Women's preferences for how health practitioners respond to coercive control by a partner: Open-ended survey qualitative analysis

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Background
Coercive control by intimate partners is a major public health issue, negatively impacting women's health. Healthcare practitioners have a crucial role in responding yet often lack confidence to provide support.

Objective
This study explored Australian women's preferences for supportive messaging from health practitioners when discussing coercive control.

Discussion
An open-ended question in an online survey asked women who had experienced coercive control: 'What words could your health practitioner say that you would find helpful and supportive?'. Responses (n = 682) were analysed using directed content analysis. Findings align with two global frameworks: LIVES (Listen-Inquire-Validate-Enhance safety-Support) and CARE (Choice and control-Action and advocacy-Recognition and understanding-Emotional connection). Specific script health messaging is provided for healthcare practitioners to use in conversations with victim-survivors of intimate partner violence, including to counter coercively controlling tactics by abusive partners. Findings re-inforce the need for health practitioners to provide a sensitive first-line response, with tailored messaging to counteract affects of coercive control. Training and system support are needed to build health practitioner capacity to identify and respond to coercive control in the context of intimate partner violence.

COERCIVE CONTROL in the context of intimate partner violence (IPV) is a major public health concern.[1,2] Coercive control is an intentional pattern of behaviours by a partner or ex-partner that causes fear and harm to those experiencing IPV.[3,4] It can include physical, sexual, psychological abuse (deprivation of human rights, social isolation, intimidation, monitoring and harassment), threats to harm, financial abuse, reproductive coercion, mental health and substance abuse coercion and technology-facilitated abuse.[3,4] Coercive control, which is experienced more commonly by women than men, results in significant physical, mental, sexual and reproductive health issues.[1,5] Even without the presence of physical or sexual violence, coercive control pervades the environment of the relationship, causing women to curb their behaviour out of fear for their sense of safety and that of family members.[3,6]

The health sector plays a crucial part in responding to women experiencing coercive control by intimate partners.[7] It is estimated that a general practitioner (GP) working full-time will see five women a week who have experienced IPV in the past 12 months.[8] Despite GPs being the main professional group women disclose IPV to[5] and women reporting they want their health practitioners to ask about IPV,[9] victim-survivors face many barriers to disclosing their experiences.[10] Further, healthcare practitioners often lack the confidence to respond appropriately.[11] Consequently, women survivors' experiences following disclosure do not always meet their expectations.[12]

Based on systematic review evidence and consensus guidelines, the World Health Organization recommends health practitioners use the LIVES framework (Listen-Inquire about needs and concerns-Validate experiences-Enhance safety-Support) as a first line response to IPV.[13] A qualitative metasynthesis identified that women survivors want this response to be provided in the context of a CARE framework (Choice and control-Action and advocacy-Recognition and understanding-Emotional connection).[12]

Previous systematic reviews have examined women's experiences and expectations of health practitioners' enquiry and response,[9,12] providing guidelines on specific phrases for IPV screening tools.[14] However, few studies have focused specifically on identifying appropriate and supportive words that

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health practitioners might say to survivors, with most guidelines informed by clinician voices.[14] This study aimed to understand the health messaging and support needs of Australian women who had experienced coercive control by an intimate partner.

Methods

This analysis was from a larger project – UNderstanding COercive control and psychological ViolencE to inform health sectoR change (UNCOVER), an online survey of 1026 English-speaking Australian adult women conducted from February to April 2022. Participants were recruited from a panel of people registered for research with iLink, a commercial company (Pureprofile Group, Sydney, NSW, Australia). iLink uses various authentication and quality-checking methods to ensure the integrity of its data. Panel members were sent information about the study and invited to participate. Women aged 18 years and over were eligible for the study if they answered 'yes' to having experienced at least one of seven coercive controlling behaviours in the last five years: (1) being made to feel afraid; (2) day-to-day activities controlled; (3) isolation from friends and family; (4) being monitored, manipulated or harassed; (5) threats of hurt or others being hurt; (6) physical harm; and/or (7) pressured into unwanted sexual activity. The survey took approximately 30 minutes to complete and included a range of questions about psychological, physical and sexual abuse experiences by any partner or ex-partner, and preferences for support. The survey was completed online. Within the survey, suggestions for available supports were offered, including a self-directed mindfulness exercise and contact details for domestic and family violence (DFV) resources.

This paper reports on analysis of the following optional open-ended survey question answered by women: 'Imagine you told your health practitioner about feeling worried or frightened about emotionally hurtful or controlling behaviour in your relationship. What words could your health practitioner say in response that you would find helpful and supportive? Please write any ideas that you have. There are no wrong answers.' Data were extracted from the 682 participant responses to this question.

Table 1. Open-ended survey question participant characteristics (n = 682)

		All participants		Australian population (women)[A]
Characteristic		**No.**	**%**	**%**
Age (years)[B]	18–29	128	18.8	21.8
	30–39	162	23.8	18.6
	40–49	117	17.2	16.6
	50–59	138	20.2	15.6
	60–69	85	12.5	13.2
	70+	52	7.6	9.1
Gender of current partner[C]	Male	370	76.0	–[D]
	Female	116	23.8	–[D]
	Non-binary	1	0.2	–[D]
Indigenous		54	7.9	3.9[E]
Non-English language background		82	12.0	27.3[E]
Tertiary education		226	33.1	36.0
Paid employment		378	55.4	62.4
Healthcare card		391	57.3	21.0
Children living at home		454	66.6	48.0
Lives in rural/regional area[B]		236	34.6	34.0

[A]Population data are weighted proportions from Australian Bureau of Statistics (ABS) (2021), other than age and residential regionality provided, which is provided by iLink (Pureprofile Group, Sydney, NSW, Australia). Values are presented as percentages of women as a proportion of the total Australian population.

[B]ABS (2021) age population data provided by iLink (courtesy of Muriel Geagea [iLink], 30 September 2024).

[C]n = 487 participants reported being in a current relationship and responded to the partner gender question.

[D]Comparable data not available.

[E]Gender-specific data not available.

Data analysis

Directed content analysis was untaken, which is a deductive qualitative method[15] that provides a structured framework while also allowing flexibility to adjust or add new codes or categories.[15] This approach was appropriate given the large volume of responses and the short answers provided. We chose the LIVES[13] and the CARE[12] frameworks as our pre-determined categories as they are international guides for health practitioners' responses to women experiencing IPV. Data were coded in NVIVO 20 (Version 20; Lumivero, Denver, CO, USA) by the first author and reviewed by other authors during regular meetings. New categories were generated as appropriate and discussed and agreed with the team.

Ethical, safety and wellbeing issues

Ethical approval was received from The University of Melbourne Human Research Ethics Committee (no. 22680). Participants were given an information sheet and gave electronic consent. A 'Quick Exit' button was available should participants need to exit the survey for safety reasons. The survey was completed anonymously, with the option of providing their contact details

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(stored separately) should participants wish to go into a draw to win an iPad. Participants were encouraged to take regular breaks while completing the survey and provided with a link to resources for support at numerous points. Researcher wellbeing was also a consideration. During the analysis phase, the first author debriefed as needed with other members of the team and spaced the analysis work to allow for reflection and recovery. The team met regularly to reflect on their responses to the findings in the context of their own experiences as clinicians and researchers.

Reflexivity

Authors were all women from the same research centre and have backgrounds in general practice, social work, psychology, sociology and public health. The team brought expertise in a variety of relevant fields including clinical practice, health policy, systems interventions, and qualitative and quantitative research. All aspects of the study (design, recruitment, analysis) were approached from a feminist standpoint.

Results

Table 1 shows the characteristics of the 682 participants who responded to the open-ended question compared to the Australian population (where available). The study sample was nationally representative when compared to age, level of tertiary education and rurality. Approximately half of participants (378, 55.4%) were in paid employment, lower than the national average (62.4%), and 57.3% (391) had a healthcare card, higher than the national average (21.0%). There were 82 non-English-speaking background participants (12.0%), lower than the national average (27.3%), and 7.9% (54) were Aboriginal and Torres Strait Islander participants, higher than the national average (3.9%).

Of the 682 participants, 72 (10.6%) responses were not included as they indicated they had nothing further to contribute (eg 'nothing thank you', 'I don't know'). A low number of participants (33, 4.8%) stated they would not be willing to discuss their experiences with a health practitioner or indeed anyone, with some of these women describing adverse experiences with health practitioners such as being disbelieved, having their confidentiality broken, being told to leave but having nowhere to go, or being prescribed medication for anxiety/depression with no recognition of their IPV and no follow-up. Thus, 577 responses were included in the final directed content analysis.

Overall, responses from participants about what they wanted from health practitioners largely aligned with the LIVES and CARE frameworks,[12,13] strengthening the rationale for the use of these tools to guide health practitioner responses globally. Some participants provided specific words they wanted health practitioners to use, whereas others provided ideas for the type of response health practitioners could provide. This study provides specific words and phrases suggested by study participants in Figure 1, and includes their ideas for types of responses within the body of the paragraphs below. One additional category, 'strength and hope' that women wanted health practitioners to communicate to them, was identified.

Listen–Inquire–Validate–Enhance safety–Support (LIVES)

Listen (68 responses)

Participants told us they wanted health practitioners to 'talk less, listen more', 'encourage me to keep talking' and 'listen patiently and have empathy'. They also said they wanted 'respect' and 'confidentiality' and 'non-judgemental responses'. They provided words and phrases that health practitioners could use to demonstrate to patients that they were listening, they cared, they would not judge, and that the information shared would be kept private. Phrases health practitioners could use included: 'I am here to listen and help'; 'Tell me how that looks and feels for you'; 'Take some deep breaths and start at the beginning'; 'You're in a safe space now and you are free to talk about anything you need to'; and 'Tell me what you are comfortable sharing' (Figure 1).

Inquire (34 responses)

Participants said they wanted health practitioners to ask what support they needed. Participants suggested health practitioners ask simple questions such as 'What can we do to support you?' and 'What do you need?' to show that they are willing to address individual women's needs and concerns (Figure 1).

Validate (90 responses)

Many women asked that health practitioners provide validation in the form of believing their experiences, by saying what happened to them is unacceptable and reassuring the victim-survivor it was not their fault. Phrases were suggested to counteract the negative messages they might be receiving from their abusive partner. The most common phrases participants said they wanted to hear were 'I believe you' and 'It's not your fault' (Figure 1).

Enhance safety (20 responses)

Participants said they wanted health practitioners to discuss plans for both physical and emotional safety. Some participants suggested health practitioners ask if women feel safe at home and if they need help to leave and provide options for safe places to go (Figure 1). Participants also wanted health practitioners to discuss ways women could protect themselves from emotional harm associated with coercive control.

Support (107 responses)

Participants said they wanted information about professional services and peer support groups, accompanied by additional assurances of confidentiality and safety. They also wanted reassurance that the practitioner would be available for ongoing support (Figure 1). One participant said they wanted referral to a service '... that my partner wouldn't try and stop me from seeking help from'.

Choice and control-Action and advocacy-Recognition and understanding-Emotional connection (CARE)

Choice and control (34 responses)

Participants responded that they wanted the decision making about their relationship and next steps to rest with survivors (Figure 1). Participants stated they wanted healthcare practitioners to give them a range of options, and to work in partnership with them to develop a plan that they were comfortable with.

Action and advocacy (59 responses)

Participants provided phrases that healthcare practitioners could use to show their role was to 'do more than just listen' (Figure 1). Participants wanted practical suggestions and supports such as housing and financial assistance and for practitioners to be

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LIVES

LISTEN

- 'I am here to listen and help'
- 'Tell me how that looks and feels for you'
- 'Take some deep breaths and start at the beginning'
- 'You're in a safe space now and you are free to talk about anything you need to'
- 'Tell me what you are comfortable sharing'

INQUIRE

- 'What can we do to support you?'
- 'What do you need?'
- 'How can I help?'

VALIDATE

- 'I believe you' and 'It's not your fault'
- 'You must feel really frightened'
- 'I understand and trust what you said'
- 'Your concerns and experiences are valid, you have the right to be respected and feel safe'
- 'Don't feel bad. You are a good person and don't have to put up with that behaviour'
- 'I'm sorry that happened to you. You didn't deserve it'

ENHANCE SAFETY

- 'Do you feel safe where you are? Do you need help to leave?'
- 'Is home a place you do or do not consider you are safe?'
- 'We'll get help now to remove you and your family to safety'
- 'You don't have to go home I know a place you'll be safe'
- 'We can actually do something to help and protect you'
- 'Can we look at ways to address not only your emotional harm from that behaviour but also put in a safety plan to protect you from the behaviour'

SUPPORT

- 'I am here for you. How can I help?'
- 'I know of some services that may help'
- 'I can offer helpful information and advice for you'
- 'Would you like to meet with some other women who feel the same way in a safe group setting?'
- 'Your partner will not find out. Let's call some resources together confidentially'

CARE

CHOICE AND CONTROL

- 'Lets work together to figure out how we can make things better for you'
- 'There is help out there [and] these are the options... what are you most comfortable with?'
- 'What baby steps could you take to domino towards that Utopia? What are some options for dealing with obstacles?'
- 'There are different approaches to address this'
- 'I am worried for you. I have these services I can recommend to help you, would you be willing to take a look?'
- 'Let us know your thoughts [and] we will back you up'

ACTION AND ADVOCACY

- 'I will contact a psychologist or therapist to help you with what you are going through because emotional abuse is draining yourself within'
- 'I am going to do all I can to get you help'
- 'There is support available and I will help guide you through the process of accessing these services'
- 'If you ever need me to help you make a call just let me know'
- 'We can help with practical solutions. There is effective help available'
- 'I will be bulk billing your appointments with me so please come when you need. Shall we make weekly appointments?'

RECOGNITION AND UNDERSTANDING

- 'Healthy partners do not try to control the other person. Your autonomy is a basic right of all people. You do not deserve to be put down by a partner [and] they have no right to do that to you'
- 'You are not mental or need to be committed to a mental hospital...you're normal [and] in a very hard situation'
- 'Just because you're in a relationship with someone doesn't mean you owe them anything and it doesn't make it okay for them to treat you the way they do'
- 'There is no shame and you are not lesser because of all of this. You are not at fault at all'
- 'These comments are not acceptable. I can understand how hurt you must feel by this'

EMOTIONAL CONNECTION

- 'You are not alone'
- 'That's great you have opened up to me. I won't forget. I will be beside you if you want to take anything further'
- 'How are you? How is the family? I'm here if you need'
- 'I am here for you and we can help'

Figure 1. Health messaging based on victim-survivor voices.

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proactive in helping organise these supports. One participant said 'I want them to give me practical advice or easy ways to access things. Life is so hard that you need support and people who can help you because sometimes you don't think you are worthy of help and need others to make the first step'. Suggestions included making phone calls on behalf of patients instead of just providing contact details of services, making follow-up appointments and offering to bulk bill.

Recognition and understanding (53 responses)

Participants wanted health practitioners to understand and respond appropriately to the different forms of abuse experienced, including non-physical violence. Many women provided phrases that health practitioners could use to demonstrate they understood the impacts of non-physical abuse tactics, including control, shaming and verbal abuse (Figure 1).

Emotional connection (78 responses)

Participants stated they wanted health practitioners to provide 'any kind words' and reassure them they were not alone in order to build trust. One participant said she wanted 'Just words that assure me that the practitioner is on my side'. Importantly, respondents perceived that a health practitioner who asked about the 'entire family' was demonstrating particular empathy and care. 'You are not alone' was the most common phrase suggested (Figure 1).

Strength and hope (22 responses)

A new category generated from the data was 'strength and hope'. Participants reported they would appreciate simple words of reassurance from health practitioners that they had shown great strength and resilience to survive IPV and that there was a reason to be optimistic about the future. Words of strength were perceived necessary to counteract the messages women were receiving from their partners that they were useless and worthless. Phrases communicating the strength of victim-survivors suggested by women included:

> *To have survived all of that you are a survivor and you are stronger than him.*

> *You are good enough. You are enough.*

> *You've been so strong fighting through that time. You're the strongest person I see in this world.*

Further, participants wanted words of hope that things will get better to counteract the message that they would be trapped in their abusive relationship forever. Participants wanted to know 'That I wasn't in a permanent situation' and 'that there was a way out'.

Discussion

This study explored preferences for health practitioner supportive messaging with a large sample of Australian women who experienced coercive control in the context of IPV. The study found that most participants' preferences for support aligned with LIVES [13] and CARE,[12] confirming these as appropriate models for providing validating and practical support for women experiencing coercive control.[9,12] Aligned with LIVES, participants told us they wanted health practitioners to listen with empathy and without judgement; to inquire about needs and concerns; to validate and believe victim-survivors' experiences and tell them it is not their fault; to discuss ways to enhance their safety; and to offer options for support. Importantly, women told us they wanted health practitioners to reassure them that the health setting was a confidential and safe place to discuss IPV. Participants told us they wanted this first-line response provided in the context of the CARE framework: they wanted choice and control, they wanted health practitioners to do more than just listen, to show that they recognise and understand women's experiences and to show empathy and connection. Consistent with studies focused on recovery after IPV, participants said they wanted health practitioners to provide supportive messages of strength and hope.

In addition to use of the above strategies, this study highlights the need for specific scripts and health messaging to counteract the controlling behaviours and tactics women have experienced from their abusive partners. Healthcare practitioners find scripts helpful in gaining confidence and allowing them to use different phrases depending on the individual woman.[14,16] The findings provide health practitioners with scripts (specific words and phrases) as a guide when responding to disclosures of DFV and coercive control. Of particular importance for victim-survivors of coercive control is to be told they are believed and that what they have experienced is not their fault. Coercively controlling partners manipulate victim-survivors into thinking abusive behaviours are their fault and frequently tell them they are 'crazy' and 'unstable'.[17–19] More than any other response, victim-survivors in this study told us they wanted validating messages from their health practitioner that allow them to feel recognised and understood.[17]

Additionally, women said they want messages of strength and hope from their health practitioner, to counter their partner making them feel like they are hopeless and worthless, and that there is no way out of their situation. Qualitative studies have found that women in coercively controlling relationships are frequently subject to humiliation and feel like they are psychologically entangled or entrapped.[18,20] Several studies have found that feelings of strength and hope fosters victim-survivors' self-efficacy, improves psychological wellbeing and is central to recovery.[21–24] Our study reinforces the importance of practitioners validating victim-survivors' strengths and giving them hope for the future.

Together, these findings highlight the importance of health practitioners counteracting the forms of abusive tactics and words used by partners, with phrases tailored to the circumstances of individual women. However, we also recognise that for health practitioners to respond appropriately, there is a need to improve education to increase the comfort and confidence to have these types of conversations with victim-survivors.[25] Only 5% of our participants said they would not speak to their health practitioner about their experiences. This confirms findings from other studies that women want to have conversations about DFV when a trusted, empathetic connection has been established.[12,26] There is also a need to build system capabilities so that multidisciplinary collaboration and referrals to specialist services, where indicated, become standard practice.[27,28]

A key strength of this study is the identified specific, supportive health messaging

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for health practitioners to use, based on victim-survivor voices. Scripts and tools for identifying and responding to victim-survivors of IPV have historically been developed by researchers and clinicians and, if worded poorly, risk disempowering and retraumatising those they are intended to help.[14] Smaller qualitative studies have provided in-depth insights into women's experiences of IPV and victim-survivors' preferences for health practitioner support.[29–31] However, this study is the first large Australian study with a diverse sample to have asked women who have experienced coercive control for their health messaging preferences. Although the open-ended survey question approach presents limitations in the richness of data collected, the large volume of responses partially negates this limitation. Women without internet access are not represented in this study and we do not know if their preferences are different to those with internet access because of isolation and limited access to other types of information such as that available online. We also note the underrepresentation of women from a non-English-speaking background as a limitation of the study. Non-English-speaking women might have different preferences for disclosure, and might have different health messaging preferences because of societal and cultural influences. Future research could further develop and pilot test these findings with health practitioners in different health settings. Future research could also explore the differences in the experiences of same-sex or gender-diverse partners.

Conclusion

GPs have an important role in providing a first-line response to coercive control. GPs could use the words suggested by victim-survivors from this study in the context of the LIVES and CARE frameworks. The health messaging suggested point to a broader need for capacity building in the health sector to provide initial and ongoing support to victim-survivors. This needs to be in the context of system interventions, which have been shown to provide health practitioners with the skills, capabilities, confidence and resources they need to provide an effective response.[7,32]

Key points

- GPs are the main professional group women disclose intimate partner violence to, yet GPs often lack the confidence to respond appropriately.
- Victim-survivors want health practitioners to provide a supportive, validating and empathic response, using words and phrases aligned to two global frameworks: LIVES and CARE.
- GPs have an important role in recognising and responding to the different forms of abuse women experience, including coercive control.
- GPs could use validating messaging tailored to the individual circumstances of their patients to counteract the negative messaging used by an abusive partner to coercively control.
- General practice training and system support is needed to build the skills, capabilities, confidence and resources needed to provide an effective response.

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