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Is it coercive controlling violence? A cross-sectional domestic violence and abuse survey of men attending general practice in England

ABSTRACT

Objective: Surveys that examine prevalence of domestic violence and abuse (DVA) without consideration of impact, severity or context have limitations. The paper uses results from the first survey of a European clinical male population, the largest such study internationally, that measured a range of emotional, physical and sexual behaviours that could be construed as DVA, including experience and perpetration, and a range of impacts. The paper asks to what extent the behaviour reported by the men can be characterised as coercive controlling violence.

Method: A survey was administered to male patients in sixteen general practices (family medicine clinics) in England. Of 1,368 respondents who completed four screening questions regarding behaviour consistent with DVA, 707 (52%) completed detailed questions on lifetime experience of possibly harmful emotional, physical and sexual behaviours, perpetration, and impacts, and if they had ever been in a domestically violent or abusive relationship. One-way ANOVA was used to establish optimal thresholds across abuse and impact scales in order to ascertain severity of men's reported experiences.

Results: More than half (52.5%; 95% CI 48.7% to 55.9%) the men reported experiencing potentially harmful physical, emotional or sexual behaviour from a partner, however only 4.4% of the men experienced coercive controlling violence and of those nearly half also reported perpetration against their partner.

Conclusions: While a large minority of men presenting to general practice experience or perpetrate DVA behaviour in relationships, only a small minority experience coercive controlling violence and only one in forty have experienced such violence as victims only.

Keywords: domestic violence and abuse; coercive controlling violence; male victims and perpetrators; male patients; impact; survey

INTRODUCTION

Since the 1990s there has been extensive debate regarding the nature of domestic violence and abuse (DVA) as measured by general population and clinical surveys. While research, policy and practice concerning DVA has tended to focus on heterosexual women victimised by male partners, as the largest victim group (Britton, 2012), it is increasingly recognised that domestic abuse occurs across all population groups, including men (Hester et al., 2015; Home Affairs Select Committee, 2008; Britton 2012). The question remains how men are affected, whether they may be affected differently to women, and how this may differ in heterosexual and same sex relationships (Donovan & Hester, 2014, Buller, Devries, Howard, & Bacchus, 2014). In this paper we focus on the findings from a large sample of heterosexual male patients in primary care in England, situating these within the wider literature on the epidemiology of DVA, and asking whether their experiences of DVA can be characterised as coercive controlling violence.

It has become apparent that the nature of the DVA and those it affects may appear different depending on the samples used, types of violence asked about, and the extent to which consequences and effects are taken into account. The evidence tends to suggest that different populations – whether general population or agency (e.g. police, health, DVA agency) samples - provide different answers, with population surveys more likely to include individuals experiencing situational couple violence and agency samples more likely to involve the more harmful coercive controlling violence that constitutes 'real domestic violence and abuse' (Johnson et al, 2014). Moreover, while questionnaire-based surveys tend

to assume that participants interpret questions in similar ways, this is not necessarily the case (McCarry, Hester, & Donovan, 2008). Men and women have been found to answer differently: men tending to under-report their perpetration of violence and may over-report victimisation (Hearn, 1996, Gadd et al, 2002). General population prevalence data may provide greater semblance of gender symmetry, with gender asymmetries more apparent if incidence and impact are also included (Myhill 2015). Questions about incidence and impact are more likely to capture the ongoing and particularly harmful, fear-inducing elements that make up coercive controlling violence and abuse (Stark 2007). The types of violence and abuse asked about also shape the forms of DVA identified. Focus on physical violence and aggression provides more gender symmetry (Archer 2002), while including questions about sexual violence and coercively controlling behaviours provides greater gender asymmetry, as these are more likely to be experienced by women from men and in the context of coercive controlling violence (Johnson 2006, Graham- Kevan and Archer 2003; Hamby 2015).

The term 'Domestic violence and abuse' can mean many things, which in the context of intimate relationships may be characterised by a continuum from, at one end, 'negative behaviour' that involves one off-events and longer lasting situational couple violence, to the particularly harmful, inequality producing, liberty constraining, coercive controlling violence abuse at the other (Hester et al., 2015; Stark 2007). While any negative behaviour in relationships should not be condoned, we none the less have to differentiate between these different forms of intimate partner behaviour, as they require different types and levels of support and intervention. Coercive controlling violence requires particular attention to the safety of victims, including understanding of the effects of living in an ongoing context of fear (Stark 2007; Williamson, 2010). In December 2015 legislation was enacted in England and Wales, regarding a new criminal offence of controlling or coercive behaviour in intimate

or familial relationships (Serious Crime Act 2015 section 76). The new offence draws on Stark and Johnson's work, and defines Coercive Control as "**a purposeful pattern of behaviour** which takes place over time in order for one individual **to exert power, control or coercion over another"** (Home Office 2015: 3, emphasis in original). It includes any combination of physical, sexual or emotional DVA behaviours such as "assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim" (Home Office 2015: 3). The offence involves behaviour on the part of the perpetrator which must have had a "serious effect" on the victim, meaning that it has caused the victim to fear violence will be used against them on "at least two occasions", or it has had a "substantial adverse effect on the victims' day to day activities (Home Office 2015: 3). It is the only DVA-specific offence in England and Wales, and useful for the purposes of this article because it defines what is deemed particularly severe, dangerous and harmful DVA.

As a means of differentiating between DVA behaviours, researchers have used the notion of severity, although attempting to assess this in a variety of ways. Most surveys use some form of 'act based' questions and scales, but how these are rated, combined and analysed will affect measures of severity. Severity may be assessed via the type of violence used, usually based on physical violence being rated as more severe, and/or using incidence to differentiate levels of severity (e.g. Statistics Canada 2004). The Conflict Tactics Scale (CTS) provides a classic example of this, rating physical violence, physical injuries sustained and frequency of tactics used as indicators of severity (Straus, Gelles, and Steinmetz 1980, Straus 1999; and see Hamby 2015). However, the CTS provides no consideration of the context, for instance no differentiation between a push and severe physical violence leading to hospitalisation. Using physical injury as a key measure of severity also has particular limitations, as some of the most injurious violence involves women using weapons against their male partners in

protection and/or self-defence (Johnson et al 2014; Hester, 2013), and precludes impact of a wider range of potentially abusive behaviours. Qualitative interviews with female survivors have consistently shown that the psychological, emotional, coercive behaviours they experience have greater impact and are more harmful long term than the physical violence (Glass 1995), as also reflected in the English offence of Coercive Control. Moreover, frequency or incidence does not in and of itself indicate severity. Frequency may indicate what Stark calls regular 'fights' (2010) rather than ongoing coercive control.

Some population surveys have attempted to move beyond these criticisms by including questions about what could be construed as coercively controlling behaviours (e.g. the US NVAW and UK CSEW). None the less, population surveys using CTS-type questions will almost inevitably overestimate what might be deemed 'intentional harmful behaviour'.

One of the most oft quoted analysis of types of DVA in surveys data, is that alluded to earlier, by Johnson and colleagues, providing distinctions between situational couple violence and coercive controlling violence. Johnson and Leone (2005) argued that it was possible to find both types of abuse in a nationally representative survey with a large sample, such as the US NVAWS. More recently Johnson et al (2014) reworked their analysis of the NVAWS survey using data on past, rather than current, intimate relationships to provide an operationalization of coercive controlling and situational couple violence, their rationale being that as current perpetrators fear exposure and victims fear retribution from their abuser, both groups are likely to be underrepresented in general population samples. This echoes other European studies, where individuals currently in relationships are less likely to report DVA than in relationships they have already left (Donovan and Hester, 2014; Hester et al., 2015; Nybergh, Taft, Enander, & Krantz, 2013)

In Johnson et al (2014)'s re-analysis of the US NVAWS, physical violence was assessed by responses to a 12-item version of the CTS with respondents categorised into "Non-Violent" if they reported "No" on all of the Items, and as "Violent" if they reported "Yes" (p 193). Severity was assessed via a Severe Violence Scale based on the items which they deemed to have been conventionally identified as severe violence. A Coercive Control Scale was constructed from a subset of nine survey items that dealt with non-violent control tactics used by the respondent's partner. Using cluster analysis involving the Coercive Control Scale with a threshold of five revealed two clusters: high control, which the authors equated with coercive controlling violence, and low control, which they equated with situational couple violence. While confirming patterns in previous findings (Johnson 2006, 2008; Graham-Kevan and Archer 2003), the results were deemed more accurate, showing that 22% of women experienced coercive controlling violence from ex-husbands, while only 5.4% of men experienced coercive controlling violence from their ex-wives. Situational couple violence was perpetrated more equally by men and women (7.4% of ex-husbands, 3.9% of ex-wives). Coercive controlling violence was found to involve a wider variety of acts of violence, more frequent violence, and more injuries and psychological distress than situational couple violence. It should be noted, however, that impact data in the NVAWS was limited to physical injuries sustained in the most recent incident of partner violence.

In the UK the CTS approach also underpins the Crime Survey England and Wales (CSEW) where it is used in the interpersonal violence module to assess frequency of domestic violence. Despite limitations regarding impact, the CSEW interpersonal violence module includes questions that may reflect the impact of coercively controlling behaviour. Myhill (2015) re-analysed the CSEW data using these questions to provide a measure of severity and typology of coercive controlling violence for intimate partners. Respondents were

characterised as having experienced coercive control if they said their partner had both "Repeatedly belittled you to the extent that you felt worthless" and "frightened you, by threatening to hurt you or someone close to you" (page 362), deemed to reflect abuse that was ongoing, denigrating, perceived as threatening, and had caused a degree of fear. By contrast, all other respondents who reported physical violence or acts of emotional or psychological abuse were classified as having experienced only situational violence. Myhill's analysis involved the people who had experienced only one abusive relationship since the age of 16 (*n* = 3,544). Of these, about one in 20 men (6%, n=52) who reported some form of DVA were found to experience what could be termed coercive controlling violence and nearly a third (30%, n=791) of the DVA reported by women could be classified similarly (as compared to general prevalence figures from the 2008/2009 CSEW which estimated 24% of women and 12% of men had experienced nonsexual DVA). Experience of coercive controlling violence was found to involve more severe and more frequent physical violence, and was more likely to persist over time than situational violence. Myhill (2015) using past and current relationship data thus ends up with similar, albeit slightly higher, results regarding exposure to coercive controlling violence to those of Johnson et al (2014) using past relationship data.

In the current study we used clinical, rather than general population, samples. Clinical samples, such as those in health, criminal justice and DVA agency settings, generally show a higher degree of DVA experience than the general population (Ramsey, Dunne, Rose, Arsene, & Norman, 2009, Hamberger & Larsen, 2015). While clinical studies have largely focused on female victim-survivors, increased prevalence also appears to be relevant for men in health settings (Hamberger & Larsen 2015; Hester et al., 2015). A small number of studies of DVA have samples of male patients, but mostly in the US and with a few European

studies. A review by Randle and Graham (2011), mainly US-based, found some evidence of male victims in agency samples subjected to life-threatening violence and fearing their female partner's aggression and attempts at controlling their behaviours, but data on health settings was limited. A study of 712 men in the US attending an emergency department, found 20% disclosed physical, sexual or emotional abuse from a partner in the past year (Rhodes et al 2009), but there were no attempts to assess severity or measure impacts beyond health related associations. In England, a survey of female and male patients in four general practices (family medicine clinics) included responses from 178 men (Westmarland et al 2004), finding 15% of men experiencing DVA behaviours over their lifetime (compared with 27% for women). A question about feeling frightened was used to elicit impact. Just over one in ten of the men (11%) said that they had occasionally or often felt frightened because of the behaviour of a partner or someone at home (as compared to 25% of women). However the study did not otherwise assess severity of DVA behaviours. A Slovenian study looked at DVA experience of women and men in the past five years in a family health clinic (Selic et al 2011). Of the men, 8.0% reported exposure to physical and psychological violence, compared to 20% of women. However, data on consequences were not included in the analysis and impact was therefore not assessed.

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The RESPONDS Study

To overcome the problems associated with limited impact data in surveys, and to develop a more 'realist' measure of severity, we devised the COHSAR survey and analysis in an earlier study (McCarry et al., 2008; Hester, Donovan, & Fahmy, 2010). Like Myhill (2015) we were concerned to reflect the lived experience of victim-survivors in the construction of survey questions. The COHSAR has good internal consistency reliability, and has been used in health care settings, although it has not been tested against other measures. In the current

study we applied the (the PROVIDE study) approach to a sample of male patients in order to ask:

- To what extent can the intimate relationship behaviour reported by the men be characterised as behaviour commensurate with coercive controlling violence?

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METHOD

The study used a cross-sectional survey approach with male patients in the waiting rooms of general practices in England.

Sample and data collection

A stratified random sample of general practices in south west England was used to reflect the profile of practice populations in England in respect of the proportion of patients from ethnic minorities (postcode level census data); levels of deprivation (index of multiple deprivation) and population density (city, town, village) (see author for more details). From September 2010 to June 2011 members of the research team administered a paper questionnaire to unaccompanied male patients in the waiting rooms of 16 clinics. Only those 18 years or older and able to read English were included, and men were not approached if they were unwell or appeared distressed. A total of 1368 heterosexual men answered the questionnaire, of whom 707 answered the detailed questions on experience and perpetration of DVA behaviour reported in this paper. Of 371 who reported experiencing one or more DVA behaviours, 219 also answered questions regarding impact of those behaviours. The attrition in responses (1368 to 707, and 371 to 219) appears to be largely due to participants not having the time to complete the questionnaire before being called in to their appointment with a clinician.

Questionnaire

The questionnaire had two main sections, with questions of particular relevance for this paper as follows. Part One included questions on demographic characteristics consistent with Crime Survey England and Wales (age in years, ethnicity, income, education and housing status) (Osborne 2011), four 'screening' questions about experience of behaviours that might be construed as DVA (Hester et al., 2015). Participants were asked if they were currently or had been in a relationship that could be described as "domestically violent or abusive". Part Two elicited more detailed questions about experience of potentially harmful physical, emotional and sexual behaviours (multi-response with 47 questions – see Table 2) and their perceived impacts (multi-response with 25 questions – see Table 3) based largely on the COHSAR measure (Williams et al., 2014). The questionnaire booklet included a detachable information sheet with contact details of support services and national help lines.

Analysis – identifying coercive controlling violence

Data were entered into an Access database and cleaned, then imported to an SPSS database for analysis in the current paper. Only individuals who responded to all four screening questions in Part One, who were heterosexual and who also answered all the abuse and impact questions in Part Two regarding intimate partner DVA were included in the sub-sample for this paper (707 of 1368). Exposure was calculated and Pearson's Chi-square with continuity correction was used to differentiate between sociodemographic groups and experience of DVA behaviour.

A particular strength of the COHSAR research is the possibility for exploring the intersection of DVA behaviours and impact that the approach provides. Thus it is possible to begin to statistically differentiate between experiences that constitute coercive controlling violence on the one hand, and those apparent DVA behaviour experiences without the harmful impact

that coercive controlling violence and abuse involves, on the other. Given that coercive controlling violence is a pattern of behaviour over time, we set out with the assumption that where individuals experience higher levels of DVA behaviour from a partner, this may be assumed to be associated with a greater impact upon respondents. By combining statistically both DVA behaviours and impact in the earlier COHSAR study, this association was indeed found to be the case, reflected in the relationship between the frequency of incidents of DVA and their impact on respondents' lives (Hester et al., 2010). This analytical approach was replicated in the current paper.

Since the frequency of incidents and impacts of DVA can be assumed to be theoretically interdependent (coercive controlling violence involves behaviour over time and harmful impact), establishing the optimal threshold for any set of impacts and DVA items was achieved by maximising the statistical 'fit' between these scales using one-way ANOVA. This is represented graphically in the results section below, plotting values for the impact and DVA scales at any unspecified point in the respondents' lives. Through analysis of variance we identified the optimal fit between these two variables, resulting in four distinct groups with high or low experience of DVA behaviours reported and high or low impact. This was carried out using a combined emotional, physical and sexual abuse scale, as we have previously found that a combined scale is more effective in targeting the more extreme end of the DVA spectrum, and thus more likely to identify coercive controlling violence (Hester et al., 2010, 2015). Respondents were consequently deemed to have experienced coercive controlling violence if they reported both high levels of DVA experience *and* reported that this had a significant impact upon their lives.

To determine reliability of the items relating to DVA experiences both separate and combined scales were developed. Three separate scales relating to emotional, physical, and sexual abuse were created, as well as a combined scale including the three items. An impact scale with 25 of the 27 impact items was also created (leaving out two 'positive' items: "didn't have an impact", "made you feel loved/wanted"). All scales were found to be reliable as follows:

- *Emotional Abuse*. These items can be reliably scaled (Alpha = .84) producing a 23-item scale with achieved values between 0 and 16.
- *Physical Behaviour*. These items can be reliably scaled (Alpha = .89) producing a 14-items scale with achieved values between 0 and 13.
- *Sexual Behaviour*. These items can be reliably scaled (Alpha = .81) producing a 10-item scale with achieved values between 0 and 9.
- *Combined Behaviour*. These items can be reliably scaled (Alpha = .92) producing a 47-item scale with achieved values between 0 and 34.
- *Combined Impact*. These items can be reliably scaled (Alpha = .92) producing a 25-item scale with achieved values between 0 and 23.

RESULTS

Demographic characteristics

Of 2431 men in the general practices who were eligible and invited to complete the survey, 1368 (56%) completed the Part One questions and of these 707 (52%) answered the questions in Part Two relevant to this paper. Participants were aged between 19 and 90 years of age, mostly between 45-64 or 25-44 years, with a sizeable minority over 65 (Table 1). The vast majority had an intimate partner and lived with them. Most were employed with an income of £30,000 or less. More than half were educated to at least 'A' level (the exam required for university entrance) and towards two-thirds owned their own property.

TABLE 1 ABOUT HERE

Experience of DVA behaviour from an intimate partner

Experience of potentially harmful emotional behaviours was reported to be more widespread than physical and sexual behaviours, with just over half (50.9% 95% CI 47.2 to 54.7) reporting any such emotional, 14.6% (95% CI 12.1 to 17.1) reporting any such physical, and 6.9% (95% CI 5.1 to 8.9) reporting any such sexual behaviour at some time (Table 2). A quarter (24.8%; 95% CI 21.6 to 27.7) of men reported their partners had 'been jealous or accused them of cheating', more than one in ten (11.6%; 95% CI 9.2 to 14.2) had been 'slapped, pushed or shoved', and about one in 20 (4.7%; 95% CI 3.2 to 6.5) had had 'sex for the sake of a quiet life'.

TABLE 2 ABOUT HERE

Using Pearson's Chi-square with continuity correction, marked social differences in experiences of DVA behaviour were evident in relation to men's age group, self-reported income band, and employment (for those under the age of 65). Experience of any type of potentially harmful emotional behaviours across the lifetime were significantly more frequent for men who were younger (18 to 24; 25 to 44 years), but also more highly educated (degree level and above). Experiencing any type of potentially harmful physical behaviours were significantly more frequent across the lifetime amongst the young (25 to 44 years) and unemployed men under the age of 65, and experiencing any type of negative sexual behaviour was significantly more frequent across the lifetime for the younger age groups (25 to 44 years) in particular.

Fifty-nine (8.5%; 95% CI 6.4 to 10.5) of the 697 men who answered the question whether they had ever been in a DVA relationship, reported that they had. For these men, younger age (25 to 44 years) was again a significant predictor associated with higher scores on the emotional DVA scale and combined DVA scale, using Spearman's rank.

Perceived impact

Of the 219 men who completed the impact items (Table 3), 115 reported they did not experience any of the items on the impact scale (52.5%; 95% CI 45.9 to 59.4). Sixty-nine out of 160 who answered the impact query "Did not have an impact" reported no impact from their experiences of potentially harmful emotional, physical or sexual behaviours. Most of those who reported an impact felt sad as a result of their experience (32.5%; 95% CI 25.3 to 40.0), felt they had to watch what they said or did (28.0%; 95% CI 21.1 to 35.1), or it affected the sexual side of their relationship (26.8%; 95% CI 20.0 to 33.3).

TABLE 3 ABOUT HERE

In relation to the individual items the impact over their lifetime was significantly more prevalent amongst younger men, those without degree level education and those on low incomes.

Incidence, impact and coercive controlling violence

As indicated earlier, in our research it was possible to test whether the relationship between the frequency of behaviours and their impact on respondents' lives reflected the assumption that higher levels of abuse should be associated with a greater impact upon respondents (Walby & Allen 2004). Overall the empirical (Spearman's rank) correlation between scores on the impact scales and DVA scales relating to the lifetime period supported this assertion with strong correlations evident between impact and the combined behaviour scale (.47, $p<.001$). Using one-way ANOVA to maximise the statistical 'fit' between the impact and combined behaviour scales resulted in a threshold for behaviour items of 8 on the y-axis and 6 for impact on the x-axis. This can be represented graphically, as illustrated by Figure 1.

FIGURE 1 ABOUT HERE

Out of the 707 men, 371 (52.5%; 95% CI 48.7 to 55.9) men experienced at least one form of DVA behaviour during their lifetime. Of the 371 men: 250 (67.4%; 95% CI 62.5 to 72.1) experienced potentially harmful emotional behaviours only, 62 such emotional and physical behaviours (16.7%; 95% CI 12.9 to 20.4), 31 (8.4%; 95% CI 5.8 to 11.4) such emotional, physical and sexual behaviours, 17 (4.6%; 95% CI 2.6 to 6.8) such emotional and physical behaviours, 10 (2.7%; 95% CI 1.1 to 4.3) only such physical behaviours, and 1 (0.3%; 95% CI 0.0 to 0.8) only such sexual behaviour.

Of the 219 men who answered the impact questions, 31 can be classified as experiencing high abuse and high impact (14.2%; 95% CI 9.7 to 19.0), 17 as experiencing low abuse and high impact (7.8%; 95% 4.3 to 11.5), 29 as experiencing high abuse and low impact (13.2%; 95% CI 8.8 to 18.2), and the largest proportion, 142 as experiencing low abuse and low impact (64.8%; 95% CI 58.6 to 71.6) (Table 4). Given the general assumption that experiencing high abuse and high impact are commensurate with coercive controlling violence, the 31 men can thus be classified as experiencing such DVA. This is 4.4% of the entire sample of 707 men. This group of men experienced combinations of mainly emotional and physical behaviours that might be harmful or combinations of such emotional, physical and sexual behaviours.

TABLE 4 ABOUT HERE

Nearly three-quarters (21, 70.0%; 95% CI 52.1 to 83.3) of the men deemed to have experienced coercive controlling violence also self-defined as having been in a relationship that they characterised as DVA. A further 20 men who self-defined in this way can be classified as having experienced less severe emotional behaviours rather than coercive controlling violence as they are in the low DVA and low impact category.

Perpetration

The men were asked if they had used any of the potentially harmful physical, emotional or sexual behaviours (as listed in Table 2) against a partner. Of the 707 respondents, 199 (28.1%; 95% 25.0 to 31.6) reported perpetrating at least one of the items during their lifetime. The largest groups of respondents, about one in ten, said they had driven too fast when their partner was in the car, (9.8%; 95% CI 7.6 to 12.0) or accused their partner of cheating (9.2%; 95% CI 7.1 to 11.3). When asked for reasons as to why they used the behaviours, most said it was because they loved or cared for their partner (35.1%; 95% CI 23.6 to 46.2), because the partner had hit them first (33.3%; 95% CI 21.1 to 46.3), or because they were unhappy in the relationship (29.8%; 95% CI 18.6 to 41.8).

Thirty one of the men met the threshold of experiencing coercive controlling violence, that is, only 4.4% of the entire sample. We used this calculated frequency to establish a threshold for perpetration on the ever perpetrated scale. The top 4.4% on the scale were considered to be perpetrators. Thus, 38 men constituted the top 4.4%. This group of men used 5 or more (from 4-17) different forms of violence during their lifetime. When we incorporate reports of perpetration against a partner alongside the victim categories, derived from the combined DVA behaviour scale and impact scale, almost half (n=15, 48.9%; 95% CI 32.0 to 65.2) of the 31 men in the coercive controlling violence category also reported using DVA behaviour of some sort against their partner. Thus the men who reported experiencing but not perpetrating coercive controlling violence (i.e. victims only) constituted 2.3% of the total sample. In the low abuse and low impact category, nine of the 142 men also reported perpetration (6.3%; 95% CI 3.4 to 11.6). (Table 4)

DISCUSSION

Limitations

While this paper uses data from the first large scale survey of men in general practices, not all men in the practices were included in the survey. We excluded men under the age of 18, those who did not speak English or who were too ill to answer the questions. We do not know the absolute number of eligible men in the practice who were waiting to see a clinician and therefore cannot calculate a true recruitment rate. The study is cross-sectional and can only report associations. As it is a clinical sample the findings cannot be generalised to the wider population.

Men with higher education were over-represented in the overall sample of 1368, and the sub-sample of 707 used in this paper had higher numbers of younger men, private house owners and those in relationships. However the proportion of men who reported experience, perpetration or both did not differ across the main and sub-samples. Only 219 of the 371 men (59%) who experienced one or more DVA behaviours answered the impact questions, which may have limited this aspects of the data.

Research Implications

We set out to answer the question: To what extent can the intimate relationship behaviour reported as experienced by the male patients in our survey of primary care practices be characterised as behaviour commensurate with coercive controlling violence? The answer is that just under one in twenty (heterosexual) male patients in primary care clinics in England may be deemed to have experienced coercive controlling violence, in the sense of experiencing both high levels of DVA behaviour and high levels of impact, although at least half of these men are also using some form of violence or abuse against their partners.

Our overall finding that 4.4% of men experienced behaviour commensurate with coercive controlling violence is a lower than the findings of Johnson et al (2014) of 5.4%, and Myhill (2015) of 6% whereas we might expect a higher frequency in our sample given the clinical setting of our study Our slightly lower proportion of men experiencing coercive controlling violence may be explained by our approach, with greater emphasis on impact. It could also be influenced by the sample consisting of only heterosexual men, while the NVAS (Johnson et al 204) and CSEW (Myhill 2015) also include some men in same sex relationships. There is some evidence to suggest that men in same sex relationships report higher prevalence of potential DVA experience than heterosexual men (Donovan & Hester, 2014). Overall, however, our approach possibly echoes more closely the meaning of Coercive Control in the UK legislation, than Johnson or Myhill's approaches.

By including perpetration in our analysis it is apparent that less than one in 40 (2.3%) of the men experiencing coercive controlling violence could be deemed to be just victims. We thus appear to have a sub-group of men (n=15, 2.3%) who might fit Johnson's categories of 'violent resisters' or of using 'mutual controlling violence'. Indeed 13 of these 15 men did respond affirmatively to the question 'retaliated by shouting at your partner', suggesting some form of retaliatory or mutually abusive behaviour. Myhill (2015) did not include perpetration in his analysis, and therefore could not differentiate men who might only be victims.

The largest category of men in our study who experienced DVA behaviours were found to experience low levels of DVA behaviour and low impact. The vast majority of these (133 of 142, Table 5) may possibly be experiencing situational couple violence, which is

characterised by sporadic, isolated episodes of DVA behaviours and low impact (Johnson & Leone 2005).

In our previous analysis using a more limited set of four screening questions (Hester et al., 2015), we found that nearly a quarter of the men reported ever having experienced one or more of these DVA behaviours. Most reported experiencing the 'emotional abuse' screening item of ever having felt frightened of the behaviour of a partner. In the analysis presented here, we were able to look at more detailed answers. While potentially harmful emotional behaviours was still reported as the most prevalent experience, most of the men reported that their partners had been jealous or accused them of cheating rather than that they were frightened of their partners. Thus, while fear may be deemed as a key characteristic of coercive controlling violence, this was by no means the main form of behaviour reported by the men. Only one in eight (13.3%) reported being frightened by things their partner said or did. Our findings appear to echo those of Ansara and Hindin (2010), who found, using latent class analysis regarding the national Canadian survey data, that most men experienced 'jealousy and verbal abuse' from partners.

Nyberg (2014), based on interviews with men who experienced DVA behaviour from partners, found the men talked about the greater impact of emotional behaviour, rather than fear, in particular aspects of being belittled and humiliated, which their female partners were reported as using to control them. To some extent our survey data reflects this, with only a small number of our respondents reporting experience of fear, while about one in five of the men did report controlling behaviours involving being regularly insulted or put down, being told what to do or who to see, and having their spending controlled. Also of the men in our survey who answered both behaviour and impact questions and also self-defined as

experiencing DVA, a fifth (n=10, 19.6%) reported only emotional behaviours used against them. However in our threshold analysis only one of these ten men were categorised as experiencing coercive controlling violence, and the remaining nine were subject to little or no impact as a result of the behaviour.

While many of the men's experiences were not fear inducing or dangerous, they still appeared to leave the men feeling sad, having to watch what they said or did, and/or affected the sexual aspect of their relationships. In other words, while most of the men in our survey were not experiencing the fear and danger characteristic of coercive controlling violence, they might still be experiencing negative impacts. We found previously that the men experiencing DVA behaviours exhibit anxiety and depression two to three times greater than those without such DVA experiences (Hester et al., 2015), and this is also reflected in the current analysis by the many men responding that they felt anxious or sad (Table 2). The question that Nyberg raises (as do Ansara and Hindin 2010) is whether we need another way of categorising men's experiences of DVA relationships that places greater emphasis on emotional abuse. In some ways our analysis would suggest that another categorisation might be useful, but only if this makes clear that such emotional DVA for heterosexual men tends not to involve fear and danger (in the way it can do for heterosexual women survivors), and does not in the vast majority of cases constitute coercive controlling violence. It may perhaps be argued that the emotional behaviour the men themselves defined as experiencing DVA was situated in a wider patriarchal context where, as a consequence, the men felt their positioning as men slighted or undermined, and their 'entitlement' dented, but did not feel in fear or danger of their life (Hester, 2010).

The younger men in our sample reported greatest likelihood of experiencing DVA behaviours, and there was some association with low income. This echoes findings from UK population surveys. However, while UK population surveys show greatest risk to the age of 25 (Smith et al 2010), the risk for the men in our survey tended to extend to their mid-forties. This may be explained by our study focusing on life time exposure, where there would be an expectation of increase in exposure over time, although that would also suggest that older men would report the highest levels of DVA, which is not the case in our findings. This is an area that requires further investigation.

Clinical and Policy Implications

DVA behaviour in heterosexual relationships is experienced or perpetrated by a considerable number of heterosexual men presenting to general practices, with a very small minority deemed to have experienced (and possibly perpetrated) coercive controlling violence. Heterosexual men may perceive that they have experienced 'real DVA' (coercive controlling violence) if they are experiencing less dangerous or severe forms of DVA behaviour, and may express concerns such as jealousy, belittling or humiliation. With regard to the UK legislation on Coercive Control, only DVA experience involving ongoing fear, threat and control, might attain the threshold of an offence, and most cases would not require intervention by the criminal justice system. Instead, clinicians and other support services may be better placed to provide intervention and support. The men in our survey were already engaging with primary care clinicians, who might be able to ask initial questions about DVA relationships and to refer the men to specific services with expertise regarding male DVA victims or perpetrators (Williamson et al., 2014). Heterosexual men may have a range of needs of support and intervention depending on the severity of their experiences of DVA

behaviour or coercive controlling violence and whether they are/have been using violence and abuse against their partners.

Clinicians also need to be aware that heterosexual men aged between 18- 44 (or younger) are at greater risk of experiencing DVA behaviour in intimate relationships, and high educational attainment is associated with risk of experiencing emotional DVA behaviours.

Conclusion

Surveys that examine prevalence of domestic violence and abuse (DVA) without consideration of impact or severity have limitations. The paper uses results from the first survey of a European clinical male population, and the largest such primary care study internationally, that measured a range of emotional, physical and sexual behaviours that could be construed as DVA, including experience as well as perpetration, and a range of impacts. Using the COHSAR approach allowed us to analyse both behaviour and impacts and to disaggregate the experience of merely DVA behaviour from coercive controlling violence and abuse. Our finding that 4.4% of the male patients reported experience of what may be deemed coercive controlling violence concurs with the results from Johnson et al (2014) and Myhill (2015), indicating, as Hamby has also pointed out, the possibility to compare and explore "the impact of different operationalizations on rates" (Hamby 2015: 8). However, our approach also shows the importance of taking into account both impact and perpetration alongside experience of DVA behaviour if we are to understand the nature of DVA and coercive controlling violence for men and implications for clinicians and DVA agencies.

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