A Typological Identification of Intimate Partner Violence Perpetrators in Mexican Samples

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Abstract. This study explored different types of intimate partner violence (IPV) perpetrators (and victims) in Mexican clinical and non-clinical samples and the differential mental effects among IPV types through Johnson's typological framework. A total of 365 participants (court-mandated men to intervention programs, victims of domestic violence seeking psychological support and male and female high school students) provided information about their IPV perpetration/victimization experiences and data on several mental health indicators. Less-controlling violence prevails in non-clinical samples, and more high-controlling IPV prevails in clinical samples, the latter more frequently reported to be mutually-perpetrated. More adverse mental health effects were associated to more coercive IPV. Implications indicate the need to acknowledge the heterogeneity of IPV in practice and research in clinical and non-clinical samples in Mexico.
Key words: intimate partner violence typology, coercive controlling violence, situational couple violence, partner violence in Mexican samples

Una identificación tipológica de perpetradores(as) de violencia de pareja en muestras mexicanas

Resumen. Se exploran diferentes tipos de perpetradores (y víctimas) de violencia de pareja (VP) e indicadores de salud mental asociados en muestras clínicas y no-clínicas mexicanas mediante la tipología de Johnson. Un total de 365 participantes (agresores en programas de intervención, víctimas de violencia doméstica que demandan apoyo psicológico/legal y hombres y mujeres estudiantes de bachillerato) aportaron información acerca de sus experiencias asociadas a su victimización/perpetración de VP y varios indicadores de salud mental. En muestras no-clínicas prevalece una VP menos coercitiva, mientras que en muestras clínicas prevalecen tipos de VP altamente coercitivos, principalmente violencia mutua y con más condiciones adversas de salud mental. Se concluye que es necesario reconocer la heterogeneidad de la VP en la atención/intervención e investigación en México.
Palabras clave: tipología de violencia de pareja, violencia coercitiva controladora, violencia situacional, violencia de pareja en muestras mexicanas

Introduction

Typically the study on partner violence in Mexico has been characterized by a focus on gendered violence research and intervention efforts which have aided women victims of domestic violence and shaped public opinion on such phenomenon (e.g. Agoff *et al.*, 2006; Híjar & Valdés Santiago, 2010; INEGI, 2013; Olaiz *et al.*, 2003). One of the main challenges in Mexico in terms of IPV research (as well as in treatment and intervention) lies within an appropriate diagnosis of types of partner abuse or Intimate Partner Violence (IPV) perpetrators (and victims) in relationship dynamics (in either victims or perpetrators of IPV) as research in Mexico has investigated associated forms of IPV while identification of partner abuse perpetrator (and victim) characteristics through a typological approach remains as an alley of enquiry. Current domestic violence research provides guidance and suggestions exclusively to victims and perpetrators of violence against women allegedly borne out of structural gender inequality differentials. There is conclusive empirical research elsewhere (e.g.

Bogaerts *et al.*, 2011; Graham-Kevan & Archer, 2003; Hines & Douglas, 2010; Johnson, 2008; 2009; Kelly & Johnson, 2008; Langhinrichsen-Rohling *et al.* 2012; Laroche, 2005; Ramos-Lira & Saltijeral-Méndez, 2008; Straus & Winstok, 2013) that supports the heterogeneity of Intimate Partner Violence perpetrators and victims. Derived from these distinctions are the implications for mental health (Hines & Douglas, 2011; Johnson & Leone, 2005; Próspero, 2008; Straus & Winstok, 2013) and physical injury (Straus & Gozjolko, 2014) in victims and perpetrators of different types of partner violence. Thus, this study has undertaken as its main focus to identify different types of IPV (based on relationship dynamics) in Mexican samples as to our knowledge there is only one empirical study (Ramos-Lira & Saltijeral-Méndez, 2008) in Mexico that has endeavoured to investigate a typology of IPV perpetrators, thus a typological approach identifying different types of partner abuse perpetrators (and victims) in Mexico is virtually unexplored.

The current study uses Johnson's typology of intimate partner violence perpetrators (Johnson, 2008) as its framework to investigate different types of IPV in Mexican samples. The following section addresses the main aspects in regard to a typology based on dyadic patterns of coercive control, as this element has been accounted crucial for explanatory analyses of IPV in the literature (e.g. Johnson, 2008; Próspero, 2008).

1. Johnson's typology of intimate partner violence

Over the years clinical work and research on partner abuse has developed theoretical models or typologies of partner abuse or intimate partner violence perpetrators (Chase *et al.*, 2001; Gondolf, 1988; Gottman *et al.*, 1995; Holtzworth-Munroe & Stuart, 1994; Johnson, 2006; Tweed & Dutton; 1998) to explain couple dynamics that involved some form of abuse by either or both members of the couple. Johnson's empirically-tested and widely accepted typology of partner violence perpetrators (Johnson, 2008) acknowledges the existence of various types of IPV that differ from one another in their etiology and developmental trajectories. The central element of Johnson's typology lies within the patterns of coercive control used by any member of the couple. Johnson identified four kinds of partner violence perpetrators (and victims). The Situational Couple Violent (SCV) perpetrator is characterized by using low levels of any form of coercive control and/or physical violence. This type of violence is usually considered to be borne out of everyday life conflicts between the couple, and can involve either minor physical violence or severe acts of physical violence, even lethal, homicidal physical abuse from either or both members of the couple. Typically this form of abuse has been found to bear the least psychopathological traits and it has been deemed the prevailing type of IPV in non-clinical samples (general population, community or student samples). Coercive controlling violence (CCV) (formerly known as *Intimate Terrorism* by Johnson) is a type of partner violence which is embedded within a general pattern of higher levels of coercive control with/or in the absence of physical violence. As such, the CCV perpetrator can be recipient or not of violent resistance from an intimate partner. This type of partner abuse is considered to stem from stereotypical sex-role views and beliefs supported by wider societal beliefs. The Violent Resistor is that perpetrator that it is thought to resist its own victimization from a CCV perpetrator with violence of its own, typically resorting to lower levels of coercive controlling behavior and/or physical violence to "get back at" or escape the coercive controlling partner. A final type identified by Johnson and colleagues are relationships where both intimate partners are highly controlling and violent (both members are CCV perpetrators) against each other (mutually controlling violence: MCV) in order to gain control of the relationship itself. To clarify, the CCV and MCV types are defined by their exacerbated levels of different forms of coercive control tactics (e.g. intimidation, isolation emotional and economic control, threats) in combination or in the absence of physical violence in order to control the intimate partner and the relationship itself (Johnson, 2008; 2011). Typically these last three types of violence perpetrators are more commonly found in clinical or selected samples (e.g. victims from shelters, court-mandated perpetrators to intervention programs) while the SCV type is more often found in non-clinical samples (e.g. high school/university students, general population samples). Studies in different countries such as Canada, the US and the UK have found more dramatic mental health outcomes for highly coercive controlling violence (CCV) compared to situational couple violence (SCV) perpetration/victimization (Hines & Douglas, 2011; Johnson & Leone, 2005; Laroche, 2005; Próspero, 2008). Therefore, the objective of this investigation is twofold: first we aim to investigate the existence of various types of IPV perpetrators in Mexican samples and secondly, we aim to test for differential mental health effects in perpetrators and victims of types of IPV that vary in their patterns of coercive control used. For the sake of conciseness and space reasons in this research paper, the reader is encouraged to see Johnson (2008) for a full description of the coercive control typology being used as the framework for this study.

The aforementioned objectives will be investigated via the following research hypothesis:

a) A higher proportion of CCV, VR and MCV perpetrators are bound to be commonly found in a clinical sample whilst SCV is more likely to be found in a non-clinical sample.

b) Perpetrators of ccv (and mcv) will experience higher levels of adverse mental health conditions than perpetrators of scv.

c) Victims of ccv (and mcv) will experience worse mental health conditions (e.g. higher levels of emotional flooding symptoms, ptsd, depressive symptoms and fear of an intimate partner) than victims of scv.

2. Methods

2. 1. Sample

Data obtained came from a clinical sample of 108 court/mandated men to intervention programs for domestic violence at the Unidades de Atención y Reeducación a Personas que Ejercen Violencia de Género (Attention and Re-education Units for People who Perpetrate Gender Violence), 59 women victims of domestic violence who sought psychological and legal assistance from the Unidades de Atención a Mujeres en Situación de Violencia (Attention Units to Women in Situations of Violence), both at the Consejo Estatal de la Mujer y Previsión Social from the State of Mexico (State of Mexico's Women State and Social Welfare Council) and a non/clinical sample of 198 (91 males and 107 females) high school students from high schools within the Autonomous University of the State of México (uaemex) system. It is important to clarify that men and women from clinical (court-mandated men and victims of partner abuse seeking psychological support) and non-clinical samples (male and female high school students) were recruited considering Johnson's (2006) recommendations as situational violence is more commonly found in non-clinical samples while highly coercive-controlling violence has been associated to clinical/selected samples. One of Johnson's criticisms when identifying types of ipv is the failure to acknowledge participant recruitment exclusively from either type of sample that can mostly depict the type of violence commonly associated to the particular recruited sample. Hence to test for differences among types of ipv it was necessary to include participants from both, clinical and non-clinical settings. All participants were residents of the State of Mexico and were 18 or older and were or had been in an intimate relationship in the past 12 months. Ethical approval was obtained from the Women State Council and authorities at the uaemex high schools prior commencement of data collection.

2. 2. Measures

Physical violence was assessed by responses to the 14-item Spanish adapted version of the cts (Straus & Ramírez, 2007) that enquired about participant's minor (throw something at a partner that might hurt her/him; push, grab or shove a partner; slap a partner) and severe (kick, bite or hit a partner with a punch, hit a partner with something; choke a partner; used a knife or gun against a partner) physical violence perpetration and victimization within the previous 12 months reporting it on a 5-point scale (0 = never occurred-4 = occurred very frequently). The Spanish version of the cts (Straus & Ramírez, 2007) was adapted to Mexican participants living in central Mexico, reporting reliability alphas of α = 0.87 and 0.91 for the perpetration and victimization scales, respectively in the current study.

A 14-item Coercive Control scale used was translated and adapted from Johnson *et al.* (2014) enquiring participants about several forms of controlling behaviour perpetration/victimization experiences such as partner isolation from friends and family networks (*tries/tried to limit your contact with family and friends*), jealousy or possessiveness (*is or has been jealous or possessive*), monitoring (*insists on knowing who you are with*) and emotional control (*makes you feel inadequate*), verbal aggression (*shouts or swears at you*), humiliating/ridiculing a partner (*calls you names or puts you down in front of others*) and economic control (*prevents you from knowing or having access to the couple's income even when you ask*) controlling behaviors within the previous 12 months. Internal consistency of the controlling behavior scale was verified obtaining an alpha of 0.86 and 0.91 for the perpetration and victimization scales, respectively in the present study.

2. 2. 1. Beck Depression Inventory ii- bdi-ii (Beck et al., 1996)

It is a widely used 21-item measure used to enquire participants about experienced depressive symptoms within the 12 previous months and after a conflict with an intimate partner. The bdi-ii has shown satisfactory validity and reliability scores with psychiatric and non-clinical populations. Severity of symptoms scores range from 0-63. Suggested scores on levels of depression based on clinical samples are: minimal depression (scores 0-13), mild depression (scores from 14-19), moderate depression (scores ranging 20-28) and severe depression (scores from 29-63). The Mexican standardized version (Jurado *et al.*, 1998) was used in the present investigation. The alpha reliability coefficient obtained in this study was $\alpha = 0.92$.

2. 2. 2. Partner Flooding Scale (Heyman & Smith-Slep, 1998)

This is a 15-item measure that uses a 5-point scale (0 = never-4 = almost always) that allowed for enquiry of emotional flooding symptoms (diffuse physiological arousal) experienced by participants after a conflict episode with an intimate partner within the past 12 months. These are symptoms of psychological distress triggered by another person's negative attitudes.

It involves the person's higher order cognitive processes that become overwhelmed by distressing and aversive experiences of a person being unable to resolve conflict rationally, but reactively (O'Leary *et al.*, 2007; Portland Relationship Institute, 2010). The severity of emotional flooding symptoms scores range from 0-60. The reliability coefficient in the present study was $\alpha = 0.96$.

2. 2. 3. Post-traumatic Symptom Scale (*PSS*) (*Foa et al., 1993*)
This is a 12-item measure that uses a 4-point scale (0 = not at all-3 = five or more times) that enquired participants about symptoms of PTSD experienced after any conflict episode with their intimate partner within the past 12 months. It addresses re-experiencing symptoms (i.e. distressing thoughts or images, flashbacks, emotional upset in response to trauma reminders), avoidance (i.e. cognitive and behavioral avoidance, psychogenic amnesia, loss of interest, detachment from others, etc.) and arousal (i.e. irritability, concentration problems, hypervigilance). The PSS has been used with victims of rape and non-sexual assault victims and has shown satisfactory internal consistency, high test-retest reliability and concurrent validity (Foa *et al.*, 1993). Severity of PTSD symptoms scores range from 0-48. As in the case of the Partner Flooding Scale and Coercive Control Scale, a Spanish version of the PSS was adapted for this study. The reliability coefficient of the PSS in the present study was $\alpha = 0.94$.

A question using a 5-point scale (0 = Not at all fearful-4 = very highly fearful) that enquired participants about how fearful about their partner they generally felt within the past 12 months was included. This question was included as some research on partner violence (Anderson *et al.*, 2010; Cascardi *et al.*, 1999) suggests that victims of higher levels of coercive control and/or physical aggression experience more fear of an intimate partner at the expense of their well-being (Brown *et al.*, 2008).

The Coercive control scale, emotional flooding scales and the post-traumatic symptom scale used in this study were adapted for participants living in central México. The adaptation process included the translations of these scales into Spanish by the principal author. A revision of the translated scale was conducted by a panel of five researchers at the UAEMex, and construct validity was tested through principal components factor analysis that retained one factor in each of the scales explaining 55% and 64% of the variance in the coercive control perpetration and victimization scales, respectively, 66.3% of the variance in the emotional flooding scale and 58.9% of the variance in the PSS.

3. Deriving types of Intimate partner violence

The same procedure outlined in Johnson *et al.* (2014: 195-196) was used to obtain partner violence types. For this, we initially treated physical aggression and coercive control as continuous variables instead of dichotomous variables; as the coercive control typology considers the patters of behavioral acts used by intimate partners as tactics. We conducted Ward's method cluster analysis of the seven items composing the coercive control scale using data from our clinical (court-mandated men, victims filing for domestic violence) and non-clinical (high school students) samples. An appropriate two-cluster solution was found as shown by changes in the final distance scores considerably leveling off past the two-cluster solution (final distance coefficients = 1757, 416, 208, 87, 57, etc.), composed of 40% ($n = 140$) of highly coercive controlling individuals and a cluster of low coercive controlling participants comprised of 60% ($n = 210$) of participants. A cut-off point of four acts of coercive controlling behaviors (differentiating low coercive control perpetrators versus high coercive control perpetrators) was obtained by comparing the results of the Ward's method cluster analysis with scores of the coercive control scale (table 1). Applying the chosen cut-off point we then classified all court-mandated men, victims of domestic violence seeking legal/psychological assistance and high school students as either, SCV, CCV, VR or MCV perpetrators by considering participant's physical aggression and coercive control perpetration and victimization patterns. As outlined by Johnson *et al.* (2014: 196) it is necessary to have dyadic data (information on perpetration *and* victimization from participants) to convert low and high level controlling violence into the coercive control typology.

4. Results

The first research hypothesis was partially supported. That is, while SCV was more commonly found in a non-clinical sample; IT was the least commonly found in clinical samples of victims and perpetrators. It was actually, MCV the most prevalent type of IPV within a sample of victims and perpetrators. VR was more commonly reported in clinical samples that SCV as expected (table 2).

Table 1. Ward's method two-cluster solution by coercive control scale scores of participants.

	Coercive/controlling acts								
Cluster membership	0	1	2	3	4	5	6	7	*n*
Low control	28.6	28.6	21	21.9	0	0	0	0	210
High control	0	0	0	0	25.7	31.4	24.3	18.6	140

Note: table product of the present study.

In regard to the second research hypothesis separate One-way ANOVAs were conducted for depressive symptoms (F [4, 240] = 13.259, $p = 0.001$), emotional flooding symptoms (F [4, 274] = 26.806, $p = 0.001$), PTSD symptomatology (F [4, 272] = 20.743, $p = 0.001$) and fear of an intimate partner (F [4, 273] = 13.580, $p = 0.001$) using perpetration data of court-mandated men (clinical sample) and male and female high school students (non-clinical sample). Compliance with parametric tests standards allowed for computed Post-hoc Tukey HSD tests to show CCV perpetrators scored significantly higher than SCV perpetrators but only in PTSD symptomatology ($p = 0.007$), whereas MCV perpetrators experienced significantly higher levels of depressive symptoms ($p = 0.001$), PTSD symptomatology ($p = 0.001$), fear of an intimate partner ($p = 0.001$) and emotional flooding symptoms ($p = 0.001$) than SCV perpetrators (table 3). Actually MCV perpetrators also reported experiencing significantly higher levels of depressive symptoms than non-violent participants ($p = 0.001$), CCV ($p = 0.024$) and VR perpetrators ($p = 0.007$).

MCV perpetrators displayed significantly higher levels of PTSD symptomatology than non-violent participants, SCV and VR perpetrators ($p = 0.001$), higher levels of fear of an intimate partner than non-violent individuals, SCV ($p = 0.001$) and CCV perpetrators ($p = 0.004$); and higher levels of emotional flooding symptoms than non-violent participants, SCV and CCV perpetrators ($p = 0.001$).

To test the third research hypothesis separate One-way ANOVAs were conducted for scores on depressive symptoms (F [4, 193] = 16.614, $p = 0.001$), emotional flooding symptoms (F [4, 230] = 53.950, $p = 0.001$), PTSD symptomatology (F [4, 226] = 26.168, $p = 0.001$) and fear of an intimate partner (F [4, 234] = 14.056, $p = 0.001$) using victimization data from women filing for domestic violence (clinical sample) and female and male university students (non-clinical sample). Post-hoc Tukey HSD tests show that victims of CCV experience significantly higher levels of depressive symptoms ($p = 0.006$), emotional flooding symptoms ($p = 0.001$), PTSD symptomatology ($p = 0.001$) and fear of an intimate partner than victims of SCV (table 3). Likewise victims of MCV displayed higher levels of depressive and emotional flooding symptoms, PTSD symptomatology and fear of an intimate partner ($p = 0.001$) than victims of SCV (table 4). Actually CCV victimization was found also linked to higher levels of depressive symptoms ($p = 0.017$) than in non-violent victims, higher levels of emotional flooding symptoms than non-violent and VR victims ($p = 0.001$), higher PTSD symptomatology than non-violent victims ($p = 0.001$) and more fear of an intimate partner than non-violent and VR victims ($p = 0.001$).

Victims of MCV showed the worst mental health outcomes in general, experiencing also significantly higher levels of depressive and emotional flooding symptoms than non-violent and VR victims, higher levels of PTSD that non-violent ($p = 0.001$) and VR victims ($p = 0.003$) and more fear of an

Table 2. Intimate partner violence perpetration by sample type.

Type	Court-mandated men 108 (%)	Female victims 59 (%)	High school students 198 (%)
Non-violent	0	3 (5.1)	46 (23.2)
SCV	21 (19.4)	5 (8.5)	82 (41.4)
CCV	12 (11.1)	1 (1.7)	30 (15.2)
VR	23 (21.3)	17 (28.8)	9 (4.5)
MCV	47 (43.5)	33 (55.9)	17 (8.6)

Note: some totals do not add up to 100% because of missing data, SCV = situational couple violence, CCV = coercive controlling violence, VR = violence resistance, MCV = mutual controlling violence. Table is product of the present study.

Table 3. Mental health indicators of different types of IPV perpetration.

Mental health indicator	n	M (SD)	Confidence intervals	
Depressive symptoms	NV = 33	6.6 (11)	2.6	10.4
	SCV = 86	8.7 (8.8)	6.8	10.6
	CCV = 32	12.7 (8.5)	9.6	15.8
	VR = 31	11.8 (10.3)	8	15.5
	MCV = 63	19.1 (10.8)	16.4	21.8
Emotional flooding	NV = 50	7 (11.6)	3.7	10.3
	SCV = 97	11.9 (12.6)	9.4	14.4
	CCV = 40	14.7 (12.8)	10.6	18.8
	VR = 30	27.9 (15.5)	22.1	33.7
	MCV = 62	27.8 (13.8)	24.3	31.3
PTSD symptoms	NV = 48	3.9 (6.7)	2	5.9
	SCV = 95	8 (10)	5.9	10
	CCV = 41	14.3 (10.1)	11.1	17.5
	VR = 31	10.5 (9.4)	7.1	14
	MCV = 62	19.6 (12)	16.5	22.6
Fear of a partner	NV = 49	1.1 (0.5)	1	1.3
	SCV = 96	1.3 (0.6)	1.1	1.4
	CCV = 40	1.4 (0.7)	1.2	1.6
	VR = 31	2 (1)	1.6	2.31
	MCV = 62	1.9 (1)	1.7	2.2

Note: table is product of the present study. NV = non-violent, SCV = situational couple violence, CCV = coercive controlling violence, VR = violent resistance, MVC = mutual controlling violence.

intimate partner than non-violent ($p = 0.001$) and VR victims ($p = 0.002$). An interesting finding was that victims of MCV experienced significantly higher levels of PTSD symptomatology ($p = 0.009$) than victims of CCV (table 4).

5. Discussion

Findings in the current study confirm Johnson's prediction about prevailing SCV in non/clinical samples, however the presence of MCV (rather than CCV) more commonly found in clinical samples of victims and perpetrators in the present study contrasts Johnson's assertion that CCV is typically characteristic in clinical samples while MCV is rare. The prevalence here of CCV and MCV supports Straus & Gozjolko (2014) recent findings that most highly coercive controlling violence in intimate relationships is mutual and not unidirectional. Further research in México using a typological framework of IPV perpetrators and investigating motivations of specific types of IPV perpetrators will further validate findings here presented. It is important to mention that Johnson (2010) has identified CCV as the "usual" domestic violence cases brought to court or the police attention whilst MCV is characteristic of couple where both partner are highly controlling/coercive against one another, independently of the outcomes (injuries, adverse mental health symptoms). Thus there is urgent need to further investigate family interaction patterns in Mexico, partner abuse and associated motivations in light of the dichotomy brought by a collectivistic traditional society (Cruz-Martínez *et al.*, 2013) versus the recent advances of structural gender equality (Frías, 2008; United Nations, 2013) that can shape family structure, collective beliefs about aggression, gender roles and sociocultural premises within this society (Díaz-Loving *et al.*, 2011). That is, results here suggest that future research in Mexico could benefit from an approach that includes gender violence as well as other types of IPV (e.g. situational IPV, mutually highly coercive IPV) in clinical studies as well as in nationally representative surveys (e.g. ENDIREH [National Survey about Relationship Dynamics in Households]). Overall, these findings support what other typologies of IPV perpetrators (e.g. Graña *et al.*, 2014; Holtzworth-Munroe & Stuart, 1994; Johnson & Ferraro, 2000) suggest about the heterogeneity of IPV.

Our second research hypotheses confirmed Johnson's findings that highly coercive/controlling IPV perpetrators displayed the highest levels of psychopathology albeit it appears through different developmental pathways and psychological profiles. MCV perpetrators in this study appear to resemble Holtzworth-Munroe & Stuart's (1994) dysphoric/borderline batterers characterized by high levels of depression, psychological distress and moderate to high physical and psychological IPV. These perpetrators have been found to be emotionally dependent or insecurely attached to an intimate partner (Johnson & Ferraro, 2000). CCV perpetrators in this study were found to have more moderate levels of depressive symptoms and psychological distress than MCV perpetrators, with also moderate to high severity of physical and psychological IPV and may resemble more adequately the generally-violent/psychopathic perpetrator (Holtzworth-Munroe & Stuart, 1994; Johnson & Ferraro, 2000). These are important distinctions that require screening for perpetrator type and subtype prior to any intervention. Also importantly, intervention programs should go beyond single-sex equality and respect-focused re-education and include appropriate clinical attention to highly volatile and distressed perpetrators, attachment dynamics (dysphoric/borderline subtype) and initiatives that address the generalized use of violence and

Table 4. Mental health indicators of different types of IPV victimization.

Mental health indicator	*n*	M (SD)	Confidence intervals	
Depressive symptoms	NV = 25	7 (8.1)	3.6	10.3
	SCV = 75	8 (9.6)	5.8	10.2
	CCV = 31	15.2 (11)	11.1	19.2
	VR = 19	10.2 (9.1)	5.8	14.5
	MCV = 48	21.3 (10.1)	18.3	24.2
Emotional flooding	NV = 44	4.8 (7.8)	2.4	7.1
	SCV = 88	10 (11.3)	7.6	12.3
	CCV = 31	31.5 (16.3)	25.5	37.5
	VR = 24	14 (9.9)	9.8	18.2
	MCV = 48	34 (14.4)	29.8	38.2
PTSD symptoms	NV = 40	5.4 (7.3)	3.1	7.8
	SCV = 86	7.6 (10.4)	5.3	9.8
	CCV = 33	16.6 (13)	12	21.1
	VR = 24	15 (10.3)	10.7	19.3
	MCV = 48	24.6 (11.6)	21.2	27.9
Fear of a partner	NV = 42	1.1 (0.4)	1	1.3
	SCV = 90	1.2 (0.7)	1.1	1.4
	CCV = 33	2.3 (1.3)	1.8	2.7
	VR = 25	1.4 (0.8)	1.1	1.8
	MCV = 49	2.2 (1)	1.9	2.5

Note: table is product of the present study. NV = non-violent, SCV = situational couple violence, CCV = coercive controlling violence, VR = violent resistance, MVC = mutual controlling violence.

antisocial personality traits and psychopathy (generally-violent/antisocial perpetrator).This is important as there is empirical research that has identified psychopathological features in different types of perpetrators (Graña *et al.*, 2014; Holtzworth-Munroe & Stuart, 1994; Stewart *et al.*, 2013). This does not imply the pathologization of partner violence but rather provides additional information on the nature of ipv as a multifactorial phenomenon (Dutton, 2006; Medeiros & Straus, 2007). Clinical (and non-clinical) ipv intervention efforts should also bear in mind strategies related to violence resistance (e.g. alternatives to violence, neutralizing entrapment) and situational couple violence perpetration (e.g. anger management counselling, communication and conflict management, couple sources of conflict, substance abuse intervention when necessary) as has been suggested by previous research (Johnson, 2014). In light of the heterogeneity of perpetrators (and victims) of partner abuse it has been suggested that a risk-need responsivity approach will contribute to the implementation of effective interventions (Stewart *et al.*, 2013). Therefore, research in Mexico incorporating risk analyses on different types of perpetrators appears warranted. In all, these recommendations will aid efforts to approach partner abuse perpetrator interventions in a more tailored manner rather than under a "one-size fits all" approach.

The third hypothesis confirms the importance of distinguishing amongst ipv victim (and perpetrator) types. Findings here show victims of ccv and mcv display higher levels of adverse mental health conditions than other ipv types (the latter faring worst in several mental health indicators than the former, for example, although by no means a thorough depression analysis is intended, victims of mcv reached a moderate depression clinical cut-off compared to victims of ccv experiencing mild depression in the bdi-ii). That is, victims of violence characterized by a generalized pattern of coercive control (and more so those in a mutually violent and coercive relationship) appear to experience worse mental health outcomes than victims of less coercive ipv. Aid delivery programs for victims of ipv should also include identification (screening) of the ipv type (and subtype if it is the case) and strategies appropriate to particular types of victimization. For example, for victims of scv, counselling on couple sources of conflict, couple communication and conflict and anger management are suggested. Assistance for victims of ccv should include efforts to neutralize relationship entrapment, transitional support when leaving a coercive and violent relationship as well as clinical assistance to cope with acute psychological distress and depression issues, traumatic event aftermath, etc.

Prospective analysis

Findings here highlight the need for appropriate diagnosis of ipv when delivering treatment efforts to victims and intervention assistance to perpetrators of ipv, particularly in clinical or selected populations (i.e. victims filing for ipv / receiving State Council psychological or legal aid, court-mandate-perpetrators attending re-educational intervention programs). Efforts to ameliorate ipv in Mexico will greatly benefit if appropriate screening of ipv perpetration type becomes standard procedure in all secondary ipv prevention programs. Findings here suggest that a thorough revision of victim assistance and perpetrator programs is warranted. That is, victim and perpetrator intervention initiatives in Mexico should consider ipv as a phenomenon that lies within a spectrum of types of violence (gender violence, situational couple violence, mutual violent control, etc.) as opposed to only one type of violence borne out of structural gender inequality differentials. Furthermore, research designs that investigate different types of ipv perpetrators (and victims) will shed light into this virtually unexplored approach in Mexico and will grant confirmation of findings here outlined. Empirical research identifying types of perpetrators (and victims) alongside motivations, beliefs and attitudes of collectivistic versus individualistic-oriented individuals will further clarify differences in violent and/or coercive controlling interactions between intimate partners. A further alley of future inquiry should include the assessment of conventional primary and secondary ipv prevention efforts (i.e. re-educational intervention programs for perpetrators of ipv-Híjar & Valdés-Santiago, 2010; legislation initiatives defining ipv as a gender issue – Cámara de Diputados del h. Congreso de la Unión, 2014) versus tailored programs stemming from typological empirical studies in Mexico. The present study considers no single type of ipv victim/perpetrator is less germane to assistance and research than others, but rather that all types of ipv are worthy of consideration in their own right, and all efforts to tackle ipv should consider all types of ipv.

Conclusion

The present empirical study provides evidence of the heterogeneity or intimate partner violence and associated mental health differentials in victims and perpetrators of ipv in Mexico using a typological approach as its framework for the first time. Important differences were found in the experiences of adverse mental health indicators by perpetrators and victims. Findings here highlight two key points: the need for more research on ipv using a typological approach to inform practitioners, and due consideration and revision of definition and standards of ipv intervention programs currently used in Mexico.

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