Use of the MMPI-2 in Child Custody Evaluations Involving Battered Women: What Does Psychological Research Tell Us?

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I. Introduction

The effects of domestic violence on survivors, who are primarily women, may be severe. Battered women's advocates often note that, in custody cases, the batterer often "looks better" to the court than the victim does because he is confident and calm, whereas she is still suffering the effects of his abuse and therefore may appear hysterical, weepy, angry, or otherwise not "together."[1]

When a custody evaluation is conducted by a psychologist, the revised version of the Minnesota Multiphasic Personality Inventory (MMPI-2) is often used as part of the evaluation process.[2] The MMPI-2, like other traditional psychological tests, was not designed for use in custody evaluations

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1. LUNDY BANCROFT & JAY SILVERMAN, THE BATTERER AS PARENT 122-23 (2002); Joan S. Meier, *Domestic Violence, Child Custody, and Child Protection: Understanding Judicial Resistance and Imagining the Solutions*, 11 AM. U.J. GENDER SOC. POL'Y & L. 657, 690 (2003); Joan S. Meier, *Notes from the Underground: Integrating Psychological and Legal Perspectives on Domestic Violence in Theory and Practice*, 21 HOFSTRA L. REV. 1295, 1312 (1993).

2. Marc J. Ackerman & Melissa C. Ackerman, *Child Custody Evaluation Practices: A 1996 Survey of Psychologists*, 30 FAM. L.Q. 565, 573 (1996).

and arguably should not be used for such purpose except "when specific problems or issues that these tests were designed to measure appear salient in the case."[3] However, if an evaluator chooses to use it, great care should be taken to make sure that it is not misinterpreted. A misinterpretation could result in placing custody of a child with a batterer, which could put the child at severe risk. Additionally, for many parents, especially those who have been primary caretakers, loss of custody of their children is the most frightening thing they can imagine, short of death. Loss of such an important liberty interest should not occur because of flawed information presented to the court by anyone, including one deemed to be an expert.

Abusers typically disavow any wrongdoing and claim the mother is "crazy" or unfit in some other way.[4] The MMPI-2 cannot disprove a batterer's claim of innocence, because there is no known MMPI-2 abuser "profile."[5] In fact, many MMPI-2 profiles of batterers do not reveal any psychopathology.[6]

Battered women, however, based on the results of the MMPI-2, may appear to be suffering from various psychopathologies, including but not limited to borderline personality disorder, paranoia, histrionic personality disorder, or even schizophrenia.[7] The custody evaluator may conclude that the mother's apparent psychopathology is a personality disorder and

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3. GARY MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 503 (2d ed. 1997).

4. Judith L. Herman, *Crime and Memory*, *in* TRAUMA AND SELF 3, 11-12 (Charles B. Strozier & Michael Flynn eds. 1996); *cf.* Catherine Ayoub et al., *Alleging Psychological Impairment of the Accuser to Defend Oneself Against a Child Abuse Allegation: A Manifestation of Wife Battering and False Accusation*, *in* ASSESSING CHILD MALTREATMENT REPORTS: THE PROBLEM OF FALSE ALLEGATIONS 191, 201-03 (Michael Robin ed. 1991) (finding that in a study of mothers who alleged fathers abused their children, but where fathers alleged the mothers were "crazy," investigation revealed that all the fathers were abusive to the mothers).

5. Randy K. Otto & Robert P. Collins, *Use of the MMPI-2/MMPI-A in Child Custody Evaluations*, *in* FORENSIC APPLICATIONS OF THE MMPI-2 (Yossef S. Ben-Porath et al., eds. 1995). Research using the other most commonly used personality assessment tool, the Millon Clinical Multiaxial Inventory (MCMI) likewise has not demonstrated any one batterer profile. Robert J. Craig, *Use of the Millon Clinical Multiaxial Inventory in the Psychological Assessment of Domestic Violence: A Review*, 8 AGGRESSION & VIOLENT BEHAVIOR 235, 240 (2001).

6. Amy Holtzworth-Munroe & Gregory G. Stuart, *Typologies of Male Batterers: Three Subtypes and the Differences Among Them*, 116 PSYCHOLOGICAL BULL. 476 (1994) and sources cited therein; Gayla Margolin, *Interpersonal and Intrapersonal Factors Associated with Marital Violence*, *in* FAMILY ABUSE AND ITS CONSEQUENCES: NEW DIRECTIONS IN RESEARCH (Gerald T. Hotaling et al., 1988); Catherine Wall, *Battered Women and their Batterers: Personality Variables and Attitudes Toward Violence* (1993) (unpublished Ph.D. dissertation, California Institute of Integral Studies) (U.M.I. No. 9324523).

7. Lynne B. Rosewater, *Battered or Schizophrenic? Psychological Tests Can't Tell*, *in* FEMINIST PERSPECTIVES ON WIFE ABUSE (KERSTI YLLO & MICHELE BOGRAD EDS., 1988); LENORE E. WALKER, ABUSED WOMEN AND SURVIVOR THERAPY: A PRACTICAL GUIDE FOR THE PSYCHOTHERAPIST 75 (1994) (*see also* 111-13 and 379 for further discussion of problems of misdiagnosis).

therefore characterological (a "trait"). Personality disorders are viewed by many psychologists as highly treatment resistant and therefore curable, if at all, only with very long-term therapy and often psychotropic drugs.[8] The custody evaluator might even conclude that the mother's apparent "psychopathology" caused the physical conflict between the parents.

> Clinicians inadvertently maintaining such assumptions may examine a battered woman's profile and conclude, "Oh, no wonder she gets beat up. She's crazy, schizophrenic, borderline, and unstable," and the clinician may fail to investigate alternative conceptualizations for the woman's psychological presentation.[9]

Failure to investigate other possible causes could even lead the custody evaluator to doubt whether the woman was abused at all—perhaps someone so unstable has made false allegations or perhaps she has attacked her partner and he has simply acted in self-defense.

An "alternative conceptualization" is that the woman's psychological presentation is a reaction to the abuse she has suffered (a reactive "state"). If battered women's MMPI elevations are reactive, one would expect that their MMPIs prior to being battered would be relatively "normal," that their MMPIs during the battering relationship would be elevated, and that their MMPI elevations would decrease after the abuse ended. Additionally, it might be expected that the severity of the abuse suffered by the woman or the length of time she was abused might correlate with the MMPI elevations.

This article surveys the available research on battered women's MMPI/MMPI-2 profiles. That research tends to support the hypothesis that a battered woman's MMPI-2 profile often is a result of the abuse she has suffered (a reactive "state") and therefore should not be viewed by child custody evaluators as evidence that she has personality traits indicating that she would not be a fit parent.[10]

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8. THEODORE MILLON & ROGER DAVIS, PERSONALITY DISORDERS IN MODERN LIFE 87 (2000).

9. John Morrell & Linda Rubin, *The Minnesota Multiphasic Personality Inventory-2, Posttraumatic Stress Disorder, and Women Domestic Violence Survivors*, 32 PROF. PSYCHOL: RES. & PRAC. 151 (2001).

10. Mention should be made of the assumption by some mental health practitioners that domestic violence causes the quality of the victim's parenting capabilities to suffer. *See* Cris M. Sullivan et al., *Beyond Searching for Deficits: Evidence that Physically and Emotionally Abused Women Are Nurturing Parents*, 1 J. EMOTIONAL ABUSE 51, 52 (2000). If one accepted this assumption, one could draw the conclusion that custody to the battered mother might not be in the best interests of the child. Even putting aside the important and obvious, but often overlooked, question of whether custody to the abuser of the child's mother would be more likely to be in the best interests of the child (*see generally* BANCROFT & SILVERMAN, *supra* note 1), research does not support any assumption that the mother's parenting capabilities are substantially impaired by the domestic violence she suffered. *Id.* Individual battered women, like individual nonbattered women, may have parenting deficits (as well as strengths), but no assumptions should be made that all battered women are incapable of being good parents to their children, especially after the abusers have been removed from the home and the battered mothers have had time to recover from the abuse. Alytia Levendosky & Sandra Graham-Bermann, *Behavioral*

II. What Is the MMPI-2?

The original (1942) MMPI was a self-report questionnaire, containing 566 questions to be answered yes or no.[11] The MMPI-2 (1989) is a revised version, containing 567 questions. Based on the answers the testee gives to those questions, the testee's score is generated for each of the MMPI clinical scales. The names of the scales, along with approximate ordinary language descriptions of what the scales appear to measure, are as follows:

1. Hypochondriasis (Hs): concerns about one's body and health.
2. Depression (D): depression.
3. Hysteria (Hy): repression or tendency to sit on one's feelings.
4. Psychopathic Deviate (Pd): anger
5. Masculinity-Femininity (Mf): a high score may indicate lack of comfort with one's biological sex or cultural sex roles.[12]
6. Paranoia (Pa): fearfulness, suspicion
7. Psychasthenia (Pt): anxiety, worry, or tension.
8. Schizophrenia (Sc): confusion in thought processes; feelings of being overwhelmed.
9. Hypomania (Ma): a high score may indicate high activity level
10. Social Introversion (Si): high indicates introverted; low indicates extroverted.

The names of scales 1-4 and 6-9 are labels that were standard diagnoses at the time the MMPI was first being developed, but improvements in diagnosis and treatment of mental illnesses since that time have made many of the names outmoded and misleading. Additionally, elevations on a particular scale do not necessarily indicate the testee can be diagnosed as having the mental disorder or condition matching the "name" of that scale. The categories of mental disorders currently commonly used by psychiatrists and psychologists are those found in the fourth edition of the *Diagnostic*

Observations of Parenting in Battered Women, 14 J. FAM. PSYCHOL. 80 (2000). Nor should a battered mother be viewed as neglectful simply because domestic violence occurred in her home. *In re* Nicholson, 181 F. Supp. 2d 182 (E.D.N.Y. 2002) (granting a preliminary injunction against the city of New York, prohibiting the city from removing children from mothers who were victims of domestic violence because, as victims, they "engaged in domestic violence"). In Nicholson v. Williams, 203 F. Supp. 2d 153 (E.D.N.Y. 2002), Judge Weinstein elaborated on the grounds for the injunction. In Nicholson v. Scoppetta, 3 N.Y.3d 357, 820 N.E.2d 840 (N.Y. 2004), the New York Court of Appeals addressed three questions certified to it by the federal court, and held that exposing a child to domestic violence is not presumptively neglectful.

11. Except as otherwise noted, the following discussion of the MMPI and the MMPI-2 is taken from ALAN F. FRIEDMAN ET AL., PSYCHOLOGICAL ASSESSMENT WITH THE MMPI-2 (2001).

12. Scale 5 was added after the MMPI was originally published—as was scale 0—and is not truly a clinical scale in the same sense as scales 1-4 and 6-9. *See* FRIEDMAN ET AL., *supra* note 11, at 112-19 and 316-20. This article will not attempt to analyze battered women's scores on scale 5.

and Statistical Manual of Mental Disorders (DSM-IV), published in 1994, to which text revisions were added in 2000 (DSM-IV-TR).

The MMPI was first published in 1942. The MMPI revisors did not attempt to track the symptoms of the mental disorders as categorized in any version of the DSM. Therefore, for example, a testee with clinical elevations on the MMPI-2 8 (Sc) scale may not meet the DSM-IV-TR diagnostic criteria for schizophrenia. For these reasons, numbers rather than names are now used to describe the MMPI-2 clinical scales.[13]

A testee's raw scores on the scales are converted into uniform T scores so that scores on the different scales can be compared. Someone who achieves a uniform T score of fifty on a clinical scale has scored at about the fifty-fifth percentile, which means that about 45% of the population would score above fifty. It is usually recommended that a T score of sixty-five or above be considered in the "clinically significant" range.[14] Some prefer to use seventy as the cutoff. A uniform T score of sixty-five is at the ninety-second percentile, which means that only 8% of the population would score above sixty-five. Similarly, only 1% would score above eighty.

In addition to the clinical scales, the MMPI also has "validity" scales, which seek to measure the mindset of the testee toward taking the test. For example, most testees trying to convince a judge or jury of an insanity defense would try to "fake bad." Most parents involved in child custody evaluations would want to try to look as good as possible.[15] The issue of how batterers and battered women score on the validity scales is an important one, but is outside the scope of this article.

A. How the MMPI Was Created

The original purpose of the MMPI was for differential diagnosis of psychiatric patients (*e.g.*, as depressed, schizophrenic, paranoid, etc.) and to weed out military inductees with psychiatric disorders. That is not the main purpose of the MMPI-2 at the present time.

The creators of the original MMPI started out by formulating about

13. *See* FRIEDMAN ET AL., *supra* note 11, at 9; JOHN R. GRAHAM, MMPI-2: ASSESSING PERSONALITY AND PSYCHOPATHOLOGY 225-26 (1993); ROBERT M. KAPLAN & DENNIS P. SACCUZZO, PSYCHOLOGICAL TESTING: PRINCIPLES, APPLICATION, AND ISSUES 412 (4th ed. 1999).

14. FRIEDMAN ET AL., *supra* note 11, at 21-22, referencing J.N. BUTCHER & C.L. WILLIAMS, ESSENTIALS OF MMPI-2 AND MMPI-A INTERPRETATION (1992).

15. Kay Bathurst, et al., *Normative Data for the MMPI-2 in Child Custody Litigation*, 9 PSYCHOL. ASSESSMENT 205 (1997); Allan Posthuma & James Harper, *Comparison of MMPI-2 Responses of Child Custody and Personal Injury Litigants*, 29 PROF. PSYCHOL.: RES. & PRAC. 437 (1998); Jeffrey Siegel, *Traditional MMPI-2 Validity Indicators and Initial Presentation in Custody Evaluations*, 14 AM. J. FORENSIC PSYCHOL. 55 (1996); Otto & Collins, *supra* note 5, at 245 (noting that the MMPI validity scales can be useful even when both parents respond defensively if one parent responds much more defensively than the other).

1,000 questions for possible use on the MMPI. Some questions were obviously related to the diagnoses, but more questions were not. Each of those questions was then tested on three groups: (1) individuals in a psychiatric setting diagnosed with a specific psychiatric disorder (*e.g.*, depression); (2) individuals in a psychiatric setting with diagnoses other than the specific disorder being targeted; and (3) "normal" people drawn from the community. The creators of the MMPI retained a question for use in the MMPI if the responses to it differentiated between (1) institutionalized individuals with the specific diagnosis (*e.g.*, depression) and institutionalized individuals with other diagnoses; and (2) institutionalized individuals with the specific diagnosis (*e.g.*, depression) and "normal" individuals.

In the 1930s and 1940s, it was believed that persons in clinical psychiatric settings could be categorized as certain discrete psychiatric types. We now know that things are not so simple—there are many more diagnoses and many overlap.

Gradually, the MMPI and MMPI-2 were put to a different purpose, which is the reason for its current popularity: to "generate descriptions of and inferences about individuals (normal subjects and patients) on the basis of their [MMPI] profiles."[16] For example, if a person had significant elevations on the 4 and 8 scales, an inference could be drawn that s/he had characteristics similar to other persons who had significant elevations on those scales and that s/he would demonstrate behaviors similar to those persons. What must be kept in mind is that inferences are only inferences, and may prove to be incorrect as to a particular person tested.

B. How to Interpret an MMPI-2 Profile

Assuming that the individual being tested submitted an answer sheet that did not omit or double-mark a significant number of answers,[17] the examiner would then proceed to interpret the results of the MMPI-2 validity scales. This article will not address the validity scales, which are complex, except to say that these scales attempt to determine the general mind-set of the person as he or she is taking the test. Persons who are taking the MMPI-2 as part of a custody evaluation normally would try to answer in such a way as to present themselves in a good light.[18] Consequently, the examiner would need to take that into account when interpreting the MMPI-2 data.

16. GRAHAM, *supra* note 13, at 8.

17. If too many items are omitted or double-checked, the results will be invalid. *See* FRIEDMAN ET AL., *supra* note 11, at 186-87.

18. Presenting oneself in a good light to an extreme degree is sometimes called "faking good." Child custody evaluators must be aware of, and take into account, the possibility that parents may be "faking good." *See* sources cited in note 15, *supra*.

A common way to interpret MMPI-2 elevations is to determine a participant's two or three highest clinical T score values and designate those two or three numbers (in descending order) as the two-point or three-point code of the individual.[19] For example, if an individual's three-point code was reported as 247, this would mean that her highest score was on the depression (2) scale, her second-highest score was on the psychopathic deviate (4) scale, and her third-highest score was on the psychasthenia (7) scale.

The second step in the interpretation process is to consult interpretation manuals sometimes referred to as "cookbooks,"[20] describing the personality characteristics and behaviors of individuals that could be predicted based on the code patterns. For example, in one such book an individual with a 247 three-point code is described in part as follows:

> This code pattern reflects an anxious, guilty, acting-out individual. Essentially, 27/72 persons are hyperresponsible "worriers," 24/42 individuals feel angry, defeated, and depressed; and 47/74 persons show compulsive, cyclical acting out followed by remorse and guilt. Taken together, these codes reflect a person who is hyperresponsible but self-defeating, anxious and guilty but acting out, clinging and dependent but emotionally distancing.[21]

Such a description can then be used by the examiner to formulate hypotheses about the individual being tested, whose personality may or may not actually correspond to the "typical" 247 individual.

Services exist that will provide computer-generated MMPI-2 interpretive reports, so that the examiner does not have to consult interpretation manuals. The danger of relying on these reports is obvious, but some examiners do so nonetheless.[22] Such reliance could be particularly harmful to battered women.[23] A custody litigant prejudiced by overreliance on such reports would have no way of knowing about such overreliance without obtaining all the raw data used by the examiner. Therefore, discovery of the raw data is extremely important.[24]

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19. The MMPI-2 can be scored by hand, but errors in scoring can easily occur. There are companies that provide computerized scoring services for a fee, so that the risk of human error can be avoided (assuming the computers are correctly programmed). FRIEDMAN ET AL., *supra* note 11, at 183, n.6. These companies also provide computerized interpretation services, which are discussed at text accompanying notes 22-24 *infra*.

20. *See, e.g.*, GRAHAM, *supra* note 13, at 270.

21. FRIEDMAN ET AL., *supra* note 11, at 262-63.

22. GRAHAM, *supra* note 13, at 275.

23. Lynne B. Rosewater, The Problems with Computerized Test Interpretations in a Forensic Arena 6 (Unpublished paper presented at the Annual Meeting of the American Psychological Association, Boston, MA, August 24, 1999, on file with the author).

24. Timothy M. Tippins, *Custody Evaluations—Part IV—Full Disclosure Critical*, N.Y. LAW JOURNAL 1/15/04, p. 3, col. 1.

The third step in the interpretation process is for the examiner to scrutinize the content scales and subscales and "critical items" endorsed by the individual, and to examine any possibly relevant supplementary scales.[25] Some child custody evaluators seem to omit or gloss over this step.[26] This article will not address this step in the process further except to mention the Posttraumatic Stress Disorder (PTSD) supplementary scale (PK) in Part III. E. below.[27]

The fourth step in the interpretation process is to place the MMPI results in the context of relevant data about the individual. Friedman et al. caution that certain "potent factors" specific to the individual should be considered:

> The MMPI-2 user should be particularly alert to the need to modify MMPI-2 clinical interpretations because of a person's age, intelligence, social or ethnic class, educational level, health status, medication influences, *prior life traumas, and current situational difficulties*.[28]

Friedman et al. give an example that is highly relevant to the issue of battered women:

> [Participants] sometimes obtain profiles that initially appear more pathological than is warranted once the referral question, current situation, and background information are obtained. For example, a client with an MMPI-2 profile peaking on Scale 4 with T scores about 70 may be going through a difficult divorce. Somewhat alienated and experiencing difficulties with trust, this individual may be responding understandably to his or her current difficulties.[29]

If all child custody evaluators carefully followed this recommended procedure by putting the MMPI-2 results into the context of the individual's history and current situation, it is likely that fewer misdiagnoses of battered women would occur. Overreliance on a computer-generated interpretive report would hinder this procedure and is an additional reason why such reports should not be followed slavishly.

III. MMPI-2 Profiles of Battered Women

A. MMPI-2 Scores Prior to Battering

As might be expected, no reported studies have investigated the MMPI-2

25. *See* FRIEDMAN ET AL., *supra* note 11, chapters 7 (critical items, content scales, and subscales) and 8 (supplementary scales).

26. This comment is based on the author's experience with reading the child custody evaluations of her own and other attorneys' clients. However, because it is rare that the court and the attorneys are provided (or obtain access to) the evaluator's full file, including but not limited to any raw data and interpretations of the MMPI-2, this comment must be considered speculative. Research is needed to investigate child custody evaluators' practices in this regard.

27. See text accompanying note 91 *infra*.

28. FRIEDMAN ET AL., *supra* note 11, at 418 (emphasis added).

29. *Id.* at 420.

scores of battered women prior to being battered. Such a study would have to be a longitudinal study taking baseline MMPI-2 scores from a large group of subjects (perhaps high-school seniors) and then following those subjects for a substantial period of time, interviewing and administering the MMPI-2 at intervals, perhaps along with other instruments. As yet, no such study has been reported. Therefore, we do not know with any degree of certainty whether battered women, prior to being battered, were "normal" or showed certain psychological problems (and, if so, what problems). However, research on MMPI-2 scores of battered women strongly suggests that they are usually "normal" prior to the abuse.

B. MMPI and MMPI-2 Scores of Women in a Battering Relationship

In thirteen studies, the MMPI or MMPI-2 was administered to battered women either while the women were still in the battering relationship or shortly thereafter. In eight of the twelve studies of groups of battered women, all or many of the battered women were recruited from domestic violence shelters and outpatient domestic violence clinics.[30] The other four studies tested battered women in other settings. Back, Post, and D'Arcy[31] studied battered women residents of a psychiatric hospital. Gellen et al. looked at battered women who were in a residential center for "distressed women."[32] Margolin recruited only participants who were living with their spouses.[33] In a study by Charboneau, the participants were all living in their own homes, with or without their mates.[34] Finally, a case study of one battered woman was reported by Follingstad.[35]

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30. Philip L. Davidson, The Development of an MMPI Profile for Battered Women: A Partial Replication of Rosewater's 1982 Study (1991) (unpublished master's thesis, University of Houston-Victoria, Houston, TX); Patricia Egan, Assessment and Diagnosis of Trauma and Psychological Problems in Abused and Battered Women (1997) (unpublished Ph.D. dissertation, The Chicago School of Professional Psychology) (U.M.I. No. 9820775); Fariha Khan et al., *MMPI-2 Profiles of Battered Women in Transition*, 60 J. PERSONALITY ASSESSMENT 100 (1993); Morrell & Rubin, *supra* note 9, Amber Rollstein & Jeffrey Kern, *Correlates of Battered Women's Psychological Distress: Severity of Abuse and Duration of the Postabuse Period*, 82 PSYCHOL. REP. 387 (1998); Rosewater, *supra* note 7; Wall, *supra* note 6; Judy Wilson, The Psychological Functioning, Self-Concept, and Locus-of-Control of Battered Women in a Spouse Abuse Shelter, (1990) (unpublished Ph.D. dissertation, University of Florida).

31. Susan Back, et al., *A Study of Battered Women in a Psychiatric Setting*, 1 WOMEN & THERAPY 13 (1982).

32. Murray I. Gellen et al., *Abused and Nonabused Women: MMPI Profile Differences*, 62 PERSONNEL & GUIDANCE J. 601 at 602 (1984).

33. Margolin, *supra* note 6, at 204.

34. Dolores Charboneau, *A Comparison of Psychological Traits in Currently Battered, Formerly Battered, and Non-Battered Women (MMPI)* (1986) (unpublished D. Ed. dissertation, University of South Dakota) (on file with the U. of S. Dakota Library).

35. Diane Follingstad, *A Reconceptualization of Issues in the Treatment of Abused Women: A Case Study*, 17 PSYCHOTHERAPY: THEORY, RES., & PRAC. 294 (1980).

In all of the thirteen studies, except Wilson's,[36] the MMPI mean (average) clinical scale scores of the group of battered women were reported. Wilson reported the clinical scale scores of each of her sixteen participants and did not report the mean of all sixteen scores on each scale.[37] For purposes of this review, the mean scores of Wilson's sixteen participants on all clinical scales have been calculated in order to compare them with the means reported in the other studies. With the exception of the Margolin study,[38] all studies found the mean scores of the battered women were elevated above a T score of sixty-five on at least one clinical scale.

Two studies that reported individual scores on the MMPI clinical scales reported that some battered women did not show high elevations on any MMPI clinical scales: three out of thirty-one participants in the study by Khan et al.[39] and five out of sixteen participants in Wilson's study[40] showed no significant elevations. The fact that some battered women do not show MMPI elevations would shed some doubt on the "trait" hypothesis that battered women are battered because they are "crazy" and provoke abuse.[41]

The code patterns for the mean clinical scale scores found in the thirteen studies are as follows:

Back et al. (1982)	482
Charboneau (1986)	426
Davidson (1991)	486
Egan (1997)	648
Follingstad (1980)	376
Gellen et al. (1984)	489
Khan et al. (1993)	648
Margolin (1988)	463 (but none at sixty-five or above)
Morrell & Rubin (2001)	681 (PTSD) & 468 (non-PTSD)[42]
Rollstin & Kern (1998)	468

36. Wilson, *supra* note 30.
37. *Id.* at 185.
38. Margolin, *supra* note 6.
39. Khan et al., *supra* note 30, at 104.
40. Wilson, *supra* note 30, at 136.
41. Assuming that battered women are "normal" prior to the battering, it would be important to investigate what protects some battered women from developing the symptoms of psychological impairment measured by the MMPI-2. For example, can it be accounted for by a short length of abuse, low severity of abuse, supportive relatives and friends, some inner strength of those women, or some other factor(s)? There is an enormous literature on the subject of psychological resilience, but a discussion of that issue is beyond the scope of this article.
42. Morrell and Rubin administered the MMPI-2 and the Posttraumatic Stress Diagnostic Scale (PDS) to 93 battered women. The PDS identified 58 as meeting DSM-IV (1994) criteria for PTSD. The non-PTSD participants commonly reported PTSD symptoms but did not meet full criteria for a PTSD diagnosis. Morrell & Rubin, *supra* note 9, at 153. *See* discussion of PTSD at text accompanying notes 81-99 *infra*.

Rosewater (1988)	486
Wall (1993)	6824 (the scores for the 2 & 4 scales were almost identical)
Wilson (1985)	642

The similarities in the code patterns are striking. Six out of the thirteen studies reported a three-point code with a combination of 4, 6, and 8.

Egan's study provides a good illustration. A comparison between the mean scores of the thirty-eight battered women and the mean scores of the thirty-four women in the control group reveals the following:[43]

Clinical Scales	1	2	3	4	5	6	7	8	9	0
Battered Women	63.3	66.1*	64.3	73.1*	50.3	74.4*	66.2*	69.4*	58.0	55.4
Control Group	55.9	52.0	55.5	51.9	51.6	48.4	50.6	50.6	49.0	46.8

* Statistically significant findings

Elevations on the 6 (paranoid) scale for battered women are not surprising and, in fact, might be expected, because fearfulness and suspicion of others might be viewed as a logical outcome of having been abused by one with whom an individual had an intimate relationship. Intimate relationships are supposed to be based on trust, and abuse in an intimate relationship would destroy that trust.

Elevations on the 8 (schizophrenia) scale for battered women are also not surprising, because the eight scale measures confusion in thought processes and feelings of being overwhelmed. It is not necessary to be schizophrenic in order to receive an elevated score on the 8 scale. Being abused by an intimate partner could certainly cause confusion in thought processes and feelings of being overwhelmed.

Elevations on the 4 (psychopathic deviate) scale, on the other hand, are more difficult to interpret. Follingstad, a single case study, was the only study that reported a three-point code that did not include an elevated four scale.[44] With the exception of Morrell and Rubin, all the studies of groups of battered women reported three-point code scores for mean MMPI scale scores that included a 4. Morrell and Rubin reported a 681 three-point code for their battered women who met the criteria for PTSD and a 468 code for their non-PTSD battered women.[45]

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43. Egan, *supra* note 30, at 38.

44. Diane R. Follingstad, *A Reconceptualization of Issues in the Treatment of Abused Women: A Case Study*, 17 PSYCHOTHERAPY: THEORY & PRAC. 294 (1980). In this case, the woman and man were dating, not married or living together, and their relationship was not a lengthy one.

45. The fact that the PTSD battered women had a 681 3-point score does not mean their 4 scale was not elevated—in fact, the mean 4-scale elevation was actually higher for the PTSD battered women (70.32) than for the non-PTSD women (66.83). Morrell & Rubin, *supra* note 9, at 154.

As a noted text on the MMPI indicates, "Scale 4 was developed to measure the 'personality characteristics of the amoral and asocial subgroup of persons with psychopathic personality disorders' . . ."[46] "Psychopathic" is an extremely strong term. No one would feel safe recommending custody of a child to a psychopath.

If a custody evaluator did not look more deeply into the possible reasons for an elevation on the 4 scale, the evaluator might infer that the individual had serious characterological traits similar to the "typical" high scale 4 persons, who

> show impulsiveness, poor interpersonal judgment, unpredictability, social alienation, and a reduced sense of responsibility and morals. They may evidence poor work and marital adjustment. They tend to sacrifice long-term goals for short-term desires and seem limited in their capacity to anticipate consequences. Social relations typically are shallow, and strong loyalties rarely are developed. Although these persons sometimes make good first impressions, their unreliability, self-orientation, manipulativeness, and resentment soon become apparent.[47]

This is a very damning description to apply to a parent in a custody evaluation. To make matters worse, the most common three-point code types for battered women in the thirteen studies are various combinations of 4, 6, and 8. A 46 code has been described as follows: "Key features are anger, resentment, distrust, sullenness, irritability, hypersensitivity to criticism or to demands by others, and projection of blame onto others."[48] A 48 code has been described as follows:

> Adults with this code almost always show severe problems, usually as a major personality disorder or a psychotic process. Distrust is a central characteristic for this group and is characterized by a sense of profound alienation and disconnection from others.[49]

A custody evaluator seeing such an MMPI profile for a parent would be loathe to suggest custody to such an individual.

A custody evaluator who looked more deeply into the possible meanings of Scale 4 elevations, however, would find much cautionary language about such elevations that would be relevant to battered women. For example,

> Duckworth and Anderson (1995) viewed "fighting something" (p. 164) as a cardinal feature of an elevated Scale 4. They suggested that the individual may be in conflict with his or her parents, friends, spouse, society, or school and that *it is essential to examine the context in which the person is being assessed.*[50]

46. FRIEDMAN ET AL., *supra* note 11, at 101, quoting W.G. DAHLSTROM ET AL., AN MMPI HANDBOOK: VOL. 1. CLINICAL INTERPRETATION 195 (rev'd ed. 1972).

47. FRIEDMAN, *supra* note 11, at 296.

48. *Id.* at 300.

49. *Id.* at 307.

50. *Id.* at 105 (emphasis added), quoting from J.C. DUCKWORTH & W. ANDERSON, MMPI INTERPRETATION MANUAL FOR COUNSELORS AND CLINICIANS (1995).

The context of custody litigation and domestic violence would certainly be essential to examine, but often this caution is not heeded.

Another important issue regarding Scale 4 is its source. In a 1992 article, Rhodes described her study of MMPI 4 scale scores of battered women and nonbattered women. She pointed out that it is not surprising that battered women have elevated scores on the 4 scale when the criterion group used to create the 4 scale probably contained many victims of physical and sexual abuse.[51] Thus, it is logical that abused women would score high on the four scale. However, that does not mean that they would have scored high on the 4 scale if they had not been abused.

In a 1990 dissertation, Wilson expressed her suspicions that the psychological deficits ascribed to her battered women sample by the MMPI results might be caused by (or enhanced by) the abuse they had suffered.[52] She called for more research to address that issue:

> There are few conclusive studies concerning battered women and their psychological characteristics. Earlier studies blamed the victim for her abuse. More recent theories postulate that battered women have psychological characteristics similar to prisoners of war or victims of brainwashing techniques. Long-term follow up studies are needed to assess the changes which occur in these characteristics as a battered woman escapes her violent home and rebuilds a healthy, nonviolent life for herself and her children.[53]

Wilson called for longitudinal studies to answer the "characterological versus reactive" question:

> Do battered women have dysfunctional psychological areas as a result of their childhood experiences that influence their choices of mates and choices of behavior once in a spouse abuse marriage or is there a post-battering personality which is a result of the battering?"[54]

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51. Nancy Rhodes, *Comparison of MMPI Psychopathic Deviate Scores of Battered and Nonbattered Women*, 7 J. FAM. VIOLENCE 297 (1992). Rhodes states (298-99):

> The criterion group used by Dahlstrom et al., [AN MMPI HANDBOOK] (1972) in developing the scale was made up of predominantly female delinquent individuals who were placed in a psychiatric setting by court order. Delinquency was defined as stealing, lying, truancy, sexual promiscuity, alcohol abuse, and forgery (but did not include capital offenses) . . .
>
> It is particularly relevant to note the similarities between the criterion group used in the development of scale 4 and the profile of the typical victim of sexual abuse. Behavioral indicators of sexual abuse include running away from home, substance abuse, sexual promiscuity, truancy, and shoplifting. Such antisocial behaviors are also associated with physical abuse and neglect (Edwards and Gil, [BREAKING THE CYCLE: THE ASSESSMENT AND TREATMENT OF CHILD ABUSE AND NEGLECT] 1986) and apply to both males and females. This implies that it is quite possible that many members of the criterion group used by Dahlstrom et al. (1972) in the development of the Psychopathic Deviate scale were themselves victims of physical or sexual abuse.

52. Wilson, *supra* note 30.

53. *Id.* at 154-55.

54. *Id.* at 154.

C. MMPI Scores Tend to Normalize After the Abuse Ends

A good way to investigate whether a battered woman's elevated MMPI scores are characterological or reactive would be to compare those scores with the MMPI scores of the same woman after the battering relationship has been terminated for some period of time. If the elevations decreased, that would seem to support the reactive theory. Follingstad's pioneering study in 1980 made such a comparison, with results that suggest the validity of the reactive theory.[55] Follingstad found that the three highest MMPI scores of her battered patient, "Barbara," while the abuse was going on were a T-score of 80 on the 3 (Hysteria) scale, of 72 on the 7 (Psychasthenia) scale, and of 70 on the 6 (Paranoia) scale.[56] Nine months after Barbara terminated therapy, which was a few months after she successfully broke off the abusive relationship, Barbara's MMPI scores were substantially reduced: 55 on the 3 scale and 55 on the 7 scale. The 6 scale remained elevated (67), but Follingstad noted that such an indication of continuing anger and distrust was "at least partially understandable due to the negative experiences she had undergone."[57]

A less ideal, but still somewhat persuasive, method to investigate whether a battered woman's elevated MMPI scores were characterological or reactive would be to compare the MMPI scores of groups of currently (or very recently) battered women with scores of different groups of formerly battered women. Several studies have made such comparisons.[58] These studies tend to show that MMPI elevations decrease after the battered women has been out of the abusive relationship for a period of time and therefore lend support to the view that such elevations are reactive rather than characterological.

Charboneau, another 1980s pioneer in this field, compared MMPI scores of twelve currently battered women, twelve formerly battered women, and twelve never battered women.[59] Charboneau had hypothesized that her study might find "traits that may be influential in keeping currently battered women in abusive situations and unable to overcome their victimization."[60] The data, however, seem to point more in the direction of a reactive state theory.[61]

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55. Follingstad, *supra* note 43.
56. *Id.* at 297.
57. *Id.* at 301-02.
58. Back et al., *supra* note 31; Charboneau, *supra* note 34; Gellen et al., *supra* note 32; Margolin, *supra* note 6; Rosewater, *supra* note 7.
59. Charboneau, *supra* note 34.
60. *Id.* at 6 (emphasis added).
61. In different parts of her dissertation, Charboneau seems to take different positions. On the one hand, when discussing the elevations of the three groups on Scale 1, Charboneau notes that "Some of the characteristics which Graham attributed to people with elevated scores on

The mean MMPI scores of Charboneau's three groups on the five highest scales are as follows:

Clinical Scales	2	4	6	7	8
Currently Battered Women	70.42	76.5	68.33	64.33	66.08
Formerly Battered Women	55.42	68.33	58.92	55.59	59.25
Never-Battered Women	49.83	54.42	58.92	49.50	50.50

The fact that the MMPI elevations are lower for formerly battered women than for currently battered women could be interpreted as evidence that the elevations decreased when the women were no longer being abused, indicating that the abuse had caused the elevations. Similarly, the MMPI clinical scale scores for never battered women are (with the one exception of the 6 scale) even lower than the clinical scale scores for the formerly battered women.

Lynne Bravo Rosewater was the first researcher to address head-on the question of whether the elevated MMPI clinical scale scores for battered women were a cause or a result of their abuse:

> Repeatedly I have seen professionals fail to distinguish the symptoms of victims of violence from the symptoms of the sufferers of mental illness or to understand their interplay. . . . In blatant victim blaming fashion, two common errors are made: the extreme fearfulness (paranoia) and confusion created by repeatedly experiencing violence are misdiagnosed as psychiatric symptoms, and/or the woman is diagnosed as having a character disorder, which is seen as a predisposition for the violence that occurs. Thus the victimized woman is viewed either as "crazy," with her tales dismissed as ravings, or as inadequate and provoking the violence in her life.[62]

Rosewater administered the MMPI to three groups of currently battered women: Group I (fifty women) in a battered woman's shelter; Group II

Scale 1 would seem appropriate for battered women. These characteristics include excessive bodily concern (possibly concern over pain from beatings). . . ." *Id.* at 96. Thus, she seems to characterize the elevations on Scale 1 as reactive.

On the other hand, in the "Implications and Discussion" section of her dissertation, Charboneau states:

> The findings that battered women score high on Scale 4 with consistency may suggest not only that battered women have feelings of non-conformity, rebellion, anger, and disregard for social custom but also may suggest something more. In what may be the major finding of this study, this researcher hypothesizes that these women's feelings may cause them to be attracted to men who also have [the same] feelings. Furthermore, these men's feelings of anger appear to be vented through acts of violence. *Id.* at 92.

The logical leaps in this paragraph are not sufficiently justified by the data. From elevations on scale 4 Charboneau leaps to hypothesizing that because battered women have such elevations they have certain feelings, that because of those feelings they are probably attracted to men with similar feelings, and that men with those feelings vent their anger "through acts of violence." In other words, certain traits in certain women cause them to be attracted to men who subsequently batter them.

62. Rosewater, *supra* note 7, at 200.

(twenty-nine women) from an early intervention program; and Group III (twenty-seven women) from a witness victim service center.[63] She compared the mean MMPI clinical scale scores for these three groups to the mean scores of twelve formerly battered women who had been clients of the three previously mentioned programs and had suffered no abuse for at least one year.[64]

Rosewater also collected information from each participant concerning the length of time in the relationship, the length of time battered, the level of violence of the batterer's behavior, the level of physical damage to the woman, and the frequency of battering on a scale of one to six from "less than once every 2 years" to "more than once a week."[65]

One of the goals of Rosewater's research was to determine if a composite "MMPI profile" exists for battered women and, if so, what it would appear to signify in terms of possible diagnoses.[66] Another goal was to determine whether any of the other abuse variables she measured, such as the length of time in the relationship, correlated with the elevations on the MMPI profiles.[67]

The MMPI pattern that emerged for the currently battered women was a 486 profile for Groups I and II and a 468 profile for Group III. For interpretation purposes, those code types are the same.[68] The elevated Scale 4 (T=71) of the currently battered women measures anger, the elevated Scale 8 (T=70) measures confusion, and the elevated Scale 6 (T=70) measures fear.

If a mother going through a custody evaluation were to have a 486/468 pattern, the custody evaluator could conclude, on the basis of commonly used MMPI interpretation manuals, that the mother had a personality disorder or paranoid schizophrenia. Rosewater pointed out, however, that if the MMPI profile was placed within the context of the woman's life, it would indicate "a reactive behavior set to being a victim of violence, which includes anger, confusion, fearfulness, weakness, and a sense of pessimism."[69] Thus, taken out of context, the MMPI scores of a battered woman might lead a mental health evaluator to misdiagnose the woman as severely mentally ill—even psychotic—while she was actually suffering from the effects of the abuse. Rosewater thought the battered woman's condition could be most accurately described as Posttraumatic Stress Disorder (PTSD).[70]

63. *Id.* at 204.
64. *Id.* at 204-05.
65. *Id.* at 205-06.
66. *Id.* at 204.
67. *Id.* at 212.
68. *Id.* at 207.
69. *Id.* at 211.
70. Lynne B. Rosewater, *Feminist Therapy: Implications for Practitioners, in* WOMEN AND MENTAL HEALTH POLICY 197-206 (Lenore Walker, ed. 1984). *See* discussion of PTSD at text accompanying notes 81-99 *infra*.

The formerly battered women had lower elevations than the currently battered women. Their MMPI mean profile was 849. That profile sets them apart from the currently battered women in terms of "less alienation and less feeling of inferiority."[71] In other words, the formerly battered women appeared to be recovering from the effects of having been abused.

D. Correlations Between Length, Frequency, or Severity of Abuse and MMPI Elevations

Another way to test whether MMPI elevations in battered women are characterological or reactive would be to investigate whether the length of time a woman is abused, the frequency of the abuse, or the severity of the abuse is positively correlated with her elevations on the MMPI. If so, then the elevations are more likely to be reactive than characterological. Rosewater found that the frequency of the abuse correlated positively with elevations on the 1, 2, 6, 7, and 0 scales. Two other studies have used similar methodology, with similar results.[72]

Khan et al. administered the MMPI-2 to thirty-one battered women in shelter. Each participant also completed a questionnaire regarding the length of time she had been abused, which of nine types of physical abuse she had experienced, and which of nine types of psychological abuse she had suffered. Each participant also was asked to estimate, on a scale of zero to nine, the severity of the psychological abuse and the severity of the physical abuse.

On the mean profile of these battered women, scales 4, 6, and 8 were elevated, thus replicating many of Rosewater's findings.[73] What predicted the overall average T-score was severity of psychological abuse.[74] Based on all their findings, Khan et al. concluded that MMPI elevations are, to some extent at least, reactive, and that clinicians should be careful to avoid misdiagnosing battered women as mentally ill.[75]

Rollstin and Kern directly posited as their research question the inquiry first raised peripherally by some previous researchers and directly by Rosewater and by Khan et al.: Are battered women's elevations on the MMPI clinical scales characterological or reactive to the abuse they have suffered? Rollstin and Kern compared MMPIs on currently battered women with MMPIs on women who had been out of the abusive relationships for a year, to see if the longer women are out of abusive situations the more

71. Rosewater, *supra* note 7, at 211.
72. Khan et al., *supra* note 30; Rollstin & Kern, *supra* note 30.
73. *Id.* at 104.
74. *Id.* at 107.
75. *Id.* at 109.

normal they appear on the MMPI (*i.e.*, the more their profiles resemble the profiles of average, nonabused women).

They reported that the results of their study "provided only mixed support" for the hypothesis that the MMPI-2 elevations of battered women were a reactive state.[76] On the one hand, the elevations of formerly battered women were not significantly different from the elevations of recently battered women. On the other hand, after performing more complex analyses, Rollstin and Kern determined that severity of both physical and psychological abuse were significantly associated with MMPI-2 scores.[77] Concerning the finding that the MMPI-2 elevations were not related to the duration of time since the abusive relationship had ended, Rollstin and Kern queried whether "the period of time these women had been out of their relationships had still not been long enough for them to experience emotional improvement."[78]

An additional finding is directly applicable to the issue of the use of the MMPI in custody cases involving battered women:

> Unexpectedly, larger numbers of children were significantly associated with increased psychologic disturbance. . . . The number of children was not associated with any other measure, including physical abuse . . . or psychological abuse. . . .[79]

Rollstin and Kern theorized that this finding may reflect the amount of life disruption which occurs after the battered woman has left the abusive relationship as well as the emotional difficulties experienced by the children both during and after the relationship. Experience suggests that it often takes a year or more to stabilize one's life situation and that children exacerbate the extent of that disruption.[80]

This should be kept in mind by custody evaluators when interpreting MMPIs of battered mothers.

E. What Causes Battered Women's MMPI-2 Elevations?

The research discussed above supports a conclusion that battered women are not "crazy" before they are battered. So what causes their high MMPI elevations? The simple answer may be that the abuse they have suffered causes the elevations. Not surprisingly, a substantial number of battered women suffer from Posttraumatic Stress Disorder (PTSD).[81]

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76. Rollstein & Kern, *supra* note 30, at 393.
77. *Id.* at 393.
78. *Id.*
79. *Id.* at 392.
80. *Id.* at 393.
81. Morrell & Rubin, *supra* note 9, at 153, (finding that fifty-eight of ninety-three women (62%) met DSM-IV criteria for PTSD). *See also* Anita Kemp et al., *Incidence and Correlates*

In order for a diagnosis of PTSD to be made using the DSM-IV criteria, the individual must have experienced a traumatic event or events and responded with "intense fear, helplessness, or horror." In addition, the individual must have the following symptoms: (1) at least one symptom of re-experiencing the event (*e.g.*, nightmares, flashbacks, or intense reactions to exposure to "cues that symbolize or resemble an aspect of the traumatic event"); (2) three or more symptoms of attempting to avoid thinking about the event (which could include numbing, amnesia for part of the trauma, and avoidance of people, places and things that might be reminders of the trauma); and (3) two symptoms of "increased arousal," which could include "difficulty falling or staying asleep," "irritability of outbursts of anger," "difficulty concentrating," "hypervigilance," or "exaggerated startle response." These symptoms must have lasted more than one month. Finally, a diagnosis of PTSD requires that the individual suffer "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[82]

Posttraumatic Stress Disorder was added to the third edition of the DSM in 1980.[83] Mental health practitioners first noticed the symptoms of what came to be known as PTSD in military personnel returning from war. These soldiers often displayed certain symptoms, which were sometimes called "shell shock," and that condition was renamed PTSD. Researchers noted the presence of similar symptoms in World War II concentration camp survivors.[84] By the time the DSM-IV was published in 1994, the definition of PTSD had been revised. Since the 1980s, studies of trauma had proliferated, and investigations of the effects of trauma on populations other than military personnel—such as survivors of natural disasters and accidents, rape survivors,[85] abused children, and battered women—

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of Posttraumatic Stress Disorder in Battered Women: Shelter and Community Samples, 10 J. INTERPERSONAL VIOLENCE 43, 47 (1995) (81% of the sample met the PTSD criteria). Mary Ann Dutton and Lisa A. Goodman have stated:

> Studies have documented high rates of PTSD among battered women, for example, 31% to 60% [citations omitted] of battered women seeking help from domestic violence programs while living at home and 40% to 89% [citations omitted] of those living in a battered women's shelter met PTSD criteria.

Mary Ann Dutton and Lisa A. Goodman, *PTSD Among Battered Women: Analysis of Legal Implications*, 12 BEHAVIORAL SCIENCES & L. 215, 220 (1994).

82. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 467-68 (4th ed. 1994).

83. Philip A. Saigh & J. Douglas Bremner, *The History of Posttraumatic Stress Disorder*, in POSTTRAUMATIC STRESS DISORDER: A COMPREHENSIVE TEXT 1 (Philip A. Saigh & J. Douglas Bremner eds., 1999). Unless otherwise noted, information on the history of PTSD is taken from this source.

84. *Id.* at 3.

85. Ann Burgess & Linda Holmstrom, *Rape Trauma Syndrome*, AM. J. PSYCHIATRY 131 (1974).

informed mental health professionals' understanding of the causes and effects of PTSD.

What used to be called "battered woman syndrome" is now more often denominated as PTSD.[86] Some experts suggest, however, that the effects of interpersonal violence (rape and abuse of children and intimate partners) perhaps are broader than the diagnostic criteria of PTSD and lead to a more serious form of PTSD than traumas that are not interpersonal in nature. This more serious form of PTSD is sometimes called "complex" PTSD[87] or DESNOS (Disorder of Extreme Stress Not Otherwise Specified).[88]

A crucial factor regarding PTSD is that it is now understood that any previously healthy individual exposed to a trauma can develop PTSD.[89] For decades researchers tried to determine whether "shell shock" in combat veterans could be accounted for by any pre-existing psychological problems of soldiers who suffered from it. If so, those individuals could be weeded out of the recruitment pool. However, it was discovered that normal, psychologically healthy young men were coming down with the disorder—there is no way to predict who will get it and who will not.[90] It is a normal and natural response to an abnormal situation. Sadly, 9/11 has brought this lesson home to millions of Americans who now suffer from PTSD as a result of the terrorist attacks.

When the MMPI was first developed in the 1930s and 1940s, PTSD was not a recognized psychiatric disorder. By the time the second edition of the MMPI was published in 1989, PTSD had been recognized in the DSM-III (1980), but the revisors of the MMPI did not make revisions to accommodate it. A PTSD scale was never added to the ten clinical scales that already existed. Instead, a PTSD Supplementary scale (called PK) was developed, using the already-existing questions on the MMPI-2.[91] The relationship between the MMPI-2 and PTSD has now been researched on each of the populations described above, including battered women, although research on battered women has not been as voluminous as research on many of the other groups.

In one study on the MMPI-2 scores of battered women, Morrell and

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86. Nancy Kaser-Boyd. *Battered Woman Syndrome: Clinical Features, Evaluation, and Expert Testimony* 41, at 44, *in* B.J. CLING (ED.), SEXUALIZED VIOLENCE AGAINST WOMEN AND CHILDREN: A PSYCHOLOGY AND LAW PERSPECTIVE (2004).

87. JUDITH L. HERMAN, TRAUMA AND RECOVERY 115-29 (1992).

88. Toni Luxenberg et al., *Complex Trauma and Disorders of Extreme Stress (DESNOS) Diagnosis, Part One: Assessment*, 21 DIRECTIONS IN PSYCHIATRY Lesson 25 (2001).

89. DSM IV-R, *supra* note 82, at 466.

90. Saigh & Bremner, *supra* note 83, at 3.

91. Sean Perrin et al., *Assessing the Effects of Violence on Women in Battering Relationships with the Keane MMPI-PTSD Scale*, 9 J. TRAUMATIC STRESS 805 (1996).

Rubin compared battered women diagnosed with PTSD with battered women who did not meet the criteria for PTSD.[92] Of the ninety-three women participants, fifty-eight (62%) met the DSM-IV criteria for PTSD, whereas thirty-five (38%) did not.[93] Many of the non-PTSD (NPTSD) participants reported symptoms indicative of PTSD, but were not diagnosed with PTSD because they failed to meet the full criteria for PTSD.[94]

The NPTSD participants had MMPI-2 elevations above T=65 on the F,[95] 4, and 6 scales. They also had elevations on the 7 and 8 scales that approached T=65. The MMPI-2 scores of the PTSD participants were even higher, with T-scores above sixty-five on nine of thirteen scales. Although there were no statistically significant differences between the PTSD and NPTSD groups, it is noteworthy that 10% of the PTSD group reported "extreme and permanent injuries," while only 3% of the NPTSD group reported such injuries.[96]

The study by Morrell and Rubin gives support to the reactive state theory. By definition, posttraumatic stress disorder is a sequela ("post") of trauma. The fact that such an overwhelming percentage of battered women are diagnosed with PTSD tells investigators that they have suffered severe trauma. The trauma they report is domestic violence.[97]

Because it is not uncommon for battered women to minimize or even fail to disclose their abuse, Morrell and Rubin recommend that:

> clinicians reviewing profiles with significant findings on any of the K, 1 (HS), 2(D), and 4(Pd), as well as F, 6(Pa), or 8(Sc) scales, should consider additional investigation into the presence of PTSD and domestic violence experiences. Clinicians interpreting an F-6-8 profile in a domestic violence survivor should recognize that, on average, she will have significant levels of emotional turmoil, prominent difficulties with trusting others, suspiciousness, and paranoia. This level of stress is not unreasonable because many domestic violence survivors live with their perpetrator day in and out or at least have contact with him periodically. This continuing interface with the perpetrator keeps emotional turmoil, fear, paranoia, and distrust consciously present.[98]

Morrell and Rubin's recommendations are particularly on the mark with regard to battered women who have children, especially if the parents are involved in a custody dispute. In that case, the victim must see the

92. Morrell & Rubin, *supra* note 9.

93. *Id.* at 153.

94. *Id.*

95. The F scale is a validity scale. See text accompanying notes 15 and 17-18 *supra*.

96. *Id.* at 152.

97. In some instances, battered women report other traumas as well, such as a serious accident or child sexual abuse. Then the analysis is more difficult. *Cf.* B.J. CLING, SEXUALIZED VIOLENCE AGAINST WOMEN AND CHILDREN: A PSYCHOLOGY AND LAW PERSPECTIVE 26 (2004) (Rape Trauma Syndrome).

98. *Id.* at 155.

batterer in court. Additionally, she usually has contact with him when visitation starts and ends, and sometimes she must even have some contact between visitations in order to make visitation arrangements and communicate with regard to the children. These constant reminders of the trauma of the abuse may delay her healing processes and may extend her PTSD symptoms.[99] Those symptoms, in turn, may cause a forensic evaluator to view her as a poor candidate for custody.

IV. Conclusion

The purpose of this review of studies of battered women's MMPI/MMPI-2 scores is to determine whether elevated MMPI/MMPI-2 scores of battered women on the clinical scales represent characterological "traits" or reactive "states." The answer to this question is crucial for battered women litigants in custody cases. Research to date seems to lend more support to the reactive state theory. When tested while domestic violence is ongoing or has just ended, battered women typically exhibit MMPI/MMPI-2 elevations on several clinical scales. However, MMPI/MMPI-2 scores tend to normalize after the abuse ends, as time passes. Additionally, the frequency and severity of the abuse appears to be correlated with the MMPI/MMPI-2 elevations, suggesting that the elevations are caused by the abuse.

As one researcher and her colleagues cautioned, if MMPI/MMPI-2 elevations in battered women are likely to be reactive to the abuse they have suffered, this

> raises the question of whether custody evaluations should be carried out with abused women in transition because their acute state of psychological distress may influence an accurate evaluation of their capacity to parent.[100]

Further research on the issue of MMPI-2 scores of battered women is clearly necessary, and custody evaluators should keep this caution in mind for the sake of the children, who otherwise may be placed in the custody of the men who abused their mothers, with potentially disastrous consequences.[101]

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99. *See* text accompanying notes 79-80 *supra*.

100. Khan et al., *supra* note 30, at 109.

101. A discussion of the dangers posed to children by placement in the custody of parents who are batterers is beyond the scope of this article. *See, e.g.*, BANCROFT & SILVERMAN, *supra* note 1, at 150-56.