The study was designed to evaluate and analyze personality pattern, psychopathological symptoms, and forms of abuse suffered by a sample of 20 women who were recruited from a shelter home for battered women and three barangay community base centers in Metro Manila. Results showed that battered women suffered different forms of abuse characterized by various combination of physical abuse, psychological abuse, economic abuse, and sexual abuse. Using the MCMI-II, results revealed predominance of schizoid personality pattern and presence of avoidant, compulsive, and self-defeating personality patterns. Likewise, the women manifested symptoms of anxiety and dysthymia. Implications for counseling practice and assessment were also discussed.

Keywords: Battered women, forms of abuse, personality profile, counseling, assessment

Assessing the Personality Profile of Battered Women

Alicia F. Estrellado
De La Salle University, Manila, Philippines

Women tend to make their personal world out of their social relationship with an intimate partner in life. They feel they belong if they have an intimate partner in life. If this social relationship turns out according to their expectation, they feel happy, satisfied, and even lucky. And if their kind of intimate relationship is what truly makes them happy, what they need to do is to sustain it and keep it ever working.

However, if it turns out contrary to their expectation, they end up shattered, or selfless. For them, life becomes a calvary, with much crosses to bear and blows to parry. Quite an agony to live with for all the violations it does to their being. That is why their kind of intimate relationship is the one associated with the terms “intimate partner violence,” “violence against women,” and “battered women.”

Violence against women is a problem so prevalent and intense. According to the World Health Organization (WHO), women around the world face the threat of experiencing abuse at the hands of their partner or spouse (Garcia-Moreno, Jassen-Ellsherg, Heise, & Watts, 2006). In 2009, the Philippine National Police (PNP) reported 9,485 cases related to violence against women, a 37.4 percent increase from the 2008 report. Based on the PNP twelve-year period data from 1997-2009, abuse by an intimate partner accounts for 45.5% of all violent against women cases nationwide (Philippine Commission on Women, 2010).

Violence related to intimate partners can take many forms, ranging from psychological or emotional intimidation to life-threatening episodes of physical assault. Abusive relationships have been described as coercive patterns of behavior and impulsively ferocious (Murphy & Cascardi, 1993). Researchers have indicated an extensive range of psychopathological symptoms that seem to be associated with intimate partner abuse (Gleason, 1993, Khan, Welch, & Zilmmer, 1993; Stuart, Moore, Gordon, Ramsey, & Kahler, 2006; Vitanza, Voge, & Marshall, 1995). It is significant to be knowledgeable about the psychopathological symptoms the battered women suffer, however, to have a better understanding of the dynamics of battered women, it is essential to assess and identify their basic personality profile.

Review of Related Literature

Intimate partner violence is a major health problem that has devastating physical, mental, and psychological consequences on women. In addition to bruises, swollen eyes, and broken bones inflicted by physical blows, abuse takes a severe toll on battered women's well-being generating hindrances in their integral growth as a person (Campbell, 2002; Estrellado & Salazar-Clemeña, 2007; Heru, 2007; Vitanza, Vogel, & Marshal, 1995).

Research has shown adverse effects associated with loss of self-confidence, relationships and cognitive processes (Campbell & Soeken, 1999; Estrellado & Salazar-Clemeña, 2007; Forte, Cohen, Du Mont, Hyman, & Romans, 2005). The women exposed to recurring and inevitable abusive circumstances make them feel helpless and develop a strong and extremely harmful perception of themselves and the world (Estrellado & Salazar-Clemeña, 2007).

The question of what is more crippling and dangerous between the physical and psychological abuse is very subjective. Some studies show that psychological abuse has greater bearing on women's psychological functioning that can result to psychopathology than physical abuse (Cogan & Porcerelli, 1996; O'Leary, 1999; Pico-Alfonso, 2005). The current literature on intimate partner violence suggests that women who have endured abusive relationship manifest symptoms of psychopathology related to posttraumatic stress disorder (PTSD), depression, somatization, and generalized anxiety disorder (GAD) (Campbell, 2002; Mertin & Mohr, 2000, Stuart et al., 2006). This was supported by the research of Kramer, Lorenzo, and Mueller (2004) and Vitanza, Vogel,

and Marshall (1995) who found that women's experience with different forms of abuse also predicted increased levels of anxiety and depression and poor well-being. Likewise, Danielson, Moffit, Caspi, and Silva (1998) assessed the relationship between intimate partner abuse and psychopathology and found that women experiencing any form of abuse exhibited symptoms related to mood and eating disorders. Among the women who experienced intense abuse in terms of frequency and duration, they were diagnosed as suffering from mood disorder, substance abuse, and antisocial personality disorder (Danielson, Moffit, Caspi, & Silva, 1998).

Assessment has been done to determine the association between intimate partner abuse and personality disorders. Back, Post, and D'Arcy (1982) found that 83% of battered women from a psychiatric ward were diagnosed as suffering from borderline or passive-aggressive personality disorders. Some researchers observed higher scores in antisocial, borderline, and obsessive-compulsive disorders (Gleason, 1993; Shields, Resick, & Hanneke, 1990). Using the Minnesota Multiphasic Personality Inventory (MMPI), studies were done to determine the presence of personality disorders among battered women. Rosewater (1988) found that battered women obtained higher elevation on psychopathic deviate, paranoia, and schizophrenia scales. In another study of 31 battered women, Khan et al. (1993) revealed that battered women had high scores on four MMPI clinical scales such as psychopathic deviate, paranoia, schizophrenia, and hypomania. The findings of the studies implied that elevations on MMPI scales were probably caused by the abuse experienced by the women rather than by any fundamental pathological development.

In addition to MMPI, Millon Clinical Multiaxial Inventory (MCMI) was also utilized to assess presence of personality disorder with battered women. Cogan and Porcerelli (1996) administered the MCMI-II to battered women and found that 28% of them obtained elevation on the dependent personality disorder scale. Another study explored the personality profiles and presence of psychopathological symptoms among eighteen (18) women attending the residential services for battered women. The finding was a predominance of schizoid personality pattern but a low presence of anxiety and depression (Pérez-Testor, Castillo, Davins, Salamero, & San-Martino, 2007). When Pico-Alfonso, Echeburúa, and Martinez (2008) compared the personality disorder symptoms of abused women with non-abused women, the finding was that women victims of intimate partner violence had higher scores in schizoid, avoidant, self-defeating personality pattern scales and in three pathological personality scales namely the schizotypal, borderline, and paranoid (Pico-Alfonso, Echeburúa, & Martinez, 2008). The manifestations of psychopathological symptoms may be perceived as the pervasive effects of abuse on the women. It is assumed that peculiar behavior manifested by the battered women may be considered as their survival technique to keep themselves and their children safe and to be in control of their environment to the best of their perceived capacities.

What are battered women like? It is difficult to construct a general psycho-logical profile for them and separate long standing characteristics associated to their psychosocial response to abuse. There are studies though showing the presence of pathological symptoms that developed as a consequence of abuse. But, there is little proof to identify a premorbid personality characteristics of the battered women (Goodman, et al., 1993) and that the literature of many studies in identifying the personality characteristics of battered women, tend to emphasize the negative attributes such as low self-esteem, helplessness, shame, and self-blame.

Walker's (1984) study showed no specific personality characteristics that suggest a victim-prone personality for battered women. This was supported by Browne (1987) whose data showed that although gender has an impact on being a victim of intimate partner abuse, no particular personality pattern leads to a person's becoming a victim. Herman (1992) suggests that the abuse caused battered women to undergo personality changes that make them susceptible to more episodes of abuse. Living with the daily threat and fear of abuse and possibly death affect how a woman thinks, feels, and behaves. This implies that the action of the perpetrators, rather than the premorbid functioning of the women, is responsible for producing these changes (Herman, 1992).

After a considerable review of these studies, the researcher discovered that so far, no study using the MCMI-II has yet been done to assess the personality profile of battered Filipino women. Thus, the researcher attempted using the MCMI-II to discover possible personality characteristics and presence of personality disturbance among the woman participants. Although the use of assessment with battered women has long been discouraged because of the possible labeling and perception that they have psychological disorder, it should also be considered that whatever information may be obtained is vital in identifying possible factors related to the vulnerability and the risk of manifesting maladaptive behavior. Knowledge of personality pattern of battered women provides implications that may be used to help mental health professionals, particularly the counselors, not only to identify problem areas for the clients but also to design appropriate therapeutic intervention.

In the light of the given information, the present study aims to determine and analyze the forms of abuse, the types of personality profile, and the manifestation of psychopathological symptoms in battered Filipino women – consequently to make the implications of the findings of this study help counselors specify the appropriate psychological and therapeutic support needed by the participants.

Method

Participants

The participants in this study were 20 battered women selected by using the non-random purposive sampling method from those recommended by professionals who know them and have worked with them.

The demographic information in Table 1 shows that the participants' age range from 20 years old to 52 years old, making an average age of 33.15 years. They have lived together with their respective abusive intimate partner from two (2) to twenty (20) years with an average of 11.25 years.

Table 1
Socio-Demographic Profile of the Battered Women

Variables		f
Age	50-54	2
	45-49	2
	40-44	3
	35-39	3
	30-34	3
	25-29	4
	20-24	3
Educational Attainment	Elementary	5
	High School	8
	College	7
Occupation	Housewife	7
	Unemployed	6
	Yaya	1
	housemaid	2
	Beautician	1
	Sewer	1
	Vendor	2
Marital Status	Separated	12
	Living with Partner	8
Years of Marriage	1-5	7
	6-10	5
	11-15	4
	16-20	2
	21-25	2
Number of Children	0-3	8
	4-7	9
	8-10	3

Twelve (12) of them left, making an average duration of 9.2 years of living with their respective intimate partner and eight (8) of them stayed on, making an average duration of 12.6 years.

Based on the participants' educational attainment and occupational engagement, most of them belong to the low socioeconomic bracket. In educational attainment, eight (8) finished high school, seven (7) reached college level, and five (5) finished their elementary schooling. In occupation, seven (7) of them are housewives, seven (7) are employed, and six (6) are unemployed.

The professionals who recommended them for participation in this study consisted of a psychologist, a social worker, and a representative from a

community health organization. Their recommendations were based on the following criteria requested of them to use by the researcher: (1) the participants have been victims of intimate partner abuse for at least one year; and (2) there was no manifestation of significant impaired mental state at the time of recruit

Instruments

Personal Information Sheet. This is a researcher-made personal information sheet composed to contain the following information: participant's name, age, educational attainment, occupation, marital status, years of marriage or stay with an abusive partner, and number of children.

Interview Guide Questions. This is a semi-structured interview guide consist-ing of questions deemed by the researcher to yield answers necessary in finding the different forms of abuse experienced by the women participants and other circumstances related to intimate partner violence.

Millon Clinical Multiaxial Inventory-II (MCMI-II). This is a 175-item self-report inventory which provides information for clinical assessment and for making evaluation related to treatment. Raw scores are transformed into base rate (BR) score to allow comparison to a normative group of clients and to reflect the nonnormal distribution. A base rate of 85 or greater suggests a disorder of clinical significance while a score of 75-84 indicates presence of characteristics of the disorder.

In the presentation of results, the researcher classified a score of 75-84 as moderate elevation and a base rate of 85 or greater as high elevation. MCMI-II contains two scales (desirability and debasement) that are used to detect the presence of sets and invalid profiles. In this study, women with valid profiles have been considered. The MCMI-II scales are divided into the following categories: Clinical Personality Pattern, Severe Personality Pathology; Clinical Syndrome, and Severe Syndrome.

Procedure

Twenty participants were identified from a non-government organization (*N*=8) that provides services to women victims of violence and three baranggay community centers (*N*=12) in Manila which handles community problems such as violence against women. An appropriate introduction of the researcher and the purpose of the study started off the interview and the administration of the MCMI-II. The entire session lasted from 1 to 11/2 hours. The participants were assured of the confidentiality of the interview and psychological test data.

Results

Forms of Abuse

The type of the intimate partner violence experienced by the women in the study is not consistent. The women struggle with diverse pattern of physical abuse, emotional abuse, sexual abuse, and economical abuse. The intensity of each form of abuse also differs. The responses of the women to the question about the forms of abuse experienced are summarized in Table 2.

Physical abuse. All the women in the study suffered physical abuse at the hands of their abusive partners or spouse. Likewise, all of them experienced combinations of physical abuse, most of them cannot recall the number of times they had been physically abused by their partners. Their experience of physical abuse varied from a simple assault (e.g., being punched, slapped, pushed or choked) to battering with a dangerous weapon (e.g., knife or gun). Four women were hospitalized due to injuries sustained through intimate partner violence.

Psychological abuse. As shown in Table 2, all the women experienced psychological abuse. Humiliation, which included being yelled at, uttering put downs and being labeled as worthless and incompetent, is a common element underlying psychological abuse in intimate relationships.

Even if psychological abuse is not accompanied by physical abuse, the women experienced threats of physical harm. Sixteen (16) women reported that their abusive partners terrorized them through their looks, gestures, or actions meant to remind them of their partners' capacity for physical violence such as punching walls, breaking things or holding deadly weapons. Eight of the women felt they were isolated because they were not allowed to socialize freely or to have a job. They were restricted from visiting their family or friends. The study also revealed that the spouse/partner's womanizing was another category of psychological abuse experienced by seven of the women in the study. Two of the women shared agonizing experiences that involved their children who were molested by their live-in partners.

Economic abuse. Money was another device used by which men can further control the women, ensuring their financial dependence on them. Eight women reported that they had inadequate financial support. They may be given money for their basic needs but they were required to submit receipts of spending.

Sexual abuse. Ten women revealed they were sexually abused by their partners. Seven of them reported that they had sex with their partners in response to the threat of violence. Two participants were forced to perform

unwanted sexual practices or humiliating acts during intercourse and one was forced to work as a prostitute to provide money for the family.

Table 2
Forms of Abuse Experienced by Women

Domain	Categories	f
Physical	Simple Assault and Battering	14
	Punched	7
	Slapped	8
	Pulled hair, dragged by hair	6
	Pushed, thrown, dragged	5
	Choked	12
	Kicked, butted repeatedly with head	10
	Assault and Battering with a Dangerous Weapon	
	Attacked with hard objects	15
	Threatened with a knife/gun	6
Emotional	Verbal Abuse	20
	Threats of physical harm	16
	Isolation	8
	Husband's womanizing	7
	Children molested	2
Economical	Inadequate financial support	8
	Mishandling of family income	5
Sexual	Marital rape/forced sex	7
	Unwanted sexual practice	2
	Exploitation through prostitution	1

MCMI-II Personality Profiles of the Woman Participants

The participants obtained high elevation on schizoid and moderate elevations on avoidant, schizoid, compulsive, and self-defeating personality pattern scales.

In terms of other scales (Severe Personality Pathology, Clinical Syndrome, and Severe Syndrome), the women had moderate elevations on anxiety, somatoform and dysthymia. The means and interpretation of base rate scores showing these results are given in Table 3.

Table 3
Means and Interpretation of Base Rate Scores of MCMI-II Scales

MCMI-II Scales	Base Rate Score	Interpretation
Clinical Personality Pattern		
Schizoid	85	High Elevation
Avoidant	81	Moderate Elevation
Dependent	66	Average
Histrionic	58	Average
Narcissistic	70	Average
Antisocial	66	Average
Aggressive-Sadistic	67	Average
Compulsive	81	Moderate Elevation
Passive-Aggressive	65	Average
Self-Defeating	78	Moderate Elevation
Severe Personality Pathology		
Schizothypal	73	Average
Borderline	71	Average
Paranoid	69	Average
Clinical Syndrome		
Anxiety	80	Moderate Elevation
Somatoform	73	Average
Bipolar-Manic	59	Average
Dysthymia	83	Moderate Elevation
Alcohol Dependence	58	Average
Drug Dependence	55	Average
Severe Syndrome		
Thought Disorder	69	Average
Major Depression	69	Average
Delusional Disorder	64	Average

Table 4 shows significant results for each participant. Schizoid personality scale is present in the profile of 15 women. The avoidant personality pattern is apparent in 11 profiles. Likewise, compulsive and self-defeating personality patterns are found in 10 profiles. There are instances when these four personality pattern scales (schizoid, avoidant, compulsive, and self-defeating) are present in the same profile. There are five instances when schizoid, avoidant and self-defeating are found in the same profile. Elevations of scores in schizoid, avoidant, and compulsive personality patterns are found in four profiles. In further two instances, schizoid, compulsive, and self-defeating personality patterns are present in the same profile. There are also cases when these four personality patterns are combined with other scales. Despite the individual differences, the presence of schizoid, avoidant, compulsive and self-defeating personality patterns is evident in the profiles of the participants.

Table 4
MCMI-II Personality Pattern and Clinical Scales with a BR > 75

WOMEN	MCMI-II Profile		
	BPP	CS	SS
P1	Schizoid, Narcissistic		
P2	Schizoid, Compulsive, Self-Defeating		
P3	Schizoid, Avoidant, Dependent, Compulsive	Anxiety, Somatoform, Dysthymia	Major Depression
P4	Avoidant, Dependent, Compulsive	Anxiety, Somatoform, Dysthymia	
P5	Avoidant		
P6	Schizoid, Avoidant, Self-Defeating	Anxiety, Dysthymia	Major Depression
P7	Schizoid, Avoidant, Compulsive	Anxiety, Somatoform	
P8	Schizoid, Avoidant, Compulsive, Self-Defeating	Anxiety	
P9	Histrionic, Anti-social		
P10	Schizoid, Compulsive, Self-Defeating	Anxiety, Dysthymia	
P11	Schizoid, Avoidant, Compulsive	Somatoform, Dysthymia	
P12	Schizoid, Compulsive, Self-Defeating	Anxiety, Drug Dependence	
P13	Schizoid, Avoidant, Compulsive Passive-Aggressive		
P14	Schizoid, Avoidant, Self-Defeating	Anxiety, Dysthymia	Major Depression
P15	Narcissistic, Passive-Aggessive		
P16	Schizoid, Compulsive, Self-Defeating	Anxiety	
P17	Schizoid, Avoidant, Dependent, Self-Defeating	Anxiety, Dysthymia	
P18	Histrionic	Anxiety, Somatoform	
P19	Schizoid, Avoidant, Self-Defeating	Anxiety, Dysthymia	
P20	Schizoid, Avoidant, Dependent, Self-Defeating	Anxiety, Dysthymia	

In terms of the Clinical Syndrome, 13 women obtained moderate elevation in the anxiety scale and 10 in dysthymia scale. As regards the Severe Syndrome, three women obtained moderate elevations in the major depression scale.

Discussion

The study aims to determine and analyze the forms of abuse and personality profile of 20 battered women from a shelter home for women and community-health based centers.

Forms of Abuse

The findings here show that all the woman participants suffer physical and psychological at the hands of their respective abusive partner. Most of these abuses happen when the respective abusive partner of the woman participants is under the influence of alcohol or drugs.

The psychological abuse, on the other hand, is oral in nature. It did not show any visible sign of abuse but the woman participants said that they feel intimidated, humiliated, and isolated. They also feel that their self-concept and identity are undermined and violated. All of these, according to the woman participants, are as damaging and heartbreaking as physical abuse

Most of these woman participants are financially dependent on their respective partner and are consequently forced to ask or beg for money from them to meet the basic needs of the family. This dependency opens their condition to economic abuse and gives the abusive partner other means to humiliate and control them.

The last form of abuse experienced by the woman participants is sexual abuse in the form of non-consensual sex. Some of them however, are reluctant to share this experience because they believe that it is their obligation to satisfy the sexual needs of their respective partner or spouse.

MCMI-II Personality Profiles of the Women

Personality Pattern. Through the use of the MCMI-II, several personality profile patterns of the woman participants came out. The personality profile patterns are the (1) schizoid personality pattern, (2) avoidant personality pattern, (3) compulsive personality pattern, and (4) self-defeating personality pattern. In addition to these personality patterns, a clinical syndrome also came out in their profile.

Schizoid Personality Pattern. This personality pattern comes out predominant in the profile of the participants. Women with this personality pattern tend to have little self-awareness of insight into the implications of their interpersonal relationship and that their experience of abuse may give rise to shame (Millon, 1987). They choose to distance themselves from others because they are not comfortable with the idea of other people knowing about their abuse (Garcia, Garcia, & Lila, 2009).

Studies on battered women's survival strategies reveal that women tend to be in cahoots with their abusive partner in helping portray the abuse as indiscernible caused by shame (Garcia, Garcia, & Lila, 2009; O'Leary, 1999).

This is their way of protecting whatever "social integrity" is left with them. Their "silence" only protects their abusive partner, thus, propagating the abuse. There are also participants who allowed the researcher to have a glimpse of their horrifying world with their partner or spouse. During interviews, these women appear detached and often smile when describing their life-threatening experiences, separating their affective response such as fear, embarrassment, and fright from their description. The intensity of the abuse tends to make the women learn not to recognize their feelings. Some of them believe that being beaten may be easier to endure if they fasten from any emotional response to the abuse. This implies that the woman participants are detached, impersonal, and rarely seek involvement (Maiuro & O'Leary, 2001).

Avoidant personality pattern. The profile of the woman participants also reveals the presence of avoidant personality pattern. This indicates that the women tend to perceive themselves as inadequate, socially inept, and inferior (Millon, 1987). Most of the participants expressed the belief that their self-esteem crushed as a result of repeated abuse by their respective intimate partner or spouse (O'Leary, 1999). The physical blows, frightening threats, repeated insults, and baseless accusations hurled at them slowly ate away their sense of self-worth and self-concept. Some of the participants felt themselves like trash, a feeling which made them lose their self esteem. They do not anymore believe in their own abilities, particularly in their ability to make competent and realistic decision concerning their lives (La Violette & Barnnet, 2000). This afforded the abusive partner more opportunities to control them. Likewise, the presence of avoidant personality pattern also implies that the women seem to overreact to minor events. The typical fear, the anticipation of further attack, and magnified unpredictable nature of assaults trigger the women to become hyperarousal (Lehmann & Spence, 2007). It is significant to note that avoidant personality pattern is combined with high elevation in schizoid scale. This shows that the women are not only uninterested and unskilled in interpersonal relationship but also uncomfortable around people because they fear rejection. The abuse is the source of the feeling of being rejected and the abuse was done by the person who was expected to love and protect them. How can they expect others to accept or like them?

Compulsive personality pattern. The compulsive personality pattern in the profile of the battered women reveals that they are more likely to do better in structured and concrete working environment but they have difficulty in adjusting to changing working situations that require spontaneous response (Millon, 1987). The combination of schizoid and compulsive personality patterns suggests that the women may also be absorbed in their own sufferings, although they are emotionally controlled. In the midst of their threatened and confused lives, they believe that it is better for them to be restrained and disciplined and always conforming to their partners' wishes (Tifft, 1993).

Most women run around the house, making sure that everything is "perfect" in the eyes of their partner or spouse so as not to trigger his rage. Some of them even said that there were times when small mistakes such as disarranged toys or chairs would allow to set off their partner's fury. Situated in an environment like this, they were always vigilant, watchful, controlled, and scared.

Self-defeating personality pattern. The presence of self-defeating personality pattern in the profile of the participants implies self-sacrificing traits of the women (Millon, 1987). They may often avoid pleasurable experiences. For them, pleasure is perceived as something they do not deserve. They may be weighed down by their deep inner guilt and their sense of never ending, unfulfilled obligations for others, particularly their partner and children. They may not be able to express their anger at people they care for or even deny that they harbor such feeling. In time, the erratic and persistent abuse weakens the battered women, upholding pessimism (Vitanza, Vogel, & Marshall, 1995). The women reported that they tried to initiate solution-focused techniques such as talking with their partner and trying to become better wives to alleviate their partner's anger, but they were unsuccessful. With such failure, slight changes happen in the woman's consciousness until all driving force to avoid the abuse seem to wane and the women unconsciously become passive in their response to their partner's rage. The self-defeating personality pattern may explain why women stay in abusive relationships.

Clinical Syndrome. The clinical syndromes present in the profile of the woman participants are anxiety and dysthemia.

Anxiety in its severe degree is the prevalent emotional experience (Gleason, 1993; Kaser-Boyd, 2004). This shows them with a world psychologically filled with tension. Most women expressed that they almost die of fright whenever they hear the drunken voice of their partner or spouse because they do not know what would happen to them. Campbell (2003) found that the consequence of any form of abuse may produce increased level of anxiety. Violent acts of an abusive partner is perceived by women as an imminent doom that could make them quiver and terrified, constantly sad and apprehensive.

Dysthymia reflects hopelessness and pessimism (Millon, 1987). The unpredictable and persistent abuses incapacitate the battered women. These can make them uphold feelings of powerlessness and helplessness instead of empowerment and usefulness. They may remain involved in everyday life but they nurture feelings of discouragement, guilt, and self-doubt. At their lowest ebb, they may succumb to suicidal ideation, social withdrawal, and diminished effectiveness in their day-to-day functioning.

The personality profile of the women may reflect the typical effects of the abuse. Somehow it was able to portray the range of symptoms typically manifested by battered women. However, the women's reaction to abuse

varies. Some of women exhibited only one personality pattern but profiles of other women revealed combinations of personality patterns. Presence of some clinical syndromes was also found in most profiles. The variation in the women's personality profile may depend on variety of abuse-related factors such as characteristic of the abusive relationship, the circumstances surrounding the abuse, the characteristics of the women themselves, and the intensity of the abuse experienced.

Implications for Counseling

Personality profile of the participants reveals predominance of schizoid personality pattern and presence of avoidant, compulsive, and self-defeating personality styles. Also, the woman participants manifested clinical syndromes of anxiety and dysthymia. Given this profile, the counselors would now know the need to focus on some issues in order to understand the dynamics of battered women and in identifying appropriate psyhosocial and therapeutic support they need.

With schizoid personality pattern coming out dominant in the profile of the participants, it is vital to address concerns related to their tendency towards interpersonal distance and emotional withdrawal. Given this information, counselors must be prepared and patient for long silences and distant relationships. Their initial goal with them is to increase their social interaction and then gradually make them feel as comfortable as possible.

Counselors can take into consideration that these women are weakened physically and emotionally and need someone to empathize with them with genuine concern. In getting to know them, it is important that they be made to know that they do not have to share anything they do not want to reveal. Once they develop trust, they may slowly unveil important information about them.

However, it is also important that they be assured of the handling with confidentiality all the information they volunteered to share. Without this assurance, they may be afraid to open up. They may be afraid again of their partner for their possible turning on them vengeful if they find out they asked help from others. That is why it is important that they be assured that no information will be given without their consent.

Emotional withdrawal is another issue to be addressed among the participants. Recovery may include relearning to feel and to express their feelings appropriately.

With woman participants manifesting avoidant personality pattern, initially, the biggest issue in handling them is their minimizing of situation (Wilson, 2006). They may appear credible if they say that they are in control of what is happening to them. They may also express that they are simply doing what their partner wants them to do and that they have nothing to fear. That is why the important task counselors need to work out in them is the making of them able to overcome denying and minimization. Counselors should make them understand how their rights as persons have been violated and then

focus their intervention on lessening the risk of harm, on the possibility of leaving their respective abusive partner and on addressing the psychological effects of abuse. If the women would still decide to stay with their abusive partner, the counselor may help them realize the consequences of such decision.

Another issue related to having avoidant personality pattern is the high level of arousal which may be the primary reasoning for prematurely terminating counseling. The counselors may use techniques such as arousal reduction, muscle relaxation, and thought stopping.

Then with women manifesting compulsive personality pattern, in as much as they have difficulty releasing internal tension and that they may perceive as violation of their privacy any requirement for them to do self-exploration, counselors can handle them well if initially, they do not make them do so. They would rather best start by providing them emotional support and then making them examine, experience, and express their feelings. Then, they can focus on working out on the women's irrational pattern of behavior and the consequences of such on their well-being and day-to-day functioning.

With women in whom self-defeating personality pattern in the profile is present, the big challenge to counselors is that of making the battered women happy. This is not easy to achieve if these women do not want to be happy. They have endured the abuse and therefore they have been used to being always dump and humiliated. The women may no longer feel that they deserve any pleasure and happiness this world can offer them. The longer the women have lived in an abusive relationship, the more difficult they will find to stand up for themselves. They have to be supported to be assertive and empowered. They need to recognize their strength as a person and this can be achieved by embracing an empowerment mode of counseling (Dutton, 1992). Central to this is helping the women realize that they have choices in life and that they can make decisions that promise their worth and dignity. Helping them shed light on their rights and develop skills to protect them from being exploited would be significant milestones toward the womens' healing process.

The abuse has done much damage to the women. The most obvious repercussion is their slaughtered self-esteem. To recover, they need to believe that they can survive. They need to recognize their worth and value. An initial step then that can be taken for them is to help them believe that they can influence and change themselves and the course of their lives. They can create a world bigger, better, and brighter than the one created by their abusive partner or spouse.

Implications for Assessment

Assessment of intimate partner violence tends to focus on the woman and her experiences. There must be specific reasons for doing this. Considering battered women's unique set of responses to their abusive experiences and discrete collection of posttraumatic repercussions, there is much to know, explore, and assess.

Clinicians and researchers have varied reasons and methods to assess the dynamics of battered women. The common reason given is to describe accurately the psychological functioning of the battered women. To be specific, clinicians and researchers want to understand the psychological factors related to the decision of staying in and leaving an abusive relationship. The present study focused on the evaluation of the personality patterns, presence of psychopathological symptoms and forms of abuse directed at the participants. It was limited to the use of semi-structured interview and the MCMI-II. Depending on the goal of the clinician, there are various assessment tools that can be utilized.

There are scales that have been commonly used in clinical setting with battered women. To measure forms of aggression and violence in the family, Conflict Tactic Scales can be employed (Strauss, 1979). For the assessment of the depression, anxiety, and other abuse-related problems exhibited by the battered women, Symptom Checklist-90-R (Deragotis, 1977), Trauma Symptom Inventory and Beck Depression Inventory (Beck & Steer, 1987) can be used.

Battered women's traumatic reactions are necessary for understanding the extent of their psychological disturbance. For this purpose, more complicated psychological tests such as MMPI-2 (Wilson & Walker, 1990) and MCMI-III may be administered to the battered women. Likewise, Rorschach, a projective test, has been used test to assess the effects of abuse and to describe a more complete psychological functioning of battered women (Kaser-Boyd, 2004). MMPI-2, MCMI-III, and Rorschach have provided clinicians and researchers not only a complete profile of battered women, these tests are able to measure and identify severity of the effects of abuse. Given this information, some questions have been raised: Are there particular personality profiles that specify women who are susceptible to become abused? Are the pathological symptoms developed directly as a result of the abuse? Likewise, clinicians are also cautioned to make their interpretation and diagnosis unless there are other supporting data available.

The use of standardized tests is highly recommended in making a comprehensive clinical picture of the battered women. However, the psychological tests may not be able to ask pertinent questions related to battered women's personal/family history and other significant factors that contributed to battered women's trauma profile. Hence, there is a need to employ other assessment devices such as clinical interview and observation. Given the complexity of battered women's experiences, clinical interview and observation may be used to assess their mental or emotional state. Clinical interview may be effective for defining the presenting problem and obtaining thorough information from which clinicians can analyze battered women's response to abuse.

Indeed, assessment of intimate partner violence is complex. The field of assessment has much to offer considering the increase of more sophisticated assessment tools that are available in the market. This results to more accurate assessment of the abuse-related disturbances that leads to a more effective intervention for battered women.

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Dr. Alicia F. Estrellado is presently an assistant professor at the Counseling and Educational Psychology Department of the De La Salle University. She holds a Ph.D in Counseling Psychology, major in Clinical Counseling, from the De La Salle University. Dr. Estrellado has worked with individuals in clinical setting. Her interest in psychopathology grew out of her work as a guidance psychologist at the Armed Forces of the Philippines Medical Center, Psychiatry department. She also taught at the College of the Holy Spirit for 29 years.