Tri-County Batterer Intervention Provider Network Meeting Minutes-March 8th 2011

Attendance: Chris Huffine (Allies in Change Counseling Center), Justin Donovan (Pacific University/Allies), Linda Castaneda (Manley Interventions), Jacquie Pancoast (ChangePoint), Samantha Naliboff (VOA Home Free), Amanda Binley (Bridges to Safety), Regina Rosann (Abuse Recovery and Ministry and Services), Wendy Viola (Portland State University), Aaron Potratz (Cedar Counseling Center), Dean Camarda (Allies in Change Counseling Center)

Minutes by Wendy Viola, edited by Chris Huffine

Group Discussion Topic: Mental Health Issues Among Abusive Men

The intention today is *not* to decide whether or not these men inherently carry a diagnosis, but rather to talk about concerns regarding clients who may have other psychological issues in addition to being abusive.

Many clients who come in have multiple diagnoses, and it's often a struggle to connect them to the resources that they need in the community.

A substantial number of providers have a background in mental health, but also a large number of them who have very little knowledge of mental health. It's easy for those with a background in the area to forget that others in the field don't have very much training at all in mental health.

It could, and often is, easy for men to use their diagnoses as excuses or rationales for their abusive behavior, and use their diagnoses to avoid taking responsibility for their abusive behavior. Within drug and alcohol treatment programs, participants are taught that they have an extra responsibility to avoid the substance, but that isn't the case for men with mental health diagnoses. Another distinction may be that the intentional step of consuming a substance is involved in drug and alcohol- "excused" DV, but not in the case for mental health diagnoses.

Few men in BIPs, however, have official diagnoses, or embrace their diagnoses, and therefore don't use them as excuses. If they have received mental health treatment, they may have had their abusive behavior informally sanctioned by mental health professionals, as well as by the society-wide belief that individuals with mental health issues can't be held responsible for certain behaviors. There is also a lot of ignorance among the clients about their own potential mental health issues, as well as resistance to official diagnoses. More often, men in BIPs blame their partners' mental health issues (bipolar, borderline PD), than their own.

This issue was previously discussed (with minutes of those discussions) on 10/24/2000, 5/8/2001, 8/5/2003, and 1/4/2005. Generally, a greater awareness of mental health issues would be very worthwhile for BIP providers, and it would be worthwhile to keep our eyes peeled for mental health training in the area.

There's a concern among providers about medicalizing a belief system. The perpetration of DV, and its consequences and precursors may look like mental health issues, but in fact aren't real diagnoses, and it may be risky to medicalize these tendencies.

Types of mental health issues:
1. Mood disorders: depression, anxiety (including somatizing), OCD; chronic, inappropriate level of affect

2. Thought disorders: bipolar (categorized as a thought disorder because of the manic phase), schizophrenia

3. Learning disabilities/information processing: Attention Deficit Hyperactivity Disorder; autism/Asperger's; dyslexia, etc. These can be easily misdiagnosed. For example, many other conditions (e.g., high intelligence, a learning disability, depression) can be mistaken for ADHD. Likewise, many men struggle with emotional expression and interpersonal connection who are NOT autistic.

4. Personality disorders: likely to drive providers the craziest. These individuals are also most likely to stir up other group members. Some people mistakenly believe that most abusive men have personality disorders, which is not the case, as illustrated that most get along with everyone else except for family members.

5. Traumatic brain injury: In abusive men this can lead to more impulsive and less discrete abusive behavior. This can also lead to otherwise non-abusive people having angry and abusive outbursts.

6. Trauma: PTSD, continuing distress from childhood trauma. New diagnosis in the newest DSM: complex trauma disorder (which would result from ongoing trauma) vs. simple trauma (the result of one acute traumatic incidents)

7. Substance abuse

Clients often refer to the "diagnosis of the day"—the diagnosis that is getting more attention in public, the media, etc. Currently ADHD, autism/Asperger's are high-profile diagnoses right now, so clients will tend to claim to have or be mis-diagnosed with these diagnoses. Cultural differences can also sometimes be mistaken as mental health issues.

It's essential that BIP providers have a greater awareness of mental health issues, though we've agreed as a group that these mental health issues do not cause DV. But what is the relevance to us as BIP providers? Why should we care about the diagnoses? What's the connection between mental health issues and DV? (Most mental health providers don't address DV issues). Knowing that men have diagnoses and failing to address it may be negligent. Mental health issues may be risk factors (e.g., suicidality), and failing to address this risk is negligent. Taking ownership of mental health issues is a part of individuals' accountability, and not acknowledging one's own struggles with issues of mental health is a failure of accountability. There is space to talk about issues of mental health, self care, etc. *so long as it's all tied back to accountability*.

While mental health issues may not cause DV, their presence can interfere with the work men need to do in group. If their mental health issues are hindering their participation and learning in the group, it is the responsibility of BIP providers to get them the help that they need for the group to work for them. Getting clients the mental health support that they need may enable them to avoid the situations in which they escalate. On the other hand, perpetrators often only escalate on their family. Is it considered a mental health issue if clients have enough control to be calculating and targeted in the manifestation of their mental health diagnosis? For example, if anxiety leads to abuse in the home, why doesn't just as much anxiety lead to abuse in the workplace, or in court, etc?

Essentially, evidence based practices indicate that we need to be more comprehensive in our work with offenders, which includes increasing attention to mental health issues. We take more comprehensive approaches for addiction, sex offenders, etc., we should do the same with regards to DV. The idea of being responsive is figuring out the barriers that are preventing an individual from addressing a problem, and removing those barriers (e.g. language). To what extent may mental health issues be barriers to participation in BIPs? This may be especially relevant to men with learning disabilities. Men with criminal tendencies tend to have pretty short attention spans, so those groups are (or ought to be) run more quickly, more high-paced, etc. Learning style should be considered in deciding how to run each group. Some providers also offer individual sessions instead of groups to cater to learning disabilities and hindrances (i.e. illiteracy). This may be problematic if clients are faking, but participating in individual sessions may serve to call their bluff.

Providers need to know enough about mental health to know *when* to make referrals. A lot of domestic homicides happen when abusive men are suicidal, which makes it extremely important to be aware of depression and suicidality. It may therefore be worthwhile to provide BIP providers with training in identifying suicidality. Familial homicides by abusive men are often due to perceptions of enmeshment, or an inability to envision their family going on without them. Many men set boundaries for themselves—not allowing themselves to be physically abusive, to punch their partner with a closed fist, etc. When these men become suicidal, they may then allow themselves to cross all

of the lines they've set for themselves, and ultimately kill their partner. If BIP providers become aware of a client's suicidality or homicidal thoughts, we have a legal obligation to contact the P.O., as well as the potential victim.
Mental health issues will also show up in the group and disrupt the group's functioning. Group members pick up on each others' mental health issues, which can completely disrupt the group, making it especially important to refer out for diagnoses. If a particular client repeatedly disrupts the group, that may be a very crude indicator of their need for an evaluation. Another tell-tale sign is monopolizing the group. When clients in a group are not stabilized, the rest of the group may also rally around them, which enables them to avoid thinking and talking about themselves. It's very useful to have someone within each program who has appropriate training in both mental health and issues more specific to IPV.

The prevalence of mental health issues in groups seem to vary by county—in Linn county they tend to see more learning disabilities than in Marion, which may be due to county practices around diagnoses. There may also be differences in sentencing. This may also reflect cultural differences within the counties.

To summarize: there is a subgroup of abusive men with mental health issues, which don't cause but may exacerbate the abuse. Every provider needs to screen participants for mental health issues. We identified 7 categories of mental health issues (mood disorders, thought disorders, learning disabilities, personality disorders, brain injury, trauma, and substance abuse). The important question for BIPS is to what extent is the diagnosis interfering with the program? Providers have a responsibility to make appropriate referrals and alter some aspects of the group and homework to meet the needs of clients with mental health issues. Part of comprehensive treatment is addressing mental health issues in this way. There's some mental health training out there for BIP providers, but there could be more.