

Crisis Intervention in Interpartner Abuse

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Interpartner abuse should be distinguished from the more commonly recognized pattern of spouse abuse or battering that occurs within the context of an asymmetrical relationship wherein the abuser regularly aggresses against the abused.¹ The victim of predominantly unilateral violence is usually, though not invariably, the female member. Others are astonished that she remains in the relationship and endures repeated brutalities. She does so for one or more of several reasons. She may be terrified that if she leaves her husband will find her and kill her. She may have become so emotionally or economically dependent on her husband that separation seems more horrible than continued abuse or possible death. Fears of brutality and abandonment can have a "brain-washing" effect impairing abilities to set priorities and to make rational, adaptive decisions. Gratification of specific needs through the relationship makes abuse seem like a tolerable price to pay. Hilberman nicely summarized various forces that support the abused spouse's entrapment.² Despite repudiations in current literature, abusive treatment in some cases appears to satisfy a neurotic or masochistic desire.³

Spouse abuse, characterized by repeated unilateral brutalities and many cases of marital violence, has been discussed frequently in the literature under terms such as battered wives^{3,4} wife beating, and the assaulted wife. The phenomenon also occurs in cohabitating couples who are not married.³ The more common pattern of male-abuser and female-abused is sometimes reversed. Unilaterally directed beatings occur in homosexual relationships.

Another pattern of regular violence, interpartner abuse, should be recognized, because it may involve different dynamics and may warrant different methods of intervention. Reciprocal abuse is easily confused with unilateral abuse, when only one partner seeks help, complains of violence at the hands of the other, and presents as the sole victim. Steinmetz distinguished what she termed the "Saturday night brawl" from the "chronic battered syndrome."⁵ In the Saturday night brawl both partners engage in reciprocal recrimination, provocation, and physical abuse. Both partners take an active role in escalating their battles and causing them to get out of hand. While these distinctions are accurate, the term Saturday night brawl is something of a misnomer since physical exchanges are not always limited to one night of the week and can be as chronic and repetitive as unilateral beatings.

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Two errors can be made in responding to interpartner abuse. First, it is a natural tendency to suspect one partner to be the primary aggressor and the other, a helpless victim. Again, care must be taken not to lump interpartner abuse with unilateral beatings. Simply attempting to protect one partner from the other would be misplaced gallantry. At the other extreme is the assumption that both are at fault, and therefore both deserve whatever ill fate befalls them. This kind of thinking is used to rationalize noninvolvement.

Interpartner abuse warrants attentive concern from social service and mental health care providers on ethical grounds. Even if not physically mistreated themselves, innocent persons, such as children who witness their parents hurting each other, may be adversely affected. If both partners are "guilty" of aggression, both are also victims of their disturbed relationship. They are subjected to risks of emotional trauma, physical injury, maiming, or even death — which no one deserves. Some might imply that family violence is a subcultural norm that ought to be accepted as open mindedly as one accepts other subculturally associated behaviors. This kind of "open mindedness" uses stereotype to rationalize noninvolvement and constitutes discrimination against people of a certain ethnic class who are in need of help.

Barriers to Effective Intervention

One reason reciprocally abusing partners fail to seek treatment or counseling is that they doubt genuine help will be forthcoming. Unfortunately, their cynical views are often realized. Many, if not most, people in the helping professions want to have little to do with problems of violence. Hospitals generally lack a predesignated team or network of individuals who have some interest and competence in working with abusive partners. The result is that those seeking help are either denied help initially or sent through a tiresome succession of referrals.

Dynamics of any given case of interpartner abuse will not become clarified until treatment or counseling is well under way, but the pattern of interpartner abuse must be recognized posthaste. Both partners should be interviewed to identify this pattern. One of the first challenges, then, is to arrange to see both partners.

A second challenge is to break the cycle of violence immediately. The cycle must be interrupted if adequate intervention, let alone treatment, is to occur. Helping professionals are often uncomfortable exercising control over the behavior of others. Their training and dispositions tend more toward listening, advising, and guiding. A strictly exploratory or gently nudging approach is not enough in the face of ongoing violence. Directives must be explicit and forceful.

A potential barrier that must be appreciated before intervention is attempted is the partners' fear of separation from one another. Fear of a permanent breach in the relationship can prevent partners from seeking

help, even when they realize their relationship is on a dangerously destructive course. After intervention is initiated, fear of abandonment can inhibit one or both partners from full compliance with treatment.

A related fear is that the helping professional will side with one partner against the other. It is feared that if this happens, it will result in dissolution of the union or create an asymmetrical one in which one partner has all the power and control. The professional is not regarded as a neutral person capable of giving equal interest and assistance to both. He/she is expected to align with one partner to punish or humiliate the other.

Techniques of Crisis Intervention

The critical question for successful intervention is how does one break the cycle of violence and promote treatment compliance without threatening the relationship?

The suggested strategy is to interview both partners separately and then together. See the complainant for one hour, the other partner for one hour, and then both simultaneously for one hour. Schedule the hours one right after another, leaving no time for partners to exchange recriminations between interviews. In the individual sessions, obtain each partner's view of their discord uninhibited by the presence of the other.

The "noncomplaining" partner fears that the interviewer is siding with the complainant, so this distrust must be addressed openly. It is important for the interviewer to convey that she/he has no interest in taking sides. When the two partners are seen conjointly, their disagreements over matters of fact suggest one or both are lying or distorting the truth. They may even accuse each other of deliberate prevarication. Openly acknowledge that you cannot and will not make decisions as to who is the more truthful one. Your interest is not in identifying one partner as good and the other evil; you merely wish to help both of them achieve a better equilibrium. Complaints should be taken most seriously. Indeed intervention assumes the risk of abuse, even if one partner denies or minimizes it. If one partner denies a serious allegation made by the other, suggest that even if it is false, the allegation is so grave and the disagreement so basic it must be taken seriously for the benefit of both.

The nature and extent of abuse should be explored at the outset. How does one trigger rage in the other and vice versa? What kind of violence occurs? How serious are the injuries? Does either partner have a disability or illness such as epilepsy that increases the risk of permanent harm? Are homicidal threats made? How serious are they? Has either partner prepared to kill the other? Is either partner presently contemplating killing or harming the other? Does the potential murder victim have appropriate concern for his/her own life? Is the noncomplaining partner now feeling betrayed and wanting revenge against the partner who brought their troubled relationship to the attention of others? Has either partner used a deadly weapon to intimidate, threaten, injure or kill the other? Does either partner have ready access to a firearm?

These kinds of questions need to be asked frankly with partners individually and together in order to fully appreciate past and ongoing abuse with an eye toward effective prevention. Regardless of the answers, these questions convey a lack of timidity about facing their problems directly. These questions indicate their violence is regarded most seriously. Since abusing partners do not take their aggressive behaviors seriously enough, it is important to express sober concern without shaming or scolding them. It is as though they have come to accept violence as an unavoidable part of their relationship.

Abuse of alcohol or drugs must be carefully inquired about. Typically the substance abuser denies or minimizes the extent of his/her problem. Without joining the argument over whose view is more accurate, direct the suspected abuser to obtain a separate evaluation. This can be done with the suggestion that adequate assessment will best serve the relationship whether substance abuse is itself a problem or factor in partner abuse.

If one partner appears to have an untreated medical or mental illness that may contribute to discord and violence, handle it much the same as suspected substance abuse. If the ill partner openly complains of symptoms of physical or emotional distress, empathize and direct him/her to appropriate professionals. When the ill partner denies sickness, on the other hand, expressed empathy can be interpreted as confrontation. A firm but kind directive to obtain definitive assessment is the best approach. Tell the individual that you are placing a referral. This way, he/she knows the referral will be followed up. It is not completely left to him/her to pursue merely if he/she wishes.

Sometime near the end of the interview with both partners, make several firm directives. Referrals for medical, psychiatric, or substance-abuse disorders have been discussed. In all cases of ongoing interpartner abuse, partners must be separated. Regular, injurious assaults and threats of homicide necessitate separate living arrangements. This means one or both partners will have to move. If there is concern that one will harm the other despite separation, the feared-for partner should stay with a parent, sibling, friend, or in a shelter, but not with someone who would arouse feelings of jealousy such as an earlier lover. Separation may be temporary; it may become extended or permanent. In any case, the cycle of violence must be interrupted at the onset of intervention. Separation provides no guarantee against future violence. It is, however, thought to be safer in many cases than simply counseling cohabitating partners to cease their physical fighting.

Separation can be helpful in several ways. Again, it reduces, though admittedly does not eliminate, risk of continued violence. The directive — not recommendation — to separate further conveys the real gravity of abusive behavior and the importance of stopping it. Separation can enhance motivation to find more adaptive ways of relating to one another. Separation with interruption in abuse can help each partner gain enough emotional distance in their relationship to work on psychological issues in more

constructive ways. In the beginning, instruct both partners not to have any contact with one another outside the joint sessions. This is intended to prevent relapse into destructive ways of relating before partners have begun to approach their problems through the verbal mode with greater psychological awareness.

How does one effect separation by partners whose greatest fear is separation? And how does one assure compliance with other, equally threatening directives? Power helps. So does an openly acknowledged appreciation of the partners' fears.

Power may seem like an obscene word denoting a corruptive vice to professionals who have a deep respect for an individual's rights to privacy and self-determination. In special circumstances such as ongoing interpartner abuse, judicious use of power can be an act of kindness and respect. Of course, a clinician's legitimate, ethical, and clinically effective sources of power are limited. If an individual's employer partakes in the referral process he or she may be advised to order the employee to see you before you agree to accept the case. The abusive partner is then more likely to follow your directives than if he came in merely to appease his wife.

Initial distrust is the price paid for using power. This distrust will have to be dealt with openly. An attempt also should be made to explore and understand fears of separation in both partners. Expressed empathy and support are appropriate. Try to clarify the difference between a temporary physical separation in the service of developing a more satisfying relationship and the permanent breach in the relationship, which is most feared. It may be helpful to warn that uninterrupted cohabitation and violence can lead to irrevocable separation through abandonment, loss of love, or death. While insisting on temporary separation, explicitly and actively support the relationship to the extent that both partners support it. Counsel at the beginning that there is no guarantee that intervention and counseling will salvage their imperiled union.

Insist on seeing the couple again on the very next day and for a third and final session on the following week. If you do not follow the couple in counseling, instruct them to make an appointment to be seen at a family or marriage guidance center within a week. Since each partner may leave it to the other to make this appointment, both can easily fail to make the initial contact. One partner should, therefore, be designated to arrange for their first appointment. Tell them that while it is clearly their responsibility to make and keep this appointment, you will call the center to assure that they will be seen soon. Then make a point of calling the center both before and after their first appointment. All these measures are intended to assure continuity of care.

A serious risk is that the couple will not follow through with the referral for counseling and other directives. This is the reason for seeing the couple at least two more times. Seeing the couple on the very next day serves to keep their anger from getting out of control. It is useful in assuring that they did in fact make separate living arrangements and had no contact between

appointments. It conveys through action deep concern about their disturbed relationship and intent to provide psychological help, rather than simply to "bust" their relationship. The visit the following week is scheduled to follow their first appointment with the counseling center. Do not release care until the couple has begun counseling. During this last interview, assure that the couple has arranged for ongoing counseling.

Psychological Work

The two primary aims of crisis intervention in interpartner abuse are to interrupt violence and to assure that the couple becomes engaged in counseling. Lasting improvements in the relationship are unlikely within two weeks of intervention, but some psychological work can give partners hope that compliance with directives and counseling will eventually benefit the two of them. Several psychological issues can be broached during intervention.

Homicidal threats, even if frivolous, correspond to homicidal fantasies. Fantasies of killing another, like fantasies of killing oneself, are not always thought out in a logical way. Some open discussion of violent threats and fantasies in conjoint sessions can shore up reality adherence in an area where sound judgment and realistic thinking are tenuous during times of stress and emotional intensity. Explore the aims of homicide in fantasy. Homicidal fantasies are often associated with certain expectations. Killing one's partner may be expected to end one's own suffering. It may serve to transfer suffering from the subject to the victim. Homicide may be intended to secure a sense of power and control in the relationship. When delusional jealousy is operative, killing may be intended to prevent partner and paramour from enjoying the "love" for which the subject so bitterly pines. Where suicide and homicide are contemplated as inseparable acts, it is often with the hope of a happier union after death.

A fallacy that may be associated with homicidal fantasies is the emotional denial of physical death. The subject assumes a particular after-death result that in the heat of anger and desperation is devoid of more conventional religious beliefs. The continuity of emotional life in fantasy is divorced from continuity of life in reality. To integrate more realistic considerations with affectively determined expectations, ask the subject what would happen to his or her life, if he/she did kill his/her partner. What range of emotions could be anticipated both in the short term and long after? How would his/her own physical and social living situations be changed after murder?

Subjects may brutalize one another without adequate consideration of whether injurious beatings can lead to death. They want to punish and hurt but not kill one another. Coupling expectations in fantasy with realistic possibilities should be attempted with regard to adverse outcomes such as accidental death or maiming.

Some partners consider homicide out of fear that if they do not kill their partner, they will eventually be killed or maimed themselves. Even though

they provoke and abuse their partners, they feel trapped in an escalating struggle of violence that will apparently end only when one is killed. They may be afraid for their lives to leave, or they may simply see homicide as preferable to separation. Open discussion of threats and fantasies helps both partners appreciate the seriousness of their dangerous interactions. It should help both partners realize that violence is truly an abnormal aspect of their relationship.

Abnormal communication, both verbal and nonverbal, based on false assumptions, is often a feature of relationships with reciprocal abuse. For example, one young man believed his wife enjoyed a hard slap on her backside; in fact she felt angered and humiliated by such treatment. She, on the other hand, thought he was excited with pleasure when she sat heavily on his lap and bounced up and down, particularly since he smiled and voiced no complaints. In actuality this caused physical pain and an impulse to retaliate, but his machismo pride dictated initial stoicism. What generally started as sexual playfulness became interlaced with angry recriminations and progressed into vicious physical abuse.

Another example of misunderstandings involving physical abuse is the husky man who would point to his chin and invite his wife to, "Give me your best shot." He said he hoped this would help her to feel better; instead, it only made matters worse, because her strongest punch did not seem to phase him; her resulting futility and frustration caused her to wax even angrier.

The sex act itself can be carried out in a manner determined by false assumptions. The man may assume his wife likes rough treatment, when it causes her to feel silently used and resentful. Typically the entire relationship is devoid of communication about how one can promote feelings of pleasure in the other. There is an absence of mutual, expressed respect. Many interactions, not just the sex act, are regarded as confrontations and struggles for power, control, and preservation of self-pride.

Partners who abuse one another enter the relationship with predetermined notions that prove to be destructive. Some come from families where abuse was the norm. Whether you accept the social learning concept of modeling or the psychoanalytic defense of identification with the aggressor, the result is the same. Violence witnessed or experienced in childhood is reenacted in adulthood. It may be that some of these partners learned to provoke violence or to serve as victims as a result of childhood experiences in their families of origin.⁵

Partners may enter marriage or cohabitation with only short acquaintance and with preconceptions of how their partners should relate to them. They are enraged when their idealistic expectations are not met or when their worst fantasies are realized. Delusional jealousy is an extremely morbid form of the latter. Effective intervention and counseling involves confronting partners with their own fallacious notions.

Stony silence by one or both partners can arise in the course of intervention. Silence may be due to anger or fear. The partner who is reticent

because of anger may have no wish to cooperate, because he/she regards the intervention as punishment. A fearful partner may feel that any expression will incite the other. There may be hopeless resignation that nothing will help. The uncommunicative partner may distrust the intentions of the interviewer. Silence may be used as a defense or a weapon in interpartner negotiations wherein attempts to address conflictual issues in the past invariably and swiftly advanced to a row. Avoidance may be regarded as the only alternative to attacks and counterattacks.

To deal with affectively determined muteness, it is suggested that the interviewer take an active role, assert some control over the process and openly clarify her/his role and the purposes of intervention. Again, issues of distrust may have to be dealt with repeatedly. It may be necessary to acknowledge the silence and try to openly understand it with both partners.

Do not make the mistake of encouraging abusive partners to freely express their anger at one another in joint sessions. This may be appropriate in other forms of partner discord where inhibited expression of feelings is a primary problem. For many abusive partners, anger has been expressed too effusively, recklessly, and with intentions of berating, intimidating, and emotionally hurting one another. These partners perceive angry expressions as attacks that can be rebuffed only by counterattacks. If abusive partners resort to physical attack before attempting to resolve conflict through discussion, it may be because they regard verbally expressed anger as more malicious or hurtful. Facilitating expression of anger early during intervention may cause partners to feel even more resentful or frightened of one another between sessions. Hence, it may exacerbate risk of physical harm. They need help in modulating anger; in thinking more and feeling less, while learning not to act impulsively on their feelings. Some expression of anger is likely in the process of evaluating the nature of abuse and facilitating improved communication. The helping professional should endeavor to maintain control over verbal aggression by clarifying the hurtful or threatening nature of hostile expressions and by setting limits.

Example

The following case illustrates many of the clinical issues presented in this discussion of interpartner abuse. This case also shows one technique for bringing both partners into the intervention when one partner may be reluctant. In other cases, it may be necessary for the complaining partner to seek legal counsel to bring the noncomplaining partner into the process. Occasionally both partners present as complainants; this is the ideal situation.

Mrs. R, a 25-year-old married dependent of an active duty serviceman, USN, presented in the Emergency Room of a Naval Hospital with the complaint that her husband assaulted her the night before. Injuries were minor and did not require special treatment. Because her complaint suggested spouse abuse, I was contacted in the Psychiatric Clinic.

My first concern was how to involve her husband. Without his involvement, assessment of their relationship would be incomplete, and any attempt at intervention likely would fail. It was doubtful that Mr. R would visit a psychiatrist simply to please his wife, the target of his aggression.

Fortunately, Mr. R happened to be under the military command of the hospital, so some coercion was possible. I asked the referring social worker to bring this case to the attention of the Commanding Officer (CO) of the hospital and to ask the CO to authorize an assessment and to inform me of his authorization. When the CO telephoned me, I agreed to intervene provided that he first meet with Mr. R and order him to see me. I told him what time Mr. R should appear at the Psychiatric Clinic. Then I called back the referring social worker and asked him to tell Mrs. R to be in the clinic at the same time.

Mr. and Mrs. R arrived in the waiting area on time. After introductions, I said that I understood they were having serious problems in their relationship. I explained that I would meet with Mrs. R alone for one hour, Mr. R alone for one hour, and then both of them together for one hour.

Mrs. R reported that her husband came home late the night before in a state of intoxication. He angrily dragged her out of bed, presented a knife, and demanded that she cut him. Thus, another verbal and physical exchange was launched. According to Mrs. R, her husband frequently begged her to injure him, so he would have reason to beat her. He never threatened her with a weapon, but he did threaten to kill her, and he struck her with his fists. She would then typically return the blows and threaten to kill him, if he continued to hit her. After the fight, Mr. R would cry and swear never to abuse her again.

The couple had been married for only two months. They met about one year earlier, and were engaged for about nine months, but Mr. R was away on a cruise over most of this time, so they actually had little time in which to become acquainted before marriage. Mr. R used marijuana and alcohol excessively before marriage, but they argued only rarely, and there was no premarital physical aggression.

After marriage her new husband showed aggression that Mrs. R had not witnessed in him before. Once he broke her nose. Another time he broke a bone in his hand when his blow missed her and struck the wall. Not infrequently he locked her inside the house and took the house keys with him. She took phenobarbital and dilantin for grand mal epilepsy.

At this point it seemed as though Mrs. R was a victim of unilateral wife beating. The next step was to obtain Mr. R's view of the problem. In meeting alone with this 28-year-old man, I first acknowledged the coercive way in which he was referred. He initially regarded the intervention as punishment.

When asked about their marital difficulties, he began by describing her aggressions against him. She attacked him with knives and flower vases. Mr. R admitted they both were brutal in their verbal quarrels, but he insisted that she was invariably the aggressor in physical violence; his violence was merely protective. Mr. R had scars he claimed were inflicted by his wife.

Although she threatened to kill him, he said he never threatened to kill her.

Each had accused the other of being the primary aggressor. The working assumption now was that each had shared some of the truth, but neither had been completely truthful. Each had been aggressive to the other, and each had provoked the other to violence. Thus, neither was regarded as sole aggressor or sole victim.

Next I interviewed Mr. and Mrs. R jointly. They were both handsome individuals with athletic, mesomorphic physiques. They sat far apart and made virtually no eye contact with one another. Exploration of areas of conflict revealed that arguments centered on financial disagreements, feelings of jealousy, and Mr. R's drinking. Mrs. R accused her husband of spending money wastefully. Each suspected the other in infidelity. She complained that he was often intoxicated from marijuana and alcohol abuse, but Mr. R claimed he relinquished his marijuana habit one month ago. He now consumed no more than a six pack of beer over the course of a week. And she could not have seen him intoxicated more than three times.

After exploring their differences, I established that Mr. and Mrs. R were quite attached to one another and invested in preserving their relationship. Each denied any wishes to harm the other. But there was little reconciliation of their discrepant reports.

I expressed sober concern that unless they took some steps toward overcoming their self-defeating ways of relating to one another, there was substantial risk that someone would be seriously injured and/or their marriage would dissolve. I stressed the importance of temporary separate living arrangements for strengthening their endangered relationship. I specifically directed Mr. R to move into the Medical Holding Company of the hospital. Mrs. R was advised to stay with a relative. Regardless whether Mrs. R was correct about her husband's alcohol and drug abuse, the question was serious enough to warrant a separate evaluation by an alcohol counselor, and so I immediately scheduled an appointment for Mr. R. Mr. and Mrs. R were given the name, address, and phone number of a social worker in Family Services, and I assigned Mr. R the responsibility of making their first appointment for marital counseling. I told them I would see them together tomorrow and for a final hour next week. They were not to have any contact between appointments, as this could exacerbate ill feelings during this critical phase of intervention.

In the second joint session, I established that they had followed my directives, and they were now on the track of a program that could benefit their relationship. Mr. R was indeed in the Medical Holding Company, and Mrs. R's sister was staying with her. They were scheduled to be seen in Family Services. I shared with them my initial contacts with Alcohol Rehabilitation Service and Family Services.

In order to appreciate positive valences in their relationship, I asked what each found appealing about the other. Mr. R regarded his wife as physically attractive, intelligent, and outgoing. She perceived him as desir-

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ably handsome and compassionate. Mrs. R went on to say that she had been married before to a man who beat her regularly and once nearly killed her. She felt as though she were again traversing the same treacherous road and was afraid of where it could lead. She did not see any role she could have played in becoming involved in two successive violent relationships.

Other issues of conflict were examined. Both came from religious families. Mr. R's parents were ministers, but he had no desire to attend church. Mrs. R, on the other hand, felt that church should be an important aspect of their married life. Sex was also a trouble spot. In addition to their reciprocal suspicions of infidelity, Mrs. R felt her husband was too domineering and inconsiderate, and he experienced her as emasculating. All these factors contributed to sexual dissatisfactions for both. It was clarified that these conflicts would not be resolved in our few sessions. For now it was enough that these issues could be identified and discussed. The need for further counseling became evident to Mr. and Mrs. R, and they gained some hope that counseling would be of benefit.

I saw the couple for a final session the following week. Mr. R was scheduled for admission to the Alcohol Rehabilitation Service on the same day. Mr. and Mrs. R continued to live separately. They had had their first marital counseling session and made a commitment to continue in weekly sessions.

Some attention was given to Mr. R's initial resistance and distrust. While he no longer regarded the intervention as punishment, he thought he was being overtreated in having to enter the inpatient program for alcohol abuse. Although he still doubted that his use of alcohol was as problematic as his wife suggested, he agreed that he needed to complete the program for the survival and betterment of their marriage. Mr. and Mrs. R both stated that they found our sessions to be useful.

I asked Mr. and Mrs. R about their most serious concerns pertaining to their violence. Mrs. R could foresee killing her husband; she had contemplated killing him at times when she felt terrified of him. Intending to balance the expression of murderous fantasies with realistic considerations to bolster adaptive ego functioning, I asked what she could expect to happen if she slew her husband. She feared his death would end everything that was good for her, and she could lose her mind.

Mr. R persistently denied any wish to kill his wife, but he agreed with her concern that he could accidentally kill her by striking her too hard. She was especially vulnerable because of her seizure disorder, and they had already had a few scares. I asked what would change if he killed her. Mr. R said he would feel crushed; he could not live without her. I reminded Mr. R that if he killed his wife by "accident" or by careful planning, she would be equally dead in either case.

As the hour came to an end, I warned that immutable persistence of their violent patterns of interacting created risks of serious physical injury, homicide, and dissolution of their relationship. I encouraged them in their

initial efforts, supported the steps they had already taken, and urged them to follow through with their present program.

Summary

Most of the literature on partner abuse deals with the pattern wherein one member, the aggressor, repeatedly assaults the other, the victim. In some cases of partner abuse, however, both partners are perpetrators and victims of reciprocal violence. These cases can present as the former, more familiar pattern, if one partner functions as the complainant.

To intervene effectively, the professional should identify interpartner abuse at once. Barriers to intervention, on the part of both care providers and abusive partners, should be appreciated. The twofold challenge for the helping professional is to interrupt violence and engage partners in appropriate treatment or counseling. Techniques for accomplishing this are presented. Initial separation of partners is advised. Some important psychological issues can be profitably addressed during intervention. Ironically and simply, intervention should help abusive partners become acquainted with one another.

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