treatment. Men with personality disorders may need adjunctive treatments, such as psychosocial treatment (Lamont & Brunero, 2009), pharmacotherapy (Schulz et al., 2009), or cognitive behavioural treatment (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012), and may also require very different and modified supervision during treatment. For issues such as depression, a formal assessment may be needed to see if hospital treatment/medication is required. This may need to be completed prior to assessing the treatment required to change

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their behaviours that are linked to their use of violence. Consequently, by including the assessment of psychopathology prior to referral for intervention, it would be possible to determine some of the individuals for whom the current 'one size fits all approach' (Bowen, 2011) is likely to fail.

In conclusion, high levels of personality pathology were identified in those who continued to use violence against their intimate partners, and this differentiated desisters from persisters. Although both persisters and desisters have clinically meaningful traits and disorders across a broad range of characteristics, the rates and percentages are lower overall for the desisters than the persisters. The desisters were more like the controls than the persisters in their scores across the personality traits and clinical syndromes assessed. However, how these differences play a role in the desistance process needs further examination. Particularly there is a need to understand if any characteristics are more important or have more influence in relation to the likelihood of successfully desisting from IPV. Despite this, it is clear from this study that personality characteristics are associated with desistance and persistence of offending and need to be formally assessed prior to referral to intervention.

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Footnotes

¹ These are profiles based on primary elevations of the MMPI scales. For 24/42 primary elevations are on subscales 2 (depression) and 4 (psychopathic deviate) or 4 and 2

Table 1.

Percentages of clinically relevant scores for personality styles for controls desisters and persisters and significance of group on scores

Facet	Subscale	% within group where BR>74			$\chi^2(2)$	V	Control vs.	Control vs.	Desister vs.
		Controls	Desisters	Persisters			Desister	Persister	Persister
						$\chi^2_{(1)}(V)$	$\chi^2_{(1)}(V)$	$\chi^2_{(1)}(V)$	
Personality styles	1 Schizoid	0.0	10.8	16.0	8.12	.24			
	2A Avoidant	4.1	16.2	30.0	11.85*	.30	3.68 (.21)	11.69* (.34)	2.21 (.16)
	2B Depressive	0.0	16.2	42.0	30.20*	.33	8.54* (.31)	27.72* (.52)	7.71* (.30)
	3 Dependent	8.2	21.6	32.0	8.63	.25			
	4 Histrionic	28.6	21.6	12.0	4.19	.18			
	5 Narcissistic	22.4	18.9	12.0	1.91	.12			
	6A Antisocial	4.1	27.0	34.0	14.19*	.32	9.24* (.33)	14.28* (.38)	.48 (.07)
	6B Sadistic (Aggressive)	0.0	5.4	18.0	11.28*	.29	2.27 (.18)	9.70* (.31)	3.05 (.19)
	7 Compulsive	20.4	13.5	0.0	10.82*	.28	.69 (.09)	11.35* (.39)	7.16* (.29)
	8A Negativistic (Passive Aggressive)	4.1	8.1	26.0	11.52	.29			
	8B Masochistic (Self-Defeating)	2.0	8.1	26.0	13.89*	.32	1.75 (.14)	11.70* (.34)	4.53 (.23)
Personality Dysfunctions	S Schizotypal	0.0	2.7	14.0	9.69	.27			
	C Borderline	0.0	10.8	46.0	35.52*	.51	5.56 (.25)	29.36* (.55)	12.30* (.38)

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	P Paranoid	0.0	5.4	24.9	16.75*	.35	2.71 (.18)	13.38* (.36)	5.45 (.25)
Clinical Syndromes	A Anxiety	14.3	32.4	68.0	30.94*	.48	4.03 (.22)	29.42* (.55)	10.80* (.35)
	H Somatoform	0.0	0.0	8.0	7.09	.23			
	N Bipolar: Manic	4.1	16.2	32.0	13.34*	.31	3.68 (.21)	12.97* (.36)	2.80 (.18)
	D Dysthymia	0.0	0.0	34.0	33.42*	.50	0.0 (0.0)	20.11* (.45)	15.64* (.42)
	B Alcohol Dependence	4.1	35.1	40.1	19.06*	.37	14.12* (.41)	18.47* (.43)	.21 (.05)
	T Drug Dependence	10.2	21.6	38.0	10.72	.28			
	R Post-Traumatic Stress	0.0	5.4	10.0	5.08	.19			
Severe Clinical Syndromes	SS Thought Disorder	0.0	0.0	10.0	8.92	.26			
	CC Major Depression	2.0	13.5	50.0	34.83*	.51	4.28 (.22)	29.39* (.54)	12.53* (.38)
	PP Delusional Disorder	0.0	5.4	10.0	5.08	.19			

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Table 2.

Median, mean and standard deviations by group, and Kruskal-Wallis and post-hoc Mann-Whitney on personality styles and dysfunctions

Facet	Subscale	Group	Median	Mean (SD)	H (r)	Control vs. Desister z (r)	Control vs. Persister z (r)	Desister vs. Persister z (r)
Personality styles	1 Schizoid	C	39.00	38.63 (22.91)				
		D	36.00	37.30 (27.12)	19.79* (.33)	-.33 (-.04)	-4.03* (-.40)	-3.52* (-.38)
		P	65.40	58.72 (21.34)				
	2A Avoidant	C	25.00	29.49 (24.11)				
		D	36.00	38.78 (29.07)	25.17* (.42)	-1.46 (-.16)	-4.95* (-.50)	-3.03* (-.33)
		P	66.00	58.30 (26.20)				
	2B Depressive	C	14.00	20.12 (19.41)				
		D	40.00	44.68 (29.00)	38.26* (.54)	-4.07* (-.44)	-5.78* (-.58)	-2.39* (-.25)
		P	73.50	56.56 (31.41)				
	3 Dependent	C	35.00	37.27 (25.10)				
		D	44.00	46.68 (27.02)	17.02* (.35)	-1.65 (-.18)	-4.10* (-.41)	-2.18* (-.23)
		P	65.50	59.22 (25.83)				
	4 Histrionic	C	65.00	64.80 (17.56)				
		D	60.00	58.24 (18.35)	21.90* (-.40)	-1.38 (-.15)	-4.54* (-.46)	-2.97* (-.32)
		P	46.50	43.90 (24.95)				
5 Narcissistic	C	66.00	63.24 (17.13)					
	D	62.00	59.94 (18.42)	6.30 (-.21)	-1.01 (-.11)	-2.44* (-.25)	-1.43 (-.15)	

PSYCHOPATHOLOGIES OF MALE IPV DESISTERS

		P	56.00	53.66 (20.66)				
	6A Antisocial	C	38.00	42.28 (19.42)				
		D	58.00	66.65 (17.20)	36.84* (.46)	-5.00* (-.54)	-5.36* (-.54)	-1.16 (-.01)
		P	69.00	66.66 (17.51)				
	6B Sadistic (Aggressive)	C	36.00	37.79 (23.48)				
		D	62.00	56.95 (18.01)	29.35* (.47)	-3.64* (-.39)	-5.03* (-.51)	-2.05 (-.22)
		P	69.00	61.16 (21.12)				
	7 Compulsive	C	57.00	59.75 (17.32)				
		D	60.00	57.95 (15.17)	23.31* (-.38)	-.28 (-.03)	-4.37* (-.44)	-3.81* (-.40)
		P	43.50	43.00 (17.30)				
	8A Negativistic (Passive Aggressive)	C	29.00	35.57 (22.74)				
		D	50.00	47.95 (23.95)	30.09* (.46)	-3.00* (-.32)	-5.27* (-.53)	-2.55* (-.27)
		P	66.00	60.64 (24.32)				
	8B Masochistic (Self-Defeating)	C	12.00	19.14 (22.10)				
		D	60.00	41.86 (29.08)	27.14* (.46)	-3.35* (-.36)	-4.84* (-.49)	-2.24* (-.24)
		P	67.00	53.98 (31.97)				
Personality Dysfunctions	S Schizotypal	C	8.0	21.67 (22.59)				
		D	39.00	33.24 (27.73)	31.71*	-1.29 (-.14)	-5.41* (-.54)	-3.79* (-.41)
		P	64.50	54.34 (27.58)				

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C Borderline	C	12.00	20.84 (19.87)				
	D	48.00	50.05 (21.69)	64.43* (.71)	-5.20* (-.56)	-7.28* (-.73)	-3.92* (-.42)
	P	71.50	67.82 (22.85)				
P Paranoid	C	30.00	25.76 (23.40)				
	D	60.00	41.16 (29.83)	29.12* (.46)	-2.29* (-.25)	-5.26* (-.53)	-2.97* (-.32)
	P	67.50	56.26 (26.84)				

*Significant difference at $p \leq .002$ (Bonferroni adjustment from $p < .05$)

PSYCHOPATHOLOGIES OF MALE IPV DESISTERS

Table 3.

Median, mean and standard deviations by group, and Kruskal-Wallis and post-hoc Mann-Whitney on clinical syndromes

Facet	Subscale	Group	Median	Mean (SD)	H (r)	Control vs.	Control vs.	Desister vs.
						Desister	Persister	Persister
						<i>z</i>	<i>z</i>	<i>z</i>
Clinical Syndromes	A Anxiety	C	20.00	25.76 (26.92)				
		D	40.00	41.51 (33.31)	34.11* (.49)	-1.53 (-.17)	-5.61* (-.56)	-3.88* (-.42)
		P	79.00	67.84 (29.77)				
	H Somatoform	C	8.00	17.45 (22.59)				
		D	15.00	26.35 (25.62)	18.27* (.36)	-1.18 (-.13)	-3.99* (-.40)	-3.01* (-.32)
		P	61.00	45.30 (29.07)				
	N Bipolar: Manic	C	36.00	37.41 (23.59)				
		D	63.00	57.65 (20.12)	23.17* (.40)	-3.66* (-.35)	-4.39* (-.44)	-1.07 (-.11)
		P	64.50	61.42 (23.90)				
	D Dysthymia	C	8.00	14.10 (17.18)				
		D	24.00	33.05 (26.41)	39.80* (.56)	-3.20* (-.35)	-5.97* (-.60)	-3.42* (-.37)
		P	64.00	55.08 (32.39)				
B Alcohol Dependence	C	23.00	30.00 (25.48)					
	D	67.00	64.40 (18.75)	50.49* (.58)	-5.56* (-.60)	-6.42* (-.65)	-1.18 (-.13)	
	P	71.00	67.86 (21.46)					
T Drug Dependence	C	40.00	39.60 (25.43)					
	D	63.00	62.65 (18.36)	29.96* (.45)	-4.37* (-.47)	-4.88* (-.49)	-9.68 (-.10)	

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		P	67.00	64.90 (23.68)				
	R Post-Traumatic Stress	C	6.00	12.91 (17.82)				
		D	30.00	33.81 (24.68)	45.36* (.61)	-4.05* (-.44)	-6.10* (-.61)	-3.71* (-.40)
		P	62.50	54.58 (26.25)				
Severe Clinical Syndromes	SS Thought Disorder	C	15.00	22.04 (22.46)				
		D	31.00	36.73 (25.55)	45.24* (.58)	-2.45* (-.26)	-6.29* (-.63)	-4.47* (-.48)
		P	67.50	57.14 (22.01)				
	CC Major Depression	C	6.00	14.49 (22.21)				
		D	15.00	24.27 (29.03)	35.12* (.50)	-1.46 (-.16)	-5.49* (-.55)	-4.28* (-.46)
		P	74.00	59.18 (36.08)				
	PP Delusional Disorder	C	7.00	16.94 (19.86)				
		D	30.00	25.00 (27.02)	13.97* (.29)	-.44 (-.04)	-3.67* (-.36)	-2.49* (-.27)
		P	57.00	42.44 (30.18)				

*Significant difference at $p \leq .002$ (Bonferroni adjustment from $p < .05$)

PSYCHOPATHOLOGIES OF MALE IPV DESISTERS

Table 4.

Groupings derived from MCMI-III profile analysis

Personality Level	Personality description (within levels)	% (n)	Significant clinical syndromes (within levels)	% (n)
Severe (39.1%, n = 34) Severe personality pathology (BR>74)	1. Borderline disorder	58.8 (20)	1. Anxiety	76.5 (26)
	2. Paranoid disorder	17.6 (6)	2. Somatoform	5.9 (2)
	3. Atypical	23.5 (8)	3. Bipolar	44.1 (15)
			4. Dysthymia	35.3 (12)
			5. Alcohol	52.9 (18)
			6. Drug	38.2 (13)
			7. Post-traumatic	17.6 (6)
			8. Thought disorder	14.7 (5)
			9. Major Depression	61.8 (21)
			10. Delusional	20.6 (7)
Moderate (20.7%, n =18) Clinical personality pattern disorder (BR>84) and no severe personality pathology	1. Antisocial disorder	22.2 (4)	1. Anxiety	44.4 (8)
	2. Narcissistic disorder	5.6 (1)	2. Somatoform	11.1 (2)
	3. Atypical	72.2 (13)	3. Bipolar	22.2 (4)
			4. Dysthymia	22.2 (4)
			5. Alcohol	44.4 (8)
			6. Drug	38.9 (7)
			7. Post-traumatic	5.6 (1)
			8. Major Depression	27.8 (5)

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Low (40.2%, $n = 35$)	1. Narcissistic / conforming style	28.6 (10)	1.	Anxiety	34.3 (12)
No personality scale or	2. Avoidant / Depressive style	17.1 (6)	2.	Bipolar	8.6 (3)
clinical personality	3. Atypical	54.3 (19)	3.	Dysthymia	2.9 (1)
pattern trait			4.	Alcohol	20.0 (7)
			5.	Drug	20.0 (7)
			6.	Major Depression	11.4 (4)

PSYCHOPATHOLOGIES OF MALE IPV DESISTERS

Table 5.

Groupings derived from MCMI-III profile analysis by desister and persister

Personality Level	Group	% (n) within total group (D & P)	% within own group (D or P)	Personality description within group (D or P)	% (n)
Severe personality pathology (BR>74)	Desisters ^a	6.9 (6)	16.2	1. Borderline disorder	10.8 (4)
				2. Paranoid disorder	2.7 (1)
				3. Atypical	2.7 (1)
	Persisters ^b	32.0 (28)	56.0	1. Borderline disorder	32.0 (16)
				2. Paranoid disorder	10.0 (5)
				3. Atypical	14.0 (7)
Moderate Clinical personality pattern disorder (BR>84) and no severe personality pathology	Desisters	11.5 (10)	27.0	1. Antisocial disorder	10.8 (4)
				2. Narcissistic disorder	2.7 (1)
				3. Atypical	13.5 (5)
	Persisters	9.2 (8)	16.0	1. Antisocial disorder	0
				2. Narcissistic disorder	0
				3. Atypical	16 (8)
Low	Desisters	24.1 (21)	56.8	1. Narcissistic / conforming style	16.2 (6)

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No personality scale or clinical personality pattern trait				2. Avoidant / Depressive style	
				3. Atypical	10.8 (4)
					29.7 (11)
	Persisters	16.1 (14)	28.0	1. Narcissistic / conforming style	8.0 (4)
				2. Avoidant / Depressive style	
				3. Atypical	4.0 (2)
					16.0 (8)

^a n = 37
^b n = 50