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PERSONALITY CHARACTERISTICS OF PARTNER VIOLENT MEN: A Q-SORT APPROACH

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Our objective was to develop a personality profile of men who are violent toward their partners.A total of 52 experienced clinicians described either a current male patient who was violent toward his partner (and only toward his partner) or who was maritally distressed but nonviolent using the Shedler-Westen Assessment Procedure-200 (SWAP-200), a Q-sort instrument designed to harness the judgments of clinicians. Partner-violent patients showed significantly higher scores on the SWAP-200 antisocial and borderline personality disorder scales. In contrast, patients who were maritally distressed evidenced higher scores on the SWAP-200 obsessive, avoidant, and high-functioning depressive scales. The men who were violent toward their partners were more antisocial and emotionally dysregulated, which is consistent with theory, and less obsessive, which has not been theoretically explored. The groups did not differ on theoretically important dimensions of personality including paranoid, dependent, and hostile features.

Male violence toward female partners continues to be a major public health problem in the United States (U.S. Department of Health and Human Services, 2000). Partner-violent men are heterogeneous and one dimension that differentiates between subtypes is the generality of violence. Among maritally violent men, 24% to 33% (Holtzworth-Monroe, Meehan, Herron, Rehman, & Stuart, 2000; Kandel-Englander, 1992; Shields, McCall & Hanneke, 1988) are also violent toward nonfamily members and more than half of men who are court mandated for treatment have been violent toward nonfamily members in the past year (Gondolf, 1999; Hotaling, Straus & Lincoln, 1989).

Subtypes of maritally violent men also differ in personality characteristics, studied thus far with self-report measures such as the Millon Clinical

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Multiaxial Personality Inventory (Millon, Millon, & Davis, 1994) and the Minnesota Multiphasic Personality Inventory-2 (Butcher, Dahlstrom, Graham, Tellegen & Kaemmer, 1989). Studies suggest that men who are violent toward their partners have antisocial features (Beasley & Stoltenberg, 1992; Bland & Orn, 1986; Dutton & Starzomski, 1994; Hart, Dutton & Newlove, 1994; Tweed & Dutton, 1998). However, the relevant studies have failed to differentiate between partner-violent and generally violent men. Generally violent men are especially likely to have antisocial features (Babcock, Jacobson, & Gottman, 2000; Holtzworth-Monroe et al. 2000; Holtzworth-Monroe & Stuart, 1994; Waltz, Babcock, Jacobson, & Gottman, 2000). Further, studies have often focused only on antisocial characteristics and no study has differentiated between maritally violent and generally violent men and considered a full range of personality characteristics.

Our research group decided to use experienced clinicians as informants for the development of a personality profile of partner-violent men for several reasons. Clinicians tend to be sophisticated observers of human behavior (including the therapist-patient interaction). Although clinicians can and do have biases, multiple contacts with patients and the use of psychometrically sound instruments are likely to provide a more accurate description of the personality characteristics of partner-violent men than can be gleaned through self-report measures (Shedler, Mayman & Manis, 1993). Westen and his colleagues (Shedler & Westen, 1998; Westen & Harnden-Fischer, 2001; Westen, Muderrisoglu, Fowler, Shedler & Koren, 1997; Westen & Shedler, 1999a, b; Wilkenson-Ryan & Westen, 2000) have demonstrated the usefulness of clinician-report measures in studying personality and personality pathology.

The aim of the present study was to develop a personality profile of men who are violent toward their partners (and only toward their partners) using a psychometrically sound clinician-report measure. We compared the profiles of partner-violent and maritally distressed but nonviolent men. We chose the maritally distressed nonviolent comparison group to control for being in psychotherapy and to control for the possible confound of marital distress in partner-violent men.

METHOD

PARTICIPANTS

The participants were psychologists and clinical social workers willing to participate in the present study. The participants were selected from the State of Michigan's register of licensed psychologists and the Michigan Chapter of the National Association of Social Workers' register of board certified clinical social workers. Those who were engaged in private practice or practiced within a mental health clinic in Michigan were surveyed by mail to determine if they were currently treating a male patient who, in the past year, had been violent toward only their partner, violent toward both a partner and nonpartner, or who had not been violent toward either their partner or toward nonpartners, but were maritally distressed. Clinicians who indi-

cated that they were currently working with a patient who was violent toward their partner only or a nonviolent maritally distressed patient, seen for at least five psychotherapy sessions, were invited to participate in a study to develop a personality profile of partner-violent men. Violence was operationalized as having "hit, kicked, punched, or otherwise hurt" their partner or a nonpartner in the past year.

Among the respondents were 108 clinicians with a partner-violent patient and 326 clinicians with a maritally distressed patient. Research materials were sent to an equal number of male and female psychologists and social workers seeing partner-violent and maritally distressed patients. Concordant with our available funding, we sent research materials to 80 clinicians, selected on the basis of years of experience, of whom 71% provided data. A total of 25 clinicians provided data describing a patient who was violent toward his partner and not toward nonpartners. A total of 27 clinicians provided data describing a patient who was not violent toward either his partner or toward nonpartners and was maritally distressed. Five clinicians provided data on a patient who was violent toward both a partner and a nonpartner in the past year and these data were not included in the final data analysis. After a complete description of the study, each clinician provided informed written consent and described one patient, who remained completely anonymous. The respondents were paid an honorarium of $60 for their participation. The study was approved by the institutional review board of the Wayne State University School of Medicine, Detroit, Michigan.

MEASURES

The clinicians completed a questionnaire asking about themselves and their clinical practices. Questions concerned the responding clinician's age, ethnicity, length of clinical practice, practice setting, theoretical orientation, and whether they were a psychologist or clinical social worker. Clinicians also completed a questionnaire about one of their patients. Questions about patients concerned the length of treatment, treatment setting, referral information, demographic information, DSM-IV clinical diagnosis at the beginning of psychotherapy, history of psychiatric hospitalizations, number of arrests within the last 5 years, whether the patient had been violent toward partner and nonpartner within the past year, and developmental history (e.g., family stability, physical and sexual abuse, violence-related behaviors, absence of father). Clinicians also described their patient's enduring personality patterns using the Shedler-Westen Assessment Procedure-200 Q-sort (SWAP-200; Westen & Shedler, 1999a, b).

The SWAP-200 Q-sort includes 200 items to assess personality and personality pathology. The 200 items subsume descriptive statements derived from DSM-III and DSM-IV Axis II diagnostic criteria, research on healthy and pathological personality traits, and clinical literature on personality and personality disorder.The item set was refined through extensive feedback from over 1,000 clinicians who applied the SWAP-200 to a hypothetical, prototypical patient for each of the Axis II disorders or to one of their patients. The hypothetical, prototypical composite profiles yield Personality

Disorder scores for each DSM-IV Axis II disorder. The composite profiles derived from descriptions of actual patients yield Q-factor scores.

Each SWAP-200 Q-sort item is printed on a separate index card. The 200 cards are sorted into eight categories, ranging from 0 ("irrelevant to the patient being described") to 7 ("highly descriptive of the patient being described"). Westen and Shedler (1999a) indicate that "SWAP-200 statements are written in a manner close to the data (e.g., 'Tends to be passive and unassertive' or 'Living arrangements are chaotic and unstable') and items that require inference about internal processes are written in clear and unambiguous language (e.g., 'Is unable to describe important others in a way that conveys a sense of who they are as people; descriptions lack fullness and color' or 'Tends to blame others for own failures or shortcomings; tends to believe his or her problems are caused by external factors'). Writing items in this way minimizes idiosyncratic and unreliable interpretive leaps" (p. 261). These features allow clinicians of any theoretical orientation to describe patients reliably.

The SWAP-200 yields both categorical and dimensional diagnostic information for the personality disorder scores, as well as a high functioning scale. A diagnosis can be derived by correlating a patient's SWAP-200 Q-sort profile with empirically derived prototypes of each DSM-IV personality disorder. This process yields an MMPI-like profile using T-scores to determine the extent to which a patient matches each Axis II disorder. A patient's profile may yield a categorical diagnosis (e.g., antisocial personality disorder) if a patient's score exceeds the cutoff T-score for the antisocial subscale of 60 (i.e., one standard deviation above a mean of 50; J. Shedlar, personal communication, January 20, 2003). Dimensional scores can also be used by eliminating cutoffs. In addition to the traditional DSM-IV categories, Westen and Shedler (1999a, b) have developed empirically derived diagnostic clusters using Q-analysis, which is similar to factor analysis (Block, 1961). Like the traditional diagnostic categories, the Q-factor scores are converted to T-scores with a mean of 50 and a standard deviation of 10.

In their study of personality disorders, Westen and Shedler (1999b) reported internal consistency (coefficient α) $\geq .90$ for the SWAP-200 for each diagnostic category derived from the Q-sort approach (both personality disorder and Q-factor scores). Westen and Muderrisoglu (2001) reported interrater reliabilities of the SWAP-200 for 24 outpatients at greater than .80. Validity has been assessed by comparing the profiles of actual patients with particular diagnoses and the profiles of prototypical patients with the same diagnoses. The validity coefficients ranged from .79 to .93 (Westen & Shedler, 1999b). Correlations between SWAP personality disorder scores and clinician ratings of personality ranged from .57 to .70 (Wilkenson-Ryan & Westen, 2000). Validity has also been supported by correlations between Global Assessment of Functioning (GAF) ratings and the SWAP-200 psychological health scale. The correlation between the high-functioning SWAP scale and GAF ratings was .48 (Westen & Shedler, 1999b). In a sample of eating disordered patients, the SWAP-200 Q-factor scores demonstrated incremental validity beyond Axis I diagnosis in pre-

dicting eating disorder symptoms and adaptive functioning (Westen & Harnden-Fischer, 2001).

STATISTICAL ANALYSIS

Characteristics of the clinicians and of the patients in the two groups were compared with the *t*-test for continuous variables, and χ^2 or one-tailed Fisher's Exact tests for nominal data. SWAP-200 data were converted to Personality Disorder and Q-factor scores following Westen and Shedler's (1999b) procedures. Comparisons between the two groups were made with multivariate analysis of variance (MANOVA) tests, with analysis of variance (ANOVA) follow-up tests as appropriate.

RESULTS

STUDY GROUP CHARACTERISTICS

Clinicians who provided data included 33 psychologists and 19 social workers. Of the clinicians, 56% were male and 90% were Caucasian. The clinicians were experienced, with an average of 20.6 years (*SD* = 7.1) of clinical practice. With respect to clinical orientation, 50% described their orientation as psychodynamic, 27% as cognitive behavioral, and 23% as eclectic.The patients had been in psychotherapy for an average of 15.0 months (*SD* = 12.0, range = 2 to 58 months). More of the partner-violent men had been referred for psychotherapy by the courts (24% of the partner-violent vs. 0% of the maritally distressed, Fisher's Exact test, $p = .02$).

The partner-violent and maritally distressed men did not differ in most demographic characteristics. The partner-violent men were younger (M = 38.84 [SD = 9.05]) than the maritally distressed men (M = 43.85 [8.72], $t(50) = 2.03$, $p = .05$). A total of 83% of the patients were Caucasian. In terms of socioeconomic status, evaluated on a 5-point scale, 2% were identified as poor, 25% were identified as working class, 29% were identified as middle class, 40% were identified as upper-middle class, and 4% were identified as upper class. With respect to education, 2% had not completed high school, 25% had completed high school, 19% had some college, 29% had graduated from college, and 25% had completed graduate work. With respect to employment, 4% were described as unable to keep a job, 6% were described as not working, 11% were described as having frequent job changes, 31% were described as not working to potential, and 48% were described as working to potential. Few of the patients (15%) had been hospitalized for psychiatric reasons as an adult and few (9%) had a history of sexual abuse while growing up. Consistent with their group status, more of the partner-violent men had been physically abused while growing up (52% of the partner-violent vs. 19% of the maritally distressed, Fisher's Exact test, $p < .01$), and had witnessed physical abuse within the home (44% vs. 15%, Fisher's Exact test, $p < .01$). More of the partner-violent men had been arrested in the past 5 years (60% of the partner-violent vs. 4% of the maritally distressed, Fisher's Exact test $p < .001$). As noted earlier, patients who had been violent toward

TABLE 1. SWAP–200 Personality Disorder T–Scores for Partner Violent and Maritally Distressed Patients

Personality Disorder	Partner Violent (*N* = 25)	Maritally Distressed (*N* = 27)	F (*df* = 1,51)	Effect Size Cohen's *d*
Paranoid	51.84 (9.43)	47.09 (8.67)	3.58	
Schizoid	44.29 (8.10)	46.48 (8.38)	0.92	
Schizotypal	44.71 (7.83)	44.60 (8.52)	0.01	
Antisocial	55.91 (8.52)	47.85 (5.56)	16.59***	1.12
Borderline	50.43 (9.50)	42.44 (7.80)	11.04**	.92
Histrionic	50.30 (6.69)	45.48 (7.03)	6.41*	.70
Narcissistic	53.84 (9.09)	48.11 (6.98)	6.58*	.71
Avoidant	43.02 (7.76)	47.23 (7.83)	3.78*	.54
Dependent	43.19 (8.06)	47.34 (7.58)	3.67	
Obsessive	47.17 (8.39)	52.55 (6.20)	6.98**	.73
High Functioning	51.64 (9.56)	59.28 (9.09)	8.72**	.82

Note. SWAP-200 = Shedler-Westen Assessment Procedure-200; df = degrees of freedom. *$p < .05$; **$p < .01$; ***$p < .001$.

nonpartners were excluded from the study to avoid the confound of global violence versus nonviolence.

PATIENT DIAGNOSTIC INFORMATION

Clinicians rated the most severe level of violence toward partners by the partner-violent men as "mild" for 28%, "moderate" for 56%, and "severe" for 16% of the men. More of the partner-violent patients were rated by their therapists as having alcohol use problems (56% of the partner-violent vs. 7% of the maritally distressed, Fisher's Exact test, $p < .01$). The patient groups did not differ significantly on clinician-rated drug use problems (16% of the partner-violent and 4% of the maritally distressed; Fisher's Exact test, $p = .19$). All of the partner-violent and 93% of the maritally distressed patients had at least one DSM-IV Axis I diagnosis as determined by the clinician at intake. The most common diagnoses for both groups were depression (major depressive disorder [MDD], dysthymia, depression not otherwise specified [NOS]) and Adjustment Disorders.The two groups did not differ statistically in the number of patients who had at least one Axis II diagnosis (56% of the partner-violent vs. 40% of the maritally distressed patients, Fisher's Exact test, $p < .21$). The most common Axis II diagnosis was Narcissistic Personality Disorder for the partner-violent group and Personality Disorder NOS for the maritally distressed group. Partner-violent patients had lower Axis V GAF ratings (53.2 [*SD* = 6.7] for partner-violent vs. 59.7 [*SD* = 10.9] for maritally distressed patients, $t(50) = 2.56$, $p < .01$).

SWAP-200 PERSONALITY CHARACTERISTICS

The SWAP-200 yields personality disorder scores based on prototypes of Axis II disorders and yields empirically derived Q-factor scores. We began by

TABLE 2. Personality Styles Q–Factor Scores for Partner Violent and Maritally Distressed Patients

Personality Style	Partner Violent (N = 25)	Maritally Distressed (N = 27)	F (df = 1,51)	Effect Size Cohen's d
Dysphoric	43.79 (8.12)	46.79 (6.71)	2.12	—
Antisocial	56.12 (8.78)	48.11 (5.81)	15.26***	1.10
Schizoid	45.38 (7.83)	46.80 (8.32)	.40	—
Paranoid	50.43 (7.96)	47.35 (9.02)	1.69	—
Obsessive	53.20 (9.59)	60.24 (8.71)	7.70**	.77
Histrionic	49.99 (5.55)	49.67 (7.24)	.03	—
Narcissistic	44.42 (10.69)	45.68 (10.73)	.18	—
Avoidant	43.55 (7.57)	48.37 (6.99)	5.70*	.66
Hi FX Depressive	49.69 (9.18)	55.72 (7.52)	6.74**	.72
Emotionally Dysregulated	46.05 (8.78)	40.66 (8.69)	4.93*	.62
Dependent	47.74 (8.72)	45.99 (8.04)	.57	—
Hostile	52.04 (8.91)	50.37 (8.57)	.47	—

Note. df = degrees of freedom. *$p < .05$; ** $p < .01$; ***$p < .001$.

comparing SWAP-200 personality disorder scores of partner-violent and maritally distressed men, shown in Table 1. The differences were tested with MANOVA, Wilk's (11, 40) = 2.74, $p < .01$. The results of the follow-up ANOVA tests are shown in Table 1. The partner-violent men had higher scores on Antisocial, Borderline, Histrionic, and Narcissistic personality disorder scales (T-scores for partner-violent men for these disorders show relative, but not absolute elevations, because the normative sample consisted exclusively of patients with personality disorders). The maritally distressed men had higher scores on Avoidant and Obsessive personality disorder scales and on the High Functioning scale. The effect sizes are medium to large, with the Antisocial PD scale showing the largest effect size.

We continued by comparing the SWAP-200 Q-factor scores of men in the two groups, which reflects their match to empirically derived personality disorder prototypes, rather than DSM-IV personality disorders. These results are shown in Table 2. The differences between the groups in the Q-factor scores were tested with MANOVA, Wilk's (12, 39) = 2.36, $p = .02$. The partner-violent men had higher Q-factor scores on Antisocial and Emotionally Dysregulated scales. The maritally distressed men had higher Q-factor scores on the Obsessive, Avoidant, High Functioning Depressive scales, and on the High Functioning scale. The effect sizes are medium to large, with the Antisocial Q-factor scale showing the largest effect size.

A strength of the Q-sort methodology is that it allows researchers to provide a narrative description of the average profile of a group useful for clinical work, by rank ordering items that characterize each group in descending order of diagnostic importance (i.e., from those with the highest to the lowest mean rankings). Tables 3 and 4 list the 16 items that best describe each of the groups.

TABLE 3. Composite Description of Maritally Distressed Psychotherapy Patients (*n* = 27)

Item	Mean Score
Tends to be conscientious and responsible.	4.52
Appreciates and responds to humor.	4.52
Has difficulty acknowledging or expressing anger.	4.41
Tends to feel she or he is inadequate, inferior, or a failure.	4.04
Has moral and ethical standards and strives to live up to them.	4.04
Is articulate; can express self well in words.	4.00
Tends to be angry or hostile (whether consciously or unconsciously).	3.93
Tends to feel guilty	3.78
Enjoys challenges; takes pleasure in accomplishing things.	3.74
Tends to be anxious.	3.74
Tends to elicit liking in others.	3.74
Tends to be controlling.	3.63
Tends to get into power struggles.	3.59
Tends to express aggression in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).	3.56
Tends to be critical of others.	3.56
Tends to feel unhappy, depressed, or despondent	3.48

Note. Items are listed in descending order of diagnostic importance.

DISCUSSION

Although several investigators have assessed personality pathology in partner-violent men (Beasley & Stoltenberg, 1992; Bland & Orn, 1986; Dutton & Starzomski, 1994; Hart et al., 1994; Tweed & Dutton, 1998), the present study compares a broad range of personality characteristics of psychotherapy patients who are violent toward their partners and only toward their partners or are maritally distressed. The groups are different in Personality Disorder scores, empirically derived Q-factor scores, and individual items from the SWAP-200.

With respect to the personality disorder score profiles, the partner-violent men are higher in cluster B personality characteristics (e.g., antisocial, borderline, histrionic, narcissistic), reflecting a dramatic and emotional quality that is more characteristic of partner-violent than maritally distressed men (Beasley & Stoltenberg, 1992; Dutton, 1998). The maritally distressed men are higher in two of three cluster C personality characteristics (e.g., avoidant and obsessive), reflecting a more anxious and inhibited quality. The picture of the two groups of men is supported when we consider the Q-factor scores. Unlike the personality disorder scores of the SWAP-200, which were developed from descriptions of prototypical patients with personality disorders, Q-factor scores were derived from Q-analysis of descriptions of actual patients with personality pathology. With the Q-factor scores, the partner-violent men have higher scores on the Antisocial and Emotionally Dysregulated dimensions, whereas maritally distressed men have higher scores on the Obsessive, Avoidant, and High Functioning Depressive scales. The two groups do not differ on the Q-factor scales Dependent and Hostile. Although

TABLE 4. Composite Description of Partner Violent Psychotherapy Patients (*n* = 25)

Item	Mean Score
Tends to be controlling.	4.56
Tends to be angry or hostile (whether consciously or unconsciously).	4.12
Tends to react to criticism with feelings of rage or humiliation.	3.76
Tends to feel misunderstood, mistreated, or victimized.	3.76
Tends to act impulsively, without regard for consequences.	3.68
Tends to be conflicted about authority (e.g., may feel he or she must submit, rebel against, win over, defeat, etc.).	3.68
Tends to express intense and inappropriate anger, out of proportion to the situation at hand.	3.56
Tends to hold grudges; may dwell on insults or slights for long periods.	3.56
Tends to become irrational when strong emotions are stirred up; may show a noticeable decline from customary level of functioning.	3.52
Tends to be critical of others.	3.52
Tends to get into power struggles.	3.44
Tends to feel unhappy, depressed, or despondent.	3.32
Enjoys challenges; takes pleasure in accomplishing things.	3.32
Tends to break things or become physically assaultive when angry.	3.24
Tends to fear she or he will be rejected or abandoned by those who are emotionally significant	3.20
Seeks to dominate an important other (e.g., spouse, lover, family member) through violence or intimidation.	3.20

Note. Items are listed in descending order of diagnostic importance.

both dependency and hostility have been theoretically associated with partner violence (Dutton, 1998; Tweed & Dutton, 1998), the relevant studies have lacked maritally distressed control groups. The maritally distressed men are more guilty and unhappy in spite of a generally high level of functioning (High Functioning scale and GAF rating).

Consideration of the items endorsed ranked highly by the reporting clinicians describing the men in the two groups gives us a clearer picture of their dynamics and allows us to elaborate the findings. Previous studies have identified partner-violent men as being angry and hostile. In the present data, men in both groups are angry or hostile, critical, and unhappy. Men in both groups are concerned with rejection or abandonment, which has also been identified in previous research as a component of the "abusive personality" (Bowlby, 1984; Dutton, 1998). Although both groups tend to be controlling, the controlling item was the first-ranked or most salient item for the partner-violent men (mean score = 4.56) and was 12th ranked for the maritally distressed men (mean score = 3.63). The most characteristic items of men in the partner-violent group have to do with feelings of rage, humiliation, being mistreated or victimized, and impulsivity. The cluster of items suggests that the partner-violent men are quite vulnerable (Cogan, Porcerelli, & Dromgoole, 2001) with poor coping mechanisms (Porcerelli, Cogan, Kamoo & Leitman, in press). Only 2 of 18 items characterize a healthy attribute in the partner-violent men. The most characteristic items of the men in the maritally distressed group include both positive and negative features. The positive features of the maritally distressed men include

conscientiousness and appreciation of humor. The problematic features include difficulty acknowledging or expressing anger and feelings of inadequacy, guilt, and anxiety. Unlike the partner-violent men, the maritally distressed men are high functioning, with many strengths, but are inhibited and mildly depressed.

Men in both groups evidenced clinically relevant suffering and conflict. Using J. Shedler's suggestion (personal communication, January 20, 2003) that personality disorder T-scores one SD or more above the mean may be the best cutoff value for identifying personality disorders, 10 of 25 partner-violent men (40%) and 6 of the 27 maritally distressed men (22%) had a personality disorder. The treating clinicians reported that 56% of the partner-violent and 40% of the maritally distressed men had at least one Axis II clinical diagnosis. The difference between frequency of SWAP-200 and clinical diagnoses was not statistically significant (Fisher's Exact Test, $p = .23$). If, however, we chose to use the Westen and Shedler criteria (1999a) of two SD above the mean, only one of the partner-violent patients and none of the maritally distressed patients would have received a personality disorder diagnosis. Thus, the criteria of one SD appears to be warranted given the fact that the standardization sample consisted entirely of patients with personality disorders. There is a need for normative SWAP-200 data.

Although the partner-violent men have higher scores than the maritally distressed men on the personality disorder and Q-factor Antisocial scales, these scale elevations mainly reflect problems with affect regulation and impulsivity. In the partner-violent men, we do not find the lack of morality and empathy that characterizes the patient with antisocial-psychopathic personality. In the men who are violent only toward their partners we do not see as salient characteristics the absence of remorse for injuring others and we do not see the pleasure in being sadistic or aggressive toward others that characterize the SWAP-200 descriptions of the antisocial-psychopathic person. Although the partner-violent men have higher scores than the maritally distressed men on the Borderline personality disorder scale and the Q-factor Emotionally Dysregulated scale, they do not have the overwhelming out of control quality and extreme feelings of inadequacy or helplessness or the level of neediness and despondency that characterize patients with borderline personality disorder (Wilkenson-Ryan & Westen, 2000).

LIMITATIONS

There are several limitations of the present study. First, the sample size is relatively small, which becomes particularly important because we are interested in scales on which the two groups do not differ and the small sample size risks Type II errors. Although we have emphasized the importance of differentiating partner-violent only from generally violent men, in fact, we did not include a generally violent group in the present work and this needs to be done in a future study. Finally, the patients had been in psychotherapy for more than a year on the average and it is possible that differences between the groups may have been muted because of the effects of psychotherapy.

Our research group plans a study that includes a nationally representative sample of experienced psychiatrists, psychologists, and social workers and expanded groups of violent patients. Our data suggest that Q-sort methodology in the hands of clinicians can provide important contributions to the understanding of partner-violent men, which we believe can aid in the development of more effective psychotherapeutic strategies.

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