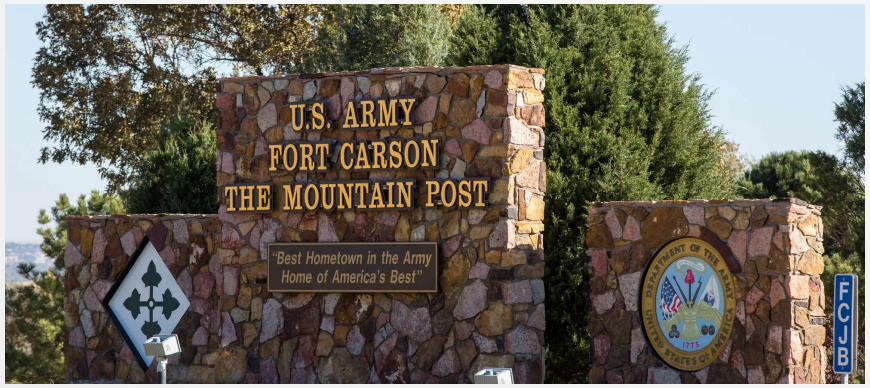
APPLYING THE CARE METHOD TO TREAT THOSE WHO HAVE COMMITTED DOMESTIC VIOLENCE

NIL BUCKLEY, MA,LPC, LAC, DVCS, NCC, ACS
Founder of Vivus Counseling | Author of The CARE Method

PRESENTER BACKGROUND

MY HOUSE IN THE VILLAGE OF BARRACÃO DE MADEIRA

LENÇOIS MARANHENSES



FORT CARSON

DELAWARE/PENNSYLVANIA

PRESENTER BACKGROUND

UNIVERSITY OF COLORADO - COLORADO SPRINGS

CENTENNIAL CORRECTIONAL FACILITY

RESPECT | INTEGRITY | SERVICE

FOURTH JUDICIAL DISTRICT

4TH JUDICIAL - COLORADO

CDHS

COLORADO

Department of Human Services

DEPARTMENT OF HUMAN SERVICES

PRESENTER BACKGROUND

VIVUS COUNSELING

VIVUS COUNSELING SERVICES LLC

Care FORENSICS By Nil Buckley

CARE FORENSICS SOLUTION

TRAINING OBJECTIVES

BY THE END OF THIS TRAINING, YOU WILL BE BETTER ABLE TO:

1. Identify common client characteristics relevant to domestic violence treatment.
2. Describe five frequent mistakes professionals make in domestic violence interventions.
3. Recognize implicit biases and understand their impact on clinical effectiveness.
4. Apply strategies to reduce client defensiveness and resistance.
5. Conduct treatment in ways that minimize the risk of further harm to others.

A BRIEF HISTORY OF DV OFFENDER TREATMENT IN THE U.S.

- 1970s–1980s: Domestic violence becomes recognized as a social issue—not just a "private family matter."
  - The battered women's movement emerges.
  - First shelters and advocacy organizations appear (e.g., Duluth's DAIP).

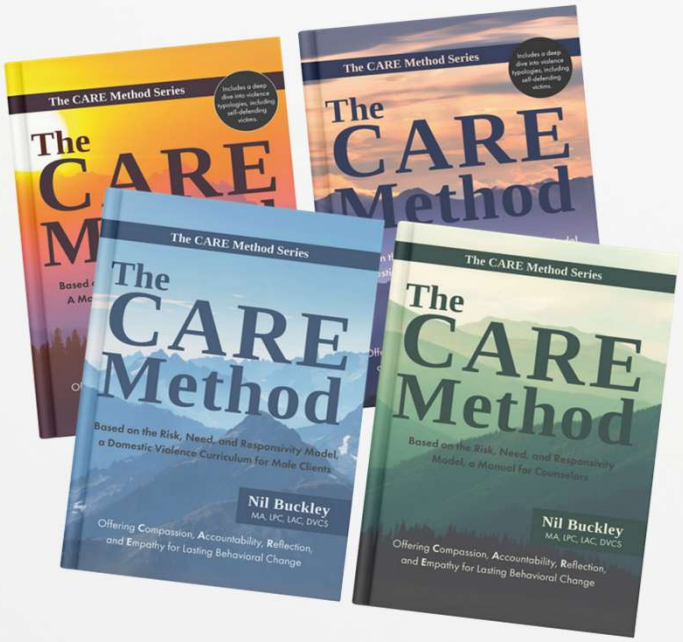
- 1981: The Duluth Model (Minnesota) launches the first Batterer Intervention Program (BIP), emphasizing:
  - Power and control as the root of abuse.
  - Group accountability.
  - A feminist and non-therapeutic approach.
  - Note: Duluth became a national prototype, even though it lacked outcome research early on.

- 1994: The Violence Against Women Act (VAWA) passes, funding prevention, shelters, and court coordination.
  - States begin mandating BIPs for DV convictions, often using a 52-week group model.

A BRIEF HISTORY OF DV OFFENDER TREATMENT IN THE U.S.

- 2000s–Present: Growing research shows mixed results from traditional BIPs.
  - Criticism of “one-size-fits-all” approach.
  - Shift toward evidence-based practices:
    - Risk–Need–Responsivity (RNR) model.
    - CBT and Motivational Interviewing.
    - Trauma-informed approaches.
    - Greater focus on evaluating outcomes, not just attendance.

THE ORIGIN OF THE CARE METHOD

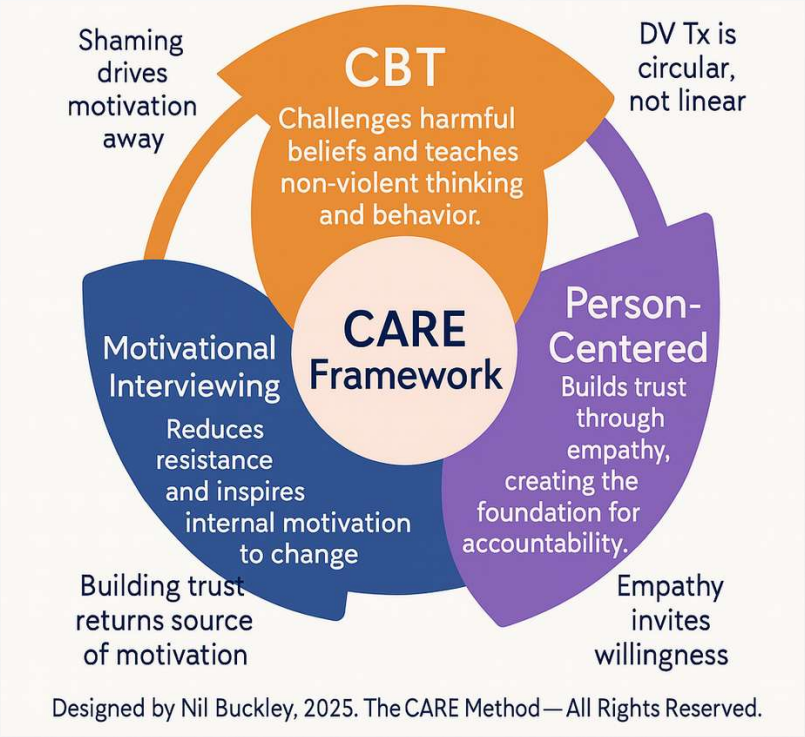


- As a DVOMB provider, I realized there was no set curriculum—just a requirement to use evidence-based practices.
- I kept repeating topics. Clients often said, "Didn't we already cover this?"
- I used loose handouts, mostly from Therapist Aid, without clear structure or alignment with DVOMB core competencies.
- That's when I started researching effective approaches for DV treatment—and began to recognize my own mistakes (we'll come back to this).
- Each lesson took 2–6 hours to build. I focused on person-centered, MI, and CBT principles.
- Feedback from clients was strong—and soon, outside counselors wanted to use it too.

WHAT DISTINGUISHES THE CARE METHOD FROM OTHER BIPS CURRICULUM?

WHAT DISTINGUISHES THE CARE METHOD FROM OTHER BIPS CURRICULUM?

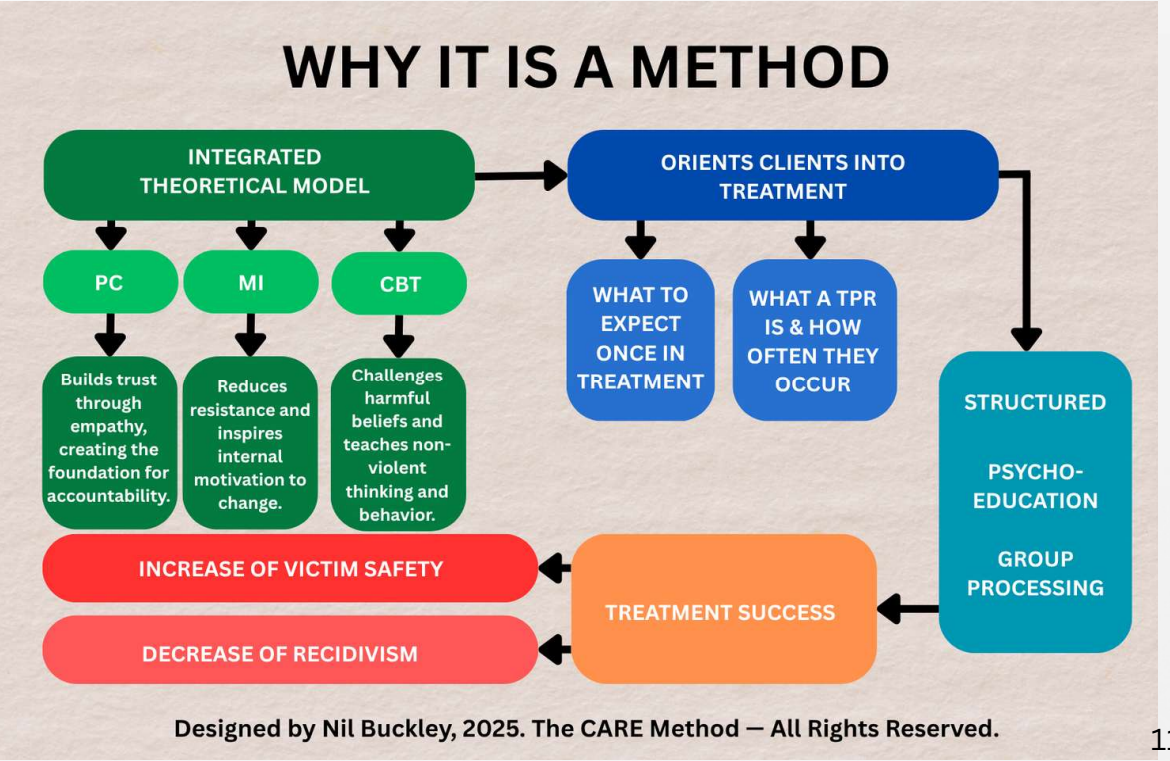
1) IT UTILIZES AN INTEGRATED THEORETICAL MODEL



WHAT DISTINGUISHES THE CARE METHOD FROM OTHER BIPS CURRICULUM?

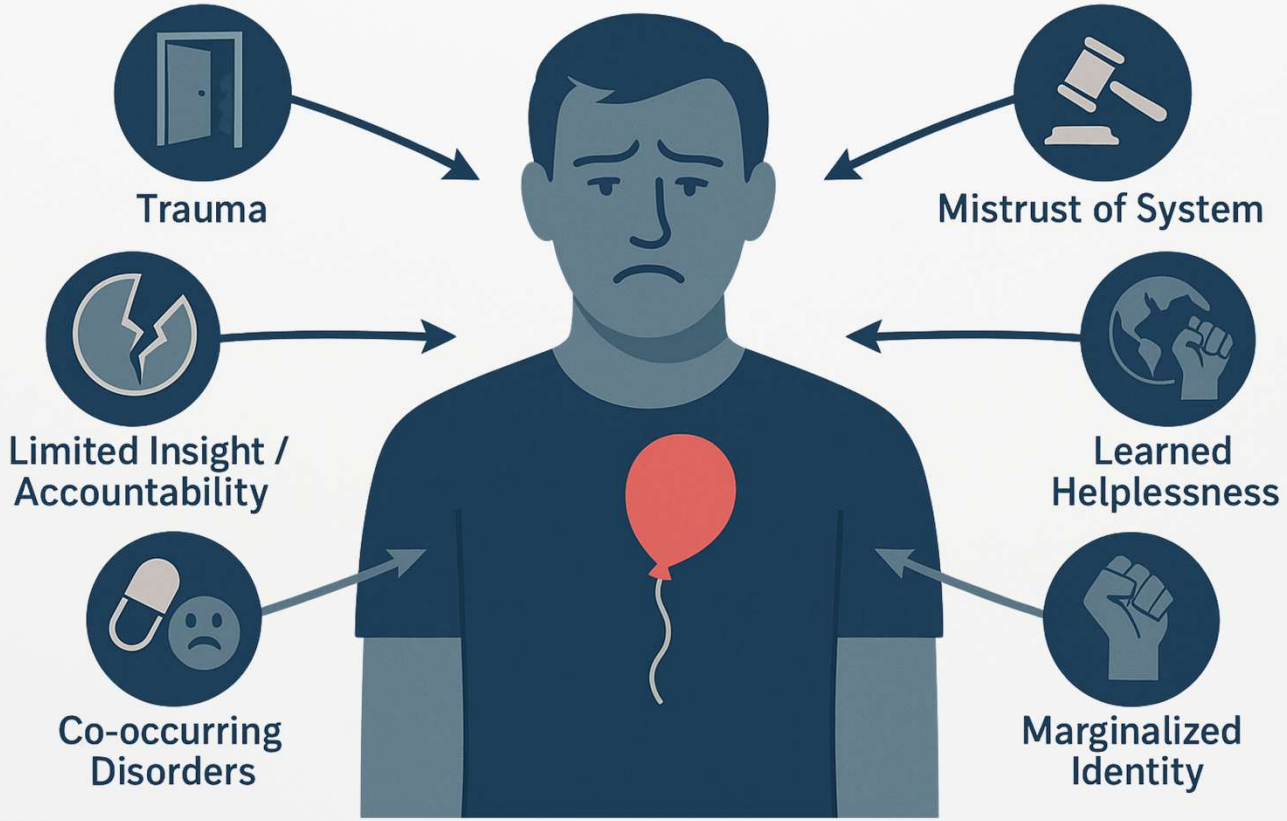
2) IT ORIENTS CLIENTS INTO TREATMENT

3) IT IS A STRUCTURED CURRICULUM THAT FOLLOWS A SPECIFIC SESSION SCHEDULE



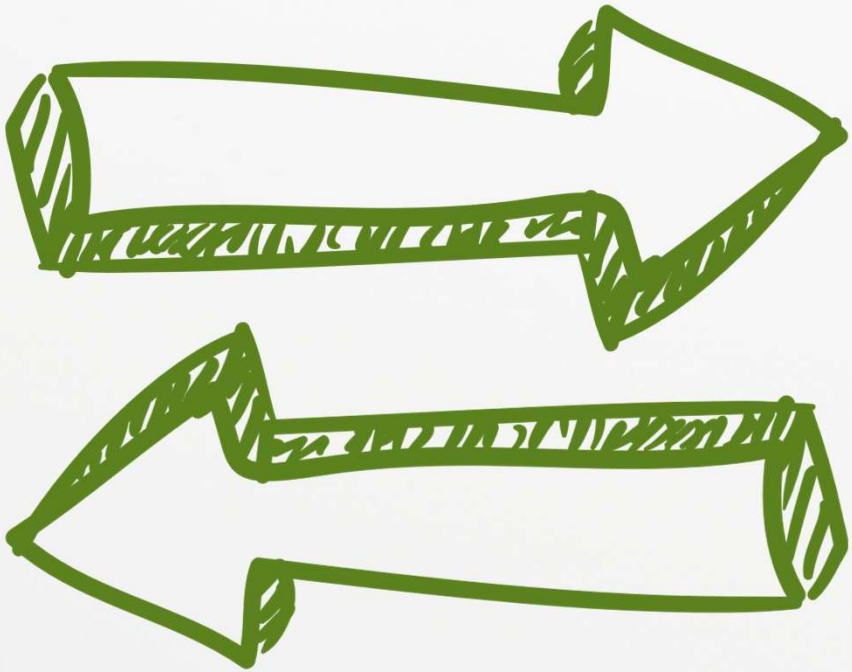
SO WHO ARE OUR CLIENTS? WHAT ARE COMMON CHARACTERISTICS THEY SHARE?

WHO ARE OUR CLIENTS?



CLIENTS CRIMINOGENIC NEEDS & RESEARCH FINDINGS

- Trauma exposure disrupts emotional regulation and trust in relationships (van der Kolk, 2014)
- High ACE scores are strongly associated with violence, substance use, and relational instability (Felitti et al., 1998)
- Many clients mistrust the system and view us providers/professionals as part of their legal consequences
- Insight and accountability are often limited due to **shame, defensiveness,** and **distorted thinking**
- Mental health and substance use disorders are often attempts to manage trauma (Stuart & Conrod, 2003)
- Clients frequently hold marginalized identities that intersect with barriers to treatment access (Sokoloff & Dupont, 2005; Messing et al., 2014)



SO WHAT DRIVES CLIENT'S MOTIVATION TOWARD CHANGE — AND WHAT DERAILS IT?

HERE ARE 5 COMMON MISTAKES

COMMON MISTAKE #1

NOT KNOWING HOW TO CHALLENGE CLIENTS IN A CLINICALLY EFFECTIVE WAY

COMMON MISTAKE #2

PLACING CLIENTS IN TREATMENT WITHOUT TREATMENT PLANS

COMMON MISTAKE #3

DISREGARDING CLIENT'S BUY-IN

COMMON MISTAKE #4

NOT STRUCTURING GROUP SESSION

COMMON MISTAKE #5

NOT TAKING CARE OF YOURSELF: COMPASSION FATIGUE AND BURNOUT

AND HERE IS HOW IMPLICIT BIAS MAKES IT WORSE

IMPLICIT BIAS IN DV WORK

Gender Bias:

- This is one of the most well-documented issues in DV intervention. It leads to misidentifying female offenders as victims and assigning inappropriate interventions.
- Research: Henning & Feder (2004) – Found systematic bias in how men and women are processed and treated post-arrest.

IMPLICIT BIAS IN DV WORK

Cultural Bias:

- When clinicians misread culturally influenced behaviors (e.g., eye contact, tone, emotion), they may mislabel clients as resistant or non-compliant.
- Research: Bent-Goodley (2005) – Advocates for culturally responsive DV intervention practices to avoid misdiagnosis and disengagement.

IMPLICIT BIAS IN DV WORK

Socioeconomic Bias:

- Leads to over-scrutiny of low-income individuals and under-detection in affluent families, affecting risk assessment and referrals.
- Research: Fugate et al. (2005) – Found that middle- and upper-class survivors are less likely to be identified or believed, which translates to how offenders are screened and referred.

IMPLICIT BIAS IN DV WORK

Confirmation Bias

- In treatment, once a clinician forms a judgment about a client (e.g., “he’s manipulative”), it skews their interpretation of all subsequent behavior.
- Research: Nickerson (1998) – Cognitive psychology research confirms that confirmation bias undermines objectivity—critical in forensic and therapeutic work.

IMPLICIT BIAS IN DV WORK

Implicit Racial Bias

- DV offenders of color are often rated as higher risk, more resistant, or less insightful, impacting risk assessments and treatment plans.
- Research: Richie (2012); Goff et al. (2008) – Documented racial disparities in criminal justice and clinical interpretation of aggression.

IMPLICIT BIAS IN DV WORK

Heteronormative Bias

- DV counselors may misassign victim/offender roles in LGBTQ+ relationships, or fail to recognize dynamics like mutual coercion or bidirectional violence.
- Research: Messinger (2011) – Emphasized how same-sex DV is often overlooked due to provider assumptions rooted in heteronormativity.

IMPLICIT BIAS IN DV WORK

Trauma Minimization

- Counselors often overlook the offender's trauma history, which is crucial in behavior change. This impairs therapeutic alliance and outcomes.
- Research: Day et al. (2009); Levenson (2014) – Advocated for trauma-informed frameworks even when working with court-mandated clients.

IMPLICIT BIAS IN DV WORK

Therapeutic Pessimism

- Counselors who believe DV offenders “never change” become disengaged, reducing treatment quality and contributing to dropout.

TREATMENT STRATEGIES THAT WORK

Compassion

Accountability

Reflection

Empathy

THE CARE PILLARS AS STRATEGIES TO REDUCE DEFENSIVENESS AND RESISTANCE

COMPASSION: FROM PERSON CENTERED THEORY:

Dr. Carl Rogers, the founder of Person-Centered Therapy, emphasized that unconditional positive regard, empathy, and congruence (authenticity) are essential conditions for successful therapeutic change. His core belief was that people possess an innate capacity for growth, and that certain relational conditions allow that growth to unfold—even in difficult or court-mandated populations.

According to Carl Rogers, a founder of person-centered therapy, resistance in clients (including those who are guarded or resistant to change) arises primarily from a perceived threat in the therapeutic relationship.

Rather than viewing resistance as an inherent character flaw in the client, Rogers believed that the therapist's actions play a significant role in minimizing this perceived threat.

THE CARE PILLARS AS STRATEGIES TO REDUCE DEFENSIVENESS AND RESISTANCE

COMPASSION: FROM PERSON CENTERED THEORY:

HERE'S HOW PERSON-CENTERED THERAPY, ACCORDING TO ROGERS, ADDRESSES THIS:

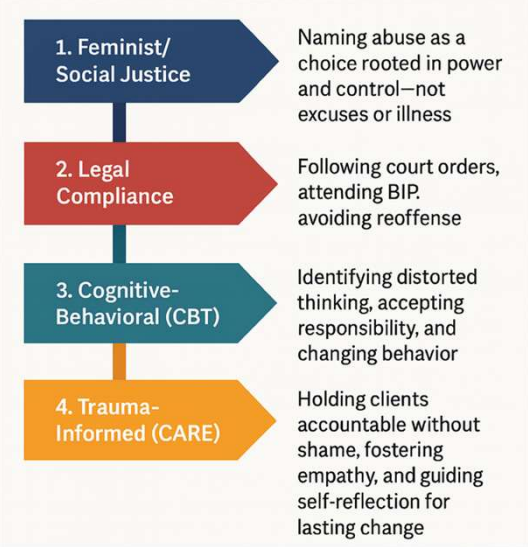
- Minimizing threat: Person-centered therapy creates a safe and non-judgmental environment by focusing on unconditional positive regard, empathy, and congruence. This safe space allows clients to drop their defenses and explore their feelings more freely.
- Building a strong therapeutic relationship: The therapist's role is to build a relationship based on trust and acceptance. This allows the client to feel secure enough to engage in self-exploration and work towards positive change.
- Empathy and understanding: The therapist actively listens and reflects back the client's thoughts and feelings, demonstrating a genuine understanding of their experiences. This validates the client's internal frame of reference, making them feel heard and understood.
- Congruence (genuineness): The therapist is authentic and transparent in the relationship, which further builds trust and encourages the client to be genuine as well.

"When the therapist is experiencing a warm, accepting, and understanding attitude toward what is a central part of the client's experiencing, change is likely to occur."
(Rogers, 1957)

THE CARE PILLARS AS STRATEGIES TO REDUCE DEFENSIVENESS AND RESISTANCE

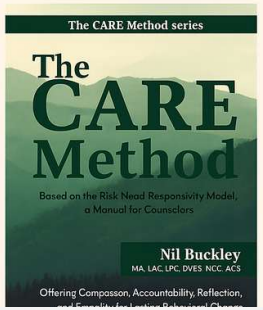
ACCOUNTABILITY

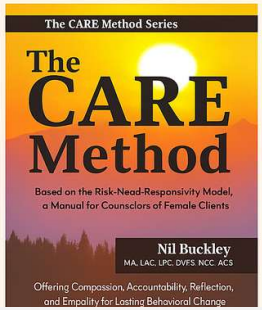
WHAT DOES ACCOUNTABILITY MEAN IN DV TREATMENT (MULTIPLE THEORIES)



THE CARE METHOD BELIEVES...

Accountability isn't punishment—
it's the gateway to transformation.
Clients can acknowledge harm,
take ownership, and grow—
—when we create space for safety,
compassion, and truth.





THE CARE PILLARS AS STRATEGIES TO REDUCE DEFENSIVENESS AND RESISTANCE

REFLECTION: FROM PERSON CENTERED TO MOTIVATIONAL INTERVIEWING

Reflection originates from Carl Rogers' person-centered therapy, which emphasized empathic understanding and unconditional positive regard. Miller and Rollnick, the founders of MI, drew heavily from Rogers and expanded reflection into a structured counseling method aimed at evoking behavior change.

In MI, reflection is used to:

- Demonstrate understanding without judgment.
- Help clients hear their own ambivalence.
- Guide them gently toward change (not push them).

THE CARE PILLARS AS STRATEGIES TO REDUCE DEFENSIVENESS AND RESISTANCE

REFLECTION: FROM PERSON CENTERED TO MOTIVATIONAL INTERVIEWING

THERE ARE TWO MAIN TYPES:

- **Simple reflection:** Restates what the client said.
  - Client: “I don’t need this class. I only came because the judge made me.”
  - Therapist: “You’re feeling like you’re here against your will.”

- **Complex reflection:** Adds meaning or emphasizes the emotion or motivation behind the statement.
  - Therapist: “I hear you saying that you’re frustrated that others don’t see your side, and maybe you’re not even sure this is fair.”

THE CARE PILLARS AS STRATEGIES TO REDUCE DEFENSIVENESS AND RESISTANCE

REFLECTION: FROM PERSON CENTERED TO MOTIVATIONAL INTERVIEWING

REFLECTION HELPS DISARM RESISTANCE BY:

- Reducing reactance: Instead of arguing or correcting, the counselor reflects the client's thoughts and feelings, creating openness.
- Building rapport: When clients feel heard rather than judged, they're more likely to engage—even if they didn't choose to be there.
- Fostering insight: Reflection leads clients to hear themselves, which increases self-awareness and personal motivation for change.

"Accurate empathy—conveyed through reflection—is a key component in reducing resistance and increasing change talk."
— Miller & Rollnick, 2013

THE CARE PILLARS AS STRATEGIES TO REDUCE DEFENSIVENESS AND RESISTANCE

EMPATHY: Rogers (1957): *"When the therapist is experiencing an empathic understanding of the client's world... then therapeutic movement or change is more likely to occur."*

EMPATHY AND TREATMENT SUCCESS (INCLUDING COURT-ORDERED CLIENTS)

- Therapeutic Alliance: Empathy enhances rapport and helps court-ordered clients—who often enter treatment feeling judged, coerced, or defensive—lower their resistance.
- Reduces Reactance: Research shows that empathy reduces psychological reactance, a form of resistance that occurs when people feel their freedom is being threatened (Brehm, 1966; Miller & Rollnick, 2013).
- Motivational Interviewing (MI): Empathy is central to MI, which emphasizes meeting clients where they are without confrontation. MI practitioners use reflective listening and empathy to gently guide clients toward change, especially those who are ambivalent or externally motivated.

THE CARE PILLARS AS STRATEGIES TO REDUCE DEFENSIVENESS AND RESISTANCE (CONT.)

EMPATHY: Rogers (1957): *"When the therapist is experiencing an empathic understanding of the client's world... then therapeutic movement or change is more likely to occur."*

BEHAVIORAL OUTCOMES: MULTIple studies have linked higher counselor empathy with:

- Increased client engagement
- Lower dropout rates
- Greater behavior change
- Improved outcomes in substance use, DV treatment, and probation settings (Elliott et al., 2011; Moyers et al., 2005)

SO NOW THAT WE'VE COVERED THE FOUNDATIONS… WHAT MAKES GROUP FACILITATION TRULY EFFECTIVE?

EFFECTIVE GROUP FACILITATION

Strong Therapeutic Alliance—Without Collusion
Build trust, but never at the cost of reinforcing denial or justifications. Connection must support—not replace—accountability.

Clear Expectations and Consistent Boundaries
DV offenders often test limits; effective facilitators maintain firm structure with clarity, fairness, and follow-through.

EFFECTIVE GROUP FACILITATION

Use of Reflections to Explore Responsibility
Reflective listening helps shift blame narratives and encourages clients to hear themselves. It's one of the most powerful tools to elicit accountability.

Confrontation with Empathy (Not Aggression)
Effective confrontation in DV work is respectful, calm, and specific—not punitive or shaming. This helps reduce defensiveness while still challenging harmful thinking.

EFFECTIVE GROUP FACILITATION

Exploration and Disruption of Cognitive Distortions
Clients must learn to identify and change harmful belief systems (e.g., entitlement, minimization, externalization of blame). This is central to reducing reoffense.

Prioritization of Victim Safety in All Discussions
Every group session should return to the impact of behavior on victims. This keeps focus on harm done and counters self-centered narratives.

EFFECTIVE GROUP FACILITATION

Understanding Resistance as Part of the Process
Court-ordered clients often arrive angry, defensive, or disengaged. Facilitators must respond with curiosity, not punishment—and help clients find their own reasons to change.

Trauma-Aware, But Behavior-Focused
Understand trauma's role in the client's history without using it to excuse abusive behavior. Clients can hold trauma and accountability at the same time.

EFFECTIVE GROUP FACILITATION

Group Cohesion and Peer Feedback
A healthy group culture reinforces norms of accountability and empathy. Peer confrontation, when well-facilitated, can be more powerful than staff-led confrontation.

Facilitator Presence: Calm, Attuned, and Prepared
Your tone, pacing, and emotional regulation deeply affect the room. DV groups need leaders who embody clarity, compassion, and clinical precision.

INTEGRATED RELIATRAX MATERIALS TO ENHANCE GROUP FACILITATION

- Individual Competency Presentations
- Individual Competencies Presentation Tracker (For the Counselor)
- The CARE Method Homework (Prelude Chapters and Original Chapters x21)
- Letter of Accountability Template
- Letter of Apology to The Children Template
- DV Discharge (Based on the CARE Method)
- CARE Method Pre and Post Testing (for Research purposes)

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EXAMPLE OF THOUGHTFUL AND INSIGHTFUL HOMEWORK COMPLETED IN RELIATRAX

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HW7 The Amygdala Hijack

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vivus.reliatrax.net

Homework 7: The Amygdala Hijack

1. Identify and describe 3-5 triggers which have led to an "amygdala hijack" for you in the past. (Please consider sharing more recent events.)
Passive-aggressive comments aimed at getting under my skin. Obnoxious, ignorant actions/ lack of forethought. Incompetence, no common sense. Fear of abandonment. Insolence.

2. Identify and describe physical cues which you have experienced while triggered in the past.
My heart rate will increase, I will get physically heated, my muscles will tense, I will become very irritable, and I will transition into fight mode.

3. Share some of the Consequences which resulted from your Amygdala Hijack (s) in the past or recently.
I've faced legal trouble as a result of my actions. I have broken things and caused physical/property damage. I have ruined relationships because I don't care about burning bridges. Additionally, I have caused trauma and anguish to people I love and have loved.

4. Share about the thoughts and emotions you experienced once you were calm and able to reason and reflect on your actions.
Regret, guilt, and shame are the three main emotions and feelings I have when something like this happens. I end up beating myself up, self-deprecating, and ruminating over the situation. I tell myself it won't happen again, but without the proper tools, it would continue to happen, and when under the influence, I wouldn't care. Knowing this was a thing was always anxiety ridden.

5. What was the impact it had on others?
Sometimes it would make those around me feel confused, or even as if I were just trying to manipulate the situation. Other times it would get noticed that I was down and because they still loved me, they would try to help make me feel better. Either way, without me actually learning to control the emotions and the resulting actions, it never made a difference.

6. Were you able to make amends? If so, how? If not, why not?
Amends for me is a tricky subject. Actions mean more than words to me. Those who I can speak with barring court orders, like my parents, sister, and friends, I have had in depth conversations on multiple occasions as I have progressed through this process. I believe living amends are absolutely the best way to go about making a difference. Regardless of not being able to speak with my victim in this case, I am living proof that people can and do change if they want to and if they put the effort in to change their lifestyle, the way they process emotions, and the way they handle themselves in difficult situations.

5/8/2025 DV Note Session Note limited

HW7 The Amygdala Hijack

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7. How would you describe/rate your current ability to detect triggers, and control impulsive reactions to triggering situations? Mild, Moderate, High? How can you improve?

I have a high level of awareness concerning my emotional and physiological changes if triggered. I know and can feel myself switching, and when I feel this happening, I use some of the different tools in my tool box like breathing techniques, turning the mind, moving from the situation, and calling someone if I feel too overwhelmed. I can always improve, and intend to, however I am proud of my ability to control my outbursts.

8. Was your Prefrontal Cortex Hijacked when you committed your Domestic Violence Offense? Yes or No? If you could go back, what would you have done differently?

Both the immediate impact of the amygdala hijack and the prolonged effects of the prefrontal cortex hijack were present when the incident happened. I was completely emotionally and mentally faulted when I chose to do what I did, and those effects were absolutely elongated as I was trying to justify my actions. As time continued, I held on to the animosity and was upset for quite a while. If I could go back, which I can't, I would apply what I have learned over the last two years and not make the mistake I did in that moment.

9. What is your plan for prevention of the Amygdala Hijack?

I will continue to strengthen my mental and emotional fortitude and practice the skills that I have gained through this program and others that I have been a part of, I will continue to seek therapy and stay connected with professionals who can help me when I feel I may be slipping, and I will use what I have learned to become better and better with each passing day.

[redacted] HW7 The Amygdala Hijack 5/29/2025
Client Portal Form 1 of 2 Completed by [redacted]

Client Signature: [redacted] Date: 5/29/2025

[redacted]

Completed in secure client portal.

5/8/2025 DV Note Session Note limited

THIS IS HOW RELIATRAX ALLOWS US TO SEE HOMEWORK WITH AREAS FOR GROWTH

ReliaTrax
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HW7 The Amygdala Hijack

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Homework 7: The Amygdala Hijack

1. Identify and describe 3-5 triggers which have led to an "amygdala hijack" for you in the past. (Please consider sharing more recent events.)
Aruguing, trying to help, defending

2. Identify and describe physical cues which you have experienced while triggered in the past.
Adjitation, sweating, restlessness

3. Share some of the Consequences which resulted from your Amygdala Hijack (s) in the past or recently.
Loss of respect, integrity and creates negativity

4. Share about the thoughts and emotions you experienced once you were calm and able to reason and reflect on your actions.
Sometimes it's left hanging and not taken care of, sometimes a realization accurs

5. What was the impact it had on others?
They realize what happened and the issue

6. Were you able to make amends? If so, how? If not, why not?
Yes.

7. How would you describe/rate your current ability to detect triggers, and control impulsive reactions to triggering situations? Mild, Moderate, High? How can you improve?
Moderate. I can improve by seeking support and learning tools to cope.

3/21/2025 MMSE Assessment limited

HW7 The Amygdala Hijack

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8. Was your Prefrontal Cortex Hijacked when you committed your Domestic Violence Offense? Yes or No? If you could go back, what would you have done differently?
Yes, I would have never called 911 instead I would have called 988

9. What is your plan for prevention of the Amygdala Hijack?
To walk away and focus on what matters

Client Signature: Date: 5/21/2025

Completed in secure client portal.

3/21/2025 MMSE Assessment limited

REAL CLIENT FEEDBACK ON THE CARE METHOD

Ms. Buckley's thoughtful, comprehensive curriculum comes together with her compassionate yet no-nonsense approach to create an incredibly impactful and invaluable treatment program. I am thrilled to see it become available to a wider audience, as I wholeheartedly believe in its ability to affect countless lives for the better. I cannot overstate my gratitude for the time I spent in treatment with Nil; she and her program have helped me to heal, grow, and take accountability in new and truly transformative ways!

I received services from Vivus Counseling. Mrs Buckley’s classes are both challenging and rewarding for anyone seeking to understand themselves and others. The process of this scientifically based and backed curriculum is excellent in the field of self-betterment and mental health treatment. I recommend it for everyone who wants to grow emotionally and physically and become more self-aware.

The time I spent under the CARE method was a learning experience I never knew that I needed. The insight that was given to me was more than just doing assignments and having discussions with the group. It was life changing. The way the curriculum was structured was very comprehensive and full of information that left me with new perspectives about myself, my life and the way I handled various triggers and issues.

FINAL THOUGHTS & RESOURCES

- Where to find The CARE Method
- How to implement it in your agency
- Additional training, consulting, or support

HTTPS://SITES.GOOGLE.COM/VIVUSCOUNSELING.COM/THE-CARE-METHOD-LINKS/HOME

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THANK YOU

Thank you for your commitment to safer communities and lasting change

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QUESTIONS & ANSWERS