Tri-County Batterer Intervention Provider Network Meeting Minutes June 13, 2017

Present: Chris Huffine (Allies in Change), Bekka O'Shea (Center for Family Success), Karla Upton (Multnomah County DCJ), Linda Castaneda (Castaneda Counseling), Amy Simpson (Eastside Concern), Michael Davis (Eastside Concern), Matt Johnston (Domestic Violence Safe Dialogue)

Minutes by Kate Sackett, edited by Chris Huffine

Presentation/Discussion Topic: Trauma-informed care – applications to batterer intervention and abusive partners who are childhood trauma survivors

Chris Huffine gave a presentation on trauma-informed care as it pertains to batterer intervention and working with abusive partners who are themselves childhood trauma survivors. This topic is well known in Oregon and the phrase is familiar to many, but the concept itself is not necessarily well understood. Attached is a copy of his presentation.

Trauma informed care often gets conflated with trauma specific services, which are services that actually focus on working with someone's trauma and helping them heal from trauma. Trauma specific services are often offered by counselors or mental health providers. Trauma informed care is a more general way of providing any sort of service (e.g., legal, social, governmental) that considers *how trauma survivors may respond differently than "normal" or "expected" or "typical" ways*, and makes accommodations for them, when possible.

Mandy Davis, a faculty member at Portland State University, has done work on the neurobiology of trauma, as individuals who have experienced trauma have different brain functioning than those who have not. Trauma affects the way we respond to the world ("neurons that fire together, wire together") with survival mechanisms acting first and faster than the thinking brain. For example, in trauma survivors, the amygdala is hyper-vigilant, scanning for danger or threat, and is quick to react and respond to perceived threats (e.g., loud sounds, images, or other threats of danger) to promote survival. This response tunes out verbal cues and can lead to misinterpretations. Trauma can also be compounded in complex trauma. ACES studies show that individuals who have experienced multiple forms of trauma are at higher risk of physical and mental health and other problems.

Examples of trauma symptoms include hyper-vigilance, dissociation, distractibility or concentration problems, anxiety, depression, hostility, emotional lability, sleep problems, overeating, and being "uncooperative." Trauma survivors can also commonly be negatively characterized as "non-compliant," "resistant" or "defiant," flaky, and irresponsible. These characterizations stem from staff or others not understanding their valid reasons for being mistrustful and not considering their input on how they need to be treated differently.

A psychologist found that trauma survivors experienced community health re-traumatization from interacting with the infrastructure (e.g., long waits, distant locations), a denial of abuse (ignoring, silencing, minimizing), exerting power and control over the client, repression of emotions, being pathologized and blamed, failure to listen to or take seriously their concerns, using diagnosis to label, a lack of compassion or understanding, automatic expectations that they will or should be trusting, penalties for being "dishonest," and lack of privacy or confidentiality. (More information can be found in an online publication on Community Retraumatization, compiled by Ann Jennings, at www.theannainstitute.org/COMMUNITY%20RETRAUMATIZATION.pdf).

When surviving trauma, any new encounters (e.g., with a provider or others in the system) have the potential to add to or reinforce the trauma, reactivate the trauma, or provide a sense of safety and emotional helping regulation and new learning. We as providers can ask ourselves what, if any, of these negative experiences have we contributed to in our clients?

The goal for providing trauma informed care is to shift in our approach to working with people from asking "what is wrong with _____?" to "what happened to _____?"

The hierarchy of recovery suggests that safety leads to emotional regulation, which leads to cognitive processing, which leads to exploration, which leads to new learning, which leads to acquiring resources for growth/recovery, which leads to making meaning, which leads to a coherent narrative, which ultimately leads to recovery. It is important to recognize that this long process starts with *safety*.

A definition of trauma informed care from SAMHSA is "an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid re-traumatization." This essentially means a commitment not to repeat these traumatic experiences to restore clients in whatever way possible.

The goals of trauma informed care are to increase desired outcomes, reduce re-traumatization, and help clients heal and recover.

One model of trauma informed care is the "four R's": realize, recognize, respond, and resist (more information on this model can be found on the SAMHSA website). Realization involves understanding that trauma exists and can affect groups (e.g., historical trauma and oppression) as well as individuals. Survivors may cope with their trauma in different ways which need to be taken into consideration. Recognition involves recognizing the signs of trauma, which can vary from person to person. Responding involves applying a trauma informed approach (e.g., staff training, agency self-evaluation, operationalizing in agency policies and procedures) and making

accommodations whenever possible. Resisting re-traumatization involves monitoring self and others for re-traumatization.

In addition, the CARES model of trauma informed care includes steps to collaborate, encourage autonomy, be respectful, show empathy, and encourage and support safety. Three key tenets of trauma informed care outlined by Mandy Davis are as follows:

1) Create safe context: This includes physical safety, being trustworthy, setting clear and consistent boundaries, being transparent, being predictable, and giving choices. Examples include signage, seating/room arrangement, explaining the "why's", a non-triggering environment such as not too crowded or noisy, attend to unease, and let them know what's next.

2) Restore power: This can include giving choices, empowering them, focusing on strengths, and skill building. Examples include offering choices (at least three if possible) focusing on the future, and making arrangements.

3) Valuing the individual: This includes offering respect, compassion, mutuality, acceptance and non-judgment. Examples include making specific referrals, life experience valued, flexibility, being relational (a lot of non-verbals here).

Finally, six key principles from SAMHSA on trauma informed care include:

1. Safety (physical and psychological safety in the agency space, including signage)
2. Trustworthiness and transparency (being as clear as possible about reasons behind policies, procedures, and decisions)
3. Peer support (so survivors do not feel alone)
4. Collaboration and mutuality (making it less hierarchical in general and when working with clients)
5. Empowerment, voice, and choice (e.g., involving them in decision-making, facilitating rather than controlling recovery)
6. Acknowledge cultural, historical, and gender issues (including practice of cultural humility)

These principles are very similar to what we are teaching the men to do in BIPs (e.g., being collaborative). Other qualities of BIP work consistent with trauma informed care include being curious, making mutual agreements, being relational, and being mindful of the relationship and the person.

In sum, one way to think of trauma informed care is as really good customer service, where you do everything you can to help the person feel welcome, safe, and accommodated. It also involves flexibility, such as being able to flex policies and procedures to accommodate the particular needs of the individual. It also requires humility (including cultural humility) to not presume to

know what is going to work best for any particular client and being willing to make adjustments to standard operating procedures on the part of the agency to accommodate these clients.

This is also consistent with the "responsivity" aspect of the Risk/Needs/Responsivity approach to offering evidence-based forensic services, so there is also significant forensic empirical support for applying this model to offenders. Trauma informed care is an excellent model of how to be respectful, compassionate, and relational with others in general, which is what we are trying to teach clients in the programs. For some, this is still a provocative idea to treat abusive partners with compassion and respect and/or to apply trauma informed care principles to working with them. In treating abusive partners this way though, we challenge them to treat their partners well.

Chris distributed handouts with material by Fernando Mederos on addressing trauma issues in groups with abusive partners and material from Trauma Informed Oregon on trauma informed care. Additional material is available at https://traumainformedoregon.org/resources/resources-organizations/

The experience of learning about trauma informed care is similar to the hype around Motivational Interviewing, which is operationalizing what good clinicians do. Trauma informed care is very similar in that many organizations are already doing trauma informed care without having any formal training in it, due to the culture of their agency. Other agencies though are not working in this model and do need training in this area.

How do we apply these concepts to our work with abusive partners? What are programs already doing that are in line with trauma informed care? What else could programs be doing to provide trauma informed care?

Group discussion:
The discussion started with a provider saying that trauma informed care starts by acknowledging that nearly everyone in some programs has experienced some form of trauma, especially those in programs that address co-occuring issues like substance abuse (e.g., majority of their clients score at least 6 or 7 on the ACES questionnaire at their agency). Recently, one client who was a child soldier in Africa with many complex experiences of trauma was going through a BIP for a second time and was involved in trauma-specific services as a supplement. His openness and his change talk was extremely different the second time around when he was involved in outside counseling. He was very encouraging to other clients about how going to therapy helped him. Another client who also came back for the second time started a therapy practice part way through and his openness, accountability, and willingness to share really increased. One of our jobs as providers in those situations is to offer referrals. For men with co-occurring trauma, if that trauma is not directly treated through other services (e.g., counseling) it may compromise the work providers can do with them in BIPs. Screening for trauma and potential referral is very important in those situations.

Poverty can also be an important early experience to take into consideration that can be traumatizing. Trauma survivors are more vulnerable in general, so when survivors are also in poverty that can lead to downward drift (e.g., not having enough supervision for children if living in a one-parent home, which can lead to additional trauma or victimization for the children).

One area of difficulty is not having good referral sources for trauma. It would be helpful to have a compiled list of known referrals. The way that we do referrals can also be a key issue themselves. Warm handouts are a form of trauma informed care, so another question is whether we can minimize referrals at all and make it more connected to other providers to minimize the burden on clients to make connections and follow up on referrals. Funding streams and other structural constraints can limit or otherwise influence the ability to practice trauma informed care in these ways.

Coordination with referral sources can be very important as well to let the referral source know what is possible to provide through the BIP and what needs the client may have beyond that. Many counselors have training in trauma as it is commonly covered in training programs, but complex trauma can be a particularly significant sub-specialty (requiring a larger skill-set, variety of techniques, and background in topics including the influence of trauma on the brain). It can be challenging to find counselors or therapists who are able to do good work with our clients.

Being clear and decisive with clients are some of the most important qualities of working clients who have experienced trauma. For example, a recent situation came up in a parenting class when clients who were formerly kicked out of class had to be either allowed to complete the class or not and ambiguous language created some problems.

Talking openly about trauma in BIP groups and how having experienced trauma sometimes leads people into the behaviors that got them arrested can also be important. Central to that work though is not to blame their traumatic experiences for their abusive behavior, so that when they begin to understand how their histories have contributed to their behaviors they are still taking responsibility for them. For example, one client claimed that he was experiencing PTSD and brought a service dog to the group. He became more toxic to the group though when he talked about how the providers had no right to hold them accountable for their behavior or talk about their police reports. Good communication with the PO and consultation with their own clinical team led them to refer him to a PTSD group at the VA. Although it was not clear whether or not he was experiencing PTSD, it was clear that he was not appropriate for their treatment at that time.

As providers try to avoid the hole of blaming trauma for domestic violence issues, this is another opportunity to examine where clients are justifying their abusive behavior in ways that allow them to continue to engage in the behavior. This comes back to the accountability piece of encouraging global or primary accountability *as well as* accountability for trauma recovery.

Mindfulness practice can be very helpful to allow the men in the room to be more present and be centered in the room, but this also needs to be trauma informed. For example, make sure it is known to clients that they can have their eyes open if they want. The clinical director at the Refuge Recovery treatment center in LA discusses trauma informed care for mindfulness practice, with examples such as that focusing on the breath may not be safe for trauma survivors so it is important to offer alternatives such as mindfulness of sound or walking around to incorporate other somatic, body-centered practices.

An area of greater tension can be around the flexibility of policies on the part of groups and agencies (e.g., being late, missing group, not completing homework). The traditional approach is to give clients a little bit of room but not very much in order to hold them accountable. None of those procedures are trauma informed, because it presumes that clients could do things the "right" way but they are *choosing* to do them the wrong way. Rather than saying "this is the rule and if you are breaking it you are done," take time to explore and ask why. For example, "Why are you being late? Why are you not doing the work?" are helpful questions for providers when they are genuinely trying to understand what the barriers are for the client. This can help providers make a trauma informed decision about how to respond, rather than having a hard, inflexible policy for all clients. In working with clients, changes and impacts on clients seem to be most memorable when providers or others step out of their usual roles and relate to them more as people.

Phrasing can also be very helpful in these moments of trying to understand, such as "what's going on?" or "what is preventing you from coming to the group on time?" rather than asking "why" questions, which can prompt defensiveness (e.g., "why can't you get to group on time?").

Agency size can also influence their flexibility on policies, as increased size can limit flexibility. Working with support staff on trauma informed training could also be helpful, as staff do the best they can but could also benefit from more resources. Being compassionate, polite, and kind towards clients can set the tone and help staff deal with clients who are triggered to de-escalate situations by supporting staff themselves.

Explaining the reasons behind policies is also very important. Having an awareness of your own needs as a provider and the agency's needs can be a practical way of having flexibility to see where there is room for flexibility. Also continually posing questions to clients to ask them what they need can aid in this effort, and helping them work through the question if they can't identify their needs at that time. Start with their behavior to help them identify what need they are trying

to get met and help them learn how to vocalize that as well. This is especially helpful when considering that during trauma, there was no room to express wants and needs, so normalizing that can be helpful.

Feeling safe in a group, especially in later stage groups, can involve giving feedback and talking about their experiences and can make people feel safer by not feeling judged. Breaking people up into small groups to discuss difficult issues can help there as well, even if there is some collusion going on especially earlier on in groups. That collusion organically begins to fall away as they work with material in the group over time. This also builds more intimate relationships between individuals in the group so they begin to trust the non-judgment more and more, which leads to more progressions and faster progressions in accountability.

Emotion regulation skills are also an important part of dealing with their trauma and reducing their abusive behavior, which is a tight correlation between working in trauma informed care models and helping clients address their abusive behavior.

Another area of tension is being person-centered in this work and understanding that working with clients as people involves not labeling them, but working with them with warmth and acknowledgment rather than seeing them only as batterers or perpetrators. It can be particularly triggering for trauma survivors if they do not feel that they are being seen as whole people. For example, a large black man who was court mandated and originally mandated to anger management was being difficult in a BIP group and with the office staff, so a clinician met with him individually. In working with him as a person, meeting him eye to eye, this client disclosed a significant history of trauma. The clinician quickly disarmed this guy by working with him with respect and genuine curiosity, which led to great shifts for the man throughout the rest of the program. He came in with some vigilance and defensiveness from often being perceived as threatening or intimidating as a large black man, so rather than coming down hard with a policy to "get him in line," it created space to acknowledge that he was not feeling safe in the agency and better engaged him in the program material. Emotional honesty is also very helpful in acknowledging your own reactions to clients as providers so that you can communicate safety to clients.

It is helpful to continually scan the room to monitor whether anyone is getting triggered or dissociated or is experiencing emotional dysregulation, especially in groups with a majority of trauma survivors. If a provider notices something, he can use cue words with clients in the group (e.g., "chair") to prompt the client to be mindful and get back in the moment. What can appear to be someone not paying attention can actually be dissociation. For example, a client who came into the group already escalated and triggered who was met with confrontation. The group became completely flooded, stormed out of the room, and slammed the door. The provider in this case unfortunately called the PO immediately afterward, who violated the client and put him in jail, which ultimately resulted in the man losing his job. Reading the client and recognizing he

was escalated, adjusting the confrontation style, and avoiding the report to the PO could have radically shifted the situation.

Another aspect of trauma informed care for batterer intervention is using the PO as a consultant, and not only as "the hammer" for reinforcement. Relationship building with POs can help providers know how they will understand reports and what they will do with information. Staying in communication with POs can further support those relationships.

During the discussion, providers were surprised to realize that in groups, clients who report their own abusive behavior do not seem to trigger trauma survivors. Many of them seem to be deeply in their justifications when they discuss this, which can encourage collusion but there can also be good feedback in mature groups to push back on that. Justifications are so strong that they seem to be a barrier to triggering the trauma. Behaviors seem to be more likely to trigger elevated responses from clients during groups in real time. There seems to be a difference in hearing behavior versus experiencing behavior, and between reporting behavior versus acting it out (e.g., in role plays). Reporting and hearing behavior rather than experiencing or acting out behavior seem to prevent trauma survivors from being triggered. Many people actually process some trauma though doing exercises like sharing their arrest. Clients say they were scared or nervous to do that exercise but feel relief after, which comes from the challenging but non-judgmental feedback in the group. Be mindful thought of role plays that involve role playing abusive behavior, which can be triggering for trauma survivors. There is a difference between reporting and acting. Video clips that involve violence or abusive behavior, if well acted, can also be triggering. Duluth videos are old enough that clients can separate themselves and it is easier to see someone else doing something.

Accountability also does not seem to "play into" trauma. This is in some ways the positive alternative to what they experienced in their abusive lives, where they are only asked in groups to take accountability for the behavior that is under their control, rather than being blamed for many other things as they were when they experienced trauma.

Some programs have policies that clients can only complete the program when they admit or are accountable to everything in the police report. This may be difficult for clients who have trauma experiences if there is a rigid expectation of accepting everything in the police report, especially if the report does not align with their experiences or memories. Agencies can be more trauma informed if they give space to discuss how the report differs from their account of the experience, to give them some autonomy in telling their story, while still talking about embellished memory, to give them more voice in that process. It is important to build safety for accountability in the group so that it is okay to admit to mistakes and behavior that they can then be accountable for.

Policies of mandatory reporting, such as reporting to PO, can create a parallel to secret keeping in dysfunctional families. Can men be honest in groups, knowing there are potential repercussions for sharing information that will be reported to their PO? Knowing that men especially early on will be guarded and have a low sense of safety in groups can help create safety in groups.

It can also be easy to overlook trauma responses of other staff and colleagues, so it is important to be mindful of not triggering anyone else's trauma. Taking universal precautions to use these same skills in professional relationships can be helpful. Administrative workers can be especially easy to overlook in agencies, as well as how to treat colleagues and other members of the CCR. For example, a video that included images of domestic violence were triggered by staff members at an agency in the past.