A Clinical Approach to Individual Work with Men who engage in Intimate Partner Violence

Kylie Nix

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Welcome

I acknowledge the Traditional Owners of the Yidinji Nation, which is the land we are fortunate enough to congregate on today. I pay my respects to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander cultures.

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Today's Session

- The Introduction: What this presentation is
- The Gaps: What this presentation is not
- Why I'm doing this
- The Facts
- The Language
- The Model
- Car park for now – 2023 will see the full 6-hour version being delivered!

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What this presentation is….

- A brief introductory step to developing an integrated clinical framework for working with men who participate in intimate partner violence.
- I hope it sparks your own exploration of how to enhance one on one treatment outcomes for men who participate in intimate partner violence.
- A one-hour snippet of 6-hour workshop scheduled in 2023.
- Apologies for the rush and PowerPoint overload!

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Mind the Gaps: What this Presentation is NOT

- Today's presentation is a VERY brief generalised introduction only on very limited time. Several specialized and unique areas will not be specifically addressed in detail. These unique needs extend far beyond today's session. Not only is there insufficient time, but building them in to my presentation would not honour the complexities that these unique needs require.
- What's NOT the focus of today's session:
  - Marginalised community members and unique demographic groups - Despite recognising that the following individuals are at an increased risk of and face unique factors that make them a priority focus:
    - CALD
    - Aboriginal and Torres Straight Islanders
    - Victim-survivors with disability or mental health concerns
    - LGBTIQA+
    - Regional and very remote areas
    - Older victim-survivors
  - Higher-end lethality and risk – Best practice recommends men who are at a greater risk of physical harm and lethality are to be involved in higher level treatment programs such as behavioural change programs (32+ hours!) and judicial multidisciplinary response teams. One on one clinical counselling is most definitely NOT a place for such perpetrators.
- Clinical engagement skills 101 – Assumes you have basic clinical engagement skills and experience.

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Why am I doing this?

- I developed areas of strengths in working with men – DV and sexual offending behaviours while working with QLD Corrections.
- But I wanted to “do more” to break the cycle of offending.
- Commenced one on one practice with the focus on working with men.
- High stakes work – we have to do it safely!
- Then this happened…

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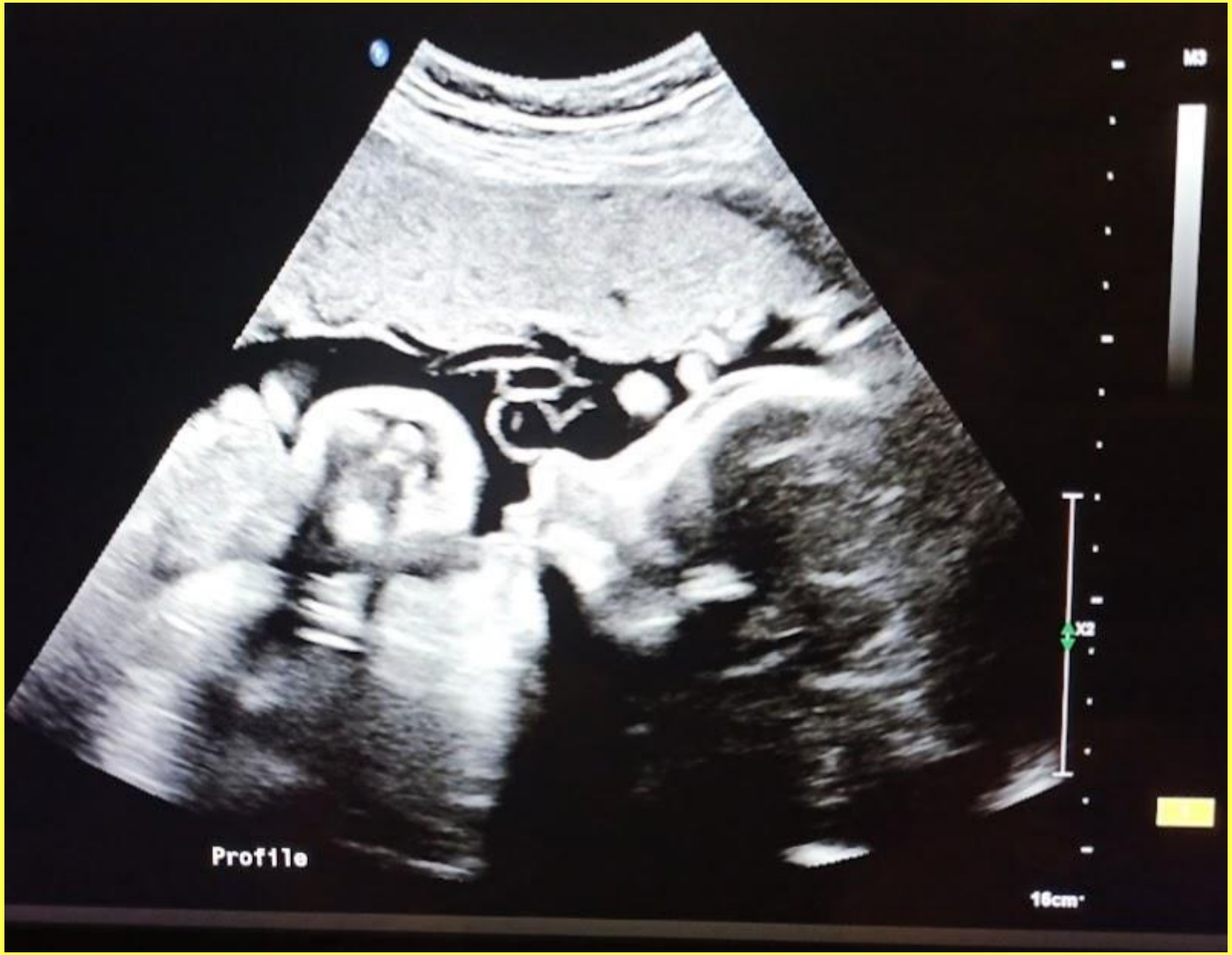

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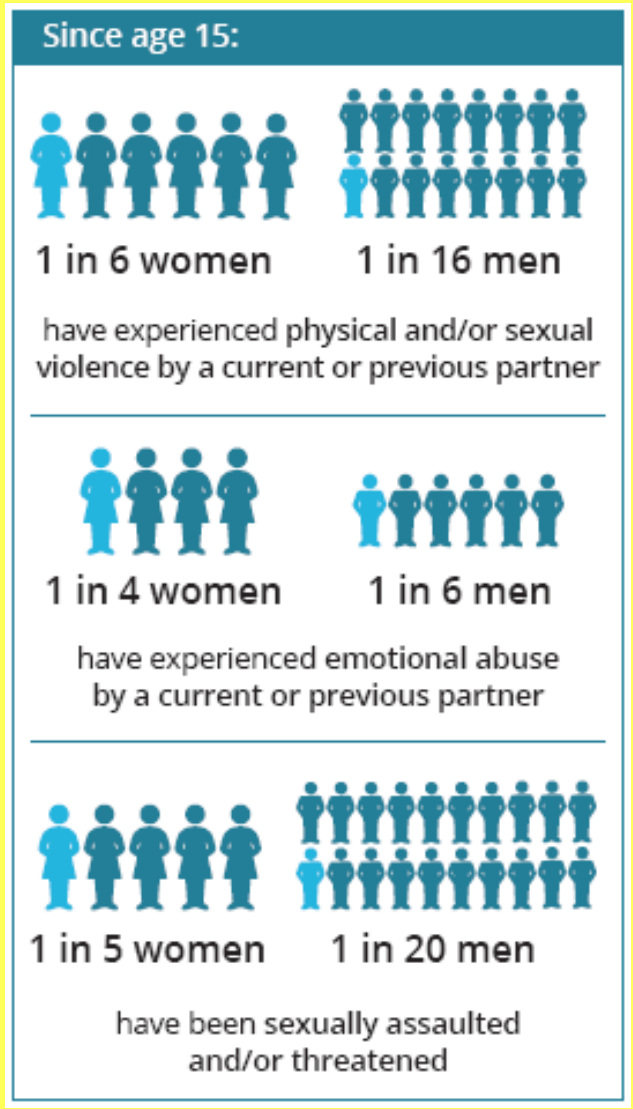
WHAT WE KNOW: THE FACTS



Women, children and men die from DFV– your client could be involved in one of them!

Since the age of 15:

- 1 in 6 women and 1 in 16 men had experienced physical and/or sexual violence from a current or previous cohabiting partner.
- 1 in 20 people had experienced violence from a current or previous boyfriend, girlfriend or date—7.4% women and 1.9% men.
- 1 in 4 women and 1 in 6 men have experienced emotional abuse from a current or previous partner.
- More than 1 in 2 women and 1 in 4 men who have experienced emotional abuse from a previous partner have also been assaulted or threatened with assault.
- 1 in 5 women and 1 in 20 men have experienced sexual violence.

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WHAT WE KNOW: THE FACTS

- Emotional abuse and harassment or controlling behaviours committed by cohabitating partners are the **most common** form of domestic violence. Followed by coercion and control tactics and lastly physical and sexual violence.

- A perpetrator's current and past actions and behaviours bear significant weight in determining risk.

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“The Model”…..

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But not before....

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The Importance of Group Work!

- Men's Behavioural Change Programs (MBCP) are internationally identified as the preferred and leading most effective form of treatment (dependent on participant typology of violence, level of risk and lethality and responsivity barriers).
- Traditional MBCPs are conducted in group formats are facilitated by thoroughly trained and supported/supervised professionals with robust assessment tools. They are integrated with women's and judicial/risk teams and services, spanning a minim of 15 weeks of sessional engagement (+ pre and post assessment feedback processes).
- Referral and engagement in a MBCP is always preferred.
- Have relationships with your local MBCP team and services. Know the group dates, mixes and nature of work. Talk to it and encourage attendance!

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“The Model”…..

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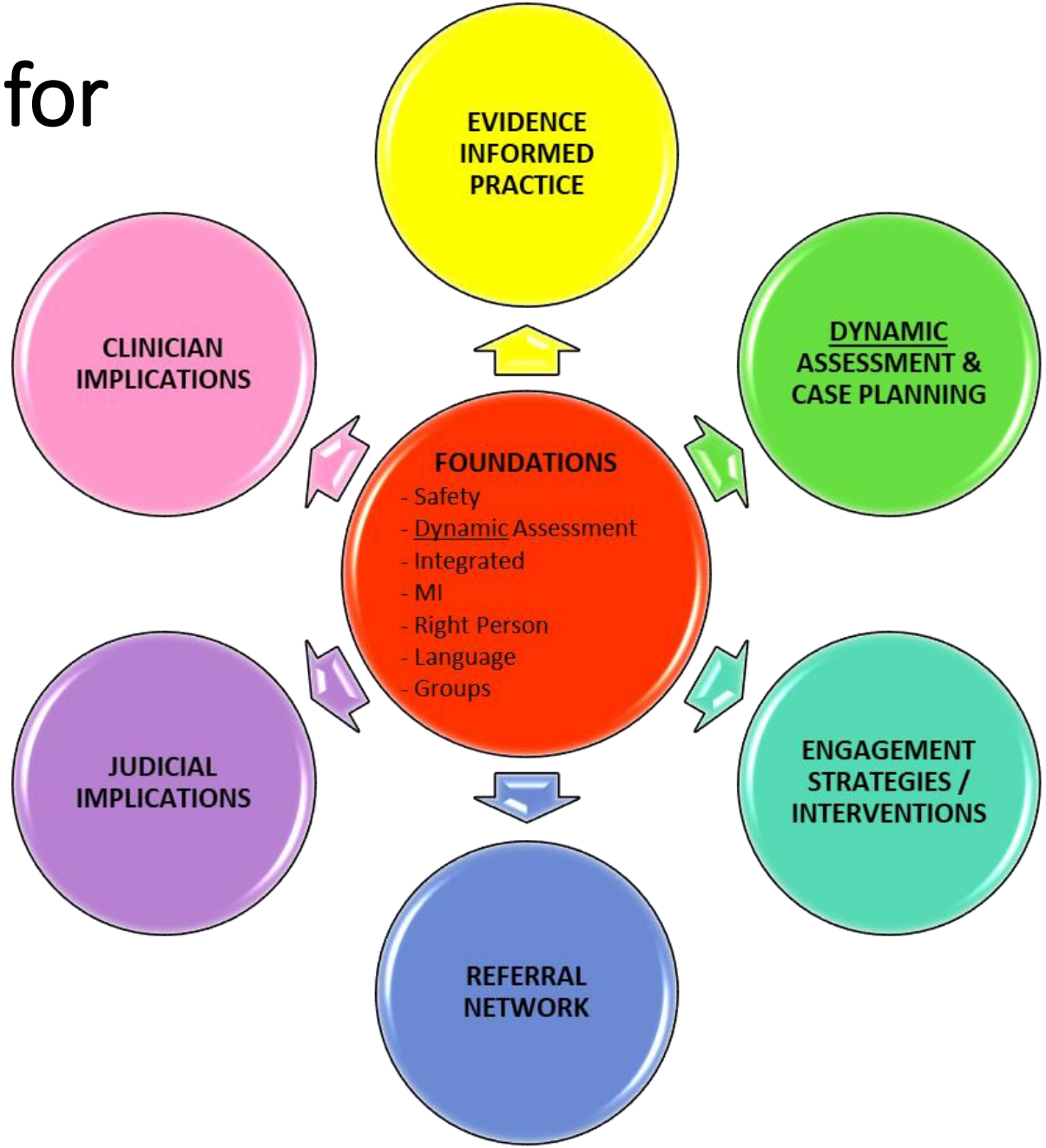
Integrated Framework for Clinical DFV Work

FOUNDATIONS
- Safety
- Dynamic Assessment
- Integrated
- MI
- Right Person
- Language
- Groups



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Foundations:

The ‘heart’ of what you do and how you do it

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Foundations

- **Safety** is central. Safety for the abused survivors – women and children. Their voices and lived experiences must be in the room. Safety for our clients, the abusers. Safety for ourselves and our loved ones.
- **Dynamic assessment,** risk is a living entity – NOT stagnant. What did I learn about risk today?
- An **integrated**, systemic response to risk assessment and management, whereby all relevant agencies work together, is critical. We can not mirror the secretive and isolating practices of our clients. Information sharing is key. Clear is kind. Proactive information sharing and limitations of privacy and confidentiality is a given. 'No go' without it. 'Referral Network' area expands on this.
- Client centered using **Motivational Interviewing (MI)** strategies. MI anchors the client to investment in treatment and the hard work being done.

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Foundations: Right Person

- **Where am I coming from?** Exploration of your own practice framework for working with men who abuse and self-reflection of why you do the work. i.e. What lens do I view DFV through? What assumptions do I bring to the work? How does this impact on my practice?

- **Your Lens:** Best practice notes you must include a gendered feminist framework that locates IPV and DFV against children as occurring within a society where male dominance is normalised, and men feel entitled to use coercion and control to maintain positions of privilege that serve to exploit and/or control the sexual and social freedom of women.

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Foundations: Language

- Critical importance!
- No hard and fast rule.
- Client context is important. Move in. Move out. Use all of those on the men's list with various levels of intensity and dosage.
- Women and children are always referred to by their first names, appropriate title or, victim, victim survivor, survivor etc.

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Foundations: Language

- **Men**
- Perpetrator
- Abuser
- Offender
- Individual that commits acts of Intimate Partner Violence (IPV exclusively)
- Individual that commits acts of domestic violence (between current and former intimate partners)
- Individual that commits acts of DFV (broader familiar kinships and networks)
- Men who abuse
- Domestically violent men
- Assholes
- Evil
- Bastards
- Bullies
- Cunts
- Liars
- “Anger management issue”
- More?????

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Foundations: Language

- **Women**
- Survivor
- Victim Survivor
- Abused
- Victim
- Women
- Child/ren
- Conniving bitches
- Cunts
- Sluts
- Crazy bitches
- Liars
- Fucked in the head

- Mental
- More????

Kids

- Child/Children/son/daughter
- Victim
- Victim Survivor
- Little shits
- Little bitch
- Mumma’s boy / Mumma’s girl
- Brainwashed
- More????

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Foundations: Groups

- The importance of groupwork.
- Attendance to a MBCP is always encouraged if available!
- Conduit to referral and engagement.

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Evidence Informed Practice

- Knowledge is key to safety. Practitioner responsibility to maintain currency, or seek supervision, guidance or mentorship in the area of IPV is critical – **Working in isolation is dangerous to victims, children, yourself and men!**

Warning! Heavy Theory content!

- Theoretical frameworks (*Queensland Government Department of Child Safety, Youth and Women: Domestic and Family Violence Services Practice Principles, Standards and Guidance 2020,* pages 18 & 19):
    a. Gendered analysis and feminist theory acknowledging the power imbalance that underpins domestic and family violence and how perpetrators exercise power and control over victims. Feminist practice and theory also offer well-developed models for practice, for example, in client engagement, collaborative risk assessment and safety planning, and strategic and structural advocacy to support safer outcomes.
    b. Human rights theories based around empowering victims and assisting them to develop greater personal agency in their own lives and assisting perpetrators to be accountable for their behaviour to those impacted by their violence and to the people and services supporting them.
    c. Theories that address intersectionality and the experience of different groups in society, such as anti-oppressive practice, and tailoring responses to the specific needs of diverse client groups. Intersectional practice acknowledges the interaction of people's experience of race, ability, sexual orientation or gender identity, marital status, or religious beliefs on their experience or on the perpetration of violence, for example, acknowledging the impact of colonisation on Aboriginal and Torres Strait Islander people.

Evidence Informed Practice

d. Trauma informed frameworks apply an understanding of the impact of trauma across the lifespan both the victim and the family, and acknowledge that this influences global executive functions, such as decision-making, emotional regulation, responses to life events and figures in authority. Attachment theories highlight the critical importance of caregivers to the wellbeing of children and acknowledges that domestic and family violence can have a direct and indirect impact on attachment relationships. Trauma informed frameworks and attachment theories also highlight the impacts on the perpetrator's patterns of perpetration and their capacity to undertake a change process towards desistance from violence.

e. Psychosocial frameworks which take into account both psychological and social factors by understanding how violence. can impact psychologically on victims and their families and the social circumstances in which violence is experienced.

f. Systems theory recognising the importance of considering and addressing the impacts and influence of multiple, related systems on circumstances and behaviour.

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Evidence Informed Practice

- Duluth – The “Duluth Model”
- Ken McMasters – Disrupting Family Violence and the 5 Typologies of Violence
- Professor Jane Monckton-Smith – The 8 Stages to Domestic Homicide
- Dr. Brian Sullivan (Deluth)
- Dr Tracy Castelino Shantiworks - (Deluth) https://www.shantiworks.com.au
- David Mandel – Safe and Together Model
- Dr. Heather McCauley - Reproductive coercion and control research
- ANROWS - https://www.anrows.org.au
- Soooooooooooo much more emerging models and findings! Exciting times.

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Dynamic Assessment & Case Planning

Dynamic assessment tool/s: Living entity – NOT stagnant. Risk assessment for the abused/women/children, the client and practitioner/myself is constant and dynamic.

- Domestic and Family Violence Common risk and Safety Framework (DFV CRSF) assessment tool or similar. National Risk Assessment Principles for domestic and family violence (ANROWS), Ken McMasters (HMA) – Your agency?
- Risk and lethality. Lethality check list for warning signs.
- 'Red Flags' – immediate and dynamic changes.
- Risk Note*** Intimate partner sexual violence must be specifically considered in all risk assessment processes. Intimate partner sexual violence (IPSV) is a uniquely dangerous form of DFV which must be specifically considered in all risk assessment and safety management processes and practices. Survivors who are sexually abused by their partners are at a much higher risk of being killed, particularly if they are also being physically assaulted.
- Strangulation – choking, gagging, passing out, arm across/around throat, "wrestling" restricted breathing, rough play, sex in the bedroom, holding head under water, pillow over face, holding shirts/top tight around throat.
- Other assessment tools such as DASS 21, K10, substances/alcohol/drug use, trauma/ACE, gambling…. More?

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Case Planning: In Addition to the Norm

- Monitor for deeper systems abuse associated with treatment. Considers broader treatment needs and referral options. Incorporating elements of case management within therapy.
- Time mindful. Identifies realistic and achievable goals within the likely engagement period i.e. MHCP 10 – 20 sessions, PHN Connect to Wellbeing, vs Open Arms, DVA more flexibility 20+ sessions. Car park for future or alternate referrals or services.
- Discusses disengagement and cancellations or missed sessions.
- Privacy – they have none.
- Signed consents to release and obtain (i.e. current partner, P&P, CSO, GP, Psychiatrist, AA sponsor).
- What will occur if an acceptable risk is determined? Their responsibilities and yours?
- Obtaining copies of formal orders and reports where possible – DVOs, court transcripts or QP9s, Court and Consent Orders.

This is general and useful but are there specific case planning responsibilities for your organization?

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Engagement Strategies / Interventions

Motivational Interviewing (MI) and client goals:

- Regardless of practitioner preferred therapies such as psychoanalysis and psychodynamic, behavioural, cognitive, humanistic and/or wholistic, strategies and interventions are recommended to be grounded in Motivational Interviewing (MI) and client goals.
- Strengths of using MI techniques when engaging in difficult deficit (shame) based conversations that may elicit resistance to change and/or coerced/involuntary clients. Goal orientated change – working on what they want a “healthy” and respectful relationship to be (or at minimum an uneventful parallel co-parent arrangement with former partner and a healthy and respectful future relationship). What beliefs (and thoughts) do they need to have to achieve their goals?
- MI anchors the client to investment in treatment and the hard work being done.

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Engagement Strategies / Interventions

- **Clear is kind –** Name the work we will be doing around IPV, or as IPV concerns arise.
- Volunteer safe practices to do challenging work:
  - Invite exit if feeling elevated or at risk – and invite their return!
  - Narratively move in, move out in questioning and pace. Consider optimal timing of questions and challenging.
- Use of the Duluth model "control log" overt or narrative – Actions, Intentions, Beliefs, feelings, Effects (her, others and yourself), Past Violence and Non-Controlling Behaviours.
- The aim is to draw out the societal, patriarchal and personal experiences that shape the client's beliefs (and thus thoughts, feelings and behaviours) about men and women in intimate partner relationships.
- Take all the time you need to unpack statements that suggest any form of manipulation, coercion or bullying. These are often made as a flippant joke or statement of fact but reflect the surface of what really goes on.

Remember *** Risk assessment for the abused/women/children, the client and practitioner/myself is – constant and dynamic.

Engagement Strategies / Interventions

Curiosity is key…..

- We're a really close family, it's just the four of us most of the time.
- She's not really a girlie, girl. She's not one for going out for lunch with the girls or catching up for a gossip.
- After 23 yrs together, she knows just how I like things.
- She's too busy too really have a hobby or interest.
- We've always had a great chemistry, she's always up for it.
- I work hard – you know long days and hours, so I like to switch off.
- She's not great with computers and stuff so I help out by doing all the online banking and bills etc.
- She used to work in an accountant firm, but she's too busy at home now to really have a career.
- She's just started studying again, b.ut I feel like the clock is ticking. I don't want to be an old dad.
- She knows if we don't "do it", I'll just use online stuff.
- She's so overwhelmed by the kids that I do my part by just getting things done, you know making the decisions and sorting things out. It's the least I can do.
- It's funny we don't really argue, she's so easy going.
- Things are different when she's pregnant.
- My family are the most important things in my life. I make sure I take great care of them and keep them safe.
- The kids and I know what she's like. It's not her fault, she gets it from her mother.
- Money's a bit tight but there's always ways to cut corners.
- We only have the one car; it just makes sense.
- The kids love to video call. They're always showing me their rooms and toys about the place.

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Engagement Strategies / Interventions

Family law:

- Clients involved in, or looking to commence Family Law matters are often seeking an ally in their views and to aid in systems abuse. Practitioner role to advocate for their responsibility to challenge and choose their beliefs and actions. Focus can also be on support during the lengthy and emotional process – this adds a layer of risk oversight.
- Specific interventions to support respectful, safe and compliant engagements.
- More in ‘Judicial Implications’ area.

Referral Network: For

- Client
- Women, victim survivor
- Children
- Extended/Others (multidisciplinary team members, employer, broader family members)

Think:

- Local
- State/Qld
- National
- Online

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Referral Network

- Discuss transparency of issues. DV is a factor, they have a current DVO or a history of IPV. Value in honesty! Being honest helps them meet their needs (client's goals).
- Groups – MBCP/SFV/DFV prevention program, Healthy Relationships, CoS, PoP, 123 Magic, Triple P, 'As Kids See It' (young people/youth) ATODS, DBT, PTSD, Veterans, Cultural & diversity focus. AA, NA, GA – Face to face AND online!
- Additional 1:1 support – addictions, trauma, gambling, adjustment, LGBTIQA+ support, psychiatry, immigration, migrant & culturally specific and appropriate services.
- Holistic – Cultural & healing, religious & spiritual groups, sports exercise / healthy mind healthy body/ social & emotional wellbeing, volunteering, hobbies & interests, community gardens, volunteering etc.
- Formal supports – Employment assistance, housing, FRC and/or legal supports, immigration, migrant and culturally specific and appropriate services; NDIS and disability, Aged Care, DVA, WorkCover, Child Safety, financial services – Good Money, Uniting Care & legal advises such as CCLS & Law Right Mental Health Law Clinic and Self Representation Service (Federal) & individual Ombudsman's.

Judicial Implications

- Independent professional integrity - AASW Code of Ethics, Social Work Values – Professional Integrity, ‘make considered and ethically accountable professional decisions’(Section 3.3 page 13).
- Client consent to release and disclose with all touchpoints is essential. See Foundations and Case Formulation – Clear to be Kind mantra. But… share anyway if need, as per….
- Domestic and Family Violence Information Sharing Guidelines May 2017
- Subpoenas and Affidavits. Get used to them!
- Family Law and ICLs
- Consider the impact of mandatory reporting, subpoenas and affidavits on working relationship if information or involvement undertaken during and post service completion.
- Seek additional professional guidance and supervision as/if/when needed.
- Your professional bodies often have a legal support resource. Don’t be afraid to reach out and ask for guidance.
- Connect with Family Law Pathways Network or local Family Law networks, or Association of Family and Conciliation Courts, SPEAQ, Work Up etc….

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Clinician Implications

- What sort of practitioner do you want to be when working with abusers and men who engage in IPV? What's your framework?
- What sort of practitioner do you NOT want to be when working with perpetrators and men who engage in IPV?
- What will you need to change to be a safe and effective practitioner when working with perpetrators and men who engage in IPV?
- Who can help you achieve these changes?
- Do you honestly think you can do the work? If not, what to do?
- Self-Care and preventing burnout: Why is self-care important?

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Thank you for joining me in exploring a ‘Clinical Approach to Individual Work with Men who engage in Intimate Partner Violence’

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