



Supporting people with social care needs who are experiencing coercive control

Evidence Scope

Ruth Ingram, RiPFA Associate

December 2016

Contents

Introduction	2
Methodology	2
What is coercive control? (and how does it relate to domestic abuse?)	3
Examples of types of controlling and coercive behaviour	4
Gender and domestic abuse.....	7
The impact of coercive control	11
How does abuse impact on mental health?	12
The REVA project (Scott et al, 2015)	14
The experience of people with care and support needs of domestic abuse	15
Intervention with perpetrators	16
Key messages and practice tips.....	17
References	18



Introduction

The aim of this Evidence Scope is to collate the available evidence to support social work practice with people who have care and support needs and are experiencing coercive control. It makes reference to academic literature, government policy and practice evidence, and in particular we have included the voices of survivors of domestic abuse.

This Evidence Scope is supported by a number of additional guidance sheets, which can all be found on the coercive control website:

<http://coercivecontrol.ripfa.org.uk/overarching-resources/>

These include:

- Guidance Sheet One: Law and Policy Summary (Pike, 2016)
- Guidance Sheet Two: Mental capacity and coercion – what does the law say? (Pike, 2016a)
- Guidance Sheet Three: What works? Evidence based interventions to prevent and respond to domestic abuse (Ingram, 2016a)
- Guidance Sheet Four: The experience of people with social care needs (Ingram, 2016b).

Methodology

There are an increasing number of systematic reviews of the evidence base in relation to domestic abuse in general and in the lives of people with care and support needs. This document draws together key strands of the evidence identified in those studies, where possible relating to a UK context. These have been illustrated with more detail from the relevant studies. Criteria applied to the studies used included relevance, sound methodology and coherence. A common finding of the systematic reviews is a lack of large, methodologically sound studies that would enable greater understanding of key issues. The field contains many methodologically sound small scale studies. These and some 'grey literature' have been used to illustrate points where no peer reviewed research was available.



What is coercive control? (and how does it relate to domestic abuse?)

Government guidance in relation to coercive control (see Law and Policy Summary (Pike, 2016)) lists behaviours perpetrated by one person against another with whom they have an intimate or family relationship. These behaviours are not limited to the context of domestic abuse.

Coercive control is exercised in situations where the behaviour of an individual or a group is being shaped into conformity to the wishes of another person or group. It has been studied in relation to the behaviour of hostage takers towards hostages, and prisoner of war camp guards towards prisoners. As described below, the formal relationship between the person exercising coercive control and the person on the receiving end in hostage or prison situations is very different to that of domestic abuse. However, the evidence states that recognising the similarity provides good insight into the behaviour of perpetrators and the impact of domestic abuse on victims/survivors. Such insight, for example, forms a basis for successful programmes that decrease abusive behaviour by domestic abuse perpetrators.

The sociologist Gilbraith (1983) described **coercive, compensatory** and **conditioned** power. Coercive power is used to inflict unpleasant or painful consequences on a person acting on their own choices so that they 'choose' to follow the preferences of the person inflicting harm rather than their own. Compensatory power wins submission by the offer of a reward and conditioned power is exercised by changing a person's belief e.g. through education or persuasion so that the person believes that behaviours they are carrying out stem from their own belief system rather than being imposed by the person who has influenced them.

Biderman (1957) created eight categories of behaviour that were used by male interrogators to force male prisoners of war to comply with their demands. The behaviours described are;

- creating isolation
- monopolisation of perception
- induced exhaustion and disability
- threats
- occasional indulgences
- demonstrating omniscience and omnipotence
- degradation
- enforced trivial demands.

Each tactic is used as part of a package to create fear, break down a person's sense of themselves and their ability to resist and ultimately to co-opt that person's sense of self and agency so that they behave in the way the perpetrator wishes.



Biderman's work was amongst that collated by Amnesty International together with the accounts of victims of torture and used to propose a theory of how physical and psychological stress is deliberately induced;

'to erode (that) morale by destroying whatever props the individual has for his mental integrity.

The victim, by being deprived in the process of debilitation of food, sleep and human contact by his torturer, becomes paradoxically dependent on his torturer for these things. ... Occasional unpredictable brief respites, when among other things the torturer becomes a sympathetic listener, make the victim feel obligated towards him.' (ibid)

The paragraph below is taken from the Home Office 2015 Guidance on coercive and controlling behaviour.

Examples of types of controlling and coercive behaviour

The types of behaviour associated with coercion or control may or may not constitute a criminal offence in their own right.

However, it is important to remember that the presence of controlling or coercive behaviour does not mean that no other offence has been committed or cannot be charged.

The perpetrator may limit space for action and exhibit a story of ownership and entitlement over the victim.

Such behaviours might include (this is not an exhaustive list):

- isolating a person from their friends and family
- taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep
- monitoring their time
- monitoring a person via online communication tools or using spyware
- depriving them of their basic needs
- depriving them of access to support services, such as specialist support or medical services
- financial abuse including control of finances, such as only allowing a person a punitive allowance
- preventing a person from having access to transport or from working
- repeatedly putting them down such as telling them they are worthless
- enforcing rules and activity which humiliate, degrade or dehumanise the victim
- forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- threats to hurt or kill



- threats to a child
- threats to reveal or publish private information (e.g. threatening to 'out' someone)
- assault
- criminal damage (such as destruction of household goods)
- rape.

The understanding of the role of coercive control within domestic abuse arose initially from work to support individual women experiencing domestic violence. Key questions that arose in that context were:

- How best to support women to live more safely?
- How best to enable women to recover from abuse?
- Why do women return to abusive partners?
(Stark, 2007)

The Duluth Domestic Violence Intervention Project in Minnesota USA, took concepts from the work of the sociologist Gilbraith and Biderman. The resulting and widely used Duluth 'Power and Control' wheel describes behaviours used by perpetrators of domestic abuse. In England Hammersmith and Fulham's Domestic Violence Project and Leeds Inter-Agency Project Women and Violence made a direct adaptation of Biderman's eight categories in a similar format (Tara-Chand, 1993).

These models propose that the behaviour of perpetrators of domestic abuse follows similar patterns to those used in torture. This approach has been validated by research. Lehmann et al, (2012) interviewed more than two thousand women using domestic abuse refuges/shelters in the USA about their experience of coercive and controlling behaviours. They identified ten clusters of coercive and controlling behaviours that can be reliably used to identify coercive control; physical, sexual, financial and emotional violence, use of privilege, threats, intimidation, minimising and denying, blaming and isolation.

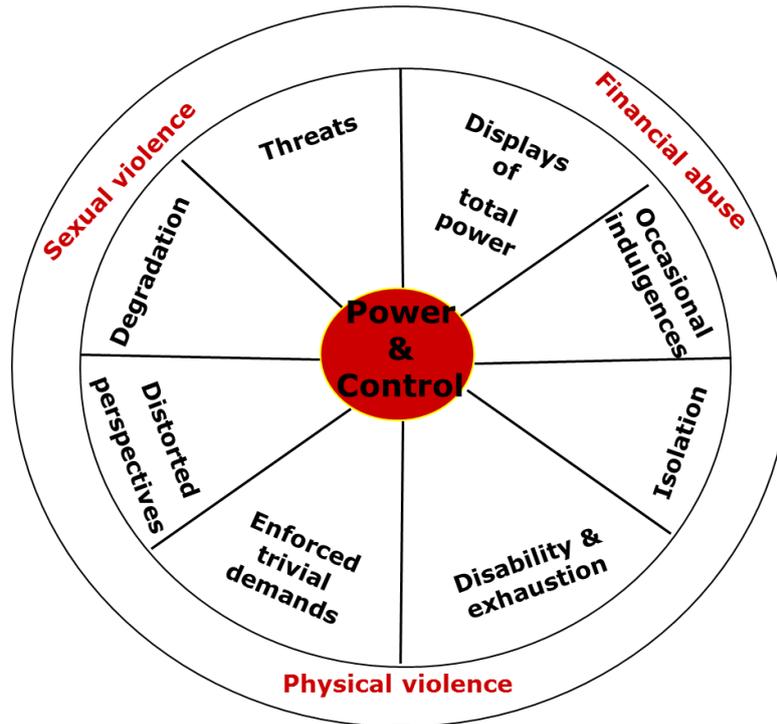


Figure 1. Power and Control wheel based on Biderman (1957) and adapted from Duluth by Leeds Inter-Agency Project (1993).

The work of Evan Stark has been particularly influential in development of the criminalisation of coercive control under the Serious Crimes Act 2015. **Stark (2007) proposes that the use of coercive control marks the fundamental difference between domestic abuse, which uses coercive control, and situational abuse which does not.** The idea that some people use violence within domestic and family relationships but do not use it as a tactic of coercive control is supported by research that has explored the meaning of the violence reported within large scale anonymous surveys such as the Crime Survey for England and Wales (CSEW), Scottish Crime and Justice Survey (SCJS) and the National Family Violence Survey (USA). Dobash and Dobash (2004) Williams et al, (2009).

Where coercive control is being used within a relationship, violence is one of the behaviours that may be used to create control. Because other forms of abuse can also be used to create control (e.g. sexual assault and financial abuse) not all situations of domestic abuse will be characterised by the use of physical violence; conversely not all relationships where there is physical violence are relationships where one person has power and control over the behaviour of the other. Where coercive control is taking place all forms of individual power may be used together with tactics that undermine psychological and physical resistance.



People subjected to coercive control commonly attempt to stop or minimise the abuse from within their relationship with the perpetrator. This usually means that the victim changes their own behaviour.

'He had got what he wanted by doing that. And OK he'd only have to do it occasionally, but then I was living with this constant watchfulness, anxiety, you know, self-regulation, and I would do anything to make sure that couldn't happen. But at the same time there was nothing I could do to make sure it couldn't happen, because it was so random. (Jennifer) (Pain, 2014:15)

Perpetrators also tell their victims that they are to blame:

'I was shocked, I was so scared but most of all he made me feel it was all my fault, it was me, I didn't know anything, I wasn't behaving right' (Nina) (ibid)

A key impact of the behaviours of coercive control can be the internalisation of this message and the transfer of the sense of responsibility for the abuse to the victim/survivor;

'I almost couldn't believe it was happening... I felt there must be a way I could stop it... I seemed to think it must be me as well, there's something I'm doing wrong and there must be a way I can explain to her and make her believe me.' (Petunia) (ibid)

High levels of shame and humiliation are also common feelings of domestic abuse and torture survivors. This can be as a direct result of degrading behaviours they have been forced into carrying out (Stark, 2007; Quiroga and Jaranson, 2005) as well as a sense of shame from not having been able to stop the abuse. Others may have been coerced into behaving against their own moral, cultural or religious beliefs or may be ashamed of not being able to protect others they love – including children and pets. These feelings can become internalised as a belief that 'this is what I deserve' and prevent survivors from seeking help.

These responses are the normal human responses to the experience of coercive control. Within this model it is coercive control, not physical violence, that is the fundamental glue that entraps people in abusive relationships.

Gender and domestic abuse

There has been considerable controversy as to whether or not domestic abuse is gendered. Both women and men report using physical force in intimate relationships to surveys such as the CSEW. This is supported by analysis of the gender of the alleged perpetrator in reported crimes (Smith et al, 2012; Williams et al, 2009). On this basis some research reviews conclude that domestic abuse is not gendered (Dixon and Graham-Kevan, 2011).



Johnson (2008) has proposed that statistics about violence which use intimate relationships count three types of violence;

- *Situational violence*, used where there is no context of domestic abuse
- *Domestic terrorism*, violence used in the context of perpetrating domestic abuse and
- *Violent resistance*, used to defend oneself from domestic abuse.

The new law on coercive control creates a distinction between violence used to perpetrate domestic abuse and other violence taking place within intimate and family relationships. It also enables prosecution of domestic abuse where physical violence is not a visible source of power and control.

Johnson (2008) and Stark (2007) propose that more women than men experience violence within the context of domestic abuse, used as part of a pattern of coercive control. This view is supported by evidence that there are key differences in the nature and impact of violence reported by men and women. For example,

- Similar numbers of men and women report 'something being thrown at them', but women are five times more likely to have been threatened by their partner (Williams et al, 2009).
- 18.6%-20% of women report being sexually assaulted within the context of partner and family abuse, whilst the equivalent figure for men is 2.5-3% (Smith et al, 2012; Williams et al, 2009).

Key differences have been found in research about the nature of violence perpetrated by men and women.

- Male perpetrators are responsible for greater numbers of violent incidents than female perpetrators (Hester, 2009)
- Violence used by men towards women has been found to have more serious consequences than for men experiencing physical abuse from women (Williams et al, 2009, Hester, 2009).
- The mental health consequences of domestic abuse appear to be more common for women (Scott et al, 2015).

Other figures relevant to the issue of gender and domestic abuse are the numbers of men and women killed by intimate (ex)-partners or family members. Recent statistics about the context or the relationship between the perpetrator and victim of crimes of murder and manslaughter in England and Wales are not published (CPS, 2016). However, it is estimated that one hundred women are killed each year by a partner or ex-partner (2 per week) (Berry et al, 2014). Since 1995, of people who have been murdered, about 50% of the women murdered and 12% of the men were killed by their partner or ex-partner (NICE, 2014).



Based on the evidence, the conclusion reached by international and UK policy makers is that domestic abuse *is* a gendered issue that is in general perpetrated by men towards women (NICE, 2014; Mallender et al, 2013; Cabinet Office, 2011; World Health Organisation, 2010; Walby et al, 2010).

This does not mean that women cannot be the perpetrators of domestic abuse towards men or women or that some men are not experiencing domestic abuse from a man or a woman. UK surveys found that the prevalence of domestic abuse in intimate LGBT relationships usually mirrors that in heterosexual relationships, with approximately one in four to one in three individuals in LGBT relationships experiencing domestic abuse at some point (Berry et al, 2014).

Feminist models propose that the high levels of gender inequality in domestic abuse exist because coercive control is used within intimate personal relationships to enforce inequality between men and women within families and households.

'Partner violence has at its core a household gender regime ... in which men expect to have the final say, set the terms of the relationship and how women and children are to behave.' (Kelly and Westmarland, 2015)

Evidence to support these models include a factor analysis across interviews with 757 adults which identified nine areas in which perpetrators of domestic abuse sought control (Dutton et al, 2005). These were;

- Personal activities/appearance
- Support/social life/family
- Household, work/economic resources
- Health
- Intimate relationship
- Legal
- Immigration
- Children/parenting.

Liz Kelly et al (Kelly et al, 2014; Kelly and Westmarland, 2015), using Eva Lungren's concept of 'space for action' (Lungren, 1998) found that women described their violent partners as trying to control four aspects of their life; everyday household work and childcare, relations with others, freedom of movement and emotional life. The researchers used these areas to design a tool for use in the UK to assess the level of coercive control being used in a relationship (CCUK). A study of women's experiences of intimate partner violence in Pakistan found that power was used to control the same areas of life (Ali et al, 2015).

Feminist ecological models (see Petkova, 2016) also provide an explanation as to why domestic abuse is such an enduring social problem. Where the coercively controlling behaviours of an individual are reinforced by social and cultural beliefs



(for example that a good husband should control the behaviour of his wife) and where social structures (for example divorce laws) prevent a person leaving an abusive relationship, abuse is more likely to continue. The evidence is that, whilst the details vary across cultures and income levels, barriers to living independently and to holding equal power with men within their families and households are experienced by women across the world (World Health Organisation, 2005).

Domestic abuse is both a symptom and cause of inequality between men and women. The use of coercive control by individuals in relationships limits the other person's rights within her home and family and also contributes to limiting her human rights within society as a whole (Fulu et al, 2013).

Ecological models propose that, because social values and the response of organisations to domestic abuse are key in maintaining domestic abuse, changing the response of social institutions (such as Local Government and the Police) to domestic abuse can be key to individuals leaving abusive relationships and also support prevention (see Guidance Sheet Three: What works? [Ingram, 2016a]).

Whilst the primary source of inequality creating domestic abuse is that between men and women, there are many other inequalities that can influence a relationship. Intersectionality (Crenshaw, 1991) refers to how inequalities are expressed in specific cultures and social contexts, creating specific barriers that constrain the survivor within those relationships AND how other sources of inequality can influence that relationship. For example, domestic abuse between a white English man living in the UK and a Malaysian man who is a Muslim with limited English, no work permit and no right to remain in the UK will be substantially affected by the latter's lack of recourse to public funds. It may also be influenced by factors including:

- homophobia
- a lack of belief from professionals
- a lack of cultural literacy in relation to both Gay and Malaysian culture (and law)
- a lack of legal literacy in relation to migrants affected by domestic abuse
- a lack of geographical proximity to one of the services for men who have experienced domestic abuse.

Consideration of inequalities in a relationship is an important aspect of responding to domestic abuse in an effective and sensitive way.



The impact of coercive control

Coercive control causes significant harm. There is evidence from Domestic Homicide Reviews (DHRs) that extreme jealousy and gender control are high risk indicators (Regan et al, 2007). It is likely that domestic abuse makes a significant contribution to the ill health and premature death of women (Ingram, 2016).

There are substantial similarities between the impact of coercive control used in different contexts. However, the details of the behaviour and its meaning both to the perpetrator and to the victim can be specific to the social and cultural context and to aspects of their individual personalities and relationship (Amnesty International, 1973; Quiroga and Jaranson, 2005; Siddiqui et al, 2008; Rich, 2014).

The experience of domestic violence has an evidenced negative impact on physical and mental health (World Health Organisation, 2005; Campbell, 2002; NICE, 2014). The impacts are very similar to those evidenced for victims of torture (Quiroga and Jaranson, 2005). Domestic abuse can cause health and social care needs (McGarry and Simpson, 2011).

Physical impacts include disability, chronic pain, gastrointestinal, and gynaecological signs including sexually-transmitted diseases (Campbell, 2002; NICE, 2014).

'He was extremely abusive and he put me into the hospital quite few times. The consequences on my health now [. . .] I have had a major bone problems, and I had to have an operation on my spine, and I am questioning whether that was to do with the beatings. I've got arthritis and I had a lots of broken bones when he was doing this, so whether that impacted [. . .] I'm sure that this possibly did impact up on me now [. . .] Like now I can hardly walk, and I have to go in a wheel chair to go about' (Participant 1: 63 years) (McGarry and Simpson, 2011: 295).

'I'm waiting for a hearing aid and now [. . .] I got severely bashed on my ear, and I'm told that I can't hear at all in this ear, and I've been told that it is perforated eardrum' (Participant 8: 76 years) (ibid: 295).

Studies of women who have experienced domestic abuse also find that they experience significantly higher levels of depression, Post-Traumatic Stress Disorder (PTSD), anxiety, suicide attempts and serious mental health conditions such as schizophrenia and bi-polar disorder (Golding, 1999; Greater London Domestic Abuse Project, 2008).

Not all abuse survivors experience problems with their mental health, however studies of people with mental health distress find that a very large percentage of women who use mental health services have experienced domestic abuse



(Warshaw, 2003). The research project "Responding Effectively to Violence and Abuse" (REVA) (Scott et al, 2015) concluded that there is an extremely strong relationship between partner violence and poor mental health. It also provides support for the idea that coercive control plays a significant role in the negative impact of domestic abuse. Other research evidence confirms that coercive control is likely to play a key role causing survivors to develop poor mental health (Jones et al, 2001; Mechanic et al, 2008).

For both torture and domestic abuse survivors, the incidents that appear to create long-term damage to sense of self and self-esteem are those where the perpetrator succeeds in colonising the person's sense of self and/or when the survivor acquiesces to the extent that they act against their own values and beliefs or cause harm to others they love (Herman, 1992; Dutton, 2009; Quiroga and Jaranson, 2005; Biderman, 1957).

A large proportion of women who seek help for the problematic use of prescribed medication, alcohol or other substances have experience of abuse. The use of alcohol and other drugs may be part of a coping strategy for living with abuse or behaviour encouraged by a perpetrator and can lead to dependency (AVA Toolkit, 2013; Campbell, 2002).

Women with drug and alcohol issues made up 10.24% of women using Women's Aids' community based services and 9.76% of women in refuge accommodation in 2015 (Women's Aid, 2016). In the REVA groups, women and men who have experienced extensive violence and abuse are more than twice as likely to be dependent on illegal drugs and to be smokers as those with little such experience. Alcohol dependence was also more common amongst people in the two 'extensive violence' groups. 38% of people in the 'extensive physical and sexual violence' group had a problematic pattern of alcohol consumption (Scott et al, 2015). These behaviours can in themselves create disability and ill-health.

How does abuse impact on mental health?

Some theories propose that the impact of abuse on mental health can be attributed to complex post-traumatic stress, the result of repeated trauma events whose impact compounds over time (Herman, 1992). Complex PTSD will be recognised as a mental health diagnosis in the USA in 2017 (DSM-V).

Others propose that the biology of stress explains the mechanism for many of the physical and mental health impacts of abuse (Johansson et al, 2013). 'Emotional labour' refers to work that requires *the management of emotion to create a publicly observable facial and bodily display* (Hochschild, 1983) such as nursing (and social work). Research shows that emotional labour may have negative health consequences if such work involves 'surface acting' (Savitch et al, 2015; Mann, 2005) for example, in relation to stress and anxiety, depression and feelings of lack of authenticity (Erikson and Grove, 2008). Complying with



the demands of another within day-to-day domestic life creates a similar situation of having to hide one's own thoughts and feelings. Furthermore, within abusive situations those demands are made in the context of fear and potential punishment for non-compliance.

A further explanation is that the techniques of coercive control, as evidenced in studies of torture, will cause the majority of human beings to involuntarily adapt their feelings, thoughts and behaviour to comply with the demands of the perpetrators, in order to survive (Quiroga and Jaranson, 2005). Internalising the demands creates psychological dependency and entrapment which in turn make it hard to leave an abusive relationship.

The response is natural and a product of human bio-psychology and adaptability. Most people, as described by Biderman (1957), develop conscious and unconscious strategies for survival that combine both resistance and compliance to the torturer's demands. Despite this most survivors continue to actively resist coercive control, sometimes in ways that may be invisible outside the relationship or which may only be known to the survivor herself (Pain, 2014b; Allen et al, 2013). Accounts by survivors about the strategies they use to survive within coercive control in intimate relationships have been documented (Pain, 2014; Kelly et al, 2013).



The REVA project (Scott et al, 2015)

The REVA project analysed the English Adult Psychiatric Morbidity Survey (APMS) and compared this to people's experiences of abuse and violence. They categorised people into six groups. One group representing 76% of the population had no or little experience of violence or abuse.

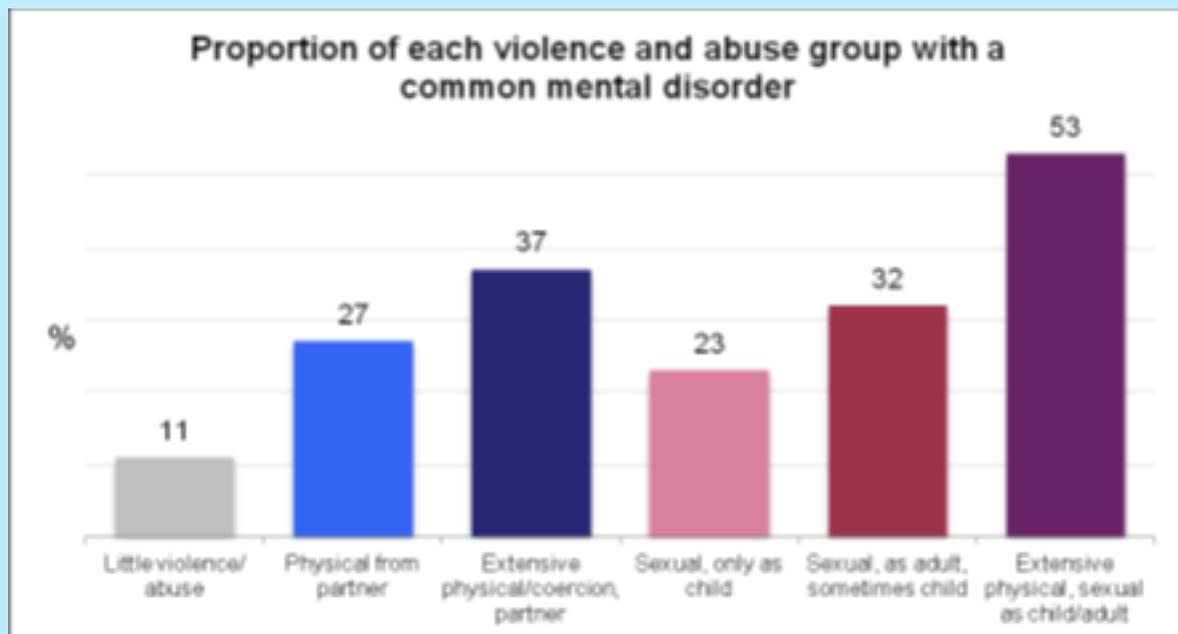
The project was able to compare levels of mental health issues experienced by the five groups who had experienced violence and abuse with the majority who had not.

They found that violence and abuse has a very significant impact on mental health.

The research identified a group equivalent to 1 in 25 of the adult population who have experienced extensive physical and sexual violence and an abuse history extending back to childhood. This group is predominantly (84%) women. More than half (52%) need assistance with two or more activities of daily living, compared with 17% in the group that has experienced little violence. 53% of the group were found to have a common mental health disorder (CMD) for example depression, anxiety or a phobia; 17% of this group experienced three or more other mental health symptoms such as psychosis, (PTSD), eating disorders and 29% had attempted suicide.

The project found that 1 in 50 of the population has experienced extensive physical violence and coercive control from a partner. They were also predominantly women (80%) and had very high levels (37%) of common mental disorder and 14% experience more than three mental health disorders. 12% had attempted suicide.

Another group representing 10% of the adult population (60% of whom were female) had also experienced physical violence from partners that was judged to be less life threatening and with lower levels of coercive control (a third had been prevented from seeing family or friends). 27% of this group experienced CMD and only 5% had experienced three or more other mental health disorders.





The experience of people with care and support needs of domestic abuse

There is increasing evidence and documentation of the experience of domestic abuse by people with care and support needs.

The Women's Aid Annual Survey of women using their services on a single day during 2015 found that 27.82% of the women using community-based services and 33.74% of those in refuge accommodation had mental health support needs; women with physical health support needs accounted for 5.29% of women using community-based services and 6.12% of those staying in refuges (Women's Aid, 2016).

A literature review found that disabled women experience more domestic abuse than women without disabilities and more domestic abuse than disabled men. More disabled men experience domestic abuse than other men, with the risk to a disabled man being similar to that to women in general. There is insufficient evidence about whether these figures illustrate that abuse is more likely to be perpetrated against disabled people or whether abuse causes impairments, or both (Public Health England, 2015; Robinson-Whelen et al, 2010).

Intersectionality, in this case the impact of the marginalisation of disabled and older people acting in addition to sexism, has been proposed as a reason why the levels of domestic abuse towards older women, disabled women and those using mental health services have not been widely documented or explored. Power and control models propose that disabled men experience a higher level of abuse than other men due to disabled men having less power in society than non-disabled men (and some non-disabled women).

Reports from those who have experienced domestic abuse suggest that behaviours used to exert coercive control at an individual level may exploit any dependency experienced by the person with care and support needs. The forms of coercive control and their impact may have commonalities across groups who face common barriers, such as older women. Barriers to participation in society such as physical accessibility and lack of accessible information also exist; for example women with learning disabilities report a low level of knowledge about refuge provision (McCarthy et al, 2015). This supports the entrapment of disabled people in abusive relationships.

There is growing evidence that perpetrators of sexual and financial abuse of older women (and men) use coercive behaviours to gain and maintain power and control over them; furthermore it has been proposed that this may be the main form of elder abuse by other family and household members (Spangler and Brandl, 2007). The characterisation of elder abuse within households being primarily caused by 'carers stress' is being challenged (Ramsey-Klawnsnik, 2000).



For further information, please see Guidance Sheet Four: The experience of people with care and support needs (Ingram, 2016b).

Intervention with perpetrators

There is an assumption that social work practice can be effective in changing family dynamics. Outcomes of case reviews held within Children's Services have highlighted failures to identify the impact of domestic abuse on children and the risk that fathers who perpetrate domestic abuse pose directly to their children (Brandon et al, 2012) and a lack of social work engagement with fathers has been 'problematized'. However, a model for successful engagement with men who are using coercive control that is safe for those they are controlling has not been offered.

There is no clear evidence about effective work with perpetrators of coercive control outside of evidenced group programmes. Current guidance in relation to engaging with perpetrators emphasises the potential risk of workers who act outside a clear joint framework with other professionals increasing, rather than decreasing, risks to survivors and children (Agnew-Davies, undated).

See Guidance Sheet Three: What works? For further details (Ingram, 2016a).



Key messages and practice tips

- Coercive control causes significant harm.
- Take time to understand the impact of coercive control on human psychology and behaviour.
- Make any safeguarding enquiries and interventions on the basis that coercive control may be taking place.
- People with care and support needs experience coercive control in intimate partnerships and family relationships. Half of all disabled women are likely to be experiencing domestic abuse.
- Disability may be used against a person with care and support needs as part of coercive control. Avoid colluding by focusing on strengths rather than impairments and taking action to remove barriers.
- Take time to understand the dynamics of coercive control and its impact on people with care and support needs (see Ingram, 2016b).
- Use relevant tools to assess whether the dynamics of coercive control explains a safeguarding, or other, situation you are assessing.
- Consider whether a person's response to your position as a professional can be explained by their role as a perpetrator or survivor of coercive control.
- Be alert for physical and mental health impacts of coercive control.
- Routinely create opportunity for safe enquiry with people with care and support needs.
- Have questions you feel comfortable asking that will enable adults at risk from domestic abuse to disclose to you.
- Practice using the DASH RIC assessment so that you feel confident using it if you believe someone may be at high risk of harm from domestic abuse.
- Read Guidance Sheet Three (Ingram, 2016a). Use and refer adults at risk to evidenced based interventions.
- Do not challenge the use of coercive control by a perpetrator with them directly (on their own or with the couple) unless you have the relevant expertise and measures are in place for your own safety and those of the survivor/any children.
- Maintain a good knowledge of local and national specialist resources for people at risk from domestic abuse.
- Maintain your legal literacy in this area and seek advice about potential options.



References

Against Violence and Abuse (AVA) (2010) *The Coordinated Community Response Model Online Toolkit*. London: AVA. Available online: <http://www.ccrm.org.uk/>

Against Violence and Abuse (AVA) (2013) *Complicated matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health*. London: AVA. Available online: <http://avaproject.org.uk/types/toolkits/>

Agnew-Davis R (Undated) *Domestic Abuse Training Manual for Health Practitioners*. London: National Domestic Violence Health Practice Forum (now called HEVAN) Home Office and Department of Health. Available online: <http://www.ccrm.org.uk/images/docs/3.bhevantrainingmanual.pdf>

Allen N E, Larsen S, Trotter J and Sullivan C M (2013) 'Exploring the core service delivery processes of an evidence-based community advocacy program for women with abusive partners'. *Journal of Community Psychology* 41(1) 1-18.

Ali P A, et al (2015) 'Intimate partner violence in Pakistan: A systematic review'. *Trauma, Violence, & Abuse* 16 (3) 299-315.

Amnesty International International Secretariat (1973) *Report on Torture*. London: Amnesty International. Available online: <https://www.amnesty.org/en/documents/act40/001/1973/en/>

Berry V L, Stanley N, Radford L, McCarry M and Larkins C (2014) *Building effective responses: An independent review of violence against women, domestic abuse and sexual violence services in Wales*. Wales: Welsh Government. Available online: <http://clock.uclan.ac.uk/10728/1/140430-violence-against-women-domestic-abuse-sexual-violence-services-FULL%20report%20EN.pdf>

Biderman A D (1957) 'Communist attempts to elicit false confessions from Air Force prisoners of war'. *Bulletin of the New York Academy of Medicine* 33 (9) 616.

Brandon, et al (2012) *New learning from serious case reviews: A two year report for 2009-2011*. London: Department for Education. Available online: https://www.uea.ac.uk/documents/3437903/4264977/DFE-RR226_Report.pdf/cfb03bcc-2193-485b-b36d-b8f1c6c1bb35

Cabinet Office (2011) *Call to End Violence Against Women and Girls: Action Plan*. London: Cabinet Office. Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118153/vawg-action-plan.pdf

Campbell J C (2002) 'Health consequences of intimate partner violence'. *The Lancet* 359 (9314) 1331-36.



Crown Prosecution Service (2016) *Violence against Women and Girls Crime Report 2015-16*. London: Crown Prosecution Service.

Crenshaw K (1991) 'Mapping the margins: Intersectionality, identity politics, and violence against women of color'. *Stanford Law Review* 43 (6) 1241-1299.

Dixon L and Graham-Kevan N (2011) 'Understanding the nature and aetiology of intimate partner violence and implications for practice: A review of the evidence base'. *Clinical Psychology Review* 31 (7) 1145-1155.

Dobash R P and Dobash R E (2004) 'Women's violence to men in intimate relationships: Working on a puzzle'. *British Journal of Criminology* 44 (3) 324-349.

Dutton M A, Goodman L A and Schmidt R J (2005) *Development and validation of a coercive control measure for intimate partner violence: Final technical report*. Washington, D.C: National Institute of Justice, Office of Justice Programs: US Department of Justice.

Dutton M A (2009) 'Pathways linking intimate partner violence and posttraumatic disorder'. *Trauma, Violence, & Abuse* 10 (3) 211-224.

Erickson R J and Grove W J C (2008) 'Emotional labor and health care', *Sociology Compass* 2 (2). Available online: <http://dx.doi.org/10.1111/j.1751-9020.2007.00084>

Fulu E, Warner X, Miedema S, Jewkes R, Roselli T and Lang J (2013) *Why do some men use violence against women and how can we prevent it? Quantitative findings from the United Nations multi-country study on men and violence in Asia and the Pacific*. Bangkok: United Nations Development Programme, United Nations Population Fund, United Nations Women and United Nations Volunteers.

Gilbraith J K (1983) *The anatomy of power*. Boston: Houghton Mifflin.

Golding J M (1999) 'Intimate partner violence as a risk factor for mental disorders: A meta-analysis'. *Journal of Family Violence* 14 (2) 99-132.

Greater London Domestic Abuse Project (2008) *Sane Responses: Good practice guidelines for domestic violence and mental health services*. London: AVA.

Herman J L (1992) *Trauma and recovery: The aftermath of violence-From Domestic Abuse to Political Terror*. New York: Basic Books.

Hester M (2009) *Who does what to whom? Gender and domestic violence perpetrators*. Bristol: Violence Against Women Research Group/University of Bristol with Northern Rock Foundation. Available online: <http://www.nr-foundation.org.uk/downloads/Who-Does-What-to-Whom.pdf>

Hochschild A R (1983) *The Managed Heart: Commercialization of Human Feeling*. Berkeley, CA: University of California Press.



Home Office (2015) *Controlling or Coercive Behaviour in an Intimate or Family Relationship: Statutory Guidance Framework*. London: Home Office. Available online:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf

Ingram R (2016) *Focus on Older Women: Improving health outcomes for Older Women*. London: Women's Health Equality Forum. Available online:

http://www.whec.org.uk/wordpress/?page_id=306

Ingram R (2016a) *Supporting people with social care needs who are experiencing coercive control. Guidance Sheet Three: What works? Evidence based interventions to prevent and respond to domestic abuse*. Dartington: Department of Health, Research in Practice for Adults and Women's Aid. Available online:

<http://coercivecontrol.ripfa.org.uk/overarching-resources/>

Ingram R (2016b) *Supporting people with social care needs who are experiencing coercive control. Guidance Sheet Four: The experience of people with social care needs*. Dartington: Department of Health, Research in Practice for Adults and Women's Aid. Available online:

<http://coercivecontrol.ripfa.org.uk/overarching-resources/>

Johansson L, Guo X, Hällström T, et al (2013) 'Common psychosocial stressors in middle-aged women related to longstanding distress and increased risk of Alzheimer's disease: A 38-year longitudinal population study'. *BMJ Open* 3. Available online:

<http://dx.doi.org/10.1136/bmjopen-2013-003142>

Johnson M (2008) *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence*. Boston: University Press of New England.

Jones L, Hughes M and Unterstaller U (2001) 'Post-Traumatic Stress Disorder (PTSD) in victims of domestic violence: A review of the research'. *Trauma, Violence, & Abuse* 2 (2) 99-119.

Kelly L, Sharp N and Klein R (2014) *Finding the Costs of Freedom: How women and children rebuild their lives after domestic violence*. London: Solace Women's Aid. Available online: **<http://solacewomensaid.org/wp-content/uploads/2014/06/SWA-Finding-Costs-of-Freedom-Report.pdf>**

Kelly L and Westmarland N (2015) *Domestic Violence Perpetrator Programmes: Steps Towards Change (Project Mirabal Final Report)*. London and Durham: London Metropolitan University and Durham University. Available online:

<https://www.dur.ac.uk/criva/projectmirabal>

Lehmann P, Simmons C A and Pillai V K (2012) 'The validation of the Checklist of Controlling Behaviors (CCB): Assessing coercive control in abusive relationships'. *Violence Against Women* 18 (8) 913-933.



Lungren E (1998) 'The hand that strikes and comforts: Gender construction and the tension between body and symbol' in R and R Dobash (eds) (1998) *Rethinking Violence Against Women*. London: Sage.

Mallender J, et al (2013) *Economic analysis of interventions to reduce incidence and harm of domestic violence: Final Report*. London and Manchester: National Institute for Health and Care Excellence (NICE). Available online: **<https://www.nice.org.uk/guidance/ph50/evidence/economic-analysis-domestic-violence-final-report-for-consultation-430410637>**

Mann S (2005) 'A health-care model of emotional labour: An evaluation of the literature and development of a model'. *Journal of Health Organization and Management* Vol 19 (4/5) 304–317. Available online: **<http://dx.doi.org/10.1108/14777260510615369>**

McCarthy M, Hunt S and Milne-Skillman K (2015) 'I know it was every week, but I can't be sure if it was every day: Domestic violence and women with learning disabilities'. *Journal of Applied Research in Intellectual Disabilities*. Available online: **<http://dx.doi.org/10.1111/jar.12237>**

McGarry J and Simpson C (2011) 'Domestic abuse and older women: Exploring the opportunities for service development and care delivery'. *The Journal of Adult Protection* 13 (6) 294-301.

Mechanic M, et al (2008) 'Mental health consequences of intimate partner abuse: A multidimensional assessment of four different forms of abuse'. *Violence Against Women* 14 (6) 634–654. Available online: **<http://dx.doi.org/10.1177/1077801208319283>**

NICE (2014) *Domestic violence and abuse: multi-agency working. Public health guideline*. London and Manchester: NICE. Available online: **<https://www.nice.org.uk/guidance/ph50>**

Pain R (2014a) 'Everyday terrorism: Connecting domestic violence and global terrorism'. *Progress in Human Geography* 38 (4) 531-550.

Pain R (2014b) 'Seismologies of emotion: fear and activism during domestic violence'. *Social and Cultural Geography* 15 (2) 127-150.

Petkova B (2016) *Historical theory of domestic abuse*. Dartington: Department of Health, Research in Practice for Adults and Women's Aid. Available online: **<http://coercivecontrol.ripfa.org.uk/overarching-resources/>**

Pike L (2016) *Supporting people with social care needs who are experiencing coercive control. Guidance Sheet One: Law and Policy Summary*. Dartington: Department of Health, Research in Practice for Adults and Women's Aid. Available online: **<http://coercivecontrol.ripfa.org.uk/overarching-resources/>**



Pike L (2016a) *Supporting people with social care needs who are experiencing coercive control. Guidance Sheet Two: Mental capacity and coercion – what does the law say?* Dartington: Department of Health, Research in Practice for Adults and Women's Aid. Available online:

<http://coercivecontrol.ripfa.org.uk/overarching-resources/>

Public Health England (2015) *Disability and domestic abuse: Risk, impacts and response*. London: Public Health England. Available online:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf

Quiroga J and Jaranson J M (2005) 'Politically-motivated torture and its survivors'. *Torture* 16 (2-3) 1-111.

Ramsey-Klawnsnik H (2000) 'Elder-abuse offenders: A typology'. *Generations* 24 (2) 17.

Regan L, Kelly L, Morris A and Dibb R (2007) *If only we'd known: An exploratory study of seven intimate partner homicides in Engleshire*. London: Child and Woman Abuse Studies Unit.

Rich K (2014) "'My body came between us": Accounts of partner-abused women with physical disabilities'. *Affilia: Journal of Women and Social Work* 29 (4) 418-433.

Robinson-Whelen S , Hughes R B, Powers L E, Oschwald M, Renker P, Swank P R and Curry M A (2010) 'Efficacy of a computerized abuse and safety assessment intervention for women with disabilities: A randomized controlled trial'. *Rehabilitation Psychology* 55 (2) 97-107.

Savitch N, Abbott E and Parker G M (2015) *Dementia through the eyes of women: Research Report*. York: Joseph Rowntree Foundation. Available online:
<http://eprints.whiterose.ac.uk/91782/>

Scott S, Williams J, McNaughton N C, McManus S, Brown A, Harvey S, Kelly L and Lovett J (2015) *Violence, Abuse and Mental Health in England Population Patterns*. London: The Reva Project.

Siddiqui N, Ismail S and Allen M (2008) *Safe to return? Pakistani women, domestic violence and access to refugee protection—A report of a transnational research project conducted in the UK and Pakistan*. Manchester: South Manchester Law Centre.

Smith, et al (2012) *Homicides, Firearm Offences and Intimate Violence 2010/11: Supplementary Volume 2 to Crime in England and Wales 2010/11*. London: Home Office. Available online:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116483/hosb0212.pdf



Spangler D and Brandl B (2007) 'Abuse in later life: power and control dynamics and a victim-centered response'. *Journal of the American Psychiatric Nurses Association* 12 (6) 323.

Stark E (2007) *Coercive Control: How men entrap women in personal life*. Oxford: Oxford University Press.

Tara-Chand A (1993) *Violence Against Women by Known Men: Training Pack*. Leeds: Inter-Agency Project/Home Office Programme Development Unit.

WHO (2005) *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses*. Geneva: WHO.

WHO and London School of Hygiene and Tropical Medicine (2010) *Preventing intimate partner and sexual violence against women: Taking action and generating evidence*. Geneva: WHO.

Walby S, et al (2010) *Physical and legal security and the criminal justice system: A review of inequalities*. Manchester: Equality and Human Rights Commission.

Warshaw C and Barnes H (2003) *Domestic violence, mental health and trauma: Research highlights*. Chicago: The Domestic Violence and Mental Health Policy Initiatives.

Williams, et al (2009) *2008-09 Scottish Crime and Justice Survey: Partner Abuse*. Scotland: The Scottish Government. Available online:
<http://www.gov.scot/Resource/Doc/296149/0092065.pdf>

Women's Aid (2016) *Women's Aid Annual Survey 2015*. Bristol: Women's Aid. Available online: **<https://www.womensaid.org.uk/research-and-publications/annual-survey-2015/>**