Tri-County Batterer Intervention Provider Network Meeting Minutes-1/4/2005

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Minutes by Paula Manley, edited by Chris Huffine

Topic: Addressing Psychological Issues in Abusive Men

In recent years two men who have been in batterer intervention in Washington County have ended up murdering their partners. In both cases there were co-existing psychological issues (one had a significant depression, the other is likely psychopathic). The presence of psychological disorders significantly increases risk of recidivism and can also complicate batterer intervention efforts. What follows is a discussion of some of the most common types of psychological disorders and how they can be addressed. This issue was previously discussed, in a somewhat different format, at the 10/24/2000 and 5/8/2001 Tri-County meetings. Contact Chris Huffine for copies of those minutes.

Psychopathic/Antisocial/Oppositional. Antisocial behavior can be seen as running on a continuum. The formal diagnosis is Antisocial Personality Disorder, which involves a pattern of criminal/exploitive/antisocial behavior. On the milder side of that are individuals who display significant patterns of criminal thinking and/or defiance and oppositional behavior but do not qualify for that diagnosis. On the more extreme side of that are men who display psychopathy, which involves a lack of conscience and a pattern of exploitive relationships. Psychopaths are quite rare, but commit a disproportionate amount of crime and DV and are far more likely to recidivate. Robert Hare has developed several assessment tools to assess psychopathy.

One person has a client who regularly comments that he does not like the way counselors perceive him. He comments to other men about how awful the other men are and that he is different than all the other men in the group. In addition, in group, when the attention is not on him he is disruptive in group (e.g., chewing ice, not engaged). Criminal thinking is a self centered point of view. Men typically have a sense of entitlement, believe they

have the right to do whatever they want to do, possess a justified perspective for criminal behavior, and have an oppositional attitude.

In group, they can fall asleep, tone of voice is defiant, roll their eyes, and are passive. A client was close to the finishing group and regularly cried about no contact with his wife. However, he did not want to take the polygraph because he was living with her. These individuals are chameleons. Typically we want them to model a normal person but you can tell that they are not internalizing the positive identity.

They do not respond well with emotional reactivity. It is best to be clear and direct with these types of people. It is best to intervene quickly when they are doing something they shouldn't be doing (e.g., don't close your eyes; you will not get credit for this group). In addition, a counselor should limit self-disclosure because they will use the information to divert attention away from themselves. A good tip is to tell the group early on that the group will not be a soap box for people trying to declare their innocence. If you have antisocial types then you should identify them early, set limits, and remove them from the group. Typically they pollute the group or intimidate the others. Overall, they can hinder the development of the group. How do you respond to men who put down others and differentiate themselves from others in the group?

Psychopathic people progress the worst in a BIP. They can also divert the group because they want to pick up tactics and strategies. They can be very smooth, charming, and compliant. It may be hard to identify these types of men early on. Typically they engage the counselor in a normal manner but there is something slightly off or uncomfortable with what they are saying. Details are hard to obtain from these types of people because they can distort real events. They have a distinct lack of empathy. When asked about how their victims felt, they end up talking about themselves or how they have been victimized. Psychopathic men aggressively put down other men. They do not have consciousness and do have a pattern of exploitation. They typically do not have long relationships. They have low emotional activity. They can be very calculated. In contrast to abusive events that may take seconds, they can engage in calculated abuse for hours/days. "Without Conscious" by Rob Hare is the best book to read to better understand psychopathy. Reed Malloy is another expert on psychopathology. These individuals are very credible; they are very good at deceiving people. Some men may seem more credible when they are lying because they are animated but are calm and flat when they are telling the truth.

The best thing with this group is to first determine that they are psychopathic and if they appear to be considering referring them out to specialized individual counseling and/or more traditional anger management (to help with their reactivity). For those individuals, continued involvement in a batterer intervention group may make them worse and may undermine the group. The P-Scan by Robert Hare is a good screening tool for identifying possible psychopathy. It is not adequate to make a full-blown diagnosis. The Psychopathy Checklist Revised (PCL-R) is the diagnostic tool to make the formal

diagnosis, but it requires extensive training and data collection. Curt St. Denis is certified to complete PCL-Rs.

Personality Disorders Personality Disorders can be defined as an ongoing pattern of imperative relationships with others. People with this disorder do not interact well with others in the group (or anywhere else). They create friction with group members and with the facilitator. They tend to annoy everyone involved. They can't help themselves. Facilitators spend a lot of time talking about them. They can really get on the bad side of their P.O./group facilitator. For example, one client while in the final steps of completing a program revealed that he felt the program was a waste of time and that he had not changed. Facilitator recommended to the PO about the client staying for 6 more weeks. The situation has escalated since then. Narcissism is challenging because they can alienate everyone involved in his treatment. For example, a narcissistic type may compliment a facilitator in an adoring manner about their ability to describe exactly what the client is feeling. Some (e.g., Borderline Personality) do not have much of a core identity and expect women to provide them with what they need. They have unrealistic expectations of women and what their role is. For example, a client finally realized that his wife was not coming back. He exploded and destroyed his home because he felt abandoned and could not cope with his wife moving on.

Key qualities to deal with these men include being as unreactive as possible, not to take their reactions personally, calmly containing and limiting their responses/acting out, setting firm, clear, concrete limits and guidelines. Facilitators should be clear and write down the provisional requirements for completing the programs. This really speaks to these types of men and their inability to notice the social cues needed in order to progress. Marsha Lennahan's work--Dialectical Behavior Therapy (DBT) is designed to help with personality disorders and includes a variety of calming/centering/containment skills.

For more information on personality disorders refer to the earlier Tri-County discussion on 8/5/03 (you can request copies of those minutes from Chris Huffine if you don't have them).

Post-traumatic Stress Disorder/Trauma Early in Life/Attachment Disorder These are folks who have experienced significant abuse and trauma in their past, typically as children. Symptoms of this can be manifested in many ways – male depression, recurring depression, violence. In men depression can manifest as irritability, being hyper-critical of others. But at the core is trauma and view of themselves in the world as being powerless. Some may transform their trauma into misogyny, particularly if their abuser was a woman. Because many men are uncomfortable making themselves vulnerable, they may tend to stuff their feelings and not talk in groups. They will "disappear" in the group but won't talk unless you pull it out. They may have anxiety and depression, which may have in the past been misdiagnosed as bipolar.

One challenge for some of these men is that being in the group can retrigger their own trauma histories. This can especially be an issue for those who have not previously worked through their own trauma. When it is extremely bad, you may need to refer the individual for one on one work with a qualified therapist, before you deal with the BIP stuff. The folks who have experienced extreme trauma may feel like they are being further traumatized. They may need to take a break from the BIP group because it is too intense for them. One subgroup of men with significant trauma history may not encounter depression until they are in the group for a while. So even appropriate treatment may escalate them.

This subgroup, who may be genuinely committed to being nonabusive, may often recidivate. They feel remorseful and may want to change, but even when there is genuine change, there is a higher risk (relative to peers) of recidivism. Another common quality of this subgroup is property abuse and/or abuse in public settings. This reflects the overwhelm these men can feel at certain points that they lead to less considered abusive behavior. This is in contrast to most abusive men who have not been traumatized who report no history of property abuse. This can occur as their trauma is re-experienced/ triggered and then they become abusive as a result. Their traumatic history does not justify the abuse, but we must recognize that it might recur. Thus, you need to deal with the trauma. Most mandated men will resist, but if they are willing this can be quite helpful – either simultaneously or sometimes in lieu of group for a while.

We should help the client "platform," to help them learn to stand back and look at what is happening. Terrence Real I *Don't Want to Talk About it"* addresses this group. Clients should be taught how to de-escalate and self-soothe. Containment is another goal – becoming accountable for behavior in a quick, timely way. He may have episodes of verbal abuse, but may learn to own the behavior immediately. In his private practice, Marc Hess has developed a sub-specialty of working with trauma in men. See also Tri-County minutes from 9/2/2003 on this issue.

<u>Attention Deficit Hyperactivity Disorder</u> These men also can be quite impulsive in their behavior--not only in their abuse, but also their behavior in group. They are more likely to interrupt others and are quicker to respond/react to information being presented. They may also be more physically restless and agitated in groups. On the other hand, those without the hyperactivity may appear to be spacing out and quite distracted. They are prone to missing details and to not paying close enough attention to what is going on in situations. Their lives can be quite disorganized which can be frustrating and contribute to their controlling behaviors. They may also do a poor job of picking up on emotional and social details in a situation. These misperceptions can also lead to greater conflict and abuse. They may misread/misperceive the emotional state of another and then respond in an inappropriate manner.

These folks need more structure--in the group, in their lives, in their tasks. These clients need work on organizational skills. They can benefit from some skill building as to learning to look around at other peoples' faces and reactions to more accurately pick up on emotional content. They may also need more concrete behavioral management skills to help with their impulsivity such as delaying their response for a few seconds, practicing listening skills, and taking time-outs. Distractions (e.g., noise, visuals) need to be minimized to help these men stay focused on the material. This group may also benefit from medications and a referral for a psychiatric evaluation should be considered. For more information on this group a good book is *Driven to Distraction*, by Hallowell and Ratey. Also refer to the Tri-County minutes from 6/3/2003 for more information (contact Chris Huffine for a copy of those minutes).

Depression/anxiety/mood disorders Early in the program many men may have some situational anxiety or depression. This is often due to the circumstances of their arrival--court involvement, limited or no contact with their partner/family, not living in the home, etc. This is a normal emotional response and typically passes with time, usually gone within a few weeks or months at most. Separate from this are men who have a full-blown Depression or Anxiety disorder. These men report a longer history of mood problems that predate the incident that is bringing them into the program. In addition to depressed mood these men may also feel quite negatively about themselves and have more generally negative views of themselves and others. Such views are not limited just to their primary victim or family. They may also report more extensive histories of life difficulties including work problems, health problems, and other sorts of interpersonal problems. They can be underachievers. Some of these men may have self-loathing, a sense of hopelessness and general despair. They may think they will never be able to get it right. When they hit a depressive or anxious spike, they may quickly act it out on their partner. This doesn't justify the behavior. Male depression was also discussed at the 6/13/2000 meeting. These may be cases where medication might be appropriate, especially when there is a lot of ruminating. See Tri-County minutes from 11/13/2001 for more information on when medications might be appropriate. Sometimes their partner may have begged them for years to get help. Medication won't stop the abuse. He still has an abuse problem, but may be more able to benefit from treatment if on meds.

Because of other life stresses and their own personal struggles, these men may not have regular attendance, and that may not be related to their power and control issues. Sanctions on these types of men may have a much greater negative effect than the intention of the PO. These men may benefit and become more motivated from encouragement and support than punishment and sanctions (which only further reinforces their negative world view and self-concept).

This group (along with men with personality disorders, particularly Borderlines) are also at greater risk of doing more extreme violence to themselves or others, particularly if bereavement (i.e., the loss of the primary relationship) is combined with obsession.

Especially when suicidal tendencies are combined, these men are extremely dangerous. It is probably the largest risk of victim lethality.

Psychosis and thought disorders Psychosis or severe thought disorders are when clients are most dangerous to the facilitator and other staff. Because they are not fully in the same world as you, they are more difficult to reason with and typical interventions that work with escalated clients may not work with these individuals. The client can distort what is going on. Thought disorders are when they see something that isn't there, are hearing voices or have significant delusions. If they appear to be thinking oddly and, with further inquiry their thinking seems even more bizarre then you are likely dealing with a thought disorder. The person may be pretty normal in other areas of their lives. If they have an active thought disorder, they should be psychiatrically stabilized first.

Should men with a diagnosed thought disorder, such as schizophrenia, attend a group? Several things to consider. First, are they relatively symptom free? If not the presence of symptoms may undermine their ability to make use of the program. If their symptoms are manageable, to what extent do they appear to be "normal" and leading a lifestyle that is comparable to other men in the group. For example, a man with schizophrenia who is unemployed, living in a group home, is not in a romantic relationship and is very concrete in his thinking may stand out as odd and may have a difficult time relating to the other men (and vise-versa) as well as to the content. On the other hand, a man with schizophrenia who has a romantic partner, is employed and living on his own may be able to do quite well. It is also to consider if the psychotic symptoms may be a result of substance abuse rather than a thought disorder. Has there been recent drug abuse? Have they had symptoms for some time?

In closing, there can be overlap among these diagnoses. Some men may have more than one diagnosis. Routinely screening all intakes for mental health issues is important both for assessing risk as well as determining if additional interventions are needed. Likewise, because mental health issues can emerge over time, men in group should be monitored on an on-going basis for possible mental health issues.