Neurobiology Applications for Community Supervision Professionals in Interpersonal Violence - Webinar Transcript

Welcome to the National Criminal Justice Training Center webinar, Neurobiology Applications for Community Supervision Professionals. My name is Greg Brown and I will be moderating for you today. Before we begin the presentation, there are some items I need to go over. This project was supported by a grant awarded by the Office of Violence Against Women, US Department of Justice. The focus of this grant is looking at victim-centered approaches to community-based corrections, focusing on corrections professionals, as well as victim advocates and victim service providers. The opinions, findings, conclusions, and recommendations expressed in this program are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

The learning objectives for today's webinar include-- gain a deeper understanding of the impact of trauma on the brain, with an emphasis on victim/survivors and offenders. The second objective is to learn at least three skills to attend to the trauma response as a community supervision professional or victim services provider. And the final learning objective is effectively addressing trauma with victims and survivors.

So today, I'm pleased to introduce you to the following presenters-- Robyn is the director of Gender and Family Justice Initiatives at the Center for Court Innovation. Robyn provides assistance and strategic planning advice to courts and communities who are interested in enhancing their response to gender-based violence by sharing research, best practices, reviewing policies and protocols, conducting needs assessments, and providing ongoing consultation.

Rebecca is the associate director of Gender and Family Justice Programs at the Center for Court Innovation. Working from a perspective of social justice, and grounded in collaboration, Rebecca assists jurisdictions nationally to enhance their core and community response to domestic and sexual violence.

Anjali is an associate with the National Criminal Justice Training Center of Fox Valley Technical College. She is also the Chief Probation Officer for the 20th Judicial District for the state of Colorado. Additionally, Dr. Nandi is a published author, having co-authored nine books.

My name is Greg Brown and I will be moderating today's webinar. I'm a program manager with NCJTC. Prior to that, I was an associate with NCJTC specializing in providing training and technical assistance to community corrections professionals, and I worked in probation for a little over 30 years supervising specialized populations and victim services in a Colorado jurisdiction. With that, Anjali, I'll hand it over to you.

Excellent. Thank you so much, Greg, and welcome, everyone, to this presentation. I'm excited to be with you and to be with Rebecca and Robyn. We have a lot to share and the place we want to start is just by letting you know what we're going to talk about today. We're going to start with talking about what is trauma and why to pay attention to it. We'll try and understand what trauma looks like, how to recognize it, and then how to be trauma-informed in our response.

So the focus of today is not to tell you how to help resolve trauma. That's really not the focus. Today, we're going to talk about a lens through which you can look and understand people's behaviors. So often, the people we serve do some of the darnedest things, and we are left kind of scratching our heads. Why do they do this? And sometimes having a trauma-informed lens provides us with explanations that help us understand where their behaviors might come from and therefore, what we can do about it to support them. And so we'll talk about the implications in our work, as well.

So in the next slide, we start to define what trauma is and why it matters. So every time we hear the word "trauma," frequently we'll think of sort of capital T trauma events. Right? These big trauma events, like something that's really harmful and threatening. Maybe experiencing violence or sexual assault, or something pretty significant, like a significant car accident.

And yet there are so many different kinds of traumas. It's not just these capital T trauma events, but sometimes a conglomeration of little t trauma events-- interpersonal events, emotional abuse, walking on eggshells all the time in a relationship, not knowing whether I'm coming or going, not sure what to expect. Those kinds of things that sort of don't seem really huge when we think about them, but really add up.

And the interesting thing about trauma is that it adds up fundamentally to brain changes, meaning trauma is not because I'm weak and therefore cannot manage a particular situation. It's because the experience has resulted in neurological changes, changes in my brain about how I then start to perceive the rest of the world. So we'll talk a little bit about that, about what these neurological changes are, and we'll talk about the good news regarding how we can start to reverse some of these changes.

We also think about trauma in terms of micro experiences, like interpersonal experience. And in fact, a lot of trauma is interpersonally based. And the good news is that we heal interpersonal trauma in relationship, meaning we don't have to be in the same relationship to heal trauma. If I was traumatized in relationship A, I can heal it in relationship B. And the cool thing is it doesn't have to be an interpersonal-- like an intimate relationship. It can be a relationship with a provider, such as you all on this call. And so we are in this amazing place to really help people heal their brains just by being present with them and quite empathic with them.

So in the next slide, we'll start to see sort of what some of these types of traumas are, and what is it that a person experiences when they're experiencing trauma? So there are some words that really stand out. The first piece is that trauma is overwhelming. When I'm experiencing trauma, I believe that I am out of control. My mind, or body, or my physicality is threatened. My emotions are threatened and there's a belief that I will not survive this, and that my own ability to manage is exceeded. So my capacity to cope is overwhelmed and I feel powerless in that particular situation. So those are some of the really key components of trauma.

So to summarize it in the next slide, we really say that trauma is an experience of intense fear. It could be horror, it could be helplessness, but essentially, it overwhelms us. And what it does is it pushes us neurologically to respond with either fight, flight, or freeze. And those responses reside in a particular part of our brain. So in the next slide, we'll show you kind of what our brain looks like.

So on your screen, if you can see this picture of the brain, you'll see that it has sort of two portions. There's the portion in the center, which is our emotion brain. This is the fight, flight, freeze part of our brain. We call this brain the limbic system. And the limbic system is our old brain that really keeps us safe. It processes most of the information. We process over 11 million bits of information in a day, which is exhausting. And luckily, our limbic system sorts through this very, very efficiently and quickly. It doesn't use as many calories as our frontal cortex, which is the other part of our brain, where on the slide, you can see that it's says intellectual and logical brain.

So we have the limbic system, sometimes called the lizard, and then we have this intellectual part of our brain, sometimes called the wizard. The wizard uses a lot of calories to function. We kind of think things through, we slow down, we're able to think about the future. The limbic system, on the other hand, just references the past. Meaning if we're stuck in our limbic system, we only have access to the past, what has happened before.

And when we start to experience trauma, one of the fundamental changes that happens is we get these two parts of our brain disconnected. Meaning that the limbic system and the frontal cortex, or the lizard and the wizard, ordinarily communicate really well. There's sort of this ongoing communication from the lizard brain to the wizard brain if the wizard needs to get involved. But in trauma, if we look-- if we do an MRI of the brain to see where is the blood flowing, we see a disconnect between the limbic system and the frontal cortex. And so essentially, we get stuck in our limbic system. We get stuck in fight, flight, freeze. And so you might notice certain ways of being or certain ways of responding to for people who have experienced trauma. And it almost looks like their brain is in conflict.

So in the next slide we kind of list out for you what are some of these key components? How do you recognize when somebody is sort of showing you that their limbic system and frontal cortex are disconnected? Because unfortunately, sometimes it looks like them pushing back, or them engaging in manipulative behavior, or them not making sense. Or maybe they're withdrawing, or maybe they're acting out, and we think, oh my gosh, why is this person being so resistant? And we come up with all of these terms that sort of-- and maybe this is just me, but I can fall into a trap very easily of kind of blaming the other person. And what a trauma-informed lens allows me to do is be able to see that the person is just trying to cope. That they are just-- their brain is in conflict and all they can think about is safety first. They're trying to keep themselves safe.

And so what happens when this brain is in conflict is where our ability to hear-- literally, our ability to hear-- is minimized. We can't really problem-solve in creative ways because we don't have access to the part of our brain that problem-solves. We don't have a sense of humor, it's hard for us to see complexity, and it's hard for us to remember anything positive.

So I'll use an example to kind of bring this all together. If you're working with somebody-- and you represent the system somehow, right? So in probation, for example, whether we like it or not, we sort of represent the system. And if a person has experienced trauma, and they're triggered in the conversation with me-- and by triggered, I mean they're stuck in their limbic system. I'm doing my best to make them feel safe, and yet they only have the past to think about. They have no positive memory. And so in the moment, they cannot trust me. They cannot believe that it's going to be different, that it's going to be OK, that I'm really here to support them, to help them through this. They are convinced-- just like all the previous experiences they've had-- they are convinced that this is going to go badly for them. That their safety is at risk, that people are out to get them, that this is really not going to be a positive experience. So when our brain is sort of in conflict, it's really important to understand what is happening.

And so what we're going to do next is Rebecca's going to kind of slow us down a little bit and really talk about the kinds of trauma that we experience. And she's going to start to kind of break it down into the micro and what we call macro experiences of trauma. Rebecca, would you like to take it from here?

Thanks so much, Anjali. It's great to be with everyone today. I think Anjali said at the beginning that oftentimes we think of trauma as big events, but trauma can be a series of smaller events that accumulate, literally, in our bodies and inform the way that we respond to the present and think about the future. And these can happen in person-to-person ways. It's happening in an interpersonal way, and Anjali highlighted some of those.

They can also happen in a larger system or in a structure. And I think that's important for us, when we're thinking about our role in the criminal legal system, as Anjali mentioned, how people are thinking about the space that they're in when they come and meet with us, and are really talking about either harm that they've done to someone else, or the harm that's been done to them by someone else. We think these types of trauma can be present in all three of these buckets, of interpersonal, systemic, or structural, or they can just be in one bucket. But as human beings, we're moving through relationships, we're moving through systems, and we're moving through structures on the day-to-day.

If you've attended some of our past webinars around risk, we've talked about the ACEs and the ACEs Expanded, those adverse childhood experiences. And in the ACEs Expanded, they were looking more at the systemic and structural types of traumas, and how those impact people and have severe mental and physical consequences in the future. And we'll talk about that a little bit in a minute.

When we're talking about intimate partner violence cases, you can say that all three of these kind of buckets of trauma can be present and impacting either the victim/survivor, or the abusive partner or probationer, or both of them.

What's really interesting about recent research is it shows how trauma can be passed intergenerationally. As Anjali mentioned, things happen in our DNA when we are traumatized and those things then can be passed on to our children. And what we think as a personal trait or a community trait can actually be personal trauma that's compounded or community trauma.

Interestingly, I'm just reading the book *My Grandmother's Hands* by Resmaa Menakem, and I encourage all of you to read it. It talks about racialized trauma and the pathway to healing. And in that book, he mentions a study by Kerry Ressler and Brian Dias that talks about memories connected to painful events can be passed down from parent to child. Trauma can be passed down through our nervous system to our DNA.

And it's really interesting then what that looks like for us when we're thinking about people with whom we're working. And making sure that we're allowing that whole person-- these interrelationships between the personal, the system, and the structural. And how we can-- how important it is to heal all those type of traumas. One of the people that we work with on our Abusive Partner Intervention Project on the national level, she is always saying that trauma that is not transformed is transferred.

So in the next slide, we're going to just break it down a little bit and talk about the different types of trauma. This is this kind of-- again, these personal traumas, as well as the historical and intergenerational trauma. These can happen in a home, in a community, and they can also be the threats of it. So once someone is traumatized, as Anjali was mentioning, they are not thinking about a future without trauma. They're constantly gauging, am I safe, am I not safe? And that part of the-- the lizard part of the brain is making those immediate visceral decisions about what is safe and how can I keep myself safe.

What does that mean for us in our work? We think about the number of people with whom we work that have experienced trauma. In the next slide, we'll see, these statistics are really jarring when we think about this kind of trauma. And you can see, there's the personal trauma around girls experiencing sexual abuse, and boys experiencing sexual abuse, women experiencing domestic violence, and children exposed to it, and sexual assault.

But then also just witnessing traumas happening. So what happens to children who are exposed to it? We see there's high rates of that. But also, teens witnessing a shooting in their community. Those who are witnessing a murder happen, or were in a home where a murder happened, or where there was an attempted murder. Those types of things really have long-term effects.

There's high rates of poly-victimization. So if I'm a girl that's experienced sexual abuse, then I might also be someone who, later in life, is a woman who's experienced domestic violence. And so really thinking about the people, again, with whom we work, who are coming in as probationers. It's not to excuse the harm that they've done, or the crimes that they've committed. But putting it into a context, and really always thinking back to this idea that trauma that's not transformed is transferred. And that can play itself out in victimless crimes, and then in the case of intimate partner violence, victim-centered crimes.

So let's look on the next slide when we think about criminal justice prevalence. Right? We're seeing most folks who are involved in the criminal justice system, they really have high rate of trauma. Twice the rate of those who are not involved in the criminal justice system. We're seeing high rates of trauma in arrested youth. I mean, this is really a very hard statistic to look at, that 75 to 93% of arrested youth.

Thinking about women, criminalized survivors we're going to be talking about that a little bit later. But women who are involved in the criminal justice system have twice as high rates of trauma as their counterparts, as men. And we're looking at those people in the system, they're at 99% of them are reporting at least one traumatic experience.

So again, when we're thinking about what this means, again, it's not to excuse the violence that someone has done, or the crimes they've committed, but really to understand it. And how we can talk about healing that trauma and creating safer communities.

So on the next slide again, as I was talking about why would we-- why do we care about trauma? I'm always going back to what Terry says-- trauma that's not transformed is transferred. Right? The trauma has so many mental and physical health consequences, substance abuse, it can drive criminal behavior, and as Anjali mentioned, it influences all of the interactions and our responses to the world around us. When we think that the world's an unsafe place, that is going to impact the way that we respond. And it's almost impossible to understand how the emotional, that intellectual brain gets shut down, but when that other part, the lizard part, of our brain takes over, it's not thinking. It is responding to the world around it immediately and thinking about, am I safe? Do I need to fight or freeze?

So let's unpack these a little bit more. In the next slide, and again those of you who are familiar with Adverse Childhood Experiences scale, this will look familiar to you, as well. When we're thinking about the impact of trauma on someone's physical and mental health, we may see an increase in mood and anxiety disorders. Again, that's, as Anjali had mentioned, really being able to-- we think that they're not able to pay attention. Oftentimes with victim/survivors, they're not able to tell their story in a chronological way, which may lead folks to think they're making things up. They are testifying in court, or when they're talking about what's happened to police, our criminal legal system [AUDIO OUT] there's this increased attempted suicide or suicides and self-harm, such as cutting and other things. We're seeing sleeping and eating issues, increase in injuries and illness, and then post-traumatic stress disorder. And we'll talk about that a bit more.

So I just referenced the post-traumatic stress disorder, which is a kind of trauma response. And you can see here that there is kind of four clusters of symptoms. And often I think about this with folks who are coming home from the military, or people who have had some of those severe traumatic incidents. And this is in DSM. I think there's a definition for it. Often it's called re-experiencing or hyperarousal. And that's that intrusion. These experiences are coming back over and over again, and people are re-experiencing that trauma.

Then there's the avoidance trauma. Kind of that flat affect unwilling to talk about it, the body takes over over and actually not allowing someone to remember what's happening. Then there's the negative alterations in cognition and mood. And that really is affecting some of the - They may seem angry. I've seen folks on the stand who burst out laughing when they're talking about something traumatic that happened to them. And then these alterations in arousal and reactivity. Sometimes it's called hyperarousal.

So what can this look like? And I think for many folks who work in, particularly, the justice system, one of the comments that you'll often hear is that that person might look manipulative. Right? There's some inappropriate emotions, guardedness, difficulties with memory. Like, oh, I don't remember this happening, I had no idea. Self-censoring, fragmented stories.

But now, with the kind of-- what we've been hearing and sort of this foundational information around trauma, you can, I hope, start to see how the trauma effects on someone's brain, and all of the historical traumas, all of these components can start to manifest in a way that, perhaps as you're seeing someone in your office or talking to someone, really what those kinds of behaviors are some of these trauma reactions.

So also, some other impacts of trauma, and just sort of an importance in thinking about this is-- and I think Anjali already touched upon this, as did Rebecca-- but just the lost sense of meaning. And the world and people can be seen as bad, and questioning spiritual beliefs, this high risk of re-victimization.

And so we've been sort of toggling a bit about who in the system we're talking about. A lot of what, I think, we've been leading up to this point is often, in the context of interpersonal violence, we've been talking about the person who uses harm. But obviously, trauma also is incredibly impactful on the survivor of the intimate partner violence. And so this concept of high risk of re-victimization, we hear this all the time in the courts. Why does this victim keep coming back? Right? And so a lot of these trauma responses can also lead to some of these kind of behaviors, and sort of the view of self and others in the world. And obviously, negative experiences with the system.

So you know, now we're fully wanting to kind of jump into this world, talking specifically about survivors of intimate partner violence, and sort of the barriers around disclosure of violence that may occur. And a lot of this is rooted in a lot of these trauma reactions that we've already started talking about. I mean, some are really as basic as no one's ever asked me about that. You will be surprised if you are-- and it's hard in this setting today to know who exactly I'm talking to, and I think we probably have a mix of folks who work both with people who use harm and people who are survivors. So depending on where you sit in that, you may have different experiences with this. But you often can hear from survivors of intimate partner violence, no one's ever asked me about that particular trauma in their life, or about those particular components. So that's obviously a key piece.

But also, there may be some of this avoidance that Rebecca talked about, where someone may deny and/or minimize what's happening to them. And we see that a lot with survivors. Oh, I just got pushed. But then later, you start to unpack that and have more deeper conversations with someone, an advocate or someone in that position. And you find out the violence was actually much, much more severe, and that little tiny fact that you heard was actually a string of many more disturbing facts.

Obviously, shame, and embarrassment, and self blame, and past negative experiences. Obviously, the relationship with the person who uses harm. Often, I do a lot of work in the context of family law and many times, people have children in common and lots of complicating factors around those components. Cultural pressures, familial pressures, external pressures, obviously. And lack of rapport or comfort with disclosing.

So once again, we're doing our toggling of who we're talking about here. And so there's a lot of information around trauma, on the impact of trauma, and substance use, and substance abuse. And this could both be someone who's using harm in an IPV relationship and/or the survivor. But you know, substances can be used to cope from an early age. Sometimes it can start, as probably many of you know, pre-teen, early adolescence, as a way to self-medicate and numb oneself from the trauma and those experiences that we were talking about earlier.

One of my sort of key pieces that I always want to leave in these kind of settings is that trauma can exacerbate the existing substance use disorder issues, but substance use disorder does not cause intimate partner violence. So just, it's not-- there's correlation, but it's not causal. And basically, there can be-- and there's been a lot of research around-- particularly women who have been victimized, who are survivors of a variety of different traumas-- physical, sexual, emotional abuse-- also have substance use disorders as a coping mechanism.

So how does all of this trauma-- as you saw the really upsetting slide that Rebecca had up quite a bit ago now, about the criminal justice prevalence and trauma, and seeing this linkage-- how does this sort of manifest? What are we talking about here? So you know, there's survivors of childhood trauma are more likely to be arrested for serious crime as juveniles and adults. Among young boys engaged in sexual offenses, 95% have experienced trauma, and 77.5% reported more than one trauma type, and nearly half had experienced physical and sexual abuse. Incarcerated veterans are another population more likely to be convicted of homicide or sexual assault than non-veterans. So there's a lot of this linkage.

And then in terms of the second bullet here, around sexual exploitation and prostitution, often we see this criminality also where people who use harm are coercing or forcing the victim or survivor to engage in illegal behavior. So sometimes it's not even just needing to break through the numbness to engage in risky behavior, but it can actually be a form of the abuse in those situations.

So continued on into that, we also see the outputs, or what is happening in some of this, is violence as a learned behavior. I really appreciated Rebecca's discussion. I think Anjali mentioned this, too, about the intergenerational components in trauma, and how this can end up becoming violence as something that someone's seeing in a variety of ways, both in the community and interpersonal in their homes, and that becomes a learned behavior. Unfortunately, seeing that linked to poor educational outcomes. And then for those of you who may either currently work or have ever worked in the juvenile systems, often seeing also some of the running away or the isolation. We see that in the adult populations, as well.

So now we wanted to try-- this is a really large group of attendees, but we try to make these interactive as best we can. I wanted to see if you all could use your chat box and do kind of a quick large group discussion around how you see trauma impacting your work. So like I said, I'm guessing that we have a variety of different disciplines here today. So if you can just go to your chat box and type in what you're experiencing.

Thanks, Robyn. So it looks like the first question is-- it sounds like trauma responses from victims and corrections clients may interfere with their ability to address safety needs for victims and risk factors for clients. Is that true? And if trauma is not addressed, can it contribute to additional issues? And I'll throw that out to Anjali first, and then Robyn and Rebecca.

Yeah, that's a great question. So unaddressed trauma can show up in many ways and can contribute to all kinds of behavior. Just one clarification-- it doesn't cause the behavior. Fundamentally, the person who is experiencing trauma is just trying to survive. They're trying to stabilize. They're trying to do their best to manage whatever is happening.

And so I just think it's important that we view it through that lens so that our response is not to punish but to support and provide resources. So yes, sometimes in response to trying to manage my trauma, I might engage in problematic behavior, like substance use, or criminal activity, or even violence, for that matter. And yet, that is not because I'm a bad person, or because I'm a criminal, or an antisocial person. It is because I'm just trying to survive. So it's really important that we view it through that lens so that we respond with resources and support.

I think that Anjali really covered that well. And in a few minutes, we'll talk specifically about how this might show up for survivors and abusive partners. I do think from the work that we've done with folks running programming for abusive partners, you know again, this issue-- if they're not able to connect the dots between what happened to them in their past, or in past relationships, and how that informs response to their partner.

There is some research that shows that perpetrating violence on another person is a trauma response to past trauma. That's not to say that it is OK, or that a person shouldn't be held accountable, but when we're thinking about groups and behavior change, really thinking about the importance of thinking about that trauma. And it's interesting because it might connect into another question I see that we have here from someone about why does the victim keep coming back and getting stuck? And I don't know, Robyn, if you want to talk a little bit about survivor trauma, and how to support safety, and decision making for survivors.

Sure. Yeah, no, obviously survivor trauma is super important in connecting people to specific survivor-centered services who can work with people to address a lot of what we were, the previous slides were talking about. But I would be remiss if I did not mention the other sort of barriers to survivor safety, which I think is sort of embedded in your question around why people may return. There are a lot of other issues, including economic issues, fear of-- potentially-- of lethality, issues around the children. Like I said, homelessness and economic components are huge.

So obviously, this, the trauma work that we're talking about here, is a key underpinning of understanding. But there are lots of other barriers to safety. And I encourage all of you, if you're somebody who doesn't work in this space, or are not working directly with survivors of intimate partner violence, to connect and make those connections with your local domestic violence or sexual violence agencies to really start the dialogue of understanding and building out what we're touching upon today.

Thanks Robyn. Just in response to you guys' question, a person who is a probation officer's trauma impacts my work in multiple ways. Clients can be standoffish, guarded, angry, et cetera. If they don't open up, we can't adequately help them.

Yeah, so it's a really good kind of encapsulation of the experience, right? If you are not opening up and showing up, how am I to help you? So my recommendation would be to take a step back and to ask in what way can I create an environment that feels really safe for this person to truly show up and open up? And that's my responsibility as a probation officer, right? To create a safe enough space where the person feels like they can start to open up with me. It won't happen in the first minute. It won't even happen, perhaps, in the first conversation. But the more we start the relationship-building with empathy and curiosity, it allows the person to return to their frontal cortex.

So one of the key ways to help people get out of their limbic system and to get their frontal cortex engaged, which is essentially what you're trying to do, is to be respectful and empathic. Empathy really reduces the feeling of a lack of safety. And heals the brain-- it literally heals the brain. Being in a supportive sort of a partnership, a relationship where I feel like we're both working towards the same goal, really helps build safety. So if I can prioritize those things and really focus on the relationship and the environment, I can increase the likelihood that the person opens up.

I'm not saying that that guarantees it. You still might struggle and won't be able to serve the person fully, but even naming that can be helpful, as well. Naming that part of my worry is that you don't feel safe enough here, and because you don't feel safe, and you are not sharing with me, I'm not able to serve you to the best of my ability. You could absolutely name that. But really it is our responsibility to create a strong, positive, safe, empathic relationship.

So I think a related comment that I'm seeing in the question box is what can work-- what to work on is directly related because depending on our client's level of arousal, will direct our approach in what they are emotionally available for and will retain.

Greg, I'm not sure if I fully understood it, but I think what the comment is saying is that we really have to adapt? Yeah, adapt to what the client is providing me. So if the client's skills are minimal, that's what I have to work with. And yes, whoever put that comment in, you're absolutely right that we get to work with whatever the client is coming up with. And then, we continue to create a safe space, a supportive environment, for them to show up fully with all their struggles, and then we can start to be more targeted in our interventions.

And here's a really interesting comment that's very timely with COVID. The person says, I hear what the professionals are saying. However, many appointments are virtual, which means the client may not be in a safe environment, especially when they often live in high crime communities, or if there's discourse within their home. So a new challenge that's really emerged since COVID and with people being forced to stay together, or stay in dangerous situations, as well as not having direct access to professionals in person.

This is such a great comment and is so, so true. A lot of times, when we're having conversations with the person that we're working with, we're not just having a conversation with them. We're having a conversation with their entire household because they are not in a confidential environment. And so it's truly problematic.

I mean one of the things that we have done with several of our clients that we are worried about, in terms of safety, is we have a very benign code word. And any time we say, so how are you? If they respond in a particular way, we know that they are not in a place to have an honest conversation. They're in a place where they're feeling a little bit threatened. And so sometimes that helps because then I know not to ask questions that could get them sort of further into a problematic situation.

I can also recommend that they step outside and let's go for a walk. And sometimes I'll have them on speaker when I ask that. I'll say part of our case plan is to really help you get outside. So I'm going to ask that you go outside and take a walk with me as we finish up the rest of this conversation. So that way I'm sort of taking on the burden of kind of forcing them outside.

Great ideas. Robyn, any additions?

I would just say, I think Anjali was giving that perspective from someone working with someone who might be a probationer, but I would add that this is an incredibly important component of working with survivors. And we've seen-- I don't know if you all saw-- even judges and people having their cases on virtual platforms with the court, and a survivor was testifying, and the person who used harm against them was in the other room, and they ended up calling the police and getting that person to some level of safety. But it is really, really critical.

And so the strategies that Anjali just mentioned are similar strategies that advocates in the field have been using when working, specifically, with survivors, including code words and things like that. So really, very dangerous time for people experiencing intimate partner violence.

Thanks, Robyn. And I think one more question and we'll move on with the presentation. How do you discuss accountability towards goals while accommodating for a trauma response? And I think that could apply to working with victims as well as criminal justice clients.

So accountability towards goals-- I would say, from the survivor point of view, I don't know that we frame it that way. That could be like re-victimizing somebody. Obviously, re-blame-- blaming them for the violence against them. So that's not typically language that would be used in a survivor-centered kind of framing. But certainly wanting to work with people and be accessible in all different ways to make sure that they're getting the support that they need. But I don't know, Anjali, if you have a reaction to that from the other perspective.

For sure. I think this is a really important question because even with folks on probation who may have harmed others, they are still showing up with their own trauma. And we need to do both. We need to show up with all the empathy that we have, but also hold them accountable. And they're not in opposition to each other. They actually work really beautifully together. Empathy doesn't mean we therefore say that their behavior is OK. In fact, we're really clear about what's OK and what's not OK. We're really clear about boundaries. And that seems to help a great deal.

So we're sort of-- this is a perfect next slide to talk about the system and "us," meaning either survivors and/or people who use harm and interact with our systems. Our systems-- whether you're working in the criminal justice space, or you're actually even working at a domestic violence agency, or work with the courts, or with any other kinds of stakeholders-- these are systems, right? And so they are often, unfortunately, not always trauma-informed. Actually, many systems are actively not. And recognizing that, and we're going to talk more today about how we could-- and we've already touched upon many ways that you can improve your practice and make it more trauma-informed.

But because of the fact that many systems aren't, people may refuse to want to discuss a lot of the trauma. They may deny or minimize the traumas that they've experienced. And actually, the systems that we operate in, actually also sort of mimic, or are in the same vein as some of the power and control dynamics that people involved in intimate partner violence situations are actually in. So it kind of, unfortunately, can reinforce and re-enact the trauma that people have experienced by just being involved with our systems. And the cycling in and out can be another sort of trauma response, or the triggering that we were talking about. So I don't know, Rebecca, if you're wanting to jump in on this?

Yeah. I mean, I would just say that one thing that we've seen in programming nationally with the abusive partners, again, is this idea of them not being able to talk about the trauma-- often the racialized trauma-- of the arrest. And the violence that happened when they were arrested. Again, that's not to minimize the reason that they were getting arrested, the harm that they've caused on their partner. But if we continue to compartmentalize people and only quote unquote fix parts of them, we won't really, I think, get to the change work and the healing that needs to happen.

Folks won't be able to do cognitive behavioral therapy if their cognitive part of their brain cannot function because the lizard part of their brain is overriding that. And it sounds like maybe it's kind of trying to minimize, deny, and blame, but it's not that. We know that probationers have their role.

And I think Anjali teed up well-- we're not talking about trauma-responsive work. We're talking about trauma-informed work. So if you have someone who is really traumatized in front of you, referred to you by the court, they may need trauma therapy in order to do the work that you want them to do. They may need some of their basic needs met before they can show up into thinking for change, or some kind of motivational group work. And so I think that's where these types of things-- folks may show up in that way, where it's like a response to us and the system that is interfering with their ability to comply with what we want them to do.

Yeah, we can go on to this slide. I think, Robyn, you were really getting to this in one of those last questions. Where trauma survivors are asking themselves, what can I do to survive and have some sense of control in this terrifying world? And that may play itself out in ways that we don't understand, or seem counter intuitive to us as probation officers or victim advocates.

Those-- the things that we're seeing are really adaptation and survival mechanisms, attempts to cope. Someone isn't really necessarily being difficult with us. It's not about us at all, actually. It's about this person trying to survive and be safe. And those responses-- you know, it's not even using the word logical. These are innate responses to keep the person safe, especially when they have this long trauma history.

It may look like manipulation and deceit to us if a survivor acts in a certain way. It may look like criminal thinking, but really these are trauma responses to what's happened to them, especially when we're talking about survivors. But I don't know, Robyn, if you want to add anything to that, or Anjali, about survivor trauma responses. I'm sure as a probation officer, you may have gotten calls from survivors that may have seemed, or that were, angry. We've seen survivors in court acting in different ways that may not make sense to us.

Yeah, this is Robyn. I would just echo all of those. And often what we even see, too, are survivors who may not be able to even recall some of the incident. Right? And often in the legal system, that can make people question whether or not-- and actually in non-legal systems, probably, too-- but question whether or not this was even really something that happened to that individual. But now, sort of understanding the trauma components and reactions, it hopefully can make people understand that that's not someone making up what happened to them, but honestly that they are not able to recall it.

Right. And in the next side, what happens if we miss it? With both survivors, because oftentimes survivors will show up in our criminal legal system as defendants or respondents. With defendants, we have this revolving door. We often ask ourselves, why are we seeing this person over and over again, right? We're missing the boat if we can inadvertently trigger or victimize someone.

The criminal legal system, it's not-- in some ways it's not set up to address these underlying problems that create environments where crimes happen. Right? The criminal legal system may not be able to provide the trauma therapy that needs to happen. Trauma really is rarely addressed in drug and alcohol treatment programs. It was, up until very recently, not addressed at all in abusive partner intervention programs. I don't know-- I can't remember the last time I looked at Thinking for Change, or the cognitive behavioral therapies that is happening in probation groups-- if there's this discussion about trauma. And so I think we're missing the boat. And we're going to continue to see people, we're going to continue to see trauma and unsafe environments in communities unless we can really address it.

And we'll move to the next slide. I think this gets to some of the questions that were raised. Why is there a barrier to our trauma response, trauma-informed response? I think we get busy in our day-to-day and it's hard to get trained, so I'm really inspired by the large numbers of people on this today. But this really is just kind of touching the tip of an iceberg in terms of training that would need to happen around trauma-informed responses.

And we're-- many of you on this call-- the system is traumatized, as well. Right? We, Robyn and I, work with judges a lot who have to move off the domestic violence court bench or the sex offense court bench because it's too hard to continue to hear these stories over and over. So we're traumatized, the system is traumatized by hearing these stories and handling these types of cases.

And of course, there's a challenge with funding for specialized services. And also I think in-- more and more, we're looking at these multidisciplinary team models to address issues, but until recently, things were handled in a vacuum. I know one thing that Robyn's really excited about is like the DV drug court model, that's looking at both domestic violence and substance abuse, and thinking about how we can handle these things.

And then there's the systematic, or systemic, resistance to change. And whether it's about not having enough money, fear of bad publicity if we start thinking about trauma with people who cause harm, and those kinds of things.

Some of this, I guess, is some common sense. Like how do we go about making our systems more trauma-informed? It's obviously with training, approach, and philosophy. That's easier said than done, right? Going to a two-hour training does not make you completely trauma-informed.

So there are limitations with this, but it's this really-- we have sites that we work with that do trauma audits, where they actually go through their systems and really are looking at, are we trauma-informed at all these different intercept points. And how can we make those changes? Obviously, you need to have political will there, you need to have money, and real leadership. Hopefully many of you on this call are in a position, perhaps, to try and do some of that.

You've heard, I think, both from Rebecca and Anjali talking about screening and assessment. Obviously, depending on your role in the system and who you're particularly interfacing with, whether you're an advocate in a domestic violence agency or you're a probation officer, there are different types of screening and assessments that are appropriate for those different environments. But making sure that those are being incorporated into your work.

And then actually looking at the environment. We talk to folks in courts and other legal stakeholders all the time. Look at your offices, look at courtrooms. I mean, for goodness sake, that's terrible and a lot of places are having a hard time making changes there. But how are we, even our spaces, how are we empowering people and being trauma-informed in those?

And then this fourth bullet is-- I cannot understate it enough. I mean, this is-- or overstate it, excuse me. This is really, really critical. Needing to make sure that you're connected within your community to those folks who are providing domestic violence services and/or those folks that are involved providing trauma care. So knowing those people, meeting them, cross-training with them, understanding the services that they provide, and making sure that systems can be wraparound and more trauma-informed across the board. And as Rebecca said, making sure that trauma issues are incorporated in all forms of treatment and other kinds of supports.

May I just add, we just were talking at the Center about this issue, the term of how are people taking care of themselves, this self care. And how it really should be team care or department care. We work at the Center, so center-wide care. We can't have just me taking care of myself and then going back into an environment that is going to re-traumatize me or not support me in being able to handle these very challenging cases. So I think just making sure that we're supporting one another and holding space for each other to talk about the difficulty of this work.

I think in the next slide, if we could all begin to shift this question, the questioning, from, "What's wrong with you?" to "What happened to you?" And coming to this work with curiosity. I think oftentimes, we are tasked with coming up with answers and coming up with solutions, but holding space to really come to your clients with curiosity. What happened to you? What's going on with you? That will help us come up with treatment responses, or programmatic responses, and supervision responses that can both hold this person accountable, but also create space for transformation and change.

And so on our next slide, we know you're thinking about survivor-centered work. If you're working with a survivor, what kinds of things you want to include into an assessment. And so really thinking about-- other people just advocate intervening, or coming to your work assuming that there is a history of trauma with your client, whether it's someone who identifies as a survivor, whether it's a probationer coming in with a long history of committing crimes against their intimate partner.

Also thinking about who will conduct this kind of screening. What do you do if you suspect trauma, but it's not disclosed? Again, making those connections to your community-based partners who are doing this work so that you're supported, and really understanding what types of assessments can help you get there.

And I think someone asked like, well, what if people keep shutting down? And I loved Anjali's response-- that's on us to come to our clients in a different way, and keep reengaging and creating a safe space so that they can disclose what's really going on so we can get to the root causes of what's playing itself out as intimate partner violence.

On the next slide again, really thinking about creating partnerships with the survivors if that's who your client is. Offering choice and control, really having your relationship be a corrective experience so that they are beginning to feel safe and seeing the system as a safe place for them to begin to unpack what has happened to them. Clients are taking risks in connecting with us due to that previous trauma and betrayal. And so especially when you're working with a survivor, creating that safe space.

And in the next slide, again, making sure that you know who those community-based advocates are, what services are available. And especially if you're a probation officer who is dealing-- who has a client who is a survivor, you have a lot then on your hand. You have that court mandate that's holding this person accountable for the crime they committed, but you're also seeing someone who has a long trauma history, who may be a survivor of intimate partner violence. And so what are the resources available in your community for them?

And that's going to really tee it up for this next slide, which are these stages of healing for survivors. And you know, it starts with that establishing safety, and really the stabilization, and teaching coping skills. Then thinking about that remembrance and mourning, right? Mourning what is lost. I just was listening to someone the other day and they said counseling is really all about grieving what didn't-- grief about what didn't happen in one's life. And so really remembering and mourning what did happen and what didn't happen, and making meaning out of it.

And then establishing those connections with others, with community, helping others heal. So I think this is really, really crucial. I don't know. Robyn, before we transition into thinking about people who cause harm through IPV, or the defendant or probationer, do you have anything that you'd want to talk about?

No. I was going to say a similar thing. I was just going to reiterate something I think that Rebecca said earlier. Many of you may be working with what we say, this dual paradigm, where somebody-- and we see this often with female identified defendants, but could be males and others, gender nonconforming folks-- but somebody could be a survivor of intimate partner violence and going through all of these stages of healing, but also involved in the criminal justice system. So not-- we are sort of siloing some of these things for the discussion today to sort of piece everything out. But obviously, there's a lot of intersection. So just wanted to remind everyone of that.

Great. So let's transition to talking about people who cause harm through IPV. Those are folks who are showing up as probationers, as defendants. And in our next slide-- we can just move on to the next slide that shows the Adverse Childhood Experiences chart. This should look familiar to you if you were on our last webinar about risk.

And I'm not going to spend too much time on it, but it does show what I was talking about. Not only that interpersonal trauma and those adverse childhood experiences, but then these community adversities. So the first study of ACEs was done primarily on white, middle class, insured people. And so more recently, researchers were looking at the larger population to see are there additional adverse childhood experiences that are impacting and causing negative outcomes for folks in the future? And so those are the things that would fall more into that kind of systemic and structural oppression. So witnessing violence, feeling discrimination. Again, these may be little things that build up over time and can lead to big T trauma.

And again, what this study showed is that the more adverse childhood experiences someone might have, the more that can have negative impacts on them and increased risk factors, such as disease, disability, early mortality. And as I said before, trauma can alter the brain and hinder development of key skills, such as emotional regulation. And that can then impact one throughout their life.

So on the next slide, when we're talking about Abusive Partner Intervention Programming, this is a recent study. Again, it was a small sample, but this is really a developing field, at looking at adverse childhood experiences in men who are participants in Batterer Intervention Programming. And so you can really see here, when they did the-- they've done the ACEs study, the ACEs test, on their participants in one group, you can really see the high levels of adverse childhood experiences in this group.

On the next slide, so what this also showed was that, as a reminder, that ACEs are associated with intense adverse emotions, such as sadness. Your participants are bringing that into Abusive Partner Intervention Programming. When we think about Abusive Partner Intervention Programming, we're thinking not in trying to undo the thoughts, feelings, and beliefs. We know that adverse childhood experiences are really impacting participants feelings about their own self-worth. Their feelings of powerlessness, and beliefs that are justifying their own events of physical violence. And so that is playing itself out. And programs around the country are really thinking about how to address this in programming. One program [INAUDIBLE] is complete that it uses as part of their comprehensive intake, but they have them actually do it in groups, or choosing one of their children and having that as if they were doing it for the child. And really talking about their own violence, it's asking the children in their home.

So we can go on to the next slide. Audre Lorde here. There is no such thing as a single-issue stuggle because we do not live single-issue lives. And again, we've talked about this, but I think it's important to always think about the multi-faceted impact of trauma, not only on those who are survivors of domestic violence, but as we're learning, many of those men who participate in group for Abusive Partner Intervention Programming have long histories themselves.

So in our next slide, Robyn, if you want to just touch on things that we haven't already been talking about. Criminal survivors and women who use force. I didn't know if there were any other things you wanted to talk about.

Sure, no problem. And Rebecca's right. We've touched upon this, women or female-identified folks who use force. And it's really important to consider. We've talked so much today about, obviously, trauma, and victimization, and interpersonal violence. But understanding what we call the context, and understanding coercive control and the tactics.

So important to consider when you're talking to someone-- particularly a female-identified person who's used force-- when you're asking about what's been happening in their relationship, who has the power? Who is in control? Who is afraid of whom? What does the violence look like? Who uses the violence? When do they use it? What are they trying to accomplish? What kinds of violence do they use? To what end? What coercive controlling tactics are utilized? How does race, ethnicity, and culture play a part? Sort of the institutional kind of components to the person who's using violence against their partner. Is this person in more danger or less danger than the partner?

So all of this needs to be analyzed and really to understand. They may have been-- if you're someone who's working in the probation space, you may have this person in front of you as the defendant in a case. And perhaps it goes all the way back to when the police were first there, and they may not have done an appropriate primary aggressor analysis on the scene. That may have actually still not been analyzed correctly by the prosecution, and now this person-- or may or may not. I mean, it depends on the, obviously, the facts of the case, but understanding the real context of the violence. And obviously understanding the history of protective orders and any other information that you can have about that case to understand sort of that trauma component for that person.

So assessing for trauma with probationers. So we've heard Rebecca speak a lot about this just previously, and we've done a few slides on the ACEs scale, the adverse childhood experiences. But also professional judgment. All of-- many of you, and I'm not sure, again, who I'm speaking to-- but many, many of you have done this work for a long time, so using that professional judgment, and understanding the story of the relationship, and/or the incident, and the world view. And the professional judgment and instinctual trauma response, and understanding how that may play into it based on our conversation today.

So kind of trying to pull it all together as we get to the end of our presentation. Now that we know, how do we respond? And we have talked about this in multiple aspects as we've led up to this slide earlier, trauma-informed care. So really, rethinking. Human-informed care. We are humans working with humans. This is a key cornerstone of this work and understanding.

All the way back from our beginning slides, when Anjali was showing us the slides of our brains and all the way to now, understanding that is really, really critical. And upholding this trauma framework. Helping us understand how clients feel, behave, and present with themselves, others, and their communities. So really keeping that frame always at the forefront when whatever lens and whatever role we have in our system, we're using that as our lens when we're talking with people and listening to them. And then incorporating a trauma-informed approach. It's really allowing the help, or the professional, whatever role that you are in your system, to connect with your client. So really using these as the cornerstones of your work.

And we can go to the next slide. Really, trauma-informed strategies, really thinking about trauma as a risk and responsivity factor for intimate partner violence. Also really recognizing that psychoeducational therapeutic interventions and CBT, cognitive behavioral therapies, programs may not be sufficient to address the deep emotional, psychological, and physiological aspects of trauma. So really understanding that you have to broaden and perhaps look at other ways to connect people to get the support they need.

And really, I think, an important one is to understand working hard to build trust and rapport with participants to facilitate that change process. I think you heard Anjali mention that in one of her responses to the questions about listening and helping people as they want to sort of get connected, and make change, and support them.

Yeah, we'd love to-- we have some discussion questions for you all here and we'd love to hear from you. What are your strengths in your agency, or in your community's trauma informed response? Where are there challenges? But we'd love to hear from you. What's working well? Where do you think you're having some strengths in your trauma-informed response?

Thanks, Rebecca. So let's let people answer in the discussion-- in the questions, those discussion questions. And then we'll start taking some questions. So with that, first question I saw in here, which I think is an Anjali question-- do you believe that exposure therapy is appropriate for working through trauma? New thoughts on ET is mixed, it seems.

Yeah, it's definitely mixed. What seems to be really helpful are things like EMDR, brainspotting. There's a curriculum called Seeking Safety, which is really supportive. And fundamentally, what we're talking about is ways to attend to the part of the brain that holds the traumatic experience. So when you engage in things like EMDR or brainspotting, you're not eliminating the trauma or the memory, you're just reducing the amount of activation that happens in the brain when the memory occurs. So maybe before, when there was a certain trigger, the activation response was a panic, for example. Now it's just a mild irritation. So in some ways, you've just minimized the activation. And it gets right at the brain, as opposed to exposure therapy, which really is what exposure therapy is trying to do. But it has mixed success. So you'll have to really match it to the person who seems to be responding best to it.

Thanks, Anjali. So the next question-- the biggest challenge I've found is that our clients are hesitant to work through trauma because they don't want to experience potential relapse in substance use.

So was the question that people are hesitant to engage in therapy to resolve trauma because they're worried that it's going to trigger them and they're going to go back to substance use? Is that the question?

Yeah. Doing any kind of trauma work and it might trigger substance abuse.

Yeah. So I mean, it's a very insightful question. So any time we do any kind of work, it is destabilizing. So it's really important that we make sure that whatever kind of work that we're doing with people-- whether it's trauma resolution, or CBT, or whatever we're doing-- that we're making sure that people have stability support in place, that they have social support in place. Now you don't always have folks who have all of this in place. And so you'll need to lean on strategies like EMDR, which can be done in really titrated ways, really sort of gentle, minimal ways that don't destabilize people so much. So yes, it is something to be paying attention to, right? Am I destabilizing this individual? So just keep that in mind. But there are definitely ways to make sure that stability is in place.

Thank you. I think this question's for all three of you but I'll start with Rebecca and Robyn. One of the strengths includes a great collaboration with our sex trafficking and DV sexual assault agencies. Weaknesses need to be more probation on board to understand this, but changes in the institution have been helpful with cognitive behavioral intervention, using Seeking Safety curriculum, and healthy relationship classes. Robyn, Rebecca, maybe you guys could speak to what you're seeing around the country on MDTs and multidisciplinary teams really coming together and having pretty amazing outcomes.

We see them more in the exploitation and trafficking realm. More and more communities, though, are starting to utilize them in the intimate partner violence space. And I'll say that in a lot of-- one of the challenges in some of the DV or IPV spaces has been confidentiality. So that's a big. We're not going to-- that's not today's topic. But it is a huge concern for survivors of intimate partner violence and how to deal with that in an MDT setting.

Which for those of you, multidisciplinary team settings often are sharing lots of information and there can be waivers to get people to allow the sharing of information to occur. And it does happen, but to make sure that that's not done in a coercive way is really critical. But we have seen it. It's part of the underpinnings of what we in domestic--

Rebecca and I come out of the domestic violence movement. And one of the cornerstones of that movement, for those of you on the call that may be working in this space or not, is a concept of coordinated community response. And not one aspect of any system can address adequately gender-based violence. You need all of these different actors, and all of these different systems-- and quite frankly, very heavily also reliant on community-based folks who are not necessarily system players-- to help with safety and access for victim-centered approaches, and that sort of autonomy that victims need to have, and the options to make choices on how they want to handle their situation. So MDTs are a powerful tool. And like I said, Rebecca and I would be happy to talk to folks more individually, because there are some potential pitfalls if those are not done properly and without understanding confidentiality.

Thanks. I think I have a question for Anjali, which is-- can you explain brainspotting? And maybe at the same time, Anjali, you could explain EMDR and how they work with trauma-- with people experiencing trauma responses.

Yes, for sure. So EMDR stands for eye movement desensitization and reprocessing, EMDR for short. And it is a way of-- and I'm sorry that this sounds complicated. It's actually quite simple. It is a bilateral stimulation of the brain in a way that activates the amygdala, which is this portion of the brain that houses an intense emotional memory. And so this bilateral stimulation, what it does is it allows the amygdala to dump the activation from those emotional memories. So essentially, when you're experiencing EMDR, what you do is you either hold on to two things that provide electrical stimulus in your hands, and it goes right hand, left hand, so on, and so forth. Or maybe it's tapping on your knees, or whatever the bilateral stimulation is. And it allows your amygdala to just sort of release some of the activation, the intensity behind the memory.

And brainspotting is something very, very similar. It's sort of this-- it's a neuropsychological way of working with trauma that allows you to, again, reduce the activation. Brainspotting is a little bit different from EMDR because it's less about bilateral stimulation and more about accessing some of your visual field. So it's about using your eyes to kind of engage that part of your brain.

So you don't actually have to talk out loud about the trauma. And this is what I find so cool about both of these methods, is that we don't actually have to have the person recount the trauma. All they have to do is think about it, because as soon as they think about it, they're activated already and we're accessing their amygdala pretty immediately. So to me, I find it a really gentle and supportive way of working with people because it is extremely respectful and non re-traumatizing in that way. So I mean we could do a whole day on this, but I hope that helped.

Thanks, Anjali. Unfortunately, I think that that's all the time we have for questions. So I'm going to need to conclude the question and answer portion of this webinar. Before we end today, I'd like to note our upcoming webinars and *Ask the Expert* sessions that are scheduled through August of 2021. So watch your inbox for registration details and visit www.ncjtc.org to find additional information on this series.

So this is going to conclude our webinar for today. I want to thank you all again for participating, and thank Robyn, Rebecca, and Anjali for their great presentation today. So thank you all. Have a great week. Thank you.