Tri-County Batterer Intervention Provider Network Meeting Minutes March 11th, 2014

Attendance: Chris Huffine (Allies in Change), Sandi Rorick (Dept. of Community Justice, Multnomah County DV unit), Guadalupe Aragon (Modus Vivendi), Olga Parker (Modus Vivendi), Jacquie Pancoast (Eastside Concern), Matt Johnston (Domestic Violence Safe Dialogue), Phil Broyles (Teras), Diana Groener (Allies in Change, Sunset, A Work in Progress), Suzanne Guy (Multnomah County Domestic Violence Coordinator's Office), Regina Rosann (ARMS), Linda Castaneda (Manley Interventions), Jaime Chavez (Cedar Counseling Center), Wendy Viola (Portland State University), Sylvia Kidder (Portland State University)

Minutes by Wendy Viola, edited by Chris Huffine

Topic: Discussion/Cross training on trauma informed care; what is the relevance of trauma informed care for working with perpetrators?

People automatically think of survivors when they hear the phrase "trauma informed care." We would like this conversation to address the use of trauma-informed care with men in our programs, and we would like to avoid having a conversation about the neurobiology of trauma. We will take it as a given that people who are traumatized process information differently.
There is a strong correlation between adverse childhood experiences and criminality. Victims of DV also have a disproportionate amount of childhood trauma, relative to the general population, before incurring the trauma of DV.

A lot of members of this group have been to trainings on trauma-informed care. Diana Groener and Fabiana Wells just facilitated a training with residents at OHSU on screening for DV and practicing trauma informed care, and Diana brought some of the handouts that she used. In the medical context, trauma informed care fits with the feminist model, in that it focuses on making sure that the client has a voice, is well-represented throughout their treatment, and has a say in what happens to his or her self. Being told what to do by the system (including the child welfare system, social services, etc.) is re-traumatizing. We can also talk about historical or social trauma, which results from being a part of a group that has been traumatized.

We have assumptions about appropriate behaviors in any given context (people will check in at the front desk, do paperwork, be polite, show up on time, etc.). Survivors of trauma may behave in unusual ways. Applying trauma informed care involves examining all of your organization's policies and systems to accommodate clients' behaviors and preferences. For example, do clients want to sit by the door? Or be in a room with a window? Are you flexible time-wise with people who may have organizational deficits due to earlier trauma? This necessitates understanding that people who have suffered trauma process information differently and responding accordingly.

Mandy Davis has led trainings on trauma informed care in the passed. She described trauma informed care as shifting the question from "what is wrong with you?" to "what happened to you?" While trauma-specific services focus on overcoming trauma, trauma informed care is something that any organization can do. Every experience that a survivor has has the potential to re-traumatize them; organizations that practice trauma informed care are careful to avoid re- traumatizing clients.

Mandy Davis' presentation included a hierarchy of needs for trauma survivors: safety comes first, then emotional regulation, then cognitive processing, then exploration, then new learning, then acquiring resources for growth. Emotional regulation and cognitive processing are necessary for emotional growth, which are necessary in order to work through trauma. Victims end up being pathologized on the basis of the ways that their symptoms show up, though there's a movement to recognize that many symptoms are sourced at trauma. We're seeing more of an effort to understand trauma, as opposed to just treating PTSD.

Traumatic experiences terrify, overwhelm, and violate the victim. In addition to fight/flight/ freeze, folding, or disassociating, is another possible stress response. There has also some increased attention to women's responses to tend and befriend as additional stress responses. Trauma informed care attempts to counter these experiences by creating safety, power, and worth by establishing safe contexts. This includes settings that are physically safe (considering who's allowed to be in the physical space) and emotional safety (clear and consistent boundaries, transparency, predictability, and choice). Then, trauma informed care restores victims' power (fostering empowerment, choice, taking a strengths perspective and skill-building), and then valuing the individual (respect, collaboration, compassion, and relationship). All of the tiers of an organization (your office, all of your staff) can engage in trauma

informed care, not just practitioners. There are probably victims in every room you ever enter, so it is appropriate to use the lens of trauma informed care in any context. Trauma informed care is essentially excellent customer service, just being thoughtful and showing deference, acknowledgment, and thoughtfulness in working with clients. This absolutely overlaps with cultural humility.

For many agencies the heightened attention to trauma informed care is a validation of what they've been doing all along. However, there are also organizations that are more rigid and punitive, where trauma informed care is a newer concept. The New York model of batterer intervention is probably the antithesis of trauma informed care, as it is based on rigidity and absolutes.

Many of the people thinking and talking about trauma informed care are those who work with survivors, however, we know that a substantial number of men that we work with (probably close to half) are trauma survivors. So what does trauma informed care look like with perpetrators? In working with perpetrators, people are much more comfortable with the idea of accountability (code for punishment) than trauma informed care.

Using trauma informed care with abusive men Using trauma informed care with abusive men involves being thoughtful about how we confront them. People who have been traumatized can sometimes over-react, so if we want to confront them, we have to be careful to avoid eliciting trauma reactions. Participants' trauma responses can distract them away from being accountable and derail the group, though sometimes it can be helpful to let participants talk about their histories of abuse. We need to be able to recognize when clients are having trauma reactions and connect them with other resources for support. Some agencies are more flexible in accommodating those who are trauma survivors and take more care to distinguish sincere trauma survivors from clients who are trying to take advantage of programs' flexibility (people who want to work with you will do so, people who don't will reveal themselves).

Is the use of trauma informed care in groups colluding? It might be helpful to think about the distinction between punishment and discipline: punishment inhibits behavior while discipline supports it. Punishment, including criminal punishment, does not create behavior change. It seems like facilitators might be letting clients off the hook by discouraging them from sitting with discomfort. Even providers who practice trauma informed care want clients to be connected to the damage that has been done to them so they can recognize the damage that they have done to others, and learn empathy in

doing so. Some providers are more likely to push participants to feel hard things and talk about what they're feeling, instead of giving clients a back door to get out of sitting with their discomfort. Providers should try to keep participants experiencing just the right amount of discomfort, as opposed to distressed, when it is their turn on the hot seat.
You want the engine to run hot, but not overheat. You want participants to experience discomfort, but not to the extent that they shut down.

Additionally, if clients are cohabitating and you send them home very distressed, they may take it out on their families. Utilizing trauma informed care can involve teaching participants self- care. Self-care can certainly involve acknowledging and managing trauma symptoms. Trauma informed care could also be used to help clients develop self-management; a lack of self- management contributes to abuse. So trauma informed care with our clients likely reduces the immediate risk of being abusive with their families when they go home.

When providers talk with groups about experiences of witnessing abuse and the neurobiology of trauma, most participants express that their first experiences of violence were in the home as a child. It can be helpful to explain that the abuse that they perpetrate re-traumatizes them, as well as any children in the home. It also begs the question of what supports we provide for children who witness violence.

Whenever one participant discusses abuse that they've perpetrated in detail, they're simultaneously scanning the room to see what reactions they're eliciting from others. Even providers may be more comfortable when participants are vague, to avoid being triggered themselves, though we often want participants to be very explicit for therapeutic purposes. The dilemma is that explicit recounting of past abusive behavior perpetrated may be a trigger for other abusive men in the room who were traumatized as children. If we're doing good work with participants, they get emotionally aroused. Confrontations and recounting experiences of abuse explicitly and graphically can be emotionally arousing. In recounting incidents of abuse, perpetrators tend to soften their stories, while survivors use more vivid descriptions. You can tell that perpetrators are doing good work when their disclosures are detailed enough to make others in the room uncomfortable (e.g., the difference between violence in a G rated movie vs. an R rated movie). For trauma survivors, emotional arousal is triggering. How do we get participants to do these things without being triggered? Often, we don't understand when participants are getting triggered as a trauma survivor; instead we see them as escalating as a result of being on the hot seat for the night.

How do you encourage accountability through a trauma informed lens? Some groups come back to the idea of vicarious trauma on a regular basis, the repetition of which seems to help. Some groups also address monitoring and self-care in this context. You have to teach participants the same self-care or decompressing which providers, ourselves, have to do. In general you also want to avoid having the men re-enacting their abuse. Any kind of re-enactment can be re- traumatizing. It's one thing to recount what happened during a conflict, it's another thing to re- enact it, using the same tone of voice or gestures. It becomes too graphic, hurtful, and potentially triggering. While role-playing abusive behavior is triggering, practicing more adaptive alternative skills is beneficial.
Some providers have intentionally shown participants very violent films to create some discomfort and use it to delve into trauma (e.g., "Once Were Warriors"). If this causes clients to begin to overheat, providers can take them in a different direction by asking about behaviors that would have been more appropriate than those that are depicted. There is some diversity of opinion about whether or not to show video clips in groups. Some participants don't recognize what constitutes violence, control issues, emotional violence, etc. The clips that come with the Duluth curriculum are very brief and demonstrate these phenomena without including any physical violence.

Some providers believe that having participants present their arrest reports to the group can be traumatizing because it's so shameful and humiliating. They're being introduced to a new group of people for the first time, and lead with a description of possibly the worst thing they've ever done. Going over arrest reports is more likely to be uncomfortable than traumatizing. Participants like to focus on the parts of the arrest reports that they believe are untrue or unfair, which can help them avoid being accountable.

There's a lot of benefit in being respectful to clients. It is therapeutic, it serves as a form of modeling, and it creates a safe environment for participants to do work. Being respectful includes acknowledging resilience. There's also the personal aspect of it: we do this work because we care about everybody (and that's what distinguishes us from clients). Being respectful to clients can also be reframed in terms of good customer service, or in terms of helping participants get through the program in order to meet the demands of their referral source.

Part of doing good work and skilled customer service is pacing: you want to start by trying to joining with the pro-social aspects of the client, and then start, in later months,

pushing participants to be more accountable. Participants expect providers to confront them, but to do so in a respectful way. This pacing can sometimes look like collusion to those on the outside, especially if only the specific moment is observed rather than seeing it as part of an on-going process that evolves over time. Martin Luther King Jr.'s words about nonviolence are relevant here (e.g., "Darkness cannot chase out darkness; only light can do that. Hate cannot chase out hate; only love can do that."). We understand the temptation to want to punish, but the successful leaders leave this behind and take a compassionate stance, even with oppressors. This can be helpful in making a case for being respectful to participants.

Collusion can be defined as agreeing with and supporting the distorted understanding of participants. We don't always jump on participants' distortions, but that's due to intentionally pacing how far we push clients. Observing distortion and making a conscious choice not to jump on it is different than collusion. Providers who collude are quick to buy into the negative characteristics of participants' partners and are largely unaware of participants' distortions, though reinforcement through ignorance is a bit different from collusion.

Like others, parole and probation varies across counties in how much it offers trauma informed supervision. Some offer excellent trauma informed supervision, but there are also cases where
P.O.'s feel pressure to be punitive. There's been a shift in supervision and case management in the last few years. Now, P.O.'s look at each offender as an individual, and try to be responsive to where they come from, develop individualized case plans, and add additional conditions that they feel work in a client's favor to help them change. Currently, Effective Practices in Community Supervision (EPICS) is used to guide case management in some counties such as Multnomah. It might be interesting to have someone come in and talk to this group about EPICS. Information on this was shared at the June, 2011 meeting.

Additional resources: Johnny Gieber offers trainings in Battleground, WA on the application of information about the neurobiology of trauma. There is also a National Council on Trauma Informed Care
(http://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/).