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**Understanding the Mental Health Impacts and Support Needs Following Coercive  
Control**

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Melbourne

### **Abstract**

Coercive control is a complex, insidious and under-researched dimension of psychological intimate partner violence (IPV) that has been associated with trauma and mental health impacts. This thesis had two overarching aims: (1) to improve the understanding of the trauma and mental health impacts of coercive control, and (2) to explore the mental health support needs and wants of women following coercive control exposure to aid their long-term recovery. To achieve these aims this thesis employed a mixed methods approach and included three separate yet interlinked studies: a systematic review and meta-analysis, and two qualitative reports. The review aimed to examine quantitative associations involving coercive control with posttraumatic stress disorder (PTSD), depression and complex PTSD (CPTSD) and included 68 observational studies. Data from 45 studies were included in the meta-analyses. Meta-analyses showed that coercive control exposure was moderately associated with both PTSD and depression. The associations were comparable to those between broader dimensions of psychological IPV and PTSD and depression that were also investigated in the review, and with associations involving physical IPV with PTSD and with depression examined in previous meta-analyses. Only one study reported on the relationship between coercive control and CPTSD and meta-analyses could not be performed.

Studies 2 and 3 addressed gaps that were identified in the systematic review and meta-analysis. To enhance the understanding of the trauma and mental health impacts of coercive control and the support needs of victim-survivors, a qualitative approach was employed for studies 2 and 3, and 16 women who had experienced coercive control were interviewed. Study 2 reported on these women's lived experience of the mental health impacts of coercive control. Study 3 explored what types of psychological supports women need and want to aid their long-term recovery. Building on the findings of study 1, studies 2 and 3 made six key contributions to the coercive control literature: (1) Clarification of the coercive control

construct by identifying entrapment (including social entrapment) and insidiousness (characterised by subtlety, intangibility, gradual worsening), as the underlying dimensions of coercive control that likely differentiate coercive control from other dimensions of IPV, and may be associated with unique mental health reactions; (2) evidence that coercive control exposure should be recognised as a traumatic event; (3) qualitative evidence for the association between coercive control and CPTSD symptoms; (4) proposition that the ongoing threat and terror, insidiousness and entrapment of coercive control contribute to the unique and complex trauma and mental health reactions that may be reflected in CPTSD symptoms; (5) the need for a holistic recovery focus that integrates clinical and personal recovery; and (6) the need for integrated trauma-and-coercive control-informed psychosocial interventions. Taken together, this thesis has made several significant contributions to the coercive control literature that have important implications for policy, clinical practice and research.

### Declaration

This is to certify that

- i) this thesis comprises only my original work towards the degree of Doctor of Philosophy, except where indicated in the preface
- ii) due acknowledgement has been made in the text to all other material used
- iii) the thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

22/01/2024

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Susanne Lohmann

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Date

I, Susanne Lohmann, declare that the research reported in this thesis was conducted in accordance with the principles for the ethical treatment of human participants, as approved for this research by the University of Melbourne Human Ethics Committee.

## **Preface**

The current thesis is presented with publications and includes three studies. The data used in the studies were from the literature (study 1), and by the PhD candidate (studies 2 and 3). All hypotheses, conceptualisation, data collection, processing and data analyses, and preparation of all chapters and manuscripts were completed by the PhD candidate. Supervisors and co-authors on publications assisted with study design and revisions on manuscripts. Study 1 has been published, the revised manuscript for study 2 is presently under review, and study 3 is in preparation for submission for publication.

Because of the Covid-19 pandemic, the PhD project outline had to be altered. Originally, study 3 was intended to be a quantitative survey-based study. However, because of Covid 19-related restrictions it was not possible to recruit enough participants (i.e., to have sufficient statistical power) through family violence services or to guarantee the safety of participants in accordance with the ethics approval for the study. Therefore, the PhD project outline was changed to include a second qualitative report (study 3).

## Publications, Presentations and Awards

### Publications

This thesis comprises three studies, including one published paper, one paper that is under peer review, and one paper that is in preparation for publication.

Study	Status	Reference
Study 1	Published in April 2023	Lohmann, S., Cowlshaw, S., Ney, L., O'Donnell, M., & Felmingham, K. (2023). The trauma and mental health impacts of coercive control: A systematic review and meta-analysis. <i>Trauma, Violence, &amp; Abuse</i> , 25(1), 630-647. <a href="https://doi.org/10.1177/15248380231162972">https://doi.org/10.1177/15248380231162972</a>
Study 2	Revised manuscript under peer review	Lohmann, S., Felmingham, K. O'Donnell, M., & Cowlshaw, S. (2024) "It's like you're a living hostage, and it never ends.": A Qualitative Examination of the Trauma and Mental Health Impacts of Coercive Control. [Manuscript submitted for publication]. <i>Psychology of Women Quarterly</i>
Study 3	In preparation	Lohmann, S., Felmingham, K. O'Donnell, M., & Cowlshaw, S. (2024) "If I hadn't had the help, I'm not sure I would have survived.": <i>What Psychological Supports Do Women Want after Coercive Control? A Qualitative Study</i> . [Unpublished Manuscript]. Melbourne School of Psychological Sciences. The University of Melbourne

### Conference Abstracts (based on work described in the thesis)

Symposium Speaker at the Australian Association for Cognitive and Behaviour Therapy (AACBT) National Conference in October 2022:

Lohmann, S., Cowlshaw, S., Ney, L., O'Donnell, M., & Felmingham, K. *The trauma and mental health impacts of coercive control: A systematic review and meta-analysis*.

**Other Presentations** (based on work described in this thesis)

Invited talk at the Mental Health Professionals' Network (MHPN) in Byron Bay on 21 February 2022: *The mental health implications of coercive control*

**Media** (based on work described in this thesis)

Article published in Mamamia online magazine on 2 June 2023: *Coercive control is as dangerous as physical violence. Hannah Clarke's parents know all too well.*

<https://www.mamamia.com.au/coercive-control-impact/>

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To my PhD advisory committee chair,

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Thank you for your courage to participate in the interviews, this PhD thesis would have not been possible without you.

To my friends,

I am immensely grateful to my all friends who have supported me throughout this journey. I would like to particularly acknowledge Susie for being my PhD buddy, it has been so incredibly helpful to travel alongside each other on this journey and to navigate the challenges and to celebrate the successes together. And Arna, thank you for being such a fabulous, supportive and fun friend, our friendship, yoga sessions and chats have kept me motivated throughout this PhD journey.

To my mother,

I am dedicating this thesis to my mother, who was a victim-survivor of coercive control. I don't have the words to express how grateful I am for everything you have done for me, and it fills me with sadness that you are not around anymore to see that I have completed a PhD.

To Paul,

Without you, I would have probably never embarked on this PhD journey. I am deeply grateful for your love, acceptance and support, including all the dinners and so many other extra things that you have done for me over the last few years, because I was so busy with the PhD. Having your support has kept me motivated and has helped me to stay focused on this project. I am looking forward to having more time and new adventures with you.

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### Abbreviations

Abbreviation	Meaning
CBT	Cognitive Behavioural Therapy
CC	Coercive Control
CBS-R	Controlling Behaviours Scale-Revised
CESD	Center for Epidemiology Depression Scale
CPTSD	Complex Posttraumatic Stress Disorder
CTS	Conflict Tactics Scale
CTS2	Revised Conflict Tactics Scale
CTT-BW	Cognitive Trauma Therapy for Battered Women with PTSD
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
DSO	Disturbances in Self-organisation
EMDR	Eye Movement Desensitisation and Reprocessing
HOPE	Helping to Overcome PTSD through Empowerment
ICD-11	International Statistical Classification of Diseases and Related Health Problems 11 <sup>th</sup> Edition
IPV	Intimate Partner Violence
MMEA	Multidimensional Measure of Emotional Abuse
PCL-C	PTSD Checklist-Civilian
PMWI	Psychological Maltreatment of Women Inventory
PTSD	Posttraumatic Stress Disorder
RCT	Randomised Controlled Trial
WHO	World Health Organisation

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*Note:* This list is not exhaustive and only contains common or important abbreviations included in the thesis.

## Chapter 1: General Introduction

### 1.1. Intimate Partner Violence Overview

*Intimate partner violence (IPV)* is a highly prevalent global human rights and public health concern that affects one in four women and one in eight men worldwide including Australia (Australian Bureau of Statistics, 2021-2022; World Health Organisation [WHO], 2013, 2017). The actual prevalence of IPV may even be higher because of underreporting of IPV due to victim-survivors' fear of repercussions, shame and stigma (Ellsberg et al., 2001; Satyen et al., 2020). IPV is associated with many long-term mental health consequences including posttraumatic stress disorder (PTSD), depression, anxiety, substance use disorders and suicidality (Beck et al., 2016; WHO, 2013). In Australia, IPV contributes to 5.1% percent of the disease burden in women aged 18-44 years and 2.2% across women of all ages (Ayre et al., 2016; Webster, 2016) and has cost the Australian economy \$22 billion in 2015-16 (Department of Social Services, 2016). During the Covid-19 pandemic IPV further increased at an alarming rate in Australia and across the world (Boxall et al., 2020; McNeil et al., 2023). For instance, a survey of 15,000 Australian women showed that for two-thirds of women who were cohabitating with a current or former partner, the pandemic coincided with the onset or escalation of IPV (Boxall et al., 2020).

IPV is often interchangeably referred to as *domestic violence* or *family violence*, but domestic and family violence are broader terms that also comprise violence occurring between other family or household members (e.g., between children and parents or siblings), whereas IPV specifically refers to violence between intimate partners (Goodman et al., 2018, Lagdon et al., 2014; Van Parys et al., 2014). As this thesis focuses on the experiences and mental health impacts on victim-survivors, who have been abused by their intimate partner or a former intimate partner, the term IPV will be used throughout this thesis. Guided by the Australian Government's recommendations for preferred family violence terminology the

term victim-survivor is used in this thesis to describe persons who have experienced domestic or family violence including coercive control by an intimate partner or former intimate partner. It is used interchangeably with persons/individuals who have experienced IPV or a specific dimension of IPV, such as coercive control (Victorian Government, 2022).

IPV includes physical, sexual, psychological abuse and *coercive control*, a chronic, patterned and entrapping victimisation process (Anderson, 2008; Heise et al., 2019; Pitman, 2016; Stark, 2007; Stark & Hester, 2019). Coercive control is characterised by a chronic and strategic pattern of behaviours and tactics from a perpetrator that puts the victim in a state of terror and entrapment, and may involve tactics such as monitoring movements, enforced social isolation, and restriction of access to financial resources, employment, education, or medical care (Pitman, 2016; Stark, 2007; Stark & Hester, 2019; WHO, 2013). These coercive and controlling tactics may also include the use of actual or threatened physical violence to maintain a sense of threat and fear (Stark, 2020). The conceptualisation of coercive control originates from sociological research perspectives, and Stark's (2007) original definition of coercive control emphasised that coercive control is men's intentional instrumentalisation of gender inequality against women in the context of heterosexual relations. Conversely, other researchers have presented coercive control as purely behavioural and engaged in by men and women at equal rates (e.g. Dutton et al., 2005; Strauss 1990, 2007; Strauss & Gelles, 1986). Johnson (1995, 2005, 2006, 2008) conceptualised the difference between coercive control and other types of psychological IPV as categorical constructs, by distinguishing between the controlling motives of coercive control (i.e. intimate terrorism) and non-controlling motives (i.e., situational couple violence). This thesis acknowledges Stark's (2007) sociological perspective that gender inequalities lie at the core of coercive control and that disproportionately more women are exposed to coercive control compared to men. For the

purpose of this thesis coercive control is distinguished from other forms of psychological IPV in line with Johnson's (1995, 2005, 2006, 2008) distinction between the motivation between intimate terrorism and situational couple violence. This thesis also looks at behaviours and tactics of coercive control and thus integrates the three aforementioned conceptualisations in the coercive control literature to examine the trauma and mental health impacts of coercive control.

Coercive control and its mental health impacts are at the centre of this thesis.

However, before looking specifically at the mental health impacts of coercive control, it is important, for context, to provide a general overview of the mental health impacts of IPV.

## **1.2. Trauma and Mental Health Impacts of IPV**

There is clear evidence for the trauma and mental health impacts of IPV (e.g., Beydoun et al. 2012; Birkley et al., 2016; Golding, 1999; Spencer et al., 2019; Trevillion et al., 2012). PTSD has been identified as the most prevalent mental health consequence of IPV for women with an estimated lifetime prevalence ranging between 31-84% compared to 12.8% in women in the general population who have not been exposed to IPV (e.g., Golding, 1999; Jordan et al., 2010; Kilpatrick et al., 2013; Spencer et al., 2019). IPV victim-survivors frequently report PTSD symptoms consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), such as recurrent distressing memories, dreams and flashbacks to violent episodes, hypervigilance, exaggerated startle response, as well as alterations in cognitions, persistent and exaggerated negative beliefs and emotional states, and avoidance behaviours (Forbes et al., 2014; Lutwak, 2018).

Previous research has also found strong associations between IPV and other mental health disorders, such as depression and anxiety (e.g., Ahmadabadi et al., 2020; Campbell et al., 2008; Duckworth & Follette, 2012; Dutton, 2009; Kuijpers et al., 2011; Signorelli et al., 2020; Spencer et al., 2019; Trevillion et al., 2012; Walker, 2016). For example, a systematic

review and meta-analysis that included 16 longitudinal studies showed significant associations between IPV, depression and suicidality (Devries et al., 2013). A more recent meta-analysis that included 207 studies found moderate associations involving IPV with PTSD ( $r = .34$ ), depression ( $r = .25$ ) and a small association with anxiety ( $r = .19$ ) (Spencer et al., 2019). However, historically most systematic reviews and meta-analyses have either only looked at the mental health implications of physical IPV exposure (e.g., Golding, 1999; Spencer et al., 2019; Stith et al., 2004), or have not distinguished between physical, sexual and psychological dimensions of IPV (e.g., Beydoun et al., 2012; Devries et al., 2013; Trevillion et al., 2012). Nevertheless, new research suggests that psychological IPV may be an equally or even stronger predictor of trauma and mental health reactions, but more research is needed to understand the mental health impacts of psychological dimensions of IPV (Dokkedhal et al., 2022; Potter et al., 2020; Salter et al., 2020).

### **1.3. Psychological IPV, Trauma and Mental Health Impacts**

Psychological IPV, which is also referred to as emotional or psychological abuse, can range from mild situational verbal aggression, insults or belittling to an insidious and prolonged pattern of coercive control (Australian Bureau of Statistics, 2014; Anderson, 2008; Heise et al., 2019; Pitman, 2016; Stark, 2007; Stark & Hester, 2019; WHO, 2012).

Psychological IPV has been estimated to be the most prevalent form of IPV in the United States and Europe (Black et al., 2011; European Union Agency for Fundamental Rights, 2014), and is equally prevalent in Australia (Australian Bureau of Statistics, 2014, 2021-2022). For instance, a large European multi-country survey that included 28 countries, found that 43% of women have experienced some form of psychological IPV, compared to 33% of women who have experienced physical and/or sexual IPV (European Union Agency for Fundamental Rights, 2014).

Despite its pervasiveness, psychological IPV has been relatively under researched. This may be partly because exposure to psychological IPV does not directly align with the DSM-5 diagnostic criterion A for PTSD (i.e., “exposure to actual or threatened death, serious injury, or sexual violence”) (American Psychiatric Association, 2013, 2022), and may have consequently received less validation as a traumatic experience compared to physical and sexual IPV that more closely align with this criterion (Dokkedahl et al., 2022; Hyland et al., 2021). And, partly because psychological IPV has been more difficult to define and measure compared to physical or sexual dimensions of IPV (García-Moreno et al., 2005; Heise et al., 2019; O’Leary, 1999; Winstok & Sowan-Basheer, 2015). For example, given that psychological IPV is dimensional and can occur on a spectrum of severity and intensity, ranging from mild verbal aggression to prolonged coercive control, and that the perception of the severity may differ across contexts and cultures, it is difficult to determine the threshold and impact of psychological abuse (Follingstad, 2009; Heise et al., 2019). This difficulty to ascertain and measure at what level of severity psychological IPV may be associated with trauma and mental health consequences may have also contributed to the historical underrecognition of the trauma and mental health impacts of psychological IPV exposure (Dokkedahl et al., 2022; Follingstad, 2009, 2011; Follingstad et al., 2005; Heise et al., 2019; Potter et al., 2020; Winstok & Sowan-Basheer, 2015). Consequently, most research to date has focused on the mental health consequences of physical and sexual IPV and more research into the mental health impacts of psychological IPV is needed (e.g., Coker et al., 2000; Dokkedahl et al., 2021, 2022; Dutton, 2009; Pico-Alfonso et al., 2006; Potter et al., 2020).

Nevertheless, several scales and sub-scales measuring psychological IPV have been developed over the years. For instance, the *Psychological Maltreatment of Women Inventory* (PMWI; Tolman, 1989, 1999), the *Composite Abuse Scale* (CAS; Hegarty et al., 1999, 2005), or the *Multidimensional Measure of Emotional Abuse* (MMEA; Murphy & Hoover, 1999;

Murphy et al.,1999), but it remains difficult to capture the relationship between the level of severity of psychological IPV and trauma and mental health impacts (Heise et al., 2019). A relatively recent study aimed to address this issue and developed a three-class coding system of psychological abuse (i.e., none, moderate-intensity abuse, high-intensity abuse) and found a dose-response relationship between the intensity of psychological abuse and severity of mental health impacts across several countries (Heise et al., 2019). This suggests that more severe and chronic dimensions of psychological IPV, such as coercive control, likely have more detrimental mental health impacts (Dokkedahl et al., 2022; Potter et al., 2020).

Concurrently, with the development and improvements in the measures of psychological IPV, a growing body of empirical evidence has emerged that suggests that the mental health impacts of psychological IPV are comparable to those of physical dimensions of IPV (Coker et al., 2000; Dokkedahl et al., 2021, 2022; Dutton et al., 1999; Lagdon et al., 2014; Lawrence et al., 2009; Mechanic et al., 2008; Rogers & Follingstad, 2014, Potter et al., 2020; Sacket & Saunders, 1999). For instance, an early study by Dutton et al. (1999) compared the trauma responses to physical, sexual and psychological violence of 149 female IPV victim-survivors who were seeking court-mandated protection from their violent partners and found that psychological IPV was the strongest predictor of PTSD. More specifically, univariate analysis suggested that all three forms of IPV were predictive of PTSD symptomology, but multivariate analysis indicated that psychological violence explained most of the variance (Dutton et al., 1999). Equally, Coker et al. (2000) surveyed 1152 women and found that women who reported psychological IPV were significantly more likely to experience adverse physical and mental health outcomes compared to women who had not experienced any form of IPV and equally as likely as women who had experienced physical IPV. A more recent systematic review of 11 electronic databases that included 51 studies and assessed whether the type of IPV was an important factor in mental health outcomes provided

systematic evidence that the mental health impacts of psychological IPV are comparable to those of physical IPV (Lagdon et al., 2014). The noteworthy mental health impacts were also highlighted in a recent large meta-analysis that included 149 studies, which found that psychological IPV had strong associations with PTSD, depression, and anxiety (Dokkedahl et al., 2022). Together, these studies highlight that exposure to psychological IPV can have equally as detrimental mental health impacts as exposure to physical IPV, and that the trauma and mental health impacts of psychological IPV need to be recognised ( Dokkedahl et al., 2022; Lagdon et al., 2014).

Furthermore, psychological IPV can occur on its own or in combination with physical and/or sexual abuse. Potter et al. (2020) compared the mental health outcomes of five different categories of IPV: physical IPV alone, psychological IPV alone, sexual IPV alone, combined psychological and physical IPV, combined sexual and psychological and/or physical IPV, Potter et al.'s secondary data analysis used data from the WHO's *Multi-Country Study on Women's Health and Domestic Violence* (García-Moreno et al., 2005) that included a large sample of 21,221 ever-partnered women (i.e., women who ever had an intimate male partner) from 11 different countries. Potter et al. (2020) used multilevel mixed effects and logistic regression modelling to analyse the associations between the five categories and measured their physical and mental health impact with the *Self-reporting Questionnaire* ([SRQ-20], Beusenbergh et al., 1994), and questions about medication usage and suicidality. The analyses showed that all of the five categories of IPV were associated with negative physical and mental health outcomes that persisted even after the abuse had ended. The combined category involving sexual and psychological and/or physical IPV was the most prevalent form of IPV that was also associated with the worst physical and mental health outcomes including a 10 times higher likelihood of suicide attempts compared to women who had not been exposed to IPV (Potter et al., 2020).

Notably, Potter et al. (2020) also found that psychological abuse was at least as detrimental to a victim-survivor's mental health than physical abuse. This study provided further evidence that psychological IPV, alone or in combination with physical and/or sexual IPV, can have detrimental mental health outcomes, but it only included one validated and broad measure of psychological distress, the SRQ-20 (Beusenbergh et al., 1994), which does not include any validated trauma measures. That is, the SRQ-20 is a general distress measure developed by the WHO and may indicate symptoms of depression, anxiety and somatoform disorders, but it does not screen for PTSD symptoms or provide any diagnostic information (Stratton et al., 2014). Identifying the associations between specific dimensions of IPV and their particular mental health outcomes is relevant because mental health reactions and treatment needs may differ depending on the type and severity of IPV exposure (Hameed et al., 2020; Warshaw et al., 2013). For instance, Dokkedahl et al.'s (2022) recent meta-analysis divided psychological IPV into three subtypes (i.e., emotional/verbal and dominance/isolation, coercive control) and found that all of these subtypes of psychological IPV had strong associations with PTSD, but coercive control was particularly strongly associated with PTSD, especially in women (Dokkedahl et al., 2022).

Whilst the mental health impacts of psychological IPV have received increasing attention, there has been very limited research into the mental health impacts of coercive control (Dokkedahl et al., 2022). Considering the particularly strong associations between coercive control and PTSD found in Dokkedahl et al.'s (2022) meta-analysis, and the limited understanding of the trauma and mental health impacts of coercive control to-date, there is a pressing need for further research into the mental health impacts of coercive control to inform prevention, treatment and recovery (Commonwealth of Australia, 2023; Department of Social Services, 2022).

#### 1.4. Coercive Control

Coercive control, which is conceptualised as distinct from situationally motivated psychological abuse because of its motivation, which is embedded in a general pattern of power and control (Johnson, 1995, 2005, 2006, 2008) is the most insidious and highly prevalent dimension of psychological IPV, occurring in up to 58% of IPV relationships (Kennedy et al., 2018; Stark, 2007; Stark & Hester, 2019). Despite its high prevalence, the extent to which coercive control plays a central role in IPV has often been overlooked because past research has predominantly focused on physical and sexual IPV, because of the methodological complexities and the under-recognition of the traumatic effects of psychological IPV that were discussed earlier. Yet, many women experience coercive control as the most insidious and devastating form of abuse and suffer at least equally as much from mental health consequences as women who have been physically or sexually abused (Anderson, 2008; Crossman et al., 2016; Dokkedahl et al. 2021; Kirkwood, 1993; Podana, 2021; Stark, 2007). Notably, survey data from 28 European Union member countries suggests that victim-survivors who have been exposed to coercive control experience more severe and harmful consequences than those who have experienced IPV without coercive control (Nevala, 2017). Given these severe and harmful consequences, it is crucial to understand what factors may differentiate coercive control from other dimensions of IPV and what factors may contribute to these negative outcomes.

Coercive control is a chronic, patterned and entrapping victimisation process that may or may not include physical or sexual violence. More specifically, coercive control is characterised by a “pattern of violence, intimidation, isolation, and control where the main goal is to degrade, isolate, and deprive women of their rights to physical security, dignity, and respect” (Stark, 2007, p.5). The coercive control construct is complex, and it can be difficult to measure the patterned and entrapping nature of coercive control compared to measuring

the occurrence of specific behaviours (e.g. threatening or controlling behaviours), or to delineate coercive control from the broader dimension of psychological abuse (Hamberger et al., 2017). Moreover, coercive control may or may not include physical or sexual violence, which further adds to its complexity (Stark, 2007). These complexities have contributed to inconsistencies in the conceptualisation and definition of coercive control (Dokkedahl et al., 2022; Dutton & Goodman, 2005; Hamberger et al., 2017; Myhill, 2015). A better understanding of the complex pattern of coercive control may help to enhance the understanding of the coercive control constructs and its trauma and mental health impacts (Brennan et al., 2019; Pitman, 2016).

Historically, Biderman (1957) was the first to systematically research methods of coercive control by examining the tactics that were used by captors to elicit compliance and exert control over American prisoners of war during the Korean war. Based on these findings Biderman developed a theory of coercion and identified eight common methods of coercion that were summarised as *Biderman's Chart of Coercion* in the 1975 Amnesty International Report on Torture. Whilst Biderman's chart of coercion was originally designed to demonstrate and explain the coercive methods of stress manipulation used to torture prisoners of war it is also applicable to the coercive tactics applied by IPV perpetrators (e.g., Amnesty International, 1975; Lehmann et al., 2012; Stark, 2007). For instance, although Biderman (1957) did not look at gender inequalities, the tactics have been recognised by gender-based domestic violence activists (e.g., Robinson & Myhill, 2021), and Stark's (2007) widely cited definition of coercive control reflects the tactics outlined in Biderman's chart of coercion. Biderman's eight coercive tactics include: (1) *isolation*, which deprives the victim of social support and their ability to resist, it develops an intense concern with self and makes the victim dependent; (2) *monopolisation of perception*, which fixes attention upon the immediate predicament, eliminates information not in compliance with demands and

punishes independence and/or resistance; (3) *humiliation and degradation*, which makes resistance more ‘costly’ than compliance, ‘animal level’ concerns that may be induced by demeaning punishments, insults and criticisms or privacy infringement; (4) *induced debility and exhaustion*, which weakens the victim’s mental and physical ability to resist; (5) *threats*, which create anxiety and despair; (6) *occasional indulgences*; which elicit positive motivation for compliance; (7) *demonstrating omnipotence*, which suggest complete control over the victim and futility of resistance; and (8) *enforcing trivial demands*, which develops a habit of compliance.

In an IPV context, more specifically, Biderman’s eight categories may present as (1) isolation of the victim-survivor from family, friends and support services; (2) monopolisation of perception may be experienced by the victim survivor as hypervigilance and a focus on the abusive partner’s mood and triggers, ‘walking on eggshells’ and a concern with day to day survival to protect herself and her children; (3) humiliation and degradation may include insults, public humiliation and enforcement of rules (e.g. dress rules) and activities which humiliate, degrade or dehumanise the victim-survivor; (4) induced debility and exhaustion may be enforced by never allowing the victim-survivor to rest even during the night or when they are ill; (5) threats to hurt or kill the woman or her children which keeps her in a constant state of terror; (6) occasional indulgences of being nice build up hope and make the woman want to stay in the relationship; (7) the abuser may demonstrate “omnipotence” by demonstrating absolute power which may include economic abuse that involves controlling the victim’s finances, such as only allowing a person a small allowance or controlling expenses, and other behaviours which threaten economic security and independence (Adams, et al., 2008, 2020; Postmus et al., 2016), or forcing the victim-survivor to take part in criminal activities, neglect or abuse of children to encourage self-blame, shame and prevent

disclosure to the authorities (8) enforcing trivial demands by implementing rigid and unrealistic rules that frequently change and often contradict (Stark, 2007, 2013).

Biderman's theory is supported by empirical evidence (e.g., Boxall & Morgan, 2021; Duron et al., 2021). For instance, a recent survey of 1,023 Australian women who have been exposed to coercive control, identified jealousy, monitoring of movements, financial abuse, social restriction, and threatening behaviours by the perpetrator as recurring themes (Boxall & Morgan, 2021). However, although Biderman's theory of coercion provides insights into the types of coercive and controlling behaviours a perpetrator may use, it does not provide an explanation of the complex and entrapping pattern of coercive control, or how coercive control may be differentiated from other less severe dimensions of psychological IPV (Biderman, 1957; Hamberger et al., 2017; Amnesty International, 1975).

Johnson (1995, 2005, 2006, 2008) conceptualised coercive control as the defining characteristic of *intimate terrorism* and contrasted it with *situational couple violence*: Johnson defined situational couple violence as a form of IPV that is situationally provoked and intimate terrorism as a form of IPV that is embedded in a general pattern of power and control where the perpetrator utilises coercive and controlling behaviours to exercise power and control over their partner. These tactics entrap the victim by creating tremendous threat and terror of further physical, sexual, or psychological violence, by isolating the victim from friends and family, and by diminishing the victim's personal and financial resources (Stark, 2007). Coercive control creates an environment of captivity because victims are trapped in the abusive relationship, and support networks may be geographically, socially or emotionally inaccessible (Herman, 1992a, 1992b; Stark, 2007).

The exposure to the ongoing threat and terror and the prolonged entrapment of coercive control may contribute to the trauma and mental health impacts on victim-survivors Herman (1992a, 1992b). Herman (1992a, 1992b) proposed that any form of captivity,

including psychological entrapment, enforced by physical, economic, social or psychological means, that bring the victim in prolonged contact with the perpetrator, can create a relationship of coercive control. This is likely due to the fear, loss of control, constant threat of danger, and entrapment victim-survivors are experiencing when they are exposed to coercive control (Coker et al., 2000; Foa et al., 2000; Herman, 1992a, 1992b). Previous research suggests that coercive control entraps the victim in the relationship by fuelling confusion, self-doubt and depression, guilt and shame that makes it harder for them to leave the relationship (Beck et al., 2011; McLean & Foa, 2017; Sacket & Saunders, 1999; Street & Arias, 2001).

Given this ongoing threat, terror and entrapment it is not surprising that several primary studies have linked coercive control with PTSD and other mental health reactions (e.g., Anderson, 2008; Cook & Goodman, 2006; Dutton et al., 2005; Jones, 2020; Levine & Fritz, 2016). Nevertheless, these studies differed widely in their purpose, populations, methodologies and measurements of coercive control, which makes it difficult to determine the strength of the associations between coercive control and PTSD. For example, the aim of Cook and Goodman's (2006) study, was to validate the *Brief Coercion and Conflict Scales* they had developed by interviewing 403 incarcerated women in in the U.S. state of Georgia. This study used mostly validated scales for mental health outcomes, but measured coercive control with the *Revised Conflict Tactics Scale* (CTS2; Straus et al., 1996). Notably, neither the original *Conflict Tactics Scale* (CTS; Straus, 1990) nor the *Revised Conflict Tactics Scale* (CTS2; Straus et al., 1996) clearly distinguish dimensions of coercive control from other dimensions of psychological IPV (Myhill, 2015). Similarly, Anderson et al. (2008) aimed to investigate whether there was a difference between outcomes of intimate terrorism and situational couple violence based on a sample of 4,575 married women from a large national survey in the United States (Tjaden & Thoennes, 2000). However, this study also measured

coercive control with a modified version of the *Conflict Tactics Scale* (CTS; Straus, 1990) and none of the outcome variables, including PTSD, were measured with validated scales.

Whilst it is not uncommon for population based studies to use broader measures, examples of other studies also highlight the varied methodologies, populations, aims and measurements. For instance, Dutton et al. (2005) surveyed 757 female and male victim-survivors and perpetrators to validate their *Coercive Control Measure for IPV* with exploratory factor analysis, whilst Jones (2020) used data from a stratified random sample of 337 incarcerated women in the U.S. state of Oklahoma to investigate the effects of coercive control on the lives of incarcerated women using structural equation modelling to measure two latent constructs: coercive demands and coercive threat of harm. Lastly, Levine and Fritz (2016) examined whether coercive control predicts PTSD and depression above and beyond the effects of childhood abuse in homeless women and measured coercive control with the *Revised Controlling Behaviours Scale* (CBS-R; Graham-Kevan & Archer, 2005).

Taken together, these individual studies reported associations between coercive control, PTSD and mental health reactions, but the differences in aims, populations, methods and measurements illustrated the pressing need for systematic research into the associations involving coercive control, PTSD and other mental health outcomes. In particular, given the ongoing threat and terror, and prolonged psychological entrapment experience, coercive control may be associated with complex trauma and complex PTSD (CPTSD; Dokkedhal et al., 2021; Herman, 1992a, 1992b; Hyland et al., 2021; Salter et al., 2020; WHO 2019).

### **1.5. Coercive Control: Complex Trauma and Complex PTSD**

Herman (1992a, 1992b) was the first to propose that the repeated and prolonged trauma experience of coercive control victimisation, including IPV exposure, may be associated with complex trauma. The term complex trauma reflects exposures to repeated or multiple and prolonged interpersonal traumatic events (e.g., childhood sexual abuse) that are

extremely threatening and/or terrifying (Briere & Scott, 2015; Cloitre et al., 2009; Herman, 1992a, 1992b; Salter et al., 2020; WHO, 2019). Herman's seminal work was also the first to formally describe the distinction between PTSD and complex PTSD (CPTSD) by proposing that prolonged interpersonal traumatic stressors, such as exposure to childhood abuse, prisons, labour camps, slavery, and IPV negatively impact a victim's self-organisation (i.e., affective dysregulation, negative self-concept, disturbances in relationships – described in more detail below) separately from PTSD symptoms. According to Herman, CPTSD develops when the victim is in extended captivity and under the control of a perpetrator, which is different to conventional PTSD that develops in response to circumscribed events. Captivity does not only refer to physical imprisonment, but also to the psychological entrapment a victim experiences where the perpetrator has control and power over them (Dokkedahl et al., 2021; Herman, 1992a, 1992b). Herman (1992a, 1992b) identified three broad areas of disturbance that go beyond simple PTSD. First, victim-survivors have more complex, diffuse and persistent symptomology. They tend to have a higher level of distress and tend to have multiple symptoms or disorders in somatic, cognitive, affective, behavioural, and relational domains. For instance, the prolonged and repeated exposure to coercive control can amplify and generalise the physiological symptoms of PTSD and victim-survivors tend to be constantly agitated, anxious and hypervigilant (Baird et al., 2019; Harper, 2019; Herman, 1992a, 1992b). Second, the ongoing threat of harm by the perpetrator contributes to character and identity changes as the victim-survivor becomes increasingly powerlessness and helpless; a sense that continues to persist in their inner world even after escaping captivity. The subjugation to coercive control produces changes to the victim-survivor's identity because their sense of self, perception of others, and their values that provide a sense of coherence and purpose are systematically broken down. Third, victim-survivors of coercive control may be

at increased risk of repeated harm either by harming themselves or by being harmed by others.

Since Herman's initial conceptualisation of complex trauma and CPTSD many studies have explored the dynamics and harmful effects of prolonged and repeated interpersonal trauma, particularly in childhood abuse, but also in war and hostage captivity. Chronic exposure to interpersonal trauma can lead to an enduring negative and disparaging self-concept, and a fearful and threatening perception of others (e.g., Cloitre, 2021; Cloitre et al., 2009, 2013; Karatzias et al., 2017; Zerach et al., 2019). These symptoms have been identified as disturbances in self-organisation (DSO; Cloitre, 2021). The latest edition of the *International Statistical Classification of Diseases and Related Health Problems* (11<sup>th</sup> ed; [ICD-11], WHO, 2019) now includes a diagnostic classification for CPTSD consistent with the DSO concept. The diagnostic criteria for CPTSD are severe and persistent disturbances in self-organisation including (1) affective dysregulation, (2) negative self-concept and (3) disturbances in relationships, additionally to the diagnostic criteria of simple PTSD.

Given the differences between PTSD and CPTSD symptom patterns, effective treatment approaches that identify and address DSO patterns in a way that is relevant to an individual's context may improve treatment outcomes for those experiencing CPTSD symptoms (Karatzias et al., 2017; Karatzias & Cloitre, 2019). Knefel et al. (2019) conducted a network analysis across four nationally representative samples containing men and women from Germany, Israel, the UK and the USA that included 1591 participants who all reported significant impairment by CPTSD symptoms, and identified negative self-concept, specifically feelings of worthlessness, as the most central CPTSD symptom. Karatzias et al. (2018) also identified negative self-concept as the most significant differential predictor of the three DSOs of CPTSD compared to PTSD in a sample of 106 mostly female participants

and proposed that targeting self-compassion may be an effective treatment target for symptoms of negative self-concept and affect dysregulation in CPTSD.

It is likely that negative self-concept and emotional dysregulation are also significant predictors of CPTSD symptom development in victim-survivors of coercive control, but this has not yet been systematically investigated. Nevertheless, shame, a complex emotion which involves negative self-evaluation and self-disorganisation, has been identified as a significant contributor to the development and persistence of PTSD symptoms in IPV victim-survivors and may also be a predictor of CPTSD symptoms (Herman, 2011, 2012; Lopez-Castro et al., 2019; Schore, 2003).

Surprisingly, only very few studies to date have investigated the link between complex trauma and coercive control in an IPV context, but the few that have provide initial evidence. For example a Canadian qualitative study that explored the trauma experience of 15 help-seeking female IPV victim-survivors found that women overwhelmingly reported the lasting impact of the complex trauma experience of coercive control on their lives, and described experiencing ongoing shame, self-blame, pain, fear and anxiety and a need for trauma-focused care (Baird et al., 2019). A recent Australian multi-method study by *Australia's National Research Organisation for Women's Safety* that combined a policy and service analysis with qualitative interviews with 40 female victim-survivors, also showed that women who are exposed to coercive control frequently experience CPTSD symptoms and may benefit from trauma-focused psychological care to promote long-term recovery (Salter et al., 2020). Another recent study looked at the prevalence of PTSD and CPTSD in a sample of 147 women in Danish shelters and found a high prevalence of both PTSD (56.5%) and CPTSD (21.1%) (Dokkedahl et al., 2021). Dokkedahl et al. (2021) also identified psychological IPV as the strongest predictor of CPTSD compared to both physical and sexual IPV. However, Dokkedahl et al. (2021) did not specifically investigate the prevalence of

CPTSD in women who have been exposed to coercive control or compared it to milder forms of psychological IPV or physical and sexual IPV. This thesis aimed to fill this important gap.

In sum, previous research has indicated that the mental health impacts of coercive control may be more severe compared to those of other dimensions of psychological IPV, and even physical IPV (Dokkedahl et al., 2022; Potter et al., 2020). Hence, it became apparent that there is a need to (a) synthesise the evidence of individual studies, (b) compare these effects with broader dimensions of psychological IPV, and (c) compare these effects with those found for physical IPV in prior research (e.g. Brennan et al., 2019; Dokkedahl et al., 2022; Pill et al., 2017; Potter et al., 2020; Stark, 2007; Stark & Hester, 2019). A better understanding of the trauma and mental health impacts of coercive control is also vitally important to support and protect victim-survivors in the light of initiatives to criminalise coercive control (Boxall & Morgan, 2021).

### **1.6. Coercive Control Policies and Initiatives**

An increasing understanding, including public awareness and media coverage of the impacts of coercive control (e.g., the horrific murder of Hannah Clarke and her children by her husband in 2020 in Queensland, Australia), has set in motion important discussions about the need for legal and policy changes. Coercive control has been criminalised in England (2015), Ireland (2018), and Scotland (2018) for several years (Pitman, 2016; Stark & Hester, 2019). In Australia, legislation relating to family and domestic violence including coercive control is generally organised at state level (i.e., sub-national jurisdiction level). Most Australian states and territories recognise coercive control as abuse and have orders and notices in place under civil law to support victim-survivors, but only a few states have so far criminalised coercive control. The state of Tasmania has criminalised some coercive controlling behaviours and the state of New South Wales has recently passed a new legislation to criminalise coercive control (Crimes Legislation Amendment (Coercive

Control) Act 2022 (NSW)). Although, legislation is implemented on a state level, the Commonwealth of Australia (2023) has recently released *National Principles to Address Coercive Control in Family and Domestic Violence* across all states, as well as a *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services, 2022) that also identified coercive control as a key target.

The release of these nation-wide initiatives and the ongoing debate in Australia and around the world whether to criminalise coercive control or not highlights both the traumatic consequences of coercive control and the importance for further research to enhance the understanding of coercive control and its mental health impacts (Boxall & Morgan, 2021). A better understanding of the nature and far-reaching mental health consequences of coercive control is crucial to guide the development and provision of mental health supports for victim-survivors and to inform policy and legislation to protect victim-survivors' safety and promote their recovery (Crossman & Hardesty, 2018; Macafee & Reeves, 2023; McMahon & McGorry, 2020). This thesis aimed to contribute to this important task.

### **1.7. Current Psychological Therapies**

Even though the high prevalence of PTSD and other mental health issues among IPV victim-survivors has been well documented (Golding, 1999; Jordan et al., 2010; Kilpatrick et al., 2013), policy recommendations have historically focused on safety and crisis management and have not included recommendations for psychological interventions that address the traumatic and long-term mental health consequences that victim-survivors may experience. For instance, none of the 227 recommendations of the *Victorian Royal Commission into Family Violence* in Australia (Neave et al., 2016) explicitly referred to the need for long-term trauma-focused psychological care, despite the clear evidence that many victim-survivors will continue to experience PTSD and other mental health reactions, long after they have left the abusive relationship (Beck et al., 2016; WHO, 2013). Whilst some

victim-survivors may recover relatively quickly after they have left the abusive relationship, many victim-survivors, particularly those who have been exposed to coercive control, may be at high risk of developing mental health reactions consistent with symptoms of PTSD and CPTSD, and may benefit from trauma-informed psychological care (Dokkedahl et al., 2021; Warshaw et al., 2013).

Several psychological therapies have been developed or adapted to support the recovery of IPV victim-survivors, but none are specifically coercive control-informed and only a few are trauma-informed. For example, a recent Cochrane systematic review investigated the effectiveness of a range of psychological therapies for female IPV victim-survivors who were 16 years old and above (Hameed et al., 2020). The review included 33 randomised controlled trials (RCTs) and quasi-RCTs, involving 5517 women. The therapies comprised (1) behaviour therapy/behaviour modification, (2) cognitive behavioural therapy (CBT), (3) third-wave therapies, such as mindfulness and acceptance and commitment therapy, (4) psychodynamic therapies, (5) humanistic therapies, (6) integrative therapies, (7) systemic therapies and (8) other psychotherapies (e.g., art and music therapy). Hameed et al. (2020) concluded that the reviewed therapies showed some efficacy in reducing anxiety and depression, but their effectiveness in reducing PTSD and revictimisation was unclear.

However, only one trauma focused therapy, *Cognitive Trauma Therapy for Battered Women with PTSD* (CTT-BW; Kubany, et al., 2004; Kubany & Watson, 2002) met the inclusion criteria for Hameed et al.'s (2020) review. CTT-BW was developed for women once they are safe. The intervention is based on traditional CBT but also includes trauma history exploration, PTSD education, stress management, exposure to abuse and abuser reminders, self-monitoring of negative self-talk, cognitive therapy for guilt, and modules on self-advocacy, assertiveness, and how to identify perpetrators. Kubany et al. (2004) conducted a RCT with 125 ethnically diverse women and found that in 87% of women who

completed CTT-BW, PTSD remitted combined with reductions in guilt and depression, and an increase in self-esteem. A replication and extension of Kubany et al.'s (2004) study provided further support for the effectiveness of CTT-BW in reducing PTSD, depression and anxiety (Beck et al., 2016). This suggests that trauma-focused therapies may be effective in reducing PTSD symptoms for victim-survivors who are safe, and that further research into trauma-focused therapies is important to support this population.

An earlier systematic review by Warshaw et al. (2013) focused specifically on trauma-focused therapies and identified nine therapies that had either been created or adapted for IPV victim-survivors, including CTT-BW. Two other therapies for women who are safe also demonstrated significant reductions in PTSD symptoms post-treatment. For instance, an RCT testing the *Helping to Overcome PTSD through Empowerment* (HOPE; Johnson et al., 2011) program, a manualised 10-session CBT-based approach to support IPV victim-survivors in shelters based on Herman's (1992a, 1992b, 2002) three-stage recovery model of recovery from complex trauma, (i.e., establishing safety, remembrance and mourning, reconnection), showed a significant reduction in PTSD symptoms post treatment. A second HOPE study extended the 10-session protocol and participants received six additional sessions post shelter within three months. This study also showed significant reductions in PTSD symptoms (Johnson et al., 2016). However, HOPE focuses predominantly on safety and empowerment and does not include any exposure therapy or other evidence-based trauma interventions (Warshaw et al., 2013). Similarly, a brief eight-week CBT-based group program for IPV victim survivors that included exposure techniques showed a strong decrease in PTSD symptoms post-treatment compared to the control group who received communication skills training at 1-, 3-, 6- and 12-months follow-ups (Crespo & Arinero, 2010).

Taken together, these studies provide some initial evidence that trauma-focused therapies may be effective in reducing PTSD symptoms and in supporting the long-term recovery of female IPV victim-survivors, but further RCTs and systematic research into the mechanisms and effectiveness of psychological therapies for this population are required (Hameed et al., 2020; Warshaw et al., 2013). Furthermore, coercive control victim-survivors may experience mental health reactions associated with complex trauma, and may experience symptoms reflecting CPTSD (i.e., affective dysregulation, negative self-concept, disturbances in relationships), additionally to symptoms reflecting PTSD, and may require both trauma and coercive control-informed psychological care (Crossman et al., 2016; Pill et al., 2017). However, despite these potentially serious and long-term mental health consequences and coercive control's ubiquity, there has so far not been any psychological research into the mental health support needs of those who have been exposed to coercive control and further research is urgently required (Hameed et al., 2020; Pill et al., 2017). This thesis aimed to address this gap.

Additionally, the review of the existing IPV intervention literature above has highlighted that researchers have mainly focused on clinical recovery, which focuses on changes in clinical outcomes, such as mental health symptoms reduction and functional improvements, and on quantitative research including RCTs, but provide little information about women's personal recovery experiences and support needs (Carman et al., 2022; Hameed et al., 2020; Karakurt et al., 2022; Macpherson et al., 2016; Oram et al., 2022; Warshaw et al., 2013).

### **1.8. Lived Experience and Personal Recovery**

Personal recovery is a process that goes beyond the symptom reduction and the functional improvement focus of clinical recovery, and instead looks at an individual's resilience, hope and the ability to live a meaningful life in the presence of mental health

challenges (Anthony, 1993; Leamy et al., 2011; Shanks et al., 2013). For example, the CHIME framework is extensively endorsed in mental health recovery research, and emphasises five mental health recovery processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (Leamy et al., 2011; van Weeghel et al., 2019). Although the CHIME framework has not yet been widely applied to IPV recovery research, there is emerging evidence from qualitative IPV research that the CHIME framework may be useful in conceptualising recovery processes following IPV exposure (e.g., Carman et al., 2022; Flasch, 2020; Flasch et al., 2017; Katz, 2015; Sinko et al., 2021). For example a meta-synthesis that included 26 qualitative IPV studies showed that victim-survivors' emphasised five key recovery components (i.e., trauma processing and re-examination, managing negative states, rebuilding the self, connecting with others, regaining hope and power) that reflect the five recovery processes outlined in the CHIME framework (Leamy et al., 2011). This suggests that a personal recovery framework such as CHIME may also be useful to understand the personal recovery process of coercive control victim-survivors may help to inform interventions. Given that personal recovery processes may be varied and nuanced, qualitative studies that deeply listen to the personal recovery needs of victim-survivors are likely best suited to inform the design and implementation of interventions that are aligned with the needs of victim-survivors (Carman et al., 2022; Macafee & Reeves, 2023; Oram et al., 2022).

### **1.9. Psychological Research and Feminist Research Perspectives**

The different lenses of clinical and personal recovery are also reflected in the different approaches of psychological research compared to feminist and social research perspectives. IPV research has originated from the feminist movement in the 1970s (Pence, 1983; Pence & Paymar, 1986). Accordingly, feminist and social researchers have traditionally focused on the gendered, social and intersectional factors (e.g., gender, class, race, culture) that contribute to

IPV, whereas psychological researchers have viewed the impacts of IPV exposure through an individualised mental health lens (e.g., Humphreys & Thiara, 2003; Moulding, 2016; Moulding et al., 2021). Feminist and social researchers have criticised this individualised mental health lens, including psychiatric diagnoses, because it positions mental health reactions as the responsibility of victim-survivors, without considering the systemic context and accountability of the perpetrator (Moulding et al., 2021). However, this criticism assumes that psychological treatments are solely guided by psychiatric diagnoses and that treatments take a one-size-fits-all approach, which does not accurately reflect best practice in mental health treatment. Best practice includes in-depth biopsychosocial case formulations, that assess a range of biological, psychological, and social factors to guide individualised treatment (Persons, 2022). Thus, conceptualising mental health reactions within a diagnostic framework does not exclude the awareness of the perpetrator's behaviours and accountability, or intersectional and systemic contexts (Hofmann & Hayes, 2019). This suggests that a coercive control-informed case formulation that is developed in collaboration with the victim-survivor, combined with diagnostic information may help to guide evidence-based treatments that are tailored to the individual victim-survivor's presentations and circumstances (Calhoun et al., 2022; Doyle et al., 2022). Nevertheless, qualitative studies that listen to victim-survivors' experiences, needs and wants are best suited to determine whether such an integrated treatment approach would benefit victim-survivors (Carman et al., 2022).

### **1.10. Gaps in the Literature**

In sum, the introduction highlighted that there is growing evidence from several primary studies that have linked coercive control with trauma and mental health impacts, but these studies vary widely in their objectives, methodologies, populations as well as in their definitions and operationalisation of coercive control (Hamberger et al., 2017). Thus, there is an urgent need for systematic research to synthesise the effects of primary studies to enhance

the understanding of the trauma and mental health impacts of coercive control (Commonwealth of Australia, 2023; Department of Social Services, 2022; Dokkedahl et al., 2022). Concomitantly, inconsistencies in the conceptualisation and definitions of coercive control have limited the understanding of the mental health impacts of coercive control, and there is a need to improve the understanding of the varying mental health impacts of coercive control to better support victim-survivors (Hamberger et al., 2017). This includes a lack of research into the associations between coercive control and CPTSD, despite a strong theoretical rationale for this link (Herman, 1992a, 1992b; WHO, 2019).

Further, most existing interventions for victim-survivors focus on safety, crisis management and advocacy, and there is presently a lack of research into mental health interventions that can support the long-term recovery of victim-survivors, especially those who have experienced coercive control (Hameed et al., 2020). Concurrently, there is a particular dearth of qualitative research into what mental health supports women need and want to aid in their long-term recovery after coercive control exposure (Hameed et al., 2020). Qualitative studies are crucial to increase the visibility and understanding of understudied, poorly understood and complex topics, such as coercive control, and the nuanced intervention needs of victim-survivors, because they are difficult to capture in quantitative research (Hardesty et al., 2019a). Furthermore, qualitative research can provide rich data that can be used to generate victim-survivor led outcomes, to generate interventions that are useful and well-received by understudied and vulnerable populations, such as victim-survivors of coercive control (Hardesty et al., 2019a; Goodman et al., 2018; Meissner, 2011).

### **1.11. Thesis Aims and Outline**

This thesis addressed these important gaps in the literature and had two overarching aims: (1) to improve the understanding of the trauma and mental health impacts of coercive control; and (2) to explore the mental health support needs and wants of women who have

experienced coercive control to aid their long-term recovery. To achieve these aims and to answer these research questions, this thesis employed a mixed methods approach and included three separate yet interlinked papers: A systematic review and meta-analysis, and two qualitative reports of in-depths analyses based on different research questions from the same qualitative interviews.

A mixed method research design was selected for three main reasons: (1) The ability to develop more effective and refined conclusions by using the results from one study to inform and design the subsequent study, (2) triangulation to provide more valid conclusions by comparing the results from the quantitative and qualitative methods for convergence and divergence, which is useful for investigating the multiple related but different phenomena in this project; and (3) to include victim-survivor led perspectives to integrate co-design and participatory research perspectives, which is both important in the engagement with vulnerable populations and essential in the development of interventions, because they can inform interventions that are helpful and well-received by victim-survivors (Clark & Ivankova, 2016; Goodman et al., 2018; Hardesty et al., 2019a; Meissner, 2011).

Chapter 2 commences by summarising the aims and objectives for systematic research into the trauma and mental health impacts of coercive control. It then presents study 1, the first systematic review and meta-analysis that specifically examined the trauma and mental health impacts of coercive control. The meta-analyses synthesised the evidence of the associations involving coercive control and PTSD and depression, and compared these associations with those of the broader dimension of psychological IPV. Chapter 3 briefly discusses the reasons for embedding lived experience in coercive control research. This is followed by an overview of the gender controversy in IPV research, which includes an explanation why studies 2 and 3 focus on the lived experience of women. This is followed by study 2, which is a qualitative study that explored the lived experience of coercive control

and associated mental health impacts based on qualitative interviews with 16 women.

Chapter 4 presents study 3, which explores the same 16 women's experiences with mental health supports and their mental health support needs and wants to aid their long-term recovery. Lastly, chapter 5 presents the general discussion which synthesises the key findings across the three studies and integrates the findings with the literature. The discussion concludes with the limitations, strengths, implications for policy, clinical practice and future research, and ends with the conclusion.

## **Chapter 2: The Trauma and Mental Health Impacts of Coercive Control**

### **2.1. Aims and Objectives**

Despite a strong theoretical framework for the associations between coercive control and PTSD and CPTSD and other negative mental health outcomes, the majority of studies has focused on the trauma and mental health impacts of physical and sexual IPV, and relatively few empirical studies have investigated these relationships. Some individual studies have linked coercive control with PTSD, CPTSD and other mental health consequences, but there has not yet been a systematic investigation of these associations (Jones, 2020; Pill et al., 2017). Moreover, to-date there has been no systematic research that has investigated the association of coercive control and CPTSD specifically or has investigated the trauma and mental health consequences of coercive control and has compared it to other dimensions of IPV. For these reasons, the first study was a systematic review and meta-analysis that aimed to synthesise the evidence of the mental health consequences following coercive control. This is considered an important and worthwhile approach because a systematic review is a standardised, rigorous and transparent approach, that can identify gaps and trends in the current evidence that may help to inform further research into the provision of evidence-based and trauma-informed psychological therapies to improve the long-term mental health outcomes after coercive control exposures (Munn et al., 2018).

## 2.2. Study 1

### **The Trauma and Mental Health Impacts of Coercive Control: A Systematic Review and Meta-Analysis**

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### 2.2.1. Abstract

Coercive control is an under researched type of intimate partner violence (IPV). The aims of this review were to (a) synthesize all available evidence regarding associations with coercive control and mental health outcomes including post-traumatic stress disorder (PTSD), complex PTSD, and depression; and (b) compare these with associations involving broader categories of psychological IPV. Primary studies which measured associations of coercive control with PTSD, complex PTSD, depression, or other mental health symptoms, were identified via a systematic search of electronic databases (PsycINFO, Medline, CINAHL, Scopus). Eligible studies involved observational designs and reported associations between coercive control and mental health outcomes, among participants who were at least 18 years old. Studies were published in peer-reviewed journals and English language. Random-effects meta-analyses were used to synthesize correlational data from eligible studies. The search identified 68 studies while data from 45 studies could be included in the meta-analyses. These indicated moderate associations involving coercive control and PTSD ( $r = .32$ ; 95% confidence interval [.28, .37]) and depression ( $r = .27$ ; [.22, .31]). These associations were comparable to those involving psychological IPV and PTSD ( $r = .34$ ; [.25, .42]) and depression ( $r = .33$ ; [.26, .40]). Only one study reported on the relationship between coercive control and complex PTSD and meta-analyses could not be performed. This review indicated that coercive control exposure is moderately associated with both PTSD and depression. This highlights that mental health care is needed for those exposed to coercive control, including trauma-informed psychological interventions.

*Keywords:* Intimate partner violence, coercive control, trauma, PTSD, complex PTSD

### 2.2.2. Background

Intimate Partner Violence (IPV) is a public health concern that has been linked with long-term mental health consequences including posttraumatic stress disorder (PTSD), depression, anxiety, alcohol and substance use disorders, as well as suicidality (World Health Organisation, WHO; 2017). IPV may include physical, sexual, and psychological abuse. Psychological IPV can include verbal aggression and intimidating and belittling behaviours, as well as coercive control (WHO, 2017). Coercive control is a form of abuse where the main goal is to degrade, isolate, and deprive a person of their rights to physical security, dignity, and respect, which puts the victim in a state of terror and entrapment, and includes tactics such as monitoring movements, social isolation, and restriction of access to financial resources, employment, education or medical care (Pitman, 2016; Stark, 2007; Stark & Hester, 2019). For instance, abusers may use tactics involving threats to hurt or kill their victims, their children or pets, or isolating them from family, friends, and support services. Coercive control may also involve economic abuse, by threatening economic security and independence (Postmus et al., 2020), intimate partner stalking (Mechanic et al., 2008), as well as reproductive coercion, such as pregnancy coercion or interference with contraception (Miller et al., 2010).

Psychometric measures often differentiate between behaviours attributed to broad forms of all psychological IPV (e.g., belittling, verbal aggression), versus specific dimensions of coercive control (e.g., monitoring, isolation) using subscales. For example, the *Psychological Maltreatment of Women Inventory* (PMWI; Tolman, 1989) provides one of the main measures of psychological IPV which distinguishes coercive controlling behaviours. It includes the emotional/verbal abuse (PMWI-EV) subscale, which captures general forms of psychological IPV, and the dominance/isolation (PMWI-DI) subscale, which captures more targeted features of coercive control.

As coercive control is both a distinct construct and a dimension of broader psychological IPV, it can be unclear whether an abusive behaviour occurs in the context of coercive control (Dutton & Goodman, 2005). For instance, verbal threats may or may not reflect coercive control, depending on whether or not these occur in the context of a broader pattern of controlling, isolating, and degrading behaviours. This aligns with Johnson's (2008) contextual distinction between psychological couple violence which occurs (a) situationally, such as eruptions of heated arguments (potentially involving threats) that are spontaneous and often mutual, and (b) coercive control (referred to by Johnson as intimate terrorism), which is characterized as an enduring pattern of violence, domination, intimidation, isolation, and control. Verbal threats can thus reflect situational couple violence or they can occur within the enduring pattern of domination that characterises coercive control.

Importantly, coercive control is both highly prevalent, occurring in up to 58% of IPV relationships, and a particularly insidious form of IPV that likely has more severe mental health implications than situational psychological IPV, or even physical IPV that is not embedded in the context of coercive control (Crossman et al., 2016; Kennedy et al., 2018; Stark, 2007). Many studies have shown positive associations between coercive controlling behaviours, including specific forms of economic abuse, stalking and reproductive coercion, with mental health outcomes including PTSD, depression and other mental health symptoms. However, the findings are mixed. For example, Beck et al. (2011) have found small associations ( $r = .18$ ), Hines and Douglas (2011) found moderate ( $r = .37$ ) and Taft et al. (2005) found large associations ( $r = .56$ ) for coercive control and PTSD. The mixed results are likely associated with methodological differences such as study settings, measures, and sample sizes.

Systematic reviews and meta-analyses can synthesise the effects of individual studies to overcome the limitations of single studies. To our knowledge, no previous systematic

review and meta-analysis has investigated the associations with coercive control and mental health outcomes or compared these effects with the mental health outcomes of general psychological IPV (Pill et al., 2017; Stark & Hester, 2019). Most meta-analyses to date have not focused on psychological IPV and have either solely focused on the mental health implications of physical IPV exposure (e.g., Golding, 1999; Spencer et al., 2019; Stith et al., 2004), or have combined different types of IPV (e.g., Beydoun et al., 2012; Devries et al., 2013; Trevillion et al., 2012). These previous meta-analyses have revealed small to moderate mean correlations between physical or combined IPV and PTSD, depression, anxiety, suicidality, and drug and alcohol use, with the most robust evidence with PTSD and with depression (Devries et al., 2013; Golding, 1999; Spencer et al. 2019; Stith et al., 2004). For instance, Golding (1999) found moderate correlations involving physical IPV with PTSD ( $r = .34$ ) and depression ( $r = .35$ ), while Spencer et al.'s (2019) recent meta-analysis also found moderate correlations with physical IPV and PTSD ( $r = .34$ ) and depression ( $r = .25$ ). Importantly, previous meta-analyses have not distinguished between effects of psychological IPV and coercive control. In part, this may be because the unique impacts of psychological IPV have only been relatively recently more broadly recognised, and because the dimensions of psychological IPV, particularly coercive control, may be more difficult to distinguish and differentiate, when compared to physical IPV (Heise et al., 2019).

Given that meta-analyses have found evidence of the mental health impacts of physical and combined IPV, and the absence of prior systematic reviews of the mental health correlates of coercive control, there is a clear and pressing need for additional systematic examinations of this evidence. This is particularly important as most existing interventions for IPV survivors focus on safety and crisis management, and there is presently a lack of evidence-based psychological programs to support the long-term recovery of those who have been exposed to IPV, particularly coercive control (Hameed et al., 2020). A better

understanding of the unique mental health consequences of coercive control would help to inform the development of such evidence-based psychological interventions, and to inform policy and legislation to promote long-term support and recovery (Crossman & Hardesty, 2018).

Moreover, the prolonged and chronic pattern of terror and entrapment of coercive control suggests that such exposures could be uniquely associated with complex PTSD (CPTSD) symptoms (Pill et al., 2017). The latest edition of the *International Statistical Classification of Diseases and Related Health Problems* (11th ed; [ICD-11], WHO, 2019) includes a diagnostic classification for CPTSD which includes symptoms associated with (1) affective dysregulation, (2) negative self-concept and (3) disturbances in relationships, which are additional to the diagnostic criteria of PTSD. An essential criterion for an ICD-11 CPTSD diagnosis is the “exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible” (WHO, 2019), which may include prolonged exposure to IPV. Given the chronic terror and entrapment experiences that characterise coercive control, with a typical length of IPV relationships ranging from 15 to 24 months, the likelihood of developing CPTSD in response to coercive control exposure may be high (Kennedy et al., 2018). This may explain in part the more detrimental mental health outcomes compared to other types of IPV (Crossman et al., 2016; Stark, 2007). In fact, it is possible that coercive control may have stronger associations with CPTSD compared to other types of IPV that reflect situational couple violence, because of the prolonged exposure to interpersonal trauma (Cloitre, 2021; Herman, 1992). Therefore, research into the associations between coercive control and CPTSD is important to inform development of effective treatment approaches to deal with the psychological consequences of experiencing coercive control (Karatzias &

Cloitre, 2019). However, as far as we are aware, there is no systematic review to-date that has examined the relationship between coercive control and CPTSD.

### **Objectives of the Present Study**

In this systematic review and meta-analysis we aimed to address limitations of past research by synthesizing the effects of individual studies to provide more precise estimates of the mental health impacts of coercive control on PTSD, CPTSD and depression. We also add to research by comparing the mental health impact of coercive control with broader dimensions of any psychological IPV. As previous meta-analyses have consistently found small to moderate correlations with physical (or combined types of IPV) and PTSD and depression, and because of the potentially more detrimental mental health impacts of coercive control, when compared to psychological IPV, it was predicted that coercive control would be positively correlated with PTSD, CPTSD and depression, and that, the strength of these associations, particularly those of CPTSD, would be stronger compared to those of general psychological IPV.

### **2.2.3. Method**

#### **Registration and Protocols**

The protocol for this systematic review and meta-analysis was preregistered with the *International Prospective Register of Ongoing Systematic Reviews* (PROSPERO) database in June 2021 (registration number: CRD42021252071), while reporting was aligned with guidelines from *Preferred Reported Items for Systematic Reviews and Meta-analyses* (PRISMA; Page et al., 2021).

#### **Literature Search Strategy**

Primary studies examining the associations between coercive control and mental health measures were identified via electronic searches of databases including PsycINFO, Medline, CINAHL and Scopus. These searches were conducted in May 2021. The search

terms for each database are shown in Appendix A.1. All records identified by the search were downloaded into Endnote (Version X9) to remove duplicates. After removing duplicates, the remaining records were uploaded into Covidence Systematic Review Software (2021). Both the title and abstract and the full text screening stages involved two independent reviewers. An exclusion hierarchy was developed by the first reviewer and discussed with the second reviewer before screening. If full text papers could not be obtained, corresponding authors were contacted to obtain full text papers. If authors could not be reached or they did not provide the full text paper, the study was excluded (only two full text papers could not be obtained).

### **Inclusion Criteria**

Studies were included if they were empirical studies involving observational designs that reported on relationships involving measures of exposure to coercive controlling behaviours and any measure of mental health symptoms or diagnoses (including self-report measures and clinical interviews). Eligible studies had to be written in English language, published in peer reviewed journals, while participants had to be at least 18 years old. There were no exclusions on the basis of gender, ethnicity, regions/country or publication year. Experimental or intervention studies, and studies that did not report primary quantitative data (e.g., case studies, case series, qualitative studies, reviews, editorials, book chapters) were excluded. Studies were also excluded if the violence was not perpetrated by an intimate partner (e.g., instead perpetrated by another family member), they only reported IPV perpetration, did not differentiate between types of IPV, or did not report any measure of coercive control, or did not report this separately from psychological IPV or other types of IPV. Only studies that measured controlling behaviours were included. Studies that only included measures that do not distinguish dimensions of coercive control, namely the *Conflict Tactics Scale* (CTS; Straus, 1990), Revised Conflict Tactics Scale (CTS2; Straus et al., 1996),

the *Severity of Violence Against Women Scale* (SVAWS; Marshall, 1992), and the *Danger Assessment* (Campbell et al., 2009) were excluded. Studies that included measures of coercive control in addition to these scales were included and are listed in the results.

### **Quality Assessment**

The risk of bias was assessed with the JBI Critical Appraisal Checklist for Analytical Cross Sectional Studies (Joanna Briggs Institute, 2017). The quality of all studies was assessed by the first reviewer, while a second reviewer independently assessed 31% of the studies (21 out of 68) which were randomly assigned by selecting every third study in alphabetical order.

### **Data Extraction and Coding**

The research team developed a coding sheet that included the study design, country, sample size and gender, recruitment source, sample characteristics, IPV and coercive control measures, mental health measures, statistical methods, and effect sizes. If effect sizes were not reported as either correlations or odds ratios with confidence intervals (CIs), or they could not be computed from the reported data, an email request for the data was sent to the corresponding authors. If the authors did not respond after one month or if they were not able provide the data, the study was excluded from the meta-analysis.

### **Data Analyses**

Quantitative estimates of associations with measures of coercive control or other forms of IPV with mental health measures were synthesised via a series of random-effects meta-analyses, which account for both within-study and between-study variance and allows for greater generalizability of results (Borenstein et al., 2010). *Comprehensive Meta-Analysis* Version 3 software (Borenstein et al., 2014) was used for these quantitative syntheses. Only cross-sectional studies or longitudinal studies that reported relevant effect sizes at a single time-point (typically study baseline) were included in the meta-analyses. Random effects

meta-analyses were performed for associations with coercive control (including economic abuse, stalking, reproductive coercion) with PTSD and depression. Only one study measured CPTSD and meta-analyses for this outcome could not be completed. To examine the strength of associations of coercive control with PTSD and depression, in comparison with the association of psychological IPV with PTSD and depression, additional random effects meta-analyses for the correlations of psychological IPV with PTSD and depression were performed. Only studies that also measured coercive control were included in this comparison, as only these studies met the inclusion criteria for this review.

A Pearson's  $r$  correlation coefficient was selected as the effect size index for purposes of reporting and were interpreted based on Cohen's (1988) guidelines whereby  $r$  values around 0.10 indicate a small, 0.30 are medium, and values around 0.50 a large effect. Only bivariate effect sizes that could be transformed into a Pearson's  $r$  correlation coefficient, such as unadjusted odds ratios and independent group means and standard deviations, were included in the meta-analysis. When a study reported a standardised regression coefficient ( $\beta$ ) without reporting a correlation coefficient, the  $\beta$  was imputed as the correlation coefficient (assuming a bivariate model) (Peterson & Brown, 2005). When a study only reported the correlation coefficient for subgroups (e.g., according to gender or ethnicity) without providing a correlation coefficient for the total sample, all subgroup correlation coefficients were transformed using Fisher's  $Z$ , and back-transformed after calculating the mean  $Z$  value to retrieve the average correlation coefficient (Corey et al., 1998).

Heterogeneity was assessed with the  $Q$  and  $I^2$  statistics, where an  $I^2$  value of 25% indicated low, of 50% moderate, and of 75% high heterogeneity (Higgins et al., 2003). A series of exploratory subgroup analyses considering (1) types of coercive control measure (general coercive control measures vs. specific economic abuse, stalking and reproductive coercion measures) and (2) study settings (domestic violence support services/shelters vs.

community) were performed to examine potential sources of heterogeneity. Subgroup analyses were only performed when at least six studies were available to be included in a subgroup. Therefore, subgroup analyses comparing gender or countries could not be performed. Statistical significance of subgroup differences was inferred when the 95% CIs for point estimates for each subgroup did not overlap (Cumming & Finch, 2005).

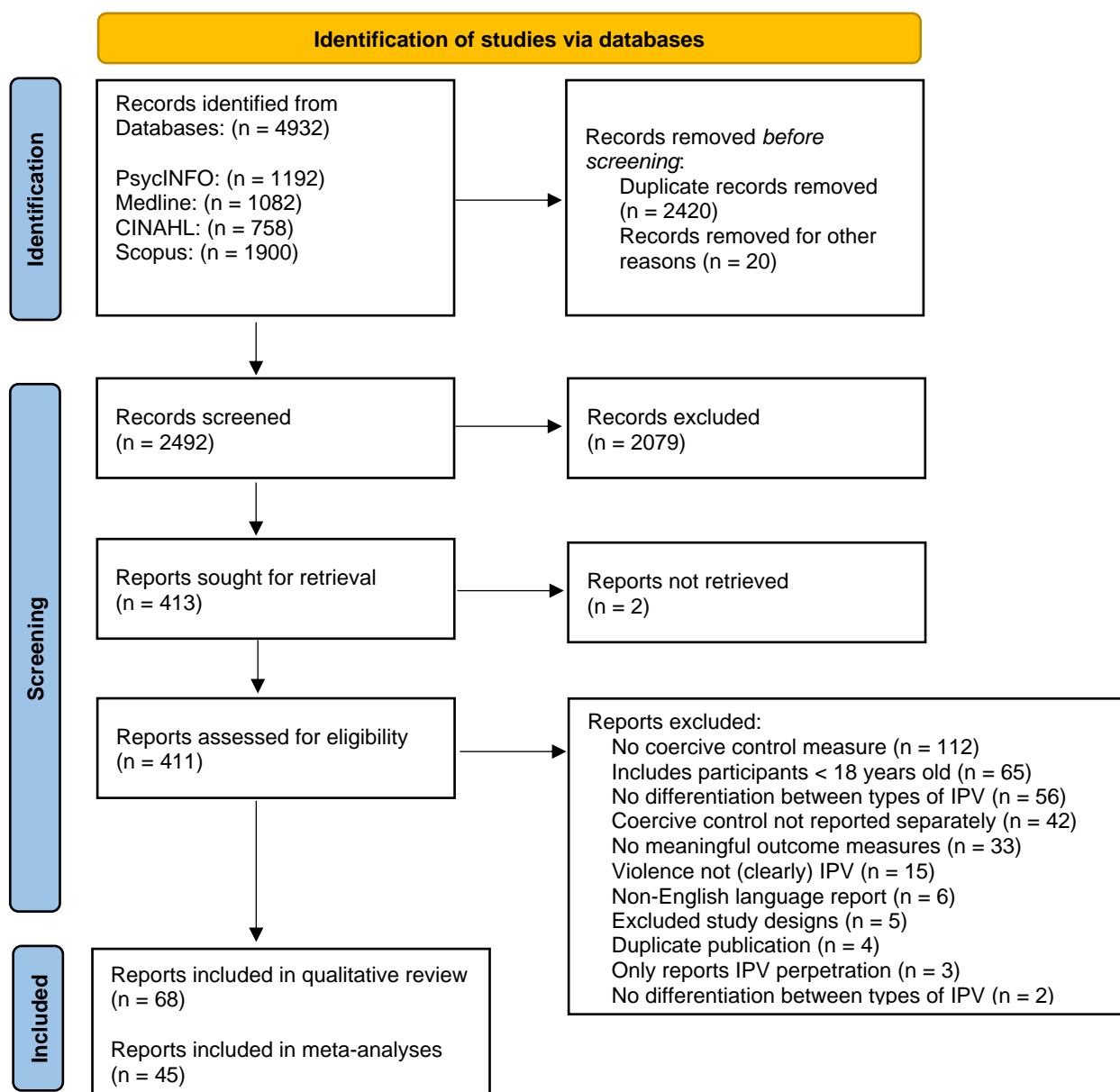
Publication bias was assessed with three tests. First, Duval and Tweedie's (2000) trim and fill test, which estimates the number of studies missing on the left or right side of the funnel plot, and also estimates the effect size if such hypothetical studies were included. Second, Rosenthal's (1979) classic fail-safe  $N$  test, which calculates how many studies with nonsignificant results would be needed to make the mean effect size nonsignificant. A large fail-safe  $N$  suggests that there is no risk of publication bias. Rosenthal recommends that the minimum fail-safe  $N$  can be computed by first multiplying the number of effect sizes by 5 and then adding 10 to that number. Finally, Orwin's (1983) fail-safe  $N$  identifies the number of potentially missing studies with an effect size of  $r = .00$  needed to reduce the mean effect size of each mental health outcome below a small effect size of  $r = .10$ .

#### **2.2.4. Results**

##### **Search Results**

The combined database search identified a total of 4932 records. After removing 2440 duplicates, there were 2492 records (PsycINFO = 1175, Medline = 476, CINAHL = 208, Scopus = 633) imported into Covidence for title and abstract screening. After title and abstract screening, 2079 records were excluded as ineligible, while 413 studies were passed on to full text screening. After the full text review a further 345 studies were excluded (see Appendix A.2 for a list of excluded studies) and 68 eligible studies were remaining. Every title, abstract and full text record was screened by two independent reviewers. Conflicts were resolved through discussion and consensus. The reviewers identified that the main reasons for

conflict were the heterogeneity and overlap of psychological abuse and coercive control measures. Data from 45 studies was available for inclusion in the meta-analyses. The PRISMA flow chart (Figure 2.1) depicts a summary of the study selection process.

**Figure 2.1***PRISMA Flow Chart of Study Selection based on Page et al. (2020)*

### Description of Studies

The included studies examined associations involving coercive control (including economic abuse, stalking and reproductive coercion) with PTSD, CPTSD, depression, suicidality, anxiety, drug and alcohol use and transdiagnostic mental health, using a variety of coercive control and mental health measures. Most studies (76%) recruited only women (k =

52), while 19% included women and men ( $k = 13$ ), including one study where female and male participants identified as lesbian, gay, bisexual, or transgender. Only 3% of studies included only male participants ( $k = 3$ ), including one study that focused on gay, bisexual, and other men who have sex with men. The vast majority (81%) of studies were conducted in developed countries, with 68% in the USA ( $n = 46$ ). The latter included one study that also included participants from Puerto Rico. These were followed by 6% of studies from Canada ( $n = 4$ ), and 6% from Europe (Denmark:  $n = 2$ , Sweden:  $n = 2$ ), and Australia ( $n = 1$ ). Other studies were from South America (Brazil:  $n = 2$ ), Africa (South Africa:  $n = 3$ , Cote d'Ivoire:  $n = 1$ , Nigeria:  $n = 1$ , Kenya:  $n = 1$ , Tanzania:  $n = 1$ ), Asia (Hong Kong:  $n = 1$ , Malaysia:  $n = 1$ , South Korea:  $n = 1$ ) and the Middle East (Jordan:  $n = 1$ ). Participants were recruited from a variety of settings, including shelters and domestic violence support services, the community, health care settings, and universities. These and other key characteristics included in the qualitative synthesis are summarised in Table 2.1.

### **Coercive Control Measures**

Coercive control was measured with a range of scales and subscales. The domination/isolation subscale of the *Psychological Maltreatment of Women Inventory* (PMWI-DI; Tolman, 1989) or its short form (PMWI-SF-DI, Tolman, 1999) were most frequently used ( $n = 17$ ). The *Controlling Behaviours Scale-Revised* (CBS-R; Graham-Kevan & Archer, 2003) was the second most frequently used measure ( $n = 7$ ), followed by the *Multidimensional Measure of Emotional Abuse* (MMEA; Murphy et al., 1999) ( $n = 6$ ), particularly the Restrictive Engulfment Subscale (MMEA-RE). Several studies in Non-Western countries used the controlling behaviours questions from the *WHO Multi-country Study on Women's Health and Domestic Violence Against Women* (WHOMCS; García-Moreno et al., 2005) ( $n = 6$ ). Other studies used the power and control questions that were developed for the *National Violence Against Women* survey (NVAWS; Tjaden & Thoennes,

1999) ( $n = 5$ ). Each of the remaining studies used a different scale: *Composite Abuse Scale* (CAS; Hegarty et al., 1999, 2005), *Women's Experiences with Battering* (WEB; Smith et al., 1999), *Scale of Power and Control* (Block, 2000), *Power and Control Scale* (PCS; Leone et al., 2007), controlling questions from the *Intimate Partner Violence among Gay and Bisexual Men Scale* (IPV-GBM; Stephenson & Finneran, 2013), coercive control subscale of the *Mediator's Assessment of Safety Issues and Concerns* (MASIC; Pokman et al., 2014), *Sexual Relationship Power Scale* (SRPS; Pulerwitz et al., 2002), coercive tactics subscale from the *Coercion in Intimate Partner Relationships Scale* (CIPRS; Dutton et al., 2007), coercive control questions from *The National Intimate Partner and Sexual Violence Survey* (NISVS; Smith et al., 2017), the Jealous/Control Scale from the *Profile of Psychological Abuse* (PPA-JC; Sacket & Saunders, 1999) and a modified version of Dutton et al.'s (2005) *Coercive Control Measure for IPV*. Specific measures of economic abuse, stalking and reproductive coercion are also identified in Table 2.1.

### **Mental Health Measures**

PTSD symptom severity was measured by 31 studies and was most frequently measured with the *PTSD Checklist-Civilian* (PCL-C; Weathers et al., 1993). Depression was measured by 38 studies, the most frequently used measure was the *Center for Epidemiologic Depression Scale* (CESD; Radloff, 1977). Notably, only one study (Dokkedahl et al., 2021) measured CPTSD by using the *International Trauma Questionnaire* (ITQ; Cloitre et al., 2018). The mental health measures of all studies included in the qualitative synthesis are summarised in Table 2.1.

### **Quality Assessment**

The reviewers initially obtained a 90% agreement and any conflicts in the quality assessment that remained were discussed and resolved by consensus. The most common risk of bias was that studies did not clearly report or address potential confounds. A summary

table of the quality assessment for all studies included in the qualitative synthesis is included in Appendix A.3. The appraisal tool does not offer guidance about cut-off scores to assess the overall level of risk of bias for each study and we could therefore not establish the overall risk of bias for each study (Munn et al., 2020).

**Table 2.1***Description of Studies Included in the Systematic Review in Alphabetical Order*

Study	Country	Study Type	Recruitment	Sample	Age Range (M; SD)	Type	IPV Measures			Mental Health Constructs and Measures	
							Coercive Control	Psychological	Physical/Sexual	Constructs	Measures
*Ahmad et al. (2018)	Malaysia	CS	Com: post-natal health care facilities	5727 w	≥18	CC	WHOMCS - CC items	WHOMCS	WHOMCS	Postnatal Depression	EPDS (Malaysian)
Alexander et al. (2019)	USA	CS	Com: Community support services	188 w	18 - 24 (21.3; 2.2)	RC	10-items (Miller, 2010)			PTSD, Depression	PCPTSD, CESD-SF
*Anderson (2008)	USA	CS 2nd	Com: NVAWS national survey	4,575 w	18 - 88	CC	NVAWS-CC items			PTSD, Depression	IES (adapted), NVAWS 8 depression items
Anderson et al. (2017)	USA	CS	Com: HIV clinic	67 w	18 - 45	RC	10-items (Miller, 2010)			PTSD, Depression	PCL-C, CESD
Basile et al. (2004)	USA	CS - 2nd	NVAWS: IPV subgroup	380 w	<18 (40)	ST	NVAWS-ST Items	NVAWS verbal abuse + CC	CTS	PTSD	IES (adapted)
*Beck et al. (2011)	USA	CS	IPV survivors - university research clinic	63 w	18 - 64 (36.75; 11.62)	CC	PMWI-DI	PMWI-EV	Interview devised by authors	PTSD	CAPS for DSM-IV
*Broughton & Ford-Gilboe (2017)	Canada	LO-2nd	IPV - subsample from WHES	157 w	20 - 64 (40.6; 9.6)	CC	WEB			Depression	CESD
*Bubriski-McKenzie & Jasinski (2013)	USA	CS 2nd	Com: IPV sample CWHRS	705 w	≥ 18 BI: (31.07; 9.46) His: (29.08; 7.79)	CC	CWHRS Power and Control Scale		CTS2	PTSD, Depression	PSS-I CWHRS- based on MOS
Coker et al. (2002)	USA	CS - 2nd	Com: NVAWS national survey	6790 w 7122 m	18 - 65	CC	NVAWS - CC items	NVAWS - verbal abuse	CTS	Depression Drug and Alcohol Use	SF-36 NVAWS Drug & Alcohol items
*Damra & Abujilban (2021)	Jordan	CS	Com: hospital gynecology/obstetric service	300 w	18 - 49 (32; 6.4)	CC	WHOMCS - CC items	WHOMCS	WHOMCS	Depression	BDI for Jordanian culture
*Dokkedahl et al. (2021)	Denmark	CS	Shelter	147 w	≥18 (34.6; 10.1)	CC	PMWI-DI	PMWI-EV	CTS2	PTSD	ITQ, HTQ, TSC-26
*Dutton & Painter (1993)	Canada	LO	IPV - shelters, support programs	75 w	≥18 (31.4)		PMWI-DI	PMWI-EV	CTS	PTSD	TSC-33

**Table 2.1 (continued)**

Study	Country	Study Type	Recruitment	Sample	Age Range ( <i>M</i> ; <i>SD</i> )	Type	IPV Measures			Mental Health Constructs and Measures	
							Coercive Control	Psychological	Physical/Sexual	Constructs	Measures
Dutton et al. (1999)	USA	CS	DV support service	149 w	18 - 58 (30)	CC	PMWI-DI	PMWI-EV	CTS2	PTSD, Depression	PSS-SR, CESD
*Emery et al. (2019)	South Korea	CS	Com	462 w	≥18	CC	NVAWS - CC items			Alcohol Use	CAGE
Fleming et al. (2012)	USA	CS	Com	192 w	≥18 (55.04; 3.92)	ST	NVAWS – ST items	CTS2	CTS2	PTSD	PCL-C
*Gibbs et al. (2018)	South Africa	CS	Com	677 w	18 - 30 (23.7)	EA	WHOMCS-CC	WHOMCS		Depression Suicidal Ideation	CESD SI: 1-item CESD
Gou et al. (2019)	Canada	LO	Com	98 w 98 m	≥18 w: (29.98; 5.49) m: (32.03; 5.51)	CC	PMWI-DI		CTS2		
Grace et al. (2020)	USA	CS	University students	354 w	≥18 (20.88; 2.31)	CC, RC	2 RC questions CAS	CAS	CAS	Depression Drug and Alcohol Use	CESD-R MFDAQ
*Groves et al. (2012)	South Africa	CS	Com: HIV	1500 w	≥18 (27.29; 5.36)	CC	SRPS	adapted WHOMCS	adapted WHOMCS	Depression, Anxiety	HSCL-25
Hardesty et al. (2019)	USA	LO	Com: mothers who filed for divorce	135 w	20.83 –53.92 (35.22; 7.02)	CC	PMWI-DI		CTS2	PTSD, Depression	PCL-C-SF CESD-SF
Hayes & Kopp (2020)	USA	CS - 2nd	Com: national NISVS	7433 w 6266 m	≥18	CC RC	Number of CC, RC past year	Number of psych. IPV past year	Number of physical IPV past year	Mental Health	Self-rated
*Hazen et al. (2008)	USA	CS	Com: Health care service users	282 w	18 - 45 (27.74; 7.12)	CC	PMWI-DI-SF	PMWI-EV-SF	CTS2	Depression, Anxiety	BSI
*Hedin & Janson (1999)	Sweden	CS	Com - antenatal clinics	207 w	18-35 (29.5, 4.5)	CC	PMWI-DI	PMWI-EV	SVAWS	PTSD, Anxiety	TSC-33 STAI
*Hines & Douglas (2011)	USA	CS	IPV support services (help-seeking group), Com	822 m (302 IPV 520 com)	18 - 59 IT: (40.49; 8.97) Com: (43.68; 10.88)	CC	PMWI-DI	CTS2	CTS2	PTSD	PCL-C
*Hines & Douglas (2012)	USA	CS	IPV services (help-seeking group), Com	822 m (302 IPV 520 Com)	18 - 59 Help-seek. (40.49; 8.97) Com: (43.68; 10.88)	CC	PMWI-DI	CTS2	CTS2	Drug and Alcohol Use	NWS Alcohol and Drug Use scale

**Table 2.1 (continued)**

Study	Country	Study Type	Recruitment	Sample	Age Range ( <i>M</i> ; <i>SD</i> )	Type	IPV Measures			Mental Health Constructs and Measures	
							Coercive Control	Psychological	Physical/ Sexual	Constructs	Measures
*Hines & Douglas (2018)	USA	CS	IPV support services (help-seeking group), Com	2212 m (611 IPV, 1601 Com)	18 - 59 IPV: (43.89; 9.18), Com: (41.77; 11.35)	CC	PMWI-DI	CTS2	CTS2	PTSD, Depression	PCL-C, CESD
*Ireland et al. (2017)	Australia	CS	Com: LGBTI	287 LGBTI w and m	≥18 (34.8; 11.2)	CC	MMEA (extended - 44 items)	MMEA (extended -44 items)	MMEA (extended - 44 items)	PTSD, Depression, Anxiety	PCL-C-SF, HAD
*Johnson & Leone (2005)	USA	CS – 2nd	Com: NVAWS national survey	4967 w (81 IT)	18 - 97 (44.55; 13.89)	CC	NVAWS - CC items		12-items adapted from CTS	PTSD, Depression	IES (adapted), 8-items depression scale (based on SF-36)
Johnson et al. (2014)	USA	CS – 2nd	Com: NVAWS national survey	7782 w 6908 m	18 -97 (46.91; 15.67)	CC	12-items CC-Scale like PMWI		12-items adapted from CTS	Depression	8-items depression scale (based on SF-36)
*Jones (2020)	USA	CS	Prison	337 w	18 - 65	CC	based on CCMIPV			PTSD	PCL-C
*Jones et al. (2005)	USA	CS	DV services, medical & com	172 w	18 - 40	CC	PMWI-DI-SF	PMWI-EV-SF, SOSPS		PTSD, Depression, Anxiety	PSDSWB BDI, BAI
*Kapiga et al. (2017)	Tanzania	CS	Com	1021 w	19 -70	CC, EA	WHOMCS - CC, EA items	WHOMCS	WHOMCS	Mental Health	SRQ-20
*Lawrence et al. (2009)	USA	LO	Com: married couples	103 w 103 m	18 - 55 w: (25; 4.3) m: (26.4; 4.7)	CC	MMEA-RE	MMEA-total		Depression, Anxiety	BDI-II, BAI
*Leone (2011)	USA	CS 2nd	CWHRS abused women sub-sample	369 w	≥18 (31; 9.62)	CC	PCS			PTSD, Depression, Suicidality	PSS-I, MOS-4 items SI + SA combined 1-item
*Levine & Fritz (2016)	Canada	CS	Shelter	51 w	19 - 58 (37)	CC	CBS-R	CTS2		PTSD, Depression	PCL-C, BDI-II
*Lovestad et al. (2017)	Sweden	CS	Com: population sample	573 w	18 - 65 (42.7; 13.01)	CC	CBS-isolating control	WHOMCS	WHOMCS	Depression	self-report of 5 DSM-IV indicators
*Ludermir et al. (2010)	Brazil	CS	Com: pregnant women from a family health program	1045 w	18 - 49	CC	WHOMCS – CC	WHOMCS	WHOMCS	Postnatal Depression	EPDS

**Table 2.1 (continued)**

Study	Country	Study Type	Recruitment	Sample	Age Range ( <i>M; SD</i> )	Type	IPV Measures			Mental Health Constructs and Measures	
							Coercive Control	Psychological	Physical/ Sexual	Constructs	Measures
*Ludermir et al. (2010)	Brazil	CS	Com: pregnant women from a family health program	1045 w	18 - 49	CC	WHOMCS – CC	WHOMCS	WHOMCS	Postnatal Depression	EPDS
Ludermir et al. (2014)	Brazil	CS	Com: pregnant women from a family health program	1120 w	18 - 49	CC	WHOMCS – CC	WHOMCS	WHOMCS	Mental Health	SRQ-20
McCauley et al. (2014)	Cote d'Ivoire	CS	Com	953 w	≥18, (37.4)	RC	based on Miller et al., 2010)			PTSD	HTQ
Mechanic et al. (2000)	USA	CS	DV support services	114 w	19-59 (35; 7.9)	(CC) ST	SBC (PMWI-DI)	PMWI-EV	CTS2	PTSD, Depression	PDS, BDI-II
*Mechanic et al. (2008)	USA	CS	DV support services	413 w	18-62 (34.5; 8.1)	CC, ST	PMWI-DI, SBC	PMWI-EV		PTSD, Depression	PDS, BDI-II
Mutiso et al. (2020)	Kenya	CS	Com: health care services	5448 w 2862 m	18 - 60+	CC	WHOMCS - CC items	WHOMCS	WHOMCS	Mental Health	MINI Plus
Newton (2021)	USA	CS	Com	69 w	≥18 (54.53; 3.19)	CC	PMWI-DI-SF	PMWI-DI-SF	CTS2	PTSD – peritraumatic emotions	CAPS for DSM-IV
*Nielsen et al. (2016)	USA	CS	Com: co-parenting	147 w	20-54 (35.2)	CC	PMWI-DI-SF	PMWI-EV-SF	CTS2	PTSD, Depression	PCL, CESD-SF
*Norwood & Murphy (2012)	USA	CS 2nd	DV support services	216 w	18 –70 (34.0, 10.1)	CC	MMEA-RE	MMEA-total	CTS2	PTSD	PCL-C-IPV
*Nnawulezi & Murphy (2019)	USA	CS	DV support services (archival data)	228 w	18 - 70 (34.23; 10.09)	CC	MMEA-RE	MMEA-total	CTS2	PTSD	PCL-C-IPV
*Ogunbajo et al. (2020)	Nigeria	CS	Com	389 m	≥18	CC	IPV-GBM-monitoring controlling	IPV-GBM	IPV-GBM	Depression, Suicidality, Anxiety	CESD SI-1-item, SA-1-item GAD-7

**Table 2.1 (continued)**

Study	Country	Study Type	Recruitment	Sample	Age Range ( <i>M</i> ; <i>SD</i> )	Type	IPV Measures			Mental Health Constructs and Measures	
							Coercive Control	Psychological	Physical/ Sexual	Constructs	Measures
Peltzer et al. (2013)	South Africa	CS	IPV survivors who obtained a protective order	268 w	18–62 (28.8; 8.0)	ST	SVS, 10 items from HARASS	SVAWS	SVAWS	PTSD, Depression Alcohol Use	PCL-C, CESD AUDIT-C
*Petra (2020)	USA	CS	Com	222 w	24 – 63 (33)	CC	MASIC-CC subscale		WAST	Depression, Anxiety	DASS-21
*Pickover et al. (2017)	USA	CS	IPV survivors, mental health research clinic	284 w	≥18 (37.84; 12.08)	CC	PMWI-DI-SF	PMWI-EV-SF	CTS2	PTSD, Anxiety	LEC, IPV-related DSM-IV-TR, ADIS-IV
Postmus et al. (2012)	USA	LO	Com	2305 w	≥18 (25.8; 6.1)	EA	Any EA in year 1	Any psych. IPV in year 1	Any physic. IPV in year 1	Depression	CIDI-SF
Prospero (2008)	USA	CS	University students	609 (361 w, 248 m)	≥18 (21.44; 4.58)	CC	CBS-R	CTS2	CTS2	Mental Health	SQ
Prospero (2009)	USA	CS	University students	573 (332 w, 241 m)	≥18 (21.4; 4.37)	CC	CBS-R	CTS2	CTS2	Mental Health	SQ
*Prospero & Kim (2009a)	USA	CS	University students	560 (325 w, 235 m)	≥18 (21.4; 4.37)	CC, EA	CBS-R	CTS2	CTS2	Depression, Anxiety	SQ
Prospero & Kim (2009b)	USA	CS	University students	676 (419 w, 257 m)	≥18 (21.6; 4.66)	CC, EA	CBS-R	CTS2	CTS2	Mental Health	SQ
*Reich et al. (2015)	USA	CS	IPV survivors - mixed recruitment	105 w	≥18 (36.94;12.68)	CC	PMWI-DI-SF	PMWI-EV-SF	CTS2	PTSD	CAPS for DSM-IV
*Sackett & Saunders (1999)	USA	CS	DV support services	60 w	≥18 (34.7; 9.1)	CC	PPA-JC	PPA		Depression, Anxiety	BDI 6-item Anxiety Scale
Sauber & O'Brien (2020)	USA	CS	DV support services, community	147 w	≥18 (34.7; 9.1)	EA	SEA-12	ABI	ABI	PTSD, Depression	PCL-C, CESD
Strauss et al. (2019)	USA	CS	University students	357 (290 w, 67 m)	18 - 25 (18.64; 1.13)	ST	32-item validated ST measure			Alcohol and Drug Use	AUDIT DUDIT

**Table 2.1 (continued)**

Study	Country	Study Type	Recruitment	Sample	Age Range ( <i>M</i> ; <i>SD</i> )	Type	IPV Measures			Mental Health Constructs and Measures	
							Coercive Control	Psychological	Physical/ Sexual	Constructs	Measures
*Street & Arias (2001)	USA	CS	Shelter	63 w	19 - 64 (32)	CC	PMWI-DI	PMWI-EV	CTS	PTSD, Depression	CMS, SCL-90-R
Stylianou (2018)	USA, Puerto Rico	LO	DV support services	457 w	≥18 (36; 9.15)	EA	SEA-12	ABI-R	ABI-R	Depression	CESD
*Taft et al. (2005)	USA	LO	Partners of IPV perpetrator group program participants	96 w	18 – 59 (34.0; 8.6)	CC	MMEA -RE	MMEA-total	CTS	PTSD	DIS for DSM-III
*Tiwari et al. (2015)	Hong Kong	CS	DV support services	613 w	≥20	CC	CBS-R (Chinese)	C-AAS		PTSD, Depression	PCL-C (Chinese) BDI-II (Chinese)
Voth Schrag et al. (2019)	USA	CS	University students	435 w	≥18 (27; 9.9)	EA	SEA-12		ABI-R	PTSD, Depression	PCL-5 LEC-5, CESD-SF
*Weaver & Etzel (2003)	USA	CS	DV support services	62 w	≥18 (34; 8.4)	CC	PMWI-DI-SF	PMWI-EV-SF	CTS2	PTSD, Depression *	PDS, BDI-II
Wolf et al. (2018)	Denmark	CS	ST support services, groups	196 w	27 - 70 (40.82;6.93)	ST	SBC	PMWI		PTSD	HTQ, TSC-33
*Wolford-Clevenger et al. (2017)	USA	CS	University students	208 (107 w, 101 m)	18 – 29 (19.61; 11.09)	CC	MMEA-RE	MMEA	CTS2	Depression, Suicidal Ideation	PDSQ
*Wolford-Clevenger & Smith (2017)	USA	CS	Shelter	134 w	19 - 67 (32.50; 8.21)	CC	CIPRS		CTS2 (modified)	PTSD, Depression, Suicidal Ideation and Attempts	PCL-C, DASS-21 SI: MSSSI SA: L-SASI

Note: \* = Studies included in the meta-analysis; Study type: CS = cross-sectional, LO = longitudinal, 2nd = secondary data analysis; Sample: w = women, m = men; Age: M = mean, SD = standard deviation.

Type of Coercive Control : CC = coercive control, EA = economic abuse, RC = reproductive coercion, ST = stalking.

Recruitment: Com = community sample (i.e., not specific IPV sample), NVAWS = National Violence Against Women survey (Tjaden & Thoennes, 1999), NISVS = The National Intimate Partner and Sexual Violence Survey (Smith et al., 2017), CWHRS = Chicago Women’s Health Risk Study (Block, 2000); WHES = Women’s Health Effects Study (Ford-Gilboe et al. 2009).

IPV Measures: ABI = The Abusive Behavior Inventory (Shepard & Campbell, 1992; ABI-R = Abuse Behavior Inventory - Revised (Postmus et al. 2016b); CAS = Composite Abuse Scale (Hegarty et al.,1999, 2005), C-AAS = Chinese Abuse Assessment Screen (Tiwari et al., 2007); CBS = Controlling Behaviors Scale (Graham-Kevan & Archer, 2003a); CBS-R = Controlling Behaviors Scale-Revised (Graham-Kevan & Archer, 2003b); CCMIPV = Coercive Control Measure for IPV (Dutton et al., 2005); CIPRS = Coercion in Intimate Partner Relationships Scale (Dutton et al., 2007); CTS = Conflict Tactics Scale (Straus, 1990); CTS2 = Revised Conflict Tactics Scale (Straus et al., 1996); HARASS = Harassment of battered women (Sheridan, 1998); IPV-GBM = Intimate Partner Violence among Gay and Bisexual Men Scale (Stephenson & Finneran, 2013); MASIC = Mediator’s Assessment of Safety Issues and Concerns (Pokman et al., 2014); MMEA = Multidimensional Measure of Emotional Abuse (Murphy et al., 1999), MMEA-RE restrictive engulfment subscale; PCS =

Power and Control Scale (Leone et al., 2007); *PMWI*, *PMWI-SF* = Psychological Maltreatment of Women Inventory (Tolman, 1989;1999) with *PMWI-DI* = dominance/isolation subscale, *PMWI-EV* = emotional/verbal abuse subscale; *PPA* = Profile of Psychological Abuse (Sacket & Saunders, 1999); *SEA-12* = Scale of Economic Abuse-12 (Postmus et al., 2016a); *SBC* = Stalking Behavior Checklist (Coleman, 1997); *SRPS* = Sexual Relationship Power Scale (Pulerwitz et al., 2002); *SVAWS* = Severity of Violence Against Women Scale (Marshall, 1992); *SVS* = Stalking Victimization Survey (Tjaden & Thoennes, 1999), *WAST* = Woman Abuse Screening Tool (Brown, 1996); *WEB* = Women's Experiences with Battering (Smith et al., 1999), *WHOMCS* = WHO Multi-country Study on Women's Health and Domestic Violence Against Women (García-Moreno et al., 2005).

PTSD: *CAPS* = Clinician-Administered PTSD Scale (Blake et al., 1990); *CMS* = The Civilian Mississippi Scale for PTSD (Vreven et al., 1995); *DIS* = Diagnostic Interview Schedule for DSM-III (Robins et al., 1982); *HTQ* = Harvard Trauma Questionnaire (Mollica et al., 1992); *IES* = Impact of Event Scale (Weiss & Marmar, 1997); *ITQ* = International Trauma Questionnaire (Cloitre et al., 2018); *LEC* = Life Events Checklist (Gray et al., 2004); *LEC-5* = Life Events Checklist for DSM-5 (Weathers et al., 2013a); *PCL* = PTSD Checklist (Blanchard et al., 1996); *PCL-C* = PTSD Checklist-Civilian (Weathers et al., 1993); *PCL-C-SF* = PTSD Checklist-Civilian Short Form (Lang & Stein, 2005); *PCL-C-IPV* = PTSD Checklist-Civilian Modified to IPV experience (Weathers et al., 1993); *PCL-5* = The PTSD Checklist for DSM-5 (Weathers et al., 2013b); *PCPTSD* = Primary Care Post-Traumatic Stress Disorder Screen (Prins et al., 2003); *PDS* = The Posttraumatic Diagnostic Scale (Foa et al., 1997); *PSDSWB* = Posttraumatic Stress Disorder Scale for Battered Women (Saunders, 1994); *PSS-I* = PTSD Symptom Scale Interview (Foa, et al., 1993a); *PSS-SR* = PTSD Symptom Scale Self-Report Version (Foa, et al., 1993b); *TSC-33* = The Trauma Symptom Checklist (Briere & Runtz, 1989); *TSC-26* = The Revised Trauma Symptom Checklist (Krog & Duel, 2003).

Depression, Suicidality, Anxiety, Mental Health: *ADIS-IV* = Anxiety Disorders Interview Schedule-IV (Brown et al., 1994); *BAI* = Beck Anxiety Inventory (Beck et al., 1988); *BDI* = Beck Depression Inventory (Beck et al., 1961); *BDI-II* = Beck Depression Inventory (Beck et al., 1996); *BSI* = Brief Symptom Inventory (Derogatis, 1993); *CESD* = Center for Epidemiologic Depression Scale (Radloff, 1977); *CESD-SF* = CESD Short Form (Andresen et al., 1994); *CESD-R* = (Eaton et al., 2004); *CIDI-SF* = International Diagnostic Interview, Short Form (Kessler et al., 1998); *DASS-21* = The Depression Anxiety Stress Scale 21 (Lovibond & Lovibond, 1995); *EPDS* = Edinburgh postnatal depression scale (Cox et al., 1987); *GAD-7* = Generalized Anxiety Disorder 7-item (Spitzer et al., 2006); *HAD* = Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983); *HSCL-25* = Hopkins Symptom Checklist (Parloff et al., 1954; Winokur et al., 1984); *MINI Plus* = International Neuropsychiatric Interview (Sheehan et al., 1997); *MOS* = Medical Outcome Study (Hays et al., 1995); *PDSQ* = Psychiatric Diagnostic Screening Questionnaire (Zimmerman & Mattia, 2001); *L-SASI* = Lifetime-Suicide Attempt Self-Injury Count (Linehan et al., 2006); *SA* = Suicide Attempt *SCL-90-R* = Symptom Checklist 90 (Derogatis, 1983); *SF-36* = Short-Form Health Survey (Ware & Sherbourne, 1992); *SI* = Suicidal Ideation; *SQ* = Symptom Questionnaire (Kellner, 1987); *SRQ-20* = Self-reporting Questionnaire (Beusenberg et al., 1994); *STAI* = State-Trait Anxiety Inventory (Spielberger et al., 1983)

Alcohol and Drug Use: *AUDIT* = Alcohol Use Disorders Identification Test (Saunders et al., 1993); *AUDIT-C* = Alcohol Consumption Questions (Bush, 1998) *CAGE* = CAGE questionnaire (Ewing, 1984); *DUDIT* = Drug Use Disorders Identification test (Stuart et al., 2003); *MFDAQ* = Monitoring the future drug and alcohol questionnaire (Bachman et al., 2011), *NWS* – National Women's Study (Kilpatrick et al., 1997).

References for these measures are provided in Appendix A.4

### **Meta-analyses**

A total of 45 studies with 107 effect sizes addressed associations involving coercive control with PTSD and depression and were included across a series of random effects meta-analyses. The numbers of studies, effect size estimates (weighted mean correlations), 95% CIs, and heterogeneity statistic ( $I^2$ ) for these meta-analyses are summarised in Table 2.2. Forest plots for each meta-analysis are included in Appendix A.5.

#### ***Coercive Control, PTSD and Depression***

The meta-analyses involving coercive control and PTSD identified a significant moderate positive association ( $r = .32$ ; 95% CI [.28, .37]) when pooled across studies, with high heterogeneity ( $Q(20) = 97.62$ ,  $I^2 = 79.51\%$ ,  $p < .001$ ). The meta-analyses involving coercive control and depression showed a significant moderate positive correlation ( $r = .27$ ; 95% CI [.22, .31]) when pooled across studies, with high heterogeneity ( $Q(37) = 289.02$ ,  $I^2 = 87.20\%$ ,  $p < .001$ ).

#### ***Subgroup Analyses***

Subgroup analyses for studies addressing associations involving coercive control with PTSD and depression were performed to examine sources of heterogeneity. These analyses included comparisons according to (1) types of coercive control measure (general coercive control measures vs. specific economic abuse, stalking and reproductive coercion measures) and (2) study settings (domestic violence support services/shelters vs. community). The inspection of the 95% CIs showed a statistically significant difference in the strength of mean correlations between coercive control and PTSD according to study settings, with a stronger pooled association observed in studies of domestic violence support services/shelters settings ( $r = .40$ , 95% CI [.35, .45]), when compared to community settings ( $r = .26$ , 95% CI [.16, .35]). There were no other significant effects. Findings for all performed subgroup

analyses including pooled correlations, 95% CIs and heterogeneity ( $I^2$ ) of studies are summarised in Appendix A.6.

### ***Psychological IPV, PTSD and Depression***

The random-effects meta-analysis showed a significant moderate positive association between psychological IPV and PTSD ( $r = .34$ ; 95% CI [.25, .42]) with high heterogeneity between studies ( $Q(18) = 156.23$ ,  $I^2 = 88.48\%$ ,  $p < .001$ ). The random-effects meta-analysis between psychological IPV and depression showed a significant moderate positive association between psychological IPV and depression ( $r = .33$ ; 95% CI [.26, .40]) with high heterogeneity between studies ( $Q(18) = 124.36$ ,  $I^2 = 85.45\%$ ,  $p < .001$ ). Inspection of the 95% CIs suggests that there are no statistically significant differences in the associations between coercive control and psychological IPV in relation to PTSD and depression (see Table 2.2).

**Table 2.2**

#### *Results of Random-effects Meta-analyses*

Association	Studies $k$	Effect Sizes $k$				Range	$r$	95% CI	$I^2$ %
		Total	Women	Men	Both				
PTSD									
Coercive Control	30	31	28	2	1	-.08 - .56	.32*	[.28, .37]	71.77*
Psychological IPV	19	19	17	1	1	-.15 - .64	.34*	[.25, .42]	88.48*
Depression									
Coercive Control	35	38	31	3	4	-.09 - .59	.27*	[.22, .31]	87.20*
Psychological IPV	18	19	15	2	2	-.08 - .60	.33*	[.26, .40]	85.45*

*Note.* Coercive Control includes economic abuse, stalking, reproductive coercion; IPV = intimate partner violence; PTSD = posttraumatic stress disorder. \* $p < .001$

### **Publication Bias**

All analyses were found to be robust against the risk of publication bias. The results of the Duval and Tweedie's (2000) trim and fill test, the classic fail-safe  $N$  test (Rosenthal, 1979), and Orwin's (1983) fail-safe  $N$  test for each meta-analysis are summarised in Appendix A.7.

### 2.2.5. Discussion

This review examined the mental health implications of coercive control and identified moderate associations with measures of PTSD and depression symptom severity, when considered across all available studies. The overall strength of these associations were comparable to those involving broader measures of psychological IPV with both PTSD and depression. Furthermore, the strength of the associations were comparable to those for physical IPV and combined IPV found in previous meta-analyses. For instance, Spencer et al.'s (2019) large meta-analysis found small to moderate correlations between physical IPV and PTSD ( $r = .34$ ), as well as depression ( $r = .25$ ).

It was unexpected that associations of coercive control with PTSD and depression would not be clearly stronger than associations involving other types of IPV (including broader measures of psychological IPV), and there are several possible explanations for this. First, considering the difficulties of distinguishing coercive control from broader dimensions of psychological IPV in psychometric measures, construct overlap remains likely and could explain similar effects (Dutton & Goodman, 2005). Relatedly, the psychometric measures and subscales that were used to measure coercive control in this review may not have fully captured whether a behaviour occurred in the context of coercive control. For instance, many measures may not fully capture whether respondents experience a threat that is embedded in a chronic pattern of power and control (Johnson, 2008). Second, the chronic pattern of terror and the effects of entrapment that characterise coercive control may be difficult to quantify, and they may not be as clearly measured in psychometric instruments compared to the occurrence of specific behaviours (Dokkedahl et al., 2019). Nevertheless, the similar strength of links involving coercive control and broader dimensions of psychological IPV and physical IPV with mental health symptoms reported in previous meta-analyses, suggests that these dimensions of coercive control are just as important and detrimental as physical IPV.

It was not possible to investigate whether coercive control was associated with CPTSD symptom severity, as only one eligible study measured CPTSD (Dokkedahl et al., 2021). This study reported a small positive correlation ( $r = .23$ ) between coercive control and CPTSD, with stronger links also observed between broader psychological IPV and CPTSD when compared to physical IPV in a shelter sample of 147 women. This dearth of empirical studies, along with Dokkedahl et al.'s initial findings and emerging evidence from qualitative studies (Baird et al., 2019; Salter et al., 2020), as well as strong conceptual reasons for expecting CPTSD symptoms to develop in response to coercive control (Cloitre, 2021; Herman, 1992; WHO, 2019), suggests an urgent need for more research into the relationship between coercive control and CPTSD.

Finally, combined subgroup analyses of economic abuse, reproductive coercion, and stalking did not indicate any meaningful differences compared to general coercive control, but these types of coercive control were not reviewed separately and may have unique impacts that could not be investigated in this review. Notably, subgroup analyses indicated that the associations between coercive control and PTSD were stronger in domestic violence support service/shelter settings compared to community settings, suggesting that the incidence and/or impact of coercive control may be greater in domestic violence crisis response settings.

### **Limitations**

The present study had several limitations, and the findings have to be interpreted accordingly. First, the findings included in the meta-analyses were cross-sectional and a direct causal link between coercive control and mental health could not be established. Second, the overall level of quality in the body of evidence could not be assessed with certainty and clear conclusions about the quality of the evidence could not be drawn. Third, most of the data in the included studies were derived from self-report measures and may be

subject to under or overreporting. We also limited our search to English language reports, which has limited the access to evidence from non-English speaking countries and cultures. Moreover, the majority of studies used symptom severity measures. Only 7.35% of the studies included in the qualitative synthesis, and only 4.44% of the studies included in the meta-analyses used diagnostic instruments (Beck et al., 2011; Mutiso et al., 2020; Newton, 2021; Pickover et al., 2017; Reich et al. 2015). Thus, there was less clear evidence for a direct link between coercive control and mental health diagnoses. Finally, high heterogeneity suggests that other study features that could not be examined in this review may account for this variability. For instance, 76% of the studies focused solely on women, and only three studies focused on men and two on gender diverse populations and subgroup analyses could not be performed. Differences in female, male and gender diverse populations may help to explain some of the heterogeneity.

## **Conclusion**

Despite these limitations, the findings of this review provide important evidence for the mental health implications of coercive control exposure. This was the first meta-analysis that examined the associations involving coercive control and mental health. Results indicate that coercive control exposure is moderately associated with PTSD and depression symptom severity. The strength of these associations were comparable to those involving measures of broader psychological IPV in the present meta-analyses, and to those for physical IPV found in previous meta-analyses. Key findings are summarised in Table 2.3.

### **Table 2.3**

#### *Summary of Critical Findings*

- 
- Coercive control exposure was moderately associated with PTSD and depression symptom severity
  - The strength of these associations was comparable to those involving measures of broader psychological IPV
  - The strength of these associations was comparable to those for physical IPV found in previous meta-analyses
-

## **Implications**

These findings have important implications for clinical practice, research, policy and legislation.

### ***Implications for Clinical Practice***

This meta-analysis provided evidence that coercive control exposure is linked to PTSD and depression, suggesting that coercive control exposure can have long-term mental health implications and that individuals who have been exposed to coercive control would likely benefit from psychological support. However, presently most IPV interventions focus on safety and crisis management (Neave et al., 2016). Subgroup analyses indicated a stronger link between coercive control and PTSD in domestic violence service/shelter settings suggesting that there is a need to include short-term mental health support in crisis response services. Moreover, evidence-based interventions are urgently needed to support long-term recovery, and clinicians need to be trained and supported so that they can provide effective short and long term care.

### ***Implications for Research***

First, the complexity of the coercive control construct and the difficulty to fully and distinctly capture it in most commonly used psychometric measures suggests the need to use more comprehensive measures of coercive control in primary studies. Equally, qualitative research approaches may be well suited to address the nuances in behaviours, such as verbal threats, to determine if they occur within the context of situational couple violence or coercive control. Third, this review identified a lack of empirical studies that have investigated the relationship between coercive control and CPTSD, and more research is needed. Finally, most of the studies were conducted in developed countries and predominantly focused on women in heterosexual relationships. More primary studies in developing countries, and studies with gender diverse samples are needed.

***Implications for Policy and Legislation***

The findings highlight that policy makers and legislators need to consider the mental health impacts of coercive control when implementing policies and legislations surrounding the criminalisation of coercive control, and to provide funding for trauma-informed mental health services that support the long-term recovery of those who have been exposed to coercive control. The implications for clinical practice, research, and policy and legislation are summarised in Table 2.4.

**Table 2.4***Implications for Clinical Practice, Research, Policy and Legislation*

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**Implications for Clinical Practice**

- Coercive control exposure is linked to PTSD and depression, suggesting long-term mental health implications that require mental health support
- Trauma-informed interventions are needed to support long-term recovery
- A stronger link between coercive control and PTSD in DV service/shelter settings suggests a need to include short-term trauma-informed mental health care in crisis response services
- Clinicians need to be trained and supported so that they can provide effective short and long term care.

**Implications for Research**

- Coercive control is difficult to capture in most commonly used psychometric measures and more comprehensive measures of coercive control need to be used in primary studies
- Research into the development of more specific coercive control measures is needed
- Qualitative research approaches may be well suited to address the nuances in behaviours, such as verbal threats, to determine if they occur within the context of situational couple violence or coercive control.
- There is lack of empirical studies that have investigated the relationship between coercive control and CPTSD, and more research is needed
- More research in developing countries is needed
- More research with gender diverse samples is needed

**Implications for Policy and Legislation**

- The mental health impacts of coercive control need to be considered in policies and legislations surrounding the criminalization of coercive control
  - Funding for trauma-informed mental health care that supports the long-term recovery of those who have been exposed to coercive control is needed
-

### 2.2.6. References

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### **Chapter 3: Lived Experience of the Mental Health Impacts of Coercive Control**

#### **3.1. Embedding Lived Experience in Coercive Control Research**

The review in Chapter 2 highlighted that it is difficult to capture the varied, complex and nuanced experiences of coercive control in quantitative measures. Given that qualitative research can provide the vital context needed to explore the complexities and nuances of coercive control, a qualitative research approach was employed to further investigate the experience of coercive control and the mental health reactions following coercive control exposure (e.g., Langhinrichsen-Rohling et al., 2012).

Hearing the voices of women who have experienced coercive control and understanding the complexity of their lived experiences and mental health reactions following coercive control, is essential to inform the design and implementation of psychological interventions (Vaughan, 2014). Study 2 was inspired by a community based participatory research (CBPR) approach, which is as an approach where researchers and participants share power, resources, and decision-making at every level of the research process to enhance understanding, integrate knowledge with action to improve the wellbeing of those most affected (Goodman et al., 2018). Integrating CBPR principles decreases the power and control of the researcher, which is particularly important for vulnerable and traumatised populations, such as victim-survivors of coercive control. The CBPR approach was guided by Goodman et al.'s (2018) *CBPR toolkit for domestic violence researchers* which is led by four questions: (1) "What are the critical questions for victim-survivors and practitioners in this community?"; (2) "How can we best explore such questions using strategies that are clear, consistent, and replicable; that is, scientifically rigorous?"; (3) "How can we ensure that these strategies are sensitive to the backgrounds, cultural practices, and life contexts of community stakeholders?"; and (4) "How can we interpret and disseminate our findings in ways that benefit survivors, practitioners, and communities?".

However, because of the Covid-19 pandemic related restrictions, severe floods that destroyed the town and secure premises from where most interviews were conducted, and limited funding, the CBPR approach could predominantly only be employed during the recruitment and interview process.

### **3.2. Gender Controversy in IPV Research**

Studies 2 and 3 focused on individuals who identify as women for several reasons. First and foremost, although men are clearly also exposed to coercive control, more women than men experience coercive control (Australian Bureau of Statistics, 2021- 2022). Second, Dokkedahl et al.'s (2022) recent meta-analysis suggests that coercive control and PTSD are more strongly associated for women compared to men. Furthermore, there has been an ongoing theoretical controversy about gender differences in IPV victimisation and perpetration for over five decades (Conroy et al., 2023; Winstok, 2011). IPV research emerged from the feminist movement in the 1970s and was initially conceptualised within a paradigm of female victims and male perpetrators in traditional heterosexual marriages, which is reflected in terminology such as wife battering/abuse (Pence, 1983; Pence & Paymar, 1986). However, evidence soon emerged that both women and men can be victim-survivors of IPV (Straus & Gelles, 1986). More recent evidence suggests that both women and men can be victims and perpetrators of IPV, but that they are affected differently and differ in their use of types of violence (Laskey et al., 2019).

The gender controversy is led by two schools of thought: One school are the feminist scholars who are proponents of *gender asymmetry* and propose that IPV is primarily perpetrated by men to assert power and control over women; or if violence is used by women, it is used for self-defence or *violent resistance* in response to men's violence (e.g., Dobash & Dobash, 1979, 2003, 2004; Dobash et al., 1992; Johnson, 2005; Saunders, 1986; Tjaden & Thoennes, 2000). The other school, family violence researchers, are proponents of *gender*

*symmetry* and propose that both men and women can be victims and perpetrators of IPV, albeit not necessarily in equal proportions or ways (e.g., Magdol et al., 1997; O'Leary et al., 1989; Straus, 2007; Straus & Scott, 2009). The fundamental difference between the two schools of thought is that feminist researchers emphasise gender differences (i.e. asymmetry), whilst family violence researchers emphasise similarities (i.e. symmetry), and do not view gender as a predictor of IPV per se, but focus instead on the dynamics of aggression (Winstok, 2011).

In an attempt to resolve the gender controversy, Johnson (2005, 2006, 2008) identified two key types of IPV: *situational couple violence* and *intimate terrorism*. Johnson's typology was briefly discussed in the general introduction, but is expanded on here in the context of the gender controversy. Johnson defined situational couple violence as a form of IPV that is situationally provoked and that tends to be equally perpetrated by men and women. Conversely, intimate terrorism is a form of IPV that is embedded in a general pattern of power and control where the perpetrator utilises controlling behaviours to exercise power and control over their partner. Intimate terrorism is the more damaging form of IPV which is predominantly experienced by women at the hands of men (Johnson, 2005, 2008; Johnson & Leone, 2005; Myhill, 2015). For instance, Tiwari et al. (2015) compared the health impacts of situational couple violence and intimate terrorism in a sample of 613 Chinese women who had been exposed to IPV. The study showed that victims of intimate terrorism reported significantly more IPV-related physical injury, higher use of medical service and more symptoms of depression and PTSD, compared to those exposed to situational couple violence.

Even proponents of gender symmetry acknowledge that women experience more frequent and severe injuries including death compared to men (e.g., Archer, 2000; Kimmel, 2002; O'Leary et al., 1989; Straus & Scott, 2009). This is supported by evidence that has

shown that women tend to experience more ongoing and severe violence and are at higher risk of re-victimisation, and mental health consequences including PTSD, depression, anxiety, substance use disorders and suicidality (e.g., Beck et al., 2016; Loxton et al., 2017; Molyneaux et al., 2020; WHO, 2013).

Therefore, whilst some women may engage in coercive and controlling behaviours, women are more likely to be exposed to a pattern of coercive control and they are also more severely affected by it (Australian Bureau of Statistics, 2021-2022; Johnson & Leone, 2005; Leone et al., 2014; Tiwari et al., 2015). For example, coercive control by men perpetrated against women is a predictor of male perpetrated intimate partner homicide, which is the predominant reason for the call for criminalisation of coercive control (Johnson et al., 2019). Given both the empirical evidence and the theoretical argument that women are clearly more frequently and severely impacted by coercive control, the qualitative studies focused on the lived experiences of women. Additionally, from a feasibility perspective, the family violence service from where participants were recruited from provides their services exclusively to women and recruitment of men was beyond the scope of recruitment pathways for this thesis.

### 3.3. Study 2

#### **“It's Like you're a Living Hostage, and it Never Ends.”: A Qualitative Examination of the Trauma and Mental Health Impacts of Coercive Control**

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### 3.3.1. Abstract

Coercive control is a complex and poorly understood dimension of intimate partner violence that is associated with trauma and mental health consequences. It is essential to understand the nuanced and varied experiences of coercive control and potential processes of traumatization. In this qualitative phenomenological study, we conducted semi-structured interviews with 16 women who had experienced coercive control and had accessed domestic violence services in Australia. Data were analysed using thematic analysis and addressed two research questions (1) How do women describe their experiences of coercive control? (2) How do women describe the impact of coercive control exposure on their mental health? Findings identified entrapment and insidiousness (characterised by subtlety, intangibility, gradual worsening), as underlying dimensions of coercive control that are likely central to the trauma and mental health reactions of women who have been exposed to coercive control. Women described a range of trauma and mental health reactions (e.g., anxiety, hypervigilance, affective dysregulation, negative self-concept, disturbances with trust and relationships). The findings have important implications for research and clinical practice, highlighting the pressing need for trauma-informed integrated psychosocial care by frontline services, health care providers and mental health professionals for women who have been exposed to coercive control.

### 3.3.2. Introduction

*Intimate partner violence* (IPV) is a major public health and human rights concern that affects one in three women in Australia and worldwide (Australian Bureau of Statistics, 2017; World Health Organisation [WHO], 2017, 2021). IPV exposure is associated with long-term physical and mental health consequences, such as posttraumatic stress disorder (PTSD), depression, suicidality, anxiety, alcohol and substance use (WHO, 2017). IPV may include physical, sexual, and psychological forms of abuse. Coercive control is a major and highly prevalent dimension of psychological IPV, occurring in up to 58% of IPV relationships (Kennedy et al., 2018). More women than men experience coercive control, and this study focuses on individuals who identify as women (Australian Bureau of Statistics, 2022). Coercive control may be characterised by degradation, isolation, and the deprivation of rights to physical security, dignity, and respect. Such exposures typically reflect a chronic pattern of behaviour from a perpetrator that puts the victim in a state of terror and entrapment, and may involve tactics such as monitoring movements, enforced social isolation, and restriction of access to financial resources, employment, education, or medical care (Pitman, 2016; Stark, 2007; Stark & Hester, 2019). These coercive and controlling tactics may also include the use of actual or threatened physical violence to maintain a sense of threat and fear (Stark, 2020).

Although there is no consistency in the conceptual literature, coercive control has been described variously as a ‘context’ for abusive behaviours (which may or may not include physical violence) (Dutton & Goodman, 2005; Stark, 2007; 2020), as well as a sub-type of IPV; which has been referenced in terms of ‘intimate terrorism’ and contrasts with ‘situational couple violence’ that does not occur in the context of coercive control (Johnson, 2008). Notwithstanding this, coercive controlling contexts or types of IPV are the main forms encountered in specialist family and domestic violence services, and in such contexts the notions of coercive control and IPV are often used synonymously (Boxall et al., 2020).

Research to date on the mental health consequences of IPV has predominantly focused on the impacts of exposures to physical violence (not necessarily embedded in a pattern of coercive control) (e.g., Spencer et al., 2019), whereas the potential implications of psychological forms of abuse have been only recently widely acknowledged (Myhill & Hohl, 2019). However, a recent systematic review and meta-analysis of quantitative observational studies (Lohmann et al., 2023) indicated that the magnitude of associations with coercive control and measures of PTSD and depression severity were comparable to associations with physical IPV exposure reported in previous meta-analyses (e.g., Golding, 1999; Spencer et al., 2019; Stith et al., 2004). It also remains plausible that coercive control may have unique and complex impacts on mental health, relative to exposures to other dimensions of violent behaviour that are not embedded in contexts of coercive control (including physical violence) (Dokkedahl et al., 2021; Fernandez-Fillol et al., 2021; Lohmann et al., 2023). Quantitative studies may thus be poorly suited to capture the nuanced features of coercive control (Crossman et al., 2016; Lohmann et al., 2023), such as whether actual or threatened physical violence occur in the context of a chronic pattern of intimidation, degradation, and power or control dynamics (Dokkedahl et al., 2019; Johnson, 2008). Coercive controlling behaviours can be sophisticated and nuanced, and qualitative methods that provide in-depth narrative accounts are essential for making visible the complexity and lived experiences of coercive control (Langhinrichsen-Rohling et al., 2012; Pitman, 2016).

Research that gives visibility to the complex impacts of coercive control on mental health is critically important as the psychological dimensions of IPV remain poorly understood. Frontline services and mental health professionals may discount the effects of non-physical abuse and may respond in ways that leave women and children unprotected (Brennan et al., 2019; Marsden et al., 2021; Pitman, 2016; Stark, 2007). There are a small number of qualitative studies that have explored the trauma and mental health implications of

IPV. These studies have documented impacts that can last well beyond the end of the abusive relationship (e.g., Baird et al., 2019; Moulding et al., 2021; Salter et al., 2020; Scheffer-Lindgren & Renck, 2008). For instance, Baird et al. (2019) interviewed 15 help-seeking women who had been exposed to IPV in Canada and documented mental health reactions consistent with PTSD, including hypervigilance, avoidance, flashbacks, nightmares, trouble sleeping, and heightened startle response, guilt and shame (American Psychiatric Association, 2022). Similarly, a study involving qualitative interviews with 40 women from Australia who had been exposed to complex trauma, including IPV, provided comparable narrative accounts of these experiences (Salter et al., 2020). The term complex trauma is commonly used to reference exposures to repeated or multiple and prolonged interpersonal traumatic events (such as childhood sexual abuse) that are extremely threatening or horrific in nature (Briere & Scott, 2015; Cloitre et al., 2009; Herman, 1992; Salter et al., 2020; WHO, 2019). On the basis of interviews, Salter et al. (2020) described the compounding and cumulative impacts of prolonged trauma and its lasting negative mental health impacts. For instance, many women reported experiencing anxiety, depression, emotion dysregulation, flashbacks, nightmares, dissociation, difficulties with concentration, and impacts on relationships that put an ongoing strain on their emotional, physical and economic resources (Salter et al., 2020). In some instances, this constellation of mental health reactions may align with complex PTSD (CPTSD) (Briere & Scott, 2015; Cloitre et al., 2009; Herman, 1992, WHO, 2019). The current edition of the *International Statistical Classification of Diseases and Related Health Problems* (11th ed; WHO, 2019) introduced a diagnostic classification for CPTSD. Diagnostic criteria for CPTSD involve disturbances in self-regulation in the domains of affective dysregulation, negative self-concept and disturbances with trust and relationships, when they occur additionally to the diagnostic criteria of PTSD. A key diagnostic criteria for CPTSD is the “exposure to an event or series of events of an extremely threatening or horrific

nature, most commonly prolonged or repetitive events from which escape is difficult or impossible” (WHO, 2019). Given the prolonged and chronic terror associated with coercive control, it is possible that at least some women who have experienced coercive control may meet diagnostic criteria for CPTSD (Lohmann et al., 2023). Notably, participants in both Baird et al.’s (2019) and Salter et al.’s (2020) studies reported complaints potentially consistent with disturbances in self-organisation, including affective dysregulation (e.g., “anger outbursts”, “absolutely zero mood regulation”); negative self-concept (e.g., guilt, shame, worthlessness) and disturbances in relationships (e.g., “difficulty maintaining and starting relationships”).

A recent Australian study that focused specifically on the mental health sequelae of IPV exposure involved life history interviews with 17 women who had been exposed to IPV and emphasised that coercive controlling behaviours had major impacts on their distress (Moulding et al. 2021). Many women in this study described how coercive control was central to eroding their sense of self, confidence and self-esteem, as well as their trust in others, which is consistent with the disturbances in self-organisation associated with CPTSD. However, to our knowledge, no qualitative study has so far specifically examined how women describe the impact of coercive control exposure on their mental health.

### **Aims of the Present Study**

Hearing the voices of all who identify as women and who have been exposed to IPV is essential to further both research and practice in this area, and to better understand the complex and nuanced construct of coercive control and potential processes of traumatization (Goodman et al., 2018; Vaughan, 2014). A better understanding of the lived experience of coercive control and its trauma and mental health impacts is also vital to inform the development of targeted and integrated trauma-informed psychosocial interventions that can support the long-term recovery of women who have been exposed to coercive control

(Crossman et al., 2016; Pill et al., 2017; Stark, 2007). Accordingly, in this qualitative study we aimed to address several gaps in past IPV research through the lens of lived experience. By interviewing women who had been exposed to coercive control we aimed to enhance understanding of the nuanced and complex construct of coercive control and its complex trauma and mental health impacts. By deeply listening to women who have experienced coercive control we also aimed to identify the defining characteristics of coercive control and how these characteristics can uniquely impact on women's mental health, so that services and mental health professionals can better support these women. We were guided by two overarching research questions:

**Research Question 1:** How do women describe their experiences of coercive control?

**Research Question 2:** How do women describe the impact of coercive control exposure on their mental health?

### **3.3.3. Method**

#### **Study Design**

This study focused on the IPV and coercive control experiences of women who resided in regional Northern New South Wales, Australia and who had accessed domestic violence support services. For context, in this region, 1070 domestic violence incidences were reported to the police between July 2021 to June 2022 and about 57% of these reports included coercive control (NSW Bureau of Crime Statistics and Research, 2023; Kim & Karystianis, 2023). More broadly, New South Wales has recently passed a new legislation to criminalise coercive control which will come into effect in 2024. In Australia legislation relating to family and domestic violence including coercive control is typically organised at the level of sub-national jurisdictions (i.e., states). However, the Commonwealth of Australia (2023) has recently released a national plan that endeavours to address coercive control across all states.

This qualitative study used a descriptive phenomenological approach and was embedded in a social constructivist paradigm, which recognises that meaning and understanding are developed through the researchers' active involvement in the construction of meaning (Kim, 2014, Tomaszewski et al., 2020). Semi-structured interviews were used to collect data as they simultaneously allow for a broad summary of participants' lived experiences and an in-depth exploration of the specific phenomena through the lens of the research questions. The study was also influenced by feminist research principles, including the recognition of power and gender imbalances, the importance of listening to women's voices, emphases on diversity and intersectionality (e.g., gender, race, class), reflexivity about the researcher's impact on participants, and the focus on practical research that promotes activism and advocacy (Beckman, 2014; Creswell & Poth, 2016). Moreover, the study was guided by qualitative community based participatory research principles, which emphasise collaboration between researchers and participants for purposes of enhancing understanding, integrating knowledge with action, and to improve the wellbeing of those most affected, which can decrease the power and control of the researcher and is particularly important for work with vulnerable and traumatised populations (Goodman et al., 2018). Although we had insufficient resources to fully incorporate a community based participatory approach, the relevant principles were integrated predominantly into the recruitment and interview processes. This involved discussing and agreeing upon recruitment materials and the interview guide with service representatives (Goodman et al., 2018). We also received guidance from service representatives on how to conduct the recruitment and interview process. This included a consultation with a First Nations representative to ensure cultural sensitivity in the recruitment and interview process with First Nations women. For instance, the First Nations representative advised to give women the choice to have their children with them at the interview, or to bring a family member as support. Service representatives also

suggested to offer women the option to have a free trauma counselling session after the interview. This service was provided by a trauma counsellor associated with the service (Goodman et al., 2018).

The study received ethics approval from the University of Melbourne (Ethics ID 22011).

### **Researchers**

The first author, a White cisgender heterosexual mature age woman, is a clinical psychology registrar and PhD candidate. The second and third authors, also White cisgender heterosexual women, are experienced clinical psychologists and researchers with expertise in posttraumatic mental health. The last author, a cisgender heterosexual man, is a psychology trained researcher with expertise in trauma and intimate partner violence. The researchers have previously published a meta-analysis examining the trauma and mental health impacts of coercive control. We acknowledge that this prior knowledge of the researched phenomena and familiarity with psychological research and practice reflects our positionality (Savin-Baden & Major, 2023). Due to our psychology backgrounds, we approached the study from a position of conceptualizing coercive control as a major form of trauma in the community, and a belief about the important role of the psychology profession in addressing the mental health impacts of coercive control. This may have enhanced the data collection and analysis because researchers were able to link the phenomena participants were describing with experience from clinical practice and evidence from prior research. However, preconceptions may have also limited the understanding of the phenomena participants described (Darwin-Holmes, 2020). For instance, although not intended by the authors, some conceptualisations of mental health reactions, may appear pathologising or stigmatising for readers who may not view the researched phenomena through a psychological lens.

## **Participants**

Participants were 16 cisgender women who identified as heterosexual and had experienced abuse by a male intimate partner. Participants were aged between 26 and 61 years ( $M = 46$ ). All participants were residing in New South Wales, Australia at the time of their interview. Aside from one, all participants were separated from the abusive partner at the time of the interview. Interviews were conducted between November 2021 and April 2022. Ten interviews took place face-to-face and six using the video conferencing platform Zoom. Interview times ranged from 44 to 108 minutes ( $M = 63$ ). The lengths of abusive relationships ranged between five months to over 40 years. Participants' demographic characteristics are summarised in Table 3.1.

## **Researcher-Participant Relationship**

None of the authors had prior contact with participants and only the first author conducted the interviews and had direct contact with participants. The first author is a long term resident of the region where participants were recruited from and is familiar with the local sociocultural environment. The combination of this familiarity and the first author's clinical experience likely facilitated an empathetic connection with participants that allowed them to feel safe and supported during the interview process, which positions the first author towards the insider end of the insider-outsider continuum (Darwin-Holmes, 2020).

## **Recruitment**

Participants were recruited through a comprehensive domestic violence and housing support service located in regional Northern New South Wales in Australia, and its wider network, using non-probability purposive sampling (Etikan et al., 2016). All who identified as women and who were service users, at least 18 years old, and who had been exposed to IPV (physical, sexual, emotional, coercive control) were eligible to participate in the study. To be included participants had to feel safe to participate in the study (i.e., they either had left the

abusive relationship or, if they were still in the relationship, they had to feel safe to participate).

We were guided by Hennink and Kaiser's (2022) systematic review that reviewed 23 articles that used empirical data or statistical modelling to assess saturation for qualitative research to determine the number of participants. Hennink and Kaiser found that data saturation for qualitative interviews was generally reached within a range of between 9 to 17 interviews for a relatively homogenous research focus and study population, such as in the present study. We also considered the relative vulnerability of the study population, and the added challenge of recruiting during major disasters (Hennink & Kaiser, 2022). These included the Covid-19 pandemic and severe floods that destroyed the town and secure premises from where most interviews were conducted.

Flyers advertising the project were put up at the service's premises and distributed by email to its network of service providers. Potential participants who volunteered to participate in the study provided consent and were contacted by phone by the first author to schedule the interview. Participants who volunteered to participate signed a consent form and completed the demographic questionnaire before the interview. In-depth semi-structured interviews, lasting approximately one hour, were conducted either face-to-face at a safe location, or via the Zoom videoconferencing platform depending on participant preferences. Interviews were conducted, audio recorded, and transcribed verbatim by the first author. Participants received a \$50 electronic gift voucher to reimburse them for their time and travel expenses after the interview. To protect their anonymity and safety, participants have been fully deidentified and assigned a number (1-16).

**Table 3.1***Participants' Demographic Characteristics (n = 16)*

Demographic Characteristics	Participants (%)
Age (years)	
18 – 29	1 (6.25)
30 – 39	3 (18.75)
40 – 49	6 (37.50)
50 – 59	5 (31.25)
60 – 69	1 (6.25)
Ethnicity/Cultural Background	
Aboriginal or Torres State Islander	3 (18.75)
Latina	1 (6.25)
Italian	1 (6.25)
White/Australian	11 (68.75)
Number of Children	
0	1 (6.25)
1	2 (12.5)
2	5 (31.25)
3	5 (31.25)
4	1 (6.25)
5	1 (6.25)
11	1 (6.25)
Accommodation	
Own Home	8 (50)
Renting	7 (43.75)
Homeless	1 (6.25)
Employment	
Full time	4 (25)
Part time	5 (31.25)
Casual	3 (18.75)
Self-employed	2 (12.5)
Unemployed	1 (6.25)
Disability Pension	1 (6.25)
Education	
Secondary	3 (18.75)
Diploma/TAFE	6 (37.5)
University – Undergraduate	7 (43.75)
Physical Disability	
Yes	1 (6.25)
No	15 (93.75)
Self-rated General Health	
Poor	1 (6.25)
Fair	5 (31.25)
Good	6 (37.5)
Very Good	4 (25)
Self-rated Mental Health	
Poor	2 (12.5)
Fair	2 (12.5)
Good	9 (56.25)
Very Good	3 (18.75)

## Materials

Participants completed a brief demographic questionnaire before the interview. The responses are summarised in Table 3.1. The interview guide included three overarching questions and nested prompts that were developed through an extensive review of the literature and in consultation with the service's representatives (Goodman et al., 2018). The questions covered three main areas of inquiry: (1) Experiences of IPV in general and coercive control in particular ("could you please tell me about your experience of intimate partner violence/ domestic violence?", "have you been exposed to coercive control, if yes what did you experience?"). This included a prompt to check whether the participant was familiar with the concept of coercive control, if not the concept would be explained as outlined in the interview guide. (2) Mental health impacts of IPV exposure ("do you think the abuse has affected your mental health, if yes how?"); and (3) what participants would need/ want from psychological support ("how do you think psychological support could benefit you?"). Because of the complexity of the responses this report focused on the first two questions and the presented data pertains to the research questions. The third question will form the basis of a separate report. The full interview guide is included in the supplementary materials. A distress protocol was created in line with the *Ethical and Safety Recommendations for Intervention Research On Violence Against Women* (WHO, 2016).

## Data Analysis

Interviews were transcribed verbatim and transcripts were analysed using a reflexive thematic approach that conceptualised themes as meaning-based patterns and acknowledged the active role of the researcher in the analytic process (Braun & Clarke, 2006; 2013, 2020). To acknowledge that the authors had prior knowledge of IPV research and theory, a combined deductive-inductive approach was used to account for themes that aligned with previous research, and were also formulated from the data (Saldaña, 2021). The data analysis was

guided by Braun and Clark's approach to systematic thematic analysis, which consists of six validated phases: (1) *familiarization with the data*; (2) *generation of codes*; (3) *searching for themes*; (4) *reviewing themes*; (5) *defining and naming themes*; and (6) *reporting*.

In the first step, data familiarization, the first author transcribed each interview and read transcripts several times, noting initial ideas and possible conceptualizations as headings in a spreadsheet. Supporting extracts of raw data were organised under these headings in the spreadsheet, which included two broad areas: (1) IPV exposure experiences and (2) mental health outcomes. In the second step, a codebook looking at these two broad areas was developed by the first author to document the generation of codes (Saldaña, 2021). The code book consisted of five columns: (1) code label, (2) definition, (3) description, (4) qualifications or exclusions, and (5) examples of participant quotes.

The first author reviewed the transcript and created the initial draft of the codebook, while the second and last author actively participated in the review and editing of the codebook. The first, second and last author met regularly to discuss the codes and any inconsistencies were resolved by consensus (Roberts et al., 2019). In the third step, the first, second and last author met regularly and searched the code book for themes, using thematic analysis mostly at a semantic level focusing on participant's descriptions of their coercive control experiences and mental health reactions. We used thematic analysis at a latent level to identify the underlying ideas, assumptions and conceptualizations that were theorised to shape or inform the semantic content of women's coercive control experience (Braun & Clarke, 2006). This process included the use of an interactive electronic mind mapping tool. The first author developed a detailed and reflexive account of procedures. The results of the thematic analysis were discussed amongst the first, second and last authors and any disagreements were resolved by consensus (Creswell & Miller, 2000). The third author was

not directly involved in this data analysis process, but critically reviewed the themes to enhance reflexivity and rigor.

### **Methodological Integrity**

Throughout the research process the authors reflected on their positionality and employed reflexivity by striving to become aware of assumptions and biases that may have influenced the data collection and analysis. For instance, the first author reflected on how being a professional middleclass White woman may have impacted on data collection when interviewing First Nations or homeless women. Reflexive journaling, regular reflexive discussions between the first, second and last author, as well as critical reflections by the fourth authors were intended to establish credibility and rigor. The study aimed to adhere to rigorous reporting guidelines by following the Standards for Reporting Qualitative Research (O'Brien et al., 2014) and the Consolidated Criteria for Reporting Qualitative Studies (Tong et al., 2007).

### **3.3.4. Findings**

#### **Experiences of Coercive Control**

All women stated that they were familiar with the concept of coercive control and reported exposures to coercive and controlling behaviours when they were asked about it during the interview process. These behaviours are summarised and supported by illustrative quotes in Table 3.2. As shown, these included monitoring of movements, such as being interrogated about their whereabouts and activities, and in some cases having phones and other electronic devices tracked. Many women described being isolated from family and friends, with such experiences being magnified for those living in remote locations. Some women also described extreme restriction of autonomy and being imprisoned in their own home for months and even years. They overwhelmingly reported that their abusive partner controlled many, if not all, aspects of their lives, including sleeping, clothing, eating, and

finances. Several women stated that the abusive partner used gaslighting, a type of psychological manipulation that leads a person to question the validity of their thoughts, memories and perception of reality (Li & Samp, 2023). These tactics made them question their own sanity or powers of reasoning. They also reported that the abusive partner used intimidation tactics that evoked extreme fear and anxiety. Moreover, women commonly described a range of threatening behaviours, predominantly threats to harm or kill the woman, her children, or pets. Some abusive partners were reported to threaten suicide if the woman would not comply with his demands, or when she disclosed plans to leave the relationship. Women often described their abusive partner as manipulating family members, friends, colleagues, or their children. Furthermore, women commonly described their partner as being jealous of activities that did not involve or centre around the abusive partner, who were also described as regularly criticizing and humiliating the women, both in private and in front of others. Finally, many women reported several types of financial abuse, such as control over finances, irresponsible spending behaviours including gambling that the abuser kept secret or lied about and exploiting women as free labour.

**Table 3.2***Women's Experiences of Coercive and Controlling Behaviours*

Coercive Control Behaviours	Quotes
Monitoring	"I would go to the gym. That was one thing I could do but it was always a call before going to the gym. After, straight after the class, if I didn't pick up straight away: Who did you know? Why don't you pick up? Who did you see? What class did you go to? Why aren't you home? What have you done today?" (1)
Tracking of Phones and Devices	"I discovered that he had tracking devices on my phone...and there was spyware on the computer..." (12)
Isolation	"He isolated me from my friends and family made it so that my friends felt very unwelcome visiting and my mom and dad felt very unwelcome visiting. And so, we lived out of town, 30 minutes out of town, and I didn't drive. ... I was isolated and controlled" (14)
Restriction of Autonomy	"He wouldn't let me out of my house for three months, he kept me prisoner in my own home for three months." (8)  [You actually didn't leave the house for 5 years?] "No. The only places we go if he was like you'd come to doctors with me, that's about it. He used to lock me in the house with him. We lived in a share house and I wasn't allowed to go outside of the room and associate with other people." (10)
Controlling Behaviours	"He started controlling money, what I wore, what I ate, when I ate, who I talked to. I mean he was trying to force feed me food I didn't even like." (10)  "And if I had actually fallen asleep, he would wake me up to go and get him food, he would wake me up to mull him up some pot, and he would wake me up for anything. So, I was always on this constant sitting on the edge." (13)
Gaslighting	"So, he did a huge amount of gaslighting "that didn't happen". "No, I'm not having an affair". "You're making it up, you know", incontrovertible evidence like it was. But you know, that's not happening. "Yeah, that didn't happen". "It wasn't that bad". "I didn't say like that". "I didn't mean it". Like I didn't do that." (3)
Intimidation	"I just coward and I wouldn't argue back. Like I tried not to argue back with him. I tried to keep things smooth. But I couldn't keep up with the housework. I was so fatigued and so confused. Everything was my fault of course. As well as having to jump to his every need." (13)
Threatening Behaviours	"I always felt like, under threat, and that I couldn't defend myself against somebody who was using their words with such malice, and ill intent. And somebody who was so clever with their words..." "Lots and lots of threatening things... He told me if I called the cops that he would kill me." (9)
Manipulation	"Someone actually did tell me after he had been arrested that he had been working on a plan. And they'd heard him, and this was actually his ex, who he beat with a colander. And she still loved him. And she'd said to me, when you do find a place, I don't want to know where it is. Because when he gets out of jail, he will come to me, he will make a beeline to me, and he will ask where you are. And if I know where you are, I will tell him I can't say no to him." (13)

**Table 3.2 continued**

Threatening Suicide	"And threatening, he's going to kill himself and says things like, I'm going to do this. And he used to send messages to the girls all the time. And that he's going to finish it off today. These goodbye messages. Like he's suicidal. Like, it's going to be the end, but he doesn't, they're just all bullshit. They are not even real. For a long time, I thought he is suicidal, that's why I rang that mental health when he disappeared that time. I literally thought he was going to kill himself." (4)
Manipulation of Family and Friends	"How did he use the kids? Um, so he would say things to them that weren't true. And then they'd come home and say something and I'd never wanted them to feel like they're in the middle. I always turn the other cheek always take the high road. I made all the sacrifices. I chose to do that because there was no winning, and the only losers would be them." (6)
Jealousy	"I was accused of having affairs with two of my ex boyfriends from 100 years back, but one died and I had an affair with someone that's in a [overseas] jail, who was a friend of mine. So, what he was doing was accusing me and attacking me about people that were not in a position to defend me and defend themselves." (16)
Denigration and Humiliation	"During the course of those four days, at one point, he made me call my mum and a number of friends and family. And I was told to tell them I was a dirty, filthy stinking whore. And it was all my fault." (13)
Financial Abuse	"We had a joint account. And all the money would go in there and I wasn't allowed to access." (7)  "I couldn't even have my purse, my money, anything. He'd have everything" (8)
Irresponsible Spending and Gambling	"I discovered that he had lots of credit cards that were maxed out... And I later found out that he was an addicted gambler." (12)  "He used to take nearly like every cent and just like gamble it. He'd used to take my key card. Back then I didn't have internet banking, or none of that. So that was like one way how he got my money and he just done pretty, like I would go, he'll let me go and get the kids' stuff and that but other than that he took the rest." (5)
Spending Money on Self but not on Family	"There was always enough money for him to wear designer clothing but I just wore things that are on sale, we'd go to shopping trips up the coast, he would buy expensive jeans and then he would give me \$50 or something you know and he would spend a few \$100." (1)  "Yeah, and stuff like making big purchases for himself, which meant the kids money, and they kind of really went without." (3)
Exploiting Women as Free Labour	"One of the devaluing things that he would do to me, I ended up being slave labour. I was working from morning till night free basically doing farm work for the produce for their business, and I didn't get it, I didn't say that I just thought he's my partner. I left my job for him. I had left my own job so I essentially became free labour." (16)

## **Underlying Sense of Entrapment and Insidiousness**

Thematic analysis at the latent level identified entrapment and insidiousness as two overarching themes and defining characteristics of the women's coercive control experiences.

### ***Entrapment***

The experience of entrapment was identified as an overarching theme, with almost all participants describing the feeling of being psychologically trapped in the coercive controlling relationship. Multiple women equated the experience to being in a concentration camp or being held hostage: "It was like being in a concentration camp,... it was a psychological boxing ring the whole time." (16) "It's like you're a living hostage, and it never ends." (1)

Several women highlighted that the abusive partner targeted their psychological vulnerabilities to foster dependency, which added to the sense of entrapment and inability to leave the relationship: "And he could see what my addictions were. And he was using that to reel me in and feeding that, so I was becoming dependent on him very, very quickly." (13) "It's like, at first, you think, oh, you know, I'm not gonna put up with this. And it's, but it's like, you are chucked into this vulnerable situation, like where do I go? What do I do?" (10)

Some women stated that they stayed in the relationship because it felt safer to stay, and because they wanted to protect their children, fearing that they would not be safe if they would have to stay with or spend time alone with the abusive partner, or that he would take the children away: "It's actually safer to stay there and play the game and keep an eye on him than it is to leave." (4)

"My neighbour said you just need to leave you really need to leave. I know, but it's really not that simple. But this was right in the middle of it. I said I can't that's actually not safe. I can't....it's going to have an impact on my kids." (3)

Women often emphasised how their social and economic circumstances contributed to the sense of being trapped in the relationship, and referenced factors including isolated living situations, being away from friends and family, limited finances, homelessness or fear of homelessness, lack of support services and pregnancy and/or childbirth. For instance, several women highlighted how pregnancy and/or childbirth increased their entrapment as illustrated by the quote below.

"I experienced health issues plus also elevated cortisol levels during the pregnancy from the stress that I was feeling. Trapped in a relationship I didn't want to be in and the coercive control was definitely building up during [my son's] pregnancy. I was very, very anxious and all the things that were going on that, you know, when he was nine days old, that physical violence, was able to start. And that went on, on and off for the next two years." (13)

One woman highlighted how traditional gender roles become more pronounced after having children, further trapping the woman in the coercive controlling relationship.

"And then when we had our next two kids, and we moved up here, and he got full time work, and we did a gender thing. And it was almost like that started to amplify. It's like, I always said, it was like a default thing. You know, how we know that underpinning a lot of this stuff is a gender thing." (3)

### ***Insidiousness***

The experience of insidiousness was identified as the second overarching theme that encompassed women's overwhelming descriptions of (1) the subtlety and intangibility and (2) the gradually worsening nature of coercive controlling behaviours. The quotes below illustrate how women described the subtlety and intangibility of coercive control, and also spoke about impacts in terms of confusion and decreases in self-esteem and social resources:

"Nothing was obvious, nothing was even tangible that I could really say this is wrong, and that there could be any kind of recourse." (6)

"It's so subtle, overtime, that you just find the end you've got, you know, no self-esteem, no friends, no resources. You feel crap about yourself, and you feel like you're crazy. You know? Yeah. So, when someone has a big explosion, and then you can kind of go all right, okay, I need to get away from this. But all the subtle stuff just makes your brain sort of foggy and you know, confused, so you're not quite sure where it's at really." (11)

Some women described how the subtle dimensions of coercive control prevented them from "picking up the signs" (1), and recognizing what was happening, whereas even those who were professionally familiar with violence did not necessarily see the signs. This was particularly salient when coercive controlling behaviours were used in the absence of physical violence: "It wasn't probably until towards the end of the relationship that I began to understand that things were kind of seriously not okay." (12); "I didn't see it coming. I didn't, I've been a police officer for 26 years. And I dealt with domestic violence on a physical level." (16)

Women consistently described that the coercive controlling behaviours increased and worsened gradually over time:

"Yeah, it's like I think it's more like over time it wears you down and makes you feel useless and you feel totally dependent on him. ... At first he didn't come across very controlling, but as we started to get more into the relationship, that's when he started controlling money, what I wore what I ate, when I ate, who I talked to." (10)

### **The Trauma and Mental Health Impacts of Coercive Control**

All women reported that coercive control had lasting negative impacts on their mental health and described the non-physical tactics of coercive control as more damaging than

tactics involving physical acts of violence due to the ongoing threat and the constant chipping away at the women's sense of self:

"I think the results of physical violence are more like hyperarousal, difficulty turning off flight and fight you know, just constant high cortisol levels, you know, people might try and manage with drugs or alcohol or. Because it's like a physical attack sort of switches that on and the other, the other is more like a hammer and chisel just constantly chipping away at you. So that you just left as like nothing, with just rubble around. Because one is more likely to be one off event and the other is more likely to be every day as well. So, it's constant, constant." (9)

"Well, you know, I've thought about this. And I feel like this [coercive control] is so much worse, because I knew what, I knew what to expect. Like once he was angry, you could see and then it ended, it wasn't controlling. This controls you, like I'm walking on eggshells." (1)

Women also described difficulties accessing supports for coercive control, because in the absence of physical signs, coercive control is hard to prove and there is no legal recourse, which made them feel helpless.

"So, it affects your life. It'll affect my kids. I remember my 18-year old daughter a few years ago said I wish he broke my back because at least the police would understand, nothing else is, they don't get it. No, no, I could prove what's going on." (1)

"I shouldn't say this, the intention is probably not good but if they had physically hit me I would have come back at them with full, you know with what I could, I would have hit him with anything okay, but I probably would have got the air rifle out, or the mace I had. I regret now that he didn't hit me because it would have given me the legal backing to fight back." (16)

Several women reported long-term physical health impacts of IPV, including lasting injuries due to physical violence, as well as feelings of physical and mental exhaustion and other somatic symptoms (such as chronic pain and fatigue) that were attributed to the ongoing stress associated with coercive control. Although only a couple of women reported receiving formal diagnoses of PTSD, anxiety or depression, the participants described a range of mental health reactions to coercive control. These included recurrent distressing memories and nightmares, dissociative reactions, self-blame, guilt and shame, anxiety, anger and irritability, self-destructive behaviours, hypervigilance, exaggerated startle response, problems with concentration, sleep disturbances as well as affective dysregulation, negative self-concept and disturbances in relationships. The main mental health reactions experienced by the women are summarised and supported by illustrative quotes in Table 3.3.

Women consistently commented that the trauma and mental health consequences of their coercive control exposure experience were ongoing, for most women even many years later. Notably, the narrative of most women suggests that they hold the belief that the trauma will never go away, as illustrated by these quotes: "A lot of that stuff happened back in my 20s. And, you know, but it's still sticking with me today. And it's, always gonna be there, it'll never be forgotten." (8)

"I think it has affected me, like, to the extent that it will always affect me, but you just have to come to terms with that. And that's happened for you. And just to let it go, but yeah, if someone treating you really badly, it stays with you forever. It's not really something you can get rid of. You just have to learn to live with it." (11)

**Table 3.3***Reactions to Coercive Control Exposure*

Mental Health Reactions	Quotes
Nightmares	"I'm having a lot of nightmares every night. You know, there's not a night I don't have nightmares." (16)
Dissociation	"I was highly dissociative, that's just how I operated." (6)
Avoidance	"So, I, yeah, I avoid having to deal with it, I resist. You know, I resist different situations. Because of things I've experienced." (15)
Self-blame	"But I blamed myself constantly. It's my fault, my fault, my fault, my fault." (16)  "I think it shits me more because I'm such a strong person and that I've allowed someone for so long to do it. I think I'm pissed off at myself. That I allowed him to do that. And that took me so long to work it out." (7)
Shame and Guilt	"I call this shame cloak. You wear your shame cloak because you don't want to, it's like you think people are going to look down on you and have an opinion about you, you wear the shame cloak and you don't tell anybody. Yeah. Because like, you know, you don't want people to look and think well, why did you stay so long?" (10)  "The guilt, just why can't I do anything to change this?" (15)
Anxiety	"Yeah, 100% it's terrifying, it's terrifying. And your fight and flight system, your whole adrenal system is just as affected by that, it is physical....The body reactions that you have are really extreme." (11)
Affective Dysregulation Anger	"It used to make me angry. I was angry for a long time. I was angry at the world. I was angry at everybody, because people saw him as this really good person. But behind closed doors, I saw the monster that he really was. And that just made me angry. You know, it's like, why can't you see what I see? And I had to work through that and let go of my anger because I was just angry all the time." (10)
Self-destructive Behaviours - Substance Use	"I've been through my phases of drinking. I've been through my phases of taking medications and overdosing with them because yeah, I wasn't functioning and I was surviving." (4)  "I smoke lots of pot and yeah, medicate that way. I have lots of insecurity. You know, Oh, yeah. I've been diagnosed with depression a lot. And been prescribed antidepressants a lot, but that I just it, it doesn't work for me, like I don't sleep, it's just not working, I'd rather smoke pot because that works for me. So, but I also have a lung disease that is killing me and I smoke pot!" (2)
Sleep Disturbances	"I don't sleep anymore. I maybe sleep two hours a night." (7)
Hypervigilance	"I close windows and blinds at night. You know, I said to my dad, I can buy a camera. We didn't, you know, because someone can kind of track that, you know. Yeah, I do. I just watch my back, somewhat. You know, sometimes I'd look and see if anyone's following me as well." (1)
Exaggerated Startle Response	"My heart used to race. I get afraid. I'm still very, very jumpy. So, if somebody touches me, and I'm not expecting it, I will scream." (14)
Problems with Concentration	"I will have to talk slowly, because I have trouble processing, I stumble the words out, so just letting you know that my concentration is very bad." (16)

**Table 3.3 continued**


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Loss of Identity	<p>"So, it was re-finding myself again. And that was hard. It was horrible. Because it's like, I didn't know myself. It was like I lost all identity of myself. And that mentally was when I turned to alcohol and drugs because I didn't know who I was. And it was just something to fill that emptiness inside of me." (10)</p> <p>"And at the end of that relationship, one of the most profound results for me was that I actually, I felt, I felt like an empty shell. Like, I felt I felt like an egg without any contents. I just had, like, zero confidence and self-esteem. Like I couldn't even decide what I wanted on my toast. Like I didn't even know who I was. I actually believed that I was nothing." (9)</p>
Negative Self-concept	<p>"So, it's so subtle, overtime, that you just find at the end you've got, you know, no self-esteem, no friends, no resources. You feel crap about yourself, and you feel like you're crazy." (11)</p>
Effects on Relationships	<p>I just seem to attract them, and I'm done with it. I can't do it anymore. To be honest, I don't think I have it in me to have my heart broken again. Like I just, and I feel like that's just my experience every time I get into some kind of relationship. So, it has had long term impacts, and I've just lost a bit of faith." (6)</p>
Inability to Trust	<p>"Because I've had so many promises broken to me. It's like I don't want people to say something and not follow it through, because it just like puts me further down. Okay. I don't trust people anymore, friends, organisations anything... Over seven years. So, a lot of mental damage. I don't go anywhere, really. If I have to go anywhere, I go out and come straight back home. It's no socializing. I don't like I just don't like being around people. Yes, I like my own company." (10)</p>
Physical Health Impacts Chronic Pain	<p>"But now for me, my symptoms are more around pain as like psychosomatic type of pain." (9)</p> <p>"It's very draining to be in those environments and to be in those dynamics and I now have long term health problems because of that I have, I got Ross River fever about four years ago, glandular fever prior to that, but before that, I've always been really healthy but I have chronic fatigue now and I think that complex PTSD has something to do with it. I think my life experiences have a lot to do with my health problems now. I experience joint pains, I, you know, my health has gone downhill the last four years dramatically I've always been very active, very healthy, I can't do anything anymore. I've got constant pain in my feet." (6)</p>
Exhaustion	<p>"Exhaustion, like physical as well because of cumulative stress. I have stayed on okay, but you know, you know, you just feel that cortisol and it just can't be good for me physically. So really, I guess a lot of stress, which I felt that I managed pretty, pretty well, but yeah, a real mental exhaustion." (3)</p> <p>"Then, yeah, just my adrenal system was bad as well. Like I would get, you know, health tests, so it'd affect me physically, as well. Yeah. It just messed around with my adrenal system and my metabolism and my hormones. And yeah, just everything sort of getting out of whack. I wasn't sleeping." (11)</p>

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### 3.3.5. Discussion

This study aimed to improve the understanding of the mental health impacts of coercive control using a qualitative approach to elevate the voices of Australian women who

had been exposed to IPV. The women in this study described many different experiences of coercive control, which included isolation and extreme deprivation of autonomy, controlling and threatening behaviours, intimidation, gaslighting, and manipulation, and were aligned with descriptive accounts of coercive controlling behaviours in international studies (e.g., Crossman & Hardesty, 2018; Stark, 2007; Stark & Hester, 2019). The present study contributed to this literature by highlighting the pervasive experiences of entrapment and insidiousness as underlying dimensions of coercive control that may partly account for the mental health reactions of women who have been exposed to these abusive behaviours.

Coercive and controlling tactics by the perpetrator are intended to entrap a woman in the abusive relationship (Stark, 2007). The model of social entrapment proposes that the effects of the individual abuser's coercive and controlling behaviours must be considered in relation to broader economic, social and cultural inequalities, that may exacerbate entrapment and collectively determine each woman's unique experience (Douglas et al., 2020; Ptacek, 1999, Tolmie et al., 2018, 2024). More specifically, coercive control affects women across cultures and socioeconomic groups, but may be particularly impactful for those from disadvantaged or diverse backgrounds who face systemic challenges that can further entrap them in abusive relationships (e.g., Gibbs et al., 2018; Goodman et al., 2009, Kulkarni, 2018). For instance, women from under resourced backgrounds may lack economic resources and may be financially reliant on abusive partners, and thus face greater hurdles when leaving abusive relationships (Costello et al., 2005; Goodman et al., 2009). Similarly, women from cultures characterised by high gender inequality, where patriarchal privilege and disempowerment of women are accepted norms, can face unique obstacles to leaving relationships (Oram et al., 2022). These inequalities may be cumulative and such intersecting dimensions of systemic entrapment must be considered alongside an abuser's use of coercive controlling behaviours (Barrios et al., 2021; Oram et al., 2022). The women in the current

study highlighted various factors that may magnify the experience (and reality) of entrapment, such as being pregnant or having children with the abusive partner, experiencing (or fearing) financial hardship or homelessness, limited social support, and gendered family or cultural expectations that make it difficult to leave abusive relationships. Additionally, the findings from this study suggest that abusers may strategically target these psychological, social, economic and cultural vulnerabilities to entrap women in abusive relationships (Crossman & Hardesty, 2018).

The women in this study also described a range of mental health reactions to coercive control. These reactions included recurrent distressing memories, nightmares, dissociative states, intense or prolonged psychological distress, persistent avoidance of stimuli associated with the coercive control exposure (i.e. avoiding situations and reminders associated with their experiences), negative cognitions (e.g., self-blame, persistent negative emotional states, such as shame, guilt, anger and fear), and marked alterations in arousal and reactivity (e.g., engaging in self-destructive behaviours, mainly alcohol and drug use, hypervigilance, exaggerated startle response, difficulties concentrating and sleep disturbances). Such reactions are consistent with symptoms of PTSD and align with findings of quantitative studies that have found significant associations between coercive control and PTSD (e.g., Lohmann et al., 2023). Moreover, given the prolonged, entrapping and insidious nature of coercive control, it seems that these mental health reactions could be framed in terms of disturbances in self-organization that are the defining characteristics of CPTSD; when they occur additionally to the presence of PTSD criteria (Briere & Scott, 2015; Cloitre et al., 2009; Herman, 1992). That is, women reported experiencing reactions that may reflect symptoms of affective dysregulation (e.g., difficulties controlling sadness or anger, or alcohol or drug use to cope with emotions); negative self-concept (e.g., negative impact on sense of self, reduced self-esteem and self-confidence, worthlessness, shame, guilt); and disturbances in

relationships (e.g., impact on future relationships, unable to imagine having another intimate relationship, or if they do that, they won't be able to fully trust a partner again, or not able to trust anyone) (WHO, 2019).

The presence of these heterogeneous and individual mental health reactions suggests that many women would benefit from mental health interventions to support their long-term psychological recovery, and that framing reactions in terms of psychiatric diagnostic criteria may enable victim-survivors to have access to evidence-based psychological treatments (Hameed et al., 2020). For instance, an early systematic review of trauma-focused therapies for IPV victim-survivors identified several interventions that had been tailored for IPV victim-survivors and were associated with reductions in PTSD symptoms post-treatment (Warshaw, 2013). A more recent meta-analysis of 25 randomised trials of psychological interventions for women who had been exposed to IPV (Karakurt et al. 2022) also found evidence that psychological interventions could reduce depression, anxiety, stress and PTSD symptoms, while increasing self-esteem and overall health. Similarly, several treatments for CPTSD have been developed. For instances, some stage-based treatments that have expanded on Herman's (1992) classic 3-stage recovery model (encompassing safety, remembrance and mourning, reconnection) have shown efficacy (Darby et al., 2023). These findings highlight that effective psychological treatments are available, and that it is important that women have access to these treatments, in addition to access to broader social supports, such as housing, financial and legal assistance (Micklitz et al., 2023; Ogbe et al., 2020).

Nevertheless, psychiatric diagnoses have been criticised from the perspective that mental health reactions are positioned as the responsibility of victim-survivors, and do not necessarily take account of the systemic context and embed accountability of the abuser (Moulding et al., 2021). However, this criticism relies on assumptions that psychological treatments are a one-size-fits-all approach that is entirely guided by psychiatric diagnoses,

which does not accurately reflect best-practice in mental health treatment. Such best practice involves conducting thorough biopsychosocial case formulations, that requires considering a range of biological, psychological, and social factors to guide individually tailored treatment and prognosis (Hofmann & Hayes, 2019; Persons, 2022). Therefore, understanding mental health reactions within a diagnostic framework should not imply that perpetrator behaviours and the systemic context are invisible or irrelevant. As long as there is a trauma-and-IPV-informed case formulation that is developed in collaboration with the victim-survivor, diagnostic information can help to guide evidence-based treatments that are tailored to the individual client's presentation (Calhoun et al., 2022; Doyle et al., 2022).

The current study also suggested mental health impacts that are associated with the insidious nature of coercive control. This was reflected in characteristics of subtlety, intangibility and gradual worsening of coercive control, which erode victim-survivors' self-worth, sense of self and independence over time. This is a novel finding given that research into the mental health impacts of coercive control has focused mainly on distinguishing the varying behaviours that may comprise coercive control, rather than the underlying features that may be common across behaviours and account for mental health impacts (Parkinson et al., 2023). This is important because such subtle dimensions of perpetrator behaviour may make it difficult for frontline services, such as law enforcement, to recognise and respond to abuse, particularly in the absence of physical violence. For instance, some women in this study described non-physical abuse tactics as more detrimental than tactics involving physical violence, because there was no visible evidence of the abuse. Not being believed or being unable to prove the occurrence of the abuse, including to the police, may further erode a woman's confidence, trust and sense of self (Baird et al., 2019; Beck et al., 2011). Relatedly, if mental health professionals do not understand these complexities and fail to identify the subtle dimensions of abuse, they may target areas that are inconsistent with the

women's needs, and women may feel misunderstood or attacked, and may not receive the support they desperately need (James & Mackinnon, 2010; Marsden et al., 202; Parkinson et al., 2023). These findings suggest a strong need to provide better protection and support for women exposed to coercive control (Brennan et al., 2019; Marsden et al., 2021; Moulding et al., 2021; Pitman, 2016).

Finally, several women in this study also described their belief that the mental health reactions associated with coercive control exposure would never go away, which may reduce their hope for recovery and further compound the negative impact on their help-seeking behaviours and long-term recovery prognosis (Carman & Kay-Lambkin, 2022). Regaining power and hope has been associated with resilience, better coping ability, greater self-efficacy and agency, positive emotions and less anxiety and depression, and as an essential step towards recovery (Munoz et al., 2016, 2017; Saleebey, 2000; Sinko et al., 2022). Psychosocial interventions that foster power and hope for long-term recovery, such as peer support may therefore be helpful (Lyons et al. 2021).

### **Limitations**

This study had several limitations. First, this study had a diverse but relatively small sample of women who have accessed domestic violence support services. Women contributed a range of perspectives to the coercive control literature, but the sample size and composition does not allow for comparisons across diverse groups and conclusions associated with demographic differences. For instance, only three women were First Nations women and this paper could not explore the unique challenges that First Nations women who have been exposed to coercive control may be faced with (e.g., sociocultural barriers to reporting and help-seeking, such as a dominant fear of losing their children, homelessness and isolation from family and community) (Langton et al., 2020). Second, all participants identified as heterosexual women and experienced abuse from male intimate partners and

findings are not transferable to women with other gender identifications. Men were not considered in the current investigation as it was beyond the scope of recruitment strategies and pathways for this study. Coercive control experiences and mental health outcomes for men, same sex attracted, and gender diverse victim-survivors may differ. Third, although all participants endorsed that they experienced coercive control, participants were not specifically asked whether their experiences of physical and sexual IPV were embedded in a pattern of coercive control or not. It was thus beyond the scope of this study to determine whether mental health reactions to coercive control exposure differ from those to other dimensions of IPV not embedded in a pattern of coercive control. Fourth, our analysis was largely descriptive and a more analytical and interpretative analysis of some of the data may have provided additional information about the patterns between coercive control tactics and mental health outcomes. Moreover, this study combined the experience of non-physical and physical tactics of coercive control, and women perceived the non-violent tactics as more impactful, but this study did not look separately at the impact of physical violence that does not occur within a pattern of coercive control. Furthermore, an inherent limitation of thematic analysis is that participant quotes are decontextualised, and the reader is not aware of the context of the quote. Finally, mental health reactions were discussed within the context of PTSD and CPTSD, but no validated measures were used to assess whether mental health reactions were associated with these diagnoses. Nevertheless, this study has important implications for research and practice.

### **Implications for Research**

This qualitative study broadens the theoretical understanding of coercive control. This study focused on women and future qualitative studies should be extended to focus on the trauma and mental health impacts of coercive control for different populations, such as men and gender diverse people, different ethnic and cultural contexts, including First Nations

people and people from culturally and linguistically diverse backgrounds (McKinley, 2022; Walker et al., 2020). The findings of this study also suggest that women who are exposed to coercive control can experience mental health reactions that reflect symptoms of PTSD and CPTSD, and additional research into the trauma and mental health sequelae of coercive control may benefit from integrating validated measures of PTSD and CPTSD. Future research should investigate whether these mental health reactions differ from exposure to other dimensions of IPV that are not embedded in a context of coercive control. Moreover, future research should focus on how to best train frontline staff, health care providers and mental health professionals so that they are better equipped to support women who have been exposed to coercive control. Finally, intervention research is needed to provide and increase the uptake of evidence-based trauma-informed integrated psychosocial care that can support the long-term recovery of victim-survivors who have been exposed to coercive control.

### **Implications for Clinical Practice**

This study revealed several important implications for frontline services, such as the police and health care providers, as well as for mental health professionals who work with women who have been exposed to coercive control. The findings highlight the need for comprehensive psychosocial approaches to understanding and addressing violence that recognises the trauma and mental health impacts of coercive control, but are considered in relation to complex processes involving both individual (e.g., psychological) and systemic (e.g., cultural) factors (Kulkarni, 2018; Moulding et al., 2021; Salter et al., 2020). This requires the conceptual integration of a mental health perspective that has traditionally viewed the impacts of IPV exposure through an individualised lens, with a feminist and social research perspective that attends to gendered, social, and systemic factors (Humphreys & Thiara, 2003; Moulding, 2016; Moulding et al., 2021). This approach may be positioned as an integrated trauma-informed care model that addresses systemic inequalities, as well as

individual mental health reactions, which is aligned with the Trauma-and-Violence-Informed Care approach (e.g., Australia's National Research Organisation for Women's Safety, 2015; Wathen & Mantler, 2022). Such an approach may begin to address concerns that some women perceive mental health treatment as stigmatizing and unhelpful because it tends to focus on the woman's mental disorders and discounts the context of the IPV relationship and the responsibility of the abuser (Humphreys & Thiara, 2003; Marsden et al., 2021).

Health care providers and mental health professionals need to be trained so that they can recognise the subtleties, complexities and impacts of coercive control exposure so that they can protect and support women by providing trauma-informed integrated psychosocial care (Australia's National Research Organization for Women's Safety, 2015). Psychologists should be aware of the systemic factors that are inherent to coercive control and integrate these into biopsychosocial case formulations to guide individualised and trauma-and-IPV-informed treatment. Mental health professionals should also provide victim-survivors with psychoeducation about the trauma and mental health impacts of coercive control and about the availability of effective evidence-based treatments, that may reduce mental health reaction severity including those associated with PTSD and CPSTD (see Phoenix Australia, 2021, for treatment guidelines), and support their healing and long-term recovery (Doyle et al., 2022; Sinko et al., 2022). However, to date, the few trauma-and-violence-informed interventions that have been trialled, have largely focused on crisis management or short-term mental health support and do not address long-term recovery needs (Wathen & Mantler, 2022). Overall, the findings of the present study suggest that women who have been exposed to the complex trauma of coercive control exposure may benefit from integrated trauma-and-violence-informed psychosocial supports that include individual mental health supports alongside social and economic supports to facilitate long-term recovery (Salter et al., 2020).

## **Conclusion**

This qualitative study of lived experience identified entrapment and insidiousness as the underlying dimensions of coercive control that likely contribute to the trauma and mental health reactions women who have been exposed to the complex trauma of coercive control may experience. This study contributed to clinical practice by identifying the pressing need for trauma-and-violence-informed integrated psychosocial care by health care providers and mental health professionals for women who have been exposed to coercive control.

### 3.3.6. References

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## **Chapter 4: Recovery after Coercive Control**

### **4.1. Mental Health Support Needs and Wants**

Study 2 identified entrapment and insidiousness (characterised by subtlety, intangibility, gradual worsening), as the underlying dimensions of coercive control that are likely central to the trauma and mental health reactions of women who have been exposed to coercive control. Study 2 further showed that women who have experienced coercive control may experience a range of mental health reactions, including those that reflect symptoms of PTSD and CPTSD. This suggests that women who have experienced coercive control may benefit from mental health supports that extend beyond crisis management or short-term mental health supports and focus on their long-term recovery needs (Wathen & Mantler, 2022). Further, study 2 revealed that the lack of understanding of the effects of social entrapment (e.g., impacts of economic, social or cultural factors) and the insidiousness (i.e., subtlety, intangibility, gradual worsening) of coercive control by health professionals can prevent women from receiving the mental health supports they need and want (Kulkarni, 2018; Moulding et al., 2021; Salter et al., 2020). This highlighted the need for the design and implementation of integrated psychosocial trauma-and-coercive control-informed interventions that recognise the trauma and mental health impacts of coercive control in relation to the complex processes that involve both individual (e.g., psychological) and systemic (e.g., social, cultural, intersectional) factors (Kulkarni, 2018; Moulding et al., 2021; Salter et al., 2020). This contributed to the decision to develop a second paper, study 3, to give voice to women's experiences with mental health supports (helpful and unhelpful), and to listen to what they need and want from mental health supports to aid in their long-term recovery based on questions and rich data collected during the interview process with the same 16 women who participated in study 2.

Including the accounts of lived experience into intervention research is vital because it allows for the co-design of interventions that are useful and well-received by the people most affected, which are in this case victim-survivors of coercive control (Hardesty et al., 2019a; Goodman et al., 2018; Meissner, 2011). Embedding voices of lived experience into intervention design and delivery is also aligned with both the 6<sup>th</sup> principle of the *National Principles to Address Coercive Control in Family and Domestic Violence*, and the *National Plan to End Violence against Women and Children 2022–2032*, which both emphasise the importance of embedding the voices of lived experience so that interventions and policies are relevant and effective for all victim-survivors (Commonwealth of Australia, 2023; Department of Social Services, 2022). For instance, the *National Plan to End Violence against Women and Children 2022–2032* emphasises that the voice of victim-survivors should be at the heart of solutions because they have specific and contextual expertise that comes from lived experience of abuse. Victim-survivors have personal experiences with strengths and weaknesses of interventions and services that are intended to support them but that can at times be unsupportive or even damaging (Department of Social Services, 2022). Accordingly, study 3 explored the helpful and unhelpful experiences with mental health supports of these women and deeply listens to what types of mental health supports they need and want to aid in their long-term recovery.

## 4.2. Study 3

### **“If I hadn't had the help, I'm not sure I would have survived”: A Qualitative Examination of what Psychological Supports Women Want after Coercive Control**

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#### 4.2.1. Abstract

Women who have been exposed to coercive control can experience long-term trauma and mental health impacts. They need mental health supports to support their long-term recovery, but it is unclear what specific mental health supports they need and want. Listening to the mental health support needs and wants of these women is vital to their recovery and to co-design effective mental health supports. In this qualitative descriptive phenomenological study we interviewed 16 women who had been exposed to coercive control about their experiences with mental health supports and asked them what mental health supports they want. Thematic analysis indicated that mental health supports play an important role in recovery. Women described both helpful and unhelpful experiences with mental health supports, as well as barriers to seeking mental health support, which provided valuable information for intervention design and delivery. Women's responses regarding the mental health supports they need and want covered five broad areas: (1) therapy processes, (2) attributes of mental health professionals, (3) types of interventions (4) support for children, and (5) funding. The findings suggest that women who have been exposed to coercive control want integrated long-term, trauma-and-coercive control-informed mental health supports that are tailored to their individual needs and stages of their recovery. The findings have important implications for research, clinical practice and policy.

*Keywords:* intimate partner violence, coercive control, trauma recovery, complex trauma, mental health support, psychosocial support, intersectionality

#### 4.2.2. Introduction

Intimate partner violence (IPV) affects one in three women worldwide (World Health Organisation [WHO], 2021, 2021a), and can include physical, sexual, and psychological forms of abuse; potentially encompassing coercive control which is an insidious dimension of psychological IPV where the abuser's tactics put the victim in a chronic state of entrapment and terror (Pitman, 2016; Stark, 2007; Stark & Hester, 2019). More women than men are exposed to IPV, including coercive control (Australian Bureau of Statistics, 2022). Many women experience long-term mental health reactions after IPV exposure, including depression, anxiety, alcohol and substance use, suicidality and posttraumatic stress disorder (PTSD) (e.g., Golding, 1999; Spencer et al., 2019; Stith et al., 2004; WHO, 2021). Given these long-term trauma and mental health impacts, it is likely that many women would want and benefit from trauma-and-IPV-informed mental health supports to aid in their long-term recovery (Australia's National Research Organization for Women's Safety, 2015; Salter et al., 2020).

Most interventions prioritise the provision of short-term crisis management, advocacy and social forms of support (Neave et al., 2016; Jordan et al., 2010; Kilpatrick et al., 2013; Lohmann et al., 2023; Warshaw et al., 2013). Although such short-term supports are vitally important for addressing safety concerns and immediate emotional needs, there is also a need for psychological interventions, such as psychotherapy and counselling, that are provided by mental health professionals and can address the long-term trauma and mental health impacts of IPV (Oram et al., 2022; Salter et al., 2020).

In Australia, the need for programs to support long-term recovery, including mental health supports, was formally recognised in the recently published *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services, 2022). This plan proposes a holistic and coordinated approach involving strategies focused on

prevention, early intervention, and response, as well as recovery and healing. Crucially, the National Plan recognises that victim-survivors need long-term, trauma-informed and integrated care that includes mental health support to recover from the physical, psychological and economic impacts of IPV exposure (Department of Social Services, 2022). The need to include mental health supports alongside social supports, education and advocacy in an integrated recovery approach has also been reflected in a narrative review that synthesised research on the recovery process after IPV exposure (Flasch, 2020). Similarly, in Australia, the co-design report of the Illawarra Women's Health Centre is proposing to establish a Women's Trauma Recovery Centre that offers an integrated, specialised and dedicated service that provides individualised and multidisciplinary wrap-around support to women to comprehensively address the impacts of domestic, family and sexual violence to improve long-term health and psychosocial outcomes for women and families (Cullen et al., 2021). Taken together, this suggests that mental health supports form an integral part in a holistic recovery process post IPV exposure.

Broader literature recognises multiple ways of conceptualising the construct of recovery, and distinguishes between at least two different definitions that may reference: (1) clinical and (2) personal recovery (Macpherson et al., 2016). Clinical recovery focuses on changes in clinical outcomes including improvements in functioning and reductions in mental health symptoms. For example, a range of psychological therapies have been developed or adapted to support the clinical recovery of IPV victim-survivors, and systematic reviews have provided evidence that at least some of these therapies are effective in changing symptom or function-related outcomes (e.g., Hameed et al., 2020; Karakurt et al., 2022; Warshaw et al., 2013). These reviews highlight that effective psychological interventions are available, and many women would benefit from access to these interventions (Micklitz et al., 2023; Ogbe et al., 2020). However, empirical studies have predominantly focused on clinical recovery and

provide little information about women's personal recovery experiences and support needs (Carman et al., 2022, Oram et al., 2022).

Personal recovery is a process that extends beyond symptom alleviation, and is focused on an individual's resilience, hope and the ability to live a meaningful life in the presence of mental health challenges (Anthony, 1993; Leamy et al., 2011; Shanks et al., 2013). There is a growing body of qualitative evidence that has explored the personal recovery experiences of women who have been exposed to IPV (e.g., Carman et al., 2022; Flasch et al., 2017; Sinko et al., 2021). For instance, a meta-synthesis of 26 qualitative studies of gender-based violence suggested that recovery was a nonlinear process requiring active engagement and patience (Sinko et al., 2021). This meta-synthesis also highlighted five components of recovery in the context of violence: (1) trauma processing and re-examination, (2) managing negative states, (3) rebuilding the self, (4) connecting with others, and (5) regaining hope and power. Whilst not directly referenced by Sinko et al. (2021), the study's findings reflect at least in part the five recovery processes outlined in the CHIME framework (Leamy et al., 2011). This framework is widely endorsed in mental health recovery research and highlights five mental health recovery processes: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (Leamy et al., 2011; van Weeghel et al., 2019). The CHIME framework has not yet been widely applied to IPV recovery research, but Sinko et al.'s (2021) findings suggest that the CHIME framework may be helpful in conceptualising recovery processes post IPV exposure (Katz, 2015).

The recovery components of trauma processing and managing negative states that were identified by Sinko et al. (2021), suggest that women who have been exposed to IPV may benefit from psychological support, as relevant therapies can assist with trauma processing and management of negative emotional states (e.g., Hameed et al., 2020). However, none of the studies included in Sinko et al.'s (2021) meta-synthesis specifically

examined the perceived mental health support needs of women to aid in their recovery. More generally, qualitative studies that have directly examined the perceived long-term mental health support needs of women who have been exposed to IPV are small in number. We found one recent qualitative study from Spain that examined perceived mental health support needs among 53 women who had been exposed to IPV and had left the abusive relationship (de Piñar-Prats et al., 2022). This study highlighted the importance of ongoing individual and group psychological supports provided by mental health professionals to aid in their long-term recovery. However, the needs of women may differ across national and cultural contexts, and further research is needed to understand the support needs in other countries, including Australia (Oram et al., 2022).

There are a small number of additional studies that have examined women's experiences with mental health professionals after IPV exposure (e.g., Bohne et al., 2016; Marsden et al., 2021; Oram et al., 2022; Tutty, 2023). For instance, Bohne et al. (2016) interviewed 60 women who had been exposed to IPV and had received counselling in five European countries. This study found that regardless of the therapeutic model, the effectiveness of counselling was determined by a positive therapeutic alliance built on mutual trust and respect, and the mental health professional's training and understanding of the dynamics of IPV. In contrast, other qualitative studies have reported more mixed experiences with mental health professionals (Marsden et al., 2021; Oram et al., 2022; Tutty, 2023). For instance, Marsden et al. (2021) interviewed 20 women in Australia who had sought help from psychologists and found that some participants reported suboptimal, and at times stigmatizing or even damaging care. However, this study focused narrowly on experiences with psychologists, and did not consider encounters with many other types of providers (e.g., counsellors, psychotherapists) that also comprise the mental health workforce in Australia.

Understanding the reasons for both negative and positive experiences with mental health professionals merits further attention because it can help improve the types and the delivery of mental health supports, so that women can receive the support they need and want. For instance, some women have reported feeling re-traumatised when the mental health professional displayed behaviours that mirrored the perpetrator's abusive behaviours, such as feeling blamed for entering or remaining in the abusive relationship, or feeling silenced or isolated by the psychologist (Marsden et al., 2021; Tutty, 2023). This suggests that some mental health professionals may not understand that women can face various external and internal challenges, such as economic and/or housing instability, fear of escalating abuse and concerns for their children's safety, that prevent them from leaving the abusive relationship (Griffing et al., 2002; Lewis et al., 2015). Some women also reported that their concerns were not taken seriously, particularly in the absence of physical abuse (Marsden et al., 2021; Tutty, 2023). As these behaviours may reflect the abuser's behaviours in a coercive controlling relationship, it is possible that women who have been exposed to coercive control may be at particular risk of re-traumatization when exposed to mental health professionals who display these behaviours (Stark, 2007). Exposure to multiple and prolonged interpersonal traumatic events that are extremely threatening or horrific in nature, such as coercive control, may elicit complex trauma reactions for some women, which may require additional care beyond the first-line treatments for single incident PTSD (Briere & Scott, 2015; Cloitre et al., 2009; Fernandez-Fillol et al., 2021; Herman, 1992; Karatzias & Cloitre, 2019; Lohmann et al., 2023, Salter et al., 2020; WHO, 2019).

On the other hand, positive experiences with mental health professionals may be a critical step in a women's recovery. Women who feel connected to their mental health professional and received trauma-and-IPV-informed care may experience this as life changing when they feel connected, prioritised, and experience a safe space to talk (Marsden

et al., 2021; Oram et al., 2022). Preliminary qualitative studies also indicate that experiences with mental health professionals may be pivotal in a woman's recovery process, and this may be particularly important for women who have been exposed to the chronic and complex trauma of coercive control (Karatzias & Cloitre, 2019). Further research is clearly needed regarding what women, particularly those who have been exposed to coercive control, value in mental health professionals (Goodman et al., 2018; Oram et al., 2022).

The aforementioned literature suggests that mental health supports including the nature of the experience with mental health professionals are integral components of personal recovery after IPV exposure. However, to our best knowledge, no qualitative study has so far explicitly explored what mental health supports women want to help with their long-term recovery after coercive control exposure. This paper aims to fill this gap with a qualitative examination of what psychological supports (e.g., types of psychological therapies, therapeutic practices and mental health professionals' attributes) women who have been exposed to coercive control, need and want to assist in their long-term recovery, which may include clinically and recovery focused interventions.

### **Aims of the Current Study**

Listening to the voices of those who identify as women and who have experienced coercive control is vital to learn what women need and want from psychological support to assist in their recovery (Goodman et al., 2018; Sinko et al., 2021). Improving the understanding of what women find helpful and unhelpful, what supports they anticipate would be beneficial, and a better understanding of barriers to seeking psychological support is essential in informing and co-designing targeted and integrated trauma, IPV and coercive control-informed psychological interventions (Crossman et al., 2016; Pill et al., 2017; Stark, 2007). Accordingly, by interviewing women who had been exposed to coercive control we aimed to address several gaps in past IPV intervention research through the lens of lived

experience. For the purpose of this paper we focused on mental health supports, such as psychotherapy and counselling that may be provided by different types of mental health professionals. We were guided by two overarching research questions:

1. How do women who have been exposed to coercive control describe their experience with mental health supports?
2. What do women who have been exposed to coercive control want from mental health support to assist their long-term recovery?

### 4.2.3. Method

#### Study Design

This study focused on the psychological intervention and recovery experiences, and perceived support needs of Australian women who have been exposed to coercive control, and have accessed specialist family and domestic violence support services. This study was conducted in regional Northern New South Wales, Australia. To provide context, the state of New South Wales has recently passed new legislation to criminalise coercive control (*Crimes Legislation Amendment (Coercive Control) Act 2022 (NSW)*). In Australia legislation relating to family and domestic violence including coercive control is generally organised at state level (i.e., sub-national jurisdictions). However, the Commonwealth of Australia (2023) has recently released *National Principles to Address Coercive Control in Family and Domestic Violence* across all states.

This qualitative descriptive phenomenological study was embedded in feminist research principles, that recognise power and gender imbalances, diversity and intersectionality (e.g., gender, race, class), the importance of women's voices, reflexivity of the researcher's influence on participants, and the emphasis on practical research that encourages activism and advocacy (Beckman, 2014; Creswell & Poth, 2016; Goodman et al., 2018). Qualitative data was collected with semi-structured interviews because they can

simultaneously provide a summary of the women's lived experiences and a comprehensive exploration of the researched phenomena from the perspective of the research questions (Savin-Baden & Major, 2023).

The study was also guided by qualitative community based participatory research principles that highlight the collaboration between researchers and participants to enhance understanding, integrate knowledge with action, and to improve the wellbeing of those affected, and to decrease the power and control of the researcher, which is especially important for research with vulnerable and traumatised populations (Goodman et al., 2018). We integrated these principles into the recruitment and interview procedures by co-designing recruitment materials and the interview guide, and by receiving guidance on how to conduct the recruitment and interview process from service representatives (Goodman et al., 2018). This involved consulting with a First Nations representative to ensure cultural sensitivity during the recruitment and interview processes with First Nations women. For example, the First Nations representative suggested giving women the choice to bring their children and/or family members to the interview. Service representatives also advised to offer participants the option to receive a free trauma counselling session after the interview. This session was provided by a trauma counsellor associated with the service (Goodman et al., 2018). The research received ethics approval from the University of Melbourne (Ethics ID 22011).

### **Researchers**

The research team consisted of three White cisgender women and one White cisgender man, all identifying as heterosexual. The first author is a clinical psychologist registrar and PhD candidate and the second and third authors are experienced clinical psychologists and researchers with expertise in posttraumatic mental health. The last author is a psychology trained researcher with expertise in trauma and intimate partner violence. The research team has previously published a meta-analysis examining the trauma and mental

health impacts of coercive control and are familiar with the constructs and empirical literature of the mental health impacts of coercive control. This prior engagement with the researched phenomena and familiarity with psychological research and practice reflects our positionality (Savin-Baden & Major, 2023). For example, because of our research and clinical training in psychology, we conceptualised coercive control as contributing to major trauma and mental health reactions. We also believe that mental health professionals play an important role in addressing the mental health impacts of coercive control and supporting recovery. Our positionality has likely enriched the data collection and analysis because researchers were able to link the phenomena participants were describing with experience from clinical practice and evidence from prior research. Nevertheless, preconceptions may have also introduced bias into data collection and analysis (Darwin-Holmes, 2020).

### **Participants**

Sixteen cisgender women, who identified as heterosexual and had experienced abuse by a male intimate partner and who were between 26 and 61 years old ( $M = 46$ ) participated in the study. All participants resided in New South Wales, Australia at the time of the interview. All participants, aside from one, were separated from the abusive partner at the time of the interview. The time since leaving the relationship ranged from a few months to over 20 years. Interviews took place from November 2021 to April 2022. Ten interviews were conducted in person and six through the video conferencing platform Zoom (due to COVID-19 related constraints). The length of the interviews ranged between 44 and 108 minutes ( $M = 63$ ). All participants reported exposure to coercive and controlling behaviours in their abusive relationships. These relationships lasted between five months to over 40 years. Table 4.1 provides a summary of participant demographics.

### **Researcher-Participant Relationship**

Only the first author conducted the interviews and had direct contact with participants. The first author is a long-time resident of Northern New South Wales and is familiar with the local sociocultural environment. This familiarity with local culture in combination with the first author's clinical experience likely allowed participants to feel safe and supported during the interview process, and created a hybrid insider-outsider position (Darwin-Holmes, 2020).

**Table 4.1**

*Participants' Demographics (n = 16)*

Demographics	Participants (%)
Age (years)	
18 – 29	1 (6.25)
30 – 39	3 (18.75)
40 – 49	6 (37.50)
50 – 59	5 (31.25)
60 – 69	1 (6.25)
Number of Children	
0	1 (6.25)
1	2 (12.5)
2	5 (31.25)
3	5 (31.25)
4	1 (6.25)
5	1 (6.25)
11	1 (6.25)
Ethnicity/Cultural Background	
Aboriginal or Torres State Islander	3 (18.75)
Latina	1 (6.25)
Italian	1 (6.25)
White/Australian	11 (68.75)
Accommodation	
Own Home	8 (50)
Renting	7 (43.75)
Homeless	1 (6.25)
Employment	
Full time	4 (25)
Part time	5 (31.25)
Casual	3 (18.75)
Self-employed	2 (12.5)
Unemployed	1 (6.25)
Disability Pension	1 (6.25)
Education	
Secondary	3 (18.75)
Diploma/TAFE	6 (37.5)
University – Undergraduate	7 (43.75)
Physical Disability	
Yes	1 (6.25)
No	15 (93.75)

## **Recruitment**

We focused on recruiting those who identify as women because more women have experienced coercive control and because of the recruitment pathways that were available to us (Australian Bureau of Statistics, 2022). Participants were recruited with non-probability purposive sampling, from a domestic violence support service in regional Australia, and its network (Etikan et al., 2016). Service users who identified as women and who had experienced abuse by an intimate partner irrespective of gender identification were eligible to participate in the study if they were at least 18 years old and had been exposed to any dimension of IPV (physical, sexual, emotional, coercive control). Participants also had to feel safe to participate and had to either have left the abusive relationship or had to feel safe to participate if they were still in the abusive relationship. We were guided by Hennink and Kaiser's (2022) systematic review of 23 reports that used empirical data to examine data saturation for qualitative research, to determine the sample size for this study. Hennink and Kaiser found that data saturation for qualitative interviews is generally reached within a range of between 9 to 17 interviews for interviews with a relatively homogenous research focus and study population, such as in the present study. We also considered the vulnerability of this population and the additional challenge to recruit participants during major disasters, which included the Covid-19 pandemic and the damaging effects of a major flood that destroyed a large part of the town where most of the interviews took place (Hennink & Kaiser, 2022). Flyers advertising the study were placed at service premises and electronically distributed through wider service networks. Potential participants who volunteered to participate and provided consent were contacted by phone by the first author to schedule an interview time. Participants completed a demographic questionnaire before the interview. In-depth semi-structured interviews that took about one hour were conducted either in person in a safe location, or by using the Zoom videoconferencing platform (depending on participant

preferences). Interviews were conducted and audio recorded by the first author. Each participant received a \$50 electronic gift voucher to compensate them for their time and travel expenses after the interview. Participants were deidentified and assigned a number (1-16) to protect their anonymity and safety.

## **Materials**

The full interview guide consisted of three questions and associated prompts. Questions were developed from an extensive literature review and in consultation with service representatives (Goodman et al., 2018). This report focused on the third question that looked at what participants would need/want from psychological support (“how do you think psychological support could benefit you?”) and the reported data pertains to the research question of this report. To assess whether women had experienced coercive control the interview guide included a question about the participant’s experience of coercive control, and if they were unsure of the construct it was briefly explained.

The data relating to the first two research questions will be published in a separate report. The full interview guide is included in Appendix B. We created a distress protocol that was aligned with the *Ethical and Safety Recommendations for Intervention Research On Violence Against Women* (WHO, 2016).

## **Data Analysis**

Transcripts were transcribed verbatim and were analysed using a combination of descriptive (semantic level) and interpretive (latent level) thematic analyses (Braun & Clarke, 2006, 2013, 2020). Descriptive analysis was used to explore and understand the characteristics and qualities of women’s experiences with mental health supports. A combined descriptive and interpretive approach was taken to synthesise the mental health needs and wants (Braun & Clarke, 2006). As the authors had prior knowledge of IPV research and theory, a combined deductive-inductive approach was employed to interpret

themes that aligned with past research, and to formulate directly from the data (Saldaña, 2021). We were guided by Braun and Clark's approach to systematic thematic analysis, which consists of six validated phases: (1) *familiarization with the data*; (2) *generation of codes*; (3) *searching for themes*; (4) *reviewing themes*; (5) *defining and naming themes*; and (6) *reporting*.

During the data familiarisation phase, the first author transcribed the interviews and reviewed the transcripts, and noted ideas and possible categories of mental health support experiences and needs in a spreadsheet. Raw data was then organised under these headings. To generate codes the first author developed a codebook to record the generation of codes (Saldaña, 2021). The code book included five sections: (1) code label, (2) definition, (3) description, (4) qualifications or exclusions, and (5) examples of participant quotes. Even though only the first author transcribed and reread the transcripts, and generated the first draft of the codebook, the second and last author actively participated in the ongoing review and analysis of the codebook. The first, second and last author held regular meetings to discuss and analyse the codes, and resolved any discrepancies by consensus (Roberts et al., 2019).

During the next step, the first, second and last author met regularly and searched the code book for themes, using thematic analysis mostly at a descriptive level focusing on participant's descriptions of their experiences with mental health supports and their recovery needs and wants. Next we used a more interpretative approach to synthesise the information about mental health support needs participants provided (Braun & Clarke, 2006; 2013). This process involved using the interactive mind mapping software Miro (2022). Throughout the data analysis the first author maintained a detailed and reflexive account of procedures. The first, second and last authors discussed the results of the thematic analysis and resolved any conflicts by consensus (Creswell & Miller, 2000). The third author did not participate directly

in this data analysis process, but critically reviewed the themes to improve reflexivity and rigor.

### **Methodological Integrity**

The authors strived to reflect on their positionality and used reflexivity to increase awareness of assumptions and preconceptions that may have biased the data collection and analysis. For instance, the first author reflected that being a middleclass White psychologist may have impacted on First Nations or homeless women during the interview process. The research also collectively reflected on how being psychology trained may introduce bias towards the importance of mental health supports facilitated by professionals. We intended to improve credibility and rigor with reflexive journaling, regular discussions between the first, second and last author, and critical reflections by the third author. We aimed to adhere to rigorous reporting guidelines by following the Standards for Reporting Qualitative Research (O'Brien et al., 2014) and the Consolidated Criteria for Reporting Qualitative Studies (Tong et al., 2007).

## **4.2.4. Findings**

### **Experiences with Mental Health Supports and Professionals**

Women described experiences with a range of mental health support options, such as helplines, peer support or psychoeducation, as well as interventions provided by mental health professionals, which is the focus of this paper. Women saw a range of different mental health professionals, such as psychologists, counsellors, psychotherapists and mental health social workers. Overall, the women in this study experienced mental health supports as generally valuable and helpful as illustrated by the following quotes: "If I hadn't had the help, I'm not sure I would have survived it" (12); "Well, what really, really helped me, I did see psychologist throughout for some support. And that was really good." (3); "I saw a

psychotherapist for about three or four years on and off. And she passed away. But that was incredibly, incredibly helpful. I don't know where I'd be now without that experience.” (6)

A few women reported negative experiences with mental health professionals. For instance, one participant described being “victim-shamed” for staying in the abusive relationship: "I was going to see a psychologist in that time, but she victim-shamed me constantly. Like it really hit me hard. It's your fault. You stayed. It's your fault. I used to walk out crying, she victim-shamed me so badly. (16)

Another woman, who also worked as a domestic violence support worker, reported that she was advised to leave the abusive relationships when she did not feel safe to do so.

I went to see one psychologist and she said to me in the first session, well, I told her what I did. And she said, Well, I guess you know, in your job, you're always telling women to leave? And I just said no, that's not that is not my role at all. And I don't do that. And I'm also not wanting that from you. And so that's what she said to me. And I said, Look, I can't, you know, I'm fully aware of the issues here, but I can't it's not safe, and I need support in what I'm doing. (3)

The types of engagement with mental health professionals were varied. Some women described finding it helpful to see a mental health professional for regular ongoing support, whereas others described engaging on an as needed basis:

I would always engage when I really needed something when something wasn't working in my life when I couldn't control or handle a situation because I can't control anything, like life is life. So when I couldn't handle things, or was not handling things very well I would get support around it. (2)

Women's responses to their past experiences with mental health supports, and their needs and wants from mental health supports covered three different areas: (1) helpful and

unhelpful therapeutic processes and approaches, (2) barriers to seeking mental health support, and (3) needs and wants from mental health supports.

### **Helpful and Unhelpful Therapeutic Practices and Approaches**

Women described experiencing a range of helpful and unhelpful therapeutic practices and attributes they valued in mental health professionals. Helpful practices included feeling heard and validated by the mental health professional:

Yeah, feeling heard and also being told, you know, being validated, you know, and also that yes, I do have PTSD, you know, just to have that because of that, you know, it's not just because you know, you've been told for a long time, you're crazy. (1)

Women also highlighted the importance of a safe and respectful relationship with the mental health professional:

When you've had experience of an abusive relationship, and counselling, like a safe therapeutic relationship is actually a balm for that because you get to control what you talk about, it doesn't have to be everything out there straightaway, you can have that experience of respect and safety. (3)

One of the First Nations women emphasised the special need for confidentiality within her cultural context:

With my counselling. It was good that I could talk to someone. I reckon if I spoke with someone that I knew, or someone culturally connected, like Aboriginal, I can say I wouldn't been able to do it. Because, in a way, like how can I explain it? Like if I, I reckon if I spoke to another indigenous person, a lot of indigenous people yarn, and it could leak somewhere. (5)

Unhelpful processes also included victim-shaming, a lack of safety, being advised to have couple's counselling or to leave the relationship when it wasn't safe to do so. Women also found it unhelpful when their main presenting concerns were not addressed:

But I think in all honesty, I don't think any of the counselling that I did really helped me with the situation that I was in. It helped me with, to be able to talk about whatever I was dealing with, but I honestly don't think any of it was effective at all with the reality that I was dealing with. (12)

In the context of mental health support, women described different therapeutic approaches they found helpful, including Cognitive Behaviour Therapy (CBT), trauma-focused therapies, Eye Movement Desensitization and Reprocessing (EMDR), imagery, somatic therapies, Emotional Freedom Technique (tapping), and interventions that address self-blame. For instance, the quote below highlights one of the women's positive experience with several therapeutic approaches:

I think being able to talk with someone who is a professional, mental health professional, they're dealing with trauma, issues of trauma, trauma therapy, mindfulness, things like that...they're holding space for you. But they're also like, just supporting you to think about things in a different way. Yeah, so to be able to just reframe your mind and your choices, and, you know, yeah, I just feel into the body a lot more connected with the body. (10)

Several women highlighted the specific value of psychoeducation as part of therapy, as it helped them to recognise that they were in an abusive relationship, as illustrated by the quote below:

Being told, like explaining what you're doing, when you don't know. That's how I knew what I was going through. There was a counsellor, I was saying about my teenager, and it was just parenting stuff and she identified it, because it just came into the conversation. (1)

### **Barriers to Seeking Mental Health Support**

Many women described barriers to accessing mental health supports. The most common included cost, lack of funding for services, and the bureaucracy involved with accessing publicly funded sessions (e.g., complicated referral processes, long waitlists):

I think at the time, when I needed psychology appointments they were only giving out like four at a time, under the [Australian government funded Medicare] plan, and I think you need a way to skip the plan as well, because it's another appointment that the woman has to go to. And there's a chance that you might not go, and then you don't get your plan, and then you can't see a psychologist so less red tape and hoops to get those appointments. (9)

Even when women could access funded sessions, they commented that funding was limited to very few sessions which they perceived as insufficient considering the level of trauma they had experienced: "Six sessions with a psychologist I don't know what that will do....You actually need to talk to someone very regularly for several years." (14)

Another barrier to seeking mental health support was articulated by several women, who described fearing the perpetrator could use their engagement with mental health supports against them: "I don't want that, because he subpoenas my records. I'm not going to go to mental health services because he would just use that against me. Yeah, so that's a huge barrier, huge, huge barrier." (3)

Some women also described concerns that therapy would be overwhelming whilst they are struggling with ongoing external challenges. This perspective that therapy would be too demanding, rather than being supportive and addressing their needs, prevented them from seeking support:

I don't want to go to counselling or support because I actually just can't, I just got to keep going. And I'm scared they defy access to support. I'm just going to collapse in a heap and I won't get back up. And I can't, because I've to keep going for my kids. (7)

## Mental Health Supports Women Want

Women's responses to questions about the mental health supports they need and want covered five broad areas: (1) therapy processes, (2) attributes of mental health professionals, (3) types of interventions (4) support for children, and (5) funding. Table 4.2 provides a summary of women's suggestions in these areas supported by quotes. Some of the attributes overlapped with the helpful practices women had experienced.

**Table 4.2**

### *Mental Health Supports Women Want*

Types of Support	Quotes
1. Therapy Processes	
Constructive feedback	"I wanted, you know, constructive feedback... And also, and maybe some things will never be fixed, but I need to be aware of them and know, when I'm behaving in that way. Or, you know, I have that kind of thinking pattern to instead of just running with it going oh gosh." (14)
Improve self-esteem and confidence	"Increase confidence, building your self-esteem so, you know, that you're worth taking care of." (9)
Healthy coping strategies	"Yeah, I would like to not kill myself with pot, like, because that's what's happening really, you know, it's not the healthiest of it is dealing with stuff. It's the way I'm most comfortable with, but there are consequences to that that are not good. Like, I might not get to see my grandkids grow up or, you know, and it's real stuff. So, yeah, that I'd like other ways of dealing with it." (2)
Psychoeducation: Recognising signs of coercive control	"I had no idea. Zero idea that I didn't even know I was in a violent relationship... It's very difficult because when you're in it, you don't listen. I didn't know. I wish someone had come and slapped me. I was like being under a spell? Yeah. Yeah, I don't know. I mean, I wish someone would have told me." (14)
Building safety	"One thing that can help right now. Starting where I was and then trying to build safety, increase safety...The digital world, the planning, the preparing, preparing for the next time." (3)
Supportive counselling	"Just someone to talk to, just I think mostly for me, it's just to be able to communicate with someone. I think just to get things off your chest, you know, and that what you say does matter." (7)
Work through emotions	"Just someone working with you on, on how you could work through those different emotions, yeah." (15)
Relearn life skills	"I just need to learn basic skills again. Life skills, and it's not easy it's really not. Learn how to shop. It's also you still need someone to hold your hand as you're walking that fine line because it's hard." (10)

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 2. Attributes of Mental Health Professionals
 

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Non-judgemental	“Someone having that unconditional acceptance and someone who understands why women stay, many, many reasons they do or not, not feeling judged around that meeting me where I was and what I needed as well.” (3)
Respectful	“If they treat me as a fully thinking, functioning human being who can take on information and process it and analyses it, you know, treat me as my own resource.” (3)
Trustworthy	“Honestly, just somebody there to sort of take you by the hand, and it’s okay. You know, like having a best friend. Just being able to talk openly and feeling comfortable and not being afraid that she’s going to ridicule me or put me in a too hard basket. You know, that was good.” (10)
Flexible	“And then yeah, supporting women, you know, however they may need to be supported. So, something that maybe isn’t right for them, you know, this kind of thing that you could offer them isn’t right for them, or there’s something else or slightly more flexible.” (11)

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**Table 4.2 continued**


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Attuned to client’s needs	“I think someone who will listen to you, you know, sometimes you don’t want advice. Sometimes you do just want to download and, you know, and tell your story and if you’re having a real shit day, and, you know, you feel like the whole world’s on top of you. Having someone say, yes, that’s shit. You know, gosh, that’s awful. That’s exactly what you need. And then when you’re in the mental space, then, you know, ways to work on what’s going on for you. Someone who is attuned I guess? Yeah, someone who is attuned to what you need, and who is being empathetic rather than sympathetic.” (14)
Appropriately trained	"And also, one other thing that's very important for you is to when you are seeking support, make sure it's the right person. Knowledge, that they know what they're doing with abuse, narcissistic abuse, neglect, not a psychologist who deals in women's sports. It's got to be someone that that knows what they're doing, and doesn't victim shame the victim. I can't be stronger. I can't express it any stronger." (16)

## 3. Types of Interventions

Group therapy, support groups	<p>"I think being able to talk to other women in the same situation, would have been massively helpful. So if there was like, you know, a group or even an online organisation, I think the UK are a lot better about stuff like that, would have been really helpful. So community, especially because I was an expat. And I didn't have family in Australia." (12)</p> <p>"I never ever did it ever. And I have since watched other groups. And I was just wished that that had been available for me, the idea of being able to talk to other women that had had similar experiences that would have been amazing... That would have been very, very helpful for me. Yeah. And also just sharing little tips and tricks, you know, like that people might discover how to deal with triggering situations and things like that." (14)</p>
Residential support programs	“In fact, I would have liked and I don’t even think it exists, but like a rehab, it seems like there is no live in service for if you’re really struggling, unless you’ve got a drug problem. Yes. And that’s very sad, I would have happily gone on some kind of weird retreat, and in group therapy, talk to other people and, you know, listen to other people’s experiences, and, you know, normalise my own, you know, behaviour, listen to the bad things that other people had done in DV relationships.” (14)
Psychoeducation embedded in support groups	“We need something where they can go to a course so they can learn about coercive control, narcissism. Have they got a mental problem? Their partner? Is it drug related? Is it alcohol related? How do we manage it, we need strategies to learn to survive. And if we have a support group where we meet people like that, at least you know you’re not alone and that when you have got a chance you could ring them and say, or texts keep each other we one of the girls in our group organised that messenger group. So we can, yeah, So you’ve got that contact. So it’s wonderful. And yes, we need something for DV like

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	that as well. So that would be really good. And you got to remember a lot of domestic violence, as of learning now comes from people who were in that situation in the first place; where I grew up in that you don't know any different. (4)
4. Support for children	"Women with children need a lot of help, because the children...they're lost in all of this. They want their dads. They don't get it because then they'll rebel. You know, because they want their dad. They don't need to be brainwashed they need help. They need to be comforted as well. Yeah, because everyone wants to respond to the mom but forget about the kids. And they're the ones that you know, they grow up to be either really great or really rebellious. So they're the ones that really do need a lot of support, too." (3)
5. Funding	
"DV wellbeing packages"	"Yeah, funding, that's another one, you know, if you could fund like, a wellbeing package for a woman, you know, and it doesn't have to be just counselling, but whatever works for her as a mental health support package or something, but it can be, like, massage can be part of that, or art therapy, or whatever, you know, I mean, I just come up with that." (9)

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**Table 4.2 continued**

Giving funds directly to women	"But you know that cash payment, women are supposed to be getting, it's not cash, and women aren't getting it. And it needs, yeah, it needs to be managed by the woman that money, it shouldn't be managed by a caseworker. Because the woman knows what she needs to get out or to build her life back up, whatever. But when you put it in the hands of the caseworker, then the caseworker has to approve all of this. And it's just like having another perpetrator. Not perpetrator, but somebody's telling you what to do." (9)
Long-term funded mental health support	"Basically long term support as long as it as long as it takes rather than which I guess, you know, we've got people on mental health plans and they extend it, but cost for me that was free. And the kind of the financial stuff that if it was a paid service." (3)
Access to a wide range of therapies	"And there needs to be more support for people or capacity to be able to access these kinds of long term supports that don't fit into the box." (6)
	"Psychological sessions not attached to a GP mental health care plan...Access and funding to a wide range of modalities: Spiritual rebuilding and storytelling, journaling followed by ceremonial burning of the writing (recreating memories), EFT Tapping, Acupuncture, Kinesiology (worked well), Nutritional appointments, Herbal medicine, Non-violent communication education, massage voucher, dancing, yoga." (9)
Support to choose services	"And maybe even someone to help you decide what it is that you do want. Even you know, like, someone you know, you get that package or whatever, and, and someone speaks with you about what is going to work for you what is going to be good for your wellbeing, and supports you to access that in a way because I think a lot of women do especially put themselves last you know. Even in Australia too, it probably be cultural, but just that looking after yourself is somehow, you know, you're selfish or, something like that." (11)

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*Note:* DV = Domestic Violence, GP = General Practitioner, EFT = Emotional Freedom Technique

Many women spoke to the need of integrated services with a holistic approach as illustrated by the quote below:

One thing that I really liked about [Name of Support Service], is that they have psychological service in house. And I like that, because the building is a safe space, I would use their service, I would feel safe going into that office. And I would know

that my social worker was in the building. And it would just feel like a routine that was, for my benefit, more of a holistic approach. (14)

Aside from mental health supports, women emphasised the need for social supports (e.g., housing), financial support and education, practical support (e.g., help with forms, applications and appointments), and legal support (family courts, navigating coercive control legislation). Several women also highlighted the need for fairer and more respectful treatment and support from police (e.g., with preparation of statements, referral to support services), and support from health professionals and services (e.g., ongoing check-in calls). One woman also commented on the need for support from schools to provide safety and support for children. Several participants highlighted the need for ongoing advocacy and public conversation, information (e.g., flyers in medical centres) and education about coercive control. Finally, some women described the need to make the funding process more easy, effective and empowering for women:

You got to somehow prove to the government to get anything. And I think that's terrible because it's number one, it's just psychologically demeaning and takes away people's dignity really having to beg for something that's actually should be there for you anyway, because it's funded too. Yeah, I just think that those pathways need to be a lot easier. (11)

#### **4.2.5. Discussion**

This qualitative study explored the mental health support needs and wants of Australian women who have been exposed to coercive control. The findings indicated high levels of perceived value and importance attributed to long-term mental health supports after coercive control exposure, which is notwithstanding concerns that mental health supports can at times be stigmatising and may minimise the gendered, social, and systemic context of the IPV relationship, as well as the responsibility of the abuser (e.g., Moulding et al., 2021). The

present study thus highlights an important role for mental health supports alongside advocacy and social supports, in relation to the promotion of long-term recovery, which aligns with the recovery focus of the *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services, 2022). Women in this study also described both helpful and unhelpful practices in their encounters with mental health supports and provided practical suggestions to improve supports for women who have experienced coercive control. These addressed therapeutic approaches and practices, attributes of mental health professionals, as well as types of interventions and funding.

Women described experiencing a range of therapeutic approaches (e.g., CBT, EMDR, supportive counselling) and broadly described these as helpful. They emphasised that therapies should be tailored to individual needs and that each woman should be able to access a range of therapies depending on her preferences and circumstances. This perspective reflects findings from Paphitis et al.'s (2022) realist review, which included evidence from 60 studies that were triangulated with expert consultations. The review found that the mental health of women who have been exposed to IPV is best supported by providing holistic, trauma-informed, and individualised interventions that consider the culture, context, and complexity of each woman's situation.

In regard to attributes of mental health professionals, women emphasised the importance of the therapeutic relationship (e.g., feeling safe, heard, respected by the health professional), and the mental health professional's understanding of the nature and impact of coercive control. This also aligns with previous qualitative studies that have suggested that the type of therapy may be less relevant when compared to the nature of the therapeutic alliance and the mental health professional's understanding of the impact of IPV (Baier et al., 2020; Bohne et al., 2016; Roddy, 2013; Roddy & Gabriel, 2019; Tarzia et al., 2020). The helpful attributes of mental health professionals which were described by participants in this study are also in line

with the three competencies Roddy and Gabriel (2019) identified based on semi-structured interviews with women and men who had received domestic violence counselling. These competencies referenced: (1) adequate counselling skills, (2) knowledge (e.g., understanding processes and impacts of coercive control), and (3) mental health professionals' characteristics (e.g., confident, authentic, calm, warm, non-judgemental).

Contrary to some previous research (e.g., Marsden et al., 2021), the women in the present study mostly reported positive experiences with mental health professionals. Nevertheless, a small number of women described negative encounters which were mainly associated with mental health professionals providing inappropriate advice to leave the abusive relationship, or engaging in behaviours that were characterised as victim blaming (Marsden et al., 2021). These negative experiences would appear to reflect a lack of understanding of the nature and impact of coercive control, and the complex economic, social and cultural factors that often prevent women from leaving abusive relationships (Douglas et al., 2020). This highlights that for women who have been exposed to coercive control, the effects of abusive behaviours must be considered within the context of wider economic, social and cultural disparities, which contribute in complex ways to a sense of entrapment, and major barriers to leaving an abusive relationship (Douglas et al., 2020; Ptacek, 1999; Tolmie et al., 2018, 2024). The findings suggest that mental health professionals require trauma-informed understanding of these psychosocial complexities of coercive control because they can impact women's experiences and decision making processes, above and beyond intrapsychic factors (Salter et al., 2020).

This study made an important contribution to the literature by exploring the perceived barriers to seeking mental health supports by women who have been exposed to coercive control in an Australian context. These participants described several barriers to seeking mental health supports, including cost, limited availability of government funding and the

bureaucracy involved with accessing funded sessions (e.g., complicated referral processes, long waitlists). Moreover, some women expressed concern that seeking mental health support could be used against them by the perpetrator (e.g., concerns that notes could be subpoenaed during family court proceedings). Although relevant to an Australian context, the findings parallel results from a recent systematic review from the USA which identified that lack of material resources, access challenges, and perceived consequences of disclosure were some of the main barriers to help-seeking generally in the context of IPV exposure (Robinson et al., 2021).

A further contribution of this paper was the exploration of the needs and wants regarding mental health supports among Australian women exposed to coercive control. For instance, some participants proposed a “well-being package” that would provide women with funding similar to the Australian National Disability Insurance Scheme (2013), which provides funding for eligible people with a disability and supports access to therapies based on their individual needs and wants, including the access to a support coordinator. Considering the heterogeneity of women’s circumstances and support needs, such a funding approach would likely be empowering and may itself support recovery (Leamy et al., 2011). Such a package could also provide access to social and economic supports and women could choose depending on their individual needs and stages of their recovery. For example, prior research has indicated that women may have different needs at the early stages after leaving the abusive relationship (e.g., social and economic supports such as housing and supportive counselling), compared to subsequent stages when they may feel ready to process their trauma, and rebuild their identities and lives (Flasch et al., 2017; Sinko et al., 2020). Several women in the present study also spoke about the benefits of mental health supports provided in a group format, additional to individual therapy, which can facilitate connection, hope, empowerment, meaning making and learning (de Piñar-Prats et al., 2022). Access to

residential group programs, similar to those available for alcohol or drug recovery, were also proposed, which is a novel suggestion that merits further research. Finally, several women emphasised the need for mental health supports for their children. Although outside of the scope of the present paper, this is an important consideration given that coercive control is also a unique contributor to adverse childhood outcomes, and has been linked with complex, wide-ranging, and detrimental consequences (Xyrakis et al., 2022).

### **Limitations**

This study had several limitations. Although the sample was relatively diverse the composition of the sample does not permit transferability across diverse groups or inferences associated with demographic differences. First, the sample included only women who accessed domestic violence support services in regional Australia. Although recruitment was open to women with all gender identities, only cisgender women who identified as heterosexual and who were abused by male intimate partners participated in the study. Men were not included in this study because it was beyond this study's scope of recruitment pathways which were situated in a specific service for women, and mental health support needs for men and gender diverse people may differ (Walker et al., 2022). Second, only three women were First Nations women and any unique mental health support needs of First Nations women could not be explored. Third, although all participants were exposed to coercive control, the study did not delineate whether participants experienced other dimensions of IPV (e.g., physical, sexual, psychological IPV) that were not embedded in a pattern of coercive control and the support needs may not be unique to women who have been exposed to coercive control. Furthermore, the research questions of this phenomenological study were broad, and we did not ask specific questions, such as whether women had accessed mental health supports or what types of supports or at what point they may have accessed these supports.

## **Implications**

Taken together, this study provided a rich and in-depth account of the mental health supports women who have been exposed to coercive control need and want. This study also highlighted that there are some needs that are relatively consistent across all women, such as needing to feel safe, respected and understood by mental health professionals. Women also need mental health professionals to be trained in the complexities of coercive control including the impact of intersectional inequalities and power imbalances, such as gender and cultural norms and economic status that can further entrap a woman in the abusive relationship (Kulkarni, 2018; Potter, 2013). On the other hand, this study revealed that women's mental health support needs can differ depending on their unique circumstances (Paphitis et al., 2022). This suggests that an individualised, trauma-and-coercive control-informed approach that provides autonomy and caters for each women's individual needs and circumstances is likely most effective in supporting long-term recovery (Paphitis et al. 2022; Tarzia et al., 2020). The study also showed that coercive control exposure is influenced by a dynamic interaction between individual, relational, community and systemic factors (Frosh, 2003; Salter et al., 2020). This indicates that effective trauma-informed mental health supports have to be integrative and should address psychological trauma within a psychosocial context (Huang et al., 2014). In addition, supports should be available over the long term and should include options for both individual and group therapy (de Piñar-Prats et al., 2022; Ogbe et al., 2020).

### ***Implications for Policy***

Women in this study provided noteworthy perspectives and suggestions that may have important implications for policy. Notably, women identified limited government funding as a barrier to access mental health support, particularly when they need to access long-term mental health support (i.e., in Australia government supported Medicare funding presently

only provides 10 sessions per calendar year, and often requires an additional payment of a gap fee). This study also revealed that the administrative processes (e.g., having to return to the doctor after six sessions to access funding for the additional four sessions per calendar year) may deter women from seeking mental health support. This highlights the need for increases in government funding and easier referral pathways to access mental health support. Furthermore, this study showed that some women are concerned that the mental health professional's notes could be subpoenaed and used against them by the perpetrator. Policies that can help to protect women who experience coercive control from potential system abuse by the perpetrator are needed, so that women can feel safe to access mental health supports during family court proceedings. This may, for instance, involve strengthening confidentiality and privacy protections for coercive control victim-survivors similar to those available for victim-survivors of sexual assault in some jurisdictions, such as the *Sexual Assault Communications Privilege Act 2010* (NSW).

Finally, this study provided evidence for the need of integrated psychosocial trauma-and-coercive control-informed services that provide mental health support alongside advocacy, social and economic supports (Australia's National Research Organization for Women's Safety, 2015; Salter et al., 2020). Policy makers should consider the proposition of an integrated support package that could provide women with funding and choices of mental health, social, and economic supports that would best suit their individual needs and circumstances.

### ***Implications for Clinical Practice***

This study revealed several important implications for mental health professionals who work with women who have experienced coercive control. This study provided information that may contribute to co-designing trauma-and-coercive control-informed interventions (Australia's National Research Organisation for Women's Safety, 2015). First,

mental health professionals need to be trained to better understand the complex psychosocial impacts of coercive control exposure including the effects of intersectionality and social, economic and cultural diversity that can impact women differently (Salter et al., 2020). Second, the study also showed that women value group programs and mental health professionals should consider offering group programs additionally to individual therapy (Crespo et al., 2021; de Piñar-Prats et al., 2022). Moreover, the study highlighted that the support needs of women differ based on a woman's individual circumstances, needs and on the stage of her recovery. This suggests that trauma-and-coercive control-informed treatments need to be tailored accordingly (Paphitis et al., 2022).

### ***Implications for Research***

This qualitative study suggests that women who have been exposed to coercive control want long-term, trauma-and-coercive control-informed mental health supports that are tailored to their individual needs and circumstances (Flasch et al., 2017; Paphitis et al., 2022). Further research is needed to decide whether these findings are transferable to other populations. The focus of this study was on the mental health support needs of those who identify as women and future qualitative studies should look at different populations, such as men and gender diverse individuals, and people from different ethnic and cultural contexts (Kulkarni, 2018; Walker et al., 2022). This study has also highlighted that further research into mental health supports for children who have been exposed to coercive control in their families is needed (Xyrakis et al., 2022). Future research should also examine how to best train mental health professionals so that they can better support women who have been exposed to coercive control.

Moreover, the interacting and intersectional nature of coercive control related trauma suggests that further research into the design and delivery of integrated psychosocial trauma-

and-coercive control-informed approaches are needed (Baird et al., 2019; Salter et al., 2020). This should include qualitative research that focuses on co-designing interventions in consultations with victim-survivors across social, cultural and economic contexts (Cullen et al., 2021; Koss et al., 2017; Kulkarni, 2018). Future research should also include more specific questions about mental health needs at different stages of leaving the abusive relationship and during the recovery process.

Finally, IPV mental health intervention research to date has predominantly taken a clinical lens that focuses on symptom reduction of PTSD, anxiety, depression, or other psychopathologies. Future intervention research may benefit from using a recovery framework, such as CHIME, as processes such as hope and optimism about the future, identity, meaning in life, and empowerment are more relatable for victim-survivors compared to a measures of symptom reduction (de Piñar-Prats et al., 2022; Leamy et al., 2011). This suggests that the CHIME framework may also be a useful in guiding research into mental health support design and delivery for women who have been exposed to coercive control (Idris et al., 2023). Such a holistic recovery focus approach would also be aligned with the long-term recovery and healing perspective of the *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services, 2022).

## **Conclusion**

This qualitative study aimed to listen to the experiences of those who identify as women and to understand their mental health support needs following coercive control. The findings from this study suggest that women who have been exposed to coercive control need and want, integrated, long-term, trauma-and-coercive control-informed mental health supports that are tailored to their individual needs. The findings have important implications for research, clinical practice and policy.

#### 4.2.6. References

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## Chapter 5: General Discussion

### 5.1. Summary

Coercive control is an under-researched, complex and nuanced dimension of psychological IPV that is characterised by a chronic pattern of behaviour from a perpetrator that puts the victim in a prolonged state of terror and entrapment (Stark, 2007). Coercive control has been associated with trauma and mental health impacts, but several key gaps in the coercive control literature have contributed to a limited understanding of the mental health impacts of coercive control to date. First, the coercive control construct is complex and it can be difficult to delineate coercive control from the broader dimension of psychological IPV (Hamberger et al., 2017). Relatedly, inconsistencies in the conceptualisation, definition and measurements of coercive control have contributed to a limited understanding of the mental health impacts of coercive control (Dokkedahl et al., 2022; Dutton & Goodman, 2005; Hamberger et al., 2017; Myhill, 2015). Several primary studies have linked coercive control with trauma and mental health impacts, but these studies vary in their methodologies, and definitions and operationalisation of coercive control, and there is an urgent need for more systematic research. Second, most existing interventions for victim-survivors focus on safety, crisis management and advocacy. Consequently, there is presently a lack of mental health interventions that support the long-term recovery of victim-survivors, as well as a dearth of research into what mental health supports women need and want to aid in their long-term recovery after coercive control exposure (Hameed et al., 2020).

This thesis aimed to address these important gaps in the literature and had two overarching aims: (1) to improve the understanding of the trauma and mental health impacts of coercive control; and (2) to explore the mental health support needs and wants of women who have experienced coercive control to aid their long-term recovery. To achieve these

aims, the thesis employed a mixed methods approach and included three papers: A systematic review and meta-analysis, and two qualitative reports of in-depths analyses based on different research questions from the same qualitative interviews.

Study 1 was a systematic review and meta-analysis that examined the associations involving coercive control with PTSD, CPTSD, and depression. This review aimed to synthesise the effects of individual studies to provide more precise estimates of the mental health impacts of coercive control on PTSD, CPTSD, and depression. The review also aimed to compare the mental health impacts of coercive control with broader dimensions of psychological IPV. A systematic search of four data bases (PsycINFO, Medline, CINAHL, Scopus) identified 68 studies that could be included in the qualitative synthesis and data from 45 studies could be included in the random effects meta-analyses. Because only one of the included studies reported on the relationship between coercive control and CPTSD (Dokkedahl et al., 2021) meta-analyses could not be performed. Meta-analyses showed moderate associations involving coercive control and PTSD ( $r = .32$ ; 95% CI [.28, .37]) and depression ( $r = .27$ ; 95% CI [.22, .31]), providing evidence for the mental health impacts of coercive control. The strengths of these associations was comparable to those involving measures of broader psychological IPV that were also meta-analysed for comparison. Moreover, the strength of the associations was comparable to those of physical IPV found in previous meta-analyses (e.g., Golding, 1999; Spencer et al., 2019). The comparable strength of associations involving coercive control and that of physical IPV found in previous meta-analyses was an important finding because it suggests that coercive control, and psychological dimensions of IPV more broadly, can have equally detrimental trauma and mental health impacts as physical IPV (Dokkedahl et al., 2022). Given that only the mental health impacts of physical IPV have been extensively researched to-date, these findings highlight that it is equally as important to enhance the understanding of the mental health

impacts of coercive control. Overall study 1 provided evidence for the trauma and mental health impacts of coercive control, indicating that coercive control poses a significant mental health burden on victim-survivors.

Furthermore, study 1 showed that inconsistent definitions of coercive control in primary studies are concomitant with varying approaches to the measurement of coercive control in these studies (Hamberger et al., 2017). These inconsistencies make it challenging to compare the mental health impacts of coercive control across primary studies. Definitional inconsistencies and their implications more generally will be discussed later (see section 5.2.1). Crucially, the review made a key contribution to the literature by looking at primary studies that used similar approaches and by synthesising the strengths of the links between coercive control and mental health impacts. Relatedly, study 1 showed that it is difficult to capture the varied, complex and nuanced experiences of coercive control in quantitative measures. Given that qualitative research can provide the vital context needed to explore the complexities and nuances of coercive control, a qualitative research approach was employed to further investigate the mental health reactions following coercive control exposure (e.g., Langhinrichsen-Rohling et al., 2012).

Study 2 was a qualitative phenomenological study that explored the experiences and mental health reactions following coercive control exposure through the lens of lived experience based on semi-structured interviews with 16 women who had accessed domestic violence support services in regional New South Wales, Australia. This study focused on two research questions: (1) How do women describe their experiences of coercive control?, and (2) how do women describe the impact of coercive control exposure on their mental health?

Thematic analysis identified entrapment and insidiousness (characterised by subtlety, intangibility, gradual worsening), as the key characteristics and underlying dimensions of coercive control that (a) differentiate it from other dimensions of psychological IPV, and are

(b) central to the trauma and mental health reactions following coercive control exposure. Entrapment was considered to be an overarching theme because all participants described that they felt psychologically trapped in the coercive controlling relationship and that it had a negative impact on their mental health. Further, study 2 highlighted that the entrapment experience of coercive control needs to be understood within the context of the model of social entrapment (Tolmie et al., 2024). Namely, the effects of the perpetrator's coercive and controlling behaviours must be considered within the context of broader economic, social and cultural inequalities, that may intensify the entrapment experience, and collectively determine each woman's individual experience (Douglas et al., 2020; Ptacek, 1999, Tolmie et al., 2018, 2024). Participants reported a range of factors that can increase entrapment in an abusive relationship, such as being pregnant or having children with the abusive partner, experiencing (or fearing) financial hardship or homelessness, limited social support, and gendered family or cultural norms that make it challenging to leave abusive the relationship. Thus, although coercive control impacts women across cultural and socioeconomic backgrounds, the impacts may tend to be more detrimental for women who face socioeconomic, cultural or other systemic disadvantages (Gibbs et al., 2018; Goodman et al., 2009, Kulkarni, 2018; Oram et al., 2022). Moreover, the findings from this study showed that a perpetrator may deliberately target a woman's psychological, social, economic and cultural vulnerabilities to entrap her in the abusive relationships (Crossman & Hardesty, 2018).

The second overarching theme was the insidiousness of coercive control, reflected in characteristics of subtlety, intangibility and gradual worsening of coercive control. Participants reported that these characteristics made it difficult to recognise the signs of coercive control or to prove it to the police, especially in the absence of physical violence. The findings suggest that insidiousness impacted on women's mental health by eroding their self-worth, sense of self and independence over time. This was a novel finding because

previous research has predominantly focused on identifying behaviours that may constitute coercive control, whereas this study revealed that it is likely that the underlying features that are shared across these behaviours account for the mental health impacts (Parkinson et al., 2023).

The women in this study also described a range of trauma and mental health reactions that reflect symptoms of PTSD, such as recurrent distressing memories, nightmares, dissociative states, intense or prolonged psychological distress, persistent avoidance of stimuli associated with the coercive control exposure, negative cognitions, marked alterations in arousal and reactivity, hypervigilance, exaggerated startle response, difficulties concentrating and sleep disturbances. As expected, given the ongoing threat and terror, and the prolonged, entrapping and insidious nature of coercive control, several of the reported mental health reactions also reflected disturbances in self-organisation (i.e., affective dysregulation, negative self-concept, disturbances in relationships), that are consistent with the ICD-11 diagnostic criteria for CPTSD when they occur additionally to PTSD criteria (WHO, 2019).

The qualitative interviews from study 2 provided very rich and detailed information from a lived experience perspective. The interviews also included questions and provided data about these women's experiences with mental health supports, as well as what types of mental health supports they may consider to be beneficial. This drove the decision to develop a second paper, study 3, to give voice to women's experiences with mental health supports, and to enhance the understanding of the types of mental health supports women need and want to aid their recovery. Thus, study 3 also employed a qualitative phenomenological approach that was based on the same interviews with the 16 women as in study 2.

Study 3 aimed to enhance the understanding of mental health support needs and wants of women who have been exposed to coercive control by exploring, what mental health

supports women found helpful and unhelpful, and what mental health supports they anticipate to be beneficial for their recovery. The study also aimed to contribute to a better understanding of the barriers to seeking mental health supports. To achieve these aims the study was guided by two broad research questions: (1) How do women who have been exposed to coercive control describe their experience with mental health supports?, and (2) what do women who have been exposed to coercive control want from mental health support to assist their long-term recovery?.

Overall, participants experienced mental health supports as valuable. They described a range of helpful and unhelpful therapeutic practices and attributes of mental health professionals. Helpful practices and processes included feeling safe, and being heard, validated and respected by the mental health professional. Unhelpful practices and processes, on the other hand, included victim-blaming, lack of safety (e.g., being advised to have relationship counselling or to leave the relationship when it was not safe). Relatedly, women experienced it as unhelpful when their main presenting concerns were not addressed during therapy.

Moreover, the study identified that women experienced limited government funding and complex administrative processes (e.g., complicated referral processes, long waitlists) as major barriers to accessing mental health supports, especially if they require long-term mental health supports. Several women also expressed concern that the perpetrator could use their engagement with mental health supports against them. Other women were concerned that therapy would be too overwhelming whilst they were dealing with ongoing external challenges. This perspective that therapy would be too demanding, rather than being supportive and addressing their needs, prevented them from seeking support. Taken together, women's reports provided valuable information for intervention design and delivery.

Thematic analysis indicated that mental health supports play an important role in the recovery after coercive control and identified five broad areas: (1) therapy processes (e.g. individualised and flexible); (2) attributes of mental health professionals (e.g., feeling safe, heard, respected by the health professional), and the mental health professional's understanding of the nature and impact of coercive control; (3) types of interventions (e.g. group programs); (4) support for children; and (5) funding (e.g., more funding, easier and more empowering access to long-term funding).

Furthermore, women's reports in study 3 were less orientated toward clinical recovery (i.e., symptom reduction and functional improvement), and more focused on personal recovery, which is a process that goes beyond clinical recovery and takes into account an individual's resilience, hope and the ability to live a meaningful life in the presence of mental health challenges (Anthony, 1993; Leamy et al., 2011; Shanks et al., 2013). This suggests that a personal recovery framework (e.g. CHIME), which focuses on hope and optimism about the future, identity, meaning in life, and empowerment, is likely more relatable for victim-survivors compared to a clinical recovery framework (de Piñar-Prats et al., 2022; Idris et al., 2023; Leamy et al., 2011; van Weeghel et al., 2019). Nevertheless, some women also commented on the value of psychiatric diagnoses, suggesting a need for supports that are orientated toward a holistic recovery approach that integrates components of clinical and personal recovery.

Overall, the findings of this study suggest that women who have been exposed to coercive control want holistic recovery-orientated, integrated long-term, trauma-and-coercive control-informed mental health supports that are tailored to their individual needs and circumstances. That is, many women highlighted the need for integrated services that provide holistic and individualised care that provides flexible access to social, financial, legal and practical supports, as well as advocacy and education about coercive control alongside mental

health supports. Finally, the findings of study 3 also provided some novel and practical suggestions, such as an integrated and flexible support package similar to the *Australian National Disability Insurance Scheme* (2013). This support package is based on an individual's needs and goals and provides access to a wide range of supports, including mental health, social and practical supports that will help a person with a disability to pursue those goals. A similar program for victim-survivors could provide them with funding and choices of mental health, social, economic and practical supports depending on their individual needs, goals, circumstances and stage of recovery.

## **5.2. Synthesis of Findings and Overall Discussion**

Taken together, the findings across the three studies have highlighted six key points: (1) Inconsistencies in the conceptualisation and definitions of coercive control; (2) the need to recognise coercive control as a traumatic event (3) emerging evidence for the associations between coercive control and CPTSD; (4) the unique trauma and mental health impacts of coercive control; (5) the need for a holistic recovery focus that integrates clinical and personal recovery; and (6) the need for integrated trauma-and-coercive control-informed psychosocial interventions. Each of these key points is discussed in more detail below.

### ***5.2.1. Inconsistencies in the Conceptualisation and Definitions of Coercive Control***

Inconsistencies in the conceptualisation and definitions of the coercive control construct were evident throughout this thesis. To start, it was predicted that the associations involving coercive control and PTSD, CPTSD and depression would be stronger relative to associations with broader dimensions of psychological IPV that were also investigated in the review, and with the associations involving physical IPV examined in past research. It was therefore surprising that the meta-analyses showed that the associations of coercive control with PTSD and depression were generally comparable to the links involving other types of IPV (including broader measures of psychological IPV). However, this may be explained by

the conceptual complexities of coercive control and inconsistencies in definitions in the literature. Coercive control has been described varyingly as a ‘context’ for abusive behaviours (which may or may not include physical violence) (Dutton & Goodman, 2005; Stark, 2007; 2020), as well as a sub-type of IPV, which has been referred to as ‘intimate terrorism’ and contrasted with ‘situational couple violence’ that does not occur in the context of coercive control (Johnson, 2008; Johnson & Leone, 2005). Given these conceptual and definitional inconsistencies it can be difficult to distinguish coercive control from broader dimensions of psychological IPV, and the psychometric measures used to measure coercive control in the studies that were included in the review may not have fully captured whether a behaviour occurred in the context of coercive control or not (Dutton & Goodman, 2005; Dokkedahl et al., 2019, 2022). Relatedly, the chronic patterns of terror and entrapment that characterise coercive control may not be sufficiently captured in available psychometric measures (Dokkedahl et al., 2022; Stark, 2007). These limitations in measurement may, at least in part, explain the similar effects found in the review. They also called attention to the need to better understand the pattern of terror and entrapment that underlies coercive control, and to the need to create a consistent definition, and to develop measures that reliably reflect this definition (Hamberger et al., 2017).

Study 2 provided a preliminary response to some of these issues. The experiences described by participants in the qualitative interviews contributed rich information that enhanced the clarity of the coercive control construct and its measurement. Firstly, the study highlighted that the experience of entrapment has to be considered by definitions and measures of coercive control, which should also recognise the power imbalances associated with intersectional inequalities (e.g., social, economic, cultural, gender) that can worsen the entrapment in abusive relationships (Douglas et al., 2020; Ptacek, 1999; Tolmie et al., 2018, 2024). Concomitantly, the perpetrator’s coercive and controlling tactics may target their

victim's psychological, socioeconomic and cultural vulnerabilities to foster dependency and further entrap them in the abusive relationship. Secondly, the study indicated that dimensions of subtlety and intangibility, and the gradually worsening nature of coercive controlling behaviours are the key factors constituting a broader characteristic of insidiousness. Together, this suggests that measures of coercive control should be broadened beyond measuring the occurrence of specific coercive and controlling behaviours, and should (a) consider factors that reflect the experiences and impacts of social entrapment, and (b) also consider factors reflecting the subtlety and intangibility, and the gradually worsening nature of coercive controlling behaviours that constitute insidiousness. Given the gradually worsening nature of coercive control, measures should also take into account how these factors and their impacts may change over time.

Equally, definitions of coercive control should be broadened to include these key factors. It is important to acknowledge that Stark's (2007, p.5) classic definition that coercive control is a "pattern of violence, intimidation, isolation, and control where the main goal is to degrade, isolate, and deprive women of their rights to physical security, dignity, and respect" was based on the premise of gender inequality and intersectionality. Nevertheless, this definition could be further extended to make insidiousness, subtleness and the gradual worsening of behaviours more salient in the definition, and the following extension to Stark's (2007) definition is proposed: Coercive control is an insidious pattern of abuse, characterised by subtlety, intangibility and often gradually worsening of behaviours, such as intimidation, isolation, and control, often targeting the victims psychological, socioeconomic or cultural vulnerabilities, where the main goal is to degrade, isolate, and deprive a person of their rights to physical and psychological security, dignity, and respect to entrap the person in the abusive relationship.

### 5.2.2. *Recognising Coercive Control as a Traumatic Event*

The meta-analyses showed that coercive control is associated with PTSD, and the mental health reactions described by the participants in the qualitative explorations of this thesis indicated that coercive control is likely also implicated in symptoms of both PTSD and CPTSD. This suggests that coercive control exposure constitutes a traumatic experience. However, coercive control, and psychological IPV more broadly, have still not been fully recognised as traumatic events, likely due to the challenges of defining the boundary between traumatic and nontraumatic events (Hyland et al., 2021). That is coercive control exposure does not necessarily align with criterion A of PTSD (i.e., “exposure to actual or threatened death, serious injury, or sexual violence”) in the *Diagnostic and Statistical Manual of Mental Disorders*, not even in its latest 2022 edition the DSM-5-TR. However, both the review and the qualitative reports in this thesis, as well as prior research (Dokkedahl et al., 2021, 2022) clearly show, that those who have experienced coercive control can experience mental health reactions consistent with the other DSM-5-TR diagnostic criteria of PTSD (i.e., criteria B-H; e.g., intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, marked alterations in arousal and reactivity). The focus on the DSM-5 criteria A may, at least in part explain why the trauma of coercive control has not been more widely acknowledged to date (Hyland et al., 2021).

The ICD-11, on the other hand, takes a more flexible approach by allowing for a clinical evaluation of what constitutes a traumatic event for the individual, and coercive control may be classified as a traumatic event based on a clinical assessment (WHO, 2019). Moreover, the ICD-11 criterion A for PTSD is broader and includes “exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature”, which is aligned with participant’s descriptions in study 2. Importantly, the ICD-11 criterion A for CPTSD clearly includes the experience of “exposure to an event or series of events of an

extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible to escape including “prolonged domestic violence”. This reflects participants’ descriptions in study 2, who overwhelmingly described coercive control as an extremely threatening or horrific experience, with some likening it to “being in a concentration camp” or “being held hostage”. This suggests that the ICD-11 criteria A provides a more integrative and clinically useful classification system that acknowledges the trauma associated with coercive control exposure. This perspective was supported by a recent study based on a national representative sample in Ireland, which compared the rates of trauma based on the DSM–5 Criterion A definition and a broader definition of trauma consistent with ICD-11 guidelines for criterion A events plus five psychologically threatening non-criterion A events including stalking and emotional abuse (Hyland et al., 2021). The study found that all five non-criterion A events were significantly and positively correlated with both PTSD and CPTSD symptom severity, suggesting that non-criterion A events involving extreme fear and horror should be considered traumatic events (Hyland et al., 2021). These results support the findings of this thesis, and suggests that the broader ICD-11 criteria A for PTSD and particularly CPTSD are more useful to promote, both, the recognition of the traumatic impact of coercive control and its treatment.

### ***5.2.3. Emerging Evidence for a Link between Coercive Control and CPTSD***

Following on from the previous section the meta-analysis highlighted the lack of empirical research into the association involving coercive control and CPTSD to-date, whilst study 2 provided qualitative evidence for this link. Given the prolonged and chronic terror associated with coercive control, and the strong theoretical rationale for the likelihood of an association between coercive control and CPTSD (Cloitre, 2021; Dokkedahl et al., 2021; Herman, 1992a, 1992b; WHO, 2019), it was unexpected that only one study which met inclusion criteria for the review also measured CPTSD. Nevertheless, it was

noteworthy that the one included study found a small association between coercive control and CPTSD, in a shelter-based sample of 147 women (Dokkedahl et al., 2021). The combination of the theoretical rationale and these initial findings provided the foundations for exploring the associations involving coercive control and CPTSD in the qualitative interviews in study 2.

As expected, women in study 2 reported mental health reactions that align with the ICD-11 diagnostic criteria for CPTSD, which are reflected in disturbances in self-organisation (i.e., affective dysregulation, negative self-concept, disturbances in relationships) (WHO, 2019). Examples of affective dysregulation included reports of overwhelming anger, self-destructive behaviours, such as substance or alcohol use to cope with emotions, and examples of negative self-concept included descriptions of self-blame, shame and guilt. Disturbances in relationships were reflected in reports of inability to trust or difficulties to form new relationships. Together, the lack of research into the associations between coercive control and CPTSD highlighted in study 1, on the one hand, and the qualitative evidence of study 2, on the other hand, clearly point to a critical need for more studies that investigate the relationship between coercive control and CPTSD (Dokkedahl et al., 2021; Pill et al., 2017).

#### ***5.2.4. The Unique Trauma and Mental Health Impacts of Coercive Control***

The previous two sections have argued that coercive control should be recognised as a traumatic event and that the mental health reactions following coercive control exposure can reflect symptoms of CPTSD, at least for some victim-survivors. Additionally, this thesis has provided insight into the factors that may uniquely contribute to the complex trauma and mental health impacts of coercive control and why they may differ from exposure to other dimensions of IPV, not embedded in a pattern of coercive control.

The qualitative studies, in particular highlighted that the mental health impacts of coercive control differ to those of other dimensions of IPV: That is women commonly perceived the non-physical tactics of coercive control as more damaging than tactics involving physical acts of violence. The findings suggest that the unique mental health impacts may be associated with two related key factors: (1) The ongoing threat and terror, and (2) with the insidiousness and entrapment of coercive control.

The ongoing threat and terror of coercive control distinguishes it from other dimensions of IPV that are not embedded in such patterns of coercion, in line with Johnson's (2008) typology that contrasted intimate terrorism (i.e., coercive control) with situational couple violence. Moreover, as discussed above, the exposure to the ongoing, prolonged and cumulative threat and terror of coercive control is aligned with the notion of complex trauma and the diagnostic criteria and key features of CPTSD that are characterised by disturbances in self-organisation (Cloitre, 2021; Dokkedahl et al., 2021; Fernandez-Fillol et al., 2021; Herman, 1992; WHO, 2019).

The qualitative exploration also identified *entrapment* and *insidiousness* (characterised by subtlety, intangibility, gradual worsening), as important underlying dimensions of coercive control. These dimensions may differentiate coercive control from other types of IPV and may be associated with unique mental health reactions. For example, the subtlety, intangibility and gradual worsening of the perpetrator's coercive and controlling behaviours may gradually erode a victim's sense of self, and may contribute to the disturbances in self-organisation that are associated with CPTSD (Cloitre, 2021; Fernandez-Fillol et al., 2021; Herman, 1992a, 1992b; WHO, 2019). Additionally, because of the subtlety, intangibility, gradual worsening, including lack of physical evidence in the absence of physical abuse women encountered not being believed, or being unable to prove what they are experiencing, including to the police. This further diminished a woman's

confidence, trust and sense of self (Baird et al., 2019; Herman, 1992a, 1992b). Taken together, the findings of this thesis suggest that the ongoing threat and terror, insidiousness and entrapment of coercive control contribute to the unique and complex trauma and mental health reactions that may reflect symptoms of CPTSD (Fernandez-Fillol et al., 2021, WHO, 2019).

### ***5.2.5. Integrated Trauma-and-Coercive Control-Informed Psychosocial Interventions***

This thesis provided evidence that coercive control exposure can constitute a traumatic experience, and provided quantitative and qualitative evidence for the links involving coercive control and trauma and mental health reactions associated with characteristics of PTSD and CPTSD. Given, these apparent posttraumatic mental health reactions, the types of mental health supports and how they are provided can have a major impact on a victim-survivor's wellbeing and recovery trajectory (Wathen et al., 2023). This indicates that to support the recovery of victim-survivors of coercive control, interventions need to be trauma-informed and consider the traumatic impacts of coercive control (e.g. Warshaw et al., 2013; Wathen & Mantler, 2022). Core principles of trauma-informed care include safety, trust, choice, collaboration, empowerment and respect for diversity (Wathen & Mantler, 2022). Women's description of their needs and wants from psychological support provided in study 3 were reflective of these principles and contributed important suggestions of what trauma-informed approaches may look like for women who have experienced coercive control. The women emphasised the importance of safety, being listened to, feeling heard and validated without being judged; they wanted the mental health professional to respect their individual circumstances, and to consider their resources, capacities, risks at a given time during their recovery.

Furthermore, this thesis, particularly the qualitative studies, highlighted that experiences of coercive control and support needs of women who are exposed to coercive

control can differ greatly depending on individual circumstances. First, women's accounts in the qualitative interviews suggest that there may be different stages of recovery after coercive control exposure (Kita et al., 2022). Although, the participants in the qualitative studies were not directly asked whether their support needs differed depending on the time period since leaving the abusive relationship, this could be inferred from the interviews. For example, women described different support needs depending on whether they were in the decision making process to leave the abusive relationship, in crisis shortly after leaving the relationship, during family court proceedings, or when experiencing long-term impacts on their mental health, up to many years after leaving the abusive relationship. This is aligned with prior IPV research which has suggested that women's support needs differ during the early stages after separating from an abusive partner (e.g., social and economic supports such as housing and supportive counselling, support during potentially retraumatising court proceedings), compared to later stages when they have more capacity to process their trauma, and rebuild their lives and sense of self (Flasch et al., 2017; Sinko et al., 2020).

Second, both prior research and the accounts of women in the qualitative interviews showed that coercive control exposure is influenced by a dynamic interaction between individual, relational, community, intersectional and systemic factors (Kulkarni, 2018; Oram et al., 2022; Salter et al., 2020). This indicates that effective trauma-informed mental health supports have to be integrative and should address psychological trauma within a psychosocial context, and offer integrated supports (e.g., social, financial, legal supports) alongside mental health supports (Cullen et al., 2021; Huang et al., 2014; Paphitis et al. 2022).

Third, the qualitative findings highlighted that women view mental health supports as an important and integral part of their recovery after coercive control exposure. Women further emphasised the need for individualised and flexible support options which were

tailored to their needs and circumstances (e.g., intersectional factors, stages of recovery), highlighting the need for coercive control-informed case formulations that are tailored to an individual's presentations and circumstances (Calhoun et al., 2022; Doyle et al., 2022).

Taken together, the findings highlight the need for comprehensive psychosocial interventions that simultaneously recognise the trauma and mental health impacts of coercive control, and consider the complex processes involving both individual (e.g., psychological) and systemic (e.g., intersectional, cultural) factors (Kulkarni, 2018; Moulding et al., 2021; Salter et al., 2020). This requires the conceptual integration of a mental health perspective that has traditionally viewed the impacts of IPV exposure through an individualised lens, with a feminist and social research perspective that focuses on gendered, social, and systemic factors (Humphreys & Thiara, 2003; Moulding, 2016; Moulding et al., 2021). This approach may be positioned as an integrated trauma-and coercive control-informed care model that considers the complexities of coercive control, addresses intersectional and systemic inequalities, as well as individual mental health reactions. Such an approach would be aligned with a trauma- and violence-informed care approach, but would be more specifically focused on coercive control, rather than on IPV more generally (e.g., Australia's National Research Organisation for Women's Safety, 2015; Wathen et al., 2023; Wathen & Mantler, 2022).

#### ***5.2.6. Integration of Clinical and Personal Recovery Focus***

The studies that were included in the systematic review highlighted that quantitative research into the mental health impacts of coercive control tends to focus on clinical recovery, which focuses on changes in clinical outcomes such as mental health symptom reduction and improvements in functioning (Macpherson et al., 2016). Conversely, the qualitative data in study 3 suggest the need for a broader focus on personal recovery, which is a process that goes beyond symptom alleviation, and instead looks at an individual's resilience, hope and the ability to live a meaningful life in the presence of mental health

challenges (Anthony, 1993; Leamy et al., 2011; Shanks et al., 2013). Previous qualitative research also suggests that women who have been exposed to IPV are more focused on their personal recovery, compared to the clinical recovery constructs favoured by academic research (e.g., Carman et al., 2022; Flasch et al., 2017; Sinko et al., 2021). The findings of the qualitative studies and prior research thus suggest that a recovery framework, such as the CHIME framework, which focuses on processes such as hope and optimism about the future, identity, meaning in life, and empowerment is likely more relatable for victim-survivors compared to measures of symptom reduction (de Piñar-Prats et al., 2022; Idris et al., 2023; Leamy et al., 2011; van Weeghel et al., 2019). The CHIME framework is extensively endorsed in mental health recovery research, but has been rarely applied to IPV recovery research (Katz, 2015). Based on the reports in study 3 it may be useful in the conceptualisation of the recovery processes following coercive control exposure.

Nevertheless, some women in study 3 also reported the value of mental health diagnoses, which suggests that there is a need to integrate clinical recovery components, such as psychological support to reduce mental health symptoms, with a personal recovery framework, such as CHIME (Frost et al., 2017). For example, women reported specific PTSD symptoms, including intrusion symptoms (e.g., flashbacks, nightmares) which can be highly distressing and disruptive, and treating these symptoms will likely support their recovery (Iyadurai et al., 2019). A holistic recovery approach that can facilitate both clinical and personal recovery would likely provide better outcomes and would also align with the long-term recovery and healing perspective of the Australian *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services, 2022).

### 5.3 Limitation and Strengths

#### *Limitations*

The studies that are included in this thesis have several limitations that need to be considered in the interpretation of the results. The limitations for the individual studies are discussed in the limitation section of each manuscript and this section focuses on the limitations that were apparent across studies. Several limitations were evident across all studies in this thesis. First, this thesis focused predominantly on the mental health impacts of coercive control on women, and thus the findings cannot be generalised to men or gender diverse populations. More specifically, only three studies in the systematic review focused exclusively on men, and two studies on gender diverse people. Relatedly, all participants in the qualitative studies were cisgender women who identified as heterosexual and had experienced abuse by a male intimate partner.

Second, both the systematic review and the qualitative studies provided limited data about the impacts of demographic or sociocultural differences and it was not possible to draw conclusions about demographic or sociocultural impacts. Particularly, the sample size and composition of the qualitative studies did not allow for transferability across diverse groups and conclusions associated with demographic differences, such as, for example, the specific challenges First Nations woman who experienced coercive control may face (Langton et al., 2020). Similarly, participants in the qualitative studies commented on the mental health impact of coercive control on children and highlighted the need for mental health support for children, which is also reflected in prior research (Xyrakis et al., 2022). However, it was beyond the scope of this thesis to listen to the voices of children or explore their support needs. Moreover, the qualitative studies were conducted in a regional area in the Australian state of New South Wales, and the results may not be transferable to urban or remote areas, other Australian states, and other countries and cultures more generally.

Third, none of the included studies controlled for temporal factors, such as the duration or onset of mental health reactions, or the presence of pre-existing mental health issues. Likewise, participants' reports in the qualitative studies implied that women may go through different stages of recovery after coercive control exposure and that their support needs may differ depending on the stage of their recovery. However, participants were not asked specific temporal questions about whether they had different support needs at different times, and it was not possible to draw clear conclusion either about stages of recovery or associated mental health support needs. Relatedly, this thesis did not look at the history of participants. For example, survivors of child maltreatment are overrepresented in victim-survivors of coercive control, which may complicate their recovery and may impact on policy distinctions between child protection and victim-survivors' safety. (Macafee & Reeves, 2023).

Fourth, the included studies reported mental health reactions within the context of mental health diagnoses but less than 5% of the studies included in the meta-analysis employed diagnostic instruments. Equally, the qualitative studies discussed mental health reactions within the context of PTSD and CPTSD, but no validated measures were used to assess whether mental health reactions were associated with these diagnoses.

Moreover, although all participants in the qualitative studies endorsed that they had experienced coercive control, the studies did not include a control group of participants who experienced other dimensions of IPV (e.g., physical, sexual, psychological IPV) that were not embedded in a pattern of coercive control. Thus, the support needs and wants may not be unique to women who have been exposed to coercive control.

Finally, the impact of the positionality of research team needs to be considered in the interpretation of the results of the individual studies and thus the overall conclusions that can be drawn in this thesis. All authors that contributed to the individual studies are White

cisgender people who identify as heterosexual. They are also psychology and trauma trained and have conceptualised coercive control as contributing to major trauma and mental health reactions, and preconceptions associated with this positionality may have introduced bias into the interpretation of the findings of this thesis (Darwin-Holmes, 2020).

### *Strengths*

Despite these limitations, this thesis also has several notable strengths. First and foremost, the mixed methods approach provided a comprehensive and in-depth perspective of coercive control, its mental health implications and the psychological support needs that can aid the long-term recovery of victim-survivors. The mixed method approach allowed for the development of refined conclusions by using the results from one study to inform and design the subsequent studies. The triangulation allowed for more valid conclusions by comparing the results from the systematic review and meta-analysis with the finding from the qualitative studies for convergence and divergence (McCrudden et al., 2021). In particular, the qualitative studies added rich and novel information to the coercive control literature that could not have been revealed by quantitative methods alone. For instance, the review revealed challenges with the conceptual and definitional clarity of coercive control, and the subsequent qualitative investigations contributed to the literature by improving conceptual and definitional clarity. Similarly, because of the lack of studies that examined CPTSD in the review, the review could not provide any insights whether coercive control is associated with CPTSD. The qualitative studies, on the other hand, showed that participants experienced mental health reactions that are consistent with CPTSD symptoms. This demonstrates the value of a mixed methods research design and the value of including victim-survivor led perspectives, which are crucial in the engagement with vulnerable populations and essential in the development and co-design of interventions (Clark & Ivankova, 2016; Goodman et al., 2018; McCrudden et al., 2021).

Additionally, on an individual study level, it is noteworthy that the thesis includes the first systematic review and meta-analysis that specifically investigated the mental health impacts of coercive control, and compared the effects to other dimensions of IPV. Equally, this thesis included the first qualitative study that specifically explored the mental health support needs and wants of Australian women following coercive control exposure through the lens of lived experience, which provided novel insights and practical suggestions on how to support the long-term recovery of women who have been exposed to coercive control.

#### **5.4. Implications for Policy, Clinical Practice and Future Research**

The findings of the studies included in this thesis have important implications for policy, clinical practice and future research. The implications of the individual studies have been described in the individual manuscripts and are synthesised below.

##### ***5.4.1. Implications for Policy***

There are several implications for policy that can be inferred from this thesis. First, this thesis demonstrated that coercive control exposure can have long-term trauma and mental health impacts. Given the significant mental health burden of coercive control policy makers should implement policies that can help to prevent coercive control exposure (Australian Bureau of Statistics, 2022). A focus on prevention, along with early intervention, response and recovery is aligned with the recently released *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services, 2022). Importantly, this was the first time that the right for recovery and healing, and the need to support victim-survivors to be safe and healthy to be able to recover from the trauma and the physical, mental, emotional, and economic impacts of violence has been explicitly articulated in the National Plan by including the fourth pillar of recovery (Department of Social Services, 2022).

The plan defines prevention as “stopping violence against women from occurring in the first place by addressing the underlying drivers, such as social conditions that give rise to violence, by reforming institutions and systems that maintain the violence” (Department of Social Services, 2022, p. 75). The *National Principles to Address Coercive Control in Family and Domestic Violence* provide additional suggestions that more specifically pertain to preventing coercive control, such as policies that help to improve the societal understanding of coercive control by improving the understanding of the attitudes and behaviours that condone, minimise or excuse coercive control, and how these attitudes limit the effectiveness of interventions and compromise the safety of victim-survivors (Commonwealth of Australia, 2023).

Moreover, policy makers should consider the trauma and mental health impacts of coercive control on victim-survivors, and how to better protect victim-survivors when devising policies surrounding legal proceedings, such as policies that can protect victim-survivors from potential system abuse by the perpetrator when going through family court proceedings. Policies could include strengthening confidentiality and privacy protections for coercive control victim-survivors similar to those available for victim-survivors of sexual assault in some jurisdictions (e.g., *Sexual Assault Communications Privilege Act 2010* (NSW)).

Equally, the evidence of the trauma and mental health impacts of coercive control also strengthen the justification for criminalisation of coercive control. Notably a recent Australian report by the *Monash Gender and Family Violence Prevention Centre* found that the majority of victim-survivors of coercive control, including the majority of First Nations victim-survivors supported criminalisation of coercive control (Reeves et al., 2021). Policy makers should consider the mental health impacts of coercive control on victim-survivors when considering the criminalisation of coercive control (Commonwealth of Australia, 2023;

Macafee & Reeves, 2023; McMahon & McGorrery, 2020). As outlined in the 7<sup>th</sup> of the *National Principles to Address Coercive Control in Family and Domestic Violence*, considerations whether to criminalise coercive control or not should be designed in consultation with victim-survivors and should include steps to mitigate potential adverse consequences (e.g. system abuse by the perpetrator), and should minimise the chance of re-traumatisation of victim-survivors (Commonwealth of Australia, 2023). Otherwise, criminalisation may be a deterrent for victim-survivors to report coercive control, especially for disadvantaged populations that are more likely to have had negative experiences with the justice system, such as First Nations peoples, people from culturally and linguistically diverse backgrounds, gender diverse people, people with disability, or those experiencing mental illness or using substances (Commonwealth of Australia, 2023).

Finally and importantly, this thesis highlighted the need for the provision of integrated psychosocial trauma-and coercive control-informed services that provide mental health support alongside advocacy, social and economic supports (Australia's National Research Organisation for Women's Safety, 2015; Salter et al., 2020). In Australia, this approach to service delivery would be aligned with the *National Plan to End Violence Against Women and Children 2022–2032* (Department of Social Services, 2022). Several integrated recovery orientated models of care for women experiencing trauma from domestic, family and sexual violence have already been proposed in Australia, such as the model of care outlined in Salter et al. (2020) and the co-designed model of the *Women's Trauma Recovery Centre* (Cullen et al., 2021).

Relatedly, this thesis highlighted the need to provide funding so that victim-survivors could access these services. Policy makers should consider increasing government funding and easing referral pathways for victim-survivors to provide better access to such integrated long-term mental health supports. In Australia, this could include an increase of funding

through the nation-wide Primary Health Networks (Australian Government, 2023), which are independent organisations that work towards streamlining health services, particularly for those at risk of poor health outcomes. The aim of Primary Health Networks is to coordinate care so that people receive the most suitable care for their individual needs. For example, the Australian Government is presently funding pilot programs through these Primary Health Networks to test a new trauma-informed model of care to improve access to integrated support programs for victim-survivors of family, domestic and sexual violence as part of the *National Plan to End Violence Against Women and Children 2022–2032* strategy (Department of Social Services, 2022). Policy makers should also consider an integrated support package similar to the *Australian National Disability Insurance Scheme* (2013), which provides funding for eligible people with a disability and supports access to therapies based on their individual needs and wants, including the access to a support coordinator. Such a package could provide victim-survivors with funding and choices of mental health, social, and economic supports depending on their individual needs, circumstances and stage of recovery.

#### **5.4.2. Implications for Clinical Practice**

Several important implications for clinical practice can be inferred from this thesis. Before discussing these implications, it is important to again acknowledge the need for a primary focus on prevention. However, coercive control is a complex problem that requires comprehensive strategies and the focus on recovery is one of the four aforementioned pillars of the *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services, 2022). The findings presented in this thesis can inform the design and implementation of recovery orientated programs.

First and foremost, across all three studies the long-term trauma and mental health implications of coercive control were evident and women across the qualitative studies

emphasised the need for long-term mental health supports that go beyond crisis management and are orientated towards long-term recovery (Australia's National Research Organisation for Women's Safety, 2015; Department of Social Services, 2022; Salter et al., 2020; Wathen & Mantler, 2022). The accounts of lived experience across the qualitative studies provide a range of practical suggestions on how to implement a trauma-and coercive control-informed approach with a long-term recovery focus into clinical practice.

Second, women emphasised the need for mental health professionals to understand the systemic complexities they may face alongside the inherent insidiousness of coercive control. Consequently, mental health professionals need to be trained, so that they can understand (a) the complexities of social entrapment (i.e., effects of intersectional inequalities, social, economic and cultural diversity, gender and power imbalances) that can impact women differently, and (b) the insidiousness of coercive control exposure. Mental health professionals need to be aware of these systemic and inherent factors of coercive control so that they can support women by integrating them into biopsychosocial case formulations to guide individualised and trauma-and coercive control-informed treatment (Australia's National Research Organisation for Women's Safety, 2015; Commonwealth of Australia, 2023; Kulkarni, 2018; Potter, 2013; Salter et al., 2020).

Although not a direct focus of this thesis, it is important to note that women reported negative encounters with frontline services, such as the police and health care providers, which they experienced as unhelpful, and at times re-traumatising. This suggests that these service providers may not understand the pattern of social entrapment and insidiousness of coercive control, and indicates that frontline staff require training to better protect these women (Australia's National Research Organisation for Women's Safety, 2015; Brennan et al., 2019; Department of Social Services, 2022). This need for training has also been recognised in the *National Plan to End Violence against Women and Children 2022–2032*,

which recommends specialist and targeted training for health professionals, police, the judiciary and the legal profession to support a transition to pattern-based responses.

(Department of Social Services, 2022).

Second, the qualitative studies showed that the support needs of women differ based on their individual needs, circumstances and on the stage of their recovery. This suggests that an individualised, trauma-and coercive control-informed approach that provides autonomy and caters for each woman's individual needs and circumstances is likely most effective in supporting long-term recovery (Paphitis et al. 2022; Tarzia et al., 2020). On the other hand, there are some needs that seem relatively consistent across all women, such as needing to feel safe, respected and understood by mental health professionals, and mental health professionals should consider these needs when working with victim-survivors. Findings also highlighted a need for group interventions and mental health professionals should consider offering group therapy and support programs additionally to individual therapy (Crespo et al., 2021; de Piñar-Prats et al., 2022).

Moreover, mental health professionals should also provide psychoeducation about the trauma and mental health impacts of coercive control and about the availability of effective evidence-based treatments for PTSD and CPTSD (see Phoenix Australia, 2021 for treatment guidelines; Darby et al., 2023). This would provide victim-survivors with the awareness and hope that clinical recovery (i.e., mental health symptom reduction, functional improvement) and personal healing and long-term recovery are possible (Doyle et al., 2022; Sinko et al., 2022).

### ***5.4.3. Implications for Future Research***

This thesis identified several gaps and areas of research that could be explored in future research. First, this thesis highlighted the conceptual complexities and definitional inconsistencies of coercive control in the literature, and has contributed new insights and clarity to the nuanced and complex coercive control construct, including a broader definition that includes the impacts of social entrapment and insidiousness. This suggests the need to further the development and validation of coercive control measures that include dimensions of social entrapment and insidiousness in order to more accurately reflect the nuanced and varied experience of coercive control (Wilson & Fritz, 2023). More broadly, future research should measure the impacts of psychosocial dimensions of coercive control additionally to psychological and behavioural dimensions. Future psychological research should also explore how social, cultural and economic contexts could be quantified in coercive control and IPV research more generally.

Second, the meta-analysis and study 2 identified the need for more primary studies that investigate the association between coercive control and CPTSD. This is vital to better understand the mental health impacts of coercive control and to guide further intervention research (Cloitre, 2021; Karatzias & Cloitre, 2019). Relatedly, further research is needed to explore the nature and utility of psychiatric diagnostic constructs and labels, including whether and how these may be useful to victim-survivors (Doyle et al., 2022). This may also include further research into the utility of integrating a clinical recovery approach, with a broader personal recovery approach, such as CHIME (Doyle et al., 2022; Frost et al., 2017; Leamy et al., 2011).

Third, most of the studies included in the meta-analysis were either conducted in the USA or other developed countries and the qualitative studies were conducted in Australia, which is also developed country. More primary studies in developing countries and with

culturally and ethnically diverse samples, including First Nations peoples are needed to generalise findings (McKinley, 2022). Equally, the thesis predominantly examined the experiences and mental health impacts of cisgender women in heterosexual relationships and more research with men and gender diverse samples is needed (Walker et al., 2020).

All three studies, but more specifically the qualitative studies, implied a need to train service providers, such as frontline staff, health care providers and mental health professionals to enhance the understanding of the nature and impacts of coercive control so that they are better equipped to support victim-survivors of coercive control. Future research should explore how to best train and support these service providers (Ambikile et al., 2022; Department of Social Services, 2022). This may include research into how to best provide specialist training to frontline services and health care professionals about the nature and impact of coercive control, and how to take a trauma-informed approach to better respond and protect victim-survivors (Department of Social Services, 2022). Similarly, research into how to train mental health professionals may include research into developing trainings and mental health service models for coercive control (Rodriguez et al., 2020).

Further intervention research is needed to provide and increase the uptake of evidence-based trauma-and coercive control-informed integrated psychosocial care that can support the long-term recovery of victim-survivors who have been exposed to coercive control. The interacting and intersectional nature of coercive control-related trauma suggests that further research into the design and delivery of integrated psychosocial trauma-and coercive control-informed approaches is needed (Baird et al., 2019; Salter et al., 2020). This should include qualitative research that focuses on co-designing interventions in consultation with victim-survivors across social, cultural and economic contexts (Koss et al., 2017; Kulkarni, 2018).

Furthermore, the qualitative studies showed that gradual worsening of coercive control may be a key feature of insidiousness. This suggests the need for longitudinal studies that are capable of capturing the experience of gradual worsening over time. Similarly, it may be inferred from the qualitative studies that women who have been exposed to coercive control may have different support needs depending on the stage of their recovery (e.g., just after leaving the abusive relationship compared to several months or years later after leaving the abusive relationship). However, longitudinal studies are needed to provide evidence for stages of recovery post coercive control exposure (Kita et al., 2022).

Moreover, the qualitative studies revealed that further research into the mental health impacts and support needs of children who have been exposed to coercive control in their families is needed (Katz, 2022; Xyrakis et al., 2022). Relatedly, future research could also examine how to best train mental health professionals so that they can support these children. Likewise, there is a high incidence of childhood trauma amongst victim-survivors of coercive control and IPV more broadly, which may complicate their recovery and future research should investigate the implications of this complexity for policy and clinical practice (Macafee & Reeves, 2023).

Finally and importantly, future intervention research may benefit from using a recovery framework, such as CHIME, as processes such as hope and optimism about the future, identity, meaning in life, and empowerment tend to be more relatable for victim-survivors compared to measures of symptom reduction (de Piñar-Prats et al., 2022; Idris et al., 2023; Leamy et al., 2011). Such a holistic recovery focus approach would align with the long-term recovery and healing perspective of the *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services, 2022).

## 5.5. Conclusion

In conclusion, this thesis made several important contributions to the coercive control literature. Above all, it provided quantitative and qualitative evidence for the long-term trauma and mental health impacts of coercive control, and showed that women who have experienced coercive control need and want mental health supports to aid their long-term recovery. More specifically, across the three studies this thesis made six key contributions. First, the thesis contributed to the clarification of the coercive control construct by identifying entrapment and insidiousness (characterised by subtlety, intangibility, gradual worsening), as the underlying dimensions of coercive control and suggested that these dimensions differentiate coercive control from other types of IPV and may be associated with unique mental health reactions. Second, the findings of this thesis indicate that coercive control exposure should be recognised as a traumatic event. Third, and correspondingly, the findings of this thesis suggest that coercive control may be associated with CPTSD. Fourth, it was proposed that the ongoing threat and terror, insidiousness and entrapment of coercive control contribute to the unique and complex trauma and mental health reactions that may be reflected in CPTSD symptoms. Moreover, the qualitative findings highlighted the need for a holistic recovery focus that integrates clinical and personal recovery, and the need for integrated trauma-and coercive control-informed psychosocial interventions.

The findings have important implications for policy, clinical practice and research. Considering the significant mental health burden of coercive control, there is a need for policy makers to focus on prevention and recovery which is aligned with the Australian *National Plan to End Violence against Women and Children 2022–2032*. Other policy implications include the need to better protect women during legal proceedings, and a consideration of the mental health impacts of coercive control when devising legislation surrounding the criminalisation of coercive control.

Some of the important clinical implications include the need for mental health professionals to be trained, so that they can understand the complexities of social entrapment and the insidiousness of coercive control exposure to integrate these factors into biopsychosocial case formulations to guide individualised and trauma-and coercive control-informed treatment. Moreover, the qualitative studies showed that the support needs of women differ based on their individual needs, circumstances and on the stage of their recovery, suggesting the need for individualised and flexible interventions.

Several important implications for further research can be inferred from this thesis, including further development and validation of coercive control measures that include dimensions of social entrapment and insidiousness and more primary studies that investigate the association between coercive control and CPTSD. Further research into the utility of psychiatric diagnostic constructs and labels, including whether and how these may be useful to victim-survivors is another important implication for research. Finally, more intervention research into the design and delivery of integrated psychosocial trauma-and coercive control-informed interventions is needed, including longitudinal research to investigate whether victim-survivors have different support needs depending on the stage of their recovery.

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## Chapter 7: Appendices

### 7.1. Appendix A – Study 1

#### Appendix A.1 Search Syntax for each Database Search

**Table A.1.1**

*PsycINFO Search Syntax*

	Search Algorithm
1. Exposure 1	(coerc* ADJ6 control*) or coercion or coercive or "intimate terror*" or threat or humiliation or intimidation or "psychological abuse" or "psychological violence" or "psychological aggression" or "emotional abuse" or "monitoring" or "entrapment"
2. Exposure 2	"intimate partner violence" or IPV or IPA or "partner abuse" or "spouse abuse" or "domestic violence" or "domestic abuse" or "battered"
3. Outcome	"mental health" or "mental disorder*" or "mental* ill*" or psychopathology or trauma* or posttraumatic or PTSD or CPTSD or depress* or anxi* or panic or phobia or psychosis or "psychotic" or schizophrenia or "substance abuse" or "substance use" or "alcohol abuse" or "alcohol use" or alcoholism or "drug abuse" or "drug use" or suicid* or "self harm" or shame or "emotional regulation" or "emotional dysregulation" or "affect regulation" or "affect dysregulation"
4.	1 and 2 and 3

Search completed om 11/5/21: 1192 records retrieved

**Table A.1.2**

*Medline (Ovid) Search Syntax*

	Search Algorithm
1. Exposure 1	(coerc* ADJ6 control*) or coercion or coercive or "intimate terror*" or threat or humiliation or intimidation or "psychological abuse" or "psychological violence" or "psychological aggression" or "emotional abuse" or "monitoring" or "entrapment"
2. Exposure 2	"intimate partner violence" or IPV or IPA or "partner abuse" or "spouse abuse" or "domestic violence" or "domestic abuse" or "battered"
3. Outcome	"mental health" or "mental disorder*" or "mental* ill*" or psychopathology or trauma* or posttraumatic or PTSD or CPTSD or depress* or anxi* or panic or phobia or psychosis or "psychotic" or schizophrenia or "substance abuse" or "substance use" or "alcohol abuse" or "alcohol use" or alcoholism or "drug abuse" or "drug use" or suicid* or "self harm" or shame or "emotional regulation" or "emotional dysregulation" or "affect regulation" or "affect dysregulation"
4.	1 and 2 and 3
Result	Limited to English language (cannot limit for peer-reviewed in Medline)

Search completed om 11/5/21: 1082 records retrieved

**Table A.1.3***CINAHL Search Syntax*

	Search Algorithm
1. Exposure 1	(coerc* N6 control*) OR coercion or coercive OR "intimate terror*" OR threat OR humiliation OR intimidation OR "psychological abuse" OR "psychological violence" OR "psychological aggression" OR "emotional abuse" OR "monitoring" OR "entrapment"
2. Exposure 2	"intimate partner violence" OR IPV OR IPA OR "partner abuse" OR "spouse abuse" OR "domestic violence" OR "domestic abuse" OR "battered"
3. Outcome	"mental health" OR "mental disorder*" OR "mental* ill*" OR psychopathology OR trauma* OR posttraumatic OR PTSD OR CPTSD OR depress* OR anxi* OR panic OR phobia OR psychosis OR "psychotic" OR schizophrenia OR "substance abuse" OR "substance use" OR "alcohol abuse" OR "alcohol use" OR alcoholism OR "drug abuse" OR "drug use" or suicid* or "self harm" or shame or "emotional regulation" or "emotional dysregulation" OR "affect regulation" OR "affect dysregulation"
4.	1 and 2 and 3
Result	Limited to English language, peer-reviewed journals

Search completed om 11/5/21: 758 records retrieved

**Table A.1.4***Scopus Search Syntax*

	Search Algorithm
1. Exposure 1	(coerc* W/6 control*) OR coercion or coercive OR "intimate terror*" OR threat OR humiliation OR intimidation OR "psychological abuse" OR "psychological violence" OR "psychological aggression" OR "emotional abuse" OR "monitoring" OR "entrapment"
2. Exposure 2	"intimate partner violence" OR IPV OR IPA OR "partner abuse" OR "spouse abuse" OR "domestic violence" OR "domestic abuse" OR "battered"
3. Outcome	"mental health" OR "mental disorder*" OR "mental* ill*" OR psychopathology OR trauma* OR posttraumatic OR PTSD OR CPTSD OR depress* OR anxi* OR panic OR phobia OR psychosis OR "psychotic" OR schizophrenia OR "substance abuse" OR "substance use" OR "alcohol abuse" OR "alcohol use" OR alcoholism OR "drug abuse" OR "drug use" or suicid* or "self harm" or shame or "emotional regulation" or "emotional dysregulation" OR "affect regulation" OR "affect dysregulation"
4.	1 and 2 and 3
Result	Limited to English language

Search completed om 11/5/21: 2016 records retrieved, after limiting to English language and excluding books and book chapters 1900 results were retrieved

## Appendix A.2

### Reports that did not Meet the Inclusion Criteria and Reasons for their Exclusion

**Table A.2**

*Excluded Reports*

Study	Title	Journal	Volume	Issue	Pages	DOI	Exclusion Reason
Abass 2018	Association between domestic violence and depression among women attending primary health care centre in Al-hilla city	Indian Journal of Public Health Research and Development	9	12	971-975	10.5958/0976-5506.2018.01975.7	Exclusion reason: Wrong study design
Abbaszadeh 2011	Violence during pregnancy and postpartum depression	Pakistan Journal of Medical Sciences	27	1	177-181		Exclusion reason: No coercive control measure
Abbott 1995	Domestic violence against women. Incidence and prevalence in an emergency department population	JAMA	273	22	1763-7		Exclusion reason: No coercive control measure
Adebowale 2020	The association between intimate partner violence, psychiatric morbidity amongst pregnant women and partner alcohol use in southern Nigeria	African Journal of Primary Health Care & Family Medicine	12	1	e1-e7	<a href="https://dx.doi.org/10.4102/phcfm.v12i1.2226">https://dx.doi.org/10.4102/phcfm.v12i1.2226</a>	Exclusion reason: Wrong age group;
Agardh 2012	The invisible suffering: Sexual coercion, interpersonal violence, and mental health-A cross-sectional study among university students in South-Western Uganda	PLoS ONE Vol 7(12), 2012, ArtID e51424	7	12		<a href="http://dx.doi.org/10.1371/journal.pone.0051424">http://dx.doi.org/10.1371/journal.pone.0051424</a>	Exclusion reason: No coercive control measure
Ahmadabadi 2019	Intimate partner violence in emerging adulthood and subsequent substance use disorders: Findings from a longitudinal study	Addiction	114	7	1264-1273	<a href="http://dx.doi.org/10.1111/add.14592">http://dx.doi.org/10.1111/add.14592</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Ahmadabadi 2020	Intimate partner violence and subsequent depression and anxiety disorders	Social Psychiatry & Psychiatric Epidemiology	55	5	611-620	<a href="https://dx.doi.org/10.1007/s00127-019-01828-1">https://dx.doi.org/10.1007/s00127-019-01828-1</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV

Ajdukovic 2009	Family violence and health among elderly in Croatia	Journal of Aggression, Maltreatment and Trauma	18	3	261-279	10.1080/10926770902835873	Exclusion reason: No differentiation between types of abuse
Al-Modallal 2012	Psychological partner violence and women's vulnerability to depression, stress, and anxiety	International Journal of Mental Health Nursing	21	6	560-566	<a href="http://dx.doi.org/10.1111/j.1447-0349.2012.00826.x">http://dx.doi.org/10.1111/j.1447-0349.2012.00826.x</a>	Exclusion reason: Wrong age group
Albright 2019	Intimate partner violence among postsecondary students with military experience	Traumatology	25	1	58-65	<a href="http://dx.doi.org/10.1037/trm0000172">http://dx.doi.org/10.1037/trm0000172</a>	Exclusion reason: No coercive control measure
Alexander 2016	Reproductive coercion, sexual risk behaviours and mental health symptoms among young low-income behaviourally bisexual women: Implications for nursing practice	Journal of Clinical Nursing	25	23-24	3533-3544	<a href="http://dx.doi.org/10.1111/jocn.13238">http://dx.doi.org/10.1111/jocn.13238</a>	Exclusion reason: No meaningful outcome measures
Ali 1999	Emotional abuse as a precipitating factor for depression in women	Journal of Emotional Abuse	1	4	1-13	10.1300/J135v01n04_01	Exclusion reason: Violence not (clearly) IPV
Ali 2013	Intimate partner violence and mental health effects: A population-based study among married women in Karachi, Pakistan	International Journal of Behavioral Medicine	20	1	131-139	<a href="http://dx.doi.org/10.1007/s12529-011-9201-6">http://dx.doi.org/10.1007/s12529-011-9201-6</a>	Exclusion reason: No coercive control measure
Belay 2019	Intimate partner violence and maternal depression during pregnancy: A community-based cross-sectional study in Ethiopia	PLoS ONE Vol 14(7), 2019, ArtID e0220003	14	7		<a href="http://dx.doi.org/10.1371/journal.pone.0220003">http://dx.doi.org/10.1371/journal.pone.0220003</a>	Exclusion reason: Wrong age group
Bernstein 2016	Intimate partner violence experienced by HIV-infected pregnant women in South Africa: A cross-sectional study	BMJ Open	6	8		10.1136/bmjopen-2016-011999	Exclusion reason: No meaningful outcome measures
Beydoun 2010	Intimate partner violence as a risk factor for postpartum depression among Canadian women in the Maternity Experience Survey	Annals of Epidemiology	20	8	575-583	10.1016/j.annepidem.2010.05.011	Exclusion reason: Wrong age group
Blabey 2009	Experience of a controlling or threatening partner among mothers with persistent symptoms of depression	American Journal of Obstetrics and Gynaecology	201	2	173.e1-173.e9	10.1016/j.ajog.2009.04.025	Exclusion reason: No coercive control measure
Blasco-Ros 2010	Recovery from depressive symptoms, state anxiety and post-traumatic stress disorder in women exposed to physical and	BMC Psychiatry Vol 10 2010, ArtID 98	10			<a href="http://dx.doi.org/10.1186/1471-244X-10-98">http://dx.doi.org/10.1186/1471-244X-10-98</a>	Exclusion reason: No coercive control measure;

	psychological, but not to psychological intimate partner violence alone: A longitudinal study						
Bonomi 2009	Intimate partner violence in Latina and non-Latina women	American Journal of Preventive Medicine	36	1	43-48	<a href="http://dx.doi.org/10.1016/j.amepre.2008.09.027">http://dx.doi.org/10.1016/j.amepre.2008.09.027</a>	Exclusion reason: No coercive control measure
Bonomi 2009	Medical and psychosocial diagnoses in women with a history of intimate partner violence	Archives of Internal Medicine	169	18	1692-7	<a href="https://dx.doi.org/10.1001/archinternmed.2009.292">https://dx.doi.org/10.1001/archinternmed.2009.292</a>	Exclusion reason: No coercive control measure
Brewer 2018	Intimate partner violence, health, sexuality, and academic performance among a national sample of undergraduates	Journal of American College Health	66	7	683-692	<a href="http://dx.doi.org/10.1080/07448481.2018.1454929">http://dx.doi.org/10.1080/07448481.2018.1454929</a>	Exclusion reason: No coercive control measure
Bulut 2017	The relationship between postpartum depression and intimate partner violence	Journal of Clinical and Analytical Medicine	8	2	168-171	10.4328/JCAM.4801	Exclusion reason: No coercive control measure
Calvete 2007	Cognitive and coping mechanisms in the interplay between intimate partner violence and depression	Anxiety, Stress & Coping: An International Journal	20	4	369-382	<a href="http://dx.doi.org/10.1080/10615800701628850">http://dx.doi.org/10.1080/10615800701628850</a>	Exclusion reason: Duplicate publication
Calvete 2008	Coping as a mediator and moderator between intimate partner violence and symptoms of anxiety and depression	Violence Against Women	14	8	886-904	<a href="http://dx.doi.org/10.1177/1077801208320907">http://dx.doi.org/10.1177/1077801208320907</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Calvete 2007	Intimate partner violence and depressive symptoms in women: Cognitive schemas as moderators and mediators	Behaviour Research and Therapy	45	4	791-804	<a href="http://dx.doi.org/10.1016/j.brat.2006.07.006">http://dx.doi.org/10.1016/j.brat.2006.07.006</a>	Exclusion reason: No meaningful outcome measures
Campbell 1997	Mental and physical health effects of intimate partner violence on women and children	Psychiatric Clinics of North America	20	2	353-374	<a href="http://dx.doi.org/10.1016/S0193-953X%2805%2970317-8">http://dx.doi.org/10.1016/S0193-953X%2805%2970317-8</a>	Exclusion reason: Wrong study design
Carey 2019	Forms of Intimate Partner Rape Experienced by Latinas With and Without Posttraumatic Stress Disorder	Partner Abuse	10	1	59-76	10.1891/1946-6560.10.1.59	Exclusion reason: No coercive control measure
Carlson 2003	Childhood and adult abuse among women in primary health care: Effects on mental health	Journal of Interpersonal Violence	18	8	924-941	<a href="http://dx.doi.org/10.1177/0886260503253882">http://dx.doi.org/10.1177/0886260503253882</a>	Exclusion reason: No coercive control measure
Cascardi 1995	Characteristics of women physically abused by their spouses and who seek treatment regarding marital conflict	Journal of Consulting and Clinical Psychology	63	4	616-623	<a href="http://dx.doi.org/10.1037/0022-006X.63.4.616">http://dx.doi.org/10.1037/0022-006X.63.4.616</a>	Exclusion reason: No differentiation between types of abuse

Cations 2021	Impact of Historical Intimate Partner Violence on Wellbeing and Risk for Elder Abuse in Older Women	American Journal of Geriatric Psychiatry				10.1016/j.jagp.2020.12.026	Exclusion reason: No differentiation between types of abuse
Cavanaugh 2011	Prevalence and correlates of suicidal behaviour among adult female victims of intimate partner violence	Suicide & Life-Threatening Behavior	41	4	372-383	10.1111/j.1943-278X.2011.00035.x	Exclusion reason: No coercive control measure
Certain 2008	Domestic abuse during the previous year in a sample of postpartum women	Journal of Obstetric, Gynaecologic, & Neonatal Nursing: Clinical Scholarship for the Care of Women, Childbearing Families, & Newborns	37	1	35-41	<a href="http://dx.doi.org/10.1111/j.1552-6909.2007.00200.x">http://dx.doi.org/10.1111/j.1552-6909.2007.00200.x</a>	Exclusion reason: No differentiation between types of abuse
Chan 2008	Prevalence of dating partner violence and suicidal ideation among male and female university students worldwide	Journal of Midwifery & Women's Health	53	6	529-537	<a href="http://dx.doi.org/10.1016/j.jmwh.2008.04.016">http://dx.doi.org/10.1016/j.jmwh.2008.04.016</a>	Exclusion reason: No coercive control measure
Chan 2011	Female victimization and intimate partner violence after the May 12, 2008, Sichuan earthquake	Violence and Victims	26	3	364-376	10.1891/0886-6708.26.3.364	Exclusion reason: No coercive control measure
Chandra 2009	Women reporting intimate partner violence in India: Associations with PTSD and depressive symptoms	Archives of Women's Mental Health	12	4	203-209	<a href="http://dx.doi.org/10.1007/s00737-009-0065-6">http://dx.doi.org/10.1007/s00737-009-0065-6</a>	Exclusion reason: No coercive control measure;
Choi 2019	Intimate Partner Violence Victimization, Social Support, and Resilience: Effects on the Anxiety Levels of Young Mothers	Journal of Interpersonal Violence			8.86261E+14	<a href="https://dx.doi.org/10.1177/0886260519888532">https://dx.doi.org/10.1177/0886260519888532</a>	Exclusion reason: Wrong age group
Christopher 2012	College women's experiences of intimate partner violence: Exploring mental health issues	NASPA Journal About Women in Higher Education	5	2	166-183	10.1515/njawhe-2012-1116	Exclusion reason: No coercive control measure;
Coker 2002	Social support protects against the negative effects of partner violence on mental health	Journal of Women's Health & Gender-Based Medicine	11	5	465-476	<a href="http://dx.doi.org/10.1089/15246090260137644">http://dx.doi.org/10.1089/15246090260137644</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Comecanha 2017	Clinically speaking, psychological abuse matters	Comprehensive Psychiatry	73		120-126	<a href="http://dx.doi.org/10.1016/j.comppsy.2016.11.015">http://dx.doi.org/10.1016/j.comppsy.2016.11.015</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV

Cook 2006	Beyond Frequency and Severity: Development and Validation of the Brief Coercion and Conflict Scales	Violence Against Women	12	11	1050-1072	<a href="http://dx.doi.org/10.1177/1077801206293333">http://dx.doi.org/10.1177/1077801206293333</a>	Exclusion reason: No coercive control measure
Costa 2015	Intimate partner violence and health-related quality of life in European men and women: Findings from the DOVE study	Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care & Rehabilitation	24	2	463-471	<a href="http://dx.doi.org/10.1007/s11136-014-0766-9">http://dx.doi.org/10.1007/s11136-014-0766-9</a>	Exclusion reason: No coercive control measure
Alsaker 2008	Health-related quality of life among abused women one year after leaving a violent partner	Social Indicators Research	86	3	497-509	<a href="http://dx.doi.org/10.1007/s11205-007-9182-7">http://dx.doi.org/10.1007/s11205-007-9182-7</a>	Exclusion reason: No differentiation between types of abuse
Alsaker 2006	Low health-related quality of life among abused women	Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care & Rehabilitation	15	6	959-965	<a href="http://dx.doi.org/10.1007/s11136-006-0046-4">http://dx.doi.org/10.1007/s11136-006-0046-4</a>	Exclusion reason: No coercive control measure
Alvarez-delArco 2013	Violence in adulthood and mental health: Gender and immigrant status	Journal of Interpersonal Violence	28	11	2203-2222	<a href="http://dx.doi.org/10.1177/0886260512475310">http://dx.doi.org/10.1177/0886260512475310</a>	Exclusion reason: No coercive control measure
Amini 2019	Mental health and social function among women subjected to intimate partner violence: A cross-sectional study	Acta Medica Iranica	57	9	544-548	10.18502/acta.v57i9.2638	Exclusion reason: No coercive control measure
Anderson 2017	Sexual minority status and interpersonal victimization in college men	Psychology of Sexual Orientation and Gender Diversity	4	1	130-136	<a href="http://dx.doi.org/10.1037/sgd0000204">http://dx.doi.org/10.1037/sgd0000204</a>	Exclusion reason: No meaningful outcome measures
Ansara 2011	Psychosocial consequences of intimate partner violence for women and men in Canada	Journal of Interpersonal Violence	26	8	1628-1645	10.1177/0886260510370600	Exclusion reason: No coercive control measure
Anuk 2018	The association of experience of violence and somatization, depression, and alexithymia: A sample of women with medically unexplained symptoms in Turkey	Archives of Women's Mental Health	21	1	93-103	<a href="http://dx.doi.org/10.1007/s00737-017-0762-5">http://dx.doi.org/10.1007/s00737-017-0762-5</a>	Exclusion reason: Violence not (clearly) IPV
Arias 1999	Psychological abuse: Implications for adjustment and commitment to leave violent partners	Violence and Victims	14	1	55-67	<a href="http://dx.doi.org/10.1891/0886-6708.14.1.55">http://dx.doi.org/10.1891/0886-6708.14.1.55</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;

Avant 2011	Psychological abuse and posttraumatic stress symptoms in college students	Journal of Interpersonal Violence	26	15	3080-3097	<a href="http://dx.doi.org/10.1177/0886260510390954">http://dx.doi.org/10.1177/0886260510390954</a>	Exclusion reason: No coercive control measure;
Aye 2020	Domestic violence victimisation and its association with mental distress: A cross-sectional study of the Yangon Region, Myanmar	BMJ Open	10	9		10.1136/bmjopen-2020-037936	Exclusion reason: No differentiation between types of abuse;
Babcock 2008	Intimate partner abuse and PTSD symptomatology: Examining mediators and moderators of the abuse-trauma link	Journal of Family Psychology	22	6	809-818	<a href="http://dx.doi.org/10.1037/a0013808">http://dx.doi.org/10.1037/a0013808</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Babcock 2013	Factors contributing to ongoing intimate partner abuse: Childhood betrayal trauma and dependence on one's perpetrator	Journal of Interpersonal Violence	28	7	1385-1402	<a href="http://dx.doi.org/10.1177/0886260512468248">http://dx.doi.org/10.1177/0886260512468248</a>	Exclusion reason: No coercive control measure
Baldry 2003	"Stick and stones hurt my bones but his glance and words hurt more": The impact of physiological abuse and physical violence by current and former partners on battered women in Italy	The International Journal of Forensic Mental Health	2	1	47-57	<a href="http://dx.doi.org/10.1080/14999013.2003.10471178">http://dx.doi.org/10.1080/14999013.2003.10471178</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Bandara 2020	Domestic violence and self-poisoning in Sri Lanka	Psychological Medicine			1-9	<a href="https://dx.doi.org/10.1017/S0033291720002986">https://dx.doi.org/10.1017/S0033291720002986</a>	Exclusion reason: Violence not (clearly) IPV
Banyard 2011	The impact of interpersonal violence in adulthood on women's job satisfaction and productivity: The mediating roles of mental and physical health	Psychology of Violence	1	1	16-28	<a href="http://dx.doi.org/10.1037/a0021691">http://dx.doi.org/10.1037/a0021691</a>	Exclusion reason: No coercive control measure
BarcelonadeMendoza 2018	Experiences of intimate partner and neighborhood violence and their association with mental health in pregnant women	Journal of Interpersonal Violence	33	6	938-959	<a href="http://dx.doi.org/10.1177/0886260515613346">http://dx.doi.org/10.1177/0886260515613346</a>	Exclusion reason: No coercive control measure
Barros-Gomes 2019	The role of depression in the relationship between psychological and physical intimate partner violence	Journal of Interpersonal Violence	34	18	3936-3960	<a href="http://dx.doi.org/10.1177/0886260516673628">http://dx.doi.org/10.1177/0886260516673628</a>	Exclusion reason: No coercive control measure
Bartlett 2018	Intimate partner violence and disordered eating among male and female veterans	Psychiatry Research	260		98-104	<a href="http://dx.doi.org/10.1016/j.psychres.2017.11.056">http://dx.doi.org/10.1016/j.psychres.2017.11.056</a>	Exclusion reason: No coercive control measure

Bauer 2000	Prevalence and determinants of intimate partner abuse among public hospital primary care patients	Journal of General Internal Medicine	15	11	811-7		Exclusion reason: No coercive control measure
Beeble 2009	Main, mediating, and moderating effects of social support on the well-being of survivors of intimate partner violence across 2 years	Journal of Consulting and Clinical Psychology	77	4	718-729	<a href="http://dx.doi.org/10.1037/a0016140">http://dx.doi.org/10.1037/a0016140</a>	Exclusion reason: No meaningful outcome measures
Beeble 2011	The impact of neighborhood factors on the well-being of survivors of intimate partner violence over time	American Journal of Community Psychology	47	3-4	287-306	<a href="http://dx.doi.org/10.1007/s10464-010-9398-6">http://dx.doi.org/10.1007/s10464-010-9398-6</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Cowden 2019	Forgiveness moderates relations between psychological abuse and indicators of psychological distress among women in romantic relationships	South African Journal of Science	115	11-12		10.17159/sajs.2019/6353	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Craner 2020	Partner Abuse Among Treatment-Seeking Individuals with Chronic Pain: Prevalence, Characteristics, and Association with Pain-Related Outcomes	Pain Medicine	21	11	2789-2798	<a href="https://dx.doi.org/10.1093/pm/pnaa126">https://dx.doi.org/10.1093/pm/pnaa126</a>	Exclusion reason: No differentiation between types of abuse
Craparo 2014	Intimate partner violence: Relationships between alexithymia, depression, attachment styles, and coping strategies of battered women	Journal of Sexual Medicine	11	6	1484-1494	<a href="http://dx.doi.org/10.1111/jsm.12505">http://dx.doi.org/10.1111/jsm.12505</a>	Exclusion reason: No coercive control measure
Daly 2008	Self-reported elder domestic partner violence in one rural iowa county	Journal of Emotional Abuse	7	4	115-134	10.1300/J135v07n04_06	Exclusion reason: No coercive control measure
deOliveiraFonseca-Machado 2015	Depressive disorder in pregnant Latin women: Does intimate partner violence matter?	Journal of Clinical Nursing	24	9-10	1289-1299	<a href="http://dx.doi.org/10.1111/jocn.12728">http://dx.doi.org/10.1111/jocn.12728</a>	Exclusion reason: Wrong age group
DeMaris 2008	Partner's stake in conformity and abused wives' psychological trauma	Journal of Interpersonal Violence	23	10	1323-1342	<a href="http://dx.doi.org/10.1177/0886260508314300">http://dx.doi.org/10.1177/0886260508314300</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
DePrince 2014	The geography of intimate partner abuse experiences and clinical responses	Clinical Psychological Science	2	3	258-271	<a href="http://dx.doi.org/10.1177/2167702613507556">http://dx.doi.org/10.1177/2167702613507556</a>	Exclusion reason: No coercive control measure

Desmarais 2014	Intimate partner abuse before and during pregnancy as risk factors for postpartum mental health problems	BMC Pregnancy and Childbirth	14	1		10.1186/1471-2393-14-132	Exclusion reason: No coercive control measure
Dhairyawar 2013	Intimate partner violence in women living with HIV attending an inner city clinic in the UK: Prevalence and associated factors	HIV Medicine	14	5	303-310	10.1111/hiv.12009	Exclusion reason: No differentiation between types of abuse
Dichter 2014	Associations between psychological, physical, and sexual intimate partner violence and health outcomes among women veteran VA patients	Social Work in Mental Health	12	5-6	411-428	<a href="http://dx.doi.org/10.1080/15332985.2013.870104">http://dx.doi.org/10.1080/15332985.2013.870104</a>	Exclusion reason: No coercive control measure
Do 2021	Intimate partner violence in female same-gender couples: An investigation of actor-partner correlates within the past year	Psychological Trauma: Theory, Research, Practice and Policy	6			6 <a href="https://dx.doi.org/10.1037/tra0001041">https://dx.doi.org/10.1037/tra0001041</a>	Exclusion reason: No coercive control measure
DomenechDelRio 2017	The Consequences of Intimate Partner Violence on Health: A Further Disaggregation of Psychological Violence-Evidence From Spain	Violence Against Women	23	14	1771-1789	<a href="https://dx.doi.org/10.1177/1077801216671220">https://dx.doi.org/10.1177/1077801216671220</a>	Exclusion reason: Wrong age group
dosSantosGomes 2018	Frailty and life course violence: The international mobility in aging study	Archives of Gerontology and Geriatrics	76		26-33	<a href="http://dx.doi.org/10.1016/j.archger.2018.02.002">http://dx.doi.org/10.1016/j.archger.2018.02.002</a>	Exclusion reason: No meaningful outcome measures
Drouin 2015	Sexting: A new, digital vehicle for intimate partner aggression?	Computers in Human Behavior	50		197-204	<a href="http://dx.doi.org/10.1016/j.chb.2015.04.001">http://dx.doi.org/10.1016/j.chb.2015.04.001</a>	Exclusion reason: No coercive control measure
Drumm 2009	Gender variation in partner abuse: Findings from a conservative Christian denomination	Affilia: Journal of Women & Social Work	24	1	56-68	<a href="http://dx.doi.org/10.1177/0886109908326737">http://dx.doi.org/10.1177/0886109908326737</a>	Exclusion reason: No coercive control measure
DuMont 2012	An exploratory study on the consequences and contextual factors of intimate partner violence among immigrant and Canadian-born women	BMJ Open	2	6		<a href="https://dx.doi.org/10.1136/bmjopen-2012-001728">https://dx.doi.org/10.1136/bmjopen-2012-001728</a>	Exclusion reason: Wrong age group
Dutton 2009	Pathways linking intimate partner violence and posttraumatic disorder	Trauma, Violence, & Abuse	10	3	211-224	<a href="http://dx.doi.org/10.1177/1524838009334451">http://dx.doi.org/10.1177/1524838009334451</a>	Exclusion reason: Wrong study design
Dutton 2005	Patterns of intimate partner violence: Correlates and outcomes	Violence and Victims	20	5	483-497	<a href="http://dx.doi.org/10.1891/vivi.2005.20.5.483">http://dx.doi.org/10.1891/vivi.2005.20.5.483</a>	Exclusion reason: Does not report any form of coercive control

Eshelman 2012	Dating violence: Mental health consequences based on type of abuse	Violence and Victims	27	2	215-228	<a href="http://dx.doi.org/10.1891/0886-6708.27.2.215">http://dx.doi.org/10.1891/0886-6708.27.2.215</a>	separately from psychological IPV Exclusion reason: No coercive control measure;
Esie 2019	Intimate partner violence and depression in rural Bangladesh: Accounting for violence severity in a high prevalence setting	SSM - Population Health	7			10.1016/j.ssmph.2019.100368	Exclusion reason: Wrong age group
Estefan 2016	Depression in women who have left violent relationships: The unique impact of frequent emotional abuse	Violence Against Women	22	11	1397-1413	<a href="http://dx.doi.org/10.1177/1077801215624792">http://dx.doi.org/10.1177/1077801215624792</a>	Exclusion reason: Wrong age group
Fisher 2006	The Extent and Frequency of Abuse in the Lives of Older Women and Their Relationship With Health Outcomes	The Gerontologist	46	2	200-209	<a href="http://dx.doi.org/10.1093/geront/46.2.200">http://dx.doi.org/10.1093/geront/46.2.200</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Fisher 2013	Intimate partner violence and perinatal common mental disorders among women in rural Vietnam	International Health	5	1	29-37	<a href="https://dx.doi.org/10.1093/inthealth/ihs012">https://dx.doi.org/10.1093/inthealth/ihs012</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
FitzPatrick 2020	Physical and Emotional Intimate Partner Violence and Women's Health in the First Year After Childbirth: An Australian Pregnancy Cohort Study	Journal of Interpersonal Violence				8.86261E+14 <a href="https://dx.doi.org/10.1177/0886260520934426">https://dx.doi.org/10.1177/0886260520934426</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Fleming 2016	Predicting three types of dissociation in female survivors of intimate partner violence	Journal of Trauma & Dissociation	17	3	267-285	<a href="http://dx.doi.org/10.1080/15299732.2015.1079807">http://dx.doi.org/10.1080/15299732.2015.1079807</a>	Exclusion reason: No coercive control measure;
Fleming 2016	Professional versus personal resource utilization in survivors of intimate partner violence	Psychological Trauma: Theory, Research, Practice, and Policy	8	3	319-324	<a href="http://dx.doi.org/10.1037/tra0000074">http://dx.doi.org/10.1037/tra0000074</a>	Exclusion reason: No meaningful outcome measures
Follingstad 2012	Factors Predicting Relationship Satisfaction, Investment, and Commitment When Women Report High Prevalence of Psychological Abuse	Journal of Family Violence	27	4	257-273	10.1007/s10896-012-9422-8	Exclusion reason: No meaningful outcome measures

Clements 2005	Perceived Control and Emotional Status in Abusive College Student Relationships: An Exploration of Gender Differences	Journal of Interpersonal Violence	20	9	1058-1077	<a href="http://dx.doi.org/10.1177/0886260505277939">http://dx.doi.org/10.1177/0886260505277939</a>	Exclusion reason: No differentiation between types of abuse
Follingstad 2012	Women Experiencing Psychological Abuse: Are They a Homogenous Group?	Journal of Aggression, Maltreatment & Trauma	21	8	891-916	10.1080/10926771.2012.708012	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Ford-Gilboe 2016	Development of a brief measure of intimate partner violence experiences: the Composite Abuse Scale (Revised)-Short Form (CASR-SF)	BMJ Open	6	12	e012824	<a href="https://dx.doi.org/10.1136/bmjopen-2016-012824">https://dx.doi.org/10.1136/bmjopen-2016-012824</a>	Exclusion reason: Wrong age group
Fortin 2012	Intimate partner violence and psychological distress among young couples: Analysis of the moderating effect of social support	Journal of Family Violence	27	1	63-73	<a href="http://dx.doi.org/10.1007/s10896-011-9402-4">http://dx.doi.org/10.1007/s10896-011-9402-4</a>	Exclusion reason: No coercive control measure
Fujiwara 2012	Factors that contribute to the improvement in maternal parenting after separation from a violent husband or partner	Journal of Interpersonal Violence	27	2	380-395	<a href="http://dx.doi.org/10.1177/0886260511416464">http://dx.doi.org/10.1177/0886260511416464</a>	Exclusion reason: No meaningful outcome measures
Fujiwara 2010	The impact of childhood abuse history and domestic violence on the mental health of women in Japan	Child Abuse & Neglect	34	4	267-274	<a href="http://dx.doi.org/10.1016/j.chiabu.2009.07.007">http://dx.doi.org/10.1016/j.chiabu.2009.07.007</a>	Exclusion reason: No differentiation between types of abuse
GarcíaOramas 2015	Mental health in women abused by their partners. A study on samples from Mexico and Spain	Salud Mental	38	5	321-327	10.17711/SM.0185-3325.2015.044	Exclusion reason: Wrong language
Gervais 2013	Objectification among college women in the context of intimate partner violence	Violence and Victims	28	1	36-49	<a href="http://dx.doi.org/10.1891/0886-6708.28.1.36">http://dx.doi.org/10.1891/0886-6708.28.1.36</a>	Exclusion reason: Wrong age group
Ghahari 2018	Marital Conflict, Cognitive Emotion Regulation, Maladaptive Schema and Sexual Satisfaction in spouse abused and non-abused women in Iran: A comparative study	Asian Journal of Psychiatry	35		1-2	<a href="http://dx.doi.org/10.1016/j.ajp.2018.04.012">http://dx.doi.org/10.1016/j.ajp.2018.04.012</a>	Exclusion reason: No differentiation between types of abuse
Glenn 2002	Violence and hostility among families of Vietnam veterans with combat-related posttraumatic stress disorder	Violence and Victims	17	4	473-489	<a href="http://dx.doi.org/10.1891/vivi.17.4.473.33685">http://dx.doi.org/10.1891/vivi.17.4.473.33685</a>	Exclusion reason: No meaningful outcome measures

Gobin 2013	The impact of childhood maltreatment on PTSD symptoms among female survivors of intimate partner violence	Violence and Victims	28	6	984-999	<a href="http://dx.doi.org/10.1891/0886-6708.VV-D-12-00090">http://dx.doi.org/10.1891/0886-6708.VV-D-12-00090</a>	Exclusion reason: No coercive control measure
Goessmann 2021	Toward a Contextually Valid Assessment of Partner Violence: Development and Psycho-Sociometric Evaluation of the Gendered Violence in Partnerships Scale (GVPS)	Frontiers in Psychology	11			10.3389/fpsyg.2020.607671	Exclusion reason: Wrong age group
Goldstein 2021	The Effects of Intimate Partner Violence and a History of Childhood Abuse on Mental Health and Stress during Pregnancy	Journal of Family Violence	36	3	337-346	10.1007/s10896-020-00149-1	Exclusion reason: No coercive control measure
Grande 2003	Domestic violence in South Australia: a population survey of males and females	Australian & New Zealand Journal of Public Health	27	5	543-50		Exclusion reason: No differentiation between types of abuse ;
Grandin 1998	Couple violence and psychological distress	Canadian Journal of Public Health. Revue Canadienne de Sante Publique	89	1	43-7		Exclusion reason: No coercive control measure
Gulliver 2013	Exploring risk factors for suicidal ideation in a population-based sample of New Zealand women who have experienced intimate partner violence	Australian & New Zealand Journal of Public Health	37	6	527-33		Exclusion reason: Wrong age group
Hacialiefendioglu 2021	Co-occurrence Patterns of Intimate Partner Violence	Pacific Symposium on Biocomputing	26		79-90		Exclusion reason: No meaningful outcome measures;
Haj-Yahia 2000	Patterns of violence against engaged Arab women from Israel and some psychological implications	Psychology of Women Quarterly	24	3	209-219	<a href="http://dx.doi.org/10.1111/j.1471-6402.2000.tb00202.x">http://dx.doi.org/10.1111/j.1471-6402.2000.tb00202.x</a>	Exclusion reason: Wrong age group
Hamdan-Mansour 2012	Evaluating the psychosocial and mental health consequences of abuse among Jordanian women	Eastern Mediterranean Health Journal	18	3	205-12		Exclusion reason: Wrong age group
Hassan 2012	Psycho-social correlates of intimate partner violence	Pakistan Journal of Psychological Research	27	2	279-295		Exclusion reason: Does not report any form of coercive control separately from psychological IPV

Hassanian-Moghaddam 2016	Violence and Abuse Against Women Who Have Attempted Suicide by Deliberate Self-Poisoning	Journal of Interpersonal Violence	31	7	1257-1273	10.1177/0886260514564157	Exclusion reason: Wrong age group
Hegarty 2013	Effect of type and severity of intimate partner violence on women's health and service use: Findings from a primary care trial of women afraid of their partners	Journal of Interpersonal Violence	28	2	273-294	<a href="http://dx.doi.org/10.1177/0886260512454722">http://dx.doi.org/10.1177/0886260512454722</a>	Exclusion reason: Wrong age group
Hellemans 2014	Intimate partner violence in Belgium: Prevalence, individual health outcomes, and relational correlates	Psychologica Belgica	54	1	79-96	<a href="http://dx.doi.org/10.5334/pb.af">http://dx.doi.org/10.5334/pb.af</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Hellemans 2015	Prevalence and impact of Intimate Partner Violence (IPV) among an ethnic minority population	Journal of Interpersonal Violence	30	19	3389-3418	<a href="http://dx.doi.org/10.1177/0886260514563830">http://dx.doi.org/10.1177/0886260514563830</a>	Exclusion reason: Wrong age group
Fahmy 2008	Determinants and health consequences of domestic violence among women in reproductive age at zagazig district, egypt	Journal of the Egyptian Public Health Association	83	1-2	87-106		Exclusion reason: No coercive control measure
Faisal-Cury 2013	Temporal relationship between intimate partner violence and postpartum depression in a sample of low income women	Maternal and Child Health Journal	17	7	1297-1303	<a href="http://dx.doi.org/10.1007/s10995-012-1127-3">http://dx.doi.org/10.1007/s10995-012-1127-3</a>	Exclusion reason: Wrong age group
Fatusi 2006	Intimate partner violence in Ile-Ife, Nigeria: Women's experiences and men's perspectives	Gender & Behaviour	4	2	764-781		Exclusion reason: Unable to obtain full text
Fergusson 2005	Partner violence and mental health outcomes in a New Zealand birth cohort	Journal of Marriage and Family	67	5	1103-1119	<a href="http://dx.doi.org/10.1111/j.1741-3737.2005.00202.x">http://dx.doi.org/10.1111/j.1741-3737.2005.00202.x</a>	Exclusion reason: No coercive control measure
Fernandez-Montalvo 2017	Therapeutic Progression in Abused Women Following a Drug-Addiction Treatment Program	Journal of Interpersonal Violence	32	13	2046-2056	<a href="https://dx.doi.org/10.1177/0886260515591980">https://dx.doi.org/10.1177/0886260515591980</a>	Exclusion reason: No coercive control measure
Hines 2010	A closer look at men who sustain intimate terrorism by women	Partner Abuse	1	3	286-313	<a href="http://dx.doi.org/10.1891/1946-6560.1.3.286">http://dx.doi.org/10.1891/1946-6560.1.3.286</a>	Exclusion reason: No meaningful outcome measures;
Hines 2011	Understanding the use of violence among men who sustain intimate terrorism	Partner Abuse	2	3	259-283	<a href="http://dx.doi.org/10.1891/1946-6560.2.3.259">http://dx.doi.org/10.1891/1946-6560.2.3.259</a>	Exclusion reason: Only measures IPV perpetration

Hirth 2012	Racial/ethnic differences in depressive symptoms among young women: The role of intimate partner violence, trauma, and posttraumatic stress disorder	Journal of Women's Health	21	9	966-974	10.1089/jwh.2011.3366	Exclusion reason: Wrong age group
Honda 2018	Sexual violence as a key contributor to poor mental health among Japanese women subjected to intimate partner violence	Journal of Women's Health	27	5	716-723	<a href="http://dx.doi.org/10.1089/jwh.2016.6276">http://dx.doi.org/10.1089/jwh.2016.6276</a>	Exclusion reason: Wrong age group
Hou 2005	Domestic violence against women in Taiwan: Their life-threatening situations, post-traumatic responses, and psycho-physiological symptoms. An interview study	International Journal of Nursing Studies	42	6	629-636	<a href="http://dx.doi.org/10.1016/j.ijnurstu.2004.09.011">http://dx.doi.org/10.1016/j.ijnurstu.2004.09.011</a>	Exclusion reason: No differentiation between types of abuse
Houry 2006	Intimate partner violence and mental health symptoms in African American female ED patients	American Journal of Emergency Medicine	24	4	444-50		Exclusion reason: No coercive control measure;
Houskamp 1991	The assessment of posttraumatic stress disorder in battered women	Journal of Interpersonal Violence	6	3	367-375	<a href="http://dx.doi.org/10.1177/088626091006003008">http://dx.doi.org/10.1177/088626091006003008</a>	Exclusion reason: No coercive control measure
Hussain 2020	Prevalence and risk factors of domestic violence and its impacts on women's mental health in Gilgit-Baltistan, Pakistan	Pakistan Journal of Medical Sciences	36	4	627-631	10.12669/pjms.36.4.1530	Exclusion reason: No differentiation between types of abuse
Huth-Bocks 2013	Relational trauma and posttraumatic stress symptoms among pregnant women	Psychodynamic Psychiatry	41	2	277-301	<a href="http://dx.doi.org/10.1521/pdps.2013.41.2.277">http://dx.doi.org/10.1521/pdps.2013.41.2.277</a>	Exclusion reason: No coercive control measure;
Ilgen 2009	The association between partner and non-partner aggression and suicidal ideation in patients seeking substance use disorder treatment	Addictive Behaviors	34	2	180-186	<a href="http://dx.doi.org/10.1016/j.addbeh.2008.10.004">http://dx.doi.org/10.1016/j.addbeh.2008.10.004</a>	Exclusion reason: Only measures IPV perpetration
Ishida 2010	Exploring the associations between intimate partner violence and women's mental health: Evidence from a population-based study in Paraguay	Social Science & Medicine	71	9	1653-1661	<a href="http://dx.doi.org/10.1016/j.socscimed.2010.08.007">http://dx.doi.org/10.1016/j.socscimed.2010.08.007</a>	Exclusion reason: Wrong age group
Issahaku 2015	Health implications of partner violence against women in Ghana	Violence and Victims	30	2	250-264	<a href="http://dx.doi.org/10.1891/0886-6708.VV-D-13-00075">http://dx.doi.org/10.1891/0886-6708.VV-D-13-00075</a>	Exclusion reason: No coercive control measure
Iverson 2018	Adoption, penetration, and effectiveness of a secondary risk screener for intimate partner	General Hospital Psychiatry	51		79-84	10.1016/j.genhosppsy.2018.01.002	Exclusion reason: No coercive control measure

	violence: Evidence to inform screening practices in integrated care settings						
Iverson 2017	Intimate Partner Violence Victimization and Associated Implications for Health and Functioning Among Male and Female Post-9/11 Veterans	Medical Care	55 Suppl 9 Suppl 2		S78-S84	<a href="https://dx.doi.org/10.1097/MLR.0000000000000741">https://dx.doi.org/10.1097/MLR.0000000000000741</a>	Exclusion reason: No coercive control measure
Iyengar 2021	A cross sectional hospital-based study of intimate partner violence and psychiatric comorbidity in pregnancy	Archives of Psychiatry and Psychotherapy	22	4	12-21	10.12740/APP/120441	Exclusion reason: No differentiation between types of abuse
Jackson 2015	Intimate partner violence before and during pregnancy: Related demographic and psychosocial factors and postpartum depressive symptoms among Mexican American women	Journal of Interpersonal Violence	30	4	659-679	<a href="http://dx.doi.org/10.1177/0886260514535262">http://dx.doi.org/10.1177/0886260514535262</a>	Exclusion reason: No differentiation between types of abuse
Jackson 2020	Intimate partner violence, firearms, and sleep disturbances: The influence of coercive control and partner firearm ownership	Sleep Health	6	6	723-730	<a href="https://dx.doi.org/10.1016/j.sleh.2020.04.013">https://dx.doi.org/10.1016/j.sleh.2020.04.013</a>	Exclusion reason: No meaningful outcome measures;
Jain 2017	A hospital-based study of intimate partner violence during pregnancy	International Journal of Gynecology and Obstetrics	137	1	8-13	10.1002/ijgo.12086	Exclusion reason: No differentiation between types of abuse
Jaquier 2013	Posttraumatic stress and depression symptoms as correlates of deliberate self-harm among community women experiencing intimate partnerviolence	Psychiatry Research	206	1	37-42	10.1016/j.psychres.2012.09.020	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Jewkes 2013	Intimate partner violence as a risk factor for mental health problems in South Africa	Key Issues in Mental Health	178		65-74	10.1159/000342013	Exclusion reason: Unable to obtain full text
Jina 2012	Adverse mental health outcomes associated with emotional abuse in young rural South African women: A cross-sectional study	Journal of Interpersonal Violence	27	5	862-880	<a href="http://dx.doi.org/10.1177/0886260511423247">http://dx.doi.org/10.1177/0886260511423247</a>	Exclusion reason: Wrong age group
Johnson 2020	Dyadic correlates of the perpetration of psychological aggression among intimate partners	Psychology of Violence	10	4	422-431	<a href="http://dx.doi.org/10.1037/vio0000257">http://dx.doi.org/10.1037/vio0000257</a>	Exclusion reason: No coercive control measure

Jovanović 2020	Health consequences of domestic violence against women in Serbia	Vojnosanitetski Pregled	77	1	14-21	10.2298/VSP171130054M	Exclusion reason: No differentiation between types of abuse
Jun 2008	Intimate partner violence and cigarette smoking: Association between smoking risk and psychological abuse with and without co-occurrence of physical and sexual abuse	American Journal of Public Health	98	3	527-535	<a href="http://dx.doi.org/10.2105/AJPH.2003.037663">http://dx.doi.org/10.2105/AJPH.2003.037663</a>	Exclusion reason: No meaningful outcome measures;
Kamimura 2014	Intimate partner violence and physical and mental health among women utilizing community health services in Gujarat, India	BMC Women's Health	14		127	<a href="https://dx.doi.org/10.1186/1472-6874-14-127">https://dx.doi.org/10.1186/1472-6874-14-127</a>	Exclusion reason: No differentiation between types of abuse
Kamimura 2016	Depression and intimate partner violence among college students in Iran	Asian Journal of Psychiatry	23		51-55	<a href="http://dx.doi.org/10.1016/j.ajp.2016.07.014">http://dx.doi.org/10.1016/j.ajp.2016.07.014</a>	Exclusion reason: No coercive control measure
Kamimura 2016	Intimate partner violence-related experiences and mental health among college students in Japan, Singapore, South Korea and Taiwan	International Journal of Social Psychiatry	62	3	262-270	<a href="http://dx.doi.org/10.1177/0020764016629700">http://dx.doi.org/10.1177/0020764016629700</a>	Exclusion reason: No coercive control measure
Kandeger 2021	The mediating effects of self-perception and somatoform dissociation in the relationship between domestic violence and suicidal ideation	Archives of Women's Mental Health	24	2	251-257	<a href="https://dx.doi.org/10.1007/s00737-020-01064-6">https://dx.doi.org/10.1007/s00737-020-01064-6</a>	Exclusion reason: No coercive control measure
Kanougiya 2021	Economic abuse and its associations with symptoms of common mental disorders among women in a cross-sectional survey in informal settlements in Mumbai, India	BMC Public Health	21	1		842 <a href="https://dx.doi.org/10.1186/s12889-021-10904-8">https://dx.doi.org/10.1186/s12889-021-10904-8</a>	Exclusion reason: No coercive control measure;
Lee 2020	Emotional dysregulation and intimate partner violence: A dyadic perspective	Psychology of Violence	10	2	162-171	<a href="http://dx.doi.org/10.1037/vio0000248">http://dx.doi.org/10.1037/vio0000248</a>	Exclusion reason: No coercive control measure
Leithner 2009	Physical, sexual, and psychological violence in a gynaecological-psychosomatic outpatient sample: prevalence and implications for mental health	European Journal of Obstetrics, Gynecology, & Reproductive Biology	144	2	168-72	<a href="https://dx.doi.org/10.1016/j.ejogrb.2009.03.003">https://dx.doi.org/10.1016/j.ejogrb.2009.03.003</a>	Exclusion reason: Violence not (clearly) IPV

Lemon 2002	Preventive healthcare use, smoking, and alcohol use among Rhode Island women experiencing intimate partner violence	Journal of Women's Health & Gender-Based Medicine	11	6	555-562	<a href="http://dx.doi.org/10.1089/152460902760277912">http://dx.doi.org/10.1089/152460902760277912</a>	Exclusion reason: No coercive control measure
Lewis 2006	Coping and Violence Exposure as Predictors of Psychological Functioning in Domestic Violence Survivors	Violence Against Women	12	4	340-354	<a href="http://dx.doi.org/10.1177/1077801206287285">http://dx.doi.org/10.1177/1077801206287285</a>	Exclusion reason: No coercive control measure
Lilly 2009	Ethnicity and risk for symptoms of posttraumatic stress following intimate partner violence: Prevalence and predictors in European American and African American women	Journal of Interpersonal Violence	24	1	3-19	<a href="http://dx.doi.org/10.1177/0886260508314335">http://dx.doi.org/10.1177/0886260508314335</a>	Exclusion reason: No differentiation between types of abuse
Longares 2018	Measuring psychological abuse in same-sex couples: Evidence of validity of the EAPA-P in a Spanish-speaking sample	Anales de Psicologia	34	3	555-561	<a href="http://dx.doi.org/10.6018/analesps.34.3.306281">http://dx.doi.org/10.6018/analesps.34.3.306281</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Lowe 2020	Do levels of posttraumatic growth vary by type of traumatic event experienced? An analysis of the Nurses' Health Study II	Psychological Trauma: Theory, Research, Practice, and Policy			No Pagination Specified	<a href="http://dx.doi.org/10.1037/tra0000554">http://dx.doi.org/10.1037/tra0000554</a>	Exclusion reason: No differentiation between types of abuse
Ludermir 2008	Violence against women by their intimate partner and common mental disorders	Social Science & Medicine	66	4	1008-1018	<a href="http://dx.doi.org/10.1016/j.socscimed.2007.10.021">http://dx.doi.org/10.1016/j.socscimed.2007.10.021</a>	Exclusion reason: Wrong age group
Lysova 2019	Prevalence and consequences of intimate partner violence in Canada as measured by the national victimization survey	Partner Abuse	10	2	199-221	<a href="http://dx.doi.org/10.1891/1946-6560.10.2.199">http://dx.doi.org/10.1891/1946-6560.10.2.199</a>	Exclusion reason: Wrong age group
Maclsaac 2018	Prevalence and characteristics of interpersonal violence in people dying from suicide in Victoria, Australia	Asia-Pacific Journal of Public Health	30	1	36-44	<a href="http://dx.doi.org/10.1177/1010539517743615">http://dx.doi.org/10.1177/1010539517743615</a>	Exclusion reason: No coercive control measure
Manzoli 2012	Abuse against women, depression, and infant morbidity: A primary care cohort study in Brazil	American Journal of Preventive Medicine	43	2	188-195	<a href="http://dx.doi.org/10.1016/j.amepre.2012.04.013">http://dx.doi.org/10.1016/j.amepre.2012.04.013</a>	Exclusion reason: No differentiation between types of abuse
Martin 2003	Substance Use Before and During Pregnancy: Links to Intimate Partner Violence	The American Journal of Drug and Alcohol Abuse	29	3	599-617	<a href="http://dx.doi.org/10.1081/ADA-120023461">http://dx.doi.org/10.1081/ADA-120023461</a>	Exclusion reason: No coercive control measure

Martin 2006	Intimate Partner Violence and Women's Depression Before and During Pregnancy	Violence Against Women	12	3	221-239	<a href="http://dx.doi.org/10.1177/1077801205285106">http://dx.doi.org/10.1177/1077801205285106</a>	Exclusion reason: No coercive control measure;
Maru 2018	The relationship between intimate partner violence and suicidal ideation among young Chinese, Korean, and Vietnamese American women	Women & Therapy	41	3-4	339-355	<a href="http://dx.doi.org/10.1080/02703149.2018.1430381">http://dx.doi.org/10.1080/02703149.2018.1430381</a>	Exclusion reason: No coercive control measure;
Massetti 2018	Healthcare Access and Cancer Screening Among Victims of Intimate Partner Violence	Journal of Women's Health (15409996)	27	5	607-614	10.1089/jwh.2017.6402	Exclusion reason: No differentiation between types of abuse
Matud 2005	The psychological impact of domestic violence on Spanish women	Journal of Applied Social Psychology	35	11	2310-2322	<a href="http://dx.doi.org/10.1111/j.1559-1816.2005.tb02104.x">http://dx.doi.org/10.1111/j.1559-1816.2005.tb02104.x</a>	Exclusion reason: Wrong age group
McNamara 2002	Perceived abuse and disability in a sample of Ohio's women's correctional population	Psychological Reports	91	3,Pt1	849-854	<a href="http://dx.doi.org/10.2466/PR0.91.7.849-854">http://dx.doi.org/10.2466/PR0.91.7.849-854</a>	Exclusion reason: No differentiation between types of abuse
Meekers 2013	Intimate partner violence and mental health in Bolivia	BMC Women's Health	13			28 <a href="https://dx.doi.org/10.1186/1472-6874-13-28">https://dx.doi.org/10.1186/1472-6874-13-28</a>	Exclusion reason: Wrong age group
Mendonca 2017	Intimate partner violence and incidence of common mental disorder	Revista de Saude Publica	51			32 <a href="https://dx.doi.org/10.1590/S1518-8787.2017051006912">https://dx.doi.org/10.1590/S1518-8787.2017051006912</a>	Exclusion reason: No coercive control measure
Mengo 2021	Intimate Partner Violence and Women's Mental Health: The Mediating Role of Coping Strategies Among Women Seeking Help From the Police	Journal of Interpersonal Violence	36	1/2	527-551	10.1177/0886260517729402	Exclusion reason: Violence not (clearly) IPV
Montgomery 2015	Violence against women in selected areas of the United States	American Journal of Public Health	105	10	2156-2166	<a href="http://dx.doi.org/10.2105/AJPH.2014.302430">http://dx.doi.org/10.2105/AJPH.2014.302430</a>	Exclusion reason: Violence not (clearly) IPV
Moraes 2016	Intimate partner violence, common mental disorders and household food insecurity: an analysis using path analysis	Public Health Nutrition	19	16	2965-2974		Exclusion reason: Wrong age group
Morales 2011	Variables asociadas a abuso físico y psicológico a la pareja	Revista Ciencias de la Salud	9	3	271-280		Exclusion reason: Wrong language
Morales 2011	Associated variables with partner physical and psychological abuse	Revista Ciencias de la Salud	9	3	271-280		Exclusion reason: Wrong language
Katz 1999	Psychological abuse and depressive symptoms in dating	Journal of Family Violence	14	3	281-295	<a href="http://dx.doi.org/10.1023/A:1022866400736">http://dx.doi.org/10.1023/A:1022866400736</a>	Exclusion reason: Wrong age group

Kaufman 2019	women: Do different types of abuse have differential effects? Health and academic consequences of sexual victimisation experiences among students in a university setting	Psychology & Sexuality	10	1	56-68	<a href="http://dx.doi.org/10.1080/19419899.2018.1552184">http://dx.doi.org/10.1080/19419899.2018.1552184</a>	Exclusion reason: No coercive control measure;
Kayha 2019	Difficulties in emotion regulation, separation anxiety, and impulsivity as predictors of women's intimate partner violence experiences	Dusunen Adam: Journal of Psychiatry and Neurological Sciences	32	2	101-112		Exclusion reason: No differentiation between types of abuse
Kelly 2010	Intimate partner violence, physical health, posttraumatic stress disorder, depression, and quality of life in latinas	The Western Journal of Emergency Medicine	11	3	247-51		Exclusion reason: No meaningful outcome measures;
Kemp 1995	Incidence and correlates of posttraumatic stress disorder in battered women: Shelter and community samples	Journal of Interpersonal Violence	10	1	43-55	<a href="http://dx.doi.org/10.1177/088626095010001003">http://dx.doi.org/10.1177/088626095010001003</a>	Exclusion reason: No differentiation between types of abuse
Kernic 2003	Resolution of depression among victims of intimate partner violence: Is cessation of violence enough?	Violence and Victims	18	2	115-129	<a href="http://dx.doi.org/10.1891/vivi.2003.18.2.115">http://dx.doi.org/10.1891/vivi.2003.18.2.115</a>	Exclusion reason: No meaningful outcome measures
Khalifeh 2015	Recent intimate partner violence among people with chronic mental illness: Findings from a national cross-sectional survey	British Journal of Psychiatry	207	3	207-212	10.1192/bjp.bp.114.144899	Exclusion reason: Wrong age group
Khalkhali 2016	Domestic Violence in Methamphetamine Psychotic Users, Psychiatric Inpatients, and Healthy People: A Comparative Study	Iranian Journal of Medical Sciences	41	6	486-493		Exclusion reason: No meaningful outcome measures;
Khan 1993	MMPI-2 profiles of battered women in transition	Journal of Personality Assessment	60	1	100-111	<a href="http://dx.doi.org/10.1207/s15327752jpa6001_7">http://dx.doi.org/10.1207/s15327752jpa6001_7</a>	Exclusion reason: No meaningful outcome measures;
Khan 2020	Women's experiences of economic coercion and depressive symptoms in Matlab, Bangladesh	SSM - Population Health	12		100641	<a href="https://dx.doi.org/10.1016/j.ssmph.2020.100641">https://dx.doi.org/10.1016/j.ssmph.2020.100641</a>	Exclusion reason: Wrong age group
Kim 2004	The Association of Antisocial Behavior and Depressive Symptoms Between Partners and Risk for Aggression in Romantic Relationships	Journal of Family Psychology	18	1	82-96	<a href="http://dx.doi.org/10.1037/0893-3200.18.1.82">http://dx.doi.org/10.1037/0893-3200.18.1.82</a>	Exclusion reason: No coercive control measure

Kimerling 2009	Unemployment among women: Examining the relationship of physical and psychological intimate partner violence and posttraumatic stress disorder	Journal of Interpersonal Violence	24	3	450-463	<a href="http://dx.doi.org/10.1177/0886260508317191">http://dx.doi.org/10.1177/0886260508317191</a>	Exclusion reason: No meaningful outcome measures;
Kocot 2003	The roles of coping and social support in battered women's mental health	Violence Against Women	9	3	323-346	10.1177/1077801202250075	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Koopman 2007	Relationships of Depression to Child and Adult Abuse and Bodily Pain Among Women Who Have Experienced Intimate Partner Violence	Journal of Interpersonal Violence	22	4	438-455	<a href="http://dx.doi.org/10.1177/0886260506297028">http://dx.doi.org/10.1177/0886260506297028</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Kramer 2004	Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics	Womens Health Issues	14	1	19-29		Exclusion reason: Violence not (clearly) IPV
Kyu 2005	Prevalence, antecedent causes and consequences of domestic violence in Myanmar	Asian Journal of Social Psychology	8	3	244-271	<a href="http://dx.doi.org/10.1111/j.1467-839X.2005.00170.x">http://dx.doi.org/10.1111/j.1467-839X.2005.00170.x</a>	Exclusion reason: No meaningful outcome measures;
LaFlair 2012	Intimate partner violence/abuse and depressive symptoms among female health care workers: Longitudinal findings	Women's Health Issues	22	1	e53-e59	<a href="http://dx.doi.org/10.1016/j.whi.2011.07.001">http://dx.doi.org/10.1016/j.whi.2011.07.001</a>	Exclusion reason: No differentiation between types of abuse
Lacey 2013	The Impact of Different Types of Intimate Partner Violence on the Mental and Physical Health of Women in Different Ethnic Groups	Journal of Interpersonal Violence	28	2	359-385	10.1177/0886260512454743	Exclusion reason: No coercive control measure;
Lacey 2021	Severe Intimate Partner Violence, Sources of Stress and the Mental Health of U.S. Black Women	Journal of Women's Health	30	1	17-28	<a href="https://dx.doi.org/10.1089/jwh.2019.8215">https://dx.doi.org/10.1089/jwh.2019.8215</a>	Exclusion reason: No coercive control measure;
Laffaye 2003	Post-traumatic stress disorder and health-related quality of life in female victims of intimate partner violence	Violence and Victims	18	2	227-238	<a href="http://dx.doi.org/10.1891/vivi.2003.18.2.227">http://dx.doi.org/10.1891/vivi.2003.18.2.227</a>	Exclusion reason: No differentiation between types of abuse

Lahav 2019	Domestic Abuse and Forgiveness among Military Spouses	Journal of Aggression, Maltreatment and Trauma	28	2	243-260	10.1080/10926771.2018.1531335	Exclusion reason: No differentiation between types of abuse
Lalley-Chareczko 2017	Sleep disturbance partially mediates the relationship between intimate partner violence and physical/mental health in women and men	Journal of Interpersonal Violence	32	16	2471-2495	<a href="http://dx.doi.org/10.1177/0886260515592651">http://dx.doi.org/10.1177/0886260515592651</a>	Exclusion reason: No coercive control measure;
Lambert 2021	Posttraumatic stress and depression among women in Kenya's informal settlements: risk and protective factors	European Journal of Psychotraumatology	12	1		10.1080/20008198.2020.1865671	Exclusion reason: No coercive control measure;
Lamis 2010	Involvement intimate partner psychological abuse and suicide proneness in college women: Alcohol related problems as a potential mediator	Partner Abuse	1	2	169-185	<a href="http://dx.doi.org/10.1891/1946-6560.1.2.169">http://dx.doi.org/10.1891/1946-6560.1.2.169</a>	Exclusion reason: Only measures IPV perpetration
Lara 2014	Intimate partner violence and depressive symptoms in pregnant Mexican women: National survey results	Revista de Investigacion Clinica	66	5	431-438		Exclusion reason: No differentiation between types of abuse
Lee 2019	Intimate Partner Violence and Psychological Maladjustment: Examining the Role of Institutional Betrayal Among Survivors	Journal of Interpersonal Violence			8.86261E+14	<a href="https://dx.doi.org/10.1177/0886260519836783">https://dx.doi.org/10.1177/0886260519836783</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Morland 2008	Intimate partner violence and miscarriage: Examination of the role of physical and psychological abuse and posttraumatic stress disorder	Journal of Interpersonal Violence	23	5	652-669	<a href="http://dx.doi.org/10.1177/0886260507313533">http://dx.doi.org/10.1177/0886260507313533</a>	Exclusion reason: No meaningful outcome measures;
Morris 2020	The Prevalence of Interpersonal Violence (IPV) Against Women and its Associated Variables: >An Exploratory Study in the Rongo Sub-County of Migori County, Kenya	Journal of Interpersonal Violence			8.86261E+14	<a href="https://dx.doi.org/10.1177/0886260520935484">https://dx.doi.org/10.1177/0886260520935484</a>	Exclusion reason: No differentiation between types of abuse
Moulding 2020	Rethinking Women's Mental Health After Intimate Partner Violence	Violence Against Women			1077801220921937	<a href="https://dx.doi.org/10.1177/1077801220921937">https://dx.doi.org/10.1177/1077801220921937</a>	Exclusion reason: No meaningful

Mouton 1999	The associations between health and domestic violence in older women: Results of a pilot study	Journal of Women's Health & Gender-Based Medicine	8	9	1173-1179	<a href="http://dx.doi.org/10.1089/jwh.1.1999.8.1173">http://dx.doi.org/10.1089/jwh.1.1999.8.1173</a>	outcome measures; Exclusion reason: Violence not (clearly) IPV
Mozzambani 2011	Psychopathology severity in women victims of violence	Revista de Psiquiatria do Rio Grande do Sul	33	1	43-47	10.1590/S0101-81082011005000007	Exclusion reason: Wrong language
Mugoya 2020	Depression and intimate partner violence among urban Kenyan caregivers of children with disabilities	Journal of Psychiatric & Mental Health Nursing	27	1	41-53	<a href="https://dx.doi.org/10.1111/jpm.12550">https://dx.doi.org/10.1111/jpm.12550</a>	Exclusion reason: No coercive control measure;
Najavits 2004	Domestic violence in women with PTSD and substance abuse	Addictive Behaviors	29	4	707-715	<a href="http://dx.doi.org/10.1016/j.addbeh.2004.01.003">http://dx.doi.org/10.1016/j.addbeh.2004.01.003</a>	Exclusion reason: No meaningful outcome measures;
Nangolo 2003	Violence against women and its mental health consequences in Namibia	Gender & Behaviour	1		16-33	<a href="http://dx.doi.org/10.4314/gab.v1i1.23310">http://dx.doi.org/10.4314/gab.v1i1.23310</a>	Exclusion reason: No meaningful outcome measures;
Nathanson 2012	The prevalence of mental health disorders in a community sample of female victims of intimate partner violence	Partner Abuse	3	1	59-75	<a href="http://dx.doi.org/10.1891/1946-6560.3.1.59">http://dx.doi.org/10.1891/1946-6560.3.1.59</a>	Exclusion reason: No coercive control measure;
Naved 2008	Spousal violence against women and suicidal ideation in Bangladesh	Women's Health Issues	18	6	442-452	<a href="http://dx.doi.org/10.1016/j.whi.2008.07.003">http://dx.doi.org/10.1016/j.whi.2008.07.003</a>	Exclusion reason: Wrong age group
Nduna 2013	Prevalence and factors associated with depressive symptoms among young women and men in the Eastern Cape Province, South Africa	Journal of Child and Adolescent Mental Health	25	1	43-54	<a href="http://dx.doi.org/10.2989/17280583.2012.731410">http://dx.doi.org/10.2989/17280583.2012.731410</a>	Exclusion reason: Wrong age group
Necho 2020	The association of intimate partner violence with postpartum depression in women during their first month period of giving delivery in health centers at Dessie town, 2019	Annals of General Psychiatry	19	1		10.1186/s12991-020-00310-6	Exclusion reason: Wrong age group
Nelson 1996	Understanding and treating post-traumatic stress disorder symptoms in female partners of veterans with PTSD	Journal of Marital and Family Therapy	22	4	455-467	<a href="http://dx.doi.org/10.1111/j.1752-0606.1996.tb00220.x">http://dx.doi.org/10.1111/j.1752-0606.1996.tb00220.x</a>	Exclusion reason: Wrong study design
Nhi 2019	Intimate Partner Violence among Pregnant Women and Postpartum Depression in Vietnam: A Longitudinal Study	BioMed Research International	2019			10.1155/2019/4717485	Exclusion reason: Wrong age group

Niaz 2002	Psychological consequences of intimate partner violence: Forms of domestic abuse in both genders	Pakistan Journal of Medical Sciences	18	3	205-214		Exclusion reason: No differentiation between types of abuse
Nilsson 2008	Acculturation, partner violence, and psychological distress in refugee women from Somalia	Journal of Interpersonal Violence	23	11	1654-1663	<a href="http://dx.doi.org/10.1177/0886260508314310">http://dx.doi.org/10.1177/0886260508314310</a>	Exclusion reason: No coercive control measure;
Nixon 2004	An exploration of comorbid depression among female victims of intimate partner violence with posttraumatic stress disorder	Journal of Affective Disorders	82	2	315-320	<a href="http://dx.doi.org/10.1016/j.jad.2004.01.008">http://dx.doi.org/10.1016/j.jad.2004.01.008</a>	Exclusion reason: No coercive control measure;
Nurius 2003	Contextualizing Depression and Physical Functioning in Battered Women: Adding Vulnerability and Resources to the Analysis	Journal of Interpersonal Violence	18	12	1411-1431	<a href="http://dx.doi.org/10.1177/0886260503258033">http://dx.doi.org/10.1177/0886260503258033</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Okafor 2021	Associations of Emotional, Physical, or Sexual Intimate Partner Violence and Depression Symptoms Among South African Women in a Prospective Cohort Study	Journal of Interpersonal Violence	36	9/10	NP5060-NP5083	10.1177/0886260518796522	Exclusion reason: No coercive control measure;
Orava 1996	Perceptions of control, depressive symptomatology and self-esteem of women in transition from abusive relationships	Journal of Family Violence	11	2	167-186	<a href="http://dx.doi.org/10.1007/BF02336668">http://dx.doi.org/10.1007/BF02336668</a>	Exclusion reason: No differentiation between types of abuse
Orke 2021	Attachment Characteristics Among Women Victimized in No, One, and Multiple IPV Relationships: A Case-Control Study	Violence Against Women				1077801220981157 <a href="https://dx.doi.org/10.1177/1077801220981157">https://dx.doi.org/10.1177/1077801220981157</a>	Exclusion reason: No differentiation between types of abuse
Peltzer 2017	Associations between intimate partner violence, depression, and suicidal behavior among women attending antenatal and general outpatients hospital services in Thailand	Nigerian Journal of Clinical Practice	20	7	892-899	<a href="https://dx.doi.org/10.4103/njcp.njcp_453_15">https://dx.doi.org/10.4103/njcp.njcp_453_15</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Pengpid 2013	Mental health, partner violence and HIV risk among women with protective orders against violent partners in Vhembe district, South Africa	Asian Journal of Psychiatry	6	6	494-499	<a href="http://dx.doi.org/10.1016/j.ajp.2013.06.005">http://dx.doi.org/10.1016/j.ajp.2013.06.005</a>	Exclusion reason: No meaningful outcome measures;

Pengpid 2018	Intimate partner sexual violence and risk for femicide, suicidality and substance use among women in antenatal care and general out-patients in Thailand	BMC Women's Health	18	1	37	<a href="https://dx.doi.org/10.1186/s12905-018-0526-z">https://dx.doi.org/10.1186/s12905-018-0526-z</a>	Exclusion reason: No coercive control measure;
Peralta 2003	Screening for intimate partner violence in a primary care setting: the validity of "feeling safe at home" and prevalence results	Journal of the American Board of Family Practice	16	6	525-32		Exclusion reason: No meaningful outcome measures;
Perrin 1996	Assessing the effects of violence on women in battering relationships with the Keane MMPI-PTSD scale	Journal of Traumatic Stress	9	4	805-816	10.1007/BF02104103	Exclusion reason: Wrong age group
Pico-Alfonso 2006	The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety, and Suicide	Journal of Women's Health	15	5	599-611	<a href="http://dx.doi.org/10.1089/jwh.2006.15.599">http://dx.doi.org/10.1089/jwh.2006.15.599</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Sarasua 2008	Differential psychopathological profile of victims of intimate partner violence according to age	Psychology in Spain	12		53-62		Exclusion reason: No differentiation between types of abuse
Scheid 2021	Feelings and feedings: Psychopathology and breastfeeding attitudes in women with a history of intimate partner violence	Psychological Trauma: Theory, Research, Practice, and Policy	13	3	394-402	<a href="http://dx.doi.org/10.1037/tra0000984">http://dx.doi.org/10.1037/tra0000984</a>	Exclusion reason: No differentiation between types of abuse
Mills 2018	Mediated effects of coping on mental health outcomes of African American women exposed to physical and psychological abuse	Violence Against Women	24	2	186-206	<a href="http://dx.doi.org/10.1177/1077801216686219">http://dx.doi.org/10.1177/1077801216686219</a>	Exclusion reason: No coercive control measure;
Miszkurka 2012	Immigrant status, antenatal depressive symptoms, and frequency and source of violence: what's the relationship?	Archives of Women's Mental Health	15	5	387-396	10.1007/s00737-012-0298-7	Exclusion reason: No differentiation between types of abuse
Schrag 2015	Economic abuse and later material hardship: Is depression a mediator?	Affilia: Journal of Women & Social Work	30	3	341-351	<a href="http://dx.doi.org/10.1177/0886109914541118">http://dx.doi.org/10.1177/0886109914541118</a>	Exclusion reason: No coercive control measure;
Schraiber 2010	Validity of the WHO VAW study instrument for estimating gender-based violence against women	Revista de Saude Publica	44	4	658-66		Exclusion reason: Wrong language

Scrafford 2019	Effects of intimate partner violence, mental health, and relational resilience on perinatal health	Journal of Traumatic Stress	32	4	506-515	<a href="http://dx.doi.org/10.1002/jts.22414">http://dx.doi.org/10.1002/jts.22414</a>	Exclusion reason: No differentiation between types of abuse
Sediri 2020	Women's mental health: acute impact of COVID-19 pandemic on domestic violence	Archives of Women's Mental Health	23	6	749-756	<a href="https://dx.doi.org/10.1007/s00737-020-01082-4">https://dx.doi.org/10.1007/s00737-020-01082-4</a>	Exclusion reason: No differentiation between types of abuse
Seedat 2005	Association Between Physical Partner Violence, Posttraumatic Stress, Childhood Trauma, and Suicide Attempts in a Community Sample of Women	Violence and Victims	20	1	87-98	<a href="http://dx.doi.org/10.1891/vivi.2005.20.1.87">http://dx.doi.org/10.1891/vivi.2005.20.1.87</a>	Exclusion reason: No coercive control measure;
Sezgin 2019	Type of Traumatic Events, Mental Health Problems, and Posttraumatic Cognitions Among Eastern Anatolian Women	Journal of Interpersonal Violence			8.86261E+14	<a href="https://dx.doi.org/10.1177/0886260519858385">https://dx.doi.org/10.1177/0886260519858385</a>	Exclusion reason: Wrong age group
Shah 2018	Intimate partner violence and psychotic experiences in four U.S. cities	Schizophrenia Research	195		506-512	10.1016/j.schres.2017.09.017	Exclusion reason: No coercive control measure;
Shamu 2016	High-frequency intimate partner violence during pregnancy, postnatal depression and suicidal tendencies in Harare, Zimbabwe	General Hospital Psychiatry	38		109-114	10.1016/j.genhosppsy.2015.10.005	Exclusion reason: Wrong age group
Shannon 2008	An examination of women's alcohol use and partner victimization experiences among women with protective orders	Substance Use & Misuse	43	8-9	1110-1128	<a href="http://dx.doi.org/10.1080/10826080801918155">http://dx.doi.org/10.1080/10826080801918155</a>	Exclusion reason: Wrong age group
Shannon 2016	Examining intimate partner violence and health factors among rural Appalachian pregnant women	Journal of Interpersonal Violence	31	15	2622-2640	<a href="http://dx.doi.org/10.1177/0886260515579508">http://dx.doi.org/10.1177/0886260515579508</a>	Exclusion reason: No meaningful outcome measures;
Sheikhan 2014	Domestic violence in Iranian infertile women	Medical Journal of the Islamic Republic of Iran	28		152		Exclusion reason: No differentiation between types of abuse
Shen 2019	Intimate partner violence and psychological distress among emerging adult women: A bidirectional relationship	Journal of Women's Health	28	8	1060-1067	<a href="http://dx.doi.org/10.1089/jwh.2018.7405">http://dx.doi.org/10.1089/jwh.2018.7405</a>	Exclusion reason: No coercive control measure;
Shepherd-McMullen 2015	Negative mood regulation expectancies moderate the	Journal of Interpersonal Violence	30	9	1553-1566	<a href="http://dx.doi.org/10.1177/0886260514540805">http://dx.doi.org/10.1177/0886260514540805</a>	Exclusion reason: No meaningful

Shevlin 2013	relationship between psychological abuse and avoidant coping Patterns of lifetime female victimisation and psychotic experiences: A study based on the UK Adult Psychiatric Morbidity Survey 2007	Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services	48	1	15-24	<a href="http://dx.doi.org/10.1007/s00127-012-0573-y">http://dx.doi.org/10.1007/s00127-012-0573-y</a>	outcome measures; Exclusion reason: Wrong age group
Shorey 2017	Examining the reactions of women in substance use treatment as participants in a study on intimate partner violence: Does shame proneness matter	Partner Abuse	8	4	395-408	<a href="http://dx.doi.org/10.1891/1946-6560.8.4.395">http://dx.doi.org/10.1891/1946-6560.8.4.395</a>	Exclusion reason: No coercive control measure;
Signorelli 2020	Depression, PTSD and alexithymia in victims of intimate partner violence: a case-control study	Revista de Psiquiatria Clinica	47	2	45-50	10.1590/0101-60830000000230	Exclusion reason: No coercive control measure;
Silva 2015	Health-related factors associated with intimate partner violence in women attending a primary care clinic in south-western Nigeria	South African Family Practice	57	2	69-76	10.1080/20786190.2014.976994	Exclusion reason: Wrong age group
Skomorovsky 2006	The buffering role of social support perceptions in relation to eating disturbances among women in abusive dating relationships	Sex Roles: A Journal of Research	54	9-10	627-638	<a href="http://dx.doi.org/10.1007/s11199-006-9030-2">http://dx.doi.org/10.1007/s11199-006-9030-2</a>	Exclusion reason: No coercive control measure;
Smith 2013	The Self Assessment of Future Events Scale (SAFE): Assessing perceptions of risk for future violence in intimate partner relationships	Journal of Marital and Family Therapy	39	3	314-329	<a href="http://dx.doi.org/10.1111/j.1752-0606.2012.00319.x">http://dx.doi.org/10.1111/j.1752-0606.2012.00319.x</a>	Exclusion reason: No coercive control measure;
Soleimani 2017	Health consequences of intimate partner violence against married women: A population-based study in northern Iran	Psychology, Health & Medicine	22	7	845-850	<a href="http://dx.doi.org/10.1080/13548506.2016.1263755">http://dx.doi.org/10.1080/13548506.2016.1263755</a>	Exclusion reason: No coercive control measure;
Solinas-Saunders 2021	Perpetration and Victimization of Emotional Abuse and Controlling Behaviors in a Sample of Batterer Intervention Program's Participants: An Analysis of Stressors and Risk Factors	Crime and Delinquency				10.1177/0011128721999349	Exclusion reason: Wrong age group
Sorbo 2014	Adult physical, sexual, and emotional abuse and postpartum depression, a population based, prospective study of 53,065	BMC Pregnancy & Childbirth	14			316 <a href="https://dx.doi.org/10.1186/1471-2393-14-316">https://dx.doi.org/10.1186/1471-2393-14-316</a>	Exclusion reason: Violence not (clearly) IPV

Stein 2021	women in the Norwegian Mother and Child Cohort Study Intimate Partner Violence Among Surgeons: We are Not Immune	Annals of Surgery	273	3	387-392	<a href="https://dx.doi.org/10.1097/SLA.00000000000004553">https://dx.doi.org/10.1097/SLA.00000000000004553</a>	Exclusion reason: No differentiation between types of abuse
Stene 2010	Psychotropic drug use among women exposed to intimate partner violence: A population-based study	Scandinavian Journal of Public Health	38	Suppl 5	88-95	<a href="http://dx.doi.org/10.1177/1403494810382815">http://dx.doi.org/10.1177/1403494810382815</a>	Exclusion reason: No coercive control measure;
Stoliker 2018	An examination of the effects of different victimization types on psychological and behavioral health outcomes and the mediating role of stress	Victims & Offenders	13	6	834-858	<a href="http://dx.doi.org/10.1080/15564886.2018.1491436">http://dx.doi.org/10.1080/15564886.2018.1491436</a>	Exclusion reason: Wrong age group
Straight 2003	The impact of partner psychological abuse on health behaviors and health status in college women	Journal of Interpersonal Violence	18	9	1035-1054	<a href="http://dx.doi.org/10.1177/0886260503254512">http://dx.doi.org/10.1177/0886260503254512</a>	Exclusion reason: Wrong age group
Straus 2009	Intimate partner violence and functional health status: Associations with severity, danger, and self-advocacy behaviors	Journal of Women's Health	18	5	625-631	<a href="http://dx.doi.org/10.1089/jwh.2007.0521">http://dx.doi.org/10.1089/jwh.2007.0521</a>	Exclusion reason: Duplicate publication
Straus 2009	Intimate partner violence and functional health status: associations with severity, danger, and self-advocacy behaviors [corrected] [published erratum appears in J WOMENS HEALTH 2009 Jun;18(6):917]	Journal of Women's Health (15409996)	18	5	625-631	10.1089/jwh.2007.0521	Exclusion reason: No coercive control measure;
Tanimu 2016	The pattern and correlates of intimate partner violence among women in Kano, Nigeria	African Journal of Primary Health Care & Family Medicine	8	1	e1-e6	<a href="https://dx.doi.org/10.4102/phcfm.v8i1.1209">https://dx.doi.org/10.4102/phcfm.v8i1.1209</a>	Exclusion reason: Wrong age group
Tasa-Vinyals 2020	Intimate Partner Violence Among Patients Diagnosed With Severe Mental Disorder	Journal of Nervous & Mental Disease	208	10	749-754	<a href="https://dx.doi.org/10.1097/NMD.0000000000001207">https://dx.doi.org/10.1097/NMD.0000000000001207</a>	Exclusion reason: No differentiation between types of abuse
Tavoli 2016	Quality of life in women who were exposed to domestic violence during pregnancy	BMC Pregnancy & Childbirth	16			19 <a href="https://dx.doi.org/10.1186/s12884-016-0810-6">https://dx.doi.org/10.1186/s12884-016-0810-6</a>	Exclusion reason: Wrong age group
Polychronopoulou 2016	The psychosocial repercussions of domestic violence in battered women	Psychiatriki	27	2	148-9		Exclusion reason: Wrong language

Porcerelli 2006	Physical and psychological symptoms in emotionally abused and non-abused women	Journal of the American Board of Family Medicine: JABFM	19	2	201-4			Exclusion reason: Violence not (clearly) IPV
Porrua-Garcia 2016	Development and validation of the scale of psychological abuse in intimate partner violence (EAPA-P)	Psicothema	28	2	214-221			Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Potter 2020	Categories and health impacts of intimate partner violence in the World Health Organisation multi-country study on women's health and domestic violence	International Journal of Epidemiology	12			12	<a href="https://dx.doi.org/10.1093/ije/dyaa220">https://dx.doi.org/10.1093/ije/dyaa220</a>	Exclusion reason: Wrong age group
Prasad 2018	Intimate partner violence: factors and types of abuse women face in and around Coimbatore District, Tamilnadu	Indian Journal of Public Health Research and Development	9	11	67-70		10.5958/0976-5506.2018.01427.4	Exclusion reason: Wrong study design
Price 2019	Experiences of Reproductive Coercion in Queensland Women	Journal of Interpersonal Violence				8.86261E+14	<a href="https://dx.doi.org/10.1177/0886260519846851">https://dx.doi.org/10.1177/0886260519846851</a>	Exclusion reason: Wrong age group
Prospero 2010	Sexual coercion and mental health symptoms among heterosexual men: The pressure to say "yes"	American Journal of Men's Health	4	2	98-103		<a href="http://dx.doi.org/10.1177/1557988308330106">http://dx.doi.org/10.1177/1557988308330106</a>	Exclusion reason: No coercive control measure;
Raffo 2010	Psychological and physical abuse among pregnant women in a Medicaid-sponsored prenatal program	Public Health Nursing	27	5	385-398		<a href="http://dx.doi.org/10.1111/j.1525-1446.2010.00871.x">http://dx.doi.org/10.1111/j.1525-1446.2010.00871.x</a>	Exclusion reason: Violence not (clearly) IPV
Ramiro 2004	Risk markers of severe psychological violence against women: a WorldSAFE multi-country study	Injury Control & Safety Promotion	11	2	131-7			Exclusion reason: Wrong age group
Ratner 1993	The incidence of wife abuse and mental health status in abused wives in Edmonton, Alberta	Canadian Journal of Public Health. Revue Canadienne de Sante Publique	84	4	246-9			Exclusion reason: No coercive control measure;
Rauer 2010	Sleeping with one eye open: Marital abuse as an antecedent of poor sleep	Journal of Family Psychology	24	6	667-677		<a href="http://dx.doi.org/10.1037/a0021354">http://dx.doi.org/10.1037/a0021354</a>	Exclusion reason: No differentiation between types of abuse ;
Records 2005	A comparative study of postpartum depression in abused and nonabused women	Archives of Psychiatric Nursing	19	6	281-290		<a href="http://dx.doi.org/10.1016/j.apnu.2005.07.010">http://dx.doi.org/10.1016/j.apnu.2005.07.010</a>	Exclusion reason: No differentiation between types of abuse ;

Reddy 2020	Childhood abuse and intimate partner violence among women with mood disorders	Journal of Affective Disorders	272	335-339		<a href="http://dx.doi.org/10.1016/j.jad.2020.03.113">http://dx.doi.org/10.1016/j.jad.2020.03.113</a>	Exclusion reason: No meaningful outcome measures
Rees 2016	A high-risk group of pregnant women with elevated levels of conflict-related trauma, intimate partner violence, symptoms of depression and other forms of mental distress in post-conflict Timor-Leste	Transl Psychiatry Psychiatry	6	e725		<a href="https://dx.doi.org/10.1038/tp.2015.212">https://dx.doi.org/10.1038/tp.2015.212</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Richardson 2020	The effect of intimate partner violence on women's mental distress: a prospective cohort study of 3010 rural Indian women	Social Psychiatry & Psychiatric Epidemiology	55	1 71-79		<a href="https://dx.doi.org/10.1007/s00127-019-01735-5">https://dx.doi.org/10.1007/s00127-019-01735-5</a>	Exclusion reason: Wrong age group
Rogers 2014	Women's exposure to psychological abuse: Does that experience predict mental health outcomes?	Journal of Family Violence	29	6 595-611		<a href="http://dx.doi.org/10.1007/s10896-014-9621-6">http://dx.doi.org/10.1007/s10896-014-9621-6</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Roh 2016	Risk and protective factors for depressive symptoms among indigenous older adults: Intimate partner violence (IPV) and social support	Journal of Gerontological Social Work	59	4 316-331		<a href="http://dx.doi.org/10.1080/01634372.2016.1214659">http://dx.doi.org/10.1080/01634372.2016.1214659</a>	Exclusion reason: No coercive control measure;
Romito 2005	The impact of current and past interpersonal violence on women's mental health	Social Science & Medicine	60	8 1717-1727		<a href="http://dx.doi.org/10.1016/j.socscimed.2004.08.026">http://dx.doi.org/10.1016/j.socscimed.2004.08.026</a>	Exclusion reason: Wrong age group
Rosen 2002	Gender differences in the experience of intimate partner violence among active duty U.S. Army soldiers	Military Medicine	167	12 959-963			Exclusion reason: No coercive control measure;
Ruiz-Perez 2005	Intimate Partner Violence and Mental Health Consequences in Women Attending Family Practice in Spain	Psychosomatic Medicine	67	5 791-797		<a href="http://dx.doi.org/10.1097/01.psy.0000181269.11979.cd">http://dx.doi.org/10.1097/01.psy.0000181269.11979.cd</a>	Exclusion reason: No coercive control measure;
Ruiz-Pérez 2018	Intimate partner violence and mental disorders: Co-occurrence and gender differences in a large cross-sectional population based study in Spain	Journal of Affective Disorders	229	69-78		10.1016/j.jad.2017.12.032	Exclusion reason: No coercive control measure;
Rurangirwa 2018	Intimate partner violence during pregnancy in relation to non-psychotic mental health disorders	BMJ Open	8	7		10.1136/bmjopen-2018-021807	Exclusion reason: Wrong age group

	in Rwanda: A cross-sectional population-based study							
Sabina 2017	Problematic alcohol and drug use and the risk of partner violence victimization among male and female college students	Journal of Family Violence	32	3	305-316	<a href="http://dx.doi.org/10.1007/s10896-017-9907-6">http://dx.doi.org/10.1007/s10896-017-9907-6</a>	Exclusion reason: No coercive control measure;	
Sabina 2008	Polyvictimization by dating partners and mental health among U.S. college students	Violence and Victims	23	6	667-682	<a href="http://dx.doi.org/10.1891/0886-6708.23.6.667">http://dx.doi.org/10.1891/0886-6708.23.6.667</a>	Exclusion reason: No coercive control measure;	
Sabri 2013	Victimization experiences, substance misuse, and mental health problems in relation to risk for lethality among African American and African Caribbean women	Journal of Interpersonal Violence	28	16	3223-41	<a href="https://dx.doi.org/10.1177/0886260513496902">https://dx.doi.org/10.1177/0886260513496902</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV	
Saito 2012	Effect of intimate partner violence on postpartum women's health in northeastern Thailand	Nursing & Health Sciences	14	3	345-351	<a href="http://dx.doi.org/10.1111/j.1442-2018.2012.00735.x">http://dx.doi.org/10.1111/j.1442-2018.2012.00735.x</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV	
Saito 2013	Effect of intimate partner violence on antenatal functional health status of childbearing women in Northeastern Thailand	Health Care for Women International	34	9	757-774	<a href="http://dx.doi.org/10.1080/07399332.2013.794459">http://dx.doi.org/10.1080/07399332.2013.794459</a>	Exclusion reason: Duplicate publication	
Salcioglu 2017	Anticipatory fear and helplessness predict PTSD and depression in domestic violence survivors	Psychological Trauma: Theory, Research, Practice, and Policy	9	1	117-125	<a href="http://dx.doi.org/10.1037/tra0000200">http://dx.doi.org/10.1037/tra0000200</a>	Exclusion reason: Violence not (clearly) IPV;	
Salom 2015	Substance use and mental health disorders are linked to different forms of intimate partner violence victimisation	Drug and Alcohol Dependence	151		121-127	10.1016/j.drugalcdep.2015.03.011	Exclusion reason: Does not report any form of coercive control separately from psychological IPV	
Salwen 2015	Sexual coercion and psychological aggression victimization: Unique constructs and predictors of depression	Partner Abuse	6	4	367-382	<a href="http://dx.doi.org/10.1891/1946-6560.6.4.367">http://dx.doi.org/10.1891/1946-6560.6.4.367</a>	Exclusion reason: No coercive control measure;	
Samelius 2010	Lifetime history of abuse, suffering and psychological health	Nordic Journal of Psychiatry	64	4	227-232	<a href="http://dx.doi.org/10.3109/08039480903478680">http://dx.doi.org/10.3109/08039480903478680</a>	Exclusion reason: Violence not (clearly) IPV;	
Samios 2020	Meaning in Life Following Intimate Partner Psychological Aggression:	Journal of Interpersonal Violence	35	7/8	1567-1586	10.1177/0886260519898437	Exclusion reason: Wrong age group	

Santos 2018	The Roles of Self-Kindness, Positive Reframing, and Growth Domains of common mental disorders in women reporting intimate partner violence	Revista Latino-Americana de Enfermagem	26		e3099	<a href="https://dx.doi.org/10.1590/1518-8345.2740.3099">https://dx.doi.org/10.1590/1518-8345.2740.3099</a>	Exclusion reason: No coercive control measure;
Terrazas-Carrillo 2016	Depression among Mexican women: The impact of nonviolent coercive control, intimate partner violence and employment status	Journal of Family Violence	31	6	721-734	<a href="http://dx.doi.org/10.1007/s10896-016-9827-x">http://dx.doi.org/10.1007/s10896-016-9827-x</a>	Exclusion reason: Wrong age group
Theran 2006	Abusive Partners and Ex-Partners: Understanding the Effects of Relationship to the Abuser on Women's Well-Being	Violence Against Women	12	10	950-969	<a href="http://dx.doi.org/10.1177/1077801206292871">http://dx.doi.org/10.1177/1077801206292871</a>	Exclusion reason: Wrong age group
ThoTran 2018	Emotional violence exerted by intimate partners and postnatal depressive symptoms among women in Vietnam: A prospective cohort study	PLoS ONE [Electronic Resource]	13	11		10.1371/journal.pone.0207108	Exclusion reason: No coercive control measure;
Tiwari 2008	The impact of psychological abuse by an intimate partner on the mental health of pregnant women	BJOG: An International Journal of Obstetrics & Gynaecology	115	3	377-84	<a href="https://dx.doi.org/10.1111/j.1471-0528.2007.01593.x">https://dx.doi.org/10.1111/j.1471-0528.2007.01593.x</a>	Exclusion reason: No coercive control measure;
Tiwari 2013	Factors mediating the relationship between intimate partner violence and chronic pain in Chinese women	Journal of Interpersonal Violence	28	5	1067-1087	<a href="http://dx.doi.org/10.1177/0886260512459380">http://dx.doi.org/10.1177/0886260512459380</a>	Exclusion reason: No coercive control measure;
Tran 2019	Are peritraumatic perceptions of fear/life threat and posttraumatic negative self-conscious appraisals/emotions differentially associated with PTSD symptoms?	Cognitive Therapy and Research	43	1	272-283	<a href="http://dx.doi.org/10.1007/s10608-018-9903-z">http://dx.doi.org/10.1007/s10608-018-9903-z</a>	Exclusion reason: No differentiation between types of abuse
Trimpey 1989	Self-esteem and anxiety: key issues in an abused women's support group	Issues in Mental Health Nursing	10	3-4	297-308		Exclusion reason: No differentiation between types of abuse
Tuel 1998	Self-esteem and depression in battered women: A comparison of lesbian and heterosexual survivors	Violence Against Women	4	3	344-362	<a href="http://dx.doi.org/10.1177/1077801298004003006">http://dx.doi.org/10.1177/1077801298004003006</a>	Exclusion reason: No coercive control measure;
Tuten 2004	Partner violence impacts the psychosocial and psychiatric status of pregnant, drug-dependent women	Addictive Behaviors	29	5	1029-1034	10.1016/j.addbeh.2004.02.055	Exclusion reason: No differentiation between types of abuse ;
Tyson 2007	Beyond violence: Threat reappraisal in women recently	Journal of Social and Personal Relationships	24	5	693-706	<a href="http://dx.doi.org/10.1177/0265407507081455">http://dx.doi.org/10.1177/0265407507081455</a>	Exclusion reason: Does not report

	separated from intimate-partner violent relationships						any form of coercive control separately from psychological IPV; Exclusion reason: Wrong age group
Urquia 2011	Experiences of violence before and during pregnancy and adverse pregnancy outcomes: an analysis of the Canadian Maternity Experiences Survey	BMC Pregnancy & Childbirth	11	1	42-42	10.1186/1471-2393-11-42	
Varma 2007	Intimate partner violence and sexual coercion among pregnant women in India: Relationship with depression and post-traumatic stress disorder	Journal of Affective Disorders	102	1-3	227-235	<a href="http://dx.doi.org/10.1016/j.jad.2006.09.026">http://dx.doi.org/10.1016/j.jad.2006.09.026</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Veloso 2019	CONSUMPTION OF ALCOHOL AND TOBACCO BY WOMEN AND THE OCCURRENCE OF VIOLENCE BY INTIMATE PARTNER	Texto & Contexto Enfermagem	28		1-17	10.1590/1980-265X-TCE-2017-0581	Exclusion reason: No differentiation between types of abuse
Vidourek 2017	Emotional abuse: Correlates to abuse among college students	Journal of Aggression, Maltreatment & Trauma	26	7	792-803	<a href="http://dx.doi.org/10.1080/10926771.2017.1308980">http://dx.doi.org/10.1080/10926771.2017.1308980</a>	Exclusion reason: Violence not (clearly) IPV;
Vilarino 2018	Psychological harm in women victims of intimate partner violence: Epidemiology and quantification of injury in mental health markers	Psychosocial Intervention	27	3	145-152	<a href="http://dx.doi.org/10.5093/pi2018a23">http://dx.doi.org/10.5093/pi2018a23</a>	Exclusion reason: No differentiation between types of abuse
Vitanza 1995	Distress and symptoms of posttraumatic stress disorder in abused women	Violence and Victims	10	1	23-34	<a href="http://dx.doi.org/10.1891/0886-6708.10.1.23">http://dx.doi.org/10.1891/0886-6708.10.1.23</a>	Exclusion reason: No differentiation between types of abuse
Vizcarra 2004	Partner violence as a risk factor for mental health among women from communities in the Philippines, Egypt, Chile, and India	Injury Control & Safety Promotion	11	2	125-9		Exclusion reason: Wrong age group
Vogel 2001	PTSD symptoms and partner abuse: Low income women at risk	Journal of Traumatic Stress	14	3	569-584	10.1023/A:1011116824613	Exclusion reason: No differentiation between types of abuse

Watlington 2006	The Roles of Religion and Spirituality Among African American Survivors of Domestic Violence	Journal of Clinical Psychology	62	7	837-857	<a href="http://dx.doi.org/10.1002/jclp.20268">http://dx.doi.org/10.1002/jclp.20268</a>	Exclusion reason: No coercive control measure
Weaver 2020	Intimate Partner Violence and Body Shame: An Examination of the Associations Between Abuse Components and Body-Focused Processes	Violence Against Women	26	12-13	1538-1554	<a href="https://dx.doi.org/10.1177/1077801219873434">https://dx.doi.org/10.1177/1077801219873434</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Weaver 2020	The Relationship Between Women's Resources and Health-Related Quality of Life in a Sample of Female Victims of Intimate Partner Violence	Journal of Social Service Research				10.1080/01488376.2020.1859433	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Webermann 2021	Intimate Partner Violence Among Patients With Dissociative Disorders	Journal of Interpersonal Violence	36	3/4	NP1441-1462NP	10.1177/0886260517746943	Exclusion reason: No differentiation between types of abuse
Wei 2019	Prevalence of Intimate Partner Violence and Associated Factors Among Men Who Have Sex with Men in China	Journal of Interpersonal Violence			8.86261E+14	<a href="https://dx.doi.org/10.1177/0886260519889935">https://dx.doi.org/10.1177/0886260519889935</a>	Exclusion reason: No meaningful outcome measures
Weiss 2015	The underlying role of posttraumatic stress disorder symptoms in the association between intimate partner violence and deliberate self-harm among African American women	Comprehensive Psychiatry	59		8-16	10.1016/j.comppsy.2014.05.018	Exclusion reason: No coercive control measure;
Wijma 2007	The association between ill-health and abuse: a cross-sectional population based study	Scandinavian Journal of Psychology	48	6	567-75		Exclusion reason: Violence not (clearly) IPV;
Willie 2018	The Impact of Adverse Childhood Events on the Sexual and Mental Health of Women Experiencing Intimate Partner Violence	Journal of Interpersonal Violence			8.86261E+14	<a href="https://dx.doi.org/10.1177/0886260518802852">https://dx.doi.org/10.1177/0886260518802852</a>	Exclusion reason: No meaningful outcome measures
Wolford-Clevenger 2016	Dating violence victimization, interpersonal needs, and suicidal ideation among college students	Crisis: The Journal of Crisis Intervention and Suicide Prevention	37	1	51-58	<a href="http://dx.doi.org/10.1027/0227-5910/a000353">http://dx.doi.org/10.1027/0227-5910/a000353</a>	Exclusion reason: No coercive control measure;

Wolford-Clevenger 2016	The association of partner abuse types and suicidal ideation among men and women college students	Violence and Victims	31	3	471-485	<a href="http://dx.doi.org/10.1891/0886-6708.VV-D-14-00083">http://dx.doi.org/10.1891/0886-6708.VV-D-14-00083</a>	Exclusion reason: Wrong age group
Wong 2016	Problem-focused coping mediates the impact of intimate partner violence on mental health among Chinese women	Psychology of Violence	6	2	313-322	<a href="http://dx.doi.org/10.1037/a0039496">http://dx.doi.org/10.1037/a0039496</a>	Exclusion reason: No differentiation between types of abuse
Wong 2011	Depression among women experiencing intimate partner violence in a Chinese community	Nursing Research	60	1	58-65	<a href="http://dx.doi.org/10.1097/NNR.0b013e3182002a7c">http://dx.doi.org/10.1097/NNR.0b013e3182002a7c</a>	Exclusion reason: No coercive control measure;
Woods 2000	Prevalence and patterns of posttraumatic stress disorder in abused and postabused women	Issues in Mental Health Nursing	21	3	309-324	<a href="http://dx.doi.org/10.1080/016128400248112">http://dx.doi.org/10.1080/016128400248112</a>	Exclusion reason: No coercive control measure;
Woods 2008	Physical health and posttraumatic stress disorder symptoms in women experiencing intimate partner violence	Journal of Midwifery & Women's Health	53	6	538-546	10.1016/j.jmwh.2008.07.004	Exclusion reason: Wrong age group;
Woolhouse 2012	Depressive symptoms and intimate partner violence in the 12 months after childbirth: a prospective pregnancy cohort study	BJOG: An International Journal of Obstetrics & Gynaecology	119	3	315-23	<a href="https://dx.doi.org/10.1111/j.1471-0528.2011.03219.x">https://dx.doi.org/10.1111/j.1471-0528.2011.03219.x</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Sullivan 2009	Testing posttraumatic stress as a mediator of physical, sexual, and psychological intimate partner violence and substance problems among women	Journal of Traumatic Stress	22	6	575-584		Exclusion reason: Does not report any form of coercive control separately from psychological IPV
Sullivan 2017	Is firearm threat in intimate relationships associated with posttraumatic stress disorder symptoms among women?	Violence and Gender	4	2	31-36	<a href="http://dx.doi.org/10.1089/vio.2016.0024">http://dx.doi.org/10.1089/vio.2016.0024</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Sumner 2011	The influence of prenatal trauma, stress, social support, and years of residency in the US on postpartum maternal health status among low-income Latinas	Maternal and Child Health Journal	15	7	1046-1054	<a href="http://dx.doi.org/10.1007/s10995-010-0649-9">http://dx.doi.org/10.1007/s10995-010-0649-9</a>	Exclusion reason: No differentiation between types of abuse
Sussex 2005	The Impact of Domestic Violence on Depression in Teen Mothers: Is	Brief Treatment and Crisis Intervention	5	1	109-120	<a href="http://dx.doi.org/10.1093/brief-treatment/mhi005">http://dx.doi.org/10.1093/brief-treatment/mhi005</a>	Exclusion reason: No differentiation

Sutherland 1998	the Fear or Threat of Violence Sufficient? The long-term effects of battering on women's health	Womens Health	4	1	41-70		between types of abuse Exclusion reason: No differentiation between types of abuse
Swan 2003	Behavioral and psychological differences among abused women who use violence in intimate relationships	Violence Against Women	9	1	75-109	<a href="http://dx.doi.org/10.1177/1077801202238431">http://dx.doi.org/10.1177/1077801202238431</a>	Exclusion reason: No meaningful outcome measures
Tadegge 2008	The mental health consequences of intimate partner violence against women in Agaro Town, southwest Ethiopia	Tropical Doctor	38	4	228-229	10.1258/td.2008.070353	Exclusion reason: Wrong age group;
Taft 2009	Posttraumatic stress disorder symptoms, relationship adjustment, and relationship aggression in a sample of female flood victims	Journal of Family Violence	24	6	389-396	10.1007/s10896-009-9241-8	Exclusion reason: No coercive control measure;
Taft 2006	Examining the correlates of psychological aggression among a community sample of couples	Journal of Family Psychology	20	4	581-588	<a href="http://dx.doi.org/10.1037/0893-3200.20.4.581">http://dx.doi.org/10.1037/0893-3200.20.4.581</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Taft 2007	Examining the correlates of engagement and disengagement coping among help-seeking battered women	Violence and Victims	22	1	3-17	<a href="http://dx.doi.org/10.1891/vv-v22i1a001">http://dx.doi.org/10.1891/vv-v22i1a001</a>	Exclusion reason: No meaningful outcome measures
Taft 2007	Posttraumatic stress disorder and physical health symptoms among women seeking help for relationship aggression	Journal of Family Psychology	21	3	354-362	<a href="http://dx.doi.org/10.1037/0893-3200.21.3.354">http://dx.doi.org/10.1037/0893-3200.21.3.354</a>	Exclusion reason: Duplicate publication;
Yanqiu 2011	Suicidal ideation and the prevalence of intimate partner violence against women in rural Western China	Violence Against Women	17	10	1299-1312	<a href="http://dx.doi.org/10.1177/1077801211425217">http://dx.doi.org/10.1177/1077801211425217</a>	Exclusion reason: Wrong age group;
Yoshihama 2009	The role of emotional abuse in intimate partner violence and health among women in Yokohama, Japan	American Journal of Public Health	99	4	647-653	10.2105/AJPH.2007.118976	Exclusion reason: Does not report any form of coercive control separately from psychological IPV

Yu 2018	Association of intimate partner violence during pregnancy, prenatal depression, and adverse birth outcomes in Wuhan, China	BMC Pregnancy & Childbirth	18	1	469	<a href="https://dx.doi.org/10.1186/s12884-018-2113-6">https://dx.doi.org/10.1186/s12884-018-2113-6</a>	Exclusion reason: No coercive control measure;
Yuan 2019	Intimate Partner Violence and Depression in Women in China	Journal of Interpersonal Violence			8.86261E+14	<a href="https://dx.doi.org/10.1177/0886260519888538">https://dx.doi.org/10.1177/0886260519888538</a>	Exclusion reason: Does not report any form of coercive control separately from psychological IPV;
Zacarias 2012	Symptoms of depression, anxiety, and somatization in female victims and perpetrators of intimate partner violence in Maputo City, Mozambique	International Journal of Women's Health	4		491-503	<a href="https://dx.doi.org/10.2147/IJWH.S29427">https://dx.doi.org/10.2147/IJWH.S29427</a>	Exclusion reason: Wrong age group;
Zakar 2016	Domestic violence against rural women in Pakistan: An issue of health and human rights	Journal of Family Violence	31	1	15-25	<a href="http://dx.doi.org/10.1007/s10896-015-9742-6">http://dx.doi.org/10.1007/s10896-015-9742-6</a>	Exclusion reason: Wrong age group;
Zakar 2013	Spousal violence against women and its association with women's mental health in Pakistan	Health Care for Women International	34	9	795-813	<a href="http://dx.doi.org/10.1080/07399332.2013.794462">http://dx.doi.org/10.1080/07399332.2013.794462</a>	Exclusion reason: Wrong age group;
Zhang 2015	Intimate partner violence among Hong Kong young adults: Prevalence, risk factors, and associated health problems	Journal of Interpersonal Violence	30	13	2258-2277	<a href="http://dx.doi.org/10.1177/0886260514552442">http://dx.doi.org/10.1177/0886260514552442</a>	Exclusion reason: No differentiation between types of abuse
Zink 2005	The Prevalence and Incidence of Intimate Partner Violence in Older Women in Primary Care Practices	Journal of General Internal Medicine	20	10	884-888	<a href="http://dx.doi.org/10.1111/j.1525-1497.2005.0191.x">http://dx.doi.org/10.1111/j.1525-1497.2005.0191.x</a>	Exclusion reason: No differentiation between types of abuse

## Appendix A.3

### Quality Assessment

**Figure A.3**

*JBI Critical Appraisal Checklist for the 68 Included Studies*

Authors	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Authors	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Ahmad et al. (2018)	Green	Green	Green	Green	Green	Green	Green	Green	Levine & Fritz (2016)	Green	Green	Green	Green	Green	Green	Green	Green
Alexander et al. (2019)	Green	Green	Red	Green	Green	Green	Green	Green	Lovestad et al. (2017)	Green	Green	Green	Green	Green	Green	Green	Green
Anderson (2008)	Orange	Green	Green	Green	Green	Green	Green	Green	Ludermir et al. (2010)	Green	Green	Orange	Green	Green	Green	Green	Green
Anderson et al. (2017)	Green	Green	Green	Green	Red	Red	Green	Green	Ludermir et al. (2014)	Green	Green	Green	Green	Green	Green	Green	Green
Basile et al. (2004)	Green	Green	Orange	Green	Green	Green	Green	Green	McCauley et al. (2014)	Orange	Green	Green	Green	Green	Red	Green	Green
Beck et al. (2011)	Green	Green	Green	Green	Green	Red	Green	Green	Mechanic et al.(2000)	Green	Green	Green	Green	Green	Green	Green	Green
Broughton & Ford-Gilboe (2017)	Green	Green	Green	Green	Orange	Green	Green	Green	Mechanic et al.(2008)	Green	Green	Green	Green	Green	Green	Green	Green
Bubriski-McKenzie & Jasinski (2013)	Green	Green	Green	Green	Green	Green	Green	Green	Mutiso et al. (2020)	Green	Green	Green	Green	Green	Green	Green	Green
Coker et al. (2002)	Green	Green	Green	Green	Green	Orange	Green	Green	Newton (2021)	Green	Green	Green	Green	Orange	Orange	Green	Green
Damra & Abujilban (2021)	Green	Green	Green	Green	Orange	Orange	Green	Green	Nielsen et al. (2016)	Green	Green	Green	Green	Green	Green	Green	Green
Dokkedahl et al. (2021)	Green	Green	Green	Green	Green	Green	Green	Green	Nnawulezi & Murphy (2019)	Red	Green	Green	Green	Red	Red	Green	Green
Dutton & Painter (1993)	Green	Green	Green	Green	Orange	Red	Green	Green	Norwood & Murphy (2012)	Green	Green	Green	Green	Green	Green	Green	Green
Dutton et al. (1999)	Green	Green	Green	Green	Orange	Orange	Green	Green	Ogunbajo et al. (2020)	Green	Green	Green	Green	Green	Green	Green	Green
Emery et al. (2019)	Green	Green	Orange	Green	Orange	Orange	Green	Green	Peltzer et al. (2013)	Green	Green	Green	Green	Orange	Red	Green	Green
Fleming et al. (2012)	Green	Green	Green	Green	Green	Green	Green	Green	Petra (2020)	Green	Green	Green	Green	Green	Green	Green	Green
Gibbs et al. (2018)	Orange	Green	Green	Green	Green	Green	Green	Green	Pickover et al. (2017)	Green	Green	Green	Green	Green	Green	Green	Green
Gou et al. (2019)	Green	Green	Green	Green	Orange	Green	Green	Green	Postmus et al. (2012)	Orange	Green	Orange	Orange	Green	Green	Green	Green
Grace et al. (2020)	Green	Green	Green	Green	Green	Green	Green	Green	Prospero (2008)	Green	Green	Green	Green	Green	Green	Green	Green
Groves et al. (2012)	Green	Green	Green	Green	Green	Green	Green	Green	Prospero (2009)	Green	Green	Green	Green	Green	Green	Green	Green
Hardesty et al. (2019)	Green	Green	Green	Green	Green	Green	Green	Green	Prospero & Kim (2009a)	Green	Green	Green	Green	Red	Red	Green	Green
Hayes & Kopp (2020)	Orange	Green	Orange	Orange	Green	Green	Green	Green	Prospero & Kim (2009b)	Green	Green	Green	Green	Green	Green	Green	Green
Hazen et al. (2008)	Green	Green	Green	Green	Green	Green	Green	Green	Reich et al. (2015)	Green	Green	Green	Green	Green	Green	Green	Green
Hedin & Janson (1999)	Green	Green	Green	Green	Orange	Orange	Green	Green	Sackett & Saunders (1999)	Green	Green	Green	Green	Green	Green	Green	Green
Hines & Douglas (2011)	Green	Green	Green	Green	Green	Green	Green	Green	Sauber & O'Brien (2020)	Green	Green	Green	Green	Green	Green	Green	Green
Hines & Douglas (2012)	Green	Green	Green	Green	Green	Green	Green	Green	Strauss et al. (2019)	Green	Green	Green	Green	Green	Green	Green	Green
Hines & Douglas (2018)	Green	Green	Green	Green	Green	Green	Green	Green	Street & Arias (2001)	Green	Green	Green	Green	Green	Green	Orange	Green
Ireland et al. (2017)	Green	Green	Green	Green	Orange	Orange	Green	Green	Stylianou (2018)	Green	Green	Green	Green	Green	Green	Green	Green
Johnson & Leone (2005)	Green	Green	Orange	Green	Green	Green	Green	Green	Taft et al. (2005)	Orange	Green	Green	Green	Orange	Red	Green	Green
Johnson et al. (2014)	Green	Green	Orange	Green	Green	Green	Green	Green	Tiwari et al. (2015)	Green	Green	Green	Green	Green	Green	Green	Green
Jones (2020)	Green	Green	Green	Green	Green	Green	Green	Green	Voth Schrag et al. (2019)	Green	Green	Green	Green	Green	Green	Green	Green
Jones et al. (2005)	Green	Green	Green	Green	Orange	Orange	Green	Green	Weaver & Etzel (2003)	Green	Green	Green	Green	Green	Green	Green	Green
Kapiga et al. (2017)	Green	Green	Orange	Green	Green	Green	Green	Green	Wolf et al. (2018)	Green	Green	Green	Green	Green	Green	Green	Green
Lawrence et al. (2009)	Green	Green	Green	Green	Green	Green	Green	Green	Wolford-Clevenger et al. (2017)	Green	Green	Green	Green	Green	Green	Green	Green
Leone (2011)	Green	Green	Orange	Green	Green	Green	Orange	Green	Wolford-Clevenger & Smith (2017)	Green	Green	Green	Green	Red	Red	Green	Green

*Note.* Q1= “Were the criteria for inclusion in the sample clearly defined?”; Q2 = “Were the study subjects and the setting described in detail?”; (Q3 = “Was the exposure measured in a valid and reliable way?”; Q4 = “Were objective, standard criteria used for measurement of the condition?”; Q5 = “Were confounding factors identified?”; Q6 = “Were strategies to deal with confounding factors stated?”; Q7 = “Were the outcomes measured in a valid and reliable way?”; Q8 = “Was appropriate statistical analysis used?”. Yes = green, No = red, Unclear = orange.

## Appendix A.4

### Supplementary Reference List of Measures

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## Appendix A.5

### Forest Plots

**Figure A.5.1**

*Forest Plot for Coercive Control and PTSD*

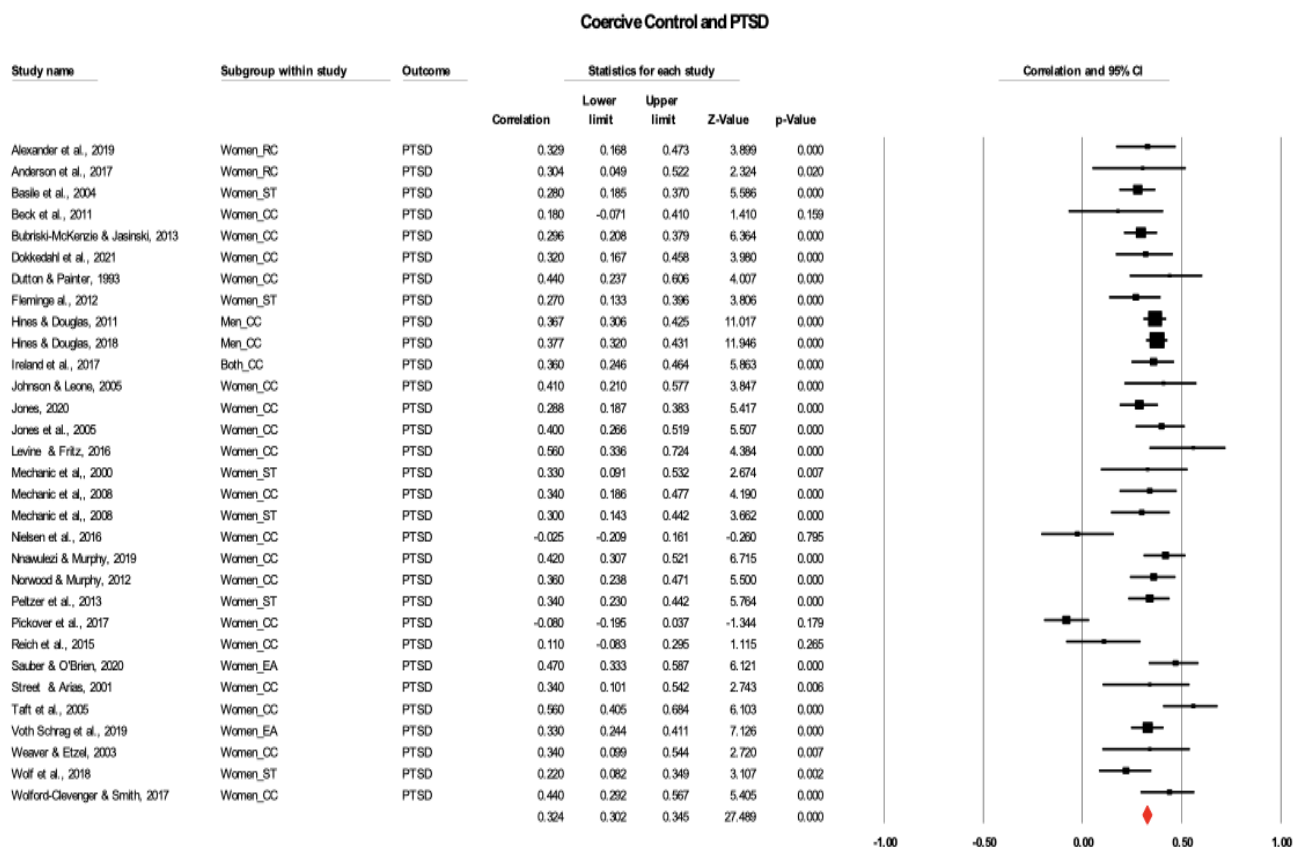
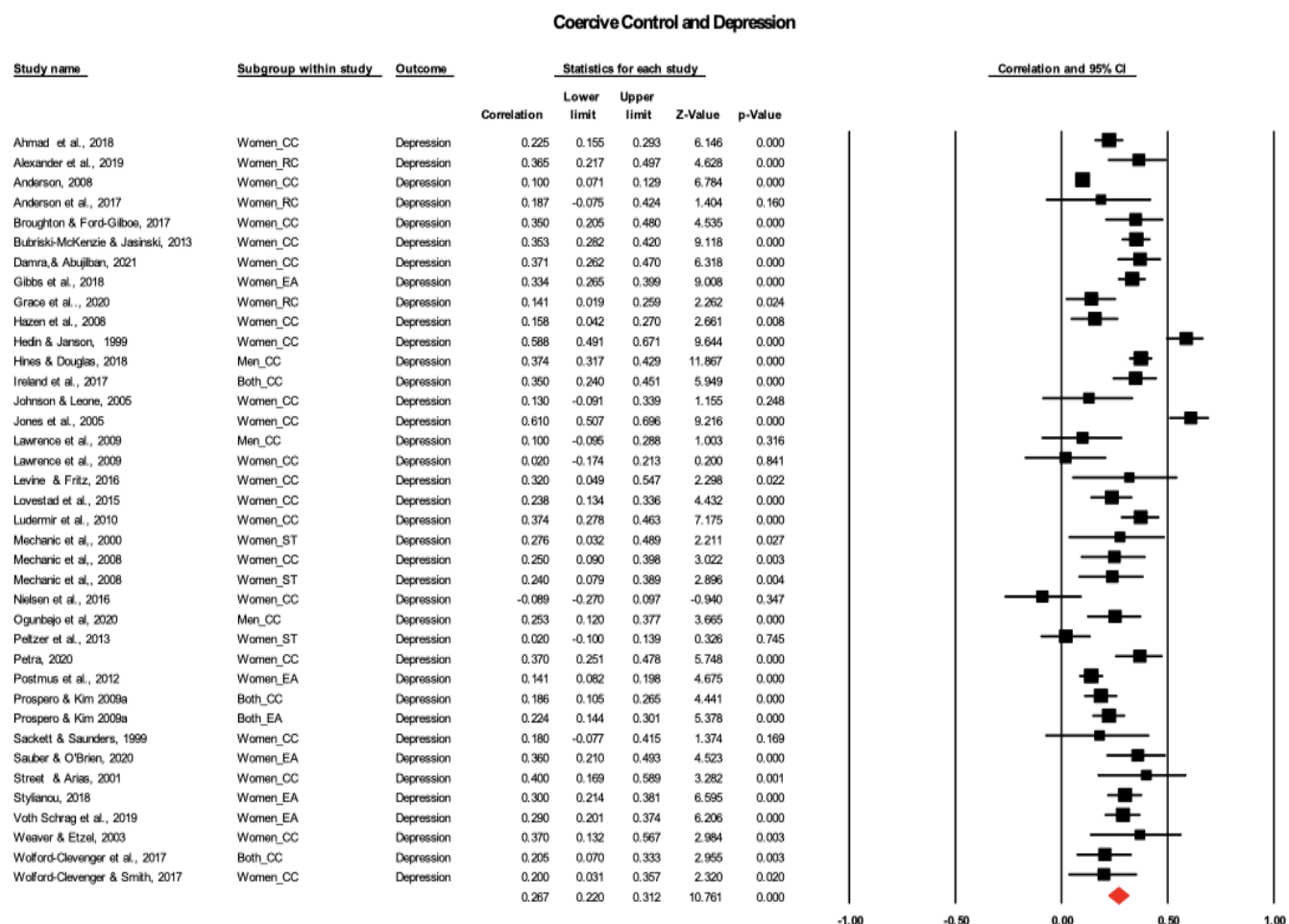


Figure A.5.2

## Forest Plot for Coercive Control and Depression



## Appendix A.6

### Subgroup Analyses

**Table A.6**

*Subgroup Analyses for Coercive Control, PTSD and Depression*

Subgroup	Studies <i>k</i>	Effect Sizes <i>k</i>				Range	<i>r</i> Mean	95% CI	<i>I</i> <sup>2</sup> %
		Total	Women	Men	Both				
PTSD									
Types of IPV									
CC	21	21	18	2	1	-.08 - .56	.33*	[.26, .39]	79.51*
EA, ST, RC	10	10	10	-	-	.27 - .35	.32*	[.27,.35]	0.00
Study Setting									
DV	10	10	10	-	-	.32 - .56	.40*	[.35,.45]	7.28
Support/Shelter									
Community <sup>1</sup>	11	11	9	2	1	-.08 - .41	.26*	[.16,.35]	86.85*
Depression									
Types of IPV									
CC	26	27	21	3	3	-.09 - .59	.28*	[.26, .39]	89.82*
EA, ST, RC	12	12	11	-	1	.18 - .30	.24*	[.18, .30]	74.48*
Study Setting									
DV	6	6	6	-	-	.18 - .40	.27*	[.19, .35]	0
Support/Shelter									
Community <sup>1</sup>	20	21	16	2	3	-.09 - .59	.28*	[.21, .35]	91.76*

*Note.* CC = Coercive Control (excluding economic abuse, stalking, reproductive coercion) ; EA = economic abuse; ST =

stalking; RC = reproductive coercion; PMWI-DI = Psychological Maltreatment of Women Inventory dominance/isolation

subscale; PCL-C = PTSD Checklist-Civilian (Weathers et al., 1993); PCL-C-IPV = PTSD Checklist-Civilian Modified to

IPV experience (Weathers et al., 1993); BDI = Beck Depression Inventory (Beck et al., 1961); BDI-II = Beck Depression

Inventory (Beck et al., 1996); <sup>1</sup>community refers to all study settings aside from DV Support/Shelter; \**P* < .001 \*\* *P* <

.05

## Appendix A.7

### Risk of Publication Bias

**Table A.7**

*Risk of Publication Bias for all Meta-analyses*

	Effect Sizes	Trim and Fill Imputed Studies	Classic Fail-Safe $N$	Orwin's Fail-Safe $N$
Correlation between	$k$		$N$	$r \leq .10$
ALL CC – PTSD	31	9	5123	73
CC – PTSD	21	5	2410	51
EA, ST, RC – PTSD	10	0	496	23
PSY – PTSD	19	0	2055	47
ALL CC - Depression	39	0	7702	49
CC – Depression	27	0	3868	34
EA, ST, RC – Depression	12	1	642	16
PSY – Depression	19	0	2422	44

*Note.* CC = Coercive Control; ALL CC = CC including economic abuse (EA); stalking (ST); reproductive coercion (RC); PSY = Psychological IPV

## 7.2. Appendix B – Studies 2 & 3

### Interview Guide

#### *Hearing the Voices of Victim-survivors of Intimate Partner Violence to Inform Psychological Interventions*

Full list of questions and prompts that will be used during interviews.

1. **Could you please tell me about your experience of intimate partner violence/ domestic violence?**
  - a. What experience did you have of intimate partner violence?
  - b. How long for did you experience this abuse for?
  - c. Have you previously experienced intimate partner violence/ domestic violence? If yes, what did you experience?
  - d. Do you think the abuse has affected your mental health, if yes how?
2. **Have you been exposed to coercive control, if yes what did you experience?**
  - a. Are you familiar with the concept of coercive control? If yes, what is your understanding of coercive control? (If participants are not familiar with the concept the interviewer will briefly explain that coercive control is a chronic, patterned and entrapping victimisation process that may or may not include physical or sexual violence that is characterised by a “pattern of violence, intimidation, isolation, and control where the main goal is to degrade, isolate, and deprive women of their rights to physical security, dignity, and respect” (Stark, 2007, p.5).
  - b. Have you experienced coercive control, if so what kind of experiences?
  - c. Do you think coercive control has affected your mental health? If yes, how?
  - d. Do you think that coercive control has impacted your mental health differently than other forms of abuse? If yes, how?
3. **What would you want from psychological support?**
  - a. What is your understanding of psychological support?
  - b. Have you ever seen a psychologist or a counsellor before? If yes, what was helpful and what was not so helpful for you?
  - c. How do you think psychological support could benefit you?
4. **Is there anything else you would like to say?**