Mental health characteristics of men who abuse their intimate partner

E Calvete

Deusto University. Psychology department.

ABSTRACT

The prevalence of psychopathological disorders amongst men who abuse their intimate partners has yet to be established. This article reviews studies carried out to ascertain the mental health characteristics of male domestic abusers. Most of these studies are based on samples of abusers under treatment or in prison. They generally assess the presence of psychopathological disorders through self-reports and diagnostic interviews are infrequently used. The results of this research show that domestic abusers tend to obtain high points for some types of personality disorders, especially narcissistic, antisocial and borderline disorders. They also present symptoms of depressive disorders and consumption of drugs and alcohol. Some studies also show that neurological problems are relatively frequent. Finally I discuss the limitations of current research and the implications for treatment of domestic abusers.

Key Words: Spouse Abuse, Psychopathology, Personality Disorders, Depression, Alcoholism, Substance Related Disorders.

Text received: May 2008 Text accepted: June 2008

Violence against women is one of the most serious problems of our society. There are various types of violence including psychological violence, harassment, sexual abuse and physical violence, which can result in homicide in its cruellest form[1]. Only in 2007, 72 women have been killed by their partners in Spain. Furthermore, data show an upward trend in this problem. For example, the comparison of two studies carried out in 1999 and 2006 have shown that prevalence rates in the general population have increased from 8.05% to 17.9% regarding physical assault and from 11.48% to 30.1% regarding sexual abuse[2-3]. Domestic abuse has severe consequences on the victims' physical and mental health, and can even evolve into various problems such as post-traumatic stress disorder, depression, anxiety and consumption of alcohol and drugs. Moreover, there is often an overlap between violence against women and violence against children. It is estimated that children are direct victims as well in around 50% of the cases. In the rest of cases they are witnesses to violence, aspect which can seriously harm their affective development[4].

As a consequence of the above mentioned, the study of violence against women has experienced a remarkable increase in the last two decades. Most of the studies have focused on the impact of domestic abuse on the victims in comparison with a relatively low number of studies focused on domestic abusers. However, from a preventive perspective, it is essential to identify the factors associated with men using violence against their intimate partner. As a result, it has been hypothesized that abusers could present particular psychopathological traits, which could cause them to be violent with their partner. This article reviews the main studies carried out on mental health characteristics of domestic abusers.

TYPES OF DOMESTIC ABUSERS

The presence of mental health problems has precisely been one of the criteria applied for most typologies of abusers. The most cited typology is likely to be that of Holzworth-Munroe and Stuart[5] which, based on evidence of three different dimen-

sions of aggression (severity of violence, generality of violence and presence of psychopathology or personality disorder) suggested the existence of three types of abusers:

The first type corresponds to the *family only abuser* who is described as less deviant on a number of indicators including impulsivity, alcohol and drug abuse and criminal behaviour. They are likely to show poor social skills and communication, a history of exposure to aggression in the family of origin and high levels of dependence on their partner. Their relationships tend to be relatively stable and in comparison with other types of abusers, family only abusers show higher levels of remorse after an assault. They represent approximately 50% of abusers.

The second type has been called the *borderline/dysphoric* abuser. They tend to get involved in moderate to severe violence. They show emotional problems, especially those related to anger management and jealousy. They are likely to show a history of parental rejection, child abuse, high levels of dependence on their partner, poor social skills and communication, hostile attitudes towards women and low levels of remorse for their violence.

The third type is the *generally violent/antisocial* abuser. They tend to use moderate to severe physical, psychological and sexual violence. These men are likely to have a family of origin history of abuse and involvement with delinquency. They also present deficits in social skills as well as positive attitudes towards violence and likely view violence as an appropriate response to any provocation. According to Holzworth-Munroe and Stuart[5], antisocial and narcissistic personality disorders are common in this group. Subsequent studies have shown that this typology does not justify all the cases. For instance, the same team of researchers have identified a fourth group of abusers, those called the low-level antisocial domestic abusers, who represent 33% of the sample studied[6]. The typology provided by Holzworth-Munroe and Stuart was essentially theoretical, but others, very similar, have been later developed by means of empirical methods. As a result, for instance, it has been possible to distinguish between domestic abusers without pathological traits, dependant passive/aggressive abusers and antisocial abusers[7]. It has also been possible to distinguish between the family only abuser with no pathology, the pathological abusers (the dysphoric/borderline) and the psychopath or antisocial type[8].

Therefore, typologies such as those mentioned earlier have emphasized psychopathological traits as the differential characteristics of some types of domestic abusers. In particular, most of these typologies refer to personality disorders (PD) and to other psychological difficulties such as depression, anxiety and substance abuse. Table 1 presents a summary of various studies on the presence of these problems amongst male domestic abusers[9-22], and the following sections describe the most important findings.

PERSONALITY DISORDERS

Most of the studies which have evaluated the psychopathology of male domestic abusers, have focused on personality disorders (PDs). These personality disorders are categorized in the DSM-IV-R-Axis II[23]. They often have their origin in childhood and are referred to as perception and social relationship patterns that are relatively chronic, generalized and rigid. As a result, people showing these disorders often have dysfunctional social relationships. These individuals do not spontaneously seek help and when they do, it has often been imposed to them.

As shown in Table I, the most relevant personality disorders amongst domestic abusers are the *borderline* type, showing general unstableness regarding interpersonal relationships, self-image, affectivity as well as impulsiveness. The *narcissistic* type is characterized by grandiosity, a need for admiration and a lack of empathy. The *antisocial* type is characterized by contempt and violation of people's rights. And finally the *paranoid* type, who has a resentful and distrustful character as well as a tendency to react with anger and aggressiveness.

Ferrer and his collaborators have reviewed, in a meta-analytic study, the research carried out between 1988 and 1998 and have concluded that although domestic abusers obtain high scores in PD, the difference, in comparison with other groups, is little[24]. Posterior to the period in which the evaluation took place, new studies have been published.

One of the most important is that of Gondolf, who evaluated 840 domestic abusers under court-referred treatment and compared them to two other samples (600 psychiatric patients and 100 people under treatment for drug consumption)[15]. According to his results, 90% of domestic abusers presented clinical personality patterns, especially the narcissistic type (25%), negativist (24%), antisocial (19%), and depressive (19%). However, only 49% of them showed scores high enough to indicate a personality disorder. In addition, in contrast with other studies, Gondolf found that relatively few abusers obtained high scores for borderline disorder (6%).

	Samples	Measures	Results for abusers
Beasley and Stoltenberg (1992)[9]	49 men in abusive and 35 in non-abusive but distressed relationships	MCMI-II Inventory of Narcissistic Personality STAI	Higher scores in the narcissistic, antisocial, schizoid, borderline and aggressive/sadistic personality disorders, as well as in state and trait anxiety.
Belfrage and Rying (2004)[10]	164 perpetrators of spousal homicide	Interview to evaluate DSM.IV criteria. Psychopathy scale PCL-SV	All cases except 5 have been diagnosed with at least one disorder. 36% psychosis, 3% dysthymia, 11% major depression, 2% substance abuse. PDs: 1% paranoid, 5% antisocial, 4% borderline, 1% histrionic, 6% narcissistic, 15% not specified.
Boyle and Vivian (1996)[11]	263 men in marital therapy (94 non-violent, 69 moderately violent and 100 severely violent). A community comparison group made up of men satisfied with their relationship partners.		The severely violent men showed higher levels of anger, depressive symptoms.
Else, Wonderlich, Beatty and Christie (1993)[12]	21 male domestic abusers and 21 non-abusers	MMPI and PDS	Abusers obtained higher scores in borderline and antisocial personality disorders. No differences found in depression symptoms or in alcohol consumption.
Flournoy and Wilson (1991)[13]	56 male abusers treated for domestic violence	MMPI	Abusers were characterized by addiction and depression tendencies
Gavazzi, Julian, and McKenry (1991)[17]	152 abusers whose use of violence against partner has been evaluated	BSI (Brief Symptom Inventory)	Violent men showed higher scores in depression, general and phobic anxiety, hostility, paranoid ideation, interpersonal sensitivity and psychoticism subscales.
Gondolf (1999)[15]	840 abusers under court-referred treatment	MCMI-III	11% major depression 40% anxiety disorder 90% scored positive for at least one PD (25% narcissistic, 24% passive-negative, 19% antisocial, and 19% depression) 26% had received treatment for alcohol or drug consumption in the past.
Grann and Wedin (2002)[16]	88 male domestic abusers in prison	PCL-R and other measures	51% alcohol or drugs abuse or dependence 27% psychopathy
Hamberger and Hastings (1991)[17]	38 alcoholic domestic abusers 61 non-alcoholic domestic abusers 92 men from the community amongst which 28 are violent.	MCMI	Abusers obtained higher scores in borderline personality disorder, especially those who were alcoholic as well
Hanson, Cadsky, Harris, Lalonde (1997)[18]	997 men divided into non-abusive (184), moderately-abusive (517) and severely abusive (296) according to a self-report test	Questionnaire with multiple measures	Men who obtained high scores in abusive behaviour showed to a large extent antisocial PD, stress symptoms, and substance consumption

	Muestras	Medidas	Resultados para los maltratadores
Hart, Dutton, and Newlove (1993)[19]	85 self- and court- referred domestic abusers	MCMI-II, Interview	The interview showed a prevalence of PD of 50%. The MCMI-II showed that 80-90% presented some PD, especially the narcissistic (58%) and antisocial (60%) disorders.
Sugihara and Warner (1999)[20]	60 domestic abusers and a community sample of 45 non-abusers	MCMI-III	Abusers obtained higher scores in various PDs, showing greater differences in paranoid, schizoid, schizotypical personality.
Estudios en España			
Echeburua, Fernández-Montalvo (2007)[22]	54 domestic abusers in prison	SCL-90-R	Levels of psychopathological symptoms similar to those of the general population. Psychiatric history is more frequent in abusers who had not attempted homicide.
Echeburua y Fernández-Montalvo (2007)[22]	162 domestic abusers in prison	SCL-90-R	12% showed probable psychopathy 71% had previous psychiatric history

Note. MCMI = The Millon Clinical Multiaxial Inventory, MMPI = The Minnesota Multiphasic Personality Inventory, BSI = the Brief Symptom Inventory, SCL-90-R = The Symptoms Check List-90-Revised, PCL-R = Hare's Psychopathy Checklist-Revised.

Table I. Description of some studies which have evaluated the mental health characteristics of male domestic abusers.

Gondolf's study, like most of the studies described in Table I, have been criticized for being based on self-reports[25]. In order to study personality disorders with a different methodology, Belfrage and Rying evaluated the 162 cases of intimate partner homicide which had taken place in Sweden between 1990 and 199910.

They reviewed the existing forensic reports, applied new measures and carried out interviews when possible (he found in his study that 24% of cases had committed suicide after the homicide).

Finally, and to close this section, there are studies which have exclusively focused on psychopathic traits associated essentially with the antisocial type of domestic abusers[26-27]. These traits include behavioural and lifestyle characteristics, such as impulsivity and antisocial behaviours, together with interpersonal and affective characteristics, such as lack of remorse as well as empathy, egocentrism and manipulation[10]. There are various studies carried out in prisons on psychopathy amongst domestic abusers, but they proved to be little consistent regarding the rates obtained. For example, Echeburua and Fernández-Montalvo[22] found a rate of 12%, much lower than that found in other studies[16]. In addition, antisocial domestic abusers in prison proved to be different from other antisocial delinquents in prison regarding some psychopathic traits. Specifically, they seem to be characterized by an inadequate affective experience and by less impulsivity and irresponsability[27].

DEPRESSION AND ANXIETY

Literature also shows that domestic abusers can present more psychopathological disorders categorized in the DSM-IV- Axis I than the general population. Amongst them, depressive disorders are the most prevalent. Those would be consistent overall with the borderline/dysphoric type of domestic abuser[26]. In the above-mentioned study carried out by Gondolf, 20% of abusers presented severe mental disorders classified in Axis I, when anxiety disorders or alcohol and drug dependence have not even been taken into consideration[15]. The most characteristic disorder was major depression (11% of the total sample). In Gondolf's opinion, depression did not seem to be a consequence of recent incidents (assault, detention) since he found that 31% of those depressed had attempted suicide or had threatened to do it in the past. As a matter of fact, it was observed that 22% of the sample had undergone some type of treatment for mental health problems in the past (8% medication, 16% psychological therapy, 6% psychiatric hospitalization)[28]. The prevalence rate of major depression that Gondolf found was similar to that

found in other studies based on men accused of intimate partner homicide[10]. As it is mentioned above, Gondolf did not count anxiety cases classified in Axis I because he thought that since this disorder is present in 40% of the cases, it could be reactive to the fact of having been arrested and referred to a programme for domestic abusers. Other studies have also observed higher scores in anxiety amongst domestic abusers[9,24].

CONSUMPTION OF ALCOHOL AND DRUGS

Various studies coincide in the finding of high rates of alcohol and drug consumption in domestic abusers[29]. For instance, Gondolf found that 26% of the sample had received treatment for alcoholism or drug consumption in the past[15]. Grann and Wedin evaluated 88 inmates convicted for intimate partner homicide or assault and found that 51% of them presented a problem of alcohol or drug abuse or dependence (31% alcohol only, 5% alcohol and another drug, and 16% multiple substances)[16].

Besides, alcohol and drug consumption seems to be directly related to violent behaviours[30,31]. For instance, Sharps and his collaborators found that two thirds of domestic abusers accused of homicide or attempted homicide had taken alcohol, drugs or both before the incident[32]. In another study, Fals-Stewart examined the diary study of couples with a history of violence during 15 months and found that a severe episode of violence is 11 times more likely to happen in the days in which the man had consumed alcohol. In addition, 60% of the episodes took place during the 2 hours of drinking[31].

Substance abuse such as barbiturate, amphetamine, opiate, cocaine and combinations of alcohol/cocaine have also been associated with violence. Particularly, cocaine consumption is receiving a lot of attention. Logan, Walker, Station and Lenkefeld[33] have divided 500 inmates according to the level of violence committed against their intimate partners (mild, moderate, extreme) and by means of interviews, they have evaluated the substance consumption. They found that those in the group of extreme violence reported 2 years more of regular cocaine consumption (4.5 years) than those in the group of moderate violence (2.9 years) or those in the group of mild violence (2.6 years). Logan and his collaborators put forward different alternative explanations for the association between cocaine and violence. For example, cocaine can cause violence on account of its pharmacological effects or can worsen and boost an aggressive and hostile temperament, which contributes to violence or, finally, cocaine abuse and violence may simply be two demonstrations of antisocial behaviour.

NEUROLOGICAL PROBLEMS

The presence of neurological deficits amongst domestic abusers is a subject which has hardly been explored[34]. For instance, Rosenbaum and his collaborators compared a sample of 53 domestic abusers with another sample of 45 men satisfied with their relationship partners and one of 32 men with conflictive relationships[35]. They found that head injury was significantly associated with domestic abuse, since the prevalence rate of head injury was considerably higher in the domestic abusers group compared to the other groups. Specifically, 83.79% of the domestic abusers group showed head injury which was clinical in 52.83% of abusers. They could also prove that in 93.1% of the cases of domestic abusers with head injury, the injury was prior to the abuse. In later work, it was observed that 48% of a sample of domestic abusers showed neuropsychological disorders. This percentage is much higher than that found in the control group (4.3%)[36].

Certain neurological and neuropsychological deficits (especially those of the frontal and/or temporal lobe) can increase the potential for impulsive aggressive actions. An interpretation of this type of findings is that neurological deficits could reduce the capacity of impulse control which in the case of impulsive violence could result in an aggressive action. As a matter of fact, an impulsive behavioural style combined with a particular cognitive trait is one of the most consistent risk factors associated with violent behaviour[37]. However, there can also be other interpretations. Prior impulsivity could increase not only the risk of head injury, for example through a greater proneness to accidents but also the risk of violent behaviour. Alcohol consumption is also a contributing risk factor not only for domestic abuse but also brain damage, for instance through reckless driving.

CONCLUSIONS AND IMPLICATIONS FOR THE TREATMENT OF DOMESTIC ABUSERS

The above review shows that the group of domestic abusers is likely to present various psychopathological disorders, but there is inconsistency between

studies regarding the nature or prevalence of these disorders. In general, there is certain consensus in that personality disorders are relatively prevalent amongst domestic abusers, especially the narcissistic and antisocial disorders, which would be characteristic of the *antisocial* type of abusers. However, and probably due to the use of different evaluation strategies, prevalence rates vary considerably from one study to another. On this respect, it is important to clarify that most of the studies are based on self-reports (for example the MCMI) and do not get to use diagnostic interviews. As a consequence, results can be biased by different factors such as the social desirability, difficulties in understanding the items,etc.[25]. On the other hand, it is also important to specify that the personality disorders found amongst domestic abusers are comprised within the range of those obtained in general prison population, since this type of disorders is the most prevalent amongst this group38. For example, in a recent study López-Barrichina, Lafuente and García-Latas found prevalence rates of narcissistic and antisocial disorders of 59.7 and 47.5% respectively[39].

This review also shows that depressive disorders are prevalent, especially in the dysphoric/borderline subtype of domestic abusers, and that such disorders are not likely to be a consequence of abuse and detention but that they existed before. Finally, problems with alcohol and other drugs are frequent amongst domestic abusers, and seem to play a key role in unleashing violent actions. It is important to point out that most of the studies currently available have been carried out in the United States and that very few have been carried out in Spain. However, the psychopathological profile of domestic abusers could differ depending on the cultural circumstances. For example, the mental health characteristics of domestic abusers in Sweden are considerably different from those found in the United States[10]. This alerts us on the need to carry out more research in our setting.

In spite of limitations, the results of the available studies have clinical implications. Concretely, the use of typologies of domestic abusers and the identification of psychopathological traits amongst them can be useful in order to determine both the efficacy of treatments and the risk of future recidivism[40].

Domestic abusers characterized by antisocial personality disorder and psychopathic traits present a higher risk of recidivism16. Besides, their response to standard treatment for domestic violence is low [8,26], probably due to the fact that their lack of remorse and empathy with the victims strongly suggest very little motivation to change. Alcohol and drug consumption are also factors associated with their decision to abandon the treatment programme[8]. In contrast, the dysphoric type of domestic abusers, who often presents symptoms of depressive disorder, is likely to be much more motivated to receive treatment and such treatment normally achieves a better result[41]. The fact that treatment efficacy depends on the type of domestic abusers has led to develop specific programmes. For instance, the antisocial type of abusers with psychopathic traits seems to have a poor response to therapy in heterogeneous groups. The treatment of choice is normally that of a homogeneous group with institutional support or individualized cognitive-behavioural treatment. In contrast, cyclical and emotionally unstable abusers respond better to therapy in heterogeneous groups and also benefit from other therapeutic approaches36.

Finally, this review has shown that neurological problems are relatively frequent amongst domestic abusers. Thus, it would be advisable to evaluate their presence in cases in which there may be some type of damage, in order to include adequate strategies of neuropsychological rehabilitation[36].

In summary, domestic abusers tend to frequently show personality disorders and other psychopathological problems, although there is no consensus on their prevalence. The fact that most of studies have taken place in Anglo-Saxon countries and that very few have been carried out in Spain suggest the need for news studies in our setting.

BIBLIOGRAPHIC REFERENCES

1. Mahoney P, Williams LM, West C M. Violence against women by intimate relationship partners. En Renzetti CM, Edleson JL, Bergen RQ (Eds.). Sourcebook on violence against women; Thousand Oaks, CA: Sage; 2001. p. 143-178.
2. Medina-Ariza J, Barberet R. Intimate partner violence in Spain: Findings from a national survey. Violence Against Women 2003; 9: 302-22.
3. Calvete E, Corral S, Estévez A. Factor structure and validity of the Revised Conflict Tactics Scales for Spanish women. Violence Against Women 2007; 13: 1072-87.
4. Edleson JL. The overlap between child maltreatment and woman abuse. 1999[acceso 20 de diciembre de 2006]. Disponible en http: //www.vaw.umn.edu/documents/vawnet/overlap/overlap.html

5. Holtzworth-Munroe A, Stuart GL. Typologies of male batterers: Three subtypes and the differences among them. Psychol Bull 1994 Nov; 116: 476-97
6. Holzworth-Munroe A, Meehan JC, Herron K, Rehman U, Stuart GL. Do subtypes of maritally violent men continue to differ over time? J Consult Clin Psychol 2003; 71: 728-40
7. Hamberger LK, Lohr JM, Borge D, Tolin DF. An empirical classification of motivations for domestic violence. Violence Against Women 1997; 3: 401-23.
8. Langhinrichsen-Rohling J, Huss MT, Ramsey S. The Clinical Utility of Batterer Typologies. J Fam Violence 2000; 15: 37-53.
9. Beasley R, Stoltenberg CD. Personality characteristics of male spouse abusers. Professional Psychology: Research & Practice 1992; 23: 310-17.
10. Belfrage H, Rying M. Characteristics of spousal homicide perpetrators: a study of all cases of spousal homicide in Sweden 1990-1999.Crim Behav Ment Health 2004; 14: 121-33.
11. Boyle DJ, Vivian D. Generalized versus spouse-specific anger/hostility and men's violence against intimates. Violence Vict 1996; 11: 293-317.
12. Else L, Wonderlich SA, Beatty WW, Christie DW, Staton RD. Personality characteristics of men who physically abuse women. Hosp Community Psychiatry 1993 Jan; 44: 54-8.
13. Flournoy PS, Wilson GL. Assessment of MMPI profiles of male batterers. Violence Vict 1991; 6: 309-20.
14. Gavazzi SM, Julian TW, McKenry PC. Utilization of the Brief Symptom Inventory to discriminate between violent and nonviolent male relationship partners. Psychological Reports 1996; 79: 1047-56.
15. Gondolf EW. MCMI-III results for batterer program participants in four cities: Less "pathological" than expected J. Fam. Violence 1999; 14: 1–17.
16. Grann M, Wedin I. Risk factors for recidivism among spousal assault and spousal homicide. Psychology, Crime and Law 2002; 8: 5-23.
17. Hamberger LK, Hastings JE. Personality correlates of men who batter and violent men: Some continuities and discontinuities. J Fam Violence 1991; 6: 131-47.
18. Hanson P K, Cadsky O, Harris A, Lalonde C. Correlates of battering among 997 men: Family history, adjustement, and attitudinal differences. Violence Vict 1997; 12: 191-208.
19. Hart S, Dutton D, Newlove T. The prevalence of personality disorders among wife assaulters. Personal. Dis 1993; 7: 329-41.
20. Sugihara Y, Warner JA. Mexican-American male batterers on the MCMI-III. Psychol Rep. 1999; 85: 163-9.
21. Echeburúa E, Fernández-Montalvo J, Amor PJ. Psychopathological profile of men convicted of gender violence: A study in the prisons of Spain. J Interpers Violence 2003; 18: 798-812.
22. Echeburua E, Fernández-Montalvo J. Male batterers with and without psychopathy: an exploratory study in Spanish prisons. Int J Offender Ther Comp Criminol. 2007; 51: 254-63.
23. DSM-IV-R. Manual diagnóstico y estadístico de los trastornos mentales. Barcelona Masson, 2001.
24. Ferrer V, Bosch E, García E, Manassero MA, Gili M. Estudio Meta-Analítico de Características Diferenciales entre Maltratadores y no Maltratadores: El Caso de la Psicopatología y el Consumo de Alcohol o Drogas. PSYKHE. 2004; 13: 141-56.
25. Dutton D. MCMI Results for Batterers: A Response to Gondolf. Journal of Family Violence. 2003; 18: 253-5.
26. Huss M, Langhinrichsen-Rohling J. Assessing the generalization of psychopathy in a clinical sample of domestic violence perpetrators. Law Hum Behav. 2006; 30: 571-86.
27. Swogger MT, Walsh Z, Kosson DS. Domestic violence and psychopathic traits: distinguishing the antisocial batterer from other antisocial offenders. Aggress Behav. 2007; 33: 253-60.
28. Gondolf EW. Characteristics of Batterers in a Multi-site Evaluation of Batterer Intervention Systems. 1996[acceso 20 de marzo de 2008]. Disponible en http: //www.mincava.umn.edu/documents/gondolf/batchar.html
29. Tilley DS, Brackley M. Men who batter intimate partners: a grounded theory study of the development of male violence in intimate partner relationships. Issues Ment Health Nurs. 2005; 26: 281-97.
30. Easton CJ, Mandel DL, Hunkele, KA, Nich C, Rounsaville, BJ, Carroll KM. A Cognitive Behavioral Therapy for Alcohol-dependent Domestic Violence Offenders: An Integrated Substance Abuse–Domestic Violence Treatment Approach (SADV). The American Journal on Addictions, 2007; 16: 24-31.
31. Fals-Stewart W. The occurrence of partner physical aggression on days of alcohol consumption: a longitudinal diary study. J Consult Clin Psych. 2003; 71: 41–52.

32. Sharps PW, Campbell J, Campbell D, Faye G, Webster D. The role of alcohol use in intimate partner femicide. Am J Addict. 2001; 10: 122-35.
33. Logan TK, Walker R, Staton M, Lenkefeld C. Substance Use and Intimate Violence Among Incarcerated Males. Journal of Family Violence 2001; 16: 93-114.
34. Corvo K, Halpern J, Ferraro FR. Frontal Lobe Deficits and Alcohol Abuse: Possible Interactions in Predicting Domestic Violence. Journal of Aggression, Maltreatment & Trauma 2006; 3: 49-63.
35. Rosenbaum A, Hoge SK, Adelman SA, Warnken WJ, Fletcher KE, Kane RL. Head Injury in Partner-Abusive Men. J Consult Clin Psychol. 1994 Dec; 62: 1187-93
36. Teichner G, Golden CJ, Van Hasselt VB, Peterson A. Assessment of cognitive functioning in men who batter. Int J Neurosci. 2001; 111: 241-53.
37. Calvete E. Justification of Violence and Grandiosity Schemas as Predictors of Antisocial Behavior in Adolescents. J Abnorm Child Psychol. En prensa.
38. Arroyo JM, Ortega E. Un programa de mejora de la calidad asistencial de los problemas de salud mental en prisión. Evaluación de resultados después de 6 años (2000-2005) Rev Esp Sanid Penit. 2007; 9: 11-20.
39. López-Barrachina R, Lafuente O, García-Latas JL. Del mito de Narciso a los trastornos de la personalidad en las cárceles aragonesas: Una aproximación al perfil de estos desórdenes en las personas privadas de libertad. Rev Esp Sanid Penit. 2007; 9: 53-63
40. Sellbom M, Ben-Porath YS, Baum LJ, Erez E, Gregory C. Predictive validity of the MMPI-2 Restructured Clinical (RC) Scales in a batterers' intervention program. J Pers Assess. 2008; 90: 129-35.
41. Bowen E, Gilchrist E. Predicting dropout of court-mandated treatment in a British sample of domestic violence offenders. Int J Offender Ther Comp Criminol. 2004; 48: 215-34.
42. Lawson DM, Dawson TE, Kieffer KM, Perez LM, Burke J, Kier FJ. An integrated feminist/cognitive-behavioral and psychodynamic group treatment model for men who abuse their partners. Psychology of Men and Masculinity, 2001; 2: 86-99.

CORRESPONDENCE

Esther Calvete
Psychology department
Deusto University
Apdo. 1, 48080 Bilbao
Telephone: 94 413 9000 (Ext. 2228)
E-mail: ecalvete@fice.deusto.es