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THE GESTALT RESISTANCES AND MILLON'S TYPOLOGY OF PERSONALITY DISORDERS: A CORRELATIONAL STUDY WITHIN A CLINICAL SAMPLE OF MALE BATTERERS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

John J. Wagner, M.A

The Ohio State University

1998

Dissertation Committee:

Dr. Darcy Haag-Granello, Co-Advisor

Dr. Michael Klein, Co-Advisor

Dr. John Gibbs

Approved by

[Signatures]
ABSTRACT

Research has shown that male batterers have a tendency to exhibit high incidences of personality disorders and resistance to treatment. The purpose of this study was to investigate the relationships between the various Gestalt resistances and Theodore Millon’s typology of personality disorders. The major objective of this research study was to provide empirical insight into which of the GCSQ-150 scales were discriminating variables between those subjects in the “disorder” and “trait” categories on six of the MCMI-III Personality Disorder Scales.

The subjects consisted of one-hundred and twenty eight voluntary males throughout the state of Ohio who have been arrested for domestic violence and are currently enrolled in a domestic violence specific treatment program. The subjects completed two instruments, the Millon Clinical Multiaxial Inventory-III (MCMI-III; Millon, 1994) and the Gestalt Contact Styles Questionnaire-150 (GCSQ-150; Woldt, Kepner, and Prosnick, 1996). Discriminant analysis was utilized in order to statistically analyze the correlations between the various Gestalt resistances and Millon’s typology of personality disorders.

Overall, the results tentatively suggest that there is a relationship between the Gestalt resistances and Millon’s (1994) typology of personality disorders. In particular the discriminant function of the GCSQ-150 Projection Scale produced three statistically
significant hypotheses for the MCMI-III Passive Aggressive Personality Disorder Scale and the discriminant function of the GCSQ-150 Projection and Retroflection produced three statistically significant hypotheses for the MCMI-III Antisocial Personality Disorder Scale. The MCMI-III Narcissistic Personality Disorder Scale produced two statistically significant hypotheses (from discriminant function of GCSQ-150 Deflection, Projection, Retroflection, and Egotism) and the MCMI-III Borderline Personality Scale produced one statistically significant hypothesis (from a discriminant function of GCSQ-150 Retroflection and Desensitization Scales).

Thus, several of the hypotheses were statistically significant, the practical meaning of such findings is questionable. More research into the specific nature of the relationships between these two constructs is, undoubtedly, warranted. Additionally, this study demonstrated the need for future research to focus on the differences between the various “typologies” of male batterers and to develop less arbitrary psychometric instruments for measuring family violence.
Dedicated and offered up to my Lord and personal Savior Jesus Christ, who alone has the power to heal every single man, woman, and child whose life have been forever changed due to domestic violence. In His Glorious name, I pray for peace, healing, and revival.
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VITA

July 29, 1967 ................................................... Born - Parma Heights, Ohio

August, 1990 ................................................... Bachelor of Arts - Kent State University
Speech Communication, Psychology

May, 1994 ........................................................ Master of Arts - The University of Akron
Marriage and Family Therapy

June, 1997 ........................................................ The Gestalt Institute of Cleveland
Three Year Post Graduate Training Program
Specialization: Working with Groups

FIELDS OF STUDY

Major Field: Education
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CHAPTER 1

INTRODUCTION

Statement of the Problem

Currently, domestic violence is reaching epidemic proportions in the United States. Spousal abuse is the leading cause of injuries to women aged 15-44 years, exceeding injuries from accidents, muggings, and cancer deaths combined (Dwyer, Smokowski, Bricout, & Wodarski, 1995). One third of all females treated in emergency rooms are alleged victims of domestic violence (Berry, 1996). Estimates vary between 21-34% (Brown, 1993) and 25-50% (Berry, 1996) as to the number of all females who will, predictably, be victims of domestic violence within their lifetime.

Currently, domestic violence is a clinically perplexing phenomenon that continues to challenge mental health professionals. Feldman and Ridley (1995), in attempting to explain the potentially poor prognosis for treating male batterers, have suggested that: a) a significant proportion of the current research has focused on describing the process of domestic violence and its consequences, rather than on the determinants and potential influences of violence among family members; b) there is much difficulty in sifting through the vast array of potential interpersonal, intrapersonal, and societal factors in order to ascertain which factors are most reliable and consistent; c) little attention has been placed on delineating logical conclusions between the theory, etiology, assessment, and treatment
of spousal abuse; and d) the development of rigorous and adequate outcome studies has been sluggish due to numerous practical and ethical issues.

Additionally, from a clinical perspective, there is evidence to suggest that many clinicians are inadequately trained to effectively assess and recognize the severity of domestic violence. Hansen, Harway, and Cervantes (1991), for example, suggest that therapists often fail to recognize violence as a presenting problem even when clearly indicated, minimize the seriousness of identified violence, recommend inappropriate interventions, and inaccurately diagnose both the offender and the victim.

Thus, within the field of domestic violence treatment, it appears that the lack of knowledge, continuity, and clinical training is a major impediment to effectively understanding and ameliorating the problem of spousal abuse. Clearly, mental health clinicians are in desperate need of increased knowledge and training with regard to the assessment and treatment of male batterers.

Rationale for the Current Study

In order to effectively reduce or ameliorate the increasing prevalence and severity of domestic violence, it is imperative that mental health clinicians possess adequate assessment and diagnostic knowledge and skill. More specifically, a clinician who works with male batterers must have sufficient clinical knowledge and skill in accurately assessing and treating issues related to personality disorders and resistances to treatment.

Personality Disorders

Several researchers have utilized the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1977) and the Millon Clinical Multiaxial Inventory-II (MCMI-II; Millon, 1987)
and found that male batterers exhibit exceedingly high prevalence rates of personality disorders. A series of studies by Hamberger and Hastings (1985, 1986) utilizing the MCMI found that 88% of the subjects demonstrated evidence of a personality disorder.

Similarly, Hart, Dutton, and Newlove (1994) administered the MCMI-II and the Personality Disorder Examination (PDE) to a clinical sample of both self and court referred male batterers. The MCMI-II revealed that between 80-90% of the subjects met the diagnostic criteria for personality disorders, while the PDE revealed that 50% met such criteria. These studies suggest that clinicians who assess and treat male batterers will, at some point during their career, encounter clinical issues related to personality disorders.

The current literature on the personality disorders of male batterers suggests that several specific disorders are more prevalent than others. Among clinical samples of male batterers, the MCMI and MCMI-II Personality Disorders of Antisocial (Beasley & Stoltenberg, 1994; Hart et al., 1994; Murphy, Le-Meyer, & O’ Leary, 1994), Narcissistic (Beasley & Stoltenberg, 1992; Hamberger & Hastings, 1985, 1986), Borderline (Beasley & Stoltenberg, 1992; Hamberger & Hastings, 1985, 1986; Hart et al., 1994), Schizotypal (Beasley & Stoltenberg, 1992; Hamberger & Hastings, 1985, 1986), Passive-Aggressive (Murphy et al., 1994), and Aggressive (Sadistic) (Beasley & Stoltenberg, 1992; Murphy et al., 1994) have been found to be the most prominent.

Previous research on the personality disorders of male batterers has used the earlier two editions of the MCMI, and a study that attempts to replicate these findings by using the MCMI-III (Millon, 1994) is warranted. The current study was the first known
study to utilize the MCMI-III in examining the personality disorders within a clinical sample of male batterers.

Resistances to Treatment

Male batterers have traditionally been known to be highly resistant to treatment (Berry, 1996; Carden, 1994; Shields & Hanneke, 1983). In addition to lacking in empathy, insight, and personal accountability, male batterers often blame others, deny their problems, and minimize their behaviors (Holtzworth-Munroe, 1988, 1992; Holtzworth-Munroe & Hutchinson, 1993). Clearly, such resistances have significant clinical implications, particularly with regard to challenging the clinician’s therapeutic capabilities and keeping the male batterer “stuck” in his maladaptive cognitive and behavioral patterns.

The Gestalt therapy model has identified 6 major resistances, or contact styles, that an individual exhibits in order to avoid, or resist, establishing contact with either his or her environment or other individuals. In applying the Gestalt model to a clinical sample of male batterers, the resistances refer to the manner in which an individual opposes or thwarts the therapeutic process. There has been only one known empirical study that has examined the Gestalt resistances of male batterers (Carden, 1993). Carden (1993) utilized the Gestalt Contact Style Questionnaire-Revised (GCSQ-R; Woldt & Kepner, 1986) in her research.

Prosnick (1996) expanded upon the GCSQ-R by adding two additional resistance scales, Egotism and Transfluence, and naming it the Gestalt Contact Styles Questionnaire-150 (GCSQ-150; Prosnick, 1996). In the final chapter of his dissertation, Prosnick (1996) recommended that future research focus on studies which further examine the reliability
and validity of the GCSQ-150. The present study was the first to empirically validate the GCSQ-150 by expanding upon Carden’s (1993) findings and providing further empirical data about the Gestalt resistances of male batterers.

Additionally, this study was the first known study to empirically examine the relationships between the Gestalt resistances and Theodore Millon’s typology of personality disorders. Millon is, arguably, one of the leading authorities on personality disorders and the creator of the MCMI, MCMI-II, and MCMI-III.

Purpose of the Study

The purpose of this study was to investigate the relationships between the various Gestalt resistances and personality disorders among a clinical sample of male batterers. More specifically, the various Gestalt resistances were empirically examined within the context of Millon’s typology of personality disorders.

This study focused on males who have physically abused their intimate female partners. It is beyond the purpose and scope of this study, however, to examine the phenomenon of domestic violence within the context of the female as being the aggressor and perpetrator. This does not, in any way, imply that spousal abuse always involves the male as the perpetrator and the female as the victim. Indeed, there is some evidence to suggest that an increasing number of females are being identified as perpetrators of domestic violence (Straus & Gelles, 1990). Future research in this area is, undoubtedly, warranted.

Significance of the Study
This study has a significant implication for mental health practitioners. By understanding the relationship between the various personality disorders and Gestalt resistances, clinicians may be able to develop more individualized and effective assessment and treatment strategies. After completing the intake and assessment process, the clinician must determine whether or not a male batterer has met the diagnostic criteria for a personality disorder. If a diagnosis of a personality disorder is clinically warranted, the clinician may be able to utilize the results of this study in order to gain valuable insight into the male batterer’s potential resistances. Such insights would, undoubtedly, be a critical component in the development of more individualized and specialized treatment strategies.

Definitions of Terms

Before discussing the research questions and hypotheses for this study, it is important for the reader to be aware of important concepts and definitions. Several key terms will be been conceptually and operationally defined below. Included are the general definitions for each of personality disorders relevant to this study and the eight scales of the GCSQ-150 -Introjection, Projection, Retroflection, Desensitization, Deflection, Confluence, Egotism, Transfluence.

**Male Batterer** - There are many different definitions of a “male batterer” within the current literature. For the purposes of this study, a male batterer is conceptually defined as a male who has been arrested and convicted of domestic violence for physically abusing his intimate female partner and who is court mandated to seek domestic violence specific treatment. Such a definition should not, in any way, minimize the fact domestic violence also includes verbal, sexual and economic abuse, in addition to various other
forms of threats, coercion, and intimidation. A substantial amount of research suggests that males who physically abuse their intimate female partner are also likely to engage in such other abusive and controlling behaviors (Carden, 1994; Murphy & O’Leary, 1989; Straus, 1974).

**Personality Disorder** - An enduring, inflexible, and pervasive pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. Such a pattern, beginning in adolescence and active across a broad range of personal and social situations, leads to clinically significant impairment in social, occupational, or other areas of functioning and is not due to direct physiological effects of a substance or medical condition (Diagnostic and Statistical Manual of Mental Disorders, Fourth edition (DSM-IV; 1994, pp. 275-276). For the purposes of this study, a personality disorder is operationally defined as a Base Rate score of 85 and above on the various personality disorder scales of the MCMI-III.

Personality styles (and disorders) reflect deeply etched and pervasive characteristics of a patient’s functioning. These characteristics tend to perpetuate themselves and aggravate everyday difficulties. They are so embedded and automatic that the patient is often unaware of their nature and of their self-destructive consequences. These advanced stages of personality pathology reflect a slow, insidious deterioration of the personality structure and usually accentuate the patient’s lifelong style of functioning. Despite evident changes in psychic cohesion, social competence, and emotional control, the patient continues to display the major personality characteristics that were previously evident (Millon, 1994, p.11).

**Schizoid Personality Disorder** - A pervasive pattern of detachment from social relationships, beginning by early adulthood and present in a variety of contexts, and
characterized by a restricted range of emotion, a preference for solitary activities, an indifference to both criticism and praise, lack of interest or pleasure in sexual activities, and few, if any, close friends or relatives (DSM-IV, 1994).

According to Millon (1994), “Schizoid patients are noted by their lack of desire and their capacity to experience pleasure or pain. They tend to be apathetic, listless, distant, and asocial” (p. 11). For the purposes of this study, Schizoid Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Schizoid Personality Disorder Scale.

**Narcissistic Personality Disorder**- A pervasive pattern of grandiosity, beginning in early adulthood, and characterized by a need for admiration, lack of empathy, sense of entitlement, extreme arrogance, interpersonal exploitiveness, unrealistic sense of self-worth, and preoccupation with fantasies of success, power, beauty, and brilliance (DSM-IV, 1994).

According to Millon (1994), “Narcissistic individuals are noted for their egoistic self-involvement. They experience pleasure by focusing on themselves… They maintain an air of arrogant self-assurance, and, without much thought or even conscious intent, benignly exploit others to their advantage” (p. 12). For the purposes of this study, Narcissistic Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Narcissistic Personality Disorder Scale.

**Antisocial Personality Disorder**- A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15, and characterized by impulsivity, irritability,
According to Millon (1994), “Antisocial individuals act to counter the pain and depredation they expect from others... They are irresponsible and impulsive, qualities they believe are justified because they judge others to be unreliable and disloyal” (p. 12). For the purposes of this study, Antisocial Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Antisocial Personality Disorder Scale.

Aggressive (Sadistic) Personality Disorder - This personality disorder was deleted from the DSM-IV (1994). However, Millon (1994) has maintained it in the MCMI-III in order to recognize that there are those individuals who may not be publicly judged as “antisocial” but who, nonetheless, derive pleasure and satisfaction from humiliating and violating the rights of others. Such individuals are typically hostile, dominating, antagonistic, combative, and persecutory, while also exhibiting extreme indifference or pleasure at the destructive consequences of their brutal and abusive behaviors (Millon, 1994).

According to Millon (1994), “These individuals are generally hostile and pervasively combative, and they appear to be indifferent to or pleased by the destructive consequences of their contentious, abusive, and brutal behaviors. Although many cloak their more malicious and power-oriented tendencies in publicly approved roles and vocations, they give themselves away by their dominating, antagonistic, and frequently persecutory actions” (p. 13). For the purposes of this study, Aggressive (Sadistic)
Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Aggressive (Sadistic) Personality Disorder Scale.

**Passive Aggressive Personality Disorder (Negativistic Personality Disorder)** - A pervasive pattern of negativistic attitudes and passive resistance to demands of adequate performance, beginning by early adulthood, and characterized by complaints of being misunderstood and unappreciated, sullenness and argumentativeness, a tendency to scorn authority, resentment towards others who are more fortunate, and resistance to fulfilling routine obligations (DSM-IV).

According to Millon (1994), “Passive aggressive individuals struggle between working towards their own rewards and the rewards offered by others. They experience endless wrangles and disappointments as they vacillate between deference and defiance. They display an erratic pattern of explosive anger or stubbornness intermingled with periods of guilt and shame” (p.13). For the purposes of this study, Passive-Aggressive Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Passive-Aggressive Personality Disorder Scale.

**Borderline Personality Disorder** - A pervasive pattern of instability in interpersonal relationships and self-image, beginning in early adulthood, and characterized by frantic efforts to avoid real or perceived abandonment, identity disturbance, impulsivity, recurrent suicidal gestures, dissociative symptoms, paranoid ideations, temper outbursts, and chronic mood swings (DSM-IV, 1994).

According to Millon (1994), “Individuals with borderline personality variants have structural defects and experience intense endogenous moods, with recurring periods of
dejection and apathy, often interspersed with spells of anger, anxiety, or euphoria. Additionally, many reveal recurring thoughts of self-mutilation and suicide" (p. 14). For the purposes of this study, Borderline Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Borderline Personality Disorder Scale.

Resistance- From the Gestalt perspective, resistances are the various mechanisms that individuals utilize in order to avoid achieving contact with either his or her environment or significant others. When chronically overused, resistances are likely to lead to pervasive patterns of maladaptive and pathological behavior (Perls, 1993). For the purposes of this study, the Gestalt resistances will be operationally defined as an individual’s raw score on each of the 8 subscales of the GCSQ-150.

Introjection- The process by which an individual uncritically accepts information from either the environment or others without challenging or questioning the meaning, value, or personal usefulness of such information (Perls et al., 1951). The individual passively accepts “what is” and incorporates information into his or her self-schema without regard for his or her own values, wants, beliefs, or the appropriateness of such information. For the purposes of this study, Introjection is operationally defined as an individual’s raw score on the Introjection subscale of the GCSQ-150.

Projection- The process by which an individual attributes those undesirable or unacceptable traits found within him or herself onto either the environment or others (Perls, 1973). Thus, such an individual is likely to disown his or her feelings and impulses and transfer them onto either the environment or others. For the purposes of this study,
Projection is operationally defined as an individual’s raw score on the Projection subscale of the GCSQ-150.

Retroflection—Literally meaning “turning back sharply against” (Perls, 1973, p. 40), it is the process by which an individual withholds his or her desire to interact with either the environment or others and, instead, treats him or herself in a way originally intended for another object or individual. Instead of directing his or her energy outward, such an individual substitutes him or herself as the primary target of the behavior. For the purposes of this study, Retroflection is operationally defined as an individual’s raw score on the Retroflection subscale of the GCSQ-150.

Deflection—The process by which an individual reduces the intensity of interpersonal contact by engaging in distracting or inappropriate behavior (The Gestalt Institute of Cleveland, 1995). Changing the subject, avoiding eye contact, using inappropriate humor, being overly talkative, focusing on details, and using language loaded with minimization’s, qualifiers, and excuses are several mechanisms by which an individual may deflect in order to avoid contact or intimacy with others. For the purposes of this study, Deflection is operationally defined as an individual’s raw score on the Deflection subscale of the GCSQ-150.

Desensitization—The process by which an individual detaches him or herself from all internal, sensory, or bodily sensations (Kepner, 1982). Such an individual chronically and habitually “numbs” him or herself and is, thus, unable to recognize or identify any internal feelings or sensation. For the purposes of this study, Desensitization is
operationally defined as an individual's raw score on the Desensitization subscale of the GCSQ-150.

**Confluence** - The process by which an individual, often out of fear of differences, merges with his or her environment to the extent that there is minimal differentiation between self and environment (Perls et al., 1951). Such an individual is likely to look to the environment, rather than inward, in order determine his or her wants, needs, or desires. For the purposes of this study, Confluence is operationally defined as an individual's raw score on the Confluence subscale of the GCSQ-150.

**Egotism** - Perls et al. (1951) described egotism as a fixation, a way of avoiding contact by becoming overly controlled, rigid, and indecisive. An egoist is likely to resist letting go and, thus, entering into the final stage of contact in which the individual and the organism reciprocally interact in the process of change. Having a tendency to suppress his or her sense of creativity and spontaneity, an egoist is more likely to prefer interaction which is highly structured, predictable, deliberate and controlled. Such interaction often leads to intense feelings of boredom, loneliness, fear, and staleness. For the purposes of this study, Egotism is operationally defined as an individual's raw score on the Egotism subscale of the GCSQ-150.

**Research Questions**

The major objective of this study was to provide empirical insight into the following questions:

1. Which of the Gestalt resistances are the most powerful discriminators between those male batterers who meet the MCMI-III diagnostic criteria for personality disorders
(BR ≥ 85) and those male batterers who do not meet the MCMI-III diagnostic criteria for personality disorders (BR ≤ 84)?

2). Which of the Gestalt resistances are the most powerful discriminators between those male batterers who meet the MCMI-III diagnostic criteria for personality "traits" (BR ≥ 75 and ≤ 84) and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "traits" (BR ≥ 85 and ≤ 74)?

3). Which of the Gestalt resistances are the most powerful discriminators between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR ≥ 85) and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74)?

Hypotheses

Eighteen hypotheses were generated for this study. Although several different Gestalt resistances may correlate with the various personality disorders, only those Gestalt resistances which have strong theoretical support from Millon's (1994) typology will be presented. As such, the hypotheses for this study will focus on six MCMI-III personality disorders (Schizoid, Narcissistic, Antisocial, Aggressive (Sadistic), Passive Aggressive (Negativistic), and Borderline), and six of the eight GCSQ-150 scales (Introjection, Projection, Retroflection, Desensitization, Deflection, and Egotism). The GCSQ-150 scales of Confluence and Transfluence were not supported by a sound theoretical rationale and are not included in the hypotheses.
The hypotheses are broken down into six categories, each representing one of the six MCMI-III scales relevant to this study. Within each category, there are three separate hypotheses measuring and comparing individuals across three domains of each variable: those individuals who meet the MCMI-III diagnostic criteria for a particular personality "disorder", those individuals who meet the MCMI-III diagnostic criteria for particular personality "trait", and those individuals who do meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait".

Schizoid Personality Disorder (Scale 1)

Hypothesis One- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III criteria for Schizoid Personality Disorder (BR > 85) and those male batterers who do not meet the MCMI-III criteria for Schizoid Personality Disorder (BR ≤ 84).

Hypothesis Two- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 75 and ≤ 84) on the Schizoid Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Schizoid Personality Disorder Scale.

Hypothesis Three- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR ≥ 85) on the
Schizoid Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR \leq 74) on the Schizoid Personality Disorder Scale.

**Rationale for Hypotheses One, Two, and Three** - Millon and Davis (1996) labeled the defense mechanism of a schizoid individual as “intellectualization”. Often being detached from his or her emotional experience, he or she is likely to be highly intellectual, analytical, and logical. A schizoid individual’s inner experience is characterized by an emotional void or emptiness.

Schizoids engage in few complicated unconscious processes. Relatively untroubled by intense emotions, insensitive to interpersonal relationships, and difficult to arouse and activate, they hardly feel the impact of events and have little reason to devise complicated intrapsychic defenses and strategies. They do harbor segments of the residuals of past memories and emotions, but, in general, their inner world lacks the intensities and intricacies found in all other pathological personalities (Millon & Davis, 1996, p. 232).

Such a description clearly suggests that a schizoid individual has developed an ability to “numb” him or herself and become desensitized to any emotional or sensory experiences. In such circumstances, it is not only the painful and unacceptable feelings that are deadened because, as Kepner (1983) noted, a highly desensitized individual also “numbs” him or herself to pleasurable and enjoyable sensations. Additionally, this is likely to lead to the suppression of creativity and spontaneity and, instead, facilitate the rigid and highly controlled behavioral patterns of the individual.

**Narcissistic Personality Disorder (Scale 5)**
Hypothesis Four - Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male batterers who meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≤ 84).

Hypothesis Five - Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 75 and ≤ 84) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Narcissistic Personality Disorder Scale.

Hypothesis Six - Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR ≥ 85) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74) on the Narcissistic Personality Disorder Scale.

Rationale for Hypotheses Four, Five, and Six - Millon and Davis (1996) labeled the defense mechanisms of the narcissist individual as "rationalization/fantasy". Once the narcissist is unable to continue rationalizing his or her behavior, he or she is likely to resort to creating fantasies in order to comfort and console him or herself. Implicit in this process is the tendency for the narcissist to distract oneself and, thus, deflect unacceptable
feelings and impulses onto the safe and reliable context of the fantasy. Millon and Davis (1996) has suggested that if such fantasies fail to provide the narcissist with the necessary psychic protection, he or she may, as a last resort, project these unacceptable feelings and impulses onto others.

From a Gestalt perspective, Perls (1969) has suggested that narcissism is the extreme form of retroflection. Similarly, a narcissist is likely to be high in egotism, as evidenced by his or her obsession or “fixation” (Perls, et al., 1951) around issues of beauty, fame, wealth, and power.

Antisocial Personality Disorder (Scale 6a)

**Hypothesis Seven** - Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≤ 84).

**Hypothesis Eight** - Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Antisocial Personality Disorder Scale.

**Hypothesis Nine** - Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria.
for either personality “disorder” or personality “trait” (BR \leq 74) on the Antisocial Personality Disorder Scale.

Rationale for Hypotheses Seven, Eight, and Nine- Millon and Davis (1996) labeled the primary defense mechanism of the antisocial individual as “acting out/projection”. In addition to demonstrating an inability to control his or her impulses, the antisocial individual also disowns his or her unacceptable feelings and attributes them to others.

Projection is another mechanism employed by an antisocial. Accustomed throughout life to anticipate indifference or hostility from others and exquisitely attuned to the subtlest signs of contempt and derision, they are ever ready to interpret the incidental behaviors of others as fresh attacks on them. Given their perception of the environment, they need not rationalize their outbursts. These are fully justified as a response to the malevolence of others. The antisocial is the victim, an innocent bystander subjected to unjust persecution and hostility. Through this projection maneuver, then, they not only disown their malicious impulses but attribute the evil to others (Millon & Davis, 1996, p.448).

Aggressive (Sadistic) Personality Disorder (Scale 6b)

Hypothesis Ten- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III criteria for Aggressive (Sadistic) Personality Disorder (BR \geq 85) and those male batterers who do not meet the MCMI-III criteria for Aggressive (Sadistic) Personality Disorder (BR \leq 84).

Hypothesis Eleven- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR \geq 75 and \leq 84) on the Aggressive (Sadistic) Personality Disorder Scale and
those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Aggressive (Sadistic) Personality Disorder Scale.

**Hypothesis Twelve:** Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Aggressive (Sadistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Aggressive (Sadistic) Personality Disorder Scale.

**Rationale for Hypotheses Ten, Eleven, and Twelve:** Millon and Davis (1996) labeled the defense mechanism of the sadistic/aggressive individual as “isolation/projection/sublimation”. The process referred to as isolation bears many striking resemblance’s to the Gestalt resistances of deflection and desensitization. In order to maintain a pattern of such vicious and savage behaviors, the aggressive/sadistic individual must find a way to “numb” him or herself and become desensitized to the emotional consequences of such behavior.

Intrapsychically and dynamically, the most distinctive transformations of the sadists’ inner world are those processed by the isolation mechanism. Many of these personalities are remarkably and cold-bloodedly detached from an awareness of the impact of their destructive acts. For example, their spouses and children are perceived as objects devoid of human feeling and sensibility. The painful consequences of their cruel behaviors are kept from the mind (Millon & Davis, 1996, p.487).
Hypothesis Thirteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Projection and Retroflection will discriminate between those male batterers who meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≤ 84).

Hypothesis Fourteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Projection and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Passive Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR > 85 and ≤ 74) on the Passive Aggressive (Negativistic) Personality Disorder Scale.

Hypothesis Fifteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Projection and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Passive Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Passive Aggressive (Negativistic) Personality Disorder Scale.

Rationale for Hypotheses Thirteen, Fourteen, and Fifteen- Millon and Davis (1996) labeled the defense mechanism of the passive-aggressive individual as “displacement”. “Perhaps the most consistent mechanism seen among negativists is their use of displacement, that is, their tendency to shift their anger both precipitously and
unconsciously from their true targets (persons or settings) to those of lesser significance” (Millon & Davis, 1996, p.552). Thus, the passive-aggressive individual is likely to shift their anger either onto others (projection) or back onto themselves (retroflection).

At one time, by projection, these persons will ascribe their destructive impulses to others, accusing the others, unjustly, of being malicious and unkind to them. At other times...they will reverse the sequence, accusing themselves of faults that justifiably should be ascribed to others (Millon & Davis, 1996, p.553).

**Borderline Personality Disorder (Scale C)**

**Hypothesis Sixteen**: Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who meet the MCMI-III criteria for Borderline Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Borderline Personality Disorder (BR ≤ 84).

**Hypothesis Seventeen**: Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Borderline Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Borderline Personality Disorder Scale.

**Hypothesis Eighteen**: Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Borderline
Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74) on the Borderline Personality Disorder Scale.

**Rationale for Hypotheses Sixteen, Seventeen, and Eighteen.** Millon and Davis (1996) labeled the primary defense mechanism, or resistance, of the borderline as "regression". One of the prominent features of this particular defense mechanism, however, is the tendency for the individual to turn his or her anger inward. This represents the primary process in the Gestalt resistance of retroflection.

Thus, aggressive urges toward others may be turned on themselves. Rather than vent their anger, they will openly castigate and derogate themselves, and voice exaggerated feelings of guilt and worthlessness. These borderlines become noticeably self-recriminating. They belittle themselves, demean their abilities, and derogate their virtues, not only to dilute their aggressive urges but to assure others that they themselves are neither worthy nor able adversaries (Millon & Davis, 1996, p. 665).

Similarly, Kepner (1993) suggested that the Gestalt resistance of desensitization is the "centerpoint" of the Borderline Personality Disorder. Being able to desensitize oneself allows the borderline to actively engage in self-destructive behaviors without feeling the physical and emotional pain associated with such behaviors.

The tendency towards body mutilation and self-destructive behaviors further supports the notion that the borderline is deeply desensitized. Borderline clients who cut themselves with razors, choke themselves, and so on, frequently report they do so "to try and feel something" or note that "it didn’t hurt because I didn’t feel anything." These are clear statements of a loss of bodily sensation and tell us the extent to which they have become dulled, deadened, or insensate (Kepner, 1993, p. 108).
Limitations of the Study

The present study had several potential limitations. Such limitations warrant serious consideration when making any clinical judgments, interpretations or generalizations based on the outcome data of the study.

First, there is a methodological limitation with regards to the self-report nature of the MCMI-III and GCSQ-150. The MCMI-III has three "modifying indices" (see Chapter 3) that are designed to provide information about the respondent's attitudes towards the instrument, including his or her level of honesty and attention. Despite such indices, there is the potential that subjects may lie, exaggerate, or minimize their responses to the instrument items. This is of particular concern when examining a clinical sample of male batterers, who are expected to evidence high levels of psychopathology and resistance. According to Anastasia (1988):

Self-report inventories are especially subject to malingering or faking. Despite introductory statements to the contrary, most items on such inventories have one answer that is recognizable as socially more desirable or acceptable than the others. On such tests, respondents may be motivated to "fake good" or choose answers that create a favorable impression...Under other circumstances, respondents may be motivated to "fake bad", thus making themselves appear more psychologically disturbed than they are...for example, in the testing of a person on trial for a criminal offense (p.549).

Second, there is a methodological limitation with regards to the administration of the MCMI-III and GCSQ-150. Service providers from various domestic violence treatment programs throughout the state of Ohio who volunteered to participate in this study administered the instruments to subjects in their programs. In order to create consistency within the administration process, each service provider was given a set of
guidelines and recommendations to follow when selecting potential participants and administering the instruments to each subject. Despite such guidelines, however, this study did not control and monitor the potential experimenter bias, in which the service provider conveys messages to the subject that influences his or her attitudes, beliefs, or perceptions about the testing instruments or study. Such messages, whether conveyed intentionally or unintentionally, may contaminate and limit the generalizability of the resulting data.

Third, there is a methodological limitation with regards to the sampling process. The service providers selected to participate in this study were randomly chosen from a directory of domestic violence treatment providers and programs obtained from the Ohio Domestic Violence Network. While every effort was made to obtain the most comprehensive and updated directory available, it is important to recognize that there may be other domestic violence treatment providers and programs in the state of Ohio who are not represented in this directory. Similarly, although each service provider was offered guidelines for choosing a random sample of subjects, this study does not control or monitor the actual sampling process conducted by each service provider. Thus, the randomness of the selected sample of both the service providers and subjects of male batterers may be somewhat limited.

Fourth, there is a measurement limitation due to the fact that several of the GCSQ-150 scales have questionable internal consistency (Prosnick, 1998). Three of the six GCSQ-150 scales produced internal consistency coefficients less than .70 (Introjection .56, Desensitization .63, and Projection .66) Although this does not render the outcome
data from these scales as useless, it is important to be aware of this limitation when analyzing the data and making any generalizations and conclusions.

Finally, there is another measurement limitation in the dichotomous nature of the MCMI-III Base Rate Scores. In utilizing Millon’s (1994) BR scoring system, an individual with a BR score of 75 and higher is categorized as having personality “traits” relevant to a particular personality disorder, while an individual with a BR score of 85 and above is categorized as actually having the particular personality disorder. One may challenge the assumption that a BR score of one (1) point is sufficient to differentiate between an individual with a personality disorder and an individual with personality “traits” relevant to the disorder. Thus, for example, in the present study there is some question as to the nature of the difference between those male batterers with a BR score of 84 (personality “trait”) and those male batterers with a BR score of 85 (personality “disorder”).

Summary of Chapter 1

The prevalence and severity of domestic violence is increasing across the United States at epidemic rates. Clinicians who work with male batterers are in desperate need of more information and clinical training regarding effective assessment and treatment strategies.

In addition to exhibiting exceedingly high prevalence rates of personality disorders, male batterers have been found to be particularly resistant to treatment. Thus, it is imperative that clinicians who work with male batterers possess sufficient knowledge and skill regarding issues of personality disorders and the various resistances. Such knowledge
may provide the clinician with insight regarding the male batterer’s potential resistances and, thus, lead to more individualized and specialized assessment and treatment strategies.

The focus of this study was on examining the relationship between the various resistances and personality disorders among a clinical sample of male batterers. More specifically, the relationship between the Gestalt resistances and Millon’s (1996) typology of personality disorders was examined. As such, this study utilized the Millon Clinical Multiaxial Inventory-III (MCM; Millon, 1994) and the Gestalt Contact Style Questionnaire-150 (GCSQ-150; Prosnick, 1996) within a clinical sample of male batterers.

In addition to the research questions, hypotheses, and relevant definitions of terms, several limitations of this study were discussed in detail. Specific limitations regarding the nature of self-report inventories, the sampling process, and the reliability of the GCSQ-150 scales were addressed.
CHAPTER 2
LITERATURE REVIEW

The Gestalt Model

The Gestalt therapy model is, arguably, one of the major therapeutic approaches among modern day mental health practitioners. Since its inception during the late 1940's, the Gestalt model has played a significant role in emphasizing the significance of the humanistic and existential components of psychotherapy. Particularly during the 1970's, the Gestalt model was instrumental in challenging the traditional views of psychopathology, offering innovative ideas about human development, and creating a fresh perspective regarding the process of change. In 1976, Hatcher and Himelstein wrote:

Contemporary psychotherapists are moving towards greater emphasis on emotional experience and on body awareness. At the same time there is a deemphasis of historical material as the significant item to be sought after in therapeutic sessions. One of the major therapies in this contemporary mold is Gestalt Therapy. Known only to relatively few individuals two decades ago, it is now well established as a major affiliation of psychotherapists and as a style of personal growth. Gestalt oriented ideas and techniques have found wide acceptance, not only among therapists, but also with many others seeking seeking greater awareness of their emotions and behavior (p.7).

Although the current trend within the mental health field is one that emphasizes a brief and solution-focused approach, the Gestalt model has proven itself as an influentially
stable and enduring therapeutic model. There are presently over thirty-four professional
Gestalt training centers located in the United States, as well as countless other
international institutes located abroad (The Gestalt Institute of Cleveland, 1995). More
importantly, perhaps, is the fact that new Gestalt training centers are currently being
developed and created at a rapid rate throughout the country. Thus, it is clear that the
theory and practice of the Gestalt model is here to stay.

Despite its sound theoretical framework and wide range of practical applicability,
the Gestalt approach is, perhaps, one of the most empirically understudied and
unsupported model currently in use by practitioners. Such lack of empirical research has
been a major criticism and shortcoming of the Gestalt model for decades. "...Gestalt
therapists have not appeared to be concerned with publishing their new developments and
ideas. Much of the exciting and illuminating work on Gestalt Therapy has remained
unpublished, circulated by hand as mimeographed handouts at workshops or conventions,
or as taped demonstrations. Other significant work has received the printed stage, but
received only limited, local distribution" (Hatcher & Himmelstein, 1976, pp. 7). Despite
the increasing interest and number of publication within the last several decades, there is
currently still a deficit of empirical and scientific research on the theory and practice of the

Kepner (1983) noted that what little empirical research has been done on the
Gestalt model has tended to focus on techniques, therapist orientation, or the applicability
to areas other than therapy. More recently, Harman (1993), in a review of the Gestalt
therapy research, suggested that the literature on Gestalt therapy can be broken down into
five specific areas: 1) the effects of Gestalt marathons; 2) an analysis of the Gloria films; 3) a comparison of Gestalt to other theoretical orientations; 4) an analysis of specific Gestalt therapy techniques; and 5) doctoral dissertations. Clearly, the current Gestalt literature is sparse with regards to empirical research and data on the underlying theoretical constructs of the model.

It is important to recognize that, due to the lack of empirical research on the underlying theoretical constructs, the general discussion of the Gestalt resistances will be drawn almost exclusively from the theoretical literature, much of which was published during the early origins of the theory, from the 1950's through the 1970's. The discussion of the measurement issues related to Gestalt resistances, however, will be drawn from the most current and up-to-date empirical research done on this construct.

**What is Gestalt therapy?**

Frederick “Fritz” Perls began his psychiatric career as a Freudian analyst and trainer (Latner, 1992). During the late 1920's, however, Perls became interested in a radically different form of psychology and psychotherapy. This controversial perspective viewed individuals and psychological phenomenon as organized and synthesized wholes, rather than the traditional Freudian viewpoint of individuals being a constellation of specific parts and entities that operate independently of each other.

For Perls, there were significant clinical implications for viewing the individual as a whole “system” which is embedded in and inseparable from the larger context of his or her environment. Furthermore, Perls began to observe that a person’s behavior can be meaningfully understood only in direct relation to his or her environment.
Throughout the next several years, Perls continued to investigate this controversial model of psychotherapy and, in 1947 published his first book, entitled "Ego, Hunger and Aggression: A Revision of Psychoanalysis" (Latner, 1992). The book re-evaluated the Freudian analytical viewpoint and contained chapters on holistic and experiential perspectives, with specific therapeutic exercises that emphasize present physical awareness rather than insight, interpretation, or analysis.

Four years later, in 1951, Perls, along with Ralph Hefferline and Paul Goodman, published the landmark book "Gestalt Therapy: Excitement and Growth in the Human Personality". This landmark book is considered to represent the birth of a humanistic and existential approach to psychotherapy known as Gestalt therapy (Gestalt Institute of Cleveland, 1995). Perls viewpoints were no longer considered to be simply a revision of the Freudian psychoanalytic model, but instead a new theory in and of itself. Many of the original concepts and tenets discussed in this book have provided the underlying framework for the modern-day Gestalt model.

Until the publication of Gestalt Therapy in 1951 Perls still considered his ideas to be revisions of the psychoanalytic theory. With the publication of Gestalt Therapy and the expansion and clarification of the theory by Paul Goodman, it became clear that a new therapy system was being proposed. This system was based upon a different theoretical understanding of human nature, a divergent view of early development, and a unique approach to treatment compatible with these perspectives. This was no longer psychoanalysis. This was Gestalt therapy. While Ego, Hunger and Aggression delineated Perls' transition away from orthodox psychoanalysis, Gestalt Therapy further described this new approach, laid a theoretical groundwork and compared it to psychoanalysis (Breshgold, 1989, p. 85).
In order to establish a solid framework from which to better understand Gestalt resistances, a discussion of several relevant tenets of the Gestalt model is warranted. More specifically, the concepts of holism, awareness, and contact will be addressed below.

Holism

The concept of holism is one of the major underlying tenets of the Gestalt model. "The word 'gestalt' (plural: 'gestalten') refers to the shape, configuration or whole, the structural entity, that which makes the whole a meaningful unity different from a mere sum of parts" (Yontef, 1979, p. 27). Integrating the concept of holism into a Gestalt therapeutic model is to emphasize the totality of an organism's functioning within the larger context of his or her environment. It is to address the totality of individual's psychological, physiological, and behavioral processes. It is to believe and understand that an individual's mind, body, and soul are inseparable components that function together to define and support the individual as a whole.

The concept of holism was a primary point of differentiation between the early Gestalt and the psychoanalytic orientations. Perls (1973) criticized the psychoanalytic psychologists for being reductionistic, analytical, and causal and for ignoring the totality of the human experience and the context of the individual's environment. According to Clarkson and Mackewn (1993):

From his earliest writing, Perls emphasized his holistic understanding of mankind. His approach is based on the inseparable unity of bodily, emotional, and mental experience, upon the integrity of language, thought and behavior. He believed that the body, mind, and soul all naturally function as one whole process. All parts of the human being are coordinated and arranged to function with complete collaboration in support of each other and the whole organism" (p. 35).
Perls (1993) contended that such collaborative support between the various systems within an individual has served to create a human organism that is self-sufficient, with an innate and inherent ability to self-regulate and restore a sense of homeostasis, or balance, when confronted with problems. This self-regulation principle should not be construed to imply that an individual will resolve all of his or her problems or meet every one of his or her needs. Instead, the term 'self-regulation' means that an individual has a tendency to utilize both his or her internal and external resources and capabilities to the fullest potential at any given time in order to maintain personal balance (Latner, 1986).

In order for the self-regulatory process to be effective, however, an individual must exhibit a reasonably high level of awareness regarding both his or her internal and environmental experience. Perls (1969), in discussing the significance of awareness and its contribution to the process of growth and change, has suggested:

...I believe that this is the great thing to understand (that awareness per-se and of itself can be curative). Because with full awareness you can become aware of this organismic self-regulation, you can let the organism take over without interfering, without interrupting; we can rely on the wisdom of the organism. And the contrast to this is the whole pathology of self-manipulation, environmental control, and so on, that interferes with this subtle organismic control (p.33).

Awareness

Awareness is at the core of the Gestalt model's view of change. Yontef (1979) defines awareness as "...a form of experiencing. It is the process of being in vigilant contact with the most important event in the individual / environment field with full sensorimotor, emotional, cognitive, and energetic support" (p.29). Awareness is a
dynamic process that is constantly changing, evolving and transcending itself and is
grounded and energized in the dominant and present need of the individual.

By paying full attention to one's immediate, moment-to-moment sensory
experience, an individual is able to better understand how he or she interacts with his or
her environment. Such understanding is, according to the Gestalt model, critical in
facilitating an individual's process of change. The more knowledge a client has about his
or her internal and environmental processes, the more options and responsibility he or she
has to the change process. "The therapist seeks to catalyze awareness in clients until they
awaken to their responsibility for thinking, feeling, and acting" (O'Leary, 1992, p. 13).

Mulgrew and Mulgrew (1987) suggested that there is a sequential process that a
client goes through in order to achieve awareness: 1) blocked awareness— the client enters
therapy with a seemingly impenetrable "wall" between him or herself and the environment;
2) inhibited awareness— the client begins to feel and become aware of his or her wants and
needs, but does not have the skills to act on these, therefore, his or her interaction with the
environment is most figural; 3) self-awareness— the client begins to view him or herself in
relationship to the environment, however, there is still an inability to form and maintain
close, interpersonal relationships with others as the client finds it risky to negotiate wants,
resolve conflicts, and exchange feelings; and 4) interpersonal awareness— the client exhibits
spontaneous and reciprocity in relationships and engages in encounters with others that
are lively, active, and unstereotyped.

Thus, awareness is a central tenet to the Gestalt model's theory of change and
growth. According to Perls (1973) an individual without awareness is likely to experience


an inability to grow and, instead, to become fixated on symptomatic and outdated patterns of behavior. On the other hand, psychologically healthy individual tends to be aware of his or her internal process- thoughts, feelings, sensations- as well as his or her environment. It is through awareness that an individual is able to actively experience his or her internal processes and establish "contact" with his or her environment.

Contact

The Gestalt concept of "contact", as described by Perls (1973), refers to the meeting or connection between either two separate individuals or between an individual and his or her environment. The Gestalt model postulates that it is the process of achieving contact with other individuals and with one's own environment that facilitates growth and change. "When contact is vibrant and dynamic and assimilation is thorough, they automatically lead to change and growth. The results of true contact and assimilation is never merely a rearrangement of the old elements but the creation of a fresh configuration containing aspects of the old personality and new materials from the environment. After each contactful experience a person has a new, enlarged, or different sense of self" (Clarkson & Mackewn, 1993, p. 55). Establishing contact with one's own environment is the primary process by which an individual satisfies his or her needs.

Polster (1987) suggested that there are three different types of contact- internal, interpersonal, and international. Internal contact refers to self-generated awareness and the experience that occurs within an individual. It often involves the integration of one's polarities and internal contradictions, and the full expression of these constructs.
Interpersonal contact involves the acknowledgment of another individual and the similarities and differences that distinguish that individual from oneself (Polster, 1987). While gratefully recognizing the similarities between individuals, effective interpersonal contact also respectfully honors and appreciates the differences that exist and does not seek to create sameness. As O’Leary (1992) stated, “Close identification makes good contact impossible, for only when there is a clear difference between what is you and what is not you, can you experience a meeting between the two” (p. 31).

According to O’Leary (1992), effective interpersonal contact is characterized by an individual’s ability to: 1) remain connected to his or her own physical sensations in order to promote effective internal contact; 2) include the resulting awareness within the context of the present interaction; 3) focus on the other individual and fully “take in” their utterances; 4) respond to the other individual; and 5) let the other person know they have been heard. O’Leary emphasized that this process involves paying attention to the both the verbal and nonverbal levels of the interaction between the individuals.

The third type of contact proposed by Polster (1987) is international contact. At this level, the building of dialogue is viewed as one of the most critical components, as each country has a strong need to both speak and, at the same time, to feel heard.

Zinker (1977) originally proposed that the process of achieving contact can be broken down into stages (see Figure 1). To illustrate this process, assume than an individual is sitting in a chair reading a book and suddenly begins to experience the sensations associated with hunger—perhaps the churning and grumbling of the stomach, the weakness in the muscles, and the dryness in the mouth. These sensations are the
body's self-regulating mechanism that alerts the individual of the present imbalance within
the system and the need for food in order to restore the natural homeostasis.

For a while, the individual is able to temporarily ignore the hunger sensations and
continue on with his or her reading. However, when left unacknowledged and unmet, the
physiological sensations begin to increase in both frequency and intensity. The individual
soon finds he or she cannot concentrate on the reading material any longer as his
awareness is now fixated upon his hunger. All other stimuli within his perceptual and
sensory field recede in his or her awareness and diminish in significance as his or her
hunger now becomes the most prominent and interesting figure.

According to Perls et al. (1951), an individual has an inherent nature for closure
and will actively and diligently strive to complete the full "gestalt" or figure. In the
present example, the individual is therefore driven to restore the homeostasis by seeking
out food in order to satisfy his hunger. Thus, he or she begins to look towards the
kitchen, cognitively imagine what food is available, and think of how he or she can best
meet the current need for food. The individual then moves into the action phase by arising
from the chair, walking into the kitchen, and actively preparing the ingredients for the
meal.

The Gestalt Institute of Cleveland (1995) added to Zinker's (1977) model by
suggesting that a "mobilization of energy" stage occurs between awareness and action. In
this stage, the organism, having identified the present awareness and need, prepares itself
to move into the action stage.
Thus, in the present example, the individual's level of excitement may increase, his or her physical system may begin to ready itself, and his or her physiological sensations may increase with the anticipation of the upcoming meal. This mobilization of energy helps to support the individual in being able to move beyond the mere awareness stage and into the action stage. Smith (1988), in support of the mobilization of energy stage, stated "The probability of satisfying contact is maximized by clear awareness, excitement, and an action-interaction sequence guided by awareness and energized by that excitement" (p. 40).
After arriving in the kitchen, the individual prepares and consumes a meal that satisfies his or her hunger. By doing such, he has achieved contact with his environment by incorporating an aspect of the environment into himself. The act of chewing and “taking in” of the food is a literal representation of the individual making contact with an aspect of his environment. Perls et al. (1951) viewed the process of eating as the prototype of an individual achieving contact with his or her environment.

After achieving contact and consuming the meal, the individual is now able to put closure on this particular figure. What were once powerful and undeniable physiological sensations of hunger now have dissipated from the individual immediate awareness, thus, allowing the opportunity for new and fresh sensations and figures to emerge in order to begin the cycle all over again. Having successfully completed the cycle of contact, the individual is likely to feel satisfied, refreshed, and energized. However, when this cycle of contact is interrupted, the individual is unsuccessful at completing the cycle and does not achieve contact.

**Interruption of the Contact Cycle**

According to the Gestalt model, psychopathology can often be traced back to a disturbance or interruption in the cycle of contact. “Neurosis is characterized by many forms of avoidance, mainly the avoidance of contact” (Perls, 1993, p. 7). When an individual’s needs are satisfied from the environment and the cycle of contact is successfully completed, he or she is free to move on and pursue new interests and opportunities for further contact. When the contact cycle is interrupted, blocked, or
rigidified, however, the harmony and flexibility of the organism / environment balance is
disturbed (Yontef, 1976). The consequences of such a disturbance is that the individual is
likely to remain stuck in “unfinished business”. Due to this repetitive pattern of negative
and unfulfilling contact experiences, such an individual is likely to have distorted
perceptual and sensory awareness and to prefer familiar, predictable, and inhibited types of

There are many ways in which the cycle of contact can be interrupted or disturbed,
and the Gestalt literature contains several different terms to the describe such a process.
The interruption of the contact cycle has been described as interruptions of contact
(Martinek, 1985), boundary process (Swanson, 1988), boundary disturbances (Perls et al.,
1951), contact boundary interference (Crocker, Latner, Polster, & Wysong, 1982), and
self-interruptions (Smith, 1979). However, the term “resistance” appears to be the most
commonly used. Therefore, for the purposes of this study, the term “resistance” will be
utilized when describing the interruption or disturbance of the contact cycle.

Before moving into a discussion of the Gestalt resistances, it is important to
differentiate how the Gestalt view of this construct differs from that of the traditional
psychoanalytic model. Sigmund Freud, considered the “father” of the psychoanalytic
model, viewed resistance as an obstacle to effective therapy and a phenomenon that
opposed the forces of “ameliorative change” (Breshgold, 1989, p. 76). Freud contended
that resistances were something to be defeated by the analyst in order to allow access to
the client’s unconscious processes. Thus, recognizing and overcoming resistances were
considered to be the primary task in therapy. Although the modern psychoanalytic theory
appears to have adopted a broader view of resistance, it is still today often viewed by psychoanalysts as an impediment to effective therapy that requires deliberate attention and thorough understanding.

The Gestalt model, on the other hand, has adopted a more functional view of resistance. Perls (1993) strongly contended that an organism’s “resisting forces” are flexible and permeable defenses that are important in assisting the organism in adapting to his or her environment. Thus, resistances are viewed as a self-regulation mechanism by which individual is able to effectively manage his or her environment.

Rather than focus on overcoming or eliminating the resistance, the Gestalt model emphasizes heightening the client’s awareness of his or her resistance and unaware conflicts. By bringing such internal conflicts into the open, the client has the opportunity to re-identify with any disowned feelings or impulses and work through any unfinished business (Perls et al., 1951). According to Breshgold (1989), the ability to actively experience and successfully close any unfinished business is the primary and most significant vehicle through which healing and growth can occur. Although an individual’s past and childhood experiences are valued and considered an important influence on his or her current level of functioning (Cole, 1994; Kirocofe, 1992), these issues are addressed within the context of on his or her present, moment-to-moment awareness.

In Gestalt therapy, resistances are the central focus of the therapeutic work, since they are the place where the patient demonstrates interference with free functioning - and at the same time demonstrates aspects of himself that are basic to him; the point of therapy is to bring that to his awareness. Resistances are
opportunities for enlarging the patient’s awareness to include his unwillingness or felt inability to experience something (Latner, 1986, pp. 125-126).

The Gestalt model has identified several of these “resistances” that an individual may utilize in order to keep him of herself from establishing contact with either his or her environment or another individual. Perls et al. (1951) identified the four original resistances as introjection, projection, retroflection, and confluence. Many years later Polster and Polster (1973) added deflection. Desensitization was empirically supported by Kepner (1982), although such a construct had been alluded to in earlier theoretical writings (Perls et al., 1951). Finally, Prosnick (1996) found empirical support for the resistance of egotism, and labeled a new factor-derived resistance as “transfluence”.

It is important to remember that the primary Gestalt resistances addressed below are generally viewed as being functional, self-regulating mechanisms that serve an adaptive role for an individual in managing his or her environment. Perls (1993) contended, however, that when such resistances are under or overused in extreme, an individual is likely to exhibit a pattern of maladaptive and pathological behavior. The discussion below will emphasize the maladaptive uses of the Gestalt resistances, however, a brief description of the functional uses will also be noted.

**Introjection**

Introjection involves the uncritical acceptance of information from the environment or significant others without questioning or challenging the meaning, value, or personal usefulness of such information (Perls et al., 1951). The individual passively accepts “what is” and simply incorporates information into his or her self-schema without considering his
or her own wants, needs, and values or the appropriateness of the new information. The boundary between between “I” and “You” is blurred, thus creating a struggle for the introjector to differentiate his or her own beliefs and values from that of others. Typically exhibiting an unquestioning view of authority, an introjector is likely to appear rigid and rule-bound, often living by an outdated set of “shoulds” that dominate his or her present behavior and thinking. The process of introjection interrupts the cycle of contact between the action and contact stage (The Gestalt Institute of Cleveland, 1995).

Introjections, when utilized with awareness as a flexible and temporary style of contact, are valuable in the process of learning (The Gestalt Institute of Cleveland, 1995). In such cases, for example, an individual may introject by imitating or modeling new behaviors, following a new set of rules during a period of crisis, or memorizing new information in order to pass an examination. Such a process, however, is only temporary until the individual determines which behaviors, beliefs, and information to assimilate into his or her self-schema and which to reject.

Perls et al (1951) made the clear and important distinction between the processes of assimilation and introjection. In assimilation, an individual selectively takes in information from the environment based on his or her current needs and desires. Information that meets the individual’s needs and is congruent with his or her value system is absorbed into the existing self-schema, while information that is of little use or contrary to an individual’s value system is discarded.

In introjection, on the other hand, there is no selectivity or discriminating of information. Instead, all of the information provided by the environment is passively
absorbed into the system by the individual with little or no regard for its purpose, value, or impact. The individual’s sense of identity is fragmented and extremely dependent upon whatever information and stimuli the environment presents.

Several authors have suggested that the origin of introjections is in an individual’s childhood experiences (Clarkson & Mackewn, 1993; O’ Leary, 1992; Perls, 1993). Although children are born with a natural and innate self-regulating mechanism to help them cope with and manage their environment, many children also experience a tremendous fear of conflict with the significant others in their lives. Thus, in order to avoid the potentially negative consequences of such conflict, a child is likely to uncritically accept the beliefs and values of his or her significant others.

Such introjects are likely to be powerful, long-lasting, and resilient, creating a maladaptive and pathological pattern of behavior that is likely to continue into adulthood. "Such toxic introjects are usually maintained, unexamined, and unchallenged, throughout one’s life...Once the toxic message is introjected, the threat of loss of love for disobeying becomes a conditioned phobic belief in imminent catastrophe whenever the toxic message is not honored" (Smith, 1988 p. 43).

If left untreated, these toxic introjects have the potential to create many significant clinical symptoms. Kepner (1982) suggested that introjection is associated with alcoholism and eating disorders such as overeating, anorexia nervosa, and bulimia. Utilized in the extreme, introjection can ultimately disturb an individual’s personality development (Clarkson & Mackewn, 1993).

First of all, the man who introjects never gets a chance to develop his own
personality, because he is so busy holding down the foreign bodies lodged in his system. The more introjects he has saddled himself with, the less room there is for him to express or even discover what he himself is. And in the second place, introjection contributes to personality disintegration. If you swallow whole two incompatible concepts, you may find yourself torn to bits in the process of trying to reconcile them (Perls, 1973, p. 34).

Thus, an introjector is likely to act as a sponge and soak up and incorporate all of the information from the environment and significant others into his or her self-schema without question or concern. It is possible, however, for an individual to completely reverse this process into another maladaptive resistance by attributing or projecting his or her internal conflicts and unfinished business onto the environment or significant others.

Projection

Projection is considered the reverse of introjection (Perls, 1973) and occurs when an individual attributes those undesirable or unacceptable traits found in him or herself onto either the environment or others. Thus, an individual who projects is likely to disown his or her feelings or impulses and, instead, transfer them onto either the environment or others. Such a projective process interrupts the cycle of contact between the action and contact stages (The Gestalt Institute of Cleveland, 1995) by distorting an individual’s perceptions of both him or herself and the environment. Because the projector often behaves as if such distortions are, indeed, reality, he or she is likely to experience a repeated pattern of unsuccessful attempts at establishing meaningful contact with either his or her environment or others.

A projection is a trait, attitude, feeling, or bit of behavior which actually belongs to your own personality but is not experienced as such; instead it is attributed to objects or persons in the environment and then experienced as directed toward you by them instead of the other way around. The projector, unaware, for instance,
that he is rejecting others, believes that they are rejecting him; or, unaware, of his tendency to approach others sexually, feels that they make sexual approaches to him (Perls et al., 1951, p. 211).

There are, however, many functional uses of projection. An individual’s ability to express empathy towards another is based solely upon the process of projection, since, due to lack of factual data, he or she can only imagine what another individuals experience is at any given moment. Projection is also helpful for an individual who is involved in the process of planning and anticipating, in order to experience oneself in a future situation. Various artists and other creative expressionists rely on the process of projection in order to express their own internal phenomenon onto their chosen medium. Finally, the field of psychology has created projective testing instruments that assist a clinician in assessing psychopathology based solely upon a client’s projections onto a series of ambiguous drawings.

One of the primary clinical syndromes found to be associated with projection is that of paranoia. A paranoid individual has developed an extremely organized set of delusions, which are extreme cases of projection, that guide his or her behavior. “The paranoiac has been found to be, in case after case, a highly aggressive person who, unable to bear responsibility for his own wishes, feelings, and desires, attaches them to objects or people in his environment. His conviction that he is being persecuted is in fact the statement that he would like to persecute others” (Perls, 1973, p. 35).

Thus, an individual who overutilizes projection to the extent that it creates pathological symptoms is likely to have distorted perceptions regarding the boundary between him or herself and the environment. Such an individual is likely to attribute
internal feelings onto external objects and, subsequently, react to such external objects as if the projection were, in fact, a reality. It is possible, however, that an individual, instead of projecting unfinished business and unresolved feelings onto the environment or others, may actually retroflect, or turn such feelings inward onto him or herself.

Retroflection

Retroflection literally means “turning back sharply against” (Perls, 1973, p. 40). A retroflector is likely to treat him or herself in a way that he or she originally wanted to treat another individual or object. Similarly, an individual may retroflect by doing to him or herself what he or she originally wanted others to do to them (Clarkson & Mackewn, 1993). Instead of directing his or her energy outward onto the environment, the retroflector substitutes him or herself as the target of such behavior. Thus, a person who engages in chronic retroflection is likely to be overwhelmed with feelings of self-loathing, guilt, resentment, self-criticism, blame, and anger. Because the individual engages in activities which prevent him or her from connecting to the environment or another individual, retroflection interrupts the cycle of contact between between the action and contact stages (The Gestalt Institute of Cleveland, 1995). Having an incessant need to be in control, a retroflector is likely to exhibit rigid, inflexible, and maladaptive patterns of behavior.

Similar to introjection, Perls et al. (1951) have proposed that retroflection is a habit learned in childhood. For a child who has been consistently punished or threatened for freely expressing his or her wants or needs, that child soon will learn to retroflect, or hold back such feelings, and most likely, turn them inward, in order to avoid the
punishment. "Punishment has the effect, not of annihilating the need to behave in a way that met with the punishment, but of teaching the organism to hold back the punishable responses" (Perls et al., 1951, p.183).

There are undoubtedly, however, many instances in which retroflection is considered to be useful. An individual who holds back his or her feelings or impulses as a way of protecting themself, and others, from physical or psychological harm is demonstrating healthy retroflection. Similarly, it is considered appropriate for an individual to temporarily hold back his or her feelings, impulses, or desires in order to attend to the needs of a significant other.

However, when retroflection is consistently overused to the extreme and becomes a primary way of avoiding contact with either the environment or others, pathology is inevitable. Such pathology is primarily manifested through psychosomatic and stress related symptoms (The Gestalt Institute of Cleveland, 1995; Kepner, 1982; Perls, 1973). Excessive muscle tensions, ulcers, high blood pressure, and heart disease are often some of the unfortunate consequences of excessive retroflection. Smith (1986) identified a continuum of physical and bodily symptoms associated with retroflection: 1) awkward actions- the individual experiences muscle weakness and clumsiness of his or her actions; 2) body stiffness- the individual experiences physical rigidity and pain in certain areas; and 3) body armor- the individual experiences extreme aches and, eventually, physical numbness in many different areas.

One of the ways that an individual may temporarily deal with such psychosomatic and stress related symptoms is to develop coping mechanisms by which he or she actually
numbs the physical sensations of pain and discomfort. By desensitizing him or herself, the individual is effectively able to experience temporary relief from the uncomfortable sensations.

**Desensitization**

The resistance of desensitization refers to an individual’s chronic, habitual, and maladaptive pattern of shutting down his or her sensory awareness, particularly in regards to internal, bodily sensations. The process of desensitization involves the deadening, dulling, or denying of one’s physical experiences. Such a process interrupts the cycle of contact between the sensation and the awareness stage (The Gestalt Institute of Cleveland, 1995).

Human beings are capable of dulling the impact of sensations either by reducing the quality of attention or by dulling the capacity of their organs of perception. This process of coping with disturbing sensations by altering the capacity for perception is called desensitization. Desensitization lessens the experience of discomfort, but it exacts a cost by reducing the capacity for liveliness and a full sense of self (Kepner, 1993, p. 99).

Being distant and detached from his or her sensory experiences, a desensitizer is likely to be highly intellectual, analytical, and logical. Such a process allows the desensitizer the opportunity to avoid taking full responsibility and ownership for his or her feelings. “The origins of desensitization seems to lie in the need to keep potentially threatening sensations from emerging into awareness where they must be acted upon” (Kepner, 1982, p. 36).

Within the current, fast-paced society, it appears easy for an individual to quickly become overstimulated, overworked, or overstressed. Thus, there are undoubtedly times
when it is necessary for an individual to temporarily deaden his or her sensory awareness in order to sufficiently tolerate and adjust to various environmental circumstances. For example, the acts of taking medication under a physician's care or temporarily suppressing one's hunger or thirst until it is appropriate to satisfy such needs are adaptive behaviors that allow the individual to effectively manage their environment.

Extreme desensitization, however, may influence the development of certain pathological conditions and personality disorders. Kepner (1993) suggested that the resistance of desensitization is the “centerpoint” of the Borderline Personality Disorder:

The tendency towards body mutilation and self-destructive behaviors further supports the notion that the borderline is deeply desensitized. Borderline clients who cut themselves with razors, choke themselves, and so on, frequently report they do so “to try and feel something” or note that “it didn’t hurt because I didn’t feel anything. These are clear statements of a loss of bodily sensation and tell us the extent to which they have become dulled, deadened, or insensate (p. 108).

Addictive behaviors are another prominent pathological consequence of the desensitization process. An individual who desires to desensitize him or herself may find quick relief in a number of temporary sources including alcohol, drugs, food, sex, or work. Any substance or behavior that serves to numb an individual’s sensory experience and deadened his or her feelings or impulses may become the source of an addiction.

Such addictive behaviors, however, provide only a temporary escape, for as soon as the self-induced, artificial “high” wears off, the unwanted feelings and impulses are quick to return. Thus, in addition to desensitizing oneself to the sensory awareness of the unwanted feelings and impulses, an individual may also choose to avoid contact by deflecting any external stimulus that may potentially arouse such feelings or impulses.
Deflection

Deflection is the process by which an individual disrupts the cycle of contact between the action and contact stage (The Gestalt Institute of Cleveland, 1995) by avoiding direct interaction with another individual. The deflector reduces the intensity of interpersonal contact with others by engaging in distracting behavior. Kepner (1982) noted that one of the major mechanism utilized by the deflector to avoid contact has to do with his or her conversational style. The deflector is likely to be detail-oriented, indirect, vague, inappropriately humorous, and overly talkative while, at the same time, using language loaded with minimizations, qualifiers and excuses. Changing the subject, avoiding eye contact, and not accepting responsibility for his or her actions are among other tactics that a deflector may utilize in order to avoid intimacy, confrontations, and ultimately, contact with others.

Deflection, however, has many adaptive purposes, many of them being social in nature. For example, vagueness and indirectness may be an effective source of protection in order to guard against another individual’s intrusiveness. Similarly, using humor may be useful in order to de-escalate a potentially dangerous conflict or to temporarily ease the sting of an embarrassing situation.

When deflection is overused as a way of avoiding contact, however, certain maladaptive behavior patterns may emerge. For instance, an individual who chronically and habitually uses deflection in order to avoid confrontations, maintain interpersonal harmony, or minimize the differences between another individual may appear exhibit overcontrolled and rigid behavioral patterns.
Confluence

A confluent individual is likely to experience a blurred sense of the boundary between him or herself and the environment. There is no clear distinction as to where “I” begin and “You” end. Having a tremendous fear of differences, a confluent individual often subjugates his or her own wants, needs, and desires in order to create and maintain harmony within his or her most important relationships. Confluence also breeds dependency, as the individual often has difficulty tolerating aloneness and, therefore, continually strives for reassurance and external affirmation. An individual who chronically and habitually utilizes confluence is likely to find that achieving contact is a very formidable, if not impossible, task.

A sensing and the object sensed, an intention and its realization, one person and another, are confluent when there is no appreciation of a boundary between, when there is no discrimination of the points of difference or otherness that distinguish them. Without this sense of boundary- this sense of something other to be noticed, approached, manipulated, enjoyed- there can emergence and development of the figure/ground, hence no awareness, hence no excitement, hence no contact! (Perls et al., 1951, p. 118).

Confluence, however, like the other resistances, also has a functional purpose. After an individual has achieved meaningful contact with either his or her environment or another individual, there is likely to be a merging of boundaries, a joining of energies, and a sense of total unity (Clarkson & Mackewn, 1993; Perls, 1973). “After contact has been achieved... At the end of any successful experience- one that is not interrupted but allowed to complete itself- there is always a confluence of energy or energy producing material” (Perls et al., 1951, p. 153). The temporary merging of boundaries, however, when
utilized with awareness, also serves to create and preserve harmony within interpersonal relationships and to establish a sense of community and connection with others.

Egotism

The Gestalt construct of egotism as a resistance to contact has often been overlooked within the current literature (Mraz, 1990; Wheeler, 1991). Perls et al. (1951) described egotism as a fixation, a way of avoiding contact by becoming overly controlled, rigid, and indecisive. An individual who uses egotism to excess is likely to resist letting go and, thus, entering into the final stage of contact in which the individual and the organism reciprocally interact in the process of change. Having a tendency to suppress his or her sense of creativity and spontaneity, an egoist is more likely to prefer interaction which is highly structured, predictable, deliberate and controlled. Such interaction often leads to intense feelings of boredom, loneliness, fear, and staleness.

Finally, if all the various pitfalls are negotiated, and the “meeting” with the new is achieved, there comes the moment when the self must “let go of the self”, for the actual contact in the fullest sense to take place...At this point the self must be “sure enough of itself to risk itself, its own given, past organization, in the new encounter. If it cannot, the result is “egotism”- the clinging to the frozen self as it was, the inability to take the plunge, and risk change, loss, unfamiliarity. Spontaneity is lost, and an exaggerated, hypercautious deliberateness appears (Wheeler, 1991, p.82).

Egotism serves many functional purposes within the human experience. It is through temporary egotism that an individual is able to slow down the cycle of contact, reflect on his or her options, and make a deliberate and conscious choice about any future action. In this way, egotism is an important element in the process of self-preservation and self-control. While supporting curiosity, exploration, and understanding, healthy
egotism also allows an individual to combat impulsivity and immaturity in his or her decision making process. Most importantly, however, healthy egotism involves the individual being able to let go, make a firm commitment, and finally, act upon the chosen decision. “Normal egotism is diffident, skeptical, aloof, slow, but not non-committal” (Perls et al., 1951, p. 533).

Transfluence

Prosnick (1996) was the first scholar to introduce the term “transfluence” within the Gestalt literature, both from a theoretical and empirical perspective. Although Elkin (1979) suggested that Gestalt therapy had many transpersonal qualities, no attempt to describe or measure a transpersonal resistance or contact style was made. Several of the major aspects of transpersonal awareness includes out-of-body experiences, precognition, clairvoyance, psychokinesis, mystical visions, spiritual value systems, and other parapsychological phenomenon (Prosnick, 1996).

The Male Batterer

The current literature on the personality profiles of male batterers is abundant with data suggesting that this particular clinical population exhibits exceedingly high levels of hostility (Barrett, Fagan, & Booker, 1994), jealousy (Barnett, Martinez, & Bluestein, 1995), impulsiveness (Bersani, Chen, Pendleton, & Denton, 1992), interpersonal and spousal dependency (Murphy, Lee-Meyer, & O’Leary, 1994), patriarchal ideologies (Smith, 1990), inexpressiveness (Ponzetti, Jr., Cate, & Koval, 1982), control needs (Vaselle-Augenstein, 1992), possessiveness (Coleman, 1980), and alienation (Hastings & Hamberger, 1988).
Additionally, male batterers may have a tendency to exhibit low levels of self-esteem (Walker, 1979), although there appears to be minimal empirical research to support this theoretical contention. Baumeister, Smart, and Boden (1996) challenged this contention and argued that an individual’s threatened egotism, not low self-esteem, is an important risk factor in an individual’s decision to use violence. According to Baumeister et al. (1996), threatened egotism results when an individual’s superior views of himself are, in some way, challenged, deflated, or disputed by another individual or circumstance. In support of this Hornung, McCullough, and Sugimoto (1981) found that husbands of working wives were more likely to become violent than were those husbands whose wives stayed at home suggesting, perhaps, that the status inconsistency within their relationship and the husband’s threatened sex-role expectations were significant factors in the violent episodes. Although caution is warranted from making any generalizations and assumptions that the wives employment status “caused” her husband to behave violently:

These findings suggest that men beat their wives to maintain the superiority of the husband role that has been threatened or jeopardized. When the man’s outcomes fall short of his expectations, he is vulnerable to feeling that his wife may not respect him, and he may especially prone to reassert his superiority with physical violence. When the wife has reached a level of occupational success that is higher than the husband’s, he is again more likely to beat her, presumably as a way of enforcing his sense of superiority (Baumeister et al., 1996, p. 19).

**Personality Disorders of Male Batterers**

The available literature on the specific personality disorders, however, is far less impressive. Only a few studies have investigated the prevalence and severity of personality disorders among a clinical population of male batterers. Such scarcity of
research is both interesting and confusing, especially considering the clinical value of increased knowledge in this area. Having knowledge only of the individual personality traits of male batterers, and viewing them as distinct and separate entities, is of questionable utility for a clinician. It is only through the process of putting such traits into a diagnostically sound framework does such knowledge become clinically useful. It would be beneficial for future research to focus on studying the specific personality disorders and integrating the findings into a practical framework from which to develop and improve clinically sound assessment and treatment protocols.

Within the current literature, several researchers have utilized the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1977) and the Millon Clinical Multiaxial Inventory-II (MCMI-II; Millon, 1987) to examine the personality disorders within a clinical population of male batterers. Hart, Dutton, and Newlove (1994) utilized the MCMI-II and the Personality Disorder Examination (PDE) in a study involving a clinical sample of self and court referred male batterers. Although both the MCMI-II and the PDE found that the Antisocial, Sadistic, and Borderline were the most prominent personality disorders among the entire sample of male batterers, there was a relatively significant discrepancy between the instrument's general diagnostic efficacy. The MCMI-II revealed that between 80-90% of the sample met the diagnostic criteria for a personality disorder, while the PDE revealed that only 50% met such criteria. While the overall diagnostic discrepancy between these two instruments poses a methodological concern, this study, nonetheless, provides some evidence as to the high prevalence rate of personality disorders among male batterers.
Similarly, a series of studies by Hamberger and Hastings (1985, 1986) found that, within a clinical sample of male batterers, 88% demonstrated evidence of a personality disorder. The first study (Hamberger and Hastings, 1985, cited in Hamberger and Hastings, 1986) assessed the personality profiles of 105 men who were court-mandated to participate in a domestic violence treatment program. Through a factor analysis of the MCMI subscales, three major derived factors emerged—"schizoid/borderline", "narcissistic/antisocial", and "passive-dependent/compulsive". In a replication study, Hamberger and Hastings (1986) utilized factor analysis and found nearly identical results as those obtained in the original 1985 study. "In general, the high degree of replication between studies provides evidence supporting the notion that psychopathology is demonstrable in spouse abusers" (Hamberger and Hastings, 1986, p. 341).

Several other researchers have utilized the MCMI-II and compared the prevalence of personality disorders of male batterers and non-batterers. Murphy, Lee-Meyer, and O'Leary (1994) found that maritally violent males scored higher than maritally nonviolent males on the Aggressive (Sadistic), Passive-Aggressive, and Antisocial Personality Disorder scales.

Similarly, Beasley and Stoltenberg (1992) recruited a voluntary group of male batterers from a local support group and a control group of maritally discordant but nonviolent men from local marriage and family clinics and university psychology clinics. Using the MCMI-II, it was found that batterers scored higher than non-batterers of the Narcissism, Antisocial, Schizotypal, Aggressive (Sadistic) and Borderline Personality Disorder scales.
Hastings and Hamberger (1994) conducted a study using three different subgroups of male batterers and controlling for “good” and “poor” premorbid histories. A male with a “good” premorbid history had at least a high school education, was employed, had no history of alcohol abuse, and did not witness or experience abuse in his family of origin. The three subgroups included - 1) Identified Batterers- 99 males who were court ordered for treatment. Thirty-three of the men (33.3%) were classified as having “good” histories; 2) Covert Batterers- 32 men whose scores on the Conflict Tactics Scale (CTS; Straus, 1979) indicated potential problems with reasoning, verbal aggression, and violence and who were not seeking treatment. Twenty of the men (62.5%) were classified as having “good” histories; and 3) Nonviolent Men- 71 men who scored below the cut-off point on the CTS and were recruited from family clinics or church sponsored marital enrichment seminars. Forty-eight of the men (67.6%) were classified as having “good” histories.

Controlling for the differences in premorbid histories, Hastings and Hamberger (1994) found that, within the nonviolent subgroup, there were no significant differences between those men with “good” or “poor” premorbid histories. However, among the two subgroups of Covert and identified Batterers, those subjects with “poor” histories revealed higher scores on the MCMI Aggressive and Negativism scales and lower on the Submissive and Conforming scales. The Identified Batterer subgroup was found to exhibit the highest levels of psychopathology, scoring higher than the Covert Batterers on the MCMI Negativism, Borderline, Anxiety, Hysteria, Depression, Alcohol, and Drug scales.
and scoring higher than the Nonviolent Men on the MCMI Aggressive, Negativism, Hypomanic, Alcohol, and Drug scales.

Greene, Coles, and Johnson (1994) utilized the Minnesota Multiphasic Personality Inventory (MMPI) in studying the personality profiles of forty men who were court ordered for anger management training after being arrested for domestic violence. Cluster analysis revealed four significant clusters identified as: 1) “Histrionic Personality”- elevations on Hysteria (Scale 3) and Psychopathic Deviate (Scale 4); 2) “Depressed Personality”- elevations on Depression (Scale 2) and Psychopathic Deviate (Scale 4); 3) “Normal Personality”- no significant elevations on any scales; and 4) “Disturbed Personality”- elevations on Hypochondriasis (Scale 1), Depression (Scale 2), Psychopathic Deviate (Scale 4), Paranoia (Scale 6), Psychasthenia (Scale 7), Schizophrenia (Scale 8), Hypomania (Scale 9), and Social Introversion (Scale 10).

Greene et al. (1994) found that the Disturbed Personality cluster evidenced not only the highest level of psychopathology, but also the highest level of anger expression. Interestingly, however, the Normal Personality cluster also revealed significantly elevated levels of anger expression that was rather similar to that of the Disturbed Personality cluster. One possible explanation for this finding may be that this particular cluster of individuals has a tendency to express their anger in either a more socially acceptable or socially hidden manner than their Disturbed Personality counterparts. Another important consideration is the fact that the males were court mandated to complete “anger management” training which is, undoubtedly, very different, both clinically and conceptually, from domestic violence treatment.
From the above discussion on the personality characteristics and personality disorders of male batterers, one may conclude that there is a general personality profile that describes or predicts certain attributes of males who abuse their intimate female partner. Such is not the case, however. Several researchers (Carden, 1994; Hamberger & Hastings, 1986; Saunders, 1992; Holtzworth-Munroe & Stuart, 1994) have suggested that domestic violence is too complex of a phenomenon to create a typical personality profile of the male batterer. Instead, it has been proposed that there are different typologies and subtypes of male batterers, each with unique and distinguishing personality traits and behaviors (Holtzworth-Munroe & Stuart, 1994; Saunders, 1992). Perhaps, however, the common link between the various typologies and subtypes of male batterers is the underlying cognitive processes and distortions.

Cognitive Distortions of Male Batterers

In order to better understand the personality characteristics and disorders of male batterers, it is imperative to examine the cognitive processes that underlie such distortions and serve to support the associated pathological behaviors. Such cognitive processes are, arguably, the driving force behind many of the personality disorders and, thus, are deserving of considerable attention within both the clinical and research fields. It has been only within the last few years, however, that researchers have begun to understand the significance of the cognitive processes within the context of domestic violence (Holtzworth-Munroe & Hutchinson, 1993) and the influence of such processes on the male batterer’s pathological behaviors.
Like most other criminals, male batterers often possess a radically unique cognitive structure that clearly differentiates them from their non-batterering counterparts. As previously discussed, one of the most important defining features of the male batterer's cognitive processes is his extreme reliance on defense mechanisms as a way of avoiding personal responsibility and accountability for his behaviors. Such defense mechanisms are the primary way in which the male batterer is able to avoid the guilt, shame, pain, and remorse that one would typically experience after perpetrating domestic violence. Thus, they are a necessary function that allows the male batterer to continue with and justify his violent, exploitive, abusive, and manipulating behaviors. In support of this, several researchers have found that male batterers avoid personal responsibility by blaming others and external factors (Davidovich, 1990; Holtzworth-Munroe, 1988).

Shields and Hanneke (1983) interviewed 69 male batterers on their reasons for being violent and coded their responses into two categories, internal or external locus of control. The researchers found that 42% of the subjects reported that their female partners were responsible for their violent behaviors.

Similarly, Bograd (1988), in a study involving a clinical sample of 15 male batterers, found that 58% of the subjects reported that they were violent because their wife had failed to fulfill her obligations of a "good wife", and 28% reported that they were violent because their wives had been physically or emotionally aggressive. Additionally, 40% of the subjects blamed their violent behaviors on alcohol or drugs and 33% of the subjects blamed their violence on their level of internal pressure or stress.
Dutton (1988) investigated the differences in the cognitive distortions between those male batterers who were self-referred and seeking treatment voluntarily, and those male batterers who were court referred and seeking treatment as a part of their probation. As expected, Dutton found that the self-referred male batterers were more likely to accept personal responsibility for their violent behaviors than their court-referred counterparts. More specifically, among the self-referred group, 52% attributed their violent behaviors to themselves, 32% attributed their violent behaviors to the situation, and 16% attributed their violent behaviors to their female partner. In contrast, among the court-referred group, only 16% attributed their violent behaviors to themselves, 44% attributed their violent behaviors to the situation, and 42% attributed their violent behaviors to their female partner.

A significant manifestation of a male batterer’s distorted cognitive processes is evidenced in his impaired social processing skills. The “hostile attributional bias” (Nasby, Hayden & DePaulo, 1979) describes the empirically supported process (Dodge, 1980) by which aggressive children are more likely than non-aggressive children to attribute hostile intent to an ambiguous stimuli.

There is evidence to suggest that the “hostile attributional bias” (Nasby et al., 1979) is also applicable to a clinical sample of male batterers. Holtzworth-Munroe, Jacobsen, Fehrenbach, and Fruzzetti (1992) found that male batterers are more likely than maritally distressed non-violent and maritally non-distressed males to attribute hostile intent and selfish motivation to their wife’s ambiguous behaviors and to judge her behaviors as being blameworthy. Additionally, compared to their nonviolent behaviors,
male batterers were found to view their violent behaviors as less representative of their personality, less likely to occur again in the future, and more attributable to the negative behaviors of their female partners (Holtzworth-Munroe, Jacobsen, Fehrenbach, & Fruzzetti, 1992).

Research suggests that there are particular social situations that appear to be particularly problematic for male batterers. Issues related to jealousy, rejection from his wife, and potential threat of public embarrassment were found to result in the male batterer being more likely to make hostile and negative attributions regarding his wife’s intent (Holtzworth-Munroe & Aglin, 1991; Holtzworth-Munroe & Hutchinson, 1993).

One of the methodological limitations of the research on the cognitive distortions of male batterers is the manner in which the data has been obtained, coded, and interpreted. Several studies (Bograd, 1988; Shields & Hanneke, 1983) have coded data in a dichotomous, exclusionary manner in which the respondent is forced to choose between two distinct and separate categories, that of attributing the violence to either oneself or to some external variable.

Cantos, Neidig, and O’Leary (1993) conducted a study of 139 military couples who were court mandate to complete domestic violence treatment. The researchers administered The Conflict Tactics Scale and interviewed each subject about their attributions for the violent episodes. The data was coded in a non-mutually exclusive manner in that both subjects were given the opportunity to attribute blame both to him or herself and to his or her partner.
Interestingly, Cantos et al. (1993) found that, although both spouses tended to frequently blame their partner for the violence, a relatively high percentage of males also included themselves in their attributions of blame. More specifically, 25% of the male blamed themselves and 33% of the males blamed their partners. Additionally, the males were also more likely to blame themselves for the most recent episode of violence than for the first episode. Although this finding suggests, perhaps, that male batterers are more likely to accept personal responsibility for their behaviors than previously thought, more empirical research using this methodology is needed before such an argument can be supported from either a clinical or theoretical perspective.

Risk Factors of Male Batterers

Within a clinical sample of male batterers, many different risk factors have been identified as contributing to or influencing the development of partner abusive behaviors. In comparison with their nonviolent counterparts, male batterers have been found to be overrepresented in the lower socioeconomic status (Aldarondo & Sugarman, 1996; Berry, 1990), young (Berry, 1990; Hamberger & Hastings, 1989; Roberts, 1987), divorced, separated, or cohabitating rather than married (Berry, 1990; Ellis, 1989; Hotaling & Sugarman, 1990), unemployed (Aldarondo & Sugarman, 1996; Berry, 1996), relatively uneducated (Berry, 1996; Hamberger & Hastings, 1989), and previously involved with the criminal justice system (Bennett, Tolman, Rogalski, & Srinivasaraghavan, 1994).

An important risk factor in the etiology of domestic violence is substance abuse. There is considerable evidence to suggest that male batterers exhibit exceedingly high
levels of substance abuse (Aldarondo & Sugarman, 1996; Berry, 1996; Carden 1993; Goldsmith, 1990; Hayes & Emshoff, 1993). Barnett and Fagan (1993), in a study involving 181 subjects, found that maritally violent and nonviolent males exhibited little variation in their frequency of alcohol use. However, with regards to the quantity of alcohol consumed, maritally violent males were found to drink significantly greater amounts of alcohol than the nonviolent males.

Stith, Crossman, and Bischoff (1991) compared 39 males enrolled in a domestic violence treatment program and 52 males enrolled in a substance abuse program. The study examined factors related to age, race, income, education, marital status, level of self-esteem, current level of marital stress, attitudes towards marital violence, history of childhood violence, level of sex-role egalitarianism, current level of relational violence, and level of alcohol abuse. Stith et al., (1993) found that, of the first 5 variable studied (age, race, income, education, marital status), only marital status was a significant discriminator between the two groups, with more of the single males being in the alcohol treatment program (27%) than in the domestic violence treatment program (5%). Additionally, there were no significant differences found between the two groups on either the current levels of domestic violence or alcohol abuse. Thus, this study provided empirical support that there is a relationship between those males who abuse alcohol and those males who engage in domestic violence.

Substance abuse has also been shown to be significantly related to recidivism in male batterers. Demaris and Jackson (1987) found that, although drug use did emerge as a significant factor, 50% of those male batterers who had problems with alcohol use upon
the initial intake re-offended after treatment, compared to 26% of those male batterers who did not have a problem with alcohol upon the initial intake. Similarly, Hamberger and Hastings (1990) found that 83% of the male batterer recidivists in their study reported substance abuse problems after treatment, compared to only 13% of the non-recidivists.

Helzer and Pryzbeck (1988) found that alcoholic males are 4 times more likely to be diagnosed with Antisocial Personality Disorder than are non-alcoholic males. As discussed in Chapter 1, males batterers have often been shown to meet the diagnostic criteria for Antisocial Personality Disorder on the MCMI and MCMI-III.

Another important risk factor in the etiology of domestic violence is the male batterer’s exposure to family of origin violence. A plethora of studies have shown that male batterers are likely to have either witnessed domestic violence between their parents or to have themselves been physically abused (Aldarondo & Sugarman, 1996; Barnett et al., 1995; Beasley & Stoltenberg, 1992; Bennett, 1995; Bennett et al., 1994; Carden, 1994; Stith et al., 1991).

Dutton (1988) proposed that male batterers who were exposed to violence in their family of origin are likely to exhibit a distinct pathological syndrome, characterized by high rates of substance abuse, generalized and severe violence, and personality disorders. Also, there is evidence that male batterers who were abused as children are more prone to score high on the Narcissistic, Antisocial, Aggressive (Sadistic), Self-Defeating, and Borderline Personality Disorder Scales, as well as the Alcohol and Drug Dependence Scales, of the MCMI-II. As discussed in Chapter 1, male batterers have often been shown to meet the
diagnostic criteria for Narcissistic, Antisocial, Aggressive (Sadistic), and Borderline Personality Disorders on the MCMI and MCMI-II.

Research suggests that those male batterers who witnessed domestic violence in their family of origin were twice as likely to recidivate after treatment than those male batterers who had not witnessed domestic violence (Demaris & Jackson, 1987). It is interesting to note, however, that being directly physically abused was shown to be unrelated to recidivism among both groups.

There is some evidence to suggest that there are demographic differences between self-referred and court-referred male batterers. Barrera, Palmer, Brown, and Kahaler (1994) found that the self-referred males tended to be better educated and employed full time, to earn more money, and to have a greater social support system than did the court-referred male batterers. Additionally, the court-referred male batterers were more likely to be separated or divorced, to have higher rates of substance abuse during their most recent violent episode, and to exhibit more denial and social introversion than the self-referred male batterer. Both groups scored significantly high on measures of family of origin violence, depression, anxiety, alienation, hypochondriasis, and impulsivity.

Although the findings by Barrera et al. (1994) suggest that there may be demographic differences between the self-referred and court-referred male batterer, other studies have reported no differences between the two groups with regard to recidivism rates (Demaris & Jackson, 1987; Feldman & Ridley, 1995). It is important to recognize that self-referred or voluntary male batterers, quite often, seek treatment as a result of some external pressure or as a way of avoiding some type of external consequence. Thus,
although presenting himself as a voluntary client, a male batterer may actually have a hidden agenda of seeking treatment as a way appeasing his fed-up female partner or judge.

**Treatment of Male Batterers**

There are many different treatment perspectives currently utilized by clinicians when working with male batterers. According to the feminist perspective (Bograd, 1984), domestic violence is the result of a patriarchal culture in which the male is supported in exhibiting dominance, power, and control. The social learning perspective (O'Leary, 1988), argues that domestic violence is a learned behavior which manifests itself within a larger social context. According to the psychological perspective (Beasley & Stoltenberg, 1992), domestic violence and violent pathology is characterological and manifested as an intrapsychic disturbance within the individual. The systems perspective (Sprenkle, 1994) views domestic violence as being influenced by faulty, dysfunctional, and pathological communication patterns and family structures.

Each of the above perspectives possesses a unique set of underlying beliefs and conceptualizations about the etiology and treatment of domestic violence. However, despite the many differences among the various treatment approaches, the majority of therapeutic models share the belief that group therapy is the primary and most effective modality in treating the male batterer (Carden, 1993). Bryant (1994) suggested that the group context is ideal for confronting a male batterer’s behavior and defense mechanisms, and for creating an environment conducive to various psychoeducational interventions.

Additionally, Bryant (1994) has noted that there are several limitations of the traditional one-on-one approach when working with male batterers:
Individual counseling creates an adversarial climate in which the batterer views the therapist as an arbitrator and counseling is perceived as persecution and not treatment. The batterer feels he must defend himself against judgment or harsh criticism and simultaneously strengthens those defenses that promote his violent behavior. The restrictive setting of individual therapy also reinforces feelings of shame and guilt associated with domestic violence, as well as feelings of isolation in the batterer (p.38).

One of the most significant limitations within the current literature is the scarcity of reliable outcome studies on the efficacy of the various treatment modalities. Researchers have struggled to find an empirical method capable of producing accurate and reliable outcome data, however, their efforts have often been hampered by the limitations associated with self-report instruments (Browne, 1993; Carden, 1994), cultural influences and insensitivity (Carden, 1994; Williams & Becker, 1994), sampling error (Carden, 1994), variations in treatment models (Palmer, Brown, & Barrera, 1992), high subject attrition rates (Gondolf, 1987), and a scarcity of longitudinal studies (Carden, 1994; Gelles, 1993; Palmer et al., 1992). Despite the scarcity of accurate and reliable outcome studies on the treatment of male batterers, a discussion of several of the most commonly utilized treatment models—cognitive-behavioral, psychoanalytic, and family systems—is warranted.

**The Cognitive-Behavioral Model**

The cognitive-behavioral approach is, perhaps, the most commonly used modality in the treatment of male batterers. Tolman and Edleson (1995), in a comprehensive review of domestic violence research, reported that the majority of male batterer treatment programs have adopted a combination of cognitive-behavioral and feminist approaches.
Similarly, Vaselle-Augenstein and Ehrlich (1992) have suggested that “most programs rely heavily on cognitive training” (p.150).

As previously discussed, the male batterer’s cognitive distortions are a critical component in understanding and effectively ameliorating his violent behaviors. Such cognitive distortions are often manifested through the use of defense mechanisms (Holtzworth-Munroe, 1988), strong patriarchal ideologies (Smith, 1990), inappropriate attitudes about violence (Berry, 1996), and impaired social skills (Holtzworth-Munroe, 1992). If left unchecked and untreated, the cognitive distortions serve to support and reinforce the male batterer’s manipulative, violent, and abusive behaviors.

The goal of the cognitive-behavioral model is to alter, modify, and restructure the cognitive processes of the male batterer. From this perspective, restructuring the cognitive distortions is the key to producing long-term attitudinal and behavioral changes.

Within the cognitive-behavioral model, there are several psychoeducational interventions that are commonly utilized, including skill building (Hamberger & Hastings, 1988), anger management (Sonkin, Martin, & Walker, 1985), and assertiveness training (Hamberger & Hastings, 1988). Several researchers have reported success when utilizing such methods (Bern & Bern, 1984; Dutton, 1986; Hamberger & Hastings, 1988).

From a cognitive-behavioral perspective, such psychoeducational interventions, in order to be effective, must be utilized within the context and framework of restructuring the male batterer’s cognitive processes. Several researchers have suggested that simply teaching a male batterer assertiveness or anger management skills without addressing the underlying faulty cognitive processes is clinically contraindicated and possesses the
potential of creating a more sophisticated and educated batterer. “In some cases, programs inadvertently create “nonviolent terrorists” who simply learn new ways to get their way as part of their “skills” acquisition” (Gondolf, 1993, p.244). Stanton Samenow (1994), arguably one of the leading experts in the treatment of criminal behavior, noted that “…all of the rehabilitative programs in the world will be of no use unless the criminal changes his thinking” (p.6). Similarly, according to Hanks (1992):

The therapist however, should guard against simplification and the premature use of directives as they can be techniques that are utilized based on the naive notion that telling people what to do will result in them doing it...The use of such directives can often result in false compliance with the treatment process, in which little long-term behavioral change is achieved (p.162).

The Psychoanalytic Model

The cognitive-behavioral model, however, is limited when working with severely pathological or psychotic male batterers, especially those with extreme forms of Narcissistic or Antisocial Personality Disorders (Gondolf, Fisher, & McFerron, 1987). In such cases, Scallia, (1994) has suggested that the psychoanalytic model may be appropriate, particularly regarding issues of defense mechanisms, “identification with the aggressor”, the therapist’s unconscious reactions, “collusion”, and the illusion of effective treatment. “This client population includes men who are deeply narcissistically injured and who respond to the phenomenological experiences of threat and helplessness with potentially lethal behavior. Being informed of certain psychoanalytic nuances affecting therapist-batterer interactions allows the therapist a greater opportunity to effectively treat this very difficult population” (Scalia, 1994, p.555).
Such males may be so entrenched and suffocated by their own intrapsychic pain and shame that they may be unable, or unwilling, to effectively respond to cognitive interventions. As such, Wallace and Nosko (1993) have argued that working with the male batterer’s deeply rooted feelings of shame within a group context is at the core of effective treatment.

As discussed previously, one of the major risk factors in domestic violence is the overwhelmingly large proportion of male batterers who have either been physically abused or witnessed domestic violence within their family of origin. The psychoanalytic model, and other approaches that emphasize intrapsychic dynamics, undoubtedly have clinical value in their ability to assist the male batterer in working through and resolving their own experiences of victimization, trauma, abuse, and neglect.

It is extremely important, however, to be aware of the male batterer’s potential to blame other individuals and external circumstances for his violent behaviors when working within the psychoanalytic framework. Such a framework may inadvertently create an opportunity for the male batterer to shift the focus of responsibility and attribute blame for his violent behaviors onto past experiences or others (i.e. family members, female partners, the legal system, counselors).

No empirical research regarding the efficacy of the psychoanalytic model in the treatment of male batterers could be located. Perhaps the biggest reason for the lack of empirical research is that many of the psychoanalytic constructs are abstract in nature and, thus, difficult to define, assess, and measure from a scientific perspective.
The Family Systems Model

Currently, the systems approach to treating marital violence is one of the most controversial issues within the field. Briefly stated, the systems theory postulates that symptomatic and pathological behaviors often emerge as a result of dysfunctional communication patterns (Haley, 1987) or inappropriate marital or family structures (Minuchin & Fishman, 1981).

Unlike the cognitive-behavioral and psychoanalytic models which emphasize intrapsychic factors, the family systems model conceptualizes the problem of marital violence as one that has emerged within the context of the relationship. Proponents of conjoint marital therapy model for the treatment of marital violence (Lipchik, 1984; Mack, 1989; Margolin, 1979; Neidig & Friedman, 1984; Sprenkle, 1994) argue that it is important for each partner within the relationship to take responsibility for his or her contributions to the violence. Thus, both partners are expected to make changes in his or her behaviors with the ultimate goal being the reduction or amelioration of the violent and aggressive interactional patterns.

Lipchick (1991), an advocate of the systemic treatment approach for working with violent couples, argues that clinicians do their clients a disservice by assuming that all couples are going to benefit from the “politically correct” approach in which the male enters a domestic violence treatment program and the female begins individual therapy. Furthermore, Lipchik noted that approximately half of her referrals were from couples who had been unsuccessfully treated from such individualized approach.
Critics of the conjoint marital therapy model for the treatment of marital violence (Bograd, 1984; Walker, 1989), often identified with the feminist perspective, argue that such a model contains potential biases against women and is clinically contraindicated. By conceptualizing the problem as relational in nature implies that the female is, in some way, responsible for her male partner’s violent behaviors (Bograd, 1984).

Similar formulations are further biased against women because they: 1) imply that the battered woman could and should control her husband’s feelings and actions; 2) attenuate the man’s responsibility for his violence; 3) ignore physical size differences between men and women; and 4) deny that violence may be linked to preexisting personality characteristics of the abusive husband and not only to transactional variables that developed over the course of the relationship (Bograd, 1984, p. 561).

As with the other previously discussed treatment approaches, the empirical research on the efficacy of the family systems approach to treating domestic violence is sparse. Several researchers have reported outcome data for maritally violent couples who have completed conjoint therapy. Lindquist, Telch, and Taylor (1984), in a follow up of eight couples, found a 100% recidivism rate with all couples reporting subsequent violence six-months after the completion of treatment. Similarly, Taylor (1984), in a follow-up study of fifty couples, found a 35% violence recidivism rate.

Thus far, Chapter 2 has addressed the Gestalt model and the various Gestalt resistances. Additionally, the personality disorders, risk factors, and several treatment modalities of male batterers were discussed. The final section of this chapter will provide the reader with an overview of the theoretical and empirical literature on the Gestalt model’s perspective of pathological aggression.
Pathological Aggression from the Gestalt Perspective

The phenomenon of pathological aggression has received very little attention within the current Gestalt literature, both from a theoretical and empirical standpoint. The minimal existing literature on the Gestalt perspective of pathological aggression is from the late 1970's and early 1980's. Thus, particularly due the societal trend of increased violence and aggression, there is clearly a need for more recent research in this area.

From a Gestalt perspective, healthy aggression is a critical feature of a well adjusted individual in actively satisfying his or her needs from the environment (Latner, 1973). Healthy aggression assists an individual in achieving contact both with his or her environment and with other individuals.

Aggression is considered to be the essential force in creating change through destructuring and assimilating that which is beneficial to the organism. On the interpersonal level, healthy aggression serves as a survival tool in enabling the person to obtain gratification of needs from others. Aggression is needed in mobilizing energy to work creatively and productively (Rogers & Ridker, 1984, p.66).

According to the Gestalt model, aggression encompasses a continuum, ranging from those behaviors which are considered to be socially acceptable and assertive to those behaviors which are considered to be violent and abusive (Rogers & Ridker, 1981). On the extreme end of the continuum, pathological aggression is characterized by pathogenic processes within the individual and an explosive or exaggerated expressive style which goes beyond the present survival needs of the situation (Polster & Polster, 1973).
A pathological individual, therefore, is unlikely to be able to respond realistically to his or her environment. Instead, the individual is likely to respond to his or her distorted and disturbed pathogenic processes, thus, creating the framework for the development and reinforcement of the cognitive distortions (Bograd, 1988; Davidovich, 1990; Shields & Hanneke, 1983). Such a process is also likely to impede an individual from completing his or her cycle of contact (Polster & Polster, 1973), thus, leading to the potential of diminished sensory functioning and a fear for survival (Perls, 1975). The four major Gestalt resistances involved in impeding the pathologically aggressive individual from achieving contact include introjection, projection, retroflection, and deflection.

According to Rogers and Ridker (1981), “introjection is dynamically central to the development and expression of pathological aggression” (Rogers & Ridker, p.67). Perls et al. (1951) have suggested that, paradoxically, pathologically aggressive individuals have an introject against aggressive behavior that denies them free, appropriate, and spontaneous expression of anger. The tensions from such unexpressed anger is likely to intensify and, if left untreated, lead to explosive outbursts of anger and violence.

The introject against aggressive behavior require the repression of such behavior and thus intensifies the aggressive energy within the individual. Introjects against aggression include a corresponding catastrophic expectation: the individual believes there will be dire consequences if he or she does express anger (Rogers and Ridker, 1981, p.67).

An individual who has disowned or distanced him or herself from his or her own anger in order to satisfy an introject is often likely to externalize these feelings and project them onto various significant others in his or her life (Perls, 1974). Believing that these significant others are, indeed, the original and true source of such anger and criticism, the
individual is likely to respond with controlling, abusive, and violent behavior. This projective process is supported by empirical research which suggests that male batterers are significantly more likely to attribute negative intentions to their partners behaviors than are non-batterers (Holtzworth-Munroe and Hutchinson, 1993).

The pathologically aggressive individual may also retroflect his or her rage and turn it inward on. Such an individual is not only fearful of his or her aggressive impulses, but also of the potential counter-aggression which may be elicited in others. By avoiding both the excitement and perceived threat of contact with others and the environment, the individual directs his or her aggressive energy towards him or herself. "In this process, contact and contact boundaries are distorted, potentiating the situation for explosive behavior toward self and others" (Rogers & Ridker, 1981, p. 68).

Deflection also has been identified as a factor in pathological aggression (Polster & Polster, 1973). Due to the disturbed and pathogenic processes, pathologically aggressive individuals frequently experience overwhelming and pervasive feelings of helplessness and fear (Rogers & Ridker, 1981). Over time and with repeated exposure, such individuals begin to exhibit non-specific, unpredictable, and generalized aggression, often directing their rage towards objects other than those which originally elicited the negative emotions. Labeled by Perls (1975) as "free floating aggression", the process of deflection is likely to result in chronic, impulsive, and maladaptive behavioral patterns.

This researcher is aware of only one prior empirical study that has examined the Gestalt resistances within a clinical sample of male batterers. Carden (1993) administered the GCSQ-R to subjects involved in the Family Violence Program, a psycho-educational
and group therapy treatment program for male batterers. The 102 subjects represented male batterers from three different levels of treatment—those who had just began to attend the psycho-educational group sessions (Phase I), those in the early stages of group therapy (Phase II), and those who have continued to participate beyond their court-mandated requirements.

Compared to the normative sample of the GCSQ-R, Carden (1993) found that male batterers scored significantly higher than the mean on the Projection and Retroflection Scales. Carden suggested that the high score on the Introjection Scale is indicative of individuals who present themselves as overly independent and dominant in order to compensate for their feelings of extreme vulnerability and social awkwardness.

Additionally, Carden (1993) found that the male batterers scored somewhat higher than the mean on the Desensitization and Introjection Scales. According to Carden, these findings suggest that the male batterers in the study possess an above average resistance to authority and sensitivity to environmental stimuli.

The wife abusers who participated in the present study are prone to avoiding/interrupting full contact with their environment by disowning and/or “stuffing” ego-dystonic feelings or thoughts. They are less likely than men in general to be assertive in their communication style or to consider compliance with rules or acceptance of direction from those in authority to be important. In ambiguous situations, they are more likely than men in general to assume that they know others are thinking, feeling, or needing and to act on their assumptions without verifying them (Carden, 1993, p. 189).

Summary of Chapter 2

This chapter presented an overview of the current literature relevant to the present study. The Gestalt model tenets of holism, awareness, contact, and the interruption of the
contact cycle were addressed. More specifically, the Gestalt resistances of Introjection, Projection, Retroflection, Deflection, Desensitization, Confluence, Egotism, and Transfluence were discussed in detail. Additionally, the personality disorders, cognitive distortions, risk factors, and treatment modalities of male batterers were addressed. Finally, the phenomenon of pathological aggression from a Gestalt perspective was presented.
CHAPTER 3

METHODOLOGY

Before moving into the discussion on the methodology of this study, a brief review of the research questions and hypotheses warranted.

Research Questions

The major objective of this research study was to provide empirical insight into the following questions:

1). Which of the Gestalt resistances are the most powerful discriminators between those male batterers who meet the MCMI-III diagnostic criteria for personality disorders (BR ≥ 85) and those male batterers who do not meet the MCMI-III diagnostic criteria for personality disorders (BR ≤ 84)?

2). Which of the Gestalt resistances are the most powerful discriminators between those male batterers who meet the MCMI-III diagnostic criteria for personality “traits” (BR ≥ 75 and ≤ 84) and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “traits” (BR ≥ 85 and ≤ 74)?

3). Which of the Gestalt resistances are the most powerful discriminators between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74)?
Review of Hypotheses

Schizoid Personality Disorder (Scale 1)

Hypothsis One- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III criteria for Schizoid Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Schizoid Personality Disorder (BR ≤ 84).

Hypothsis Two- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Schizoid Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Schizoid Personality Disorder Scale.

Hypothsis Three- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Schizoid Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Schizoid Personality Disorder Scale.

Narcissistic Personality Disorder (Scale 5)

Hypothsis Four- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male
batterers who meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≤ 84).

**Hypothesis Five-** Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Narcissistic Personality Disorder Scale.

**Hypothesis Six-** Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Narcissistic Personality Disorder Scale.

**Antisocial Personality Disorder (Scale 6a)**

**Hypothesis Seven-** Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≤ 84).

**Hypothesis Eight-** Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III
diagnostic criteria for personality "trait" (BR ≥ 75 and ≤ 84) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Antisocial Personality Disorder Scale. 

**Hypothesis Nine-** Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Antisocial Personality Disorder Scale.

**Aggressive (Sadistic) Personality Disorder (Scale 6b)**

**Hypothesis Ten-** Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III criteria for Aggressive (Sadistic) Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Aggressive (Sadistic) Personality Disorder (BR ≤ 84).

**Hypothesis Eleven-** Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Aggressive (Sadistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Aggressive (Sadistic) Personality Disorder Scale.
Hypothesis Twelve- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR ≥ 85) on the Aggressive (Sadistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74) on the Aggressive (Sadistic) Personality Disorder Scale.

Hypothesis Thirteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Projection and Retroflection will discriminate between those male batterers who meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≤ 84).

Hypothesis Fourteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Projection and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 75 and ≤ 84) on the Passive Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Passive Aggressive (Negativistic) Personality Disorder Scale.

Hypothesis Fifteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Projection and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR ≥ 85) on the Passive Aggressive (Negativistic) Personality Disorder Scale.
Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR \leq 74) on the Passive Aggressive (Negativistic) Personality Disorder Scale.

Borderline Personality Disorder (Scale C)

Hypothesis Sixteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who meet the MCMI-III criteria for Borderline Personality Disorder (BR \geq 85) and those male batterers who do not meet the MCMI-III criteria for Borderline Personality Disorder (BR \leq 84).

Hypothesis Seventeen- Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "trait" (BR \geq 75 and \leq 84) on the Borderline Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR \geq 85 and \leq 74) on the Borderline Personality Disorder Scale.

Hypothesis Eighteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR \geq 85) on the Borderline Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR \leq 74) on the Borderline Personality Disorder Scale.
Subjects

The subjects in the study consisted of 120 males throughout the entire state of Ohio who were arrested for physically abusing their intimate female partners and court mandated to complete domestic violence treatment. As will be discussed in a later section of this chapter, the present study will utilize discriminate analysis in analyzing and interpreting the outcome data. When using discriminant analysis, it is recommended that the researcher have optimally at least twenty subjects for each independent variable (Hair et al., 1995; Stevens, 1992). Due to the fact that the present study utilizes six independent variables, a sample size of 120 subjects is considered optimal.

Instrumentation

The two instruments that were utilized in the present study are the Gestalt Contact Styles Questionnaire-150 and the Millon Clinical Multiaxial Inventory-III. Each of these instruments is described later in this chapter.

Data Collection

Through the Ohio Domestic Violence Network (ODVN), a directory of active domestic violence specific treatment programs and service providers throughout the entire state of Ohio was obtained. It is important to recognize that there may be other domestic violence treatment programs and service providers throughout the state of Ohio who are not represented. However, this listing was the most complete and comprehensive one available. From the ODVN directory, a random sample of programs was chosen by selecting every 2nd program from the listing and letters were sent out to each of the selected potential treatment programs or agencies explaining the nature and purpose of the
study and requesting their voluntary participation (see Appendix A). Additionally, in order to ensure that a program or agency was eligible to participate in the study, each letter contained a separate information sheet which asked the treatment provider or agency to answer several questions regarding the nature of their treatment program and to indicate their ability and willingness to participate in the study (see Appendix B). In order to be eligible for participation in this study, each selected treatment program or service provider must have been publicly identified and documented as specifically designed to treat male batterers and receive referrals from the court system. A self-addressed, stamped envelope was provided in order that each treatment provider could mail the separate information sheet directly back to the researcher.

Each of the treatment providers who indicated an ability and willingness to participate in the study were mailed detailed information regarding the study and instructions for selecting the subjects and administering the instruments (see Appendix C). Additionally, each of the treatment providers were given ten client packets, each one containing testing booklets and scoring sheets for both the MCMI-III and the GCSQ-150. Also included in each of the client packets was a Client Information sheet describing the nature of the study and informed consent issues (see Appendix D) and a Client Demographic Information Sheet (see Appendix E).

Upon receiving these client packets, the treatment providers were asked to arrange to have ten randomly selected subjects voluntarily complete the MCMI-III and GCSQ-150. All males currently enrolled in the treatment program, regardless of whether they are in the beginning, middle, or end phase of treatment, were considered to be eligible to
participate in the study. After each subject read through the Client Information Sheet and voluntarily completed the test instruments and demographic sheet, they were asked to put the information back into the original, self-addressed, stamped envelope, seal the envelope themselves, and mail it directly back to this researcher for analysis.

As expected, several of the treatment providers appeared to have difficulty in selecting and recruiting ten voluntary subjects who were willing and able to complete both the MCMI-III and GCSQ-150. In order to achieve the targeted sample size, those treatment providers who were able to administer and collect all ten of the original client packets were sent a letter requesting their assistance in collecting more client subjects. Thus, there were several treatment providers who produced a larger number of client subjects than other treatment providers.

Instrumentation

The two instruments which were used in this study were the Gestalt Contact Styles Questionnaire-150 (GCSQ-150) and the Millon Clinical Multiaxial Inventory-III (MCMI-III). A discussion regarding the general framework, including the reliability and validity, of each of these instruments is warranted.

The Gestalt Contact Styles Questionnaire-150

The GCSQ-150 is an instrument that has evolved from the work of several researchers. In order to understand the nature of the GCSQ-150, it is also important to examine its general lineage and empirical support. The Gestalt Q-Sort, the Gestalt Contact Styles Questionnaire, and the Gestalt Contact Styles Questionnaire - Revised have all proven to be influential to the development of the GCSQ-150.
The Gestalt Q-Sort (GQS)

The first psychometric instrument that was designed to measure the Gestalt contact styles and resistances was the Gestalt Q-Sort (Byrnes, 1975). Byrnes generated items that reflected the Gestalt contact styles and resistances as described within the Gestalt literature and developed an instrument which contained seventy-two items, thirty-six of which described contactful behaviors and thirty-six of which described interruptive behaviors. The subjects included thirty college students who were divided evenly into two groups, “psychologically healthy” and “psychologically unhealthy”, based on the results of a clinical and psychometric assessment.

From the resulting data, four specific factors emerged, including a general contactfulness factor and the Gestalt resistances of retroflection, projection, and confluence (Byrnes, 1975). Each of the “psychologically healthy” subjects loaded high on the general “contact” factor, and all but one of the “psychologically unhealthy” subjects loaded high on one or more of the three Gestalt resistances. This was the first study which found empirical support for the constructs of Gestalt resistances. In the final chapter of his dissertation, Byrnes summarized the results of his study as follows:

1. Psychologically healthy subjects are similar in their contactfulness during periods of usual and peak functioning.
2. Psychologically healthy subjects are different in their ways of interrupting contact during periods of poor functioning.
3. Psychologically disturbed subjects are different in their interruption of contact.
4. Psychologically disturbed subjects differ in their ability to approach the contact
boundary functioning of psychologically healthy subjects.

5. Psychologically disturbed subjects (even at their peak) function differently from psychologically healthy subjects (p. 89).

The GQS was empirically validated on studies which examined counselor personal growth (Gerstenhaber, 1979) and the effects of Gestalt interventions on adolescents (Christian, 1982). Gerstenhaber (1979) found significant correlations between subject's scores on the GCS and the Personal Orientation Inventory (POI; Shostrum, 1963). Christian (1982) studied the impact of Gestalt psychological interventions on junior high school students. She found that those students who were exposed to the Gestalt interventions scored higher on the GQS general contactfulness factors than did those students in a control group who were not exposed to the Gestalt interventions.

As is the case for the majority of studies which utilize the Q-Sort method, Byrnes's (1975) contained a methodological limitation of a small sample size. Additionally, the instrument which Byrnes’s developed omitted items which measured other Gestalt resistances.

The Gestalt Contact Style Questionnaire (GCSQ)

Kepner (1982) added to GQS study and improved upon several of the limitations in Byrnes (1975) methodology. The subjects included 240 college students, 103 males and 131 females, with an age range from 18-75. As Kepner noted, “The range of the ages was quite wide in this sample, probably stemming from the commuter and adult education emphasis of the schools involved” (p. 49). The subjects were obtained from a technical
college in Wisconsin, Cleveland State University, and Cuyahoga Community College in Ohio.

In addition to creating additional empirical support for the three resistances revealed in Byrnes (1975) study—retroflection, projection, and confluence—Kepner (1982) also found empirical evidence for the existence of introjection and confluence. Although deflection failed to emerge as a distinct factor, a sixth factor resembling the characteristics of egotism did emerge.

Utilizing the five, factor derived scales from his study, Kepner (1982) created the Gestalt Contact Styles Questionnaire, a 76-item instrument for measuring the Gestalt contact styles and resistances. The constructs were examined through concurrent validity by comparing the scores on each scale with the scores on the Sixteen Personality Factor Questionnaire (16PF). Kepner (1982) utilized Thorndike's (1978, cited in Kepner, 1983) recommendation for factor analysis criterion of .30 in determining a "significant" loading of an item on a factor and found several face validity groups which contained significant loadings. In discussing the face and concurrent validity of each factor, the scale and correlations (p<.05) between the GCSQ and the 16PF will be given in parentheses.

1) Factor R - face validity of the items loading high on this factor describes an individual who is inhibited and withheld, physically tense and awkward, uncomfortable in social situations, confused over feelings, depressed, and possesses a poor self-image (Kepner, 1982). Concurrent validation with the 16 PF indicates that such an individual is anxious, tense, and driven (Q4= .65), guilt-prone and worried (O=.50), shy, timid, and threat-sensitive (H= -.41), suspicious, jealous, and irritable (L=.42), and emotionally
unstable (C= -.39; Kepner, 1982). This factor had 19 significant item loadings, with 11 loadings correlating at +/- .40. In general, this factor resembles the Gestalt resistance of retroflection discussed earlier. Additionally, Kepner (1982) noted that this factor resembles Byrnes' (1975) Type B person, also identified as a “retroflector”.

2) Factor P - face validity of the items loading high on this factor describes an individual who uses externalization and blame, exhibits absolutism in his or her thinking, and believes that he or she can accurately read another individual’s mind (Kepner, 1982). Concurrent validation with the 16PF indicates that such a person is anxious and tense (Q4= .47), emotionally unstable and easily upset (C= -.47), group dependent (Q2= -.38), and guilt prone (O= .37; Kepner, 1982). This factor had 20 significant loadings, with 1 loading correlating at +/- .40. In general, this factor resembles the Gestalt resistance of projection discussed earlier. Additionally, Kepner (1982) noted that this factor resembles Byrnes’ (1975) Type C person, also identified as a “projector”.

3) Factor D - face validity of items loading high on this factor describe an individual who is emotionally and interpersonally hypersensitive, has a tendency to worry and brood, is insensitive to stress, and tends to eat quickly (Kepner, 1982). Concurrent validation with the 16 PF indicates that such an individual is secure and self-assured (O= .37), possessing high ego-strength, maturity, and stability (C= .37), and relaxed (Q4= -.44; Kepner, 1982). Kepner (1982) has suggested that this apparent contradictory data may be a function of the scales ability to “bind” an individual’s anxiety.

4) Factor I - face validity of the items loading high on this factor describes an individual who views him or herself as passive and lazy, indirect and confused, and a
victim of circumstance (Kepner, 1982). Concurrent validation with the 16 PF indicates that such an individual is taciturn, inhibited, introspective, and cautious (F = -.52).

5). Factor C - face validity of the items loading high on this factor describes an individual as compliant, agreeable, lacking in cares, and uncomfortable with differences between individuals (Kepner, 1982). Concurrent validation with the 16 PF indicates that such an individual is submissive, mild, dependent, and accommodating (E = -.45; Kepner, 1982).

6). Factor Six - This factor does not resemble any specific Gestalt resistance as discussed earlier in the theoretical section. Kepner (1982) described this factor as involving arrogance, low need for control, stoic disregard, and dislike of social interchange. Similarly, this factor was found to be significantly correlated only to the Imagination scale (M = .45) of the PF 16. Prosnick (1996) has suggested that this factor resembles the often overlooked Gestalt resistance of egotism.

This author is aware of only one previous study which utilized the GCSQ in empirical research. McArthy (1985) utilized the GCSQ in examining the interruption of the sexual contact cycle among 30 males with erectile dysfunction, 15 of whom were diagnosed as having a physiogenic (physical) origin and 15 of whom were diagnosed as having a psychogenic (non-physical) origin. Among the psychogenic group, introjection was found to be primary resistances by which the subject's interrupted the sexual contact cycle.
The Gestalt Contact Style Questionnaire - Revised (GCSQ-R)

In 1986, Woldt expanded upon the GCSQ and added 24 items designed to measure the resistance of deflection, which failed to emerge in Kepner’s (1982) study. This new instrument, which contained 100 items, was renamed as the Gestalt Contact Style Questionnaire-Revised (Woldt & Kepner, 1986).

GCSO-R Normative Sample Studies

There were four separate studies (Plesec, 1987; Plummer, 1987; Roche, 1986; Santana, 1986) that were involved in the norming process of the GCSQ-R. Of the 517 subjects in the normative sample, 281 were males and 236 were females, and the age range was from 17-79 with a mean of 42.2. Table 1 illustrates the statistical data for each of the GCSQ-R scales.

Plesec (1987), in studying the contact processes of 251 smokers, ex-smokers, and non-smokers (71 males and 180 females), correlated the GCSQ-R with the General Well Being Schedule (GWB) and the Internal-External Locus of Control Scale (I-E). In general, the process of externalization correlated positively (.34) with a general measure of resistance, suggesting, perhaps, that the cycle of contact is likely to be interrupted once an individual places too much of an emphasis on external circumstances or influences. Interestingly, males were also found to score higher than females on the GCSQ-R scale of desensitization.

Plummer (1987) studied a sample of 30 high functioning Roman Catholic sisters with over ten years in religious life. In comparing this sample with a control group of 30 lay females, Plummer (1987) found that the Roman Catholic sisters evidenced higher
degrees of personality integration and adjustment, particularly in the areas of sociability, flexibility, tolerance, and general well-being.

Roche (1986) administered the GCSQ-R and the Alcoholism Recovery Index (ARI) to 159 recovering male alcoholics. The three highest correlations were reported between GCSQ-R Retroflection and the ARI subscale Affiliation/Attachment ($r=-.45$), GCSQ-R Retroflection and the ARI subscale Conviction/Commitment ($r=-.44$), and GCSQ-R Introjection and the ARI subscale of Conviction/Commitment ($r=-.41$).

Santana (1986), in a study involving forty two racially diverse Upward Bound directors, found negative correlations between the GCSQ-R resistances of projection and retroflection and perceived ability to cope. The seventeen female subjects scored higher on confluence and lower on deflection than the twenty five male subjects, suggesting that the gender socialization process is an important component in the establishment of an individual's contact style.

**Empirical Studies Utilizing the GCSQ-R**

In addition to the four normative sample studies described above, there have been several additional studies that have utilized the GCSQ-R in empirical research. A brief overview of these studies is warranted.

Hartung (1992) examined the process by which individuals interrupt their career decision making process. The researcher utilized Gestalt theory in developing the Decisional Process Inventory (DPI), a seventy item instrument intended to measure an individual's career decision making process.
Scale | Gender | Mean | S.D
---|---|---|---
Confluence | M | 69.36 | 8.11
 | F | 69.69 | 7.64
Desensitization | M | 35.61 | 5.49
 | F | 32.94 | 5.21
Introjection | M | 72.87 | 6.75
 | F | 74.42 | 6.93
Projection | M | 70.70 | 12.38
 | F | 70.28 | 11.91
Retroflection | M | 106.57 | 16.48
 | F | 102.06 | 14.53
Deflection | M | 114.25 | 16.24
 | F | 108.36 | 15.00

Table 1: Statistical data of the GCSQ-R normative sample (Prosnick, 1996)

Randolph (1988) studied the relationship between the Gestalt resistances and an individual’s perceived social family environment. Among the sample of 235 unmarried freshmen college students, 30% reported desensitization as their primary contact style and viewed their family as lacking in cohesion and being uninvolved as a family unit. The introjectors perceived their families as being neat and orderly, projectors experienced their
families as being unemotional, and retroflectors perceived their families as unsupportive and openly aggressive. Additionally, deflectors viewed their families as achievement oriented and highly conflictual, while confluencers experienced their families as social and supportive.

Michelson (1992) examined the Gestalt contact styles in adult females who had been victims of childhood sexual abuse. Interestingly, utilizing the GCSQ-R and two measures of sexual satisfaction and arousability, no differences were reported between a group of females who had been sexually victimized as children and a control group of females who had not been sexually victimized as a child.

Caffaro (1989) re-examined the deflection factor structure of the GCSQ-R in conducting a national survey of one hundred and seventy five professional Gestalt therapists and their primary contact styles. He found support for a two factor structure, resembling the constructs of deflection and confluence and, thus, developed a new twenty-two item subscale for measuring the construct of deflection (CDEFLECT).

Zavarella (1992) utilized the GCSQ-R in studying the relationship between contact styles and pre-menstrual syndrome. Interestingly, the subgroup of women least affected by pre-menstrual syndrome scored higher on the GCSQ-R Desensitization subscale. This finding appears to lend empirical support for the functionality of desensitization as a way of managing physical pain.

Myers (1990) studied the relationship between the Gestalt contact styles and stress levels among a sample of police officers. She found that those police officers who reported high stress levels also scored high on the GCSQ-R subscales of Confluence,
Projection, Retroflection, and Deflection, while those police officers who reported low stress levels scored high on the GCSQ-R subscales of Desensitization and Introjection.

Kiracofe (1992) examined the Gestalt contact styles of a clinical sample of subjects in psychotherapy and found that nineteen of the twenty-one subjects reported retroflection as being their most frequently utilized contact style. Additionally, the categorization of resistant behaviors by twenty Gestalt “experts” led to the development of the Gestalt Resistance Behaviors Rating Scale (GRBRS).

Reliability of the GCSQ-R

As indicated by Table 2, four of the six GCSQ-R scales have internal consistency coefficients that exceed .70, with the median coefficient being .77. Only two scales, Desensitization (.65) and Introjection (.45) have demonstrated questionable internal consistency. Based on the standards set by Gay (1987) and Kiracofe (1992), there is some support for the internal consistency of the Desensitization Scale, however, the internal consistency of the Introjection scale is clearly inadequate.

With regards to test-retest reliability, Gay (1987) has suggested that coefficients in the .70 range are considered adequate for empirical research involving personality measures. As indicated in Table 2, all six scales of the GCSQ-R exceed this level, with five of the six scales having test-retest reliability in the upper .70 - .80 range. Only one scale, Introjection, has demonstrated a test-retest reliability coefficient in the lower .70 range of acceptability.
Table 2: Internal consistency and test-retest reliability for GCSQ-R scales

(a) Chronbach’s alpha internal consistency sample (n=54)
(b) Test-Retest interval of 2 - 4 weeks, sample (n=54)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Internal Consistency (a)</th>
<th>Test-Retest Reliability (b)</th>
<th># of items</th>
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<td>Confluence</td>
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<tr>
<td>Desensitization</td>
<td>.65</td>
<td>.79</td>
<td>12</td>
</tr>
<tr>
<td>Introjection</td>
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<tr>
<td>Deflection</td>
<td>.77</td>
<td>.80</td>
<td>43</td>
</tr>
</tbody>
</table>

Validity of the GCSQ-R

The concurrent validity of the GCSQ-R has been established by comparing its psychometric properties to that of the Minnesota Multiphasic Personality Inventory -2 (MMPI-2), another personality instrument. Prosnick (1996) has noted that the range of internal consistencies for the GCSQ-R (.45-.86) has been found to be comparable to the range of internal consistencies for the MMPI-2 (.34-.87). Similarly, the range of test-retest reliability’s for the GCSQ-R (.72-.82) has been found to be comparable to the test-retest reliability’s of the MMPI-2 (.58-.92).
According to Anastasia (1988), "The construct related validity of a test is the extent to which the test may be said to measure a theoretical construct or trait" (p. 153). Kepner (1983) conducted a factor analysis in creating the original GCSQ. In creating the GCSQ-R, Woldt and Kepner (1986) extended and replicated Kepner’s (1983) original factor analysis structures. Such a process of replication provides evidence as to the construct validity of the GCSQ-R.

In creating the GCSQ-R, Woldt and Kepner (1986) utilized the available theoretical literature in generating items that described each resistance. The item pool was then reviewed by a panel of expert judges in order to ensure that each item was an adequate representation of the underlying constructs. This process supports the face validity of the GCSQ-R.

The Gestalt Contact Styles Questionnaire-150 (GCSQ-150)

Prosnick (1996) expanded upon the GCSQ-R by adding two new factor derived Gestalt resistance scales, Egotism and Transfluence. This new instrument, the Gestalt Contact Styles Questionnaire, a paper and pencil instrument, is designed for individuals age sixteen years and older and requires an average testing time of 30-40 minutes (Woldt, Kepner, and Prosnick, 1996). In response to each of the 150 items, each subject indicates how much he or she agrees or disagrees the statement. The GCSQ-150 utilizes a 5-point Likert scale, with the potential responses being “I strongly agree with this statement”, “I agree with this statement”, “I neither agree nor disagree with the statement”, “I disagree with this statement” and “I strongly disagree with this statement".
The GCSQ-150 includes eight Gestalt resistance scales, eight from the original GCSQ-R (Confluence, Desensitization, Introjection, Projection, Retroflection, Deflection), plus Prosnick's (1996) two factor derived scales of Egotism and Confluence. Table 3 illustrates a profile sheet which graphically depicts each subject's raw score on each of the eight scales. The ratings- "very low", "low", "average", "high", and "very high"- are determined by T-Scores, which are standardized scores with a mean of 50 and a standard deviation of 10.

<table>
<thead>
<tr>
<th>Scale Name</th>
<th>Very Low</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desensitization</td>
<td>below 30</td>
<td>31-34</td>
<td>35-39</td>
<td>40-43</td>
<td>44 above</td>
</tr>
<tr>
<td>Introjection</td>
<td>below 66</td>
<td>67-72</td>
<td>73-78</td>
<td>79-84</td>
<td>85 above</td>
</tr>
<tr>
<td>Projection</td>
<td>below 54</td>
<td>55-66</td>
<td>67-79</td>
<td>80-91</td>
<td>92 above</td>
</tr>
<tr>
<td>Retroflection</td>
<td>below 87</td>
<td>88-102</td>
<td>103-118</td>
<td>119-133</td>
<td>134 above</td>
</tr>
<tr>
<td>Deflection</td>
<td>below 82</td>
<td>83-98</td>
<td>99-114</td>
<td>115-130</td>
<td>131 above</td>
</tr>
<tr>
<td>Egotism</td>
<td>below 32</td>
<td>33-40</td>
<td>41-49</td>
<td>50-57</td>
<td>58 above</td>
</tr>
<tr>
<td>Confluence</td>
<td>below 57</td>
<td>58-64</td>
<td>65-72</td>
<td>73-79</td>
<td>80 above</td>
</tr>
<tr>
<td>Transfluence</td>
<td>below 45</td>
<td>46-60</td>
<td>61-75</td>
<td>76-90</td>
<td>91 above</td>
</tr>
</tbody>
</table>

Table 3: Raw-score ratings for the eight GCSQ-150 scales
Reliability of the GCSQ-150

The GCSQ-150 is a combination of the original GCSQ-R plus Prosnick’s (1996) two new factor derived scales of Egotism and Transfluence. As such, the reliability of the GCSQ-150 is composed of two major parts: 1) the reliability of the original GCSQ-R; and 2) the reliability of Prosnick’s (1996) two new factor derived scales of Egotism and Transfluence. The reliability the original GCSQ-R has been previously addressed (see page 98). As indicated in Table 4, Prosnick’s (1996) two factor derived scales of Egotism and Transfluence have demonstrated adequate internal consistency. The Egotism Scale (.76) meets Gay’s (1987) .70 criteria for acceptability, and the Transfluence Scale far exceeds such criteria. Prosnick (1996) did not report test-retest reliability for his factor derived Egotism and Transfluence Scales.

Validity of the GCSQ-150

Similar to the above process of establishing the reliability of the GCSQ-150, the validity of the GCSQ-150 is composed of two major parts: 1) the validity of the original

<table>
<thead>
<tr>
<th>Factor Scale</th>
<th>n</th>
<th>Mean</th>
<th>S.D.</th>
<th>Internal Consistency</th>
<th>Item Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egotism (Eg-R)</td>
<td>155</td>
<td>47.92</td>
<td>5.58</td>
<td>.76</td>
<td>2.66</td>
</tr>
<tr>
<td>Transfluence (Tf-R)</td>
<td>155</td>
<td>65.04</td>
<td>14.35</td>
<td>.90</td>
<td>2.83</td>
</tr>
</tbody>
</table>

Table 4: Internal Consistency for Prosnick’s (1996) Egotism and Transfluence scales
GCSQ-R; and 2) the validity of Prosnick’s (1996) two new factor derived scales of Egotism and Transfluence. The validity of the original GCSQ-R has been previously addressed (see page 99). The concurrent validity of Prosnick’s (1996) two factor derived scales of Egotism and Transfluence has been established by correlating each of the scales to one of two different instruments, The Ego Grasping Orientation Inventory (EGO) and the Mysticism Scale (M Scale). Table 5 illustrates the concurrent validity of Prosnick’s Egotism and Transfluence Scales.

The EGO, an instrument designed to measure an individual’s ego grasping ability, and Prosnick’s (1996) Egotism Scale have demonstrated concurrent validity at .55. According to Davis (1971), Pearson product-moment correlation coefficients in the .50-.69 range indicate a “substantial” relationship between the two variables or constructs. A coefficient of .55, therefore, suggests that the EGO and Prosnick’s Egotism Scale are sufficiently correlated, yet, not to the extent that they are identical.

Additionally the M Scale, the most widely utilized and psychometrically accepted

<table>
<thead>
<tr>
<th>Prosnick’s (1996) Scales</th>
<th>EGO</th>
<th>M Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egotism Scale (Eg-R)</td>
<td>.55*</td>
<td>-.34</td>
</tr>
<tr>
<td>Transfluence Scale (Tf-R)</td>
<td>-.11</td>
<td>.76*</td>
</tr>
</tbody>
</table>

EGO = Ego Grasping Orientation Inventory  M Scale = Mysticism Scale  * = p < .001

Table 5: Concurrent Validity of Prosnick’s (1996) Egotism and Transfluence Scales
measurement of self-transcendence (Prosnick, 1996), and Prosnick’s (1996) Transfluence Scale have demonstrated acceptable concurrent validity at .76. Davis (1971) suggests that Pearson product-moment correlation coefficients above .70 indicate a “very strong” association between the variables or constructs.

The GCSQ-150 has several significant limitations. First, the internal consistency of the Introjection Scale (.45) and the Desensitization Scale (.65) are questionable. Second, Prosnick (1998) noted that the GCSQ-150 has considerable item overlap in the factor scales which significantly reduces their discriminant validity. For example, item number 17 “I have difficulty putting uncomfortable feelings out of my mind” loaded positively on five of the six original scales (Confluence, Desensitization, Projection, Retroflection, and Deflection). Table 6 presents the intercorrelations between the GCSQ-150 for Prosnick’s (1996) study and Table 7 illustrates the 77 overlapping items for the five GCSQ-150 scales relevant to the present study.

As indicated by Table 6, in Prosnick’s (1996) study, every one of the ten correlation coefficients was statistically significant, eight at the .001 level and two at the .05 level. Additionally, the range of intercorrelations for the GCSQ-150 scales in Prosnick’s (1996) study was .16 to .86.

The Gestalt Resistance Scale (GRS) for the GCSQ-150

In order to improve upon these limitations, Prosnick (1998) developed the Gestalt Resistance Scale (GRS) for the GCSQ-150. In creating the GRS, Prosnick (1998)
<table>
<thead>
<tr>
<th>GCSQ-150 scale</th>
<th>Desensitization</th>
<th>Introjection</th>
<th>Projection</th>
<th>Retroflection</th>
<th>Deflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desensitization</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introjection</td>
<td>.16*</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projection</td>
<td>-.27***</td>
<td>-.26***</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retroflection</td>
<td>-.39***</td>
<td>-.41***</td>
<td>.86***</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Deflection</td>
<td>-.20*</td>
<td>-.37***</td>
<td>.83***</td>
<td>.82***</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Key: *= p < .05; **= p < .01; ***= p < .001

Table 6: Intercorrelations among GCSQ-150 scales in Prosnick's (1996) study

<table>
<thead>
<tr>
<th>Desensitization</th>
<th>Introjection</th>
<th>Projection</th>
<th>Retroflection</th>
<th>Deflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desensitization</td>
<td>-----</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Introjection</td>
<td>-----</td>
<td>3</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Projection</td>
<td>-----</td>
<td>18</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Retroflection</td>
<td>-----</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deflection</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7: Seventy seven overlapping items on GCSQ-R scales
restructured the scales and scoring system from the GCSQ-150 in order to eliminate item overlap. The GRS utilized exactly the same items and item composition from the original GCSQ-150. The new and restructured GRS scales and scoring system have only one item which overlaps on two different scales—item 125 "I sometimes feel like a spectator of my own life" is on both the GRS Egotism and Transfluence scales. There were twelve items (71, 78, 90, 102, 108, 120, 122, 128, 129, 130, 138, and 140) that were theoretically and empirically unsupported and, therefore, not used in the GRS restructuring process.

The sample used for scale construction and standardization of the GRS was collected by Reva Schwartz (1998) as part of her dissertation at Kent State University. The standardization sample consisted of 623 participants (444 women, 174 men, 5 unknown). The mean age was 45.07 (S.D. = 14.59, range = 18-80). The racial composition of the standardization sample was: 88.6% White, 6.3% African American, 1.3% Asian, .5% Hispanic, .8% other, and 2.4% unknown. The occupational composition of the standardization sample was: 25.2% teachers, 18.6% other, 11.7% therapists, 7.5% business, 5.6% retired, 4.5% allied health, 4.3% administrators, 4.3% sciences, 3.9% clerical, 3.4% services, 3.0% school psychologists, 2.6% medical, 2.1% communications, 1.9% arts and religion, .8% mechanics, and .5 unknown. The religious composition of the standardization sample was: 37.4% Protestant, 21.3% Catholic, 17.5% Jewish, 6.7% none, .5% Moslem, .2% Buddhist, 6.7% other, and 9.6% unknown.

The Gestalt Resistance Scales (GRS) were developed using a multi-stage, multi-method approach (Prosnick, 1998). Similar procedures, which combined both rational and statistical strategies, were used in the development of the MMPI-2 content scales.
(Butcher, Graham, Williams, & Ben-Porath, 1990). Figure 1 provides a summary of the stages, steps and multiple methodologies taken to create the GRS.

The first stage of scale development consisted of the rational identification of items comprising each of the seven Gestalt resistance areas (Prosnick, 1998). This task included examining both the previous theoretical research involving each GCSQ-150 item (Kepner, 1982; Prosnick, 1996), as well as the previous empirical research involving each GCSQ-150 item (Kepner, 1982; Prosnick, 1996, 1997; Woldt & Kepner, 1986). This was followed by a discussion with and input from the senior author of the GCSQ-150 on the above rational-empirical assessment of each item. Items were then further scrutinized to include content validity in the new scales. Each item was assigned to a resistance behavior which had shown to evidence expert judge validity in previous research (see Appendix G). The last step in Stage 1 involved the final selection of items for each of the seven resistance areas.

Stage 2 involved a factor analysis and Principal Component Analyses of the items resulting from Stage 1. Seven components were extracted from the remaining 127 items with orthogonal rotation to the VARIMAX criterion. The component structures were examined and item patterns were identified which would further inform item-scale membership.

Stage 3 was designed to statistically verify item-scale membership. After internal consistency item analyses were examined for the seven provisional scales, items which
Six Developmental Stages of the Gestalt Resistance Scales

Stage 1: Rational Identification of Items Comprising Resistance Areas
a. Identification of previous theoretical research
b. Identification of previous empirical research
c. Discussion with and input from senior author of GCSQ-150
d. Identification of items which represent resistance behaviors as identified by expert judges
e. Selection of items for resistance areas, informed by 1a through 1d above

Stage 2: Factor Analysis and Principal Component Analyses
a. Extraction of seven components with orthogonal rotation to the VARIMAX criterion
b. Examination of component structures
c. Identification of item patterns to inform item-scale membership

Stage 3: Statistical Verification of Item-Scale Membership
a. Internal consistency item analyses on provisional scales
b. Identification and deletion of items which were not correlated with scales
c. Identification and addition of items correlated with scales but which were not previously selected
d. Elimination of items more highly correlated with other scales

Stage 4: Rational Inspection of Content Scales
a. Inspection of each content dimension
b. Deletion of statistically related but content inappropriate items
c. Elimination of all item overlap

Stage 5: Final Statistical Refinement of Scales
a. Derivation of statistics and percentile scores for all scales

Stage 6: Final Rational Review of Content Scales
a. Items reviewed and precise descriptions written for each content scale

Figure 2: Developmental stages of Gestalt Resistance Scales (Prosnick, 1998)
were not correlated with scales were identified and deleted. Those items which were shown to correlate with scales, but which had not been previously selected, were identified and added. Finally, items more highly correlated with other scales were eliminated.

Stage 4 involved a rational inspection of the scales which resulted from Stage 3. Each Gestalt resistance scale was inspected, and statistically related but content inappropriate items were deleted. It was at this stage that all item overlap was eliminated.

Stage 5 was the final statistical refinement of the new scales. At this stage the percentile scores for each of the seven scales were derived.

Stage 6 was a final rational review of the Gestalt Resistance Scales. Items were reviewed and precise descriptions were written for each resistance scale.

Reliability of the GRS for the GCSQ-150

As discussed previously, the GCSQ-150 Introjection Scale originally demonstrated an internal consistency of .45, while the GCSQ-150 Projection Scale originally demonstrated an internal consistency of .85. Table 8 depicts a comparison between the internal consistency of the original GCSQ-150 factor scales and the revised factor scales for the GCSQ-150.

With regards to internal consistency, Gay (1987) has suggested that internal consistency reliability coefficients in the .70 range are acceptable for personality measurements. As indicated by Table 8, three of the six GRS scales (Retroflection, Deflection, and Egotism) meet Gay's (1987) criteria for acceptable internal consistency. Two of the six GRS scales (Projection and Egotism) demonstrated significant to slight reductions in internal consistency. The GRS Desensitization scale demonstrated a
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Desensitization</td>
<td>.65 (12 items)</td>
<td>.58 (12 items)</td>
<td>.63 (15 items)</td>
</tr>
<tr>
<td>Introjection</td>
<td>.45 (23 items)</td>
<td>.35 (12 items)</td>
<td>.56 (15 items)</td>
</tr>
<tr>
<td>Projection</td>
<td>.86 (27 items)</td>
<td>.85 (27 items)</td>
<td>.66 (10 items)</td>
</tr>
<tr>
<td>Retroflection</td>
<td>.84 (43 items)</td>
<td>.85 (27 items)</td>
<td>.87 (27 items)</td>
</tr>
<tr>
<td>Deflection</td>
<td>.77 (43 items)</td>
<td>.85 (43 items)</td>
<td>.85 (20 items)</td>
</tr>
<tr>
<td>Egotism</td>
<td>N/A (11 items)</td>
<td>.71 (11 items)</td>
<td>.70 (18 items)</td>
</tr>
</tbody>
</table>

Table 8: Comparison of internal consistency between GCSQ-R, the original GCSQ-150, and the GRS for the GCSQ-150

.02 reduction in internal consistency from Hoopingamer’s (1987) original validation study and an increase of .05 from Prosnick’s (1996) study. The internal consistency of the GRS Projection scale fell .20 from the original Hoopingamer (1987) validation study of the GCSQ-R and .19 from Prosnick’s (1996) study.

According to Anastasi (1998), internal consistency is influenced by sample size, with lower sample sizes often producing lower internal consistency coefficients. Thus, the low internal consistency on the GRS Projection scale may be, in part, explained by the low sample size of ten subjects.

The internal consistency of the GRS Introjection scale demonstrated an increase of .11 over Hoopingamer’s (1987) original validation study and .21 over Prosnick’s (1996)
study. Despite such an increase, the internal consistency of the GRS Introjection scale is still questionable at .56. Throughout all of the previous studies which have utilized the GCSQ-R and GCSQ-150, the Introjection scale has consistently demonstrated low and inadequate internal consistency (K. Prosnick, personal communication, August 24, 1998). The Introjection scale has been found to be the most heterogeneous of all the GCSQ-R and GCSQ-150 scales and, thus, likely to have the most outlier responses. Additionally, after factor analysis of the GCSQ-R and GCSQ-150 scales, the Introjection scale was found to be least based on Gestalt theory (K. Prosnick, personal communication, August 24, 1998).

**Validity of the GRS**

As previously discussed, each GRS item was assigned to a resistance behavior which was then determined to evidence expert judge validity. Such a process supports the content validity of the GRS. Additionally, the high item to scale correlation coefficients in Appendix H indicates initial construct validity. It is important to recognize that written permission was obtained by Dr. Ansel Woldt, the senior author and creator of the GCSQ-150, to reprint the GCSQ-150 items in this manuscript (see Appendix J)

**The Millon Clinical Multiaxial Inventory-III (MCMI-III)**

The MCMI-III emerged out of Millon’s (1977, 1987, 1994; & Davis, 1996) intricate theory of personality. In order to understand the nature MCMI-III, it is important to also understand the underlying theoretical framework of the instrument and Millon’s typology of personality disorders.
Underlying Theoretical Framework of the MCMI-III

There are many testing instruments that are currently being used to measure personality styles and disorders. Several of the more popular instruments include the Minnesota Multiphasic Personality Inventory, 2nd edition (MMPI-2), the Sixteen Factor Personality Questionnaire (16 PF), and the California Psychological Inventory (CPI). Each of these different measurement instruments has a unique, underlying theoretical framework from which to define, assess, measure, and interpret personality constructs. Unfortunately, the majority of available personality instruments are typically based upon the author’s unique theoretical framework which, often times, is unrelated to the diagnostic criteria utilized by the clinician in formulating a diagnosis (Butcher, 1972, cited in Millon, 1994). This is a major methodological limitation, particularly when conducting empirical research with the intention of linking theoretical constructs with treatment interventions. Without the knowledge that the clinician and the personality instrument are, indeed, assessing the same personality construct, there is considerable question regarding the reliability and validity of the resulting data.

Unlike all other personality instruments, however, the MCMI-III is significantly correlated with the DSM-IV, perhaps one of the most widely accepted and utilized diagnostic instruments currently utilized by mental health practitioners to diagnose various emotional and personality disorders. In fact, Millon played an instrumental role in the development and revision of the DSM-IV.

Few currently available diagnostic inventories are as consonant as the MCMI-III not only with the nosological format and conceptual terminology of the DSM-IV but also with it’s diagnostic criteria... Close correspondence of the instrument to
the current nosological framework is helpful to the practicing clinicians, most of whom are already familiar with the terminology and framework of the DSM (Millon, 1994, p.3).

Unlike many other theorists who use single traits in order to assess personality styles, Millon proposed a classification system based on personality prototypes, the core factors that are the most essential and descriptive features of specific personality patterns or profiles (Millon, 1994). Such a system is based on the assumptions that there are unique types or patterns of clinical behavior that are shared by a distinctive group of clients and that, furthermore, having knowledge of such types or patterns would benefit the clinician in regards to assessment and treatment planning.

The aim of prototypal diagnosis is to make the clinician aware of aspects of a patient’s history and behavior that may not have been previously identified. A further hope is that clinicians will use their knowledge about other patients who display the disorder and generalize that knowledge in a useful and valid manner for all new patients diagnosed as having that disorder (Millon, 1994, p.9).

There are three essential features of an effective classification system that has guided Millon’s unique personality theory and the subsequent development of the MCMI (Millon, 1977), the MCMI-II (Millon, 1987), and the MCMI-III (Millon, 1994). Briefly stated, they are: 1) that categories should be differentiated according to severity; 2) that the categories should reflect the fact that the presenting clinical picture is composed of several other “covering” clinical symptoms or characteristics; and 3) that each diagnostic category should not be viewed as a separate entity, but rather as a precursor, extension, or modification of other clinical categories.

These three essential features are very clearly reflected in the scoring procedures of the MCMI, MCMI-II, and MCMI-III. Millon (1994) described two basic systems by
which personality tests can be scored and standardized - norm referencing and criterion referencing.

In the norm referencing system, norms are established using a sample that is thought to represent a larger population. After each subject is compared to the mean and distribution of the standardized sample, a "standard score" is used to represent his or her position relative to the sample.

Millon (1994) noted that norm-referencing system and the associated T-scores create two significant problems when utilized with personality inventories. The first problem is the likelihood that the shape of the distribution of scores will differ between the various personality scales. Thus, the standard scores and established cut-off points lose some of their significance and meaning.

The second problem is that norm-referencing and T-scores do not take into account the prevalence of the attribute being measured. With the main objective of norm-referencing being to reflect how subjects compare to the standardized sample, the mean is typically established at 50 and the standard deviation is 10. "However, this almost never corresponds to the actual prevalence rate of a particular disorder in a particular population and therefore introduces an automatic error" (Millon, 1994, p. 26).

In order to compensate for the limitations of the norm-referencing and T-score system, Millon (1994) utilized criterion-referencing, in which a standard score is created which is anchored to the actual prevalence rates of the construct being measured. Base Rate (BR) Scores were utilized as the standardized score into which the subjects' raw scores are translated. According to Millon (1994):
The BR score was designed to anchor cut-off points to the prevalence of a particular attribute in the psychiatric population. BR scores define a continuum of the pervasiveness and severity of a psychological attribute against which any individual can be evaluated. Using a continuum is an acknowledgment that the differences between a clinical disorder and normal functioning, especially with personality scales, is one of degree rather than kind, represented as shades of increasingly problematic adaptive flexibility and tenuous stability under stress...The base rate score represents the most direct way of getting at what is explicitly of clinical interest in the first place (p.26).

In developing the original MCMI, Millon generated over 3,500 test items related to his theory of personality development (Choca, Shanley, & Van Denburg, 1995). Due to the constant development and evolution of the taxonomic theory on which the original MCMI was based, two new personality disorder scales were introduced in creating the MCMI-II, and further revisions were made in the establishment of the MCMI-III.

**MCMI-III**

The MCMI-III is a true and false, 175 item, paper and pencil instrument designed for use with adults who possess at least an eighth grade reading level. On average, most respondents are able to complete the MCMI-III within 20-30 minutes. According to Millon (1994):

The MCMI-III is not a general personality instrument to be used for normal populations or for any purpose other than diagnostic screening or clinical assessment. Normative data and transformation scores for the MCMI-III are based entirely on clinical samples and are applicable only to individuals who evidence psychological problems or who are engaged in a program of professional psychotherapy or psychodiagnostic evaluation (p.5).

As indicated by Table 9, the MCMI-III consists of eleven Clinical Personality Pattern Scales, three Severe Personality Pathology Scales, seven Clinical Syndrome Scales, and three Severe Syndrome Scales. Additionally, there are three Modifying...
Indices and a Validity Index, which will be discussed in detail in a later section of this chapter.

There are several revisions that have occurred in order to make the MCMI-III a distinctively different instrument than its predecessor, the MCMI-II. A major change includes the additions of both a Depressive Clinical Personality Pattern and a Post Traumatic Stress Disorder scale. Ninety-five items from the MCMI-II were also replaced in order to optimize the correspondence between the MCMI-III and the DSM-IV. Additionally, a new item-weighting system was introduced and the interpretative text was expanded in order to reflect the changes in the MCMI-III’s theory (Millon, 1994).

The revision process for the MCMI-III began with a selection of 150 new items which were written to sample the domains of the two new scales and to ensure that all of the scales closely correlated with the DSM-IV diagnostic criteria (Millon, 1994). Several hundred clinicians who regularly used the MCMI-II in treating adults were recruited to participate in the revision research process. In addition to administering the revised instrument to willing and consensual subjects, each clinician rated the subject on several different clinical characteristics.

The subjects in the revision research included 1,079 adults from 26 states and Canada (Millon, 1994). A total of 73 subjects were excluded from the revision process because they failed to meet certain validity conditions. The remaining 998 subjects were divided into two groups, one group of 600 (293 males, 307 females) used to define the MCMI-III scales and BR scores, and another group of 398 (197 males, 201 females) used for cross-validation purposes. In both groups, approximately 86% of the subjects were
## Clinical Personality Patterns

<table>
<thead>
<tr>
<th>Scale</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Schizoid</td>
</tr>
<tr>
<td>2a</td>
<td>Avoidant</td>
</tr>
<tr>
<td>2b</td>
<td>Depressive</td>
</tr>
<tr>
<td>3</td>
<td>Dependent</td>
</tr>
<tr>
<td>4</td>
<td>Histrionic</td>
</tr>
<tr>
<td>5</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>6a</td>
<td>Antisocial</td>
</tr>
<tr>
<td>6b</td>
<td>Aggressive (Sadistic)</td>
</tr>
<tr>
<td>7</td>
<td>Compulsive</td>
</tr>
<tr>
<td>8a</td>
<td>Passive-Aggressive (Negativistic)</td>
</tr>
<tr>
<td>8b</td>
<td>Self-Defeating</td>
</tr>
</tbody>
</table>

## Severe Personality Pathology

<table>
<thead>
<tr>
<th>Scale</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Schizotypal</td>
</tr>
<tr>
<td>C</td>
<td>Borderline</td>
</tr>
<tr>
<td>P</td>
<td>Paranoia</td>
</tr>
</tbody>
</table>

## Clinical Syndromes

<table>
<thead>
<tr>
<th>Scale</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Anxiety</td>
</tr>
<tr>
<td>H</td>
<td>Somatoform</td>
</tr>
<tr>
<td>N</td>
<td>Bipolar: Manic</td>
</tr>
<tr>
<td>D</td>
<td>Dysthymia</td>
</tr>
<tr>
<td>B</td>
<td>Alcohol Dependence</td>
</tr>
<tr>
<td>T</td>
<td>Drug Dependence</td>
</tr>
<tr>
<td>R</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
</tbody>
</table>

## Severe Syndromes

<table>
<thead>
<tr>
<th>Scale</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS</td>
<td>Thought Disorder</td>
</tr>
<tr>
<td>CC</td>
<td>Major Depression</td>
</tr>
<tr>
<td>PP</td>
<td>Delusional Disorder</td>
</tr>
</tbody>
</table>

## Modifying Indices

<table>
<thead>
<tr>
<th>Scale</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Disclosure</td>
</tr>
<tr>
<td>Y</td>
<td>Desirability</td>
</tr>
<tr>
<td>Z</td>
<td>Debasement</td>
</tr>
<tr>
<td>V</td>
<td>Validity</td>
</tr>
</tbody>
</table>

Table 9: MCMH-III Scales
white, 8% were black, 1% were Native American, and less than 1% were Hispanic, Asian, or of some other race.

Reliability of the MCMI-III

Table 10 presents information for the reliability of the MCMI-III scales that were relevant to this study (Millon, 1994). Utilizing Gay’s (1987) .70 as the standard for adequate reliability, the MCMI-III far exceeds the acceptable range of test-retest reliability on all five scales, and on four of the five scales for internal consistency. Only the Narcissistic scale (.67) has demonstrated an internal consistency coefficient that is at or minimally below the standard and acceptable level (Kirocofe, 1992; Gay, 1987).

<table>
<thead>
<tr>
<th>MCMI-III Scale</th>
<th>Internal Consistency (a)</th>
<th>Test-retest Reliability (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Schizoid</td>
<td>16</td>
<td>.81</td>
</tr>
<tr>
<td>5  Narcissistic</td>
<td>24</td>
<td>.67</td>
</tr>
<tr>
<td>6A Antisocial</td>
<td>17</td>
<td>.77</td>
</tr>
<tr>
<td>6B Aggressive (Sadistic)</td>
<td>20</td>
<td>.79</td>
</tr>
<tr>
<td>8A Passive-Aggressive (Negativistic)</td>
<td>16</td>
<td>.83</td>
</tr>
<tr>
<td>C  Borderline</td>
<td>16</td>
<td>.85</td>
</tr>
</tbody>
</table>

(a) cross validation sample (n=398)
(b) Test-retest interval 5-14 days, retest sample (n=87)

Table 10: Reliability of MCMI-III Scales Relevant to the Current Study

118
Validity of the MCMI-III

The MCMI-III contains four separate internal validity scales. There are three Modifying Indices (Disclosure, Desirability, Debasement) and a Validity Scale which are designed to provide information about the subject's "response style" (Millon, 1994). It should be noted that written permission was obtained by this author from National Computer Systems, Inc. in order to reprint up to five (5) original items from the MCMI-III in the text of this manuscript (see Appendix I).

The Validity Index (Scale V) was designed to measure the overall validity of the subject's responses to the instrument items. It consists of three highly improbable items - "I flew across the Atlantic 30 times last year", "I was on the front cover of several magazines last year", and "I have not seen a car in the last ten years" (Millon, 1994). A score of 0 indicates that the profile is valid, a score of 1 indicates that the profile is of questionable validity, and a score of 2 or more indicates that the profile is considered to be invalid. The Disclosure Index (Scale X) was designed to measure the subject's level of honesty in his or her responses to the test items. Due to the fact that the Disclosure Index is calculated from an adjusted raw score for the 11 Clinical Personality Pattern scales, there are no specific items comprising this particular scale. A BR score below 34 or above 178 indicates that the protocol should be considered invalid.

The Desirability Index (Scale Y) was designed to measure the subject's tendency to conceal his or her personal or psychological difficulties in an attempt to appear more socially attractive, virtuous, or composed. An example of an item on the Desirability Index (Scale Y) is item number thirty two, "I am always looking to make new friends and
meet new people” (Millon, 1994). The higher the BR score on the Desirability Index, the greater the likelihood that the subject was influenced by social pressures in his or her responses. In general, a BR score above 75 indicates that the respondent has a tendency to present him or herself in a socially favorable light.

The Debasement Index (Scale Z) was designed to measure the subject’s tendency to exaggerate his or her emotional and psychological symptoms. The higher the BR score, the greater the likelihood that the subject has attempted to deprecate or devalue him or herself in some way. In general, a BR score above 75 indicates that the respondent has a tendency to devalue him or herself and by “presenting more troublesome emotional and personal difficulties than are likely to be uncovered upon objective review” (Millon, 1994, p. 46). An example of an item on the Debasement Scale is item number 150, “Looking ahead as each day begins makes me feel terribly depressed” (Millon, 1994). Additionally, Millon (1994) noted that exceedingly high scores on the Debasement Index must be carefully examined, not only to determine potentially distorted psychological problems but also to determine if the subject is experiencing extreme levels of emotional distress or turmoil which may require immediate intervention.

The validity of the MCMI-III has been established by correlating the BR score for each scale with the clinicians rating and other collateral instruments. Table 11 illustrates the correlations between the BR scores for each scale and the clinicians ratings (Millon, 1994). According to Davis (1971) correlations in the .30-.49 range are indicative of a “moderate association” between the constructs. As indicated by Table 11, each of the
MCMI-III scales relevant to the present study have correlations which range from slightly to significantly below this .30 standard for moderate association.

<table>
<thead>
<tr>
<th>MCMI-III Scale</th>
<th>Correlation with Clinician Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Schizoid</td>
<td>.24</td>
</tr>
<tr>
<td>5 Narcissistic</td>
<td>.27</td>
</tr>
<tr>
<td>6A Antisocial</td>
<td>.25</td>
</tr>
<tr>
<td>6B Aggressive (Sadistic)</td>
<td>.14</td>
</tr>
<tr>
<td>8A Passive-Aggressive (Negativistic)</td>
<td>.23</td>
</tr>
<tr>
<td>C Borderline</td>
<td>.24</td>
</tr>
</tbody>
</table>

p ≤ .01 (one tailed)

Table 11: Correlations between MCMI-III Base Rate scores and clinician ratings

The correlations for between the Aggressive (Sadistic) Scale and clinician ratings appear to fall significantly below Davis's (1971) .30 standard for moderate association.

Millon (1994), in an attempt to explain such a low correlation, noted that at the time of the study, the DSM-IV diagnostic criteria was not available to the participating clinicians.

Additionally:

It should be reiterated at this point that clinician judgments were made without the benefit of a formal diagnostic interview; they were also made at the time the MCMI-II-R was administered (typically at intake). Thus there is reason to suspect that the clinician judgments were less reliable or valid than they might have been.
had they been made at a time further along in the therapeutic process (i.e., after clinicians had had many sessions with their clients) (Millon, 1994, p.30).

Millon (1994) also established the concurrent validity of the MCMI-III by correlating it with other personality and psychological instruments. These instruments include the Beck Depression Inventory (BDI), General Behavior Inventory (GBI), Symptom Checklist-90-Revised (SCL-90-R), Impact of Events Scale (IOES), State-Trait Anxiety Inventory (STAI), and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2).

Intercorrelations Among MCMI-III Scales

Table 12 illustrates the MCMI-III intercorrelations in Million’s (1994) normative sample study. The range of intercorrelations in Million’s (1994) study was -.29 to .79. The highest intercorrelation was between the Borderline and Passive-Aggressive Personality Disorder Scales and the lowest intercorrelation was between the Passive Aggressive and Narcissistic Personality Disorder Scales.

Data Analysis

The statistical technique that was utilized to analyze and interpret the outcome data for this study is discriminant analysis. Discriminant Analysis is the most appropriate analytical technique when the dependent variable is categorical in nature and the independent variables are metric (Hair, Anderson, Tatham, & Black, 1995; Stevens, 1992). In the present study, the dependent variable is the subject’s Base Rate scores on the MCMI-III scales, and the independent variables are the subject’s raw scores on the GCSQ-150 scales.
<table>
<thead>
<tr>
<th>MCMI-III Scale</th>
<th>1</th>
<th>5</th>
<th>6a</th>
<th>6b</th>
<th>8a</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>-0.43**</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6a</td>
<td>0.32**</td>
<td>NS</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6b</td>
<td>0.32**</td>
<td>NS</td>
<td>0.65**</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>0.57**</td>
<td>-0.29**</td>
<td>0.56**</td>
<td>0.64**</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0.59**</td>
<td>-0.38**</td>
<td>0.61**</td>
<td>0.57**</td>
<td>0.79**</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Key:
1 = Schizoid Personality Disorder
5 = Narcissistic Personality Disorder
6a = Antisocial Personality Disorder
6b = Aggressive (Sadistic) Personality Disorder
8a = Passive-Aggressive Personality Disorder
C = Borderline Personality Disorder
** = p < .01
NS = Not significant correlation (Millon, 1994, p. 121)

Table 12: Intercorrelations of Millon’s (1994) normative sample utilized in developing the MCMI-III scales

A categorical variable is one that utilizes arbitrary values that serve merely to identify, label, or categorize (Hair et al., 1995). As discussed in an earlier section of this chapter, a subject’s BR score at or above 85 indicates the “presence of a disorder” and a subject’s BR score between 75 and 84 indicates the “presence of a trait” (Millon, 1994). A subject who has a BR score below at or below 74 is considered to have neither a personality “disorder” nor personality “traits” associated with a particular disorder. A subject can only meet the criteria for one category—either he is categorized as “having a
disorder” or he is categorized as “not having a disorder”. It is important to recognize that a subject can meet the MCMI-III diagnostic criteria for having more than one personality “disorder”.

A metric variable, on the other hand, is a variable with a constant unit of measurement (Hair et al., 1995). In the present study, the scales on the GCSQ-150 have a constant unit of measurement in that, for example, the difference between a raw score of 25 and 26 is the same as the difference between a raw score of 50 and 51.

Discriminant analysis is considered to be the most appropriate technique when a researcher is interested in studying the differences between two groups with respect to several “discriminator” variables (Hair et al., 1995). According to Stevens (1992), there are three essential questions that can be answered by using discriminant analysis: 1) How well is one able to discriminate between the groups on the basis of some set of discriminating variables?; 2) How well does the set of variables “discriminate”?; and 3) Which discriminating variables are the most powerful predictors?

For the purposes of the present study, the emphasis is on examining the differences between those male batterers with a personality “disorder”, those male batterers with personality “traits” relevant to a particular disorder, and those male batterers with neither personality “disorders” or “traits” in correlation with the various Gestalt resistances. Thus, according to the criteria established by Hair et al. (1995) and Stevens (1992), discriminate analysis is considered to be the most appropriate statistical technique for the present study.
In order to better understand the nature and interpretation of discriminant analysis, there are several important terms which the reader must know. Thus, a brief overview of these terms is presented below.

**Eigenvalue** - The eigenvalue is a measure of the strength of the discriminant functions and the ability of the independent variables to discriminate between the groups of dependent variables (Hair et al., 1995). The eigenvalue is the ratio of variance explained by the discriminant function to the variance not explained by the discriminant function. The higher the eigenvalue, the more powerful the discriminant function. Ideally, an eigenvalue should be closer to 1.0 and as far from .000 as possible (Stevens, 1992).

**Canonical Correlation** - The canonical correlation is another measure of the strength of the discriminant functions and the ability of the independent variables to discriminate between the groups of dependent variables. Ideally, the canonical correlation should be as close to 1.0 as possible (Stevens, 1992).

**Wilks' Lambda** - The Wilks' Lambda is the proportion of unexplained variance in the discriminant score (Hair et al., 1996). It is used to compare means in the different dependent variable groups. Unlike the eigenvalue and canonical correlation, the lower the Wilks' Lambda statistic the better the discriminating power of the discriminant function. If the significance of Wilks' Lambda is greater than the alpha level utilized in the study, the group means (centroids) are assumed to be equal and there are no significant differences between the dependent variable groups. If, however, the significance of Wilks' Lambda is less than the alpha level utilized in the study, the discriminant function is statistically
significant and there is a difference between the dependent variables groups (Stevens, 1992).

**Standardized canonical discriminant function coefficients** - A statistical technique used to determine each variable's relative important in the discriminant function (Hair et al., 1995). The canonical discriminant function coefficient ranges from -1 to +1. The larger the magnitude of the coefficient (closer to -1 or +1), the more significant, or powerful, that variable is in the discriminant function. The closer a variables coefficients is to zero, the less significant, or powerful, that variable is in the discriminant function (Stevens, 1992).

**Classification Table** - An index measuring the effectiveness or predictive ability of the discriminant function in which the discriminant function is used to classify cases into one of the dependent variable groups. The higher the proportion of "correctly" classified cases, the higher the predictive and discriminating power of the discriminant function (Stevens, 1992).

**Discriminant Analysis vs. Other Statistical Techniques**

Presently, there are numerous statistical techniques available from which to analyze and interpret research data. There are several reasons why discriminant analysis was chosen over all others as the primary statistical and analytical technique of the present study. In order to further substantiate the decision to use discriminant analysis, this technique will be compared to other similar, high-level techniques with regards to their appropriateness for the present study. More specifically, discriminant analysis will be
compared to the techniques of canonical correlation, multiple regression analysis, and cluster analysis.

**Canonical Correlation**

The application and interpretation of discriminant analysis is similar to canonical correlation in several ways. Canonical correlation is a statistical technique which is designed to predict multiple dependent variables from multiple independent variables (Hair et al., 1995).

However, canonical correlation is considered to be the most appropriate statistical technique when the dependent variable is metric in nature. On the other hand, discriminant analysis is considered to be the most appropriate statistical technique when the dependent variable is categorical in nature (Hair et al., 1995; Stevens, 1992). The fact that the dependent variable in the present study is categorical in nature supports the decision to use discriminate analysis.

**Multiple Regression Analysis**

Multiple regression is another higher-level statistical technique which is considered appropriate when a researcher is interested in explaining the variance of the dependent variable through linear relationships with the independent variable (Stevens, 1992). Multiple regression analysis is a statistical technique that is utilized to analyze the relationships between a single dependent (criterion) variable and several independent (predictor) variables. The major goal of multiple regression analysis is to predict changes in the dependent variable based on changes in the independent variable. Thus, the dependent variable is "regressed" upon each of the independent variables.
By conducting separate and single analyses of the relationship between each of the
dependent and independent variables, however, multiple regression is limited in its ability
to effectively deal with the issue of multicollinearity, which is the intercorrelation of the
independent variables (Stevens, 1992). Although Prosnick (1998) created the GRS in
order to eliminate the influences of item overlap from the GCSQ-150 scales, the
theoretical constructs of the Gestalt resistances, by their very nature, have the potential to
exhibit some levels of multicollinearity (K. Prosnick, personal communication, November
28, 1997).

This being the case, the statistical technique which is chosen for the present study
must be able to deal with the potential multicollinearity. Multiple regression analysis,
therefore, does not meet this statistical need of the present study. Discriminant analysis,
on the other hand, is well suited to detect, analyze, and interpret multicollinearity and,
thus, satisfies this particular statistical need (Hair et al., 1995; Stevens, 1992).

**Cluster Analysis**

Cluster analysis is a statistical technique that is designed to classify or categorize
objects based on certain characteristics or qualities which they possess (Hair et al., 1995).
This technique groups individuals or objects into “clusters” so that the cases in one cluster
are more similar to each other than they are to cases in the other clusters. One of the
primary objectives of cluster analysis is to assess the underlying structure of the objects or
individuals in the data pool.

Cluster analysis is appropriate when a researcher is studying one specific construct,
such as psychological or personality characteristics (Hair et al., 1995). If the present study
were focused on examining either the Gestalt resistances or the personality disorders of male batterers, cluster analysis would be an appropriate statistical technique. However, due to the fact that the present study is focused on examining the relationship between the Gestalt resistances and the various personality disorders of male batterers, cluster analysis is considered to be an inappropriate statistical technique for the present study.

Summary of Chapter 3

This chapter presented an overview of the methodology for the current study. In addition to reviewing the research questions and hypotheses, the subject selection and data collection processes were addressed. The historical lineage, reliability, and validity of the Millon Clinical Multiaxial Inventory-III and Gestalt Contact Styles Questionnaire-150 was presented in detail. Finally, the statistical technique of discriminant analysis, and the relevance to the current study, was discussed.
CHAPTER 4

RESULTS

From the original ODVN listing, thirty seven treatment providers or agencies were sent letters explaining the nature and purpose of the study and requesting their participation in the study. Of the original thirty seven letters sent out, twenty one treatment providers or agencies did not respond back to the original request while sixteen responded as being either willing or unwilling to participate in the study. From the sixteen treatment providers who responded back, nine responded that they were, for whatever reason, unable or unwilling to participate in the present study while seven indicated an ability and willingness to participate.

The seven treatment providers collected a total of 172 voluntary subjects who elected to participate in the study and completed both the MCMI-III and GCSQ-150 (see Table 11). However, of the 172 completed data packets returned, forty three (25%) were found to be unusable due to the subject filling out the instruments either incorrectly (i.e, in ink), or incompletely or due to the instruments being ripped, torn, or in some other way damaged so as to render them unusable. Thus, there were a total of 129 subjects who produced usable data packets and were considered to be part of the sample.
Table 13: Number of subjects (n), number of valid subject profiles, and number of invalid subject profiles for each treatment provider participating in the present study

<table>
<thead>
<tr>
<th>Treatment Provider</th>
<th>n</th>
<th>Valid Profiles</th>
<th>Invalid Profiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency A</td>
<td>57</td>
<td>56</td>
<td>1</td>
</tr>
<tr>
<td>Agency B</td>
<td>27</td>
<td>25</td>
<td>2</td>
</tr>
<tr>
<td>Agency C</td>
<td>16</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Agency D</td>
<td>11</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Agency E</td>
<td>11</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Agency F</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Agency G</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>129</td>
<td>120</td>
<td>9</td>
</tr>
</tbody>
</table>

The MCMI-III's for each of the 129 subjects were sent to National Computer Systems for scoring. The GCSQ-150's for each of the 129 subjects were hand scored. As previously discussed in Chapter 3, the MCMI-III has validity scales (Disclosure, Debasement, and Desirability) which can detect a subject’s level of honesty, openness, tendency to fake good or bad, and general attitude at the time of test completion.

As indicated by Table 13, there were a total of nine subjects who responded to the MCMI-III in such a way that their profile was considered “invalid”. Six of the invalid responses were the result of the subject producing raw scores of greater than 178 on Scale
X (Disclosure Scale), indicating a tendency for the subject to be self-depreciating, to complain excessively, or to be extremely vulnerable and defenseless. Three of the invalid responses were the result of the subject responding to two or more of the three validity items in an unreliable manner, indicating that the subject misunderstood the questions, was unwilling to cooperate, or was confused and/or severely disturbed at the time of testing. Thus, the final sample consisted of 120 subjects who produced usable and valid test results. As discussed in Chapter 3, this number is exactly the number which is needed in order to meet the optimal criteria for sample size when utilizing discriminant analysis.

Demographics of Sample

Table 14 illustrates several of the demographic characteristics of the 120 subjects in the sample. The demographic information presented was obtained through the use of a Client Demographic Sheet (see Appendix D) that each subject completed as part of the data packet along with the MCMI-III and GCSQ-150. The total number of subjects within each demographic category varies due to the fact that some of the subjects failed to complete, either in part or full, the Client Demographic Sheet that accompanied the testing instruments.

A total of 108 subjects responded to the question regarding age. The subjects ranged in age from 18 to 57 with the mean age being 32.87, the median age being 32, and the mode being 28. The standard deviation for the sample was 8.66.

As indicated by Table 14, over half of the subjects were white (65.8%), with approximately one third being married (35.8%) and one third being single (30.0%).
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MARITAL STATUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>36</td>
<td>33.0%</td>
</tr>
<tr>
<td>Married</td>
<td>43</td>
<td>39.4%</td>
</tr>
<tr>
<td>Engaged</td>
<td>4</td>
<td>3.7%</td>
</tr>
<tr>
<td>Committed</td>
<td>5</td>
<td>4.6%</td>
</tr>
<tr>
<td>Divorced</td>
<td>21</td>
<td>19.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>109</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>RACE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>79</td>
<td>71.8%</td>
</tr>
<tr>
<td>Black</td>
<td>27</td>
<td>24.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>1.8%</td>
</tr>
<tr>
<td>American Indian</td>
<td>1</td>
<td>.9%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>110</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>AGE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-22</td>
<td>11</td>
<td>10.1%</td>
</tr>
<tr>
<td>23-27</td>
<td>19</td>
<td>17.5%</td>
</tr>
<tr>
<td>28-32</td>
<td>24</td>
<td>22.2%</td>
</tr>
<tr>
<td>33-37</td>
<td>17</td>
<td>15.7%</td>
</tr>
<tr>
<td>38-42</td>
<td>23</td>
<td>21.2%</td>
</tr>
<tr>
<td>43-47</td>
<td>11</td>
<td>10.1%</td>
</tr>
<tr>
<td>48-52</td>
<td>2</td>
<td>1.8%</td>
</tr>
<tr>
<td>53-57</td>
<td>1</td>
<td>.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>108</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 14: Demographic data for present study
Table 14: Continued from previous page

<table>
<thead>
<tr>
<th>EDUCATION</th>
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</tr>
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<tr>
<td>Grade 7</td>
<td>1</td>
<td>.9 %</td>
</tr>
<tr>
<td>Grade 8</td>
<td>3</td>
<td>2.8 %</td>
</tr>
<tr>
<td>Grade 9</td>
<td>3</td>
<td>2.8 %</td>
</tr>
<tr>
<td>Grade 10</td>
<td>11</td>
<td>10.1 %</td>
</tr>
<tr>
<td>Grade 11</td>
<td>13</td>
<td>11.9 %</td>
</tr>
<tr>
<td>Grade 12 (HS Grad)</td>
<td>43</td>
<td>39.4 %</td>
</tr>
<tr>
<td>1 Year College</td>
<td>13</td>
<td>11.9 %</td>
</tr>
<tr>
<td>2 Years College</td>
<td>8</td>
<td>7.3 %</td>
</tr>
<tr>
<td>3 Years College</td>
<td>5</td>
<td>4.6 %</td>
</tr>
<tr>
<td>4 Years College</td>
<td>6</td>
<td>5.5 %</td>
</tr>
<tr>
<td>5 Years College (Grad/Prof)</td>
<td>1</td>
<td>.9 %</td>
</tr>
<tr>
<td>7 Years College (Grad/Prof)</td>
<td>1</td>
<td>.9 %</td>
</tr>
<tr>
<td>9 Years College (Grad/Prof)</td>
<td>1</td>
<td>.9 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>109</td>
<td>100.0 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INCOME</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - $10,000</td>
<td>22</td>
<td>21.2 %</td>
</tr>
<tr>
<td>$10,001 - $15,000</td>
<td>11</td>
<td>10.6 %</td>
</tr>
<tr>
<td>$15,001 - $20,000</td>
<td>17</td>
<td>16.3 %</td>
</tr>
<tr>
<td>$20,001 - $25,000</td>
<td>15</td>
<td>14.4 %</td>
</tr>
<tr>
<td>$25,001 - $30,000</td>
<td>8</td>
<td>7.7 %</td>
</tr>
<tr>
<td>$30,001 - $35,000</td>
<td>6</td>
<td>5.8 %</td>
</tr>
<tr>
<td>$35,001 - $40,000</td>
<td>9</td>
<td>8.7 %</td>
</tr>
<tr>
<td>$40,001 - $45,000</td>
<td>2</td>
<td>1.9 %</td>
</tr>
<tr>
<td>$45,001 - $50,000</td>
<td>4</td>
<td>3.8 %</td>
</tr>
<tr>
<td>$50,001 - $55,000</td>
<td>2</td>
<td>1.9 %</td>
</tr>
<tr>
<td>$55,001 - $60,000</td>
<td>2</td>
<td>1.9 %</td>
</tr>
<tr>
<td>$60,001 - $65,000</td>
<td>1</td>
<td>1.0 %</td>
</tr>
<tr>
<td>$65,001 - $70,000</td>
<td>1</td>
<td>1.0 %</td>
</tr>
<tr>
<td>$70,001 - $75,000</td>
<td>2</td>
<td>1.9 %</td>
</tr>
<tr>
<td>$75,001 - above</td>
<td>2</td>
<td>1.9 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>104</td>
<td>100.0 %</td>
</tr>
</tbody>
</table>
Table 14: Continued from previous page

<table>
<thead>
<tr>
<th>NUMBER OF DV ARRESTS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75</td>
<td>68.2 %</td>
</tr>
<tr>
<td>2</td>
<td>22</td>
<td>20.0 %</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>8.2 %</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>1.8 %</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>1.8 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>110</td>
<td>100.0 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TREATMENT GROUPS ATTENDED</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5</td>
<td>35</td>
<td>34.3 %</td>
</tr>
<tr>
<td>6 - 10</td>
<td>4</td>
<td>3.9 %</td>
</tr>
<tr>
<td>11 - 15</td>
<td>13</td>
<td>12.7 %</td>
</tr>
<tr>
<td>16 - 20</td>
<td>27</td>
<td>26.5 %</td>
</tr>
<tr>
<td>21 - 25</td>
<td>13</td>
<td>12.7 %</td>
</tr>
<tr>
<td>26 - 30</td>
<td>5</td>
<td>4.9 %</td>
</tr>
<tr>
<td>31 - 35</td>
<td>1</td>
<td>1.0 %</td>
</tr>
<tr>
<td>41 - 45</td>
<td>1</td>
<td>1.0 %</td>
</tr>
<tr>
<td>46 - 50</td>
<td>2</td>
<td>2.0 %</td>
</tr>
<tr>
<td>76 - 80</td>
<td>1</td>
<td>1.0 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>102</td>
<td>100.0 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE OF WORK</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual labor</td>
<td>44</td>
<td>40.0 %</td>
</tr>
<tr>
<td>Factory work</td>
<td>15</td>
<td>13.6 %</td>
</tr>
<tr>
<td>Business (Sales, etc.)</td>
<td>15</td>
<td>13.6 %</td>
</tr>
<tr>
<td>Self employed</td>
<td>15</td>
<td>13.6 %</td>
</tr>
<tr>
<td>Professional (lawyer, doctor, etc.)</td>
<td>4</td>
<td>3.6 %</td>
</tr>
<tr>
<td>Student</td>
<td>1</td>
<td>1.8 %</td>
</tr>
<tr>
<td>Unemployed</td>
<td>6</td>
<td>5.5 %</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>8.2 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>110</td>
<td>100.0 %</td>
</tr>
</tbody>
</table>
half of the subjects (68%) reported having been arrested one time for domestic violence, while 20% of the subjects reported having been arrested twice. Approximately 40% were employed in some type of manual labor and 21.2% of the subjects reported earning less than $10,000 per year.

Approximately 40% of the subjects had completed high school, while about 12% had either completed 11th grade or one year of college. Nearly one-fourth of the subjects reported having less than a high school diploma. 5.5% completed the equivalent of a bachelor’s degree and three subjects (2.8%) reported having completed, in full or in part, an advanced graduate degree.

Descriptive Statistics of GCSQ-150 and MCMI-III Scales

As indicated by Table 15, of all GCSQ-150 scales, the Retroflection scale produced the highest mean, median, and mode scores while the Projection scale, on the other hand, produced the lowest mean, median, and mode scores. The Projection scale had the lowest raw score (14) while the Retroflection scale had the highest raw score (105). The Retroflection scale had the highest standard deviation (13.15), while the Introjection (5.30), Desensitization (5.33), and Projection (5.45) scales had exhibited lower standard deviation.

As indicated by Table 16, the Narcissistic Scale (Scale 5) produced both the highest mean score (63) and the highest BR Score (115) of all MCMI-III scales. The scales with the lowest mean scores were the Schizoid Scale (Scale 1- 49.53) and the Borderline Scale (Scale C - 49.36). The Aggressive Sadistic Scale (Scale 6b) had the highest range of scores (0-110), the Passive-Aggressive Scale (Scale 8a) had the highest
<table>
<thead>
<tr>
<th>Scale</th>
<th>n</th>
<th>$x$</th>
<th>Md</th>
<th>Mo</th>
<th>Range</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desensitization</td>
<td>120</td>
<td>44.24</td>
<td>44.00</td>
<td>42</td>
<td>28-58</td>
<td>5.33</td>
</tr>
<tr>
<td>Introjection</td>
<td>120</td>
<td>45.03</td>
<td>45.00</td>
<td>46</td>
<td>33-57</td>
<td>5.30</td>
</tr>
<tr>
<td>Projection</td>
<td>120</td>
<td>29.10</td>
<td>29.00</td>
<td>32</td>
<td>14-43</td>
<td>5.45</td>
</tr>
<tr>
<td>Retroflection</td>
<td>120</td>
<td>74.90</td>
<td>74.00</td>
<td>67</td>
<td>43-105</td>
<td>13.15</td>
</tr>
<tr>
<td>Deflection</td>
<td>120</td>
<td>51.11</td>
<td>50.50</td>
<td>45</td>
<td>22-79</td>
<td>11.90</td>
</tr>
<tr>
<td>Egotism</td>
<td>120</td>
<td>48.30</td>
<td>49.00</td>
<td>53</td>
<td>18-70</td>
<td>9.36</td>
</tr>
</tbody>
</table>

Table 15: Descriptive statistics for subjects raw scores on the GCSQ-150 scales

<table>
<thead>
<tr>
<th>Scale Number and Name</th>
<th>n</th>
<th>$x$</th>
<th>Md</th>
<th>Mo</th>
<th>Range</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Schizoid</td>
<td>120</td>
<td>49.53</td>
<td>60.00</td>
<td>48</td>
<td>0-102</td>
<td>26.54</td>
</tr>
<tr>
<td>5 - Narcissistic</td>
<td>120</td>
<td>63.00</td>
<td>61.00</td>
<td>53</td>
<td>23-115</td>
<td>18.22</td>
</tr>
<tr>
<td>6a - Antisocial</td>
<td>120</td>
<td>61.62</td>
<td>67.00</td>
<td>60</td>
<td>0-100</td>
<td>21.17</td>
</tr>
<tr>
<td>6b - Aggressive (Sadistic)</td>
<td>120</td>
<td>55.76</td>
<td>62.00</td>
<td>61</td>
<td>0-110</td>
<td>23.57</td>
</tr>
<tr>
<td>8a - Passive-Aggressive</td>
<td>120</td>
<td>57.87</td>
<td>66.00</td>
<td>38</td>
<td>0-97</td>
<td>27.85</td>
</tr>
<tr>
<td>C - Borderline</td>
<td>120</td>
<td>49.36</td>
<td>59.00</td>
<td>30</td>
<td>0-88</td>
<td>25.99</td>
</tr>
</tbody>
</table>

Table 16: Descriptive statistics for subjects BR scores on the MCMI-III personality disorder scales
standard deviation (27.85), and the Narcissistic Scale (Scale 5) had the lowest standard deviation (18.22). Five of the six MCMI-III scales had zero as the lowest score.

Prevalence Rates for MCMI-III Personality “Disorders” and “Traits”

Another important descriptive statistic deals with the number of subjects in each of the three dependent variable categories - those who meet the MCMI-III diagnostic criteria for a “disorder” and those who meet the MCMI-III diagnostic criteria for a “trait”. Table 17 illustrates these categories for each one of the six MCMI-III scales used in the present study. An individual may meet the MCMI-III diagnostic criteria for “disorder” or “trait” on more than one of the MCMI-III personality disorder scales.

<table>
<thead>
<tr>
<th>MCMI-III scale</th>
<th>“Disorder” (BR ≥ 85)</th>
<th>“Trait” (BR ≤ 84 and ≥ 75)</th>
<th>“Disorder” or “Trait” (BR ≥ 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>1 - Schizoid</td>
<td>4</td>
<td>3.3%</td>
<td>13</td>
</tr>
<tr>
<td>5 - Narcissistic</td>
<td>28</td>
<td>23.3%</td>
<td>18</td>
</tr>
<tr>
<td>6a - Antisocial</td>
<td>14</td>
<td>11.6%</td>
<td>25</td>
</tr>
<tr>
<td>6b - Aggressive (Sadistic)</td>
<td>6</td>
<td>5.0%</td>
<td>17</td>
</tr>
<tr>
<td>8a - Passive Aggressive</td>
<td>15</td>
<td>12.5%</td>
<td>34</td>
</tr>
<tr>
<td>C - Borderline</td>
<td>6</td>
<td>5.0%</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 17: MCMI-III “disorder” and “trait” prevalence rates
As indicated by Table 17, almost one-fourth of the male batterers in this study exhibited evidence of Narcissistic Personality Disorder (23.3%). Approximately 12% of the subjects met the diagnostic criteria for Antisocial Personality Disorder and Passive Aggressive Personality Disorder. The combination of the Schizoid, Aggressive (Sadistic), and Borderline Scales accounted for approximately 13% of the personality “disorders” among the subjects.

With regard to the personality “traits”, 28.3% of the male batterers exhibited Passive-Aggressive “traits” and 21% of the subjects exhibited Antisocial “traits”. The Narcissistic and Aggressive (Sadistic) Scales each accounted for approximately 15% of subject’s “trait” scores.

Within the entire sample of 120 subjects, however, the MCMI-III scales with the highest percentage of male batterers who exhibited either a “disorder” or a “trait” are Passive-Aggressive (40.8%), Narcissistic (38.3%), and Antisocial (32.5%). The three remaining scales include Schizoid (14.1%), Aggressive (Sadistic) (19.1%), and Borderline (17.5%).

Correlations Between GCSQ-150 Scales and MCMI-III Scales

In order to better understand the nature of the relationship between the personality disorders and Gestalt resistances of male batterers, it is necessary to examine the correlation coefficients between the MCMI-III and GCSQ-150 scales. A point biserial correlation is a Pearson r correlation coefficient which is appropriate when the statistical analysis involves one continuous variable and one categorical variable (Hopkins et al.,
Due to the fact that the dependent variable in this study is categorical and the independent variable is continuous, a point biserial correlation coefficient was utilized.

Tables 18 through 23 illustrate the point biserial correlation coefficients between the dependent and independent variables for the present study. When analyzing the outcome results for this data, it is important to understand the nature of the correlation between each of the discriminating variables within the discriminant function and the dependent variable for each of the three analyses in the hypotheses. The larger the point biserial correlation coefficient, the more the specified groups differ on that particular dependent variable.

<table>
<thead>
<tr>
<th></th>
<th>“Disorder” vs. Non-“Disorder”</th>
<th>“Trait” vs. Non-“Trait”</th>
<th>“Disorder” vs. Non-“Disorder” and Non-“Trait”</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCSQ-150 Deflection</td>
<td>.065</td>
<td>.198*</td>
<td>.083</td>
</tr>
<tr>
<td>GCSDQ-150 Desensitization</td>
<td>-.061</td>
<td>-.010</td>
<td>-.064</td>
</tr>
<tr>
<td>GCSQ-150 Egotism</td>
<td>.004</td>
<td>.142</td>
<td>.013</td>
</tr>
</tbody>
</table>

Table 18: Point biserial correlation coefficients for the MCMI-III Schizoid Scale
Key: * = correlation is significant at .05 level
### Table 19: Point biserial correlation coefficients for the MCMI-III Narcissistic Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>“Disorder” vs. Non-“Disorder”</th>
<th>“Trait” vs. Non-“Trait”</th>
<th>“Disorder” vs. Non-“Disorder” and Non-“Trait”</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCSQ-150</td>
<td>0.007</td>
<td>-0.113</td>
<td>-0.008</td>
</tr>
<tr>
<td>GCSDQ-150</td>
<td>-0.117</td>
<td>-0.084</td>
<td>-0.134*</td>
</tr>
<tr>
<td>GCSQ-150</td>
<td>0.207*</td>
<td>0.015</td>
<td>0.230*</td>
</tr>
<tr>
<td>GCSQ-150</td>
<td>0.186*</td>
<td>0.041</td>
<td>0.200*</td>
</tr>
</tbody>
</table>

Key: * = correlation is significant at .05 level

### Table 20: Point biserial correlation coefficients for the MCMI-III Antisocial Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>“Disorder” vs. Non-“Disorder”</th>
<th>“Trait” vs. Non-“Trait”</th>
<th>“Disorder” vs. Non-“Disorder” and Non-“Trait”</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCSQ-150</td>
<td>0.199*</td>
<td>0.254**</td>
<td>0.285**</td>
</tr>
</tbody>
</table>

Key: * = correlation is significant at .05 level
** = correlation is significant is .001 level
<table>
<thead>
<tr>
<th></th>
<th>&quot;Disorder&quot; vs. Non-&quot;Disorder&quot;</th>
<th>&quot;Trait&quot; vs. Non-&quot;Trait&quot;</th>
<th>&quot;Disorder&quot; vs. Non-&quot;Disorder&quot; and Non-&quot;Trait&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCSQ-150 Deflection</td>
<td>.053</td>
<td>.154</td>
<td>.070</td>
</tr>
<tr>
<td>GCSDQ-150 Retroflection</td>
<td>.086</td>
<td>.043</td>
<td>.096</td>
</tr>
<tr>
<td>GCSQ-150 Introjection</td>
<td>.035</td>
<td>.134</td>
<td>.052</td>
</tr>
<tr>
<td>GCSQ-150 Desensitization</td>
<td>.098</td>
<td>.102</td>
<td>.116</td>
</tr>
<tr>
<td>GCSQ-150 Projection</td>
<td>.137</td>
<td>.146</td>
<td>.161</td>
</tr>
</tbody>
</table>

Table 21: Point biserial correlation coefficients for the MCMI-III Aggressive-Sadistic Scale
Key: * = correlation is significant at .05 level
** = correlation is significant at .01 level

<table>
<thead>
<tr>
<th></th>
<th>&quot;Disorder&quot; vs. Non-&quot;Disorder&quot;</th>
<th>&quot;Trait&quot; vs. Non-&quot;Trait&quot;</th>
<th>&quot;Disorder&quot; vs. Non-&quot;Disorder&quot; and Non-&quot;Trait&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCSDQ-150 Retroflection</td>
<td>.255**</td>
<td>.370**</td>
<td>.378**</td>
</tr>
<tr>
<td>GCSQ-150 Projection</td>
<td>.235**</td>
<td>.375**</td>
<td>.363**</td>
</tr>
</tbody>
</table>

Table 22: Point biserial correlation coefficients for the MCMI-III Passive-Aggressive Scale
Key: * = correlation is significant at .05 level
** = correlation is significant at .01 level
Table 23: Point biserial correlation coefficients for the MCMI-III Borderline Scale
Key: * = correlation is significant at .05 level
     ** = correlation is significant at .01 level

<table>
<thead>
<tr>
<th>Scale</th>
<th>“Disorder” vs. Non-“Disorder”</th>
<th>“Trait” vs. Non-“Trait”</th>
<th>“Disorder” vs. Non-“Disorder” and Non-“Trait”</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCSDQ-150</td>
<td>Retroflection .139 .246** .170</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCSQ-150</td>
<td>Desensitization .040 .058 .047</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intercorrelations Among the GCSQ-150 and MCMI-III Scales.

In addition to examining the correlation coefficients between the various MCMI-III and GCSQ-150 scales, it is also important to the intercorrelations among the various scales within both the GCSQ-150 and MCMI-III. Understanding the level of intercorrelations among the various scales of both the GCSQ-150 and MCMI-III is critical in detecting multicollinearity. According to Hair et al. (1995), multicollinearity is the extent to which one variable in the analysis can be explained by other variables within the analysis. As the multicollinearity among the variables increases, the ability to define and variable’s effect on the outcome is diminished. Thus, as the level of intercorrelations among the variables within an analysis increases, the reliability, validity, and utility of the outcome data decreases.
Table 24 presents the intercorrelations for the GRS scales for the GCSQ-150 in the present study. In Prosnick's (1996) study, every one of the ten correlation coefficients was statistically significant, eight at the $p<.001$ level and two at the $p<.05$ level. In comparison, the present study produced eight correlation coefficients which were significant at the $p<.01$ level. Additionally, the range of intercorrelations among the GCSQ-150 scales for Prosnick's (1996) study was .16 to .86 while the range of correlations in the present study was -.021 to .73.

Table 25 illustrates the MCMI-III intercorrelations for the present study. The patterns of intercorrelations between Millon's (1994) normative sample study and the present study are somewhat similar. Both studies produced three negative correlation coefficients, all between the same scales (5 and 1, 5 and 8a, and 5 and C). All other correlations indicated a positive relationship between the variables. As indicated in Table 12 on page 123, the range of intercorrelations in Millon's (1994) study was -.29 to .79 while, according to Table 25, the range of intercorrelations for the present study was -.07 to .82.

Influences of Prior Treatment

In order to effectively account for the effects of prior treatment on a subject's outcome data, an Analysis of Variance (ANOVA) was conducted. For the purposes of this study, an ANOVA was utilized to determine whether the means of the various treatment categories are statistically significant. While A T-test is appropriate when comparing the means of two groups, an ANOVA is best statistical analysis to use when
### Table 24: Intercorrelations among GSR scales for the present study

<table>
<thead>
<tr>
<th>GCSQ-150 scale</th>
<th>Desensitization</th>
<th>Introjection</th>
<th>Projection</th>
<th>Retroflection</th>
<th>Deflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desensitization</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introjection</td>
<td>-.021</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projection</td>
<td>.28**</td>
<td>.28**</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retroflection</td>
<td>-.03</td>
<td>.55**</td>
<td>.54**</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Deflection</td>
<td>.11</td>
<td>.54**</td>
<td>.62**</td>
<td>.73**</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Key:** **= p < .01

---

### Table 25: Intercorrelations of MCMI-III scales for present study

<table>
<thead>
<tr>
<th>MCMI-III Scale</th>
<th>1</th>
<th>5</th>
<th>6a</th>
<th>6b</th>
<th>8a</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>-.07</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6a</td>
<td>.47**</td>
<td>.06</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6b</td>
<td>.47**</td>
<td>.15</td>
<td>.77**</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>.60**</td>
<td>-.04</td>
<td>.66**</td>
<td>.69**</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>.53**</td>
<td>-.13</td>
<td>.70**</td>
<td>.71**</td>
<td>.82**</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Key:** ** = p ≤ .01  * = p ≤ .05

1 = Schizoid Personality Disorder  
5 = Narcissistic Personality Disorder  
6a = Antisocial Personality Disorder  
6b = Aggressive (Sadistic) Personality Disorder  
8a = Passive-Aggressive Personality Disorder  
C = Borderline Personality Disorder

Table 25: Intercorrelations of MCMI-III scales for present study
comparing the means of more than two groups (Best and Kahn, 1989; Frankel and Wallen, 1993; Hair et al., 1995). Due to the fact that the present study has more than two categories for prior number of treatment groups, ANOVA was the chosen statistical technique.

In order to conduct an ANOVA on the present sample, several adjustments were necessary. The original data consisted of several groups which had relatively few subjects, thus, creating low variability among these groups. For example, there were only four subjects who attended between 6-10 prior treatment groups, five subjects who attended between 26-30 prior treatment groups, and five subjects who attended more than 30 groups sessions. Due to the low number of subjects in each of these groups, an ANOVA on the data in the present form was considered to be statistically inappropriate.

In order to maximize variability and increase the numbers of subjects in each group, the ten original prior treatment groups were collapsed into three groups- those subjects who attended 0-10 prior treatment groups, those subjects who attended 11-20 prior treatment groups, and those subjects who attended more than 21 or more prior treatment groups.

In conducting an ANOVA on the present data, it is necessary to examine the means between the groups based on number or prior group sessions, the ANOVA F-statistic and level of significance. If the level of significance is greater than the designated alpha level, the groups means are assumed to be equal and there is no significant differences between the groups (Hair et al., 1995; Stevens, 1992). Thus, due to the fact that the present study has established an alpha level of .05, any F-ratio level of
significance greater than .05 is not significant and indicates that, for that particular scale, there were no differences between the various treatment groups.

Table 26 illustrates the descriptive statistics for the GCSQ-150 scales based on the subject’s number of prior group sessions and Table 27 illustrates the F-ratio and level of significance for each of the GCSQ-150 scales. As indicated by Table 26, the means within each of the GCSQ-150 scales are similar. Additionally, according to Table 27, every one of the GCSQ-150 scales has demonstrated a level of significance much greater than the designated alpha level of .05., thus indicating that a subject’s number of prior group sessions was not significant and had little influence on his scores on any of the GCSQ-150 scales.

Table 28 illustrates the ANOVA descriptive statistics for the MCMI-III scales based on the subject’s number of prior group sessions and Table 29 illustrates the F-ratio and level of significance for each of the MCMI-III scales. When comparing the means of the groups, however, it is important to remember that level of statistical significance is determined by comparing the means for all three groups, not for any one or two groups individually. Thus, although there appears to be some relatively large differences between the means of several individual groups for each of the MCMI-III scales, Table 29 indicates that, when collectively compared, none of the differences are statistically significant as each MCMI-III has an F-ratio level of significance greater than the designated alpha level of .05.
<table>
<thead>
<tr>
<th>GCSQ-150 Scales and Number of Prior Group Sessions</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTROJECTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>45.10</td>
<td>5.70</td>
</tr>
<tr>
<td>11-20 prior group session</td>
<td>37</td>
<td>44.92</td>
<td>5.95</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>44.62</td>
<td>4.69</td>
</tr>
<tr>
<td><strong>DEFLECTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>51.46</td>
<td>11.64</td>
</tr>
<tr>
<td>11-20 prior group session</td>
<td>37</td>
<td>51.27</td>
<td>13.53</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>50.85</td>
<td>10.51</td>
</tr>
<tr>
<td><strong>DESENSITIZATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>43.62</td>
<td>6.26</td>
</tr>
<tr>
<td>11-20 prior group session</td>
<td>37</td>
<td>44.27</td>
<td>4.97</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>45.85</td>
<td>4.35</td>
</tr>
<tr>
<td><strong>EGOTISM</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>47.46</td>
<td>7.84</td>
</tr>
<tr>
<td>11-20 prior group session</td>
<td>37</td>
<td>49.85</td>
<td>10.14</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>49.00</td>
<td>8.87</td>
</tr>
<tr>
<td><strong>PROJECTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>28.56</td>
<td>4.69</td>
</tr>
<tr>
<td>11-20 prior group session</td>
<td>37</td>
<td>29.46</td>
<td>6.22</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>29.62</td>
<td>5.62</td>
</tr>
<tr>
<td><strong>RETROFLECTION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>74.21</td>
<td>12.43</td>
</tr>
<tr>
<td>11-20 prior group session</td>
<td>37</td>
<td>75.27</td>
<td>15.72</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>74.92</td>
<td>11.50</td>
</tr>
</tbody>
</table>

Table 26: Comparison of descriptive statistics for GCSQ-150 scales based on subjects number of prior group sessions
<table>
<thead>
<tr>
<th>GCSQ-150 Scales</th>
<th>F-Statistic</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retroflection</td>
<td>.061</td>
<td>.941</td>
</tr>
<tr>
<td>Projection</td>
<td>.370</td>
<td>.692</td>
</tr>
<tr>
<td>Introjection</td>
<td>.060</td>
<td>.942</td>
</tr>
<tr>
<td>Deflection</td>
<td>.020</td>
<td>.980</td>
</tr>
<tr>
<td>Desensitization</td>
<td>1.371</td>
<td>.259</td>
</tr>
<tr>
<td>Egotism</td>
<td>.338</td>
<td>.714</td>
</tr>
</tbody>
</table>

Table 27: ANOVA F-statistic and level of significance for GCSQ-150 scales
<table>
<thead>
<tr>
<th>MCMII-III Scales and Number of Prior Group Sessions</th>
<th>n</th>
<th>Mean BR score</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 - SCHIZOID</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>52.72</td>
<td>24.54</td>
</tr>
<tr>
<td>11—20 prior group sessions</td>
<td>37</td>
<td>48.70</td>
<td>26.83</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>49.04</td>
<td>26.77</td>
</tr>
<tr>
<td><strong>5 - NARCISSISTIC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>62.51</td>
<td>20.63</td>
</tr>
<tr>
<td>11—20 prior group sessions</td>
<td>37</td>
<td>65.08</td>
<td>17.60</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>62.77</td>
<td>16.60</td>
</tr>
<tr>
<td><strong>6a - ANTISOCIAL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>60.64</td>
<td>20.49</td>
</tr>
<tr>
<td>11—20 prior group sessions</td>
<td>37</td>
<td>61.35</td>
<td>22.33</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>64.35</td>
<td>20.07</td>
</tr>
<tr>
<td><strong>6b - AGGRESSIVE (SADISTIC)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>55.36</td>
<td>23.03</td>
</tr>
<tr>
<td>11—20 prior group sessions</td>
<td>37</td>
<td>57.57</td>
<td>23.56</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>56.77</td>
<td>23.81</td>
</tr>
<tr>
<td><strong>8a - PASSIVE-AGGRESSIVE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>62.10</td>
<td>27.36</td>
</tr>
<tr>
<td>11—20 prior group sessions</td>
<td>37</td>
<td>57.22</td>
<td>24.20</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>54.19</td>
<td>30.66</td>
</tr>
<tr>
<td><strong>C - BORDERLINE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10 prior group sessions</td>
<td>39</td>
<td>49.72</td>
<td>25.78</td>
</tr>
<tr>
<td>11—20 prior group sessions</td>
<td>37</td>
<td>52.14</td>
<td>22.77</td>
</tr>
<tr>
<td>more than 20 prior group sessions</td>
<td>26</td>
<td>47.12</td>
<td>30.05</td>
</tr>
</tbody>
</table>

Table 28: Comparison of descriptive statistics for GCSQ-150 scales based on subject's number of prior group sessions
<table>
<thead>
<tr>
<th>MCMI-III Scales</th>
<th>F-Statistic</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Schizoid</td>
<td>.270</td>
<td>.764</td>
</tr>
<tr>
<td>5 - Narcissistic</td>
<td>.209</td>
<td>.812</td>
</tr>
<tr>
<td>6a - Antisocial</td>
<td>.257</td>
<td>.774</td>
</tr>
<tr>
<td>6b - Aggressive (Sadistic)</td>
<td>.086</td>
<td>.917</td>
</tr>
<tr>
<td>8a - Passive-Aggressive</td>
<td>.709</td>
<td>.495</td>
</tr>
<tr>
<td>C - Borderline</td>
<td>.289</td>
<td>.750</td>
</tr>
</tbody>
</table>

Table 29: ANOVA F-statistic and level of significance for the MCMI-III scales
Other Relevant Findings

As discussed in Chapter 2, there is much empirical evidence to suggest that male batterers are likely to exhibit high prevalence rates of substance abuse and are also likely to have been victims of or witnessed domestic violence while growing up. Although this study is primarily focused on empirically researching the personality disorders and Gestalt resistances of male batterers, a brief examination of the subjects’ substance abuse and past history of victimization is warranted.

Three MCMI-III “clinical syndromes” scales (Scale B - Alcohol Dependence, Scale T - Drug dependence, Scale R - Post-Traumatic Stress Disorder) were utilized in measuring of male batterers’ substance abuse and past history of victimization. In order to fully understand the nature of these three “clinical syndromes”, a brief conceptual definition of each is presented below.

Scale B - Alcohol Dependence - According to Millon (1994), “A person with a high score on the Alcohol Dependence scale probably has a history of alcoholism, has tried to overcome the problem with minimal success, and, as a consequence, experiences considerable discomfort in both family and work settings” (p.15).

Scale T - Drug Dependence - According to Millon (1994), “A person with a high score on the Drug Dependence scale is likely to have a recurrent or recent history of drug abuse, tends to have difficulty restraining impulses or keeping them within conventional social limits, and is unable to manage the consequences of this behavior” (p.15).

Scale R - Post-Traumatic Stress Disorder - “This disorder is the result of an event that involved a threat to the person’s life and caused intense fear and helplessness. Images
and emotions associated with the trauma result in distressing recollections and nightmares
that reactivate the feelings generated by the original event. Symptoms of anxious arousal
(e.g., startled response, hypervigilance) persist and the patient avoids circumstances
associated with the trauma.

Although the scoring system for the clinical syndromes is similar to the scoring
system for the personality disorders, the nature of these two constructs is distinctly
different. Similar to the BR scoring system for personality disorder scales, a BR score
between 75 and 84 indicates the “presence” of a syndrome and a BR score of 85 and
above indicates the “prominence” of a syndrome. However, according to Millon (1994):

In contrast to the personality disorders, the clinical syndromes are best seen as
extensions or distortions of the patient’s basic personality pattern. These
syndromes tend to be relatively distinct or transient states, waxing and waning over
time, depending on the impact of stressful situations. Most typically, the caricature
or accentuate the basic personality style. Most of the clinical syndromes…are of
substantially briefer duration than the personality disorders. They usually represent
states in which an active pathological process is clearly maintained. During
periods of active pathology, it is not uncommon for several symptoms to covary at
any one time and to change over time in their degrees of prominence (p.14).

Table 30 presents the descriptive data for the MCMI-III Alcohol Dependence,
Drug Dependence, and Post-Traumatic Stress Disorder Scales. Of these three clinical
syndrome scales, Scale B (Alcohol Dependence) demonstrated the highest mean (63.16),
median (69.50), and mode (65) scores.

Table 31 presents the number and percentages of those subjects who were
classified as having the “presence” of a syndrome and those subjects who were classified
as having the “prominence” of a syndrome. Approximately one third of the subjects in the
<table>
<thead>
<tr>
<th>Scale Number and Name</th>
<th>n</th>
<th>x</th>
<th>Md</th>
<th>Mo</th>
<th>Range</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>B - Alcohol Dependence</td>
<td>120</td>
<td>63.16</td>
<td>69.50</td>
<td>65</td>
<td>0-109</td>
<td>23.43</td>
</tr>
<tr>
<td>T - Drug Dependence</td>
<td>120</td>
<td>55.77</td>
<td>60.00</td>
<td>60</td>
<td>0-98</td>
<td>19.35</td>
</tr>
<tr>
<td>R - Post Traumatic Stress Disorder</td>
<td>120</td>
<td>42.32</td>
<td>51.00</td>
<td>15</td>
<td>0-104</td>
<td>19.35</td>
</tr>
</tbody>
</table>

Table 30: Descriptive statistics for MCMI-III Alcohol Dependence, Drug Dependence, and Post-Traumatic Stress Disorder Scales

<table>
<thead>
<tr>
<th>MCMI-III Scale</th>
<th>“Prominence” of Syndrome (BR ≥ 85)</th>
<th>“Presence” of Syndrome (BR ≤ 84 and ≥ 75)</th>
<th>“Presence” or “Prominence” of Syndrome (BR ≥ 75)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>B - Alcohol Dependence</td>
<td>14</td>
<td>11.6%</td>
<td>33</td>
</tr>
<tr>
<td>T - Drug Dependence</td>
<td>5</td>
<td>4.1%</td>
<td>11</td>
</tr>
<tr>
<td>R - Post-Traumatic Stress Disorder</td>
<td>2</td>
<td>1.6%</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 31: Comparison of subjects who meet MCMI-III diagnostic criteria for “presence” and “prominence” of clinical syndrome on Alcohol Dependence, Drug Dependence, and Post-Traumatic Stress Disorder scales
study demonstrated either a “presence” or “prominence” of Alcohol Dependence while only 13.3% of the subjects evidenced either a “presence” or “prominence” of Drug Dependence. A small proportion of subjects (7.5%) exhibited symptomology related to the Post-Traumatic Stress Disorder.

Hypotheses

The findings for the hypotheses are broken down and discussed in six major categories, one for each of the six dependent variables (MCMI-III scales) utilized in this study. Before moving on to the results of the hypotheses, the reader is encouraged to refer back to Chapter 3 and review several of the key terms for discriminant analysis which are utilized in interpreting the results of the hypotheses for this study.

Schizoid Personality Disorder (Scale 1)

Hypothesis One- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III criteria for Schizoid Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Schizoid Personality Disorder (BR ≤ 84).

The results for this hypothesis were not statistically significant. As indicated by Table 32, Wilks’ Lamda level of significance for discriminant function is .756. Since this level of significance is much greater than the designated alpha level .05, the group centroids are assumed to be equal and there are no significant differences between the two groups. Thus, based on a linear combination of the GCSQ-150 scales of Deflection, Desensitization, and Egotism, there are no statistically significant differences between
those male batterers who met the MCMI-III diagnostic criteria for Schizoid Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III diagnostic criteria for Schizoid Personality Disorder (BR ≤ 84).

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.010</td>
<td>.101</td>
<td>.990</td>
<td>.756</td>
</tr>
</tbody>
</table>

Table 32: Statistics for the discriminant function for Hypothesis One

**Hypothesis Two-** Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 75 and ≤ 84) on the Schizoid Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Schizoid Personality Disorder Scale.

The results for this hypothesis were not statistically significant. As indicated by Table 33, the Wilks' Lambda level of significance is .191, which is much greater than the designated alpha level of .05. This suggests that the group centroids are equal and there are no significant differences between the two groups. Thus, based on a linear combination of the GCSQ-150 scales of Deflection, Desensitization, and Egotism, there
are no statistically significant differences between those male batterers who meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 75 and ≤ 84) on the Schizoid Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Schizoid Personality Disorder Scale.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.043</td>
<td>.203</td>
<td>.959</td>
<td>.191</td>
</tr>
</tbody>
</table>

Table 33: Statistics for the discriminant function for Hypothesis Two

Hypothesis Three- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Egotism, and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR ≥ 85) on the Schizoid Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74) on the Schizoid Personality Disorder Scale.

The results for this hypothesis were not statistically significant. As indicated by Table 34, the Wilks' Lambda level of significance (.678) is much greater than the designated alpha of .05. Thus, based on a linear combination of the GCSQ-150 scales of
Deflection, Desensitization, and Egotism, there are no statistically significant differences between those male batterers who met the MCMI-III diagnostic criteria for Schizoid Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Schizoid Personality Disorder Scale.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.015</td>
<td>.121</td>
<td>.985</td>
<td>.678</td>
</tr>
</tbody>
</table>

Table 34: Statistics for the discriminant function for Hypotheses Three

Narcissistic Personality Disorder (Scale 5)

Hypothesis Four- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male batterers who meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≤ 84).

The results for this hypothesis were statistically significant. As indicated by Table 35, Wilks’ Lambda level of significance (.003) is less than the designated alpha level
<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.149</td>
<td>.360</td>
<td>.871</td>
<td>.003</td>
</tr>
</tbody>
</table>

Table 35: Statistics for the discriminant function for Hypotheses Four

<table>
<thead>
<tr>
<th>Discriminating GCSQ-150 scale</th>
<th>Canonical Discriminant Function Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deflection</td>
<td>-.254</td>
</tr>
<tr>
<td>Egotism</td>
<td>.724</td>
</tr>
<tr>
<td>Projection</td>
<td>.688</td>
</tr>
<tr>
<td>Retroflection</td>
<td>-.889</td>
</tr>
</tbody>
</table>

Table 36: Canonical Discriminant Function Coefficients for Hypothesis Four

of .05. This suggests that the discriminant function is statistically significant and that, based on a linear combination the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism, there are differences between those male batterers who meet the MCMII-III criteria for Narcissistic Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMII-III criteria for Narcissistic Personality Disorder (BR ≤ 84). Although statistically significant, the low eigenvalue and canonical correlation
suggest that the discriminant function may have limited practical use and, thus, caution is warranted when making any generalizations or clinical interpretations based on the outcome.

Having established that a linear combination the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism is a statistically significant discriminator between those male batterers who meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≤ 84), it is important to examine each of the GCSQ-150 scales in the discriminant function individually in order to assess each one's discriminant power. Table 36 illustrates the canonical discriminant function coefficients for the GCSQ-150 Deflection, Projection, Retroflection, and Egotism scales.

As indicated by Table 36, the GCSQ-150 Retroflection scale's canonical discriminant function coefficient (.889) has demonstrated exceedingly high discriminating power within the discriminant function. The GCSQ-150 Egotism (.724) and Projection (.688) scales have exhibited moderate discriminating power and the Deflection scale (.254) has exhibited considerably less power and significance within the discriminant function.

With regards to the classification of cases, the discriminant function correctly classified 92.5% of the cases into one of the two groups, those male batterers who meet the MCMI-III criteria for Narcissistic Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Narcissistic Personality Disorder (BR
A random classification of cases would have produced 83.2% classification accuracy.

In order to determine the practical relevance of the classification power of the discriminant function, Hair et al. (1995) suggest that the discriminant function classification should be one and one-fourth the value of random assignment. For example, if random assignment accuracy was found to be 30%, the ideal discriminant function classification should be 37.5% (30% + ¼ 30%).

In applying Hair et al.'s (1995) classification recommendation to Hypothesis Four, the discriminant function should, ideally, be classifying cases with 100% accuracy. Thus, although the classification technique provides further support for the statistical significance of the discriminant function for Hypothesis Four, the practical relevance of this finding is questionable.

Hypothesis Five- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 75 and ≤ 84) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Narcissistic Personality Disorder Scale.

The results for this hypothesis were not statistically significant. As indicated by Table 37, the Wilks’ Lambda level of significance is .366, considerably higher than the designated alpha level of .05. Additionally, the eigenvalue and canonical correlation are relatively low while the Wilks’ Lambda (.960) is exceptionally high. Thus, based on a
linear combination of the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism, there are no statistically significant differences between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Narcissistic Personality Disorder Scale.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.042</td>
<td>.200</td>
<td>.960</td>
<td>.366</td>
</tr>
</tbody>
</table>

Table 37: Statistics for the discriminant function for Hypothesis Five

Hypothesis Six- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Narcissistic Personality Disorder Scale.

The results for this hypothesis were statistically significant. As indicated by Table 38, the Wilks’ Lamda level of significance (.001) is less than the designated alpha level of 0.05.
Thus, based on a linear combination of the GCSQ-150 scales of Deflection, Projection, Retroflection, and Egotism, there is a statistically significant difference between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Narcissistic Personality Disorder Scale.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks’ Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.197</td>
<td>0.405</td>
<td>0.836</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Table 38: Statistics for the discriminant function for Hypothesis Six

<table>
<thead>
<tr>
<th>Discriminating GCSQ-150 scale</th>
<th>Canonical Discriminant Function Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deflection</td>
<td>-0.358</td>
</tr>
<tr>
<td>Egotism</td>
<td>0.788</td>
</tr>
<tr>
<td>Projection</td>
<td>0.683</td>
</tr>
<tr>
<td>Retroflection</td>
<td>-0.851</td>
</tr>
</tbody>
</table>

Table 39: Canonical discriminant function coefficients for Hypothesis Six
Although statistically significant, the low eigenvalue and canonical correlation suggest that the discriminant function may have limited practical use and, thus, caution is warranted when making any generalizations or clinical interpretations based on the outcome.

With regards to the discriminating power of each individual variable, Table 39 illustrates the canonical discriminant function coefficient for each GCSQ-150 scale. It is important to note that the canonical discriminant function coefficient for this hypothesis are very similar to the values presented for Hypothesis Four. The GCSQ-150 scales of Egotism and Retroflection hold the most discriminating power, while the Projection scale is moderate and the Deflection scale is low in their ability discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Narcissistic Personality Disorder Scale.

The discriminant function for this hypothesis correctly classified 92.2% of the original cases. If done by random assignment, it is estimated that approximately 80.6% of the cases would be correctly classified, thus supporting the statistical significance of the discriminant function and it’s ability to discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Narcissistic Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Narcissistic Personality Disorder Scale.
In applying Hair et al.'s (1995) classification recommendation to Hypothesis Six, the discriminant function should, ideally, be classifying cases with 100% accuracy. Thus, although the classification technique provides further support for the statistical significance of the discriminant function for Hypothesis Six, the practical relevance of this finding is questionable.

Antisocial Personality Disorder (Scale 6a)

Hypothesis Seven - Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≤ 84).

The results for this hypothesis were statistically significant. As indicated by Table 40, the Wilks' Lambda level of significance is .029, which is less than the designated alpha level of .05. Thus, the GCSQ-150 scale of Projection is significant in discriminating between those male batterers who meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≤ 84). Although statistically significant, it is important to recognize that the eigenvalue and canonical correlation have produced considerably low values. This raises some question as to the overall strength of the discriminant function and justifies the use if caution when making any generalizations based on the outcome.
Table 40: Statistics for the discriminant function for Hypothesis Seven

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.041</td>
<td>.199</td>
<td>.960</td>
<td>.029</td>
</tr>
</tbody>
</table>

The GCSQ-150 Projection scale is the only scale in the discriminant function for this hypothesis. Thus, as expected, the canonical discriminant function coefficient for this particular variable is 1.00. This indicates that the discriminant function carries exactly the same information as the discriminating variable GCSQ-150 Projection scale.

With regards to the classification of cases, the discriminant function correctly classified 88.3% of the cases into one of the two groups, those male batterers who meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Antisocial Personality Disorder (BR ≤ 84). A random classification of cases would have likely resulted in 79.2% accuracy.

In applying Hair et al.'s (1995) classification recommendation to Hypothesis Seven, the discriminant function for this hypothesis should, ideally, be classifying cases with about 98% accuracy. Thus, the discriminant function fails to satisfy Hair et al.'s (1995) classification criteria, suggesting, perhaps, that although the classification technique provides further support for the statistical significance of the discriminant function for this hypothesis, the practical relevance of this finding is questionable.
Hypothesis Eight- Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Antisocial Personality Disorder Scale.

The results for this hypothesis were statistically significant. As indicated by Table 41, the Wilks’ Lambda level of significance is .009, which is less than the designated alpha level of .05. Thus, the GCSQ-150 scale of Projection is statistically significant in discriminating between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Antisocial Personality Disorder Scale. However, as with the previous hypothesis for this scale, the low eigenvalue and canonical correlation suggests that the discriminant function may have limited practical ability and discriminatory power.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks’ Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.069</td>
<td>.254</td>
<td>.935</td>
<td>.009</td>
</tr>
</tbody>
</table>

Table 41: Statistics for the discriminant function for Hypothesis Eight
The GCSQ-150 Projection scale is the only scale in the discriminant function for this hypothesis. Thus, as expected, the canonical discriminant function coefficient for this particular variable is 1.00. This indicates that the discriminant function carries exactly the same information as the discriminating variable GCSQ-150 Projection scale.

With regards to the classification of cases, the discriminant function correctly classified 77.4% of the cases into one of the two groups. If done by random assignment, it is estimated that approximately 63.0% of the cases would be correctly classified, thus supporting the ability of the discriminant function to discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Antisocial Personality Disorder Scale.

In applying Hair et al.'s (1995) classification recommendation to Hypothesis Eight, the discriminant function for this hypothesis should, ideally, be classifying cases with about 79% accuracy. Thus, the discriminant function for this hypothesis falls just short of satisfying Hair et al.'s (1995) classification criteria. Although this may support a practical utility for this particular discriminant function, it is important to consider the larger context, including the low eigenvalue and canonical correlation, when making any evaluative or interpretative judgments.

**Hypothesis Nine**—Within a clinical sample of male batterers, the GCSQ-150 scale of Projection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Antisocial Personality
Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74) on the Antisocial Personality Disorder Scale.

The results for this hypothesis were statistically significant. As indicated by Table 42, the Wilks' Lambda level of significance is .005, which is less than the designated alpha level of .05. Thus, the GCSQ-150 scale of Projection is statistically significant in discriminating between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR ≥ 85) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74) on the Antisocial Personality Disorder Scale. However, from a practical perspective, the low eigenvalue and canonical correlation suggest that the overall power of the discriminating function may be relatively weak.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.088</td>
<td>.285</td>
<td>.919</td>
<td>.005</td>
</tr>
</tbody>
</table>

Table 42: Statistics for the discriminant function for Hypothesis Nine
The GCSQ-150 Projection scale is the only scale in the discriminant function for this hypothesis. Thus, as expected, the canonical discriminant function coefficient for this particular variable is 1.00. This indicates that the discriminant function carries exactly the same information as the discriminating variable GCSQ-150 Projection scale.

The discriminant function correctly classified 85.1% of the cases into one of the two groups. If done by random assignment, it is estimated that approximately 74.6% of the cases would be correctly classified, thus supporting the statistical significance of the discriminant function and its ability to discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Antisocial Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Antisocial Personality Disorder Scale.

When applying Hair et al.’s (1995) classification recommendation to Hypothesis Eight, the discriminant function for this hypothesis should, ideally, be classifying cases with about 92% accuracy. Thus, the discriminant function for this hypothesis clearly failed to satisfy Hair et al.’s (1995) classification criteria. This finding supports the contention that, although the discriminant function was found to be statistically significant, the practicality of such findings are questionable.

Aggressive (Sadistic) Personality Disorder (Scale 6b)

Hypothesis Ten—Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III criteria for Aggressive (Sadistic)
Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Aggressive (Sadistic) Personality Disorder (BR ≤ 84).

The results for this hypothesis was not statistically significant. As indicated by Table 43, the Wilks' Lambda level of significance is .655, which is higher than the designated alpha level of .05. Thus, the group centroids are assumed to be equal and, based on a linear combination of the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection, there are no statistically significant differences between those male batterers who meet the MCMI-III criteria for Aggressive (Sadistic) Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Aggressive (Sadistic) Personality Disorder (BR ≤ 84).

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.029</td>
<td>.168</td>
<td>.972</td>
<td>.655</td>
</tr>
</tbody>
</table>

Table 43: Statistics for the discriminant function for Hypothesis Ten

Hypothesis Eleven- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Aggressive (Sadistic) Personality Disorder Scale and
those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Aggressive (Sadistic) Personality Disorder Scale.

The results for this hypothesis were not statistically significant. As indicated by Table 44, the Wilks’ Lambda level of significance is .642, which is higher than the designated alpha level of .05. Thus, the group centroids are assumed to be equal and, based on a linear combination of the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection, there are no statistically significant differences between those male batterers who meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 75 and ≤ 84) on the Aggressive (Sadistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality "trait" (BR ≥ 85 and ≤ 74) on the Aggressive (Sadistic) Personality Disorder Scale.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks’ Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.041</td>
<td>.176</td>
<td>.945</td>
<td>.642</td>
</tr>
</tbody>
</table>

Table 44: Statistics for the discriminant function for Hypothesis Eleven

**Hypothesis Twelve**- Within a clinical sample of male batterers, the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality...
"disorder" (BR ≥ 85) on the Aggressive (Sadistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74) on the Aggressive (Sadistic) Personality Disorder Scale.

The results for this hypothesis were not statistically significant. As indicated by Table 45, the Wilks' Lambda level of significance is .610, which is higher than the designated alpha level of .05. Thus, the group centroids are assumed to be equal and, based on a linear combination of the GCSQ-150 scales of Deflection, Desensitization, Projection, Introjection, and Retroflection, there are no statistically significant differences between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR ≥ 85) on the Aggressive (Sadistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR ≤ 74) on the Aggressive (Sadistic) Personality Disorder Scale.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.037</td>
<td>.189</td>
<td>.964</td>
<td>610</td>
</tr>
</tbody>
</table>

Table 45: Statistics for the discriminant function for Hypothesis Twelve
Passive Aggressive (Negativistic) Personality Disorder (Scale 8a)

Hypothesis Thirteen - Within a clinical sample of male batterers, the GCSQ-150 scales of Projection and Retroflection will discriminate between those male batterers who meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≤ 84).

The results for this hypothesis were statistically significant. As indicated by Table 46, the Wilks’ Lambda level of significance is .009, which is less than the designated alpha level of .05. Thus, based on a linear combination of the GCSQ-150 scales of Projection and Retroflection, there is a difference between those male batterers who meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≤ 84). The low eigenvalue and canonical correlation may, however, limit the discriminant function in its discriminatory and predictive capabilities.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks’ Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.085</td>
<td>.280</td>
<td>.922</td>
<td>.009</td>
</tr>
</tbody>
</table>

Table 46: Statistics for the discriminant function for Hypothesis Thirteen
As indicated by Table 47, the canonical discriminant function coefficients for both the GCSQ-150 Projection and Retroflection scales have demonstrated moderate ability within the discriminant function to discriminate between the two groups of subjects. The Retroflection scale (.65) has exhibited slightly more discriminating power than the Projection scale (.49).

The discriminant function for this hypothesis correctly classified 88.3% of the cases into one of two groups. If done by random assignment, it is estimated that approximately 78.0% of the cases would be correctly classified, thus, supporting the statistical significance of the discriminant function and its ability to discriminate between those male batterers who meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≥ 85) and those male batterers who do not meet the MCMI-III criteria for Passive Aggressive (Negativistic) Personality Disorder (BR ≤ 84).

When applying Hair et al.'s (1995) classification recommendation to Hypothesis Thirteen, the discriminant function for this hypothesis should, ideally, be classifying cases...
with about 98% accuracy. Thus, the discriminant function for this hypothesis clearly failed
to satisfy Hair et al.'s (1995) classification criteria. This finding supports the contention
that, although the discriminant function was found to be statistically significant, the
practicality of such findings are questionable.

**Hypothesis Fourteen** - Within a clinical sample of male batterers, the GCSQ-150 scales of
Projection and Retroflection will discriminate between those male batterers who meet the
MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Passive
Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not
meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the
Passive Aggressive (Negativistic) Personality Disorder Scale.

The results for this hypothesis were statistically significant. As indicated by Table
48, the Wilks’ Lambda level of significance is .000, which is considerably lower than the
designated alpha level of .05. Thus, based on a linear combination of the GCSQ-150
scales of Projection and Retroflection, there is a statistically significant difference between
those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR
≥ 75 and ≤ 84) on the Passive Aggressive (Negativistic) Personality Disorder Scale and
those male batterers who do not meet the MCMI-III diagnostic criteria for personality
“trait” (BR ≥ 85 and ≤ 74) on the Passive Aggressive (Negativistic) Personality Disorder Scale. The eigenvalue and canonical correlation are relatively low and indicate that the
discriminant function may be rather limited in it’s practical discriminatory and predictive
capabilities.
Table 48: Statistics for the discriminant function for Hypothesis Fourteen

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.226</td>
<td>.429</td>
<td>.816</td>
<td>.000</td>
</tr>
</tbody>
</table>

As indicated by Table 49, the discriminating power of each individual variable is nearly identical. Thus, both the GCSQ-150 scales of Projection (.602) and Retroflection (.581) carry almost identical weights and discriminating power within the discriminant function for this hypothesis.

The discriminant function for this hypothesis correctly classified 70.5% of the cases into one of two groups. If done by random assignment, it is estimated that approximately 56.0% of the cases would be correctly classified, thus, supporting the
statistical significance of the discriminant function and it’s ability to discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Passive Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Passive Aggressive (Negativistic) Personality Disorder Scale.

When applying Hair et al.’s (1995) classification recommendation to Hypothesis Fourteen, the discriminant function for this hypothesis should, ideally, be classifying cases with about 71% accuracy. Thus, the discriminant function for this hypothesis has satisfied Hair et al.’s (1995) classification criteria. This suggests that, in addition to being statistically significant, the discriminant function may also carry some practical significance with regards to it’s discriminatory and predictive powers. However, the relatively low eigenvalue and canonical correlation must be considered when making any inferences or generalizations based on these findings.

Hypothesis Fifteen- Within a clinical sample of male batterers, the GCSQ-150 scales of Projection and Retroflection will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Passive Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Passive Aggressive (Negativistic) Personality Disorder Scale.

The results for this hypothesis were statistically significant. As indicated by Table 50, the Wilks’ Lambda level of significance is .001, which is less than the designated alpha
level of .05. Thus, based on a linear combination of the GCSQ-150 scales of Projection and Retroflection, there is a statistically significant difference between those male batterers who meet the MCMI-III diagnostic criteria for personality "disorder" (BR \( \geq 85 \)) on the Passive Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality "disorder" or personality "trait" (BR \( \leq 74 \)) on the Passive Aggressive (Negativistic) Personality Disorder Scale. The low to moderate values of the eigenvalue and canonical correlation, however, indicate that there is some question about the practicality of such significance.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.199</td>
<td>.408</td>
<td>.834</td>
<td>.001</td>
</tr>
</tbody>
</table>

Table 50: Statistics for the discriminant function for Hypothesis Fifteen

<table>
<thead>
<tr>
<th>Discriminating GCSQ-150 scale</th>
<th>Canonical Discriminant Function Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projection</td>
<td>.507</td>
</tr>
<tr>
<td>Retroflection</td>
<td>.610</td>
</tr>
</tbody>
</table>

Table 51: Canonical Discriminant Function Coefficient for Hypothesis Fifteen
Table 51 illustrates the canonical discriminant function coefficients for this hypothesis. The values for the canonical discriminant function coefficients are somewhat similar to the coefficient values for the other hypothesis on this particular scale.

The discriminant function correctly classified 82.6% of the original cases into one of two groups. If a random classification were done, it is estimated that 71.2% of the cases would be correctly classified into one of two groups, thus, supporting the statistical significance of the discriminant function in discriminating between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR ≥ 85) on the Passive Aggressive (Negativistic) Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR ≤ 74) on the Passive Aggressive (Negativistic) Personality Disorder Scale.

In applying Hair et al.’s (1995) classification criteria to this hypothesis, the discriminant function should be, ideally, classifying about 88% of the cases correctly. Thus, in addition to the low eigenvalue and canonical correlation, the fact that the discriminant function failed to satisfy Hair et al.’s (1995) classification criteria raises some question and concerns regarding the practical capabilities of the discriminant function for this hypothesis.

Borderline Personality Disorder (Scale C)

**Hypothesis Sixteen**—Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who

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meet the MCMI-III criteria for Borderline Personality Disorder (BR $\geq 85$) and those male batterers who do not meet the MCMI-III criteria for Borderline Personality Disorder (BR $\leq 84$).

The results for this hypothesis were not statistically significant. As indicated by Table 52, the Wilks' Lamda level of significance (.283) is greater than the designated alpha level of .05. Thus, the groups centroids are assumed to be equal and, based on a linear combination of the GCSQ-150 Retroflection and Desensitization scales, there are no statistically significant differences between those male batterers who meet the MCMI-III criteria for Borderline Personality Disorder (BR $\geq 85$) and those male batterers who do not meet the MCMI-III criteria for Borderline Personality Disorder (BR $\leq 84$).

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks' Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.022</td>
<td>.146</td>
<td>.979</td>
<td>.283</td>
</tr>
</tbody>
</table>

Table 52: Statistics for the discriminant function for Hypothesis Sixteen

Hypothesis Seventeen- Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR $\geq 75$ and $\leq 84$) on the Borderline Personality Disorder Scale and those male batterers who do not meet the
MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Borderline Personality Disorder Scale.

The results for this hypothesis were statistically significant. As indicated by Table 53, the Wilks’ Lambda level of significance (.023) is less than the designated alpha level of .05. Thus, based on a linear combination of the GCSQ-150 Retroflection and Desensitization scales, there is a statistically significant difference between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Borderline Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Borderline Personality Disorder Scale. The eigenvalue and canonical correlation, however, are considerably low, thus, indicating that caution is warranted when making any inferences or generalizations about the strength of the discriminant function.

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks’ Lambda</th>
<th>significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.070</td>
<td>.256</td>
<td>.935</td>
<td>.023</td>
</tr>
</tbody>
</table>

Table 53: Statistics for the discriminant function for Hypothesis Seventeen

Table 54 illustrates the canonical discriminant function coefficients for this hypothesis. The coefficient for the GCSQ-150 Retroflection scale (.977) carries
considerably more weight within the discriminant function than does the Desensitization scale (.277).

<table>
<thead>
<tr>
<th>Discriminating GCSQ-150 scale</th>
<th>Canonical Discriminant Function Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retroflection</td>
<td>.977</td>
</tr>
<tr>
<td>Desensitization</td>
<td>.277</td>
</tr>
</tbody>
</table>

Table 54: Canonical Discriminant Function Coefficient for Hypothesis Seventeen

The discriminant function correctly classified 86.8% of the original cases into one of two groups. If random classification were done, it is estimated that approximately 77% of the cases would be correctly classified, thus, supporting the statistical significance of the discriminant function in discriminating between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) on the Borderline Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 85 and ≤ 74) on the Borderline Personality Disorder Scale.

In applying Hair et al.’s (1995) classification criteria to this hypothesis, the discriminant function should be, ideally, classifying cases with about 96% accuracy.
Thus, the discriminant function clearly is inadequate with regards to Hair et al.'s (1995) classification criteria. Although the discriminant function for this hypothesis was found to be statistically significant, the low eigenvalue and canonical correlation and inadequate classification, brings into question the practical value of such significance.

**Hypothesis Eighteen-** Within a clinical sample of male batterers, the GCSQ-150 scales of Retroflection and Desensitization will discriminate between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR $\geq$ 85) on the Borderline Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR $\leq$ 74) on the Borderline Personality Disorder Scale.

The results for this hypothesis were not statistically significant. As indicated by Table 55, the Wilks’ Lambda level of significance is .283, which is greater than the designated alpha level of .05. Thus, the group centroids are assumed to be equal and, based on a linear combination of the GCSQ-150 Retroflection and Desensitization scales, there are no statistically significant differences between those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR $\geq$ 85) on the Borderline Personality Disorder Scale and those male batterers who do not meet the MCMI-III diagnostic criteria for either personality “disorder” or personality “trait” (BR $\leq$ 74) on the Borderline Personality Disorder Scale.
Summary of Chapter 4

This chapter presented the results and outcome data for the 120 subjects scores on the GCSQ-150 and MCMI-III. More specifically, demographic data on the sample, intercorrelations within each instrument, results for the hypothesis testing, and other relevant findings were reported. As indicated by Table 56, there were eighteen hypotheses, three for each of the six MCMI-III personality disorder scales which were relevant to the study (Schizoid, Narcissistic, Antisocial, Aggressive Sadistic, Passive-Aggressive, and Borderline). For each of the MCMI-III scales, there were three separate groups, or units of analyses, utilized in correlating the Gestalt resistances with the personality disorders: 1) comparing those male batterers with a “disorder” (BR ≤ 85) to those male batterers without a “disorder” (BR < 85); 2) comparing those male batterers with a “trait” (BR ≥ 75 and ≤ 74) to those male batterers without a “trait” (BR ≥ 85 and ≤ 74); and 3) comparing those male batterers with a “disorder” (BR ≤ 85) to those male batterers without either a “disorder” or a “trait” (BR < 74). Of the eighteen hypotheses, nine were found to statistically significant. All three of the hypotheses within the Antisocial Personality Disorder and Passive-Aggressive Personality Disorder scales were

<table>
<thead>
<tr>
<th>Eigenvalue</th>
<th>Canonical Correlation</th>
<th>Wilks’ Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>.022</td>
<td>.146</td>
<td>.979</td>
<td>.283</td>
</tr>
</tbody>
</table>

Table 55: Statistics for the discriminant function for Hypothesis Eighteen
found to be statistically significant. Additionally, two of the groups produced statistically significant results for the Narcissistic Personality Disorder scale and one group produced statistically significant results for the Borderline Personality Disorder Scale.
<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Results</th>
<th>Gestalt Resistances for the Discriminant Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizoid</td>
<td></td>
<td>Deflection, Desensitization, Egotism</td>
</tr>
<tr>
<td>1</td>
<td>not statistically significant</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>not statistically significant</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>not statistically significant</td>
<td></td>
</tr>
<tr>
<td>Narcissistic</td>
<td></td>
<td>Deflection, Retroflection, Projection, Egotism</td>
</tr>
<tr>
<td>4</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>not statistically significant</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>Antisocial</td>
<td></td>
<td>Projection</td>
</tr>
<tr>
<td>7</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>Aggressive-Sadistic</td>
<td></td>
<td>Def, Desen, Proj, Intro, Retro,</td>
</tr>
<tr>
<td>10</td>
<td>not statistically significant</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>not statistically significant</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>not statistically significant</td>
<td></td>
</tr>
<tr>
<td>Passive-Aggressive</td>
<td></td>
<td>Projection, Retroflection</td>
</tr>
<tr>
<td>13</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>Borderline</td>
<td></td>
<td>Retroflection, Desensitization</td>
</tr>
<tr>
<td>16</td>
<td>not statistically significant</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>statistically significant</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>not statistically significant</td>
<td></td>
</tr>
</tbody>
</table>

Table 56: Data outcome results and Gestalt resistances which compose the discriminant function for each of the eighteen hypotheses
CHAPTER 5

CONCLUSION

In Chapter 4, the emphasis was on presenting and discussing the results from the data collection and data analysis for the study. Having done that, the reader may, at this point, be wrestling with inevitable question “So what does this all mean?” The focus of this Fifth and final chapter is on integrating the hypotheses, assumptions, and empirical results of the first four chapters into a practical and meaningful context. A major emphasis of this chapter will be on addressing the implications of the results of the study and examining potential areas for future research.

Review of Key Terms and Concepts Relevant to the Present Study

In order to fully understand the nature of the discussion in the Chapter and the implications of the results for the hypotheses of this study, it is first necessary to review the key terms and concepts related to the personality disorders and Gestalt resistances. Thus, a review of the definitions for the various MCMI-III personality disorders and Gestalt resistances relevant to this study are addressed below.

The MCMI-III Personality Disorders

Personality Disorder- An enduring, inflexible, and pervasive pattern of inner experience and behavior that deviates markedly from the expectations of the individuals
culture. Such a pattern, beginning in adolescence and active across a broad range of personal and social situations, leads to clinically significant impairment in social, occupational, or other areas of functioning and is not due to direct physiological effects of a substance or medical condition (Diagnostic and Statistical Manual of Mental Disorders, Fourth edition (DSM-IV; 1994, pp. 275-276). For the purposes of this study, a personality disorder is operationally defined as a Base Rate score of 85 and above on the various personality disorder scales of the MCMI-III.

Personality styles (and disorders) reflect deeply etched and pervasive characteristics of a patient’s functioning. These characteristics tend to perpetuate themselves and aggravate everyday difficulties. They are so embedded and automatic that the patient is often unaware of their nature and of their self-destructive consequences. These advanced stages of personality pathology reflect a slow, insidious deterioration of the personality structure and usually accentuate the patient’s lifelong style of functioning. Despite evident changes in psychic cohesion, social competence, and emotional control, the patient continues to display the major personality characteristics that were previously evident (Millon, 1994, p. 11).

**Schizoid Personality Disorder**- A pervasive pattern of detachment from social relationships, beginning by early adulthood and present in a variety of contexts, and characterized by a restricted range of emotion, a preference for solitary activities, an indifference to both criticism and praise, lack of interest or pleasure in sexual activities, and few, if any, close friends or relatives (DSM-IV, 1994).

According to Millon (1994), “Schizoid patients are noted by their lack of desire and their capacity to experience pleasure or pain. They tend to be apathetic, listless, distant, and asocial” (p. 11). For the purposes of this study, Schizoid Personality Disorder

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is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Schizoid Personality Disorder Scale.

**Narcissistic Personality Disorder**—A pervasive pattern of grandiosity, beginning in early adulthood, and characterized by a need for admiration, lack of empathy, sense of entitlement, extreme arrogance, interpersonal exploitiveness, unrealistic sense of self-worth, and preoccupation with fantasies of success, power, beauty, and brilliance (DSM-IV, 1994).

According to Millon (1994), “Narcissistic individuals are noted for their egoistic self-involvement. They experience pleasure by focusing on themselves... They maintain an air of arrogant self-assurance, and, without much thought or even conscious intent, benignly exploit others to their advantage” (p. 12). For the purposes of this study, Narcissistic Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Narcissistic Personality Disorder Scale.

**Antisocial Personality Disorder**—A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15, and characterized by impulsivity, irritability, deceitfulness, aggressiveness, recklessness, irresponsibility, and lack of remorse (DSM-IV, 1994).

According to Millon (1994), “Antisocial individuals act to counter the pain and depredation they expect from others... They are irresponsible and impulsive, qualities they believe are justified because they judge others to be unreliable and disloyal” (p. 12). For the purposes of this study, Antisocial Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Antisocial Personality Disorder Scale.
Aggressive (Sadistic) Personality Disorder- This personality disorder was deleted from the DSM-IV (1994). However, Millon (1994) has maintained it in the MCMI-III in order to recognize that there are those individuals who may not be publicly judged as “antisocial” but who, nonetheless, derive pleasure and satisfaction from humiliating and violating the rights of others. Such individuals are typically hostile, dominating, antagonistic, combative, and persecutory, while also exhibiting extreme indifference or pleasure at the destructive consequences of their brutal and abusive behaviors (Millon, 1994).

According to Millon (1994), “These individuals are generally hostile and pervasively combative, and they appear to be indifferent to or pleased by the destructive consequences of their contentious, abusive, and brutal behaviors. Although many cloak their more malicious and power-oriented tendencies in publicly approved roles and vocations, they give themselves away by their dominating, antagonistic, and frequently persecutory actions” (p. 13). For the purposes of this study, Aggressive (Sadistic) Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Aggressive (Sadistic) Personality Disorder Scale.

Passive Aggressive Personality Disorder (Negativistic Personality Disorder)- A pervasive pattern of negativistic attitudes and passive resistance to demands of adequate performance, beginning by early adulthood, and characterized by complaints of being misunderstood and unappreciated, sulleness and argumentativeness, a tendency to scorn authority, resentment towards others who are more fortunate, and resistance to fulfilling routine obligations (DSM-IV).
According to Millon (1994), "Passive aggressive individuals struggle between working towards their own rewards and the rewards offered by others. They experience endless wrangles and disappointments as they vacillate between deference and defiance. They display an erratic pattern of explosive anger or stubbornness intermingled with periods of guilt and shame" (p.13). For the purposes of this study, Passive-Aggressive Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Passive-Aggressive Personality Disorder Scale.

**Borderline Personality Disorder** - A pervasive pattern of instability in interpersonal relationships and self-image, beginning in early adulthood, and characterized by frantic efforts to avoid real or perceived abandonment, identity disturbance, impulsivity, recurrent suicidal gestures, dissociative symptoms, paranoid ideations, temper outbursts, and chronic mood swings (DSM-IV, 1994).

According to Millon (1994), "Individuals with borderline personality variants have structural defects and experience intense endogenous moods, with recurring periods of dejection and apathy, often interspersed with spells of anger, anxiety, or euphoria. Additionally, many reveal recurring thoughts of self-mutilation and suicide" (p.14). For the purposes of this study, Borderline Personality Disorder is operationally defined as a Base Rate Score of 85 and above on the MCMI-III Borderline Personality Disorder Scale.

**The Gestalt Resistances**

**Resistance** - From the Gestalt perspective, resistances are the various mechanisms that individuals utilize in order to avoid achieving contact with either his or her environment or significant others. When chronically overused, resistances are likely to
lead to pervasive patterns of maladaptive and pathological behavior (Perls, 1993). For the purposes of this study, the Gestalt resistances will be operationally defined as an individual's raw score on the 8 subscales of the GCSQ-150.

**Introjection:-** The process by which an individual uncritically accepts information from either the environment or others without challenging or questioning the meaning, value, or personal usefulness of such information (Perls et al., 1951). The individual passively accepts “what is” and incorporates information into his or her self-schema without regard for his or her own values, wants, beliefs, or the appropriateness of such information. For the purposes of this study, Introjection is operationally defined as an individual’s raw score on the Introjection subscale of the GCSQ-150.

**Projection-** The process by which an individual attributes those undesirable or unacceptable traits found within him or herself onto either the environment or others (Perls, 1973). Thus, such an individual is likely to disown his or her feelings and impulses and transfer them onto either the environment or others. For the purposes of this study, Projection is operationally defined as an individual’s raw score on the Projection subscale of the GCSQ-150.

**Retroflection-** Literally meaning “turning back sharply against” (Perls, 1973, p. 40), it is the process by which an individual withholds his or her desire to interact with either the environment or others and, instead, treats him or herself in a way originally intended for another object or individual. Instead of directing his or her energy outward, such an individual substitutes him or herself as the primary target of the behavior. For the
purposes of this study, Retroflection is operationally defined as an individual’s raw score on the Retroflection subscale of the GCSQ-150.

**Deflection**- The process by which an individual reduces the intensity of interpersonal contact by engaging in distracting or inappropriate behavior (The Gestalt Institute of Cleveland, 1995). Changing the subject, avoiding eye contact, using inappropriate humor, being overly talkative, focusing on details, and using language loaded with minimization’s, qualifiers, and excuses are several mechanisms by which an individual may deflect in order to avoid contact or intimacy with others. For the purposes of this study, Deflection is operationally defined as an individual’s raw score on the Deflection subscale of the GCSQ-150.

**Desensitization**- The process by which an individual detaches him or herself from all internal, sensory, or bodily sensations (Kepner, 1982). Such an individual chronically and habitually “numbs” him or herself and is, thus, unable to recognize or identify any internal feelings or sensation. For the purposes of this study, Desensitization is operationally defined as an individual’s raw score on the Desensitization subscale of the GCSQ-150.

**Egotism**- Perls et al. (1951) described egotism as a fixation, a way of avoiding contact by becoming overly controlled, rigid, and indecisive. An individual who uses egotism is likely to resist letting go and, thus, entering into the final stage of contact in which the individual and the organism reciprocallly interact in the process of change. Having a tendency to suppress his or her sense of creativity and spontaneity, an individual who uses egotism is more likely to prefer interaction which is highly structured.
predictable, deliberate and controlled. Such interaction often leads to intense feelings of boredom, loneliness, fear, and staleness. For the purposes of this study, Egotism is operationally defined as an individual's raw score on the Egotism subscale of the GCSQ-150.

MCMI-III Validity Scales Outcomes

As discussed in Chapter 3, the MCMI-III has three validity scales which measure a subject’s attitude at the time he or she was completing the instrument. According to Millon (1994), subjects who have BR scores of 75 or higher on the Desirability Index suggest a tendency to present oneself in a favorable light and subjects who have BR scores of 75 or higher on the Debasement Index suggest an inclination to "fake bad" and devalue oneself by exaggerating the symptoms. As indicated by Table 56, the mean score for the Desirability Index was 68 the mean score for the Debasement Index was 51. This suggests that the present sample of male batterers, in general, were relatively honest in their appraisal and disclosure of their symptoms, with neither a tendency to "fake good" or "fake bad".

Personality Disorders of Male Batterers

The purpose of this study was to empirically examine the relationships between the Gestalt resistances and Millon's (1994) typology of personality disorders. As discussed in Chapter 1, the current literature contains a plethora of theoretical and empirical research which suggests that male batterers exhibit high prevalence rates of personality disorders (Hart, et al., 1994; Hamberger & Hastings, 1985, 1986).
Additionally, among clinical samples of male batterers, six of the MCMI and MCMI-II Personality Disorders were found to be more prominent than the others. More specifically, the Antisocial (Beasley & Stoltenberg, 1994; Hart et al., 1994; Murphy, Lemeyer, & O'Leary, 1994), Narcissistic (Beasley & Stoltenberg, 1992; Hamberger & Hastings, 1985, 1986), Borderline (Beasley & Stoltenberg, 1992; Hamberger & Hastings, 1985, 1986; Hart et al., 1994), Schizotypal (Beasley & Stoltenberg, 1992; Hamberger & Hastings, 1985, 1986), Passive-Aggressive (Murphy et al., 1994), and Aggressive (Sadistic) (Beasley & Stoltenberg, 1992; Murphy et al., 1994) Personality Disorders have been shown to be more prevalent among this particular clinical population. It is these six scales that provided the impetus and framework for the present study.

In the present study, there were 73 subjects (61%) who met the diagnostic criteria for a "disorder" on at least one of the six MCMI-III personality disorder scales described above. The prevalence rates of personality disorders found in this study are well below
the 88% (Hamberger and Hastings, 1985, 1986) and 80-90% (Hart et al., 1994) prevalence rates found by other researchers. Despite this, the current findings support the contention that male batterers, in general, evidence relatively high levels of psychopathy. In further examining the prevalence rates of personality disorders among male batterers, there are several important issues which warrant attention.

First, the dichotomous nature of the MCMI-III scoring and classification structure may influence the prevalence rates of personality disorders. As discussed in Chapter 3, the current MCMI-III Base Rate (BR) scoring system classifies an individual with a BR score of 85 as having a personality “disorder”, while an individual with a BR score of 84 is classified as having a personality “trait”. As is the case with most dichotomous scoring systems, an individual either has or does not have a “disorder” and either has or does not have a “trait”. An individual cannot be classified as having both a “disorder” and a “trait” on any one particular scale.

In examining the larger context, several important questions regarding the BR scoring system arise: 1) From a clinical perspective, how different is individual with a BR score of 85 from an individual with a BR score of 84 or 83? 2) Would the results of this study be different if the BR anchor point for a personality disorder were 83 or 84 instead of 85?

In this study, there were eight subjects who had BR scores of 84 and there were fourteen subjects who had BR scores of 83. Thus, there were twenty two subjects who were currently categorized as having personality “traits” who, however, were one or two BR points below the established anchor of 85 for a personality “disorder”. Had the BR
anchor point for personality “disorder” been 83, just two points lower than the currently established anchor point of 85, there would have been ninety-five subjects, approximately 80% of the sample, who would have been categorized as having a personality “disorder”. Such a significant difference would have the potential to dramatically alter the results and outcomes of this study. Thus, although the conceptual definitions of the various personality disorders may be clear, operationally defining and empirically measuring such constructs is, undoubtedly, a difficult and formidable task.

Second, the present study was the first known study to utilize the MCMI-III with this particular clinical population. Much of the prior empirical research into the personality disorders of male batterers has utilized either the original MCMI or the MCMI-II. As discussed in Chapter 3, a new item weighting scale was introduced for the MCMI-III and ninety five items from the MCMI-II were replaced in order to optimize the correspondence between the MCMI-III and the DSM-IV. Thus, the inherent structural changes in the MCMI-III may have influenced the diagnostic and evaluative capabilities of the instrument, particularly with regards to the personality disorders.

Finally, it is important to recognize that domestic violence encompasses a wide variety of physical, emotional, verbal, sexual, social, spiritual, and economic abuse. The present study, like most prior research, was limited in that it did not differentiate or discriminate between the different types of abusive behaviors among the sample subjects. Rather, a male was considered to be eligible to participate in the present study if he was arrested and court ordered to participate in a domestic violence treatment program. There was no differentiation or discrimination between those subjects who physically or sexually
abused their partners and those subjects who emotionally or economically abused their partners. This raises the question: How are men who have physically or sexually abused their partners different than men who have emotionally or economically abused their partners, particularly with regards to the prevalence rates of personality disorders? One may speculate that there are, indeed, differences, both overt and covert, among these two subtypes of male batterers. Thus, in order to gain practical and meaningful insight into the phenomenon of domestic violence, it is important that any potential differences between the subtypes of male batterers be closely examined when studying the prevalence rates of personality disorders within this particular clinical population. This is of particular significance when one considers that the laws and legal definitions regarding domestic are changing and becoming broader in order to incorporate a wider array of abusive behaviors and that more and men are being ordered into treatment for behaviors other than physical abuse.

The Gestalt Resistances

Additionally, as discussed in Chapter 1, the current literature is lacking empirical research on the Gestalt therapy model and, in particular, the Gestalt resistances. One potential explanation for this is the fact that there are few psychometrically sound instruments designed to empirically Gestalt constructs. The Gestalt resistance instrument utilized in this study, the GCSQ-150, has undergone many revisions and improvements over the last twenty years, the most recent being Prosnick’s (1998) restructuring of the scoring system and creating the Gestalt Resistance Scale (GRS) for the GCSQ-150. The
GRS eliminated item overlap from the original scoring system and, in doing so, improved upon one of the major limitations of the GCSQ-150.

Although the reliability coefficients for each of Prosnick’s (1998) GRS scales, in general, exhibited improvements over the original GCSQ-150, several of the GRS scales continue to demonstrate relatively high intercorrelations. As discussed in Chapter 3 (see page 100), the original GCSQ-150 produced three intercorrelations above .70 while for Prosnick’s (1998) revised GRS for the GCSQ-150, five of the ten intercorrelations were above .50, including intercorrelation above .70. According to Davis (1971), a correlation coefficient in the .50-.69 range indicates a “substantial association” and a correlation coefficient of .70 or higher indicates “very strong association” between two sets of variables. There are two potential explanations for this finding.

First, the sample for the current study may, initially, appear to be homogenous in nature in that every subject had been arrested for domestic violence and court-ordered to complete a treatment program. However, there is, as discussed previously, much variability among the subjects with regards to both the nature, intensity, and prevalence of their abusive and controlling behaviors and the nature of their symptoms, personalities, and emotional difficulties. Thus, the entire sample as a whole may be considered to be, in general, relatively heterogeneous. This fact may have a significant influence on the data outcome due to the fact that the greater the variability of the sample data, the greater value of the correlation coefficient (Hopkins et al., 1996).

Second, it is important to recognize that, according to Perls (1993), each of the Gestalt resistances may be categorized under the general heading of “neuroticism”. Thus,
one may expect the Gestalt resistances would have some degree of natural association with each other. Although each of the eight Gestalt resistances has been shown to be distinct and unique constructs, each one also shares several core characteristics with the others. As discussed in Chapter 2, each of the Gestalt resistances, for example, represents an individual’s attempts to block, avoid, or interrupt the “contact cycle”.

Additionally, Perls (1993) noted that each of the Gestalt resistances, when utilized in moderation, have adaptive qualities which serve to support and maintain an organism’s level of functioning. However, when overused each Gestalt resistance has the potential, according to Perls (1993), to lead to neuroticism. “Neurosis is characterized by many forms of avoidance, mainly the avoidance of contact” (p. 7).

Results of the Hypotheses

In examining the dependent variables of the hypotheses for this study, there are two distinct categories of personality disorders—those which produced statistically significant results and those which did not produce statistically significant results. Every one of the three hypotheses for the Antisocial and Passive-Aggressive Personality Disorder scales and two of the three hypotheses for the Narcissistic Personality Disorder scale were statistically significant. On the other hand, none of the three hypotheses for either the Schizoid or Aggressive (Sadistic) Personality Disorder scales and only one hypothesis for the Borderline Personality Disorder scale, were statistically significant.

On the surface, these findings may appear to suggest that the discriminant functions for the Antisocial, Passive-Aggressive, and Narcissistic Personality Disorder scales were effective discriminators between the three various groups of subjects, while
the discriminant functions for the Schizoid, Aggressive-Sadistic, and Borderline Personality Disorders were not effective discriminators between the three groups of subjects.

In looking at the larger context, however, there are several critical issues which need to be addressed. First, in analyzing these results from a statistical context, it is important to recognize that the three dependent variable MCMI-III Personality Disorder scales which, in general, produced statistically significant results (Narcissistic, Antisocial, Passive-Aggressive) are also the scales with the highest number of subjects in either the “trait” or “disorder” category. On the other hand, the three dependent variable MCMI-III Personality Disorder scales which, in general, failed to produce statistically significant results (Schizoid, Aggressive Sadistic, Borderline) are also the three scales with the lowest number of subjects in either the “trait” or “disorder” category. Table 17 in Chapter 4 (page 138) illustrates the number of subjects in the “trait” and “disorder” categories for each of the six MCMI-III scales.

This is important when one considers that, in utilizing discriminant analysis, the number of cases in a sample is directly related to the strength of the test statistic which is required to produce statistically significant results (Hair, et al., 1995; Stevens, 1992). In this study, the Wilks’ Lambda test statistic level of significance for the Schizoid, Aggressive Sadistic, and Borderline scales would need to be of a much greater value in order to produce statistically significant results due to the low sample sizes for each of these particular scales. On the other hand, the strength and value required of the Wilks’ Lambda test statistic level of significance for the Narcissistic, Antisocial, and Passive
Aggressive scales is much lower due to the fact that these particular scales have larger sample sizes. Thus, it is reasonable to consider the possibility that the Schizoid, Aggressive Sadistic, and Borderline Personality Disorder scales failure to produce statistically significant results may be influenced, in part, by the small number of subjects in either the “trait” or “disorder” category for each of these particular scales.

Second, it is interesting to note that, of the six hypotheses, two of the MCMI-III scales (Antisocial and Passive-Aggressive) demonstrated full support by producing three hypotheses which were statistically significant, and two of the MCMI-III scales (Aggressive-Sadistic and Schizoid) demonstrated a total lack of support by producing three hypotheses which were not statistically significant. Only two of the six MCMI-III Personality Disorder scales, the Narcissistic and Borderline Scales, produced partial support of the hypotheses. The MCMI-III Borderline Personality Disorder Scale produced statistically significant results only for the hypothesis which compared those individuals who meet the MCMI-III diagnostic criteria for personality “trait” (BR ≥ 75 and ≤ 84) to those individuals who do not meet the MCMI-III diagnostic criteria for personality “trait” (BR ≤ 74 and ≥ 84) on the MCMI-III Borderline Personality Disorder Scale. For the MCMI-III Narcissistic Personality Disorder Scale, the hypothesis comparing the “trait” group to the “non-trait” group was the only hypothesis found not to be statistically significant. Both of the other two hypotheses for the MCMI-III Narcissistic Personality Disorder Scale were statistically significant.

Due to the fact that the hypotheses for this study were derived from sound theoretical and empirical rationale, the lack of support for the MCMI-III Schizoid,
Borderline, and Aggressive-Sadistic Personality Disorder Scales is interesting, and unexpected.

Schizoid Personality Disorder

The discriminant function for the MCMI-III Schizoid Personality Disorder Scale consists of the GCSQ-150 Deflection, Desensitization, and Egotism Scales. Individuals diagnosed with Schizoid Personality Disorder tend to prefer solitary activities, exhibit a restricted range of emotions, and be indifferent to criticism and praise (DSM-IV, 1994). Millon (1994) suggests that such individuals tend to have an incapacity for pleasure and pain, to exhibit unfocused and scattered communication patterns, to have little self-awareness, and to be apathetic, listless, distant, and asocial.

Appendix H presents a detailed description of each item on all of the GCSQ-150 scales. Seventeen of the twenty items for the GCSQ-150 Deflection Scale (1, 5, 16, 22, 50, 54, 62, 67, 69, 75, 76, 92, 93, 97, 98, 101, 111), eleven of the eighteen items (11, 84, 105, 106, 116, 119, 125, 127, 132, 142, 145) for the GCSQ-150 Egotism Scale, and nine of the sixteen items (24, 27, 31, 38, 57, 72, 91, 94, 103) for the GCSQ-150 Desensitization Scale seem to adequately portray an individual diagnosed with Schizoid Personality Disorder who possesses the characteristics described above.

Table 18 on page 140 illustrates the point biserial correlation coefficients for each of the these three GCSQ-150 scales with the MCMI-III Schizoid Personality Disorder Scales. It is possible that the extremely low correlation coefficient for the GCSQ-150 Desensitization Scale had a significant impact on the discriminant function. In order to explore this issue further, it is necessary to examine another body of literature.
Interestingly, in analyzing the nature of the GCSQ-150 Desensitization Scale items, there are several items which directly address an individual's physiological or bodily responses, experiences, and reactions. There is a plethora of literature which indicates that there is a relationship between criminality and physiological responses. More specifically, criminals have been shown to exhibit lower heart rate, lower skin conductance activity, and lower EEG activities than non-criminals (Magnusson, 1985; Moffit et al., 1988; Raines et al., 1990). This suggests, perhaps, that there may be a genuine and physiologically based explanation for a male batterers reports of being detached and disconnected from his bodily sensations. Thus, rather than being viewed as a psychological process intended to "numb" oneself, it may be that the lowered physiological responses actually support an individual's lowered sense of awareness.

This makes conceptual and theoretical sense when one considers the discussion in Chapter 2 regarding the Gestalt cycle of experience and awareness. From a Gestalt perspective, an individual is likely to pay attention to those stimuli which enter into his or her awareness. Desensitization is the process by which an individual is aware of some type of emotional or physiological sensation and makes an attempt to "numb" him or herself, thus interrupting the cycle of contact. However, an individual with a lowered physiological response rate may not actually be aware of his or her bodily sensations, reactions, or experiences.

There are two potential explanations for the lack of support for the three hypotheses on the MCMI-III Schizoid Personality Disorder Scale: 1) There were a low number of subjects in either the "trait" or "disorder" category which required the value of...
the Wilks’ Lambda to be much greater in order to achieve statistical significance. Only 14% of the subjects exhibited either a “trait” or a “disorder” on the Schizoid Personality Disorder Scale, thus, making any type of analysis difficult and, at best, speculative; 2). The low correlation coefficient of the GCSQ-150 Desensitization Scale with the MCMI-III Schizoid Personality Disorder scale significantly influenced the discriminant function. The GCSQ-150 Desensitization Scale may have demonstrated such a low correlation coefficient due to the fact that the subjects lack of awareness regarding their bodily sensations and experiences may be genuinely rooted in physiological, rather than psychological, processes.

**Aggressive Sadistic Personality Disorder**

Individuals diagnosed with Aggressive Sadistic Personality Disorder tend to derive pleasure and satisfaction from humiliating others, are generally unaware of self and others, and are typically hostile, dominant, antagonistic, combative, and persecutory (Millon, 1994). For the MCMI-III Aggressive-Sadistic Personality Disorder Scale, the discriminant function was composed of the GCSQ-150 scales of Desensitization, Deflection, Projection, Introjection, and Retroflection.

Tables 19 on page 141 illustrates point biserial correlation coefficients for each of these GCSQ-150 scales with the MCMI-III Aggressive-Sadistic scale. According to the criteria established by Davis (1971), each of the GCSQ-150 scales produced either a “negligible” or “low” point biserial correlation coefficient. Several of these findings make conceptual and theoretical sense. The low point biserial correlation with the GCSQ-150 Introjection Scale suggests that an individual diagnosed with Aggressive Sadistic
Personality Disorder is not likely to "passively" and uncritically accept information from the environment without challenging or questioning its meaning and value. Indeed, the hostile, dominating, and antagonistic behaviors of such individuals are the polarity of passivity.

What may be viewed as being unexpected is the fact that the GCSQ-150 Retroflection Scale produced three point biserial correlations under .10 which, according to Davis (1971), are in the "negligible" range. Typically, an individual who uses retroflection is someone who holds from interacting an a spontaneous manner and, instead, directs his or her energy inward. That is the antithesis of how people generally view an individual diagnosed with Aggressive Sadistic Personality Disorder. Such an individual is often stereotyped as one who, rather than "holding back", makes impulsive, blatant, and unpredictable attacks on other individuals and his or her environment.

There is, however, another way of viewing these results, particularly within the context of a clinical sample of male batterers. Consider that, on any given day, a male batterer may interact with many different types of individuals, including employers, co-workers, probation officers, judges, and attorneys. Undoubtedly, over a period of time, he will encounter interactions with these individuals in which he will feel angry, frustrated, and disappointed. However, despite these feelings, it is unlikely that, during those interactions with these particular individuals, he will exhibit the impulsive, antagonistic, hostile, and dominating for which he is known. Rather, he is likely to "hold back" from reacting and, temporarily, turn those feelings inward until he able to find an environment
and context in which he can unload them with minimal consequences. In a very distinct way, many male batterers engage in retroflective behaviors.

Thus, there are several factors which may have influenced the lack of support for the three hypotheses on the MCMI-III Aggressive Sadistic Personality Disorder Scale: 1) There were a low number of subjects, approximately 19%, in either the “trait” or “disorder” categories for the Aggressive Sadistic Personality Disorder Scale. Such a low number meant that the value of the discriminant function had to be higher in order to achieve statistically significant results; 2) The low individual correlation coefficients with the each of GCSQ-150 may have significantly influenced the discriminant function.

Antisocial Personality Disorder

The Antisocial Personality Disorder Scale produced three statistically significant hypotheses in using the GCSQ-150 scale of Projection as the single independent variable. This suggests that the GCSQ-150 scale of Projection is, by itself, a statistically significant discriminating variable between those male batterers who meet the MCMI-III diagnostic criteria for personality “trait” (BR≥75 and ≤84) and those male batterers who meet the MCMI-III diagnostic criteria for personality “disorder” (BR≥85).

This finding is not surprising when one considers some of the characteristics often found in individuals with Antisocial Personality Disorder which resemble the GCSQ-150 Projection Scale. According to the DSM-IV (1994), such individuals are often impulsive, irritable, reckless, deceitful, aggressive, and irresponsible. Additionally, Millon (1994) suggests that such individuals are likely to be insensitive, blame others, be skeptical of others motives, “judge others to be unreliable and disloyal” (p.12), and have difficulty
expressing empathy for others. From a clinical standpoint, many individuals with Antisocial Personality Disorder often claim to be victims of circumstance, have a flagrant disregard for the rights of others, and exhibit behaviors intended to protect themselves from perceived and imagined threats or attacks. Such individuals also tend to be externally focused and to be egocentric in their belief systems, thus, supporting the projective process.

Due to the statistical significance of this finding, one may expect that the point biserial correlation coefficient between the MCMI-III Antisocial Personality Disorder Scale and the GCSQ-150 Projection Scale would be relatively high. However, as indicated by Table 20 on page 141, the point biserial correlation coefficient between these two scales produced three coefficients between .199 and .285. Although statistically significant, these coefficients are, according to Davis (1971), in the "low" range. It is important to remember that, for the purpose of this study, the discriminant function measures the power of the GCSQ-150 Projection Scale to discriminate between the groups within the the MCMI-III Antisocial Personality Disorder Scale.

Additionally, as previously addressed in Chapter 4, the eigenvalues for each of the three hypotheses for the MCMI-III Antisocial Personality Disorder Scale were less than .10 (.04, .06, .08), and the canonical correlations for each of the three hypotheses were all in the .20-.30 range (.19, .25, .28). This suggests that, although the discriminant function for these hypotheses was found to be statistically significant, the actual and overall strength of the relationship between these two variables is questionable.
Although this finding is preliminary in nature, it does suggest that a male batterer who is diagnosed with Antisocial Personality Disorder may, on some level, have a tendency to utilize the Gestalt resistance of Projection as one of his primary mechanisms to interrupt the cycle of contact. The implications of this finding is addressed in a later section of this chapter.

Passive-Aggressive Personality Disorder

The MCMI-III Passive-Aggressive Personality Disorder Scale produced three statistically significant hypotheses is using the GCSQ-150 scales of Projection and Retroflection as the independent variables in the discriminant function. As previously discussed in Chapter 4, the canonical discriminant function coefficients for both the GCSQ-150 scales of Projection and Retroflection hold, in general, relatively equal weight within the discriminant function. Additionally, the canonical correlations for two of the three hypotheses are in the .40 range, suggesting that there is a moderate amount of practical significance for these findings. The hypothesis which demonstrated a low canonical correlation (.280) was the hypothesis comparing those individuals who meet the diagnostic criteria for a personality "disorder" (BR ≥ 85) to those individuals who do not meet the diagnostic criteria for personality “disorder” (BR ≤ 84) on the MCMI-III Passive-Aggressive Personality Disorder Scale. Due to the fact that this particular hypothesis did not control for the “trait” influences, this finding suggests that the differences between these two groups, although statistically significant, have little practical relevance.
Although the canonical discriminant function for the MCMI-III Passive Aggressive Scale suggests that there is questionable practical relevance for this finding, there is, perhaps, some value in examining each of the discriminating variables individually.

As indicated by Table 22 on page 142, four of the six the point biserial correlation coefficients for both the GCSQ-15- Retroflection and Projection scales are, according to Davis (1971), in the "moderate" range. The hypothesis which compared the subjects with a "disorder" to those subjects without a "disorder" produced point biserial correlation coefficients which meet Davis' (1971) criteria for "low" association on both the GCSQ-150 Retroflection and Projection scales.

This makes theoretical and conceptual sense when one considers the emotional and behavioral characteristics of individuals who meet the MCMI-III diagnostic criteria for Passive-Aggressive Personality Disorder. Such individuals often complain of being misunderstood and unappreciated, are resistant to fulfilling routine obligations, have a tendency to scorn authority, and express resentment towards others who are more fortunate (DSM-IV, 1994). From a clinical perspective, such individuals often “hold back” from spontaneous expressions (retroflection) and then take their anger and hostility out in indirect and subtle, yet intrusive, ways (projection).

Thus, when viewed separately, the Gestalt resistances of Retroflection and Projection may have theoretical and conceptual meaning for clinicians. Relating the dynamic interaction of the retroflection-projection process to a male batterers passive-aggressive tendencies is an important component of understanding his own cycle of violence and determining the nature of timing of therapeutic interventions.
Up to this point in the discussion, the focus has been on examining four of the six MCMI-III Personality Disorder Scales. There are, however, two scales which provided partial support for the hypotheses. The MCMI-III Borderline Personality Disorder produced one statistically significant hypothesis while the MCMI-III Narcissistic Personality Disorder Scale produced two statistically hypotheses.

For the MCMI-III Borderline Personality Disorder Scale, the GCSQ-150 Retroflection and Desensitization Scales were found to be discriminating variables only between those subjects in the “trait” category and those subjects not in the “trait” category. The GCSQ-150 Scales of Retroflection and Desensitization were not found to be discriminating variables between those subjects in the “disorder” category and those subjects not in the “disorder” category.

As indicated by Table 17 on page 138, in comparison to the “disorder” category, the “trait” category for the Borderline Personality Disorder Scale has a larger sample size and number of subjects. Thus, due to the fact that the “trait” category on the MCMI-III Borderline Personality Disorder Scale contained the largest number of subjects, in order to produce statistically significant results the required value of the test statistic for this particular hypotheses was much lower.

For the MCMI-III Narcissistic Personality Disorder Scale, the GCSQ-150 Deflection, Projection, Retroflection, and Egotism Scales were found to be discriminating variables only between those subjects in the “disorder” category and those subjects not in the “disorder” category. These particular GCSQ-150 Scales were not found to be
discriminating variables between those subjects in the "trait" category and those subjects not in the "trait" category on the MCMI-III Narcissistic Personality Disorder Scale.

As indicated by Table 17 on page 132, in comparison to the "trait" category, the "disorder" category for the MCMI-III Narcissistic Personality Disorder Scale contained a higher number of subjects. This suggests that the inconsistent sample size may have influenced the discriminant function and the outcome result.

Summary of Results

The focus of this chapter has been on addressing the results of the outcome data presented in Chapter 4. From such outcome data, several general findings can be generated. An overview of these findings is presented below. The implication of such findings and suggestions for future research will be addressed in the next section.

First, the data from this study provide tentative support for the notion that there is a relationship between the Gestalt resistances and Millon's (1994) typology of personality disorders. More specifically, this study found preliminary evidence which suggests that the GCSQ-150 Projection Scale is a statistically significant discriminating variable between the "disorder" and "trait" categories on the MCMI-III Antisocial Personality Disorder Scale. Additionally, the outcome data suggests that the GCSQ-150 Projection and Retroflection Scales are statistically significant discriminating variables between the "disorder" and "trait" categories on the MCMI-III Passive-Aggressive Personality Disorder Scale.

Second, for the MCMI-III Borderline Personality Disorder Scale, the GCSQ-150 Retroflection and Desensitization Scales were found to be statistically significant
discriminating variables between those subjects in the "trait" category and those subjects not in the "trait" category.

Third, for the MCMI-III Narcissistic Personality Disorder Scale, the GCSQ-150 Deflection, Projection, Retroflection, and Egotism Scales were found to be statistically significant discriminating variables only between those subjects in the "disorder" category and those subjects not in the "disorder" category. These particular GCSQ-150 Scales were not found to be statistically significant discriminating variables between those subjects in the "trait" category and those subjects not in the "trait" category on the MCMI-III Narcissistic Personality Disorder Scale.

Limitations of the Study

The current study, like most empirical research, has limitations, several of which were addressed at the end of Chapter 1. However, after having completed the data collection and analysis, several other limitations have emerged. A discussion of these limitations is presented below.

First, there was the data analysis limitation with regard to restriction of range within the sample. Many of the categories being examined produced an inadequate sample size. For example, only four subjects met the "disorder" criteria on the MCMI-III Schizoid Personality Disorder Scale, while six met the "disorder" criteria on the MCMI-III Aggressive-Sadistic and Borderline Personality Disorder Scales. Clearly, such low sample sizes pose a limitation with regard to producing statistically sound, reliable, and valid outcome data.
Second, this study, like most research on domestic violence, was limited by the heterogeneity of the sample. Among the 120 subjects in the sample, there was a broad and diverse range of abusive and controlling behaviors for which each subject was arrested. Some subjects may have been arrested for pushing their partners, others subjects may have been arrested for attempted murder and using a weapon during the assault, and other subjects may have sexually assaulted their partner. Additionally, there are other forms of abuse, such as economic and emotional which may have been related to the arrest incident. Such heterogeneity limits the generalizability of the sample. It would be inappropriate to generalize the results of these findings to male batterers in general due to the fact that the exact nature of each subject's offending behaviors were unknown.

Finally, another methodological limitation with regard to the sampling process involves the phenomenon of self selection. As previously indicated, each and every one of the subjects who participated in this study did so on a voluntary basis. It is important to recognize the potential that those individuals who voluntarily chose to participate in this study may possess different personality characteristics, beliefs, attitudes, and values than those subjects who, for whatever reason, did not choose to voluntarily participate in this study. Thus, the self selection process may influence or bias the sample and limit the generalizability of the results.

Implications of the Present Study

This study found preliminary evidence that there is a relationship between the Gestalt resistances and the personality disorders among a clinical sample of male batterers. Although there remains many questions regarding the exact nature and strength of the
relationship between these two constructs, the fact that the Gestalt resistances and personality disorders have demonstrated some level of association has important implications for both clinicians and researchers.

First, having knowledge that specific Gestalt resistances may be related to specific personality disorders might prove to be useful with regards to assessment protocols and treatment planning. After completing an intake and determining that a client meets the diagnostic criteria for a specific personality disorder, a clinician may use such knowledge to more effectively predict a client's future resistant behaviors, develop more individualized treatment plans, and more adequately assess a client's level of lethality and risk. For example, if a clinician diagnoses a client with Antisocial Personality Disorder and it has been established through sound empirical research that individuals with that particular disorder have a tendency to utilize projection as their primary resistance, the clinician may be able to intervene early and counteract the projective processes through specific techniques and interventions.

Second, having an awareness that certain Gestalt resistances are associated with specific personality disorders of male batterers may serve to "normalize" the process of resistance among this clinical population. Quite often, the process of resistance among male batterers is viewed as being unpredictable, haphazard, unmanageable, and chaotic. Having an understanding and expectation that male batterers with a specific personality disorder may exhibit a specific type of resistance may serve to eliminate some of the inherent unpredictability and chaos and, instead, create an atmosphere of competence, control, and manageability among clinicians.
Third, this study was the first known study to utilize the revised Gestalt Resistance Scales (GRS; Prosnick, 1998). The outcome data provided much needed empirical support for the Gestalt model and produced evidence which links Gestalt theory and the empiricism. Each of the eighteen hypotheses for this study were based upon the Gestalt model and underlying theoretical framework. The fact that nine of the eighteen hypotheses produced statistically significant results lends support to the Gestalt theory as being a scientific and empirically based therapeutic model. Such theory based, empirical outcome data may, undoubtedly, serve to add support to the Gestalt theory, which has traditionally been criticized for its lack of scientific and empirical research.

Finally, the demographics for the present sample have important implications for clinicians and scholar interested in studying family violence. As discussed in Chapter 2, male batterers, in comparison with their nonviolent counterparts, have been found to be overrepresented in the lower socioeconomic status (Aldarondo & Sugarman, 1996; Berry, 1990), young (Berry, 1990; Hamberger & Hastings, 1989; Roberts, 1987), divorced, separated, or cohabitating rather than married (Berry, 1990; Ellis, 1989; Hotaling & Sugarman, 1990), unemployed (Aldarondo & Sugarman, 1996; Berry, 1996), relatively uneducated (Berry, 1996; Hamberger & Hastings, 1989), and previously involved with the criminal justice system (Bennett, Tolman, Rogalski, & Srinivasarghavan, 1994).

Such prior research was, in general, not supported by the present study. More specifically, the present sample was composed of more subjects who were white (72%),
married (39%), between the ages of 28-42 (59%), possessing at least a high school diploma (40%), employed (85%), and who had been arrested one prior time (68%).

These findings, undoubtedly, influence scholars and clinicians to examine their own stereotypes and biases regarding domestic violence and the labels that are so often attached to male batterers. As more research becomes available which supports the contention that domestic violence is, truly, a phenomenon which transcends all races, cultures, religions, occupations, and lifestyles.

**Future Research**

This study found evidence that suggests the current methods of conceptualizing and assessing domestic violence are limited and restricted in their capabilities. The data from this study suggests that the variability which is inevitable within any clinical sample of male batterers is so significant that meaningful interpretations and generalizations are, at best, questionable. By empirically studying the characteristics, prevalence rates, and treatment modality outcomes for each specific subtype of male batterer, it is likely that both researchers and clinicians will develop a clearer understanding of the relationships between the Gestalt resistances and personality disorders within this clinical population. There is a need for researchers to develop effective psychometric instruments from which to assess and measure the various typologies of male batterers. Thus, future research which focuses on creating empirically based psychometric instruments designed to measure the various typologies of male batterers is warranted.

The rationale for the current study was based strictly upon prior theoretical and empirical research. While this approach is, undoubtedly, useful in establishing a solid
framework from which to conduct research and adding support to the existing research, it is also limited in that it may inadvertently restrict the potential for other, often unexpected, outcomes. Future research which examines each of the eight GCSQ-150 Scales and the twenty four MCMI-III Scales would, undoubtedly, be beneficial to both clinicians and researchers in better understanding the exact and specific nature of the relationship between these two constructs. While such a task may be time-consuming and formidable, the inevitable learnings would, undoubtedly, make a significant contribution to both the Gestalt and personality disorder areas of study.

This study found preliminary evidence that there is a relationship between the Gestalt resistances and personality disorders among a clinical sample of male batterers. However, in further analyzing the outcome data, it is important to recognize that the sample for this study was randomly chosen from seven treatment facilities in the State of Ohio. In order to assess the generalizations of the findings from this study, future research which would attempt to replicate this study in another geographical location with another clinical sample of male batterers is warranted.

In addition to replicating the present study, examining the constructs of the Gestalt resistances and personality disorders among different populations would be useful. In particular, studying the relationships between these two constructs within a sample of female domestic offenders would, undoubtedly, be beneficial for clinicians and scholars interested in gender issues. Additionally, such research would broaden the context of domestic violence and pioneer the work of examining the differences between the gender with regard to resistances and personality disorders.
Another important outcome of this study has to do with the efficacy of the MCMI-III and GCSQ-150. As discussed in Chapter 4, the MCMI-III BR scoring system has established a BR score of 85 as the anchor point for a personality "disorder". However, as this study demonstrated, lowering the BR by just two points, to 83, would have resulted in approximately a 20% increase in the number of subjects in the "disorder" category. Thus, although this study produced evidence to support the reliability and validity of the MCMI-III, the nature of the BR scoring system raises some question as to the practical applicability of the MCMI-III in accurately assessing personality disorders. Future research on the efficacy and scoring structure of the MCMI-III in accurately assessing and measuring personality disorders would be useful for both clinicians and researchers in helping to ameliorate the perplexing phenomenon of domestic violence.
APPENDIX A

INTRODUCTION LETTER TO SERVICE PROVIDERS
Dear [name of treatment provider]:

My name is Jack Wagner and I was referred to you by the Ohio Domestic Violence Network (ODVN). As a colleague in the field and ODVN member, I understand many of the difficulties, challenges, and frustrations involved in working with this particular clinical population.

In addition to working with male batterers in a clinical setting, I am also a third year doctoral student in Counselor Education at The Ohio State University. My main research interests include the resistances and personality disorders of male batterers, and Gestalt therapy. I am well aware of the fact that male batterers exhibit high levels of resistance to treatment and personality disorders.

As such, I am currently in the process of creating a study which will empirically examine the Gestalt resistances and personality disorders of male batterers. The main purpose of this study is to determine the relationship between the various personality disorders and the Gestalt resistances. By understanding which resistances are correlated with which personality disorders, it is hoped that clinicians, after diagnosing a client with a personality disorder, will be able to develop more specialized treatment protocols and predict the client's potential future resistances.

I would very much appreciate your participation in this study. Your participation will benefit you and your agency in an important way. As a participant, I will provide you with information about the outcome data and efficacy of treatment for your particular agency. Thus, you will have access to the descriptive group data about the Gestalt resistances and personality disorders from a small sample of subjects in your program. Since the identity of the subjects will not be known, no individual data or profiles will be reported. Nevertheless, such information would seem to have important implications with regard to your assessment and treatment protocol.

I most certainly understand and respect the extreme physical and emotional demands of being a service provider in this field. Thus, I have developed a procedure which would allow you to participate in this important study without adding much extra stress or pressure to your already busy schedule. Below is an outline of four simple steps involved as a participant in this study:
1). Should you decide that you are willing and able to participate in this study, I will send you a packet containing the following information:

   a). Ten self-addressed, stamped envelopes, each containing copies of two testing instruments, the Millon Clinical Multiaxial Inventory-III and the Gestalt Contact Style Questionnaire-150
   b). A Client Information Sheet
   c). A Client Demographic Sheet

2). After receiving the packet, I simply request that you select ten voluntary participants, at random, to complete both testing instruments. I am collecting data from males in all phases of therapy - those who are in the beginning, middle, and latter part of their treatment. On average, a client should be able to complete both instruments in approximately one hour.

3). Once you have selected the potential subjects, simply give them the client packet with the testing instruments. The client packet contains all the necessary information explaining to the client the purpose of the study, how to complete the instruments, and informed consent issues.

4). After completing the instruments, the subjects will be requested to seal them in the enclosed self-addressed, stamped envelopes and mail them directly back to me through your agency mail. I need a total of ten subjects who are willing to participate, thus, this process may involve more than one mailing.

In order to maintain a high level of ethical standards, I would request that you commit to make yourself available to any subject who may experience a negative or emotional reaction to the instrument items.

Thank you very much for your time. Please contact me by telephone at __________ or by e-mail at __________ if you have any questions or if I can be of any assistance to you. Additionally, please feel free to contact my advisor, Dr. Darcy Haag-Granello, by telephone at __________ or by e-mail at __________ at any time.

On the next page, please indicate your willingness and ability to participate in this study and return it to me in the enclosed self-addressed, stamped envelope. I would appreciate you returning this to me by ________________________________.

Sincerely,

Darcy Haag-Granello, Ph.D -Advisor

Jack J. Wagner MA, LPCC
APPENDIX B

RESPONSE LETTER FROM SERVICE PROVIDER INDICATING WILLINGNESS TO PARTICIPATE IN THE PRESENT STUDY

PLEASE CHECK THE APPROPRIATE SPACE BELOW AND RETURN THIS SHEET TO ME IN THE ENCLOSED, SELF-ADDRESSED STAMPED ENVELOPE BY ____________________________.

I AM WILLING AND ABLE TO PARTICIPATE IN THIS STUDY. I agree to ensure that subject’s have adequate support when necessary and to protect the confidentiality of the data. Please send me the packet of testing materials and information.

____________________ (signature)

Additionally, please answer the following questions:

1). Do you presently and directly work in a practice, program, or agency that provides domestic violence specific treatment, meaning that your work is specialized and intended specifically to treat males who have abused their intimate female partners?

_______ Yes ________ No

2). Do you presently receive referrals from the court system and treat male batterers who have been arrested for domestic violence and involuntarily seek treatment in order to fulfill a probation or parole requirement?

_______ Yes ________ No

I AM UNABLE TO PARTICIPATE IN THE PRESENT STUDY.

Reason (Optional) _____________________________________________

Please return this sheet to me by _____________________________. Thank you in advance for your time and your prompt response.
APPENDIX C

PROTOCOL FOR TEST ADMINISTRATION AND SAMPLE SELECTION

Dear (service provider),

Thank you so very much for your interest and willingness to participate in my study of the Gestalt resistances and personality disorders of male batterers. I am confident that you will find this study to be very informative and to require little extra effort or time on your part.

Enclosed you will find ten self-addressed, stamped client envelopes, each containing the following information:

a). One Millon Clinical Multiaxial Inventory-III test booklet and answer sheet  
b). One Gestalt Contact Style Questionnaire-150 test booklet and answer sheet  
c). Client Information Sheet  
d). Client Demographic Sheet

Please note that this study is focusing only on those male batterers who have been arrested for domestic violence and who are seeking treatment in order to fulfill a probation or parole requirement. Thus, if a subject whom you would typically select to participate in this study has not been arrested for domestic violence or is seeking treatment voluntarily, please do not select him. In that situation, please select another subject.

After having randomly identified ten potential subjects, please simply provide each selected subject with a client envelope. It does not matter where a client is in treatment due to the fact that all individuals in your treatment program are eligible to participate in this study. Regardless of whether or not a subject chooses to complete the instruments, he will be asked to put all of the testing materials back into the envelope, seal it himself, and mail it directly back to me through the agency mail. At this point, please remember to make yourself available should a subject need assistance or emotional support and also to protect the anonymity of the data in each envelope.
Again, I extend my sincerest appreciation for your willingness to participate in this study. If you have any question or concerns, please feel free to contact me by telephone at _________ or by e-mail at _________ Also, please feel free to contact my advisor, Dr. Darcy Haag-Granello, by telephone at ______________or by e-mail at ______________

Sincerely,

Darcy Haag-Granello, Ph.D- Advisor

Jack J. Wagner  MA, LPCC
APPENDIX D

CLIENT INFORMATION SHEET

Dear Client:

My name is Jack J. Wagner and I am a doctoral student in Counselor Education at The Ohio State University in Columbus, Ohio. Presently, I am conducting research which examines the personality characteristics and attitudes of males who have been arrested for domestic violence. The data from this study will be utilized to assist clinicians and researchers in their attempts to stop domestic violence.

I would very much appreciate your participation in this study. Your participation in this study requires one very simple step. You will be asked to complete two paper-and-pencil instruments, the Millon Clinical Multiaxial Inventory-III and the Gestalt Contact Style Questionnaire-150. On average, it is expected to take you approximately one hour to complete both tests.

Please be assured that your participation in this study will be completely anonymous. In order to help you feel more comfortable with this, I am requesting that you do not, in any way, disclose any information, such as your name, that may serve to identify you. Additionally, upon completing the instruments, I am requesting that you place them back in the original, self-addressed, stamped envelope, seal it yourself, and mail it directly back to me. Thus, you can be certain that neither I nor anyone else, including your service provider, will be able to determine your identity at any time.

By participating in this study, it is likely that you will enhance your self-awareness about various aspects of your personality and the manner in which you interact with others. Such self-awareness may help you in regards to successfully completing your treatment program. On the other hand, you may also experience slight and temporary emotional discomfort as you reflect and respond to each of the test questions. Your service provider has agreed to be available to assist you with any specific concerns or emotional reactions you may experience. Please be aware that you may stop taking the test at any time and discuss any concerns with your service provider.
Many people are under the misconception that completing a personality instrument like the one in this study is an indication that an individual has serious psychological problems or requires psychological help. Please understand that this is not the case. Your participation in this study does not, in any way, suggest that you have any type of psychological problem.

After completing the two instruments, please put all of the materials back into the original, self-addressed, stamped envelope, seal it yourself, and mail it directly back to me. If you choose not to participate, please put all of the blank materials back into the original, self-addressed, stamped envelope, seal it yourself, and mail it, without any stray markings, directly back to me.

If you have any questions, or if I can be of any assistance to you, please contact me at ______________ or please feel free to contact my advisor for this study, Dr. Darcy Haag-Granello, at ______________.

Thank you very much in advance for your participation in this study. Your completion of the two instruments indicates your voluntarily consent to participate in this study and that you have read and understand the above information.

Before you begin to complete the two instruments, please answer the brief questions on the following page. The information on the following page will be utilized only to examine the demographic characteristics of the all the respondents. In order to protect your anonymity please remember not to include any information which may serve to identify you.

Sincerely,

Darcy Haag-Granello, Ph.D- Advisor Jack Wagner, MA, LPCC
Please answer the following questions by circling the appropriate **bolded number** in front of the correct response. This information will be utilized for group data analysis purposes only and any information which you provide is completely anonymous. Please provide only one response for each question.

**What is your age?** (please write in space provided) ____________

**What is your current marital status?**

1 - single  
2 - married  
3 - engaged  
4 - committed  
5 - divorced  
6 - widowed

**What is your race/ethnic background?**

1 - Caucasian (White)  
2 - African American  
3 - Hispanic  
4 - Asian  
5 - Indian  
6 - Other

**What is the highest grade you completed?**

1 - 1st grade  
2 - 2nd grade  
3 - 3rd grade  
4 - 4th grade  
5 - 5th grade  
6 - 6th grade  
7 - 7th grade  
8 - 8th grade  
9 - 9th grade  
10 - 10th grade  
11 - 11th grade  
12 - 12th grade  
13 - College  
14 - 1st year college  
15 - 2nd year college  
16 - 3rd year college  
17 - 4th year college  
18 - Grad/Prof

**What is your present income?**

1 - below $10,000  
2 - $10,000-$15,000  
3 - $15,000-$20,000  
4 - $20,000-$25,000  
5 - $25,000-$30,000  
6 - $30,000-$35,000  
7 - $35,000-$40,000  
8 - $40,000-$45,000  
9 - $45,000-$50,000  
10 - $50,000-$55,000  
11 - $55,000-$60,000  
12 - $60,000-$65,000  
13 - $65,000-$70,000  
14 - $70,000-$75,000  
15 - $75,000-$80,000  
16 - above $80,000

**How many times have you been arrested for domestic violence?**

0 - 0  
1 - 1  
2 - 2  
3 - 3  
4 - 4  
5 - 5  
6 - 6  
7 - 7  
8 - 8  
9 - 9  
10 - 10  
Other

**How many prior group therapy sessions (for domestic violence) have you attended?**

1 - 0-5  
2 - 6-10  
3 - 11-15  
4 - 16-20  
5 - 21-25  
6 - 26-30  
7 - 31-35  
8 - 36-40  
9 - 41-45  
10 - 46-50  
11 - 51-55  
12 - 56-60  
13 - 61-65  
14 - 66-70  
15 - 71-75  
16 - 76-80  
17 - 81-85  
18 - 86-90  
19 - 91-95  
20 - 96-100  
21 - Other

**What type of work do you do?**

1 - Manual labor  
2 - Factory work  
3 - Clerical work  
4 - Business (sales, etc.)  
5 - Self-employed  
6 - Professional (lawyer, Dr., etc.)  
7 - Student  
8 - Unemployed  
9 - Other

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APPENDIX F

SCORING KEY FOR THE GESTALT RESISTANCE SCALES
(PROSNICK, 1998)

________________________________________________________________________

Scale 1: Cf - Confluence (15 items)

Strongly Agree (A = 5) (11 items)  8 12 20 37 43 64 65 74 86 88 137

Strongly Disagree (E = 5) (4 items)  25 34 49 55

Mean 52.87; S.D. 6.04. (n = 580).

________________________________________________________________________

Scale 2: Ds - Desensitization (15 items)

Strongly Agree (A = 5) (11 items)  24 27 31 38 60 80 82 91 103 121 141

Strongly Disagree (E = 5) (4 items)  57 72 81 94

Mean 42.29; S.D. 6.59. (n = 591).

________________________________________________________________________

Scale 3: Ij - Introjection (16 items)

Strongly Agree (A = 5) (9 items)  2 42 45 47 58 63 73 77 114

Strongly Disagree (E = 5) (7 items)  40 44 48 59 130 134 149

Mean 42.85; S.D. 6.12. (n = 588).
Scale 4: Pj - Projection (10 items)

Strongly Agree (A = 5) (9 items) 4 7 9 14 32 36 39 41 87

Strongly Disagree (E = 5) (1 item) 66

Mean 24.62; S.D. 5.19. (n = 606).

Scale 5: Rf - Retroflection (27 items)

Strongly Agree (A = 5) (18 items) 3 10 13 17 19 21 23 28 33
46 51 52 56 61 79 89 95 113

Strongly Disagree (E = 5) (9 items) 6 15 26 29 30 35 68 83 96

Mean 69.56; S.D. 13.75. (n = 581).

Scale 6: Df - Deflection (20 items)

Strongly Agree (A = 5) (20 items) 1 5 16 22 50 54 62 67 69 70
75 76 92 93 97 98 99 100 101 111

Strongly Disagree (E = 5) (0 items) none

Mean 44.34; S.D. 10.11. (n = 584).
Scale 7: Eg - Egotism (18 items)

Strongly Agree (A = 5) (18 items) 11 18 53 84 85 105 106 109 116 119 123 125 127 132 139 142 145 147

Strongly Disagree (E = 5) (0 items) none

Mean 46.38; S.D. 7.62. (n = 580).

Scale 8: Tf - Transfluence (18 items)

Strongly Agree (A = 5) (17 items) 104 107 110 112 115 117 118 124 125 126 131 136 143 144 146 148 150

Strongly Disagree (E = 5) (1 item) 135

Mean 50.90; S.D. 13.20. (n = 155).
APPENDIX G

FINAL ITEMS ASSIGNED TO GESTALT RESISTANCE SCALES
(PROSNICK, 1998)

Note: Percentage of expert agreement is in parentheses following each Gestalt Resistance Behavior. R = reversed item on GRS.

<table>
<thead>
<tr>
<th>Gestalt Resistance Behavior</th>
<th>GRS item(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONFLUENCE</strong></td>
<td></td>
</tr>
<tr>
<td>1. Client rarely talks about differences between self and others (95%)</td>
<td>8</td>
</tr>
<tr>
<td>2. Client tries to smooth out disagreements (90%)</td>
<td>20, 43</td>
</tr>
<tr>
<td>3. Client avoids or has extreme difficulty or anxiety in differentiating from reference group (90%)</td>
<td>65, 86</td>
</tr>
<tr>
<td>4. Client frequently uses &quot;we&quot; (90%)</td>
<td>57</td>
</tr>
<tr>
<td>5. Client experiences extreme discomfort when there is disagreement or confrontation (85%)</td>
<td>12, 49R</td>
</tr>
<tr>
<td>6. Client cannot say &quot;no&quot;. He/she is willing to help others at the expense of his/her own interests (85%)</td>
<td>34R, 64, 74</td>
</tr>
<tr>
<td>7. Client feels much distress about lack of agreement within his/her own reference group(s) (80%)</td>
<td>55R, 88</td>
</tr>
<tr>
<td>8. Client expresses only positive ideas about others (75%)</td>
<td>25R, 37</td>
</tr>
<tr>
<td>9. Client almost never uses &quot;I&quot; (70%)</td>
<td></td>
</tr>
</tbody>
</table>
DESENSITIZATION

1. Client doesn't let sickness keep them from doing things (100%)..............................82
2. Client feels detached or disassociated from their body sensations (100%)..............103
3. Client tolerates a lot of physical pain or abuse (100%)...........................................31
4. Client feels numb or deadened in different body areas (100%).............................94R, 141
5. Client reports that his/her body feels dull (100%).................................................
6. Client frequently uses "It" in describing their body or parts of their body (100%)....121
7. Client stays awake even when very physically tired (90%)........................................
8. Client defines him/herself as a thinking person rather than a feeling person (90%)..38
9. Client finds it easy to put uncomfortable feelings out of their mind (90%)..........27, 80, 91
10. Client often feels out of touch with the flow of life (90%)......................................
11. Client ignores or does not understand their own body messages (90%).................81R
12. Client doesn't feel when he/she is hungry or "full" (90%)........................................
13. Client hardly notices when they bump or bruise themselves (90%).......................
14. Client can withstand more fatigue and tiredness than most people (90%).............60
15. Client is not affected very much by hot or cold temperatures (90%).....................
16. Client does not know what he/she feels (85%)......................................................57R
17. Client describes situations in a factual, rational manner without referring to emotions (75%).................................................................24, 72R

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INTROJECTION

1. Client frequently uses "I should" or "I must" (95%).

2. Client is concerned that he/she knows the "correct answer" and follows the rules as determined by authorities or reference groups (90%).

3. Client views self as generally unworthy (85%).

4. Client states he/she has not lived up to his/her own or parents' expectations (85%).

5. Client frequently asks for advice or permission from authority figures or reference groups (85%).

6. Client expresses negative opinions about his/her attributes or behaviors (80%).

7. Client latches onto authority figures (80%).

8. Client compares him/herself and others, either positively or negatively, against standards or expectations of behaviors, accomplishments, attributes, etc. (75%).

9. Client describes self as lazy (75%).

10. Client is angry or disgusted with people who do not follow the rules or are not appropriate (75%).

11. Client describes self as not getting along with others or as being disagreeable (70%).

12. Client cannot describe him/herself in terms of his/her own experiencing, but rather uses rigid labels (70%).

13. A major focus of the client is achievement in one or more areas of life. The achievement lacks definition of a point at which the client actually attains the goal (70%).

14. Client feels guilt or shame (70%).
PROJECTION

1. Client believes others or situations are responsible for his/her problems (100%)...

2. Client fears that others will judge him/herself negatively (90%).................................

3. Client expects that others will not be responsive (90%)..............................................41, 66R

4. Client believes he/she has been mistreated by others (85%).........................................39

5. Client believes he/she knows the internally felt motives, emotions, etc. of others without asking (80%)..........................................................................................

6. Client believes he/she knows what others should do for their own good (80%)...........

7. Client assumes that others act and think the way the client does (80%).........................

8. Client distrusts others (80%)............................................................................................14, 36

9. Client believes others have roles to which he/she should adhere (75%)...........................

10. Client is angry or disgusted with people who do not follow the rules or are not appropriate (70%).................................................................................................7, 87

11. Client acts or plans ways to protect self from the expected actions of others (70%).....

12. Client frequently uses "he", "she", or "they should", or "must" (70%)..............................9
RETROFLECTION

1. Client holds body very still during session (85%)..........................26R, 46
2. Client talks about feelings of anger which were not expressed towards focus of anger, or refers to anger which was not expressed at the time (85%)....23, 79
3. Client holds jaw and/or face stiff (80%)........................................3, 13
5. Client believes it is important to maintain self-control (80%)........6R, 28, 33, 35R, 56
6. Client says that he/she is bored or that life is dull (80%)...........15R, 21, 68R, 89
7. Client strokes, pats, taps or hugs some part of his/her body, a personal belonging, or an object in the environment (75%)...........................
8. Client reports physical symptoms (muscle aches, headaches) (75%)...51, 52, 95, 96R
9. Client holds body very erect during session (70%)..........................113

DEFLECTION

1. Client looks away if the therapist asks a question (95%)..................70
2. Client avoids involvement with people or situations by putting things off, doing things haphazardly, directing efforts to side issues, etc. (85%).....67, 69, 92, 93, 98
3. Client ignores the intent of the question/message in the therapist's statement (80%)..54
4. Client will abruptly change focus of dialogue (80%)........................76
5. Client seeks to maintain superficial conversation or consistently uses humor to relieve tension (80%)..........................5, 99, 100, 101
6. Client may begin to talk, without waiting until the therapist has finished (70%)......22
7. Client's presentation is unfocused, vague, circumstantial, etc. (70%) ...1, 16, 50, 62, 75, 97, 111
EGOTISM

1. Client is impressed with his/her own power (100%) ............................................. 11, 147
2. Client expresses grandiose self-admiration yet they feel that their life
   lacks spontaneity or fulfillment (100%). ............................................................ 145
3. Client likes to tell other people how to run their lives (100%) ................................. 85
4. Client finds it difficult to feel truly connected to someone special (100%) ......... 119, 127
5. Client is arrogant and self-centered (100%) ..................................................... 109, 123
6. Client controls most conversations (100%) ....................................................... 18, 84
7. Client likes to stand out from the people they are with (100%) .............................. 53
8. Client pays a lot of attention to their physical appearance (90%) .........................
9. Client doesn't adjust to new or different ideas very well (90%) ............................ 106, 132
10. The client's personal boundaries are well protected (90%) ............................. 105, 125, 142
11. Client sacrifices their personal life for the appearance of "mastery" that
    they achieve through their ability to control situations (90%) ....................... 116, 139
APPENDIX H

ITEM TO SCALE CORRELATION COEFFICIENTS FOR THE GESTALT RESISTANCE SCALES (PROSNICK, 1998)

Note: Correlations < - .10 and > .10 are significant at p < .01.

<table>
<thead>
<tr>
<th>Scale 1</th>
<th>15 Items that Distinguish the GRS Confluence Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>r</td>
<td>Item Description</td>
</tr>
<tr>
<td>.39</td>
<td>8 Growing up, my family presented a united front in spite of personal differences.</td>
</tr>
<tr>
<td>.45</td>
<td>12 A lot has to happen before I finally get angry.</td>
</tr>
<tr>
<td>.28</td>
<td>20 When a situation gets tense, I sometimes find myself laughing.</td>
</tr>
<tr>
<td>.44</td>
<td>37 I get along with almost everyone.</td>
</tr>
<tr>
<td>.52</td>
<td>43 I wish people would smooth over their differences.</td>
</tr>
<tr>
<td>.46</td>
<td>64 I have difficulty saying &quot;No&quot; to people who are close to me.</td>
</tr>
<tr>
<td>.47</td>
<td>65 I like to go along with what others like to do.</td>
</tr>
<tr>
<td>.29</td>
<td>74 I can fit into almost any situation.</td>
</tr>
<tr>
<td>.39</td>
<td>86 It's important that I keep in control of myself.</td>
</tr>
<tr>
<td>.45</td>
<td>88 When people get serious, I tend to lighten things up.</td>
</tr>
</tbody>
</table>
.36 137 I avoid being too different from people I'm with.

Reverse scored items on the GCSQ-150:

- .33 25 I have been told that I was not a good child when I was growing up.
- .36 34 I would not call myself an agreeable kind of person.
- .33 49 Going against someone's wishes will not hurt their feelings.
- .39 55 If a situation is uncomfortable, I don't try to lighten it up.

---

Scale 2

15 Items that Distinguish the GRS Desensitization Scale

<table>
<thead>
<tr>
<th>r</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.34</td>
<td>24</td>
<td>I am not sensitive enough to know what others are thinking or feeling without them telling me.</td>
</tr>
<tr>
<td>.42</td>
<td>27</td>
<td>I hardly notice situations that others say are stressful.</td>
</tr>
<tr>
<td>.52</td>
<td>31</td>
<td>My feelings are not easily hurt.</td>
</tr>
<tr>
<td>.50</td>
<td>38</td>
<td>I would describe myself as a thinking person rather than a feeling person.</td>
</tr>
<tr>
<td>.30</td>
<td>60</td>
<td>I expect my body to do whatever I want it to.</td>
</tr>
<tr>
<td>.37</td>
<td>80</td>
<td>I can stay calm, even in the worst of situations.</td>
</tr>
<tr>
<td>.28</td>
<td>82</td>
<td>I don't let sickness keep me from doing things.</td>
</tr>
<tr>
<td>.36</td>
<td>91</td>
<td>I have a variety of ways to put or keep uncomfortable thoughts or feelings out of my mind.</td>
</tr>
<tr>
<td>.27</td>
<td>103</td>
<td>When I'm in dangerous situations or risky situations, I can step outside myself and observe or comment on what's happening.</td>
</tr>
</tbody>
</table>
A body isn't much more than a machine.

I rarely get headaches.

Reverse scored items on the GCSQ-150:

- Other people would say that I'm an emotional person.
- I can empathize so much with others that I almost feel what they feel.
- When I'm under stress, my body usually reacts.
- When truly sad and grief-stricken, I cry and sob freely.

Scale 3

15 Items that Distinguish the GRS Introjection Scale

<table>
<thead>
<tr>
<th>r</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.47</td>
<td>2</td>
<td>I get confused when I'm trying to decide between conflicting authorities.</td>
</tr>
<tr>
<td>.39</td>
<td>42</td>
<td>Other people have accused me of being lazy.</td>
</tr>
<tr>
<td>.32</td>
<td>45</td>
<td>I tend to eat food faster than others do.</td>
</tr>
<tr>
<td>.29</td>
<td>47</td>
<td>It's easier for me to do something by myself than to get help doing it.</td>
</tr>
<tr>
<td>.41</td>
<td>58</td>
<td>Some things must be accepted without question.</td>
</tr>
<tr>
<td>.24</td>
<td>63</td>
<td>Established authorities know what they are talking about.</td>
</tr>
<tr>
<td>.40</td>
<td>73</td>
<td>When I am tense, it makes me feel better to eat things.</td>
</tr>
<tr>
<td>.47</td>
<td>77</td>
<td>I wish there was a trick to making learning a snap.</td>
</tr>
<tr>
<td>.20</td>
<td>114</td>
<td>The world doesn't seem to have enough heroes.</td>
</tr>
</tbody>
</table>
Reverse scored items on the GCSQ-150:

- .19 40  Despite what some people say, there are no definite rights and wrongs.
- .29 44  I've lived up to the hopes my parents had for me.
- .44 48  I seek out new things, rather than let them come to me.
- .36 59  If something is difficult to understand, I will usually continue with it rather than let it drop.
- .48 130 I'd say I "digest" new or different ideas very well.
- .34 134 I like to finish things and then take time out to appreciate what I've done.
- .47 149 I'm pretty good at bringing ideas together and blending different views.

Scale 4
10 Items that Distinguish the GRS Projection Scale

<table>
<thead>
<tr>
<th>r</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.65</td>
<td>4</td>
<td>Other people are the cause of a lot of my problems.</td>
</tr>
<tr>
<td>.41</td>
<td>7</td>
<td>One should behave according to the rules laid down by those more knowledgeable.</td>
</tr>
<tr>
<td>.49</td>
<td>9</td>
<td>Loved ones should know what's going on in you without you having to say.</td>
</tr>
<tr>
<td>.51</td>
<td>14</td>
<td>People often have a hidden meaning behind what they say.</td>
</tr>
<tr>
<td>.57</td>
<td>32</td>
<td>If others around me would change their ways, I would be better off.</td>
</tr>
<tr>
<td>.56</td>
<td>36</td>
<td>People will grab all the credit they can and avoid admitting their mistakes.</td>
</tr>
<tr>
<td>.62</td>
<td>39</td>
<td>I feel that I am a victim of circumstances.</td>
</tr>
</tbody>
</table>
.46  41  I don't get the amount of love and attention that I need.
.41  87  It could well be said that I blow a lot of smoke.

Reverse scored items on the GCSQ-150:

-.27  66  People usually live up to my expectations of them.

---

Scale 5

27 Items that Distinguish the GRS Retroflection Scale

<table>
<thead>
<tr>
<th>r</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.32</td>
<td>3</td>
<td>I am tight-lipped about certain things.</td>
</tr>
<tr>
<td>.55</td>
<td>10</td>
<td>Even when I can't do anything about a problem, I tend to dwell on it.</td>
</tr>
<tr>
<td>.43</td>
<td>13</td>
<td>I have a tight jaw.</td>
</tr>
<tr>
<td>.57</td>
<td>17</td>
<td>I have difficulty putting uncomfortable feelings out of my mind.</td>
</tr>
<tr>
<td>.55</td>
<td>19</td>
<td>I often find that I have a problem.</td>
</tr>
<tr>
<td>.55</td>
<td>21</td>
<td>I feel dull.</td>
</tr>
<tr>
<td>.52</td>
<td>23</td>
<td>It's not until a situation is over that I think of what I should have said.</td>
</tr>
<tr>
<td>.52</td>
<td>28</td>
<td>If people really knew me, they would say that I am an uptight person.</td>
</tr>
<tr>
<td>.63</td>
<td>33</td>
<td>There are many things I would like to do, but feel too inhibited to try.</td>
</tr>
<tr>
<td>.48</td>
<td>46</td>
<td>I look to others to start conversations.</td>
</tr>
<tr>
<td>.42</td>
<td>51</td>
<td>My muscles often ache, even when I haven't done strenuous work.</td>
</tr>
<tr>
<td>.37</td>
<td>52</td>
<td>I am troubled by nausea or upset stomach.</td>
</tr>
<tr>
<td>.59</td>
<td>56</td>
<td>I stop myself from doing quite a few things because of embarrassment.</td>
</tr>
</tbody>
</table>
I do a lot of thinking about things.

I often feel guilty or resentful.

I often try to imagine just what it would be like to feel satisfied.

I have difficulty being comfortable.

I am a pretty anxious person.

Reverse scored items on the GCSQ-150:

- I am clever at making conversation.

- I feel satisfied in my interactions with others.

- I am smooth and graceful in my movements.

- I think of myself as a sensual person.

- I think of myself as a special person.

- I do not stay silent on things that I have a strong belief about.

- My life is varied and interesting.

- I think of myself as a sexy person.

- My mind, heart, and soul seem to be in harmony with the rest of my body.

---

Scale 6

20 Items that Distinguish the GRS Deflection Scale

<table>
<thead>
<tr>
<th>r</th>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.53</td>
<td>1</td>
<td>When I'm asked how I feel, I don't really know.</td>
</tr>
<tr>
<td>.36</td>
<td>5</td>
<td>I find it difficult to take things seriously.</td>
</tr>
</tbody>
</table>
.64 16 I find it hard to pin down what I really feel.
.51 22 I seem to apologize for things that I say.
.63 50 I am scattered and unfocused in my attention.
.46 54 I don't know what other people think of me.
.68 62 I often don't know what I really want.
.38 67 When I have problems, I like to find things to do that are distracting.
.53 69 I tend to put things off.
.44 70 I am not good at anticipating what other people will say or do.
.52 75 I am unsure of what my body sensations mean.
.57 76 I tend to beat around the bush rather than be direct.
.59 92 It seems that I have a hard time finishing things.
.30 93 I often come late to things.
.47 97 I've been told that in conversations, people often don't get my point.
.58 98 I feel pretty disconnected.
.55 99 I use social relationships or social gatherings to avoid my difficulties.
.37 100 It has been difficult for me to be serious on this test.
.57 101 I "cling" to people without really knowing what I want from them.
.53 111 I often feel as though I am out of touch with the flow of life.

Reverse scored items on the GCSQ-150:

none
## Scale 7

18 Items that Distinguish the GRS Egotism Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>The world has enough heroes.</td>
</tr>
<tr>
<td>18</td>
<td>I find it easy to guide conversations where I want them to go.</td>
</tr>
<tr>
<td>53</td>
<td>I like to stand out from the people I am with.</td>
</tr>
<tr>
<td>84</td>
<td>I don't like party conversation (chit-chat, small talk, etc.).</td>
</tr>
<tr>
<td>85</td>
<td>If others would listen to me I could tell them how to run their lives better.</td>
</tr>
<tr>
<td>105</td>
<td>My personal boundaries are very well protected.</td>
</tr>
<tr>
<td>106</td>
<td>I sometimes stay fixated on things probably because it lessens my confusion or sense of risk.</td>
</tr>
<tr>
<td>109</td>
<td>People who know me probably think I'm arrogant.</td>
</tr>
<tr>
<td>116</td>
<td>The &quot;economy&quot; of making or managing a living is more important to me than the art of living.</td>
</tr>
<tr>
<td>119</td>
<td>The love in my life leaves a lot to be desired.</td>
</tr>
<tr>
<td>123</td>
<td>My family and friends probably think I'm pretty self-centered.</td>
</tr>
<tr>
<td>125</td>
<td>I sometimes feel like a spectator of my own life.</td>
</tr>
<tr>
<td>127</td>
<td>It is difficult for me to feel truly connected to someone special.</td>
</tr>
<tr>
<td>132</td>
<td>I hate surprises, especially when a situation feels uncontrollable.</td>
</tr>
<tr>
<td>139</td>
<td>I often sacrifice my personal life for the appearance of &quot;mastery&quot; that I achieve through my ability to control situations.</td>
</tr>
</tbody>
</table>
Maintaining a certain "safe distance" helps me feel secure and in control.

I sometimes deceive myself.

I am impressed with my own power.

Reverse scored items on the GCSQ-150:

none
APPENDIX I

WRITTEN PERMISSION FROM NATIONAL COMPUTER SYSTEMS, INC. TO REPRINT ITEMS FROM THE MILLON MULTIAXIAL INVENTORY-III (MILLON, 1994)
August 12, 1998

John J. Wagner
257 Cross Country Drive S.
Westerville, OH 43081

Dear Mr. Wagner:

National Computer Systems, Inc., being the exclusive publisher and distributor of the MCMI-III inventory (Millon™ Clinical Multiaxial Inventory-III), hereby grants you permission to reprint in your dissertation five (5) test items from the MCMI-III inventory.

A copyright notice, and trademark notice if applicable, on the pages containing the test items should state as follows. The trademarks should be designated with a ™ (as noted above) in their first use and should also be footnoted as shown below.

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"MCMI-III" and "Millon" are trademarks of DICANDRIEN, INC.

Sincerely,

[Signature]

Jeff Kim
Contracts Specialist

cc Virginia Smith

Assessments
5005 Green Circle Drive Minnetonka, MN 55343 • 612-939-5000
APPENDIX J

WRITTEN PERMISSION FROM DR. ANSEL WOLDT TO REPRINT THE
GESTALT CONTACT STYLES QUESTIONNAIRE-150
(WOLDT AND PROSNICK, 1998)
I, Dr. Ansel Woldt, give my permission to John J. Wagner to reprint, both in part and in full, the items from The Gestalt Contact Styles Questionnaire-150 in his dissertation at The Ohio State University. The title of the dissertation is “The Gestalt Resistances and Millon’s Typology of Personality Disorders: A Correlational Study Within a Clinical Sample of Male Batterers”. I am the senior author of the Gestalt Contact Styles Questionnaire-150 and am able to provide permission for reprinting of the items.

Ansel Woldt, Ed.D

Date 10/19/98
APPENDIX K

THE GESTALT CONTACT STYLES QUESTIONNAIRE-150
(WOLDT AND PRSONICK, 1998)
© Gestalt Contact Styles Questionnaire 150
Ansel L. Woldt, Ed.D., James I. Kepner, Ph.D., & Kevin P. Prosnick, Ph.D.

Instructions: The following statements refer to things you know about yourself. Please circle the letter that best fits your response to each statement directly on this test booklet. Only use the middle choice, (C = I NEITHER AGREE NOR DISAGREE), when it is impossible for you to lean toward the first two or the last two answer choices. Think quickly and respond about how you really are, not how you wish you were or how you think others want you to be. Your first response is usually the best one. Following are the meanings corresponding to each letter choice:

A = I Strongly Agree with this Statement
B = I Agree
C = I Neither Agree nor Disagree with it
D = I Disagree
E = I Strongly Disagree with this Statement

Select and circle only one response for each item. Please answer all 150 items.

1. When I'm asked how I feel, I don't really know. A B C D E
2. I get confused when I'm trying to decide between conflicting authorities. A B C D E
3. I am tight-lipped about certain things. A B C D E
4. Other people are the cause of a lot of my problems. A B C D E
5. I find it difficult to take things seriously. A B C D E
6. I am clever at making conversation. A B C D E
7. One should behave according to the rules laid down by those who are more knowledgeable. A B C D E
8. Growing up, my family presented a united front in spite of personal differences. A B C D E
9. Loved ones should know what's going on in your without you having to say. A B C D E
10. Even when I can't do anything about a problem, I tend to dwell on it. A B C D E
11. The world has enough heroes. A B C D E
12. A lot has to happen before I finally get angry. A B C D E
13. I have a tight jaw. A B C D E
14. People often have a hidden meaning behind what they say. A B C D E
15. I feel satisfied in my interactions with others. A B C D E
16. I find it hard to pin down what I really feel. A B C D E
17. I have difficulty putting uncomfortable feelings out of my mind. A B C D E
18. I find it easy to guide conversations where I want them to go. A B C D E
19. I often find that I have a problem. A B C D E
20. When a situation gets tense, I sometimes find myself laughing. A B C D E
21. I feel dull. A B C D E
22. I seem to apologize for things that I say. A B C D E
23. It's not until a situation is over that I think of what I should have said. A B C D E
24. I am not sensitive enough to know what others are thinking or feeling without them telling me.________A B C D E
25. I have been told that I was not a good child when I was growing up.______________________A B C D E
26. I am graceful and smooth in my movements.__________________________________________A B C D E
27. I hardly notice situations that others say are stressful._______________________________A B C D E
28. If people really knew me, they would say that I am an uptight person.__________________A B C D E
29. I think of myself as a sensual person.______________________________________________A B C D E
30. I think of myself as a special person.________________________________________________A B C D E
31. My feelings are not easily hurt.____________________________________________________A B C D E
32. If others around me would change their ways, I would be better off.____________________A B C D E
33. There are many things I would like to do, but feel too inhibited to try.__________________A B C D E
34. I would not call myself an agreeable kind of person._______________________________A B C D E
35. I do not stay silent on things that I have a strong belief about.________________________A B C D E
36. People will grab all the credit they can and avoid admitting their mistakes.___________A B C D E
37. I get along with almost everyone.__________________________________________________A B C D E
38. I would describe myself as a thinking person rather than a feeling person.___________A B C D E
39. I feel that I am a victim of circumstances.__________________________________________A B C D E
40. Despite what some people say, there are no definite rights and wrongs._______________A B C D E
41. I don't get the amount of love and attention that I need.______________________________A B C D E
42. Other people have accused me of being lazy.________________________________________A B C D E
43. I wish people would smooth over their differences.____________________________________A B C D E
44. I've lived up to the hopes my parents had for me.___________________________________A B C D E
45. I tend to eat food faster than others do._____________________________________________A B C D E
46. I look to others to start conversations._____________________________________________A B C D E
47. It's easier for me to do something by myself than to get help doing it.__________________A B C D E
48. I seek out new things, rather than let them come to me.______________________________A B C D E
49. Going against someone's wishes will not hurt their feelings.__________________________A B C D E
50. I am scattered and unfocused in my attention._______________________________________A B C D E
51. My muscles often ache, even when I haven't done strenuous work._____________________A B C D E
52. I am troubled by nausea or upset stomach.__________________________________________A B C D E
53. I like to stand out from the people I am with.________________________________________A B C D E
54. I don't know what other people think of me.________________________________________A B C D E
55. If a situation is uncomfortable, I don't try to lighten it up.____________________________A B C D E
56. I stop myself from doing quite a few things because of embarrassment._________________A B C D E
57. Other people would say that I'm an emotional person.________________________________A B C D E
58. Some things must be accepted without question.______________________________________A B C D E
59. If something is difficult to understand, I will usually continue with it rather than let it drop.________A B C D E
## Gestalt Contact Styles Questionnaire 150

<table>
<thead>
<tr>
<th></th>
<th>A = STRONGLY AGREE</th>
<th>B = AGREE</th>
<th>C = NEITHER AGREE NOR DISAGREE</th>
<th>D = DISAGREE</th>
<th>E = STRONGLY DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.</td>
<td>I expect my body to do whatever I want it to.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61.</td>
<td>I do a lot of thinking about things.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62.</td>
<td>I often don't know what I really want.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63.</td>
<td>Established authorities know what they are talking about.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64.</td>
<td>I have difficulty saying &quot;No&quot; to people who are close to me.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65.</td>
<td>I like to go along with what others like to do.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66.</td>
<td>People usually live up to my expectations of them.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>67.</td>
<td>When I have problems, I like to find things to do that are distracting.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>68.</td>
<td>My life is varied and interesting.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69.</td>
<td>I tend to put things off.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70.</td>
<td>I am not good at anticipating what other people will say or do.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71.</td>
<td>I don't feel it's important to pay a lot of attention to my body.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>72.</td>
<td>I can empathize so much with others that I almost feel what they feel.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>73.</td>
<td>When I am tense, it makes me feel better to eat something.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>74.</td>
<td>I can fit into almost any situation.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75.</td>
<td>I am unsure of what my body sensations mean.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>76.</td>
<td>I tend to beat around the bush rather than be direct.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77.</td>
<td>I wish there was a trick to making learning a snap.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>78.</td>
<td>I think I might have a problem with taking things into my body, digesting them, and/or getting rid of them.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79.</td>
<td>I often feel guilty or resentful.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80.</td>
<td>I can stay calm, even in the worst of situations.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>81.</td>
<td>When I'm under stress, my body usually reacts.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>82.</td>
<td>I don't let sickness keep me from doing things.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>83.</td>
<td>I think of myself as a sexy person.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84.</td>
<td>I don't like party conversation (chit-chat, small talk, etc.).</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85.</td>
<td>If others would listen to me, I could tell them how to run their lives better.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86.</td>
<td>It's important that I keep in control of myself.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>87.</td>
<td>It could well be said that I blew a lot of smoke.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>88.</td>
<td>When people get serious, I tend to tighten things up.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>89.</td>
<td>I often try to imagine just what it would be like to feel satisfied.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90.</td>
<td>Where I go, what I do, and who I see is influenced a lot by my present or past addictions and/or dependencies.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>91.</td>
<td>I have a variety of ways to put or keep uncomfortable thoughts or feelings out of my mind.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92.</td>
<td>It seems that I have a hard time finishing things.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>93.</td>
<td>I often come late to things.</td>
<td>A B C D E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
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<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>94. When truly sad and grief-stricken, I cry and sob freely.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>95. I have difficulty being comfortable.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96. My mind, heart, and soul seem to be in harmony with the rest of my body.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>97. I've been told that in conversations, people often don't get my point.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>98. I feel pretty disconnected.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99. I use social relationships or social gatherings to avoid my difficulties.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100. It has been difficult for me to be serious on this test.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>101. I &quot;cling&quot; to people without really knowing what I want from them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>102. Creative possibilities come to me in quiet moments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>103. When I'm in dangerous or risky situations, I can step outside myself and observe or comment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>104. I have been aware of time standing still.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>105. My personal boundaries are very well protected.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>106. I sometimes stay fixated on things probably because it lessens my confusion or sense of risk.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107. I have been aware of my consciousness expanding beyond the limits of my body.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>108. I believe that energy fields or aura extend beyond physical bodies.</td>
<td></td>
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<tr>
<td>109. People who know me probably think I'm arrogant.</td>
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<td>110. I have traveled out of my body.</td>
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<td>111. I often feel as though I am out of touch with the flow of life.</td>
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<td>112. I have seen things, animals, and/or people that others could not see.</td>
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<td>113. I am a pretty anxious person.</td>
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<td>114. The world doesn't seem to have enough heroes.</td>
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<td>115. I have read other people's minds and they have confirmed it.</td>
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<td>116. The &quot;economy&quot; of making or managing a living is more important to me than the art of living.</td>
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<td>117. I have allowed myself to merge with some people when experiencing them.</td>
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<td>118. I have a spiritual value system that includes transporting spiders and insects outside a building instead of killing them.</td>
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<tr>
<td>119. The love in my life leaves a lot to be desired.</td>
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<td>120. I feel spiritually connected to others.</td>
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<td>121. A body isn't much more than a machine.</td>
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<td>122. I feel responsible to promote justice in the world.</td>
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<td>123. My family and friends probably think I'm pretty self-centered.</td>
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<td>124. I have experienced unexplainable coincidences that were meaningful to me.</td>
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<tr>
<td>125. I sometimes feel like a spectator of my own life.</td>
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<tr>
<td>126. A &quot;sixth sense&quot; helps me to avoid danger.</td>
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<tr>
<td>127. It is difficult for me to feel truly connected to someone special.</td>
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</table>
**Gestalt Contact Styles Questionnaire 150**

<table>
<thead>
<tr>
<th></th>
<th>A = STRONGLY AGREE</th>
<th>B = AGREE</th>
<th>C = NEITHER AGREE NOR DISAGREE</th>
<th>D = DISAGREE</th>
<th>E = STRONGLY DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>128.</td>
<td>I have felt influenced by a spiritual or transcendent force.</td>
<td>A B C D E</td>
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<tr>
<td>129.</td>
<td>I take pride in how well I place myself in the center of life.</td>
<td>A B C D E</td>
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<td>130.</td>
<td>I'd say I &quot;digest&quot; new or different ideas very well.</td>
<td>A B C D E</td>
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<td>131.</td>
<td>I have experienced flashes of future events which later came true.</td>
<td>A B C D E</td>
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<tr>
<td>132.</td>
<td>I hate surprises, especially when a situation feels uncontrollable.</td>
<td>A B C D E</td>
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<tr>
<td>133.</td>
<td>I have felt connected to a universal spiritual force.</td>
<td>A B C D E</td>
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<tr>
<td>134.</td>
<td>I like to finish things and then take time out to appreciate what I've done.</td>
<td>A B C D E</td>
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<td>135.</td>
<td>Life can be explained without resorting to anything mystical or spiritual.</td>
<td>A B C D E</td>
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<tr>
<td>136.</td>
<td>Sickness comes from spiritual and physical forces.</td>
<td>A B C D E</td>
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<tr>
<td>137.</td>
<td>I avoid being too different from people I'm with.</td>
<td>A B C D E</td>
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<td>138.</td>
<td>I value both intuition and logical reasoning.</td>
<td>A B C D E</td>
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<td>139.</td>
<td>I often sacrifice my personal life for the appearance of &quot;mastery&quot; that I achieve through my ability to control situations.</td>
<td>A B C D E</td>
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<td>140.</td>
<td>I believe that traveling out of body is possible.</td>
<td>A B C D E</td>
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<tr>
<td>141.</td>
<td>I rarely get headaches.</td>
<td>A B C D E</td>
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<tr>
<td>142.</td>
<td>Maintaining a certain &quot;safe distance&quot; helps me feel secure and in control.</td>
<td>A B C D E</td>
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<td>143.</td>
<td>I have seen or felt the energy fields or aura's that extend beyond physical bodies.</td>
<td>A B C D E</td>
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<td>144.</td>
<td>I have had a mystical vision.</td>
<td>A B C D E</td>
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<td>145.</td>
<td>I sometimes deceive myself.</td>
<td>A B C D E</td>
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<td>146.</td>
<td>I merge with some things when I concentrate on them.</td>
<td>A B C D E</td>
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<td>147.</td>
<td>I am impressed with my own power.</td>
<td>A B C D E</td>
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<td>148.</td>
<td>Spiritual or mystical experiences help me understand the meaning of life.</td>
<td>A B C D E</td>
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<td>149.</td>
<td>I'm pretty good at bringing ideas together and blending different views.</td>
<td>A B C D E</td>
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<td>150.</td>
<td>I have felt at one with all of existence.</td>
<td>A B C D E</td>
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</tbody>
</table>

**THE END!**

Thank you for your participation and assistance in this research endeavor. Your cooperation and effort in answering the items on this test is very much appreciated.
REFERENCES


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Woldt, A., & Kepner, J. (1986). Gestalt Contact Styles Questionnaire- Revised (GCSQ-R). Unpublished manuscript, Kent State University, Kent, OH.


