Tri-County Batterer Intervention Provider Network Meeting Minutes October 10, **2017**

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Minutes by Kate Sackett, edited by Chris Huffine

Discussion Topic: Multi-modal work with abusive partners

Historically, interventions have focused on helping people address problems one at a time such as helping them find work, dealing with a mental health issue, dealing with substance abuse, etc. Over the years the substance abuse field has broadened its approach to include psychological interventions, education, housing, job development assistant, and other domains (in addition to substance abuse intervention) to more comprehensively support clients' sobriety. This is referred to as multi-modal work because it goes beyond the traditional approach of providing a single modality of intervention (e.g., substance abuse, individual therapy, etc.) at a time. What could the batterer intervention field do similarly to expand intervention efforts in this field?

Part of where the field of batterer intervention runs into problems is the moral view of abusive partners as "bad" or "evil" and a resistance to giving them any kind of support. There is also a tendency in the field to resist efforts to look at other issues that abusive people have (e.g., alcohol or drug addiction), partly from a fear that it takes away from their accountability to say something else "causes it" and use that as an excuse for their behavior. To be clear, no one present was suggesting that any other issues "cause" abusive behavior, rather that it can trigger abusive behavior in those already prone to being abusive.

Co-occurring issues left unaddressed can be problematic in at least two different ways: they can help perpetuate or escalate abusive behavior and/or they can block interventions from being effective.

Substance abuse

The most obvious area that the domestic violence field has acknowledged as a relevant type of comorbidity is substance abuse. Most programs acknowledge that if an addiction issue is co-occurring with domestic violence, the addiction needs to be addressed. Marijuana use seems to be a special case where heavy use can compromise change and negatively impact memory, but it's more subtle of a compromise compared to other drugs. For many men in BIPs who seem to hit a plateau (e.g., making good progress but not reaching a higher level of accountability), there is often a hidden addiction. Once that

is dealt with, they continue moving forward. Shame issues can also come up for those with and without substance use issues.

Since a pro-abuse belief system is the root of the problem, drug abuse or alcohol abuse will exacerbate it but addiction without the belief system will not lead to domestic violence. A train-track model can help show the connections between substance abuse and domestic violence. If substance abuse is one track and domestic violence beliefs are the other track, there are all kinds of events that connect them as ties across the tracks. Challenging the abusive beliefs is important, but if someone is in the middle of substance abuse/addiction then the prefrontal cortex is not engaged and you have to work with them from their midbrain, also accounting for their trauma.

Mental health issues

Mental health issues are another area where they could be really helpful or run into some issues trying to deal with that. Depression and anxiety are obvious examples that can prevent people from engaging in the program because they are so focused on their own survival. Mood disorders can get so severe that people cannot function in group (though rare). Severe depression or anxiety may also prevent the men from showing up to the program at all. A lot of the violence that the men do is driven by distress ("hurt people hurt people"), so co-occurring psychological issues need to be addressed so as not to compromise their work in groups and to prevent suicides, homicides, and other serious consequences.

What do you do when individuals have mental health needs like PTSD (e.g., from war for veterans) that prevent them from absorbing what they're trying to work on in group? Referral to mental health services is one main recommendation. Some providers have referred people to mental health treatment before they go to the group, others had clients who went to individual counseling throughout their work in the group. Sometimes it is still in their interest and their family's interest to keep them in the program just to keep them engaged, but the issue requires tagging as an area of concern.

One concern though is that mental health professionals may collude with the denial and the pro-abuse belief system if they do not know about the dynamics of domestic violence. Men can also take their current pro-abuse beliefs and things they should be working on in the group to their individual counselor, who then gives them very poor guidance. Ideally, referrals should be to domestic violence-informed mental health providers who will coordinate with the BIP providers to keep one another informed (though this is not always possible).

It is encouraging to see how many men are open about going to individual counseling now (e.g., can encourage others in the group to go, remove stigma). Although VA counseling is sometimes available for some clients, the quality and lack of availability is still somewhat concerning. They do seem to have many other kinds of programs (classes,

yoga, etc.) that are offered if people want to take advantage of them. Another option is to have in-house counselors (e.g., graduate students) who are available to provide individual counseling within BIPs themselves (e.g., Allies in Change).

The distinction between individual and group work can be hard to navigate. The more you (a client) want to talk about present-day interactions, that is group work. The more you want to talk about your past, historical events, family history, that is individual work for therapy. It can get tricky when one or the other happens inappropriately.

Abusive partners with major mental illness (e.g., schizophrenia) who are actively psychotic cannot be seen in a group. Individuals who have voices strongly encouraging them to be violent who are able to resist those voices and do not give themselves permission to be violent can be a significant counterpoint to the men in group as an example of a group of people who do not have a pro-abuse belief system.

Oppression

Oppression is also another difficult area to navigate in batterer intervention (e.g., a man of color reacting to someone calling the police in response to a domestic violence event). The recommendation is to connect them to their community more (e.g., Latino clients with Latino groups to connect them more). The US is also an example of how the greater the gap is between the wealthiest and the poorest, the more issues they have with violence. At the macro level, this increases distress and leads to acting out. At the micro level, it can lead people to be violent and make them more likely to be caught up in the net disproportionate representation in the criminal justice system. The hierarchy of violence or genocide pyramid is also helpful to think about in relation to these structural differences, where violence at higher levels can impact those below them and those around them, but those at the bottom are only violent to others at their level.

Trauma is also a distinct issue. Experiencing oppression can make it easier to be abusive (e.g., race riots) because people may be feeling more distressed as part of that group. This is also relevant in the Risk Needs Responsivity (RNR) model to consider in being responsive. People who are not oppressed are more likely to minimize or dismiss their experiences. One example of this was in an opinion piece written by a black high school student here in Portland about microaggressions when going to school in both a mostly white school and in a mostly black school but still with mostly white teachers.

This can come up in groups when a provider may not realize or acknowledge different needs (e.g., public transport) that may be ignored by middle class providers. What do you do with the extra burden that is on oppressed people in groups to make as much progress? Helping them find their voice is really important. Help them speak in their own ways. Ask if there is a leader in the community who can help them deal with their pro-abusive beliefs (e.g., clergy or others).

Trauma

The second most common issue mentioned after substance abuse is trauma. In the RNR model, being responsive is also about offering trauma-informed care and making referrals for their trauma needs. Trauma is very common, as the majority have some history of it and that is added to if they go into jail or prison. They are trying to access trauma intervention to help them deal with that before they get to the group. If you can get that regulated, then other interventions can be more effective.

There is also a distinction between simple and complex trauma, where complex is often from early trauma in childhood, but there are differences that need to be acknowledged. There is also trauma from oppression, such as historical trauma and issues in using tools of oppressive groups (e.g., spanking). Complex trauma is very complicated.

A new study on using MDMA to enhance recovery from complex trauma and memory for abusive men who are trauma survivors investigated whether it rewires the brain for therapy to enhance their change process. It wouldn't be taken regularly, but done in conjunction with therapy sessions to do memory and trauma processing in the altered state (like LSD and mushrooms), similar to what EMDR does. It could be helpful for domestic violence perpetrators who are very effectively reactive, not the calm cool collected guys who do it.

Traumatic brain injuries (TBI)

Another group with overlap are people with traumatic brain injuries. There may be mild brain damage that may lead to symptoms like impulsivity and reactivity or memory issues, so providers need to screen for that and take that into account when intervening with them. This can also make people very dependent on their partners and affect the relationship context. There are also a lot of guys with physical problems that may have led to some pain pill use. More general self-care can also be pretty compromised, like lack of medical care, which ties into toxic masculinity.

Attachment issues

One less frequently mentioned issue is attachment style and attachment issues. Some of the guys have attachment disorders (e.g., aren't able to trust) and so combining an insecure attachment style with a pro-abuse belief system leads to abuse (not the attachment disorder alone). That can be addressed with good counseling with a skilled mental health professional, as long as the domestic violence piece is clear too. Another area to address is parenting, which can also be related to attachment issues, but it can be very motivating to men who want to be parents. Jealousy also seems related but also its own issue in not responding to the cognitive restructuring of other aspects of the pro-abuse beliefs. This relates to attachment, fear, and codependency.

Lifestyle instability

Lifestyle instability and economic issues also create stressors like becoming unemployed and losing housing, which makes people more likely to act out. Like other criminal populations, having less to lose makes people more likely to recidivate. This also affects dropout rates from programs (e.g., not having reliable transportation). Having a job that they value and housing and transportation helps people feel valuable and connected to society. Some men also derive much of their self-worth from their job, so talking to the partners can help identify if the financial pressure is real and the extra hours are needed, even though they also have stress from not having them around.

Social isolation

Limited social supports are a huge concern. These are hard to intervene on or develop, but many men come in very isolated and many of them seem very lonely and do not have friends. Though partner isolation is commonly talked about, another Tri-County topic could be on how to increase contact with good healthy peers and also respond to their connection to negative peers. Sometimes groups are the main social support for guys, but then people still do not come to alumni groups.

Criminal thinking/criminogenic factors

Criminal thinking and behavior and criminogenic factors have mostly been ignored, but a subset of men have these criminogenic factors. Starting to address criminal risk is a legitimate new avenue that needs to be considered. Some men in group have few or no criminogenic factors, but those that do have these risks need to be addressed. There is also empirical support for separating the low and high risk groups that way (e.g., can have men working in both MRT and the regular domestic violence group).

Sexually abusive behavior

Referrals where there is also a history of sex offense can be complicated. Some cases were not able to be worked with because of other groups that providers work with. Some of the cases were not worked with at all because they were in jail or prison or they were cases of statutory rape, but this is another blind spot where groups are not able to sustain or have available referrals to address this. The more extreme kinds of sex offenses are often not identified, not regularly screened for (more in psychopathic populations), but it's a more underground group of needs. The very predatory behaviors are also not always identified or dealt with. They can be identified, but people are usually not asking enough questions or know which questions to ask, or recognizing that it is an additional need. There seems to be some grey areas where there may be some or no overlap in the sex offender and abusive partner groups. The most overlap is in the high risk populations, where they engage in both realms. Adjunct services are needed for any partner who may not qualify as a sex offender but who has specific sexual kinds of abusive behavior that are not addressed by standard domestic violence groups.

Other issues

Other problems are when funding (e.g., from OHP or probation) runs out. Responsivity is also needed for learning disabilities. Stages of change and motivational interviewing can also be considered to modify interventions based on the stage in which people are in the group. This might not be a huge difference from what people do in groups anyway, but group members may need different kinds of motivational support.

Less common problems may include the number of clients who get in relationships with women with physical or mental disability, even registering as a caretaker in some cases, especially if the woman has resources (e.g., economic, emotional). This may be more common among more predatory perpetrators and not very common in general domestic violence programs.