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Personality Profiles of Women in Multiple Abusive Relationships

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Personality profiles of women with multiple abusive relationship histories ($N = 42$) *were compared to either abused women with 1 abusive relationship* ($N = 33$) *or a control group* ($N = 52$) *on the Coolidge Axis II Inventory (Coolidge & Merwin, 1992, J. Pers. Assess.* 59: 223–238*), a self-report measure based on the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV*; American Psychiatric Association, 1994). Women with multiple abusive relationships had higher rates and greater levels of dependent, paranoid, and self-defeating personality disorders than women in the other 2 groups. Women in multiple abusive relationships had significantly more depression, and women in this group with posttraumatic stress disorder (PTSD) had significantly more personality disorders than women with single abusive relationships with PTSD. Women in single abusive relationships did not exhibit more psychopathology than women in the control group with matched marital status. Theoretical and methodological issues, and treatment recommendations are discussed.*

KEY WORDS: battered women; personality profiles; multiple abusive relationships; personality disorders; posttraumatic stress disorder.

In the past, women victims of domestic violence were accused of perpetuating their own victimization. Theories of women's masochism have been used to explain the irrational behaviors of battered women (e.g., Deutsch, 1944; Freud, 1920/1961a, 1924/1961b). Regardless of the battered woman's education, economic situation, or social support, theories of masochism and psychological pathology were used to explain a battered woman's refusal

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to leave a dangerous and often times lethally violent relationship. Specific myths and stereotypes about the battered woman were challenged by subjective interviews and case surveys of women in abusive relationships. Critics of past theories that "blamed the victim" contended that investigations of the battered woman's character further victimized the woman and ignored the responsibility of the other party involved: the violent male. Attempts have been made to discredit or rationalize these assumptions of battered women (Carden, 1994; Walker 1979, 1987). However, without controlled, empirical investigations, stereotypes and myths persist.

Rosewater (1987) suggested that the victim's psychopathology is situational in nature and would gradually disappear once a woman is removed from an abusive relationship. Researchers have argued that the personality of the battered wife is not easily measured, and studies that have found personality disorders or Axis I symptoms in victims are mistakenly identifying another psychopathology for what is actually posttraumatic stress disorder (PTSD; Browne, 1993; Rosewater & Walker, 1985; Van der Kolk, 1987; Walker & Browne, 1985). Without careful assessment, PTSD could be mistakenly misdiagnosed as an enduring personality disorder (e.g., Walker, 1987). Gunderson and Sabo (1993) contended that PTSD usually is not confused with a personality disorder if the individual has functioned reasonably well in the past and has had previously healthy relationships. Evidence of a woman continuing to engage in multiple abusive relationships would lead one to consider the problem as more chronic and less adaptive.

In general, victims of domestic violence do indeed suffer from PTSD. Past studies found evidence of PTSD from 33% to 81% in samples of battered women (Astin *et al.*, 1993; Cascardi *et al.*, 1995; Gleason, 1993; Kemp *et al.*, 1995). After a victim endures chronic PTSD symptoms without intervention, it has been suggested that characterological changes could occur (Dutton, 1988; Norden *et al.*, 1995; Van der Kolk, 1987). In this light, failure to treat symptoms of PTSD can lead to more enduring and chronic forms of psychopathology.

With regard to Axis I psychopathology in abused women, Gleason (1993), using the Diagnostic Interview Schedule (DIS; Robins *et al.*, 1981), a 263-item structured interview based on the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*; American Psychiatric Association [APA], 1980), found evidence of major depressive disorder (81%), phobia (63%), and posttraumatic stress disorder (31%), and generalized anxiety disorder (47%) in 32 women receiving services at a local domestic violence center. Cascardi *et al.* (1995), using the Structured Clinical Interview for *DSM-III-R* (SCID-Axis I; Spitzer *et al.*, 1992), found elevated rates of depression (38%), panic disorder (13%), and generalized anxiety disorder (10%) in physically and verbally abused women as compared to a nonabused community control.

Standardized personality inventories have also been used to explore the personality profiles of battered women. Gellen *et al.* (1984) used the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1943) and found a significant difference between scale elevations on hysterical, depression, and psychopathic deviate among 10 abused and 10 nonabused women. The psychopathic deviate scale was also elevated significantly above a norm mean group for 46 battered females in a study conducted by Rhodes (1992). Additionally, a family discord subscale, antisocial personality characteristics, was significantly elevated compared to the control group. In a later study using the MMPI-2, Khan *et al.* (1993) found 49 out of the 56 women residing in a domestic violence shelter manifested elevations suggesting coping problems, low self-confidence, anger, and poor judgement. Regression analyses revealed that the length of abuse was the best predictor of *F* scale elevation, and the severity of psychological/emotional abuse was the only significant predictor of the overall average *T* score.

There are fewer studies of battered women evaluated for *DSM* Axis II personality disorders. Snyder and Fruchtman (1981) studied initial interviews from a battered women's shelter and performed cluster analyses on demographic and relationship history information. From these analyses, a subgroup of battered women was identified as having the chronic problems associated with personality disorders. Snyder and Fruchtman reported women in one subgroup (comprising 9% of the study sample) had developed a "resignation to domestic violence" and "has become a way of life and, despite their expressed intentions at discharge, return to the same or a similar environment" (p. 885). Additionally, this subgroup had an extensive history of violence in their family of origin and was the most likely to remain in the abusive relationship regardless of extenuating circumstances. Back *et al.* (1982) found 83% of battered women in a psychiatric facility were given a discharge diagnosis of borderline, passive-dependent, passive-aggressive, or unspecified. In comparison, only 45% of the nonbattered psychiatric patients were diagnosed with a personality disorder.

Cogan and Porcerelli (1996), using the Millon Clinical Multiaxial Inventory-II (MCMI-II; Millon, 1987), found 28% of women attending couples therapy for violent relationships were clinically elevated on the Dependent Personality Disorder Scale compared with 10% in Millon's normative sample. Faulkner *et al.* (1991) found clinical elevations on the anxiety and depression scales on the MCMI-I (Millon, 1982) in a group of women attending a cognitive/behavioral treatment program for abused spouses. It should be noted that the MCMI-I cannot be used to identify the presence or absence of a personality disorder, as it was designed only to differentiate among personality disorders in those people strongly suspected of having a personality disorder.

Research into the nature of women in multiple abusive relationships is sparse. Walker (1979) reportedly interviewed "hundreds" (p. xiii) of self-reported battered women and developed a general clinical description of a typical battered woman, although she did not use statistical analyses, structured interviews, or standardized assessments. Walker asserted that women "rarely" (Walker, 1979, p. 28) experience multiple abusive relationships. In contrast, Kemp *et al.* (1995) investigated 179 abused women, residing in a variety of community settings, and found 41% experienced more than one physically abusive relationship as an adult. Eighty-one percent met criteria for PTSD; however, no correlation was found between the history variables and the presence of PTSD.

Although preexisting psychopathology has been proffered as a causative factor in some studies of abused women (e.g., Gleason, 1993; Snell *et al.*, 1964), risk marker studies have suffered from variations in samples (e.g., court-ordered, self-report of abuse) and differences in psychological evaluation techniques. For example, the most prevalent psychological assessment inventory, the MMPI, was not originally designed to assess Axis II personality disorders, and subsequent supplemental MMPI personality scales do not provide complete coverage of the Axis II personality disorders nor of their criteria.

One major risk marker in studies of abused women has been childhood victimization. Studies have reported that between 25% and 77% of battered women have experienced physical or sexual abuse as children (e.g., Astin *et al.*, 1993; Gelles, 1976; Snyder & Fruchtman, 1981). Further, it has been shown that a history of child abuse can be a risk factor for PTSD (Kramer & Green, 1991; Roth *et al.*, 1990; Solomon *et al.*, 1988). If childhood victimization is present in some battered women, these women may be at a greater risk of developing PTSD as well as other psychopathology.

To date, there have been no studies examining the differences in psychopathology, particularly personality disorders of women who have experienced abuse in more than one relationship. Further, no studies to date have examined the comorbidity and influence of PTSD and childhood victimization of women in multiple abusive relationships. Therefore, the purpose of this study was to examine the psychopathology and backgrounds in samples of women who had been in a single abusive relationship or in multiple abusive relationships with an instrument (Coolidge Axis II Inventory, CATI;[3] Coolidge, 1993) specifically designed to assess certain Axis I and Axis II disorders in the *DSM*.

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It was hypothesized generally that women in multiple abusive relationships would exhibit significantly higher prevalence rates and greater levels of Axis I and Axis II psychopathology than women in the single abusive relationships. It was also predicted that women in multiple abusive relationships would have higher prevalence and greater levels of PTSD than women in single abusive relationships. Finally, it was predicted that women in multiple abusive relationships would have a higher prevalence of childhood victimization (physical and/or sexual abuse) than women in single abusive relationships.

METHOD

Participants and Procedure

Abused women attending educational treatment groups at a community center for the prevention of domestic violence were notified of the opportunity to participate voluntarily in this research study. Confidentiality was stressed and explained verbally and on the informed consent form. Women were informed that they were not required to complete the study to receive services at the center. A consent form was signed and a packet containing the demographic and personality questionnaires was given to all women interested in participating. Participants were paid $5 when questionnaires were returned, regardless of whether the packet had been completed.

After participation, women who reported no history of physical or sexual violence or reported only a history of verbal or emotional abuse were dropped from the study. Women who reported experiencing at least one physically violent relationship were retained for this study. The single relationship group was assigned when only one physically abusive relationship was reported, and there was no other history of physically or emotionally abusive relationships. The multiple relationship group was assigned when at least one physically abusive relationship was reported, and at least one other violent or emotionally abusive relationship was reported.

The demographics of the final sample appears in Table I: there were $N = 42$ women reporting multiple abusive relationships, $N = 33$ women reporting a single abusive relationship, and $N = 54$ women were chosen from the CATI's normative sample ($N = 937$; Coolidge & Merwin, 1992) group matched on age, education, race, and percentage of current marriages and divorces. It was subsequently determined that 49% (37 of 75) of the women in the two abuse groups had been court-ordered for the community center's services.

Table I. Demographic Characteristics of the Samples of Women in Single Abusive Relationships, Multiple Abusive Relationships, and the Control Group

	Mean (*SD*)		
	Single ($N = 33$)	Multiple ($N = 42$)	Control ($N = 54$)
Age	31 (8.1)	36 (10.2)	32 (10.3)
Education (years)	12 (1.9)	13 (2.3)	13 (0.9)
	n (%)		
Monthly income ($)			
0–599	10 (31)	14 (34)	
600–999	7 (22)	8 (20)	
1000–1999	10 (31)	13 (32)	
2000 or more	5 (16)	5 (12)	
Marital status			
Single	9 (27)	11 (26)	22 (41)
Married	9 (27)	12 (29)	21 (39)
Divorced/separated	15 (46)	19 (45)	11 (20)
Ethnic background			
White	25 (76)	31 (76)	48 (89)
Other	8 (24)	11 (24)	6 (11)
Referral source to group			
Self	15 (46)	23 (55)	
Court	18 (55)	19 (45)	
Currently in an abusive relationship	14 (42)	18 (43)	
Experienced abuse as a child	12 (36)	20 (48)	

Measures

Demographics

A 12-item, self-report demographic questionnaire was completed by the women in the two abuse groups. It assessed current and past relationship history, demographic information, and history of physical or sexual abuse as a child. In the questionnaire, a relationship was defined as abusive if there was a pattern of assaultive and controlling behaviors that included one of the following types of abuse: physical violence, sexual violence, and/or emotional tactics. Physical violence was defined as hitting, slapping, scratching, grabbing, shaking, shoving, pushing, restraining, throwing, punching, biting, choking, burning, and use of weapons. Sexual violence was defined as forced sex, not fighting to stop unwanted sexual contact or acts. Emotional abuse included intimidation by yelling or breaking objects, calling names/put downs, isolation, and threats of violence to self, spouse, family, or pets.

CATI

Psychopathology was assessed by the CATI (Coolidge, 1993; Coolidge *et al.*, 1996; Coolidge & Griego, 1995; Coolidge & Merwin, 1992), a 225-item,

self-report inventory designed to assess (a) the 10 personality disorders according to the criteria listed on Axis II in the *DSM-IV*, the two personality disorders (passive-aggressive and depressive) in Appendix B of the *DSM-IV* (APA, 1994), and the two personality disorders (self-defeating and sadistic) in Appendix A of the *DSM-III-R* (APA, 1987); (b) generalized anxiety disorder, PTSD, and depression from Axis I of the *DSM-IV*; and (c) an overall maladjustment scale consisting of 71 items. There are four validity scales assessing random-responding, the tendency to deny blatant pathology, social desirability/debasement, and answer-choice frequency. According to the CATI manual, the median scale reliability for the 14 personality disorders was .76, the test-retest reliability was .90, and the median concurrent validity with the MCMI-II personality disorder scales was .58. There was a 50% concordance rate for the personality disorder scales with clinician's judgement (for greater detail see Coolidge & Merwin, 1992).

RESULTS

Demographic and History Characteristics

Chi-square analyses did not reveal differences between the two abusive relationship groups on the demographic variables including age, ethnicity, marital status, income, referral source to group, or child abuse at a significance level of $p < .05$.

Prevalence of Psychopathology: Clinical Significance

A summary of percentages in each of the three groups who met clinical significance (i.e., two standard deviations above the CATI normative sample mean) is presented in Table II along with significance levels of chi-square analyses of the 4 Axis I scales and the 14 Axis II personality disorders scales. The most prevalent disorder on Axis I for the women in the multiple abusive relationship was PTSD (36%) while for these same women the most prevalent personality disorder scale was Dependent (21%). A cursory review of the table reveals that the women in multiple abusive relationships had the greatest rates of psychopathology whereas the women in the single abusive relationship did not appear different than the women in the control group.

Psychopathology: A Statistical Analysis of Scale Mean Comparisons

The 4 Axis I disorder scales and the 14 Axis II personality disorder scales were analyzed by multiple analyses of variance (ANOVA), and the means

Table II. Percentages of Respondents Meeting Clinical Significance for Axis I and Axis II Scales with Chi-Square Analyses[a]

	%				
	Single ($N = 33$)	Multiple ($N = 42$)	Control ($N = 54$)	χ^2	p level
Axis I & Other Scales					
Generalized anxiety	0	2	2	0.74	.690
Depression	6	17	4	5.44	.066
Posttraumatic stress	15	36	17	6.29	.043
Maladjustment	0	17	2	11.85	.003
Axis II Scales					
Antisocial	0	10	2	5.52	.063
Avoidant	9	14	11	0.51	.775
Borderline	3	12	2	5.15	.076
Dependent	0	21	2	16.39	.001
Depressive	3	14	6	3.90	.142
Histrionic	0	5	4	1.51	.471
Narcissistic	0	0	0		
Obsessive–compulsive	0	5	7	2.54	.281
Paranoid	0	10	0	5.55	.014
Passive–aggressive	0	10	2	5.52	.063
Sadistic	0	0	0		
Schizoid	9	10	4	1.54	.463
Schizotypal	0	5	4	1.51	.471
Self-defeating	3	14	5	9.89	.007

[a] T score ≥ 70.

(reported as T scores), standard deviations, F values, and significance levels are reported in Table III. In order to control for the experimentwise error rate, Holm's modified Bonferroni technique (Holm, 1979) was used. The technique involves initially setting α with the traditional Bonferroni correction for a family (e.g., Axis II) of comparisons (i.e., $\alpha/14$). The lowest p level is chosen for that family of comparisons and compared to the corrected significance level. Each subsequent comparison is made with a reduction in the number of comparisons (e.g., $\alpha/13$) until a nonsignificant comparison is found. All subsequent comparisons are declared nonsignificant regardless of the original ANOVA significance level.

Axis I Scales

Three of the four ANOVAs on Axis I scales met statistical significance according to Holm's technique: Maladjustment, PTSD, and Depression. A summary of Tukey's post hoc analyses for these scales among the three groups also appears in Table III.

Table III. Means and Standard Deviations for Axis I and Axis II Scales for the Single, Multiple Abusive Relationship Groups, and the Control Group

	Mean (*SD*)				
	Single	Multiple	Control	$F(2, 126)$	p
Axis I & Other Scales					
Generalized anxiety	55.4 (6.5)	56.6 (7.3)	54.0 (6.4)	1.78	.171
Depression	51.9 (9.8)	57.0[a] (12.1)	48.9 (9.7)	7.05	.001[b]
Posttraumatic stress	59.8 (12.0)	64.8[a] (14.3)	56.7 (12.6)	4.53	.013[b]
Maladjustment	50.7 (8.8)	56.1[c] (11.7)	47.5 (10.7)	8.58	.001[b]
Axis II Scales					
Antisocial	40.0 (8.1)	51.7 (10.0)	46.1 (8.4)	4.83	.009
Avoidant	52.3 (10.1)	57.4 (12.9)	53.3 (11.2)	2.22	.112
Borderline	50.4 (10.0)	55.3[a] (12.5)	47.6 (10.2)	5.83	.004[d]
Dependent	49.3 (10.8)	56.9[c] (14.7)	48.7 (10.0)	6.37	.002[d]
Depressive	53.3 (11.2)	57.1 (13.0)	53.8 (10.9)	1.31	.273
Histrionic	43.1 (8.0)	48.9 (10.9)	47.0 (10.2)	3.19	.045
Narcissistic	44.8 (6.0)	49.1 (10.8)	47.2 (10.2)	1.87	.159
Obsessive–compulsive	53.9 (7.8)	54.6 (9.8)	50.8 (11.2)	1.97	.144
Paranoid	47.2 (8.5)	53.7[c] (12.0)	47.3 (9.8)	5.61	.005[d]
Passive–aggressive	48.6 (10.4)	53.6 (13.0)	48.3 (11.4)	2.73	.069
Sadistic	46.3 (6.2)	47.7 (6.7)	44.0 (6.6)	3.73	.027
Schizoid	60.1 (6.8)	53.7 (11.7)	55.5 (8.4)	4.73	.010
Schizotypal	48.1 (8.1)	49.8 (10.3)	46.3 (9.3)	1.69	.189
Self-defeating	53.6 (8.5)	60.0[c] (9.1)	51.6 (10.3)	9.55	.001[d]

[a]Multiple > norm.
[b]Significant according to the Holm's modified Bonferroni technique (Holm, 1979) for 3 Axis I scales & Maladjustment scale.
[c]Multiple > single and norm.
[d]Significant according to the Holm's modified Bonferroni technique (Holm, 1979) for 14 Axis II scales.

Axis II Scales

Four of the ANOVAs on the 14 personality disorder scales met statistical significance according to Holm's technique: Borderline, Dependent, Paranoid, and Self-defeating. A summary of Tukey's post hoc analyses for these scales among the three groups also appears in Table III.

Comorbidity and Childhood Victimization

In order to test the hypothesis that women in multiple abusive relationships would have more comorbid personality disorders than women in single abusive relationships, a three-factor ANOVA was performed on the number of CATI personality disorder T score scales greater than or equal to 70. A clinical diagnosis of PTSD ($\geq T$ score of 70 or not), a childhood

history of sexual or physical abuse (yes or no), and single versus multiple abusive relationships were included as main effects in the ANOVA. There were significant main effects for the PTSD factor, $F(1, 67) = 19.77$, $p < .001$, and the single versus multiple abusive relationships factor, $F(1, 67) = 9.62$, $p < .003$, and their interaction, $F(1, 67) = 9.41$, $p < .003$, but not for any other conditions. The Tukey's post hoc procedure ($p < .05$) revealed that women in single abusive relationships and women in multiple abusive relationships were not significantly different in their mean numbers of personality disorders (T scores ≥ 70) when both groups were not clinically elevated on the PTSD scale. However, women in multiple abusive relationships did have significantly more personality disorders ($M = 2.8$) than women in single abusive relationships ($M = 1.0$) when both groups were clinically elevated on the PTSD scale.

In the examination of childhood victimization, the previous analysis reveals that although childhood victimization was highly prevalent but not significantly different between women in single abusive relationships and women in multiple abusive relationships, it was not systematically related to PTSD scale elevations nor to multiple personality disorder diagnoses.

Critical Items

Chi-square item analyses were conducted on all the CATI scale items. Significant response differences were found between the multiple and single relationship groups for over 20 items. For example, nearly four out of five women in the multiple abusive relationship group endorsed the following items: "I tend to have intense but unstable relationships," and "I have chosen people or situations that have led to disappointment, failure, or mistreatment." About three out of four women in that group endorsed the item, "When a close relationship ends, I feel devastated or helpless." By comparison, only one in four women who report multiple abusive relationships endorsed the item, "In the past, I have only been attracted to people who treated me well or cared about me." Table IV displays the endorsement of the selected items by abusive relationship group.

DISCUSSION

Women who reported multiple abusive relationships exhibit higher levels of psychopathology than women who had a single abusive relationship, confirming our initial hypothesis. Those in the multiple abusive group had greater clinical elevations on three CATI Axis II scales—Self-defeating, Dependent, and Paranoid—and two Axis I scales, Depression and PTSD. They

Table IV. A Sample of Significant Item Differences (Percentages of Endorsement) for Abusive Relationship Groups with Chi-Square Analyses

	%			
	Single ($N = 33$)	($N = 42$)	χ^2	p level
Item 13: I tend to have intense but unstable relationships	45	83	11.48	.001
Item 155: In the past, I have only been attracted to people who treated me well or cared about me	58	24	8.89	.003
Item 80: It really bothers me when I'm not the center of attention	0	21	8.04	.005
Item 9: I feel relaxed most of the time	73	40	7.76	.005
Item 33: I have chosen people or situations that have led to disappointment, failure, or mistreatment	58	86	7.48	.006
Item 12: I am easily hurt by criticism or disapproval	45	74	6.27	.012
Item 36: I consider myself dependent on others	12	37	5.73	.017
Item 56: I make extreme efforts to avoid being alone	18	43	5.17	.023
Item 203: I immediately look for another relationship when one ends	24	36	4.00	.046
Item 148: When a close relationship ends, I feel devastated or helpless	51	74	3.99	.046
Item 11: I am unwilling to get involved with people unless I am certain they will like me	27	50	3.98	.046

also had greater rates of overall psychological maladjustment according to the CATI maladjustment scale.

One of the most surprising findings in the current study was that women in single abusive relationships did not exhibit more psychopathology than women with matched marital histories. This finding should strengthen the call for more rigorous methodology in the examination of battered women, and more specifically urges the use of standardized tests and measures as opposed to unstructured clinical interviews, the use of measures to assess personality disorders, and use of appropriate control groups. The latter concern, for example, was particularly salient in this study because we found significantly greater prevalence of PTSD symptomatology for the women in multiple abusive relationships, but no difference between the women in the single abusive relationships and the control group. Our findings appear to argue against the notion that battered women are a homogenous group and

counter observations that women in serially abusive relationships are rare (e.g., Walker, 1979).

With regard to PTSD symptomatology, its presence had a significant interaction in single versus multiple abusive relationships. When PTSD was not present, there was no significant difference between those two groups in the number of clinically elevated personality disorders. However, when PTSD symptomatology was present, women in multiple abusive relationships had significantly more personality disorders than women in single abusive relationships. One implication of this finding for the diagnosis of women in abusive relationships is that when PTSD symptomatology is present, greater characterological or more enduring psychopathology may be expected. Further, even greater rates of personality disorders may be expected in these situations when these women have been involved in serially abusive relationships. These group differences appear to discount the observation (i.e., Walker, 1991) that abused women with PTSD *uniformly* reveal higher rates of psychopathology on self-report measures.

For the treatment of battered women suffering from PTSD, there are numerous techniques both for individual and group therapy (e.g., Foa & Meadows, 1997). Battered women can be educated about the signs and symptoms, effective medications and treatments, and other methods under study designed to increase the recovery time and improve the prognosis for those suffering from PTSD. However, PTSD sufferers can be less likely to respond to treatment if a long-standing Axis II personality disorder is not concurrently addressed (e.g., Southwick *et al.*, 1993). Consequently, treatment providers and battered women's advocates should be educated about Axis II disorders.

Another interesting finding in this study was that childhood victimization, as defined by a self-reported history of physical or sexual abuse, was not a factor in the number of personality disorders nor in the likelihood of multiple abusive relationships. Both groups were equally likely to have experienced abuse as a child (43% of the total sample of abused women), which supports the contention that an early history of abuse may be a significant risk marker for later physically abusive marital relationships. However, more research and controlled studies are needed into the specific nature, severity, and the developmental period when the abuse occurred.

This study is the first to explore psychopathological characteristics of women in multiple abusive relationships, and we have demonstrated that these women exhibit greater levels and prevalence rates of both Axis I and Axis II psychopathology. One important limitation and issue with these conclusions resides in the extent to which the personality disorder features are not the cause of serially abusive relationships, but a result. As has been noted (e.g., Back *et al.*, 1982; Walker, 1991), women in abusive

relationships may adopt personality disorder features as adaptive or protective responses to abnormal circumstances. The present design does not allow a clear determination of the cause–effect relationship for this issue. One possibility is that both positions may be, in part, correct: some women in serially abusive relationships may have premorbid personality disorders that result in their ending up in a succession of abusive partners, whereas some women in multiple abusive relationships may not have premorbid personality disorders but adopt these features (e.g., anger, dependency) in response to abusive partners in order to adapt and survive. Although research shows a heritable component to adult personality disorders, the *DSM* does not specify causation as part of the diagnostic criteria. Therefore, in some cases, the presence of personality disorder features in some women in multiple abusive relationships may meet the *DSM* criterion for a personality disorder because of the symptoms' pervasive, enduring, and disrupting consequences. In these cases, the etiology of the personality disorder may be less important than the treatment and the prevention of future abuse.

These findings then may have important implications for therapy. First, therapists and counselors may greatly benefit from personality disorder evaluations of their clients in order to identify women in either single abusive relationships or multiple abusive relationships who might be struggling with dependent or self-defeating symptoms or disorders that may compel a battered woman to return to her abuser or to seek out another abusive relationship. Certainly, the present findings suggest that when counselors and therapists encounter women in multiple abusive relationships, they should be acutely aware that these women may have enduring and chronic characterological features that may need to be addressed in therapy before significant change can occur.

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