

Coercive control:

Recognising relational patterns that affect patient wellbeing

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Background

Coercive control is a pattern of behaviour that occurs in relationships and families that is enabled by broader coercive control systems in the community. General practitioners, skilled at pattern recognition, can contribute to systems-wide identification of coercive control across the lifespan.

Objective

This article uses the Sense of Safety Theoretical Framework to name processes that build sense of safety in healthy relationships. It therefore enables recognition of patterns of coercive control that destroy safety.

Discussion

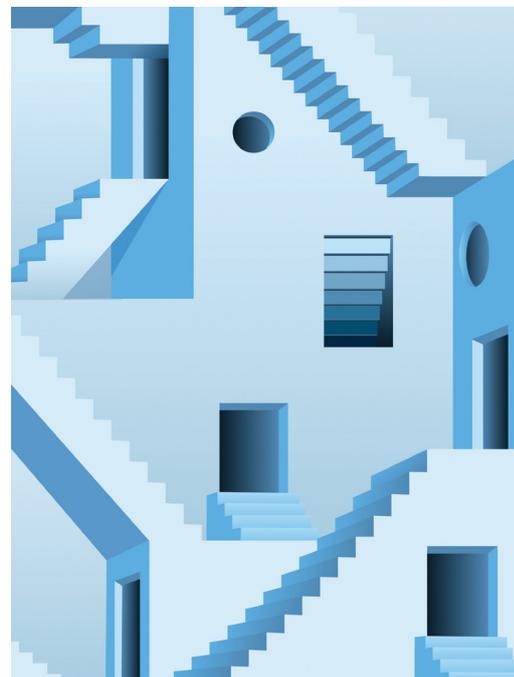
Identifying coercive control is a key early intervention strategy for addressing domestic and family violence. Patterns of repeated invasion, confusion and isolation cause threat and enable coercive control by destroying freedom, clarity and belonging. Raising awareness of these patterns helps general practitioners to identify previously hidden processes that cause harm to the physical, emotional and social health of our community.

UNDERSTANDING the patterns of behaviours, attitudes and motivations that enable coercive control can help general practitioners (GPs) to decode complex presentations. It can enable wider understanding of coercive control in parenting practices, grooming tactics in relationships, peer bullying (including online), elder abuse, workplace bullying and the domestic and family violence setting. Recognising patterns of coercive control in primary care can enable identification of this chronic process of threat that harms whole person health.¹⁻⁴ Coercive control within the context of domestic violence is very common in general practice, with 10% of women patients experiencing fear in the past 12 months in the context of coercive control by their partners.¹ Importantly, most cases of homicide are preceded by escalating (often non-violent) coercive control.⁴⁻⁸ Coercive control is now a criminal offense in New South Wales and Queensland. By recognising patterns of coercive control, GPs can contribute to early intervention enabling individuals, families and communities to move towards safety and healing.

Coercive control is defined as 'a course of conduct aimed at dominating and controlling another'.⁶ In the setting of domestic violence, coercive control is mostly perpetrated by men against women, with 27% of women and 15% of men ever experiencing violence

or emotional/economic abuse by a partner.^{6,9} Australia's National Research Organisation for Women's Safety defines coercive control as an overarching context within which domestic and family violence occurs.⁶ In the context of domestic violence, coercive control encompasses physical, sexual and psychological abuse – including deprivation of human rights, social isolation, intimidation, monitoring and harassment. It also involves threats of harm, financial abuse, reproductive coercion, manipulation related to mental health and substance use, and technology-facilitated abuse.^{4,6,10,11} This dynamic and cumulative process involves both *coercion* ('structural forms of deprivation, exploitation and command that compel obedience indirectly'¹² (p. 229)) and *control* ('the use of force or threats to compel or dispel a particular response'¹² (p. 228)) in order to produce a 'condition of unfreedom'.¹² (p. 205) People who coerce and control use a complex set of implicit or explicit threats to manipulate compliance, punish non-compliance, build a cage of entrapment and erode the other person's reality.^{4,10,12-16} This entrapment can be exacerbated by lack of access to system supports; cultural, financial or emotional barriers; and past experiences of being controlled.⁷

People who coerce and control use intimate knowledge, bonds unique to the



relationship and often seemingly benign or charming processes to assault the other person's autonomy, liberty and equality.^{3,4,10} They create patterns of subjugation, terror, intimidation, punishment and fear that enable control.^{6,12} These patterns often persist beyond separation, through ongoing surveillance and use of other societal structures such as legal, immigration, mental health services and child custody processes.^{5,6,10-12} Even without the presence of physical or sexual violence, coercive control causes women to be fearful for their own safety, their children and other family members.^{10,17}

In this paper, we use the whole person Sense of Safety Framework^{18,19} to explore the sophisticated generalist task of noticing these patterns of coercive control that affect our patients and our own lives. Responses to coercive control are discussed elsewhere.²⁰⁻²²

Role of general practice

Access to a GP might be one of the few supports an entrapped person has. Generalist capacity to recognise patterns is a sophisticated skillset that enables prevention, early intervention and discernment within complex variables.^{23,24} This approach to knowing integrates and iterates between details and the big picture while watching for movement and change over time.²³ GPs can notice patterns in the body, in patient relationships with family and community, and in wider societal structures. Pattern recognition integrates a wide range of seemingly disparate and sometimes contradictory contextual data into an overall understanding that facilitates clinical decision making in disparate settings.²⁵ GPs often know their patients well, having seen them over years, so they are often able to notice small shifts away from healthy relationships and connection towards control. GPs also need to stay aware that motivations and escalations of coercion are heterogenous, involving a range of behaviours from chaotic, insecure and reactive cruelty, to premeditated humiliation and violation.²⁶

Awareness of coercive control facilitates care that is trauma, violence and gender informed.²⁷ It can help clinicians to practice in a way that reduces barriers to disclosure,²⁷ and enable them to act as witnesses to increase accountability in a system-wide response to domestic violence. It can also

help GPs to unravel previously confusing presentations and symptoms, and understand difficult patient relationships that cross professional boundaries. It can help GPs to see patterns of violation in victims that might otherwise be misdiagnosed as mental health disorders. It can increase insight, so GPs do not miss hidden coercion that looks reasonable and loving on the surface, and protects GPs from inadvertently instigating family or couple therapy where it might cause further entrapment. It can help GPs to integrate understanding of how fear is engendered and how image management can be part of a range of premeditated techniques used to control.

Barriers to pattern recognition

Patterns can be difficult to unravel, especially if the pattern maker hides in plain sight;²⁶ presents themselves as a hero, victim or lover;²⁸ or uses unpredictable and public kindness (with private cruelty) as strategic tools of control. A key pattern of coercive control is where the person using violence Denies, Attacks, or Reverses Victim and Offender (DARVO) to claim victimhood, deflect blame and responsibility, and discredit and silence their victim.²⁸ In clinical settings, this can present as a person who uses coercive control portraying themselves as a victim. Conversely, it can present as a genuine victim-survivor who erroneously believes it is all their fault and perpetually seeks to decode confusing unpredictable kindness and abuse to work out what they have done wrong. Attending to the harm caused to victim-survivors and their children can protect clinicians from inadvertent collusion with perpetrators skilled at confusing, invading and isolating both observer and victim.

Pattern recognition is also difficult if healthcare practitioners focus on objective events (eg singular incidents of violence) and ignore dynamic, invisible and cumulative processes. Focusing on adult relationships can miss how a person using coercive control harms a whole family by destroying the safety of their own children's home. Individualised healthcare approaches that do not attend to the person's relationships and community can also obscure wider patterns of control. These forms of control include manipulation of children, threats to loved ones (or loved pets²⁹), damage to community or online

reputations,³⁰ control of reproduction,^{3,31} chemical control (including prescriptions)³² or exploitation of legal, mental health or immigration systems.^{33,34}

Pattern recognition is also blocked if the clinician's personal, cultural or religious norms see male entitlement and domination as normal (or rare), or we only see certain types of people as believable victims, rendering other (eg calmer, strategic, stoic) ways of surviving invisible.³⁵⁻³⁷ Pattern recognition can also be affected by personal lived experience that might make it difficult to be near this type of suffering, or by powerful forces that pull us towards not acting at all and remaining in bystander roles.^{38,39} As healthcare providers, we do not need to become detectives, journalists, judges or jury. We do need appropriate support (including clinical supervision and peer support) to help us unravel blocks to our awareness and to protect ourselves from the risk of vicarious trauma.

Underlying patterns that enable coercion

At the heart of coercive control is fear – fear for self or loved ones. Fear is often covered with polite compliance, sadness or anger. Fear creates cascades of hormones and autonomic nervous system changes and affects immune function.^{40,41} Research into 'allostatic load' is unravelling the links between adversity in social determinants of health, colonisation, racism and conflict within couple dyads and families.⁴²⁻⁴⁶ Using the Sense of Safety Theoretical Framework, human sensory systems are understood as being organised around a need for safety that includes physical and moral integrity (freedom), a capacity to make sense of their world coherently (clarity) and safe connection (belonging).^{18,19} As outlined in Figure 1, those who seek to coerce and control others (whether planned or reactive) can deprive the other person access to these needs.⁴⁷⁻⁴⁹

Unpredictability and incongruent kindness are key patterns of coercive control. Deprivation as a technique used to control is most effective when not constant and victims experience reprieve or the illusion of safety or connection that is then unpredictably rescinded. Coercive control in domestic and family violence has many similarities to patterns of torture identified by Biderman⁵⁰

(and explored by Hill²⁶) in prisoner-of-war settings. These techniques isolate, monopolise perception (to distort and confuse the person's reality), induce debilitation and exhaustion (to overwhelm any resistance), threaten (to cultivate despair and prevent help-seeking), occasionally indulge (a kind of 'false friendship' that is often intense and rushed to create intimacy that can be used to control), demonstrate 'omniscience' and 'omnipotence' (such as 'relentless surveillance'^{26 [p. 32]} and terrifying near-death experiences), degrade (erosion of identity and wellbeing across body, mind, heart and conscience) and enforce trivial demands (to create a 'habit of compliance'^{26 [p. 31]}). Coercion can also be enabled and normalised by systemic and rigid attitudes to gender, leadership, race or rights that normalise control, objectification or violation (including pornography^{51,52}). It can also be exacerbated by processes that reduce inhibitions to control (eg intoxication⁵³) or increase contextual loss of control (eg financial stress, job scarcity, gambling^{54,55}). Coercive control cannot be excused – it is a human rights violation that has far-reaching impacts on individuals, families and communities.

Pattern recognition across the whole person

Healthy relationships (refer to Figure 2) are imperfect and yet are marked by processes

that build a sense of *autonomy or freedom* (fair responsibility, playful flexibility, differentiation and encouragement), a *sense of clarity* (genuine trust, accountable apologies, clear boundaries and honesty) and a *confident sense of belonging* (mutual generosity, attuned responsiveness, reliable kindness and comforting). Differentiation is how individuals manage their independence and interdependence within a relationship.⁵⁶ These types of relationships protect personal integrity (freedom), coherence (clarity) and connection (belonging). They also protect physiological stress systems relevant to health.

Coercive and controlling relationships occur across a spectrum. Initial grooming processes that appear pleasant can become cruel, degrading slavery and homicide (usually femicide⁵⁷). As named in Figure 2, techniques used to control have overarching patterns that:

- *invade integrity and take away freedom* (through creating fear and compliance, enslaving, entrapping, exploiting, demanding, stalking, intimidating, threatening, depriving, punishing or violating)
- *confuse and cause incoherence* (through deception; gaslighting that decreases the victim's trust in their own reality; betrayal; injustice; ridiculing; degrading or pretending to be a victim, hero or lover; love bombing [urgent bond-forming to enable control]; and other forms of image management)

- *disconnect and destroy belonging* (through isolating, ostracising, ignoring, neglecting, marginalising, using the silent treatment, undermining, discrediting, shaming, threatening to leave or to suicide, threatening to take custody or harm a loved one [including pets], as well as offering counterfeit connection). At the heart of lost belonging is the experience of shame, which is often used to groom people into sense that there is something wrong with them that causes their aloneness.

Noticing these patterns across a spectrum of intensity can enable interventions that can change a person's life. GPs ultimately are seeking to notice so that victim-survivors do not lose a sense of their own integrity to be themselves or protect themselves (*freedom*), lose trust in their own intuitive appraisal or sense-making capacity (*clarity*) or lose their sense that they can trust others and feel support from their communities (*belonging*).

What can GPs do to recognise these patterns?

As shown in the case examples in Box 1, GPs can hone their skills at noticing patterns of coercive control. In relating to the victim-survivor, the GP might be aware of signs of physiological stress that result from living in an unsafe environment, including chronic pain, physical neglect and complex multimorbidity.¹⁹ They might also notice patterns of the victim-survivor minimising their own needs, displaying apologetic or deferential behaviours, or having high levels of compliance to medical suggestions.⁵⁸ There might also be signs of financial constraints or entrapment (eg only paying in cash so the partner cannot trace their help-seeking) or inability to make decisions without the partner's endorsement. GPs might also see children with dysregulated emotions who either suppress or have dramatic emotional responses.⁵⁹ Within the GP themselves, they might notice themselves inadvertently exhibiting more paternalism or deference in consultations or feeling a drive to protect or care for the victim-survivor.⁶⁰

In relating to a person who uses violence and control, who might also be their patient, the GP might not identify the pattern easily. Part of the pattern of coercive control can

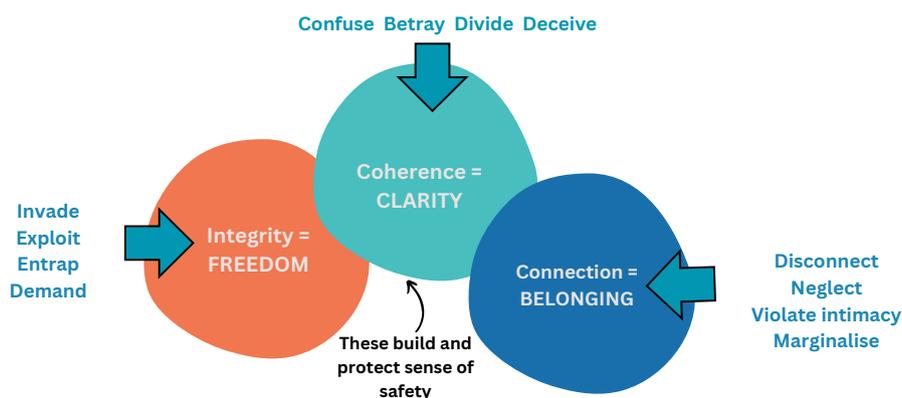
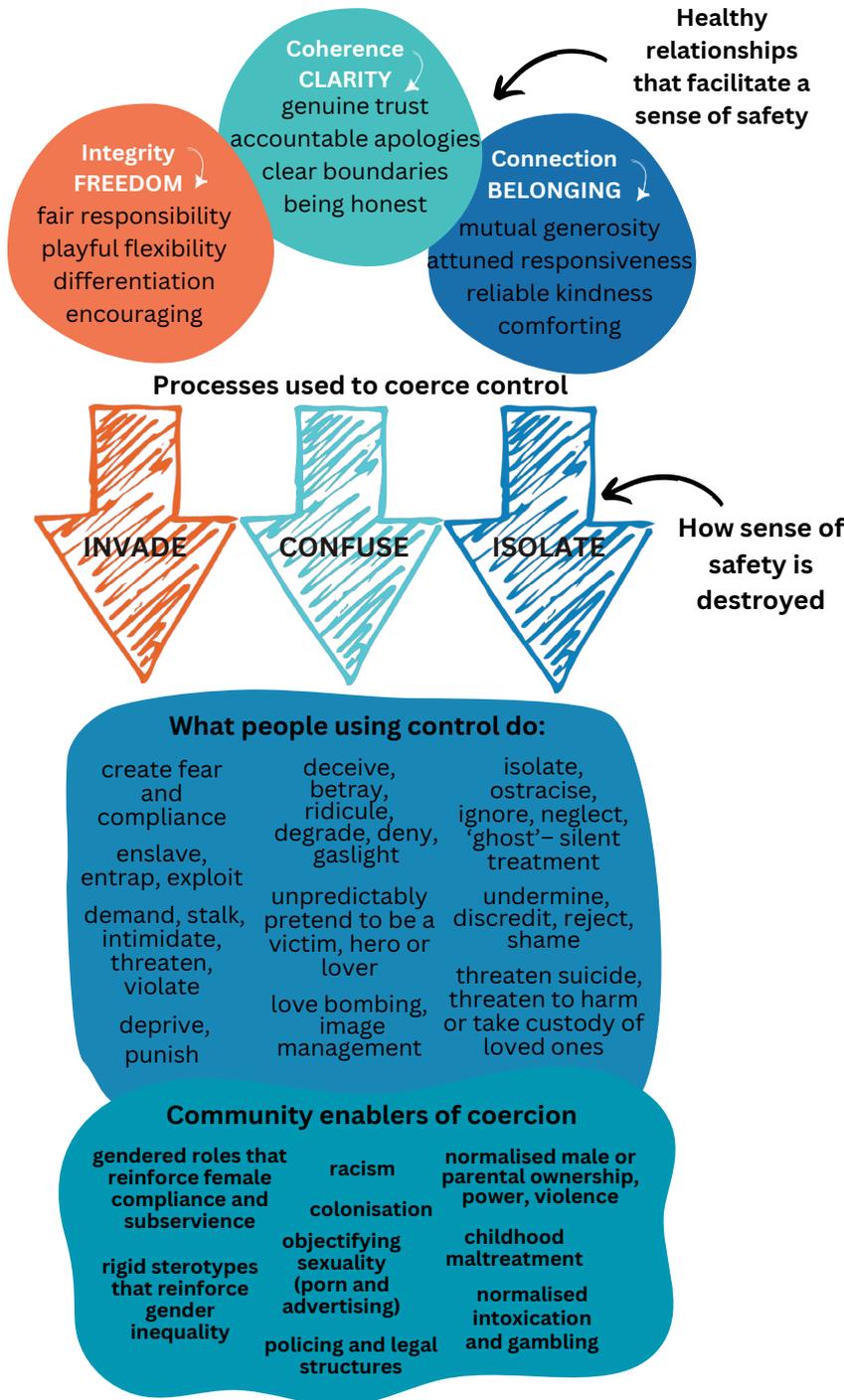


Figure 1. Processes that cause fear and loss of sense of safety.

Adapted from Lynch JM. A whole person approach to distress in health: Supporting a sense of safety. Routledge, 2021, with permission from Routledge.



be that the GP themselves inadvertently falls prey to the person using coercive control through a well-planned and skilled charm offensive that flatters and enlists the GP to collude with them.^{2,61} This ‘image management’ used by some patients is designed to coopt the authority of the GP to increase the illusion that the person is a reasonable and upright citizen, or that they are a victim of their partner’s behaviours, words and mental state. This might be part of a whole-of-life image management that includes a career in a highly reputable area of work and community leadership roles that look beyond reproach. These patients can intentionally and consistently exhibit calm, reasonable responses, with occasional portrayals of their partner as unhinged, emotional or ‘crazy’ in order to undermine their credibility. Healthcare practitioners might also notice patients with normalised personal and peer group patterns of male entitlement to control decision making and monitor women’s independence and autonomy. In other patients, healthcare practitioners might also note cruelty; assumed right to punish, humiliate or degrade; or disconnection in how they speak about others, including their own children. The GP might find themselves confused about how much to trust or comply with the person using coercive control, especially if their attendance at all appointments looks like care but is actually control.

Conclusion

People who use coercive control affect the health of individuals, families and the wider community. People who coerce use fear to decrease sense of safety to control. They achieve this through techniques that invade, confuse and isolate both the victim and any observers. GPs see these patterns every day in many different presentations across the community. This paper has used the first principle of attending to processes that destroy sense of safety to highlight patterns of coercive control to help GPs understand and care for those in our community who are entrapped and can no longer feel safe. As fear is encoded physically, knowing whether our patients are in fear is not just humane and caring, it is part of good-quality medical care.¹⁹

Figure 2. Coercive control relationship patterns.

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Box 1. Potential presentations of coercive control

Case 1

A girl, aged 16 years, presents feeling ashamed and worried about how to seek help, saying she does not know what to do. She says her boyfriend, aged 17 years, is pressuring her to send him naked photos of herself. He calls her a 'prude' and asks if she is 'ugly' when she refuses. When she sees him at school, he ignores her and loudly talks about her breasts to the other boys, which she hears if she has to walk nearby. Sometimes he sends her texts all night and gets angry when she does not respond. Other times he gives her showy clothes as gifts and expects her to wear them. Every now and then, unpredictably, he will not respond to her texts for 2–3 days ('ghosting' her). When she talks to her friends, they tell her that she will lose her boyfriend if she does not do what he says. She feels confused as she does not feel comfortable, but she has seen videos on TikTok that say 'this is just how boys are'. You sense that she is losing trust in herself and experiencing social and virtual pressures that are a risk to her.

Case 2

A male sales manager, aged 29 years, presents seeking 'anger management' after his wife has said she will not stay unless he gets counselling. He admits to taking her keys and not letting her leave the house if she is not sexually available to him every second day. He describes having 'control issues'. He has been diagnosed with obsessive compulsive disorder in the past. He had a mother who was often intoxicated because of alcohol use, and his father has been estranged since he was aged 5 years. He says he cannot remember his childhood and has difficulty describing his feelings, but occasionally if something 'throws out my plan' he describes a feeling of being 'backed into a corner', feeling worthless and wondering 'what did I do wrong?'. He describes only feeling safe if he 'has the choice' and if he can 'make order' or 'be dominant'. He sees himself as a victim and seems to have genuine regret for his controlling behaviour but takes no responsibility for change. He frames his use of violence or coercion as an 'anger management' problem or 'losing control' rather than the use of deliberate tactics to gain or retain control.

Key points

- Coercive control is a pattern of attitudes and behaviours that use intimate knowledge, relational bonds and societal structures to invade, confuse or isolate to control.
- Recognition of this pattern of behaviour is within the GP skill set.
- Coercive control harms patients both within relationships – such as those with partners, children, siblings and elders – and within broader systems including policing, legal, immigration and mental health services.
- Awareness of healthy relationship patterns can help clinicians to identify coercive control and escalations that increase risk of homicide. Coercive control is often hidden within many seemingly normal relationships that use relational intimacy, normalised social roles and beliefs, and governance structures to entrap.

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Competing interests: None.

Funding: JL and JKL are employed as clinical consultants to the Domestic, Family, and Sexual Violence Local Link team at the Brisbane South Primary Health Network. Although the Australian Government helped fund this research, it has not reviewed the content and is not responsible for any injury, loss or damage however arising from the use or reliance on the information provided herein.

Provenance and peer review: Commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

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