Tri-County Batterer Intervention Provider Network Meeting Minutes May 8, 2018

Present: Chris Huffine, Allies in Change; Jacquie Pancoast, Eastside Concern; Jason Kyler-Yano, Portland State; Regina Holmes, ARMS; Ashley Carroll, Multnomah County-DSVCO; Carrie Kirkpatrick, Department of Community Justice; Nanci Jarrard, VOA-Home Free; Phil Broyles, Teras; Tammie Jones, OJD

Minutes by Jason Kyler-Yano, edited by Chris Huffine

Discussion Topic: Addressing mental health issues in our group members

The discussion on addressing mental health issues in BIP group members included the mental health topics of suicidality, depression, substance abuse, complex trauma, major mental illness, ADHD, and personality disorders.

We began with a discussion on suicidality and how it is a dangerous risk factor for murder-suicide. Suicidality can be categorized into either being actively suicidal or having normative passing suicidal ideation. Actively suicidal people have a history of serious suicide attempts, have a clear plan, are accessing the means of carrying out that plan, are severely depressed, have very little to lose by killing themselves, and are at most risk for committing domestic murder-suicide. People with passing suicidal ideation do not have a history of serious suicide attempts, do not have a clear plan, have not taken steps toward doing it, and have clear reasons for not doing it. This second and larger group are often confused with actively suicidal people and are incorrectly treated by legitimizing their passing ideation as seriously threatening instead of as normal feelings of despair. Actively suicidal men want to end their lives, and if they are enmeshed with their partner and family, want to take their families with them. The windows of active suicidality are often small (e.g., minutes, hours or days) but they are also extremely dangerous, so it is important to safety plan with their partners and children to keep them safe and inaccessible while the window is open. The group acknowledged the heightened risk of suicidality when co-occurring with substance abuse, and even more so when a weapon is added to the equation. Assessments of suicidality as a risk factor for abuse and murder-suicide are not included in the risk assessments that most programs use, though having some indication of active suicidality would be useful for programs, law enforcement, and probation among others to properly assess risk. For a more in-depth discussion specifically on suicidality, refer to the minutes from the group's past discussion on suicidality from 4-5 years ago.

Depression can be divided into "little d" depression and "big D" Depression. Little d depression is the low-grade depression that any of us can feel at times and is associated with events that are currently happening (e.g., lost custody of kids, wife left). This type of depression is not chronic, will not be helped much by medication, and is not considered clinical depression. "Big D" Depression is the clinical type of depression characterized by chronic feelings of numbness (as opposed to sadness), disconnection from life and people, a lack of pleasure in activities previously enjoyed, rumination, and an inability to do normal tasks for functioning, among other things. This Depression may have been triggered by negative events but are not caused by them and last far beyond the time period in which the negative events occurred. Our work in groups and men's efforts to change can be undermined by clinical Depression even when men are really trying to do the work. The rumination that often accompanies Depression can help them justify their abuse by imagining that everyone is against them. Depression can aggravate the abuse because it can be expressed and operationalized as anger and aggression in our men. Program participants who exhibit clinical Depression symptomatology may need to be referred to mental health or psychiatric professionals because their needs go beyond our work in groups. A challenge in making these referrals is the limited number of mental health professionals who know how to work with an abusive man who is Depressed without inadvertently enabling their

know how to work with an abusive man who is Depressed without inadvertently enabling their abuse and/or supporting their justifications for abusing their partners. In the same way that it is important for us to not mistake our work as capable of dealing with clinical Depression, it is also important that mental health professionals who are untrained in DV matters do not mistake their work with abuse intervention and instead refer an abusive client to a BIP. One condition doesn't cause the other, but each can aggravate the other.

Substance abuse was identified as a frequent co-occurring issue with abusive men. It was identified as a risk factor for dropping out of group as well as for recidivating, as many men who come back to group due to a re-offense have also started to use again. Substance abuse can interfere with real change and the prefrontal cortex's ability to make thoughtful, better, and non-abusive decisions. When substance abuse is co-occurring with several other issues (e.g., other mental illness, DV issues), it can be difficult to tell what issue is most intrusive and thus the priority for intervention and so it is important to get the person clean first and assess from there. Because substance abuse can interfere so substantially with the work done in BIP groups, it is important to refer men with this issue (similar to the case of depression) to specialized substance abuse services, especially if they're actively using. BIPs and substance abuse programs are not a substitute for each other but are rather can be complementary interventions.

A significant subset of abusive men are childhood trauma survivors. Some of them are complex trauma survivors—having experienced multiple episodes of trauma, often within the family. Among other symptoms, these individuals can be prone to affective flooding where they become highly emotionally aroused due to current events triggering a trauma response. When in their "trauma brain" state, they may display poorer judgment, be much more impulsive, and struggle to effectively access newer learning including material they have learned in their group. These individuals are also at greater risk of becoming abusive again because of this. They may also need additional therapy work to address their trauma in order for them to successfully apply their new learning.

Major mental illness (MMI) refers to disorders which cause psychosis and include schizophrenia, bipolar disorder, and schizoaffective disorder. Each of these conditions can include delusions and hallucinations. At times these may include thoughts or images of violence. Whether people with an MMI are abusive or not depends on the presence or absence of pro-abuse beliefs, not on whether they are psychotic. There are psychotic people who have violent delusions or hallucinations, but never give themselves permission to act on these because they do not have a pro-abuse belief system. People with MMI have been successful in the program once their abusive beliefs were addressed even if they still have their illness. However, MMI can interfere with success in the group particularly if the disorder prohibits the person from relating to the group and having the group relate to them. Bipolar disorder is often misdiagnosed, including in people who have experienced trauma and/or who are abusing substances, but once those people become stabilized in their lives, these bipolar-like symptoms can go away.

Attention deficit hyperactivity disorder (ADHD) was discussed in relation to its association with self-medication through substance abuse. Many people diagnosed with ADHD as kids initially take prescription medication but as they get older self-medicate with drugs. ADHD interferes with progress in group because it makes it harder for guys to retain information in group, and it is associated with impulsivity, inattentiveness, and forgetfulness. These characteristics not only interfere with group work but also can also increase conflict in their relationships. These characteristics associated with ADHD also make it difficult for community corrections to work with these men, though understanding the clinical diagnosis of ADHD helps.
Personality disorders refer to rigid ways of thinking about other people that lead to distorted perceptions and inappropriate responses. People with personality disorders ultimately have difficulties with nearly everyone they interact with, not just family members. Most abusive partners do not have personality disorders as evidenced by their ability to get along fine with most everyone else except family members. Abusive partners with personality disorders can be particularly challenging to have in groups because they can be disruptive and often have difficulties getting along with other group members and staff including administrative staff. In

fact, administrative staff are often the first to pick up that there is something wrong with this subgroup. Many of these men also mischaracterize their partners as having Borderline Personality when they actually do not, instead display very appropriate responses to the abusive behavior they are experiencing. Abusive men with Paranoid Personality disorder are among the most dangerous for providers to work with as they are very quick to feel threatened and take offense and then respond in an aggressive manner to these (mis)perceptions.