Demand/withdraw communication in the context of intimate partner violence: Implications for psychological outcomes

Alison M. Pickover⁎, Alexandra J. Lipinski, Thomas S. Dodson, Han N. Tran, Matthew J. Woodward, J Gayle Beck

Department of Psychology, University at Memphis, 400 Innovation Drive, Memphis, TN, 38152, USA

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ABSTRACT

Intimate partner violence (IPV) is associated with symptoms of posttraumatic stress disorder (PTSD) and generalized anxiety disorder (GAD). To clarify the influence of a dyadic conflict pattern that has previously been shown to accompany violence in romantic relationships (partner demand/self withdraw) on these mental health outcomes, we examined the associations between three forms of IPV (physical, emotional-verbal, dominance-isolation), partner demand/self withdraw, and PTSD and GAD symptoms, in a sample of 284 IPV-exposed women. Using structural equation modeling, we found significant associations between dominance-isolation IPV, partner demand/self withdraw, and clinician-assessed GAD symptoms. Associations between emotional-verbal IPV and partner demand/self withdraw were also significant. Associations for physical IPV, partner demand/self withdraw, and clinician-assessed PTSD symptoms were not statistically significant. These results underscore the need for research on the mental health outcomes associated with specific forms of IPV and the long-term psychological consequences of the conflict patterns that uniquely characterize violent relationships.

1. Introduction

Over one in three women in the United States has experienced intimate partner violence (IPV) in their lifetime (Black et al., 2011). IPV can range from derogation and coercive control to physically violent acts that may cause injury or death (Breiding, Basile, Smith, Black, & Mahendra, 2015). IPV is associated with acute and chronic mental health conditions (Bogat, Levendosky, & Eye, 2005; Campbell & Soeken, 1999; Dillon, Hussain, Loxton, & Rahman, 2013) that interfere with social adjustment (Johnson, Zlotnick, & Perez, 2008; Perez & Johnson, 2008), problem-solving, and self-esteem (Beck et al., 2014). In particular, female survivors of IPV are at elevated risk of developing posttraumatic stress disorder (PTSD) as a result of relational violence (Caldwell, Swan, & Woodbrown, 2012). Research shows that anxiety symptoms consistent with generalized anxiety disorder (GAD) are pronounced in female IPV survivors as well (Suglia, Duarte, & Sandel, 2011; Tolman & Rosen, 2001). Clarifying which factors influence these symptoms remains an important research priority and is the focus of the current study.

Physical violence and psychological abuse (e.g., expressive aggression, threats, and control; Breiding et al., 2015) frequently co-occur (Dutton, 2009); however, research suggests that these types of IPV are differentially associated with mental health outcomes. For example, multiple studies suggest that psychological IPV has as strong or stronger a relationship with PTSD as physical abuse (see Dutton, 2009). Further, different psychological abuse behaviors may have unique psychological sequelae. Tolman (1989) found evidence of two separate and distinct forms of psychological abuse: an emotional-verbal type, characterized by verbal attacks, demeaning behavior, and emotional withholding; and a dominance-isolation type, characterized by efforts to isolate a partner, demands for subservience, and rigid adherence to traditional sex roles. Although some research has found both forms of psychological abuse to be associated with self-reported PTSD (Dutton, Goodman, & Bennett, 1999; Mechanic, Weaver, & Resick, 2008), other evidence suggests that only emotional-verbal IPV is associated with PTSD and that different psychological factors shape the expression of mental health outcomes following dominance-isolation IPV (Reich, Blackwell, Simmons, & Beck, 2015). Accordingly, research should examine whether trauma-relevant constructs uniformly or uniquely influence psychological outcomes when different types of IPV are experienced.

Attempts to understand the associations between IPV exposure and poor psychological outcomes have to date focused on intrapersonal, cognitive-affective factors such as shame, guilt, and posttrauma...
cognitive alterations (Beck et al., 2015; Reich et al., 2014; Street & Arias, 2001; Woodward et al., 2013), as well as perceived social support (Mburia-Mwalili, Clements-Nolle, Lee, Shadley, & Yang, 2010; Woodward et al., 2015). Meanwhile, accounts of interpersonal or relational factors that are associated with these psychological outcomes have been limited. In the larger marital and family literature, relational conflict patterns have received both theoretical (Haley, 1963; Price, 1991) and empirical (Schrodt, Witt, & Shimkowski, 2014) attention as constructs that shape individual psychosocial outcomes. In the present study, we extended this literature by examining the relationship between IPV and psychological outcomes, with attention to conflict patterns as they influence this relationship.

1.1. Demand/withdraw and intimate partner violence

Conflict patterns were first formally studied in the context of IPV by Babcock, Watzl, Jacobson, and Gottman (1993). Conceptualizing IPV as nested in a context of asymmetric social and relational power, Babcock and colleagues assessed the association between relational power and IPV among happy nonviolent, distressed nonviolent, and domestically violent intact marital dyads. Relevant to the present investigation, a component of their tripartite model of power included power processes, or conflict patterns characterizing decision-making, problem-solving, and conflict resolution (Cromwell & Olsen, 1975). Specifically, partners’ tendencies to demand and withdraw from each other in periods of discord were assessed.

Demand/withdraw can be conceptualized as a conflict pattern in which partner A chastises, nags, or makes demands of partner B, while partner B avoids confrontation, withdraws from conflict, and becomes defensive (Eldridge & Christensen, 2002). Researchers have noted that wife demand/husband withdraw is typically seen among distressed couples (Jacobson, 1989), a claim supported by Babcock and colleagues’ data. However, Babcock et al.’s most novel findings were that greater husband demand/wife withdraw uniquely characterized violent relationships, and that continuous measures of physical and psychological abuse were significantly associated with greater husband demand/wife withdraw (see also Feldman & Ridley, 2000; Holtzworth-Munroe et al., 1998).

Recorded clinical accounts reveal that women’s withdrawal, as captured in measures of the demand/withdraw pattern, develops in response to partners’ aggressive behaviors in distressed and violent relationships (Byrne, Carr, & Clark, 2004). Women report withdrawal from arguments in order to deescalate potentially violent situations, when they perceive arguments as pointless, or when their partners’ demands are unjustified or unreasonable. Empirical studies similarly suggest that many women in violent relationships adopt coping strategies in response to their partners’ violent and abusive behaviors. They act strategically to secure their safety, engaging in a number of strategies, private and public, forceful and nonforceful, designed to placate their abuser and avoid injury or assault (Gondolf & Fisher, 1988; Goodman, Dutton, Vankos, & Weinfurt, 2005; Powers & Simpson, 2012). Although behavioral strategies may decrease risk of physical injury and revictimization (Goodman, Dutton, Weinfurt, & Cook, 2003; Goodman et al., 2005); it is unclear whether strategic behavior, like demand/withdraw, is associated with negative psychological outcomes in IPV survivors.

1.2. Demand/Withdraw and psychological outcomes

In a meta-analysis of demand/withdraw communication, Schrodt et al. (2014) found a small average effect size for the relationship between husband demand/wife withdraw and physical and mental well-being (r = 0.26, p < 0.01). However, only one of the studies included (Malis & Roloff, 2006) examined the relationship between demand/withdraw and anxiety symptoms akin to those observed posttrauma. Malis and Roloff (2006) asked undergraduate students to report on serial arguments in an intact or ended romantic relationship, and on their individual well-being following the most recent argument episode. Conflict-related thought intrusion, avoidance, and hyperarousal were assessed with the Revised Impact of Event Scale (Weiss & Marmar, 1997), a self-report measure commonly used to assess posttrauma reactions in clinical samples. Stress and interference in activities of daily living were also assessed. Results of the study indicated that, controlling for gender, relational status, who initiated the argument, perceived resolvability of the argument, and number of argumentative episodes, partner demand/self withdraw predicted higher post-argument levels of stress and activity interference, and greater avoidance of thoughts about the most recent argument.

Malis and Roloff’s (2006) study suggests that disrupted psychological functioning and subjective well-being are associated with the partner demand/self withdraw conflict pattern. This effect cannot be better explained by argument characteristics, such as perceived resolvability or argument frequency. Malis and Roloff’s (2006) findings raise interest in the psychological implications of demand/withdraw for intimate relationships characterized by violence. Their findings also raise questions regarding the specific nature of distress and anxiety associated with demand/withdraw. Unfortunately, the self-report measures used by Malis and Roloff (2006) are limited in their ability to parse general distress and specific, diagnostically-based symptoms, and this methodology may have led to inflated estimates of symptomatology (Cody, Jones, Woodward, Simmons, & Beck, 2015).

1.3. Present study

To advance the field’s understanding of constructs that are associated with psychological outcomes following exposure to IPV, the present study sought to unite concepts supported by the marital and family literature to clinical findings reported in the IPV literature. Using structural equation modeling (SEM), we tested the associations between physical and psychological types of IPV, partner demand/self withdraw, and symptoms of PTSD and GAD. Based on Babcock et al.’s (1993) findings, we predicted significant associations between the IPV types (physical, emotional-verbal, and dominance-isolation) and partner demand/self withdraw. Analysis of the associations between partner demand/self withdraw and mental health consequences in IPV survivors was deemed exploratory due to the paucity of research in this area. To ensure precise measurement of symptomatology, PTSD and GAD symptoms were assessed with clinician administered measures as continuous constructs.

2. Method

2.1. Participants

Participants in this study were women assessed by a mental health research clinic for female survivors of IPV. Participants were recruited through research announcements distributed in advocacy centers, churches, and college campuses, as well as through public service announcements. Women qualified for the study if they experienced physical, emotional-verbal, or dominance-isolation IPV in an intimate relationship consistent with the Centers for Disease Control’s definition of IPV (Breiding et al., 2015), were no longer romantically involved with their abusive partner, and were no longer living with their abusive partner. A clinician-administered assessment of IPV (see below) was used to evaluate these criteria. Data were excluded for participants with psychotic symptoms (n = 8), unreliable responding (n = 10), high distress impairing study completion (n = 1), and low cognitive functioning as evaluated by

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1 It should be noted, and has been by other researchers (Goodman et al., 2003, 2005), that seeking a refined knowledge of a woman’s behavioral patterns during conflict should not be interpreted as shifting blame for violence to the IPV survivor or shifting focus away from a perpetrator’s role in violent acts. Rather, in this endeavor, we hoped that our examination could potentially be informative for women and their allies seeking to manage the safety and well-being of IPV survivors.
Table 1

Sample demographics.

<table>
<thead>
<tr>
<th>Type of intimate partner violence experienced in worst relationship</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical and psychological abuse</td>
<td>242</td>
<td>85.2</td>
</tr>
<tr>
<td>Physical abuse only</td>
<td>5</td>
<td>1.8</td>
</tr>
<tr>
<td>Psychological abuse only</td>
<td>37</td>
<td>13.0</td>
</tr>
<tr>
<td>Race/ethnicity</td>
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<td></td>
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<tr>
<td>African American</td>
<td>112</td>
<td>39.4</td>
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<tr>
<td>Caucasian</td>
<td>134</td>
<td>47.2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>9</td>
<td>3.2</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>7.0</td>
</tr>
<tr>
<td>Declined to respond</td>
<td>5</td>
<td>1.8</td>
</tr>
<tr>
<td>Educational background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary school</td>
<td>4</td>
<td>1.4</td>
</tr>
<tr>
<td>High school</td>
<td>29</td>
<td>10.2</td>
</tr>
<tr>
<td>Attended or completed college</td>
<td>202</td>
<td>71.1</td>
</tr>
<tr>
<td>Attended or completed graduate training</td>
<td>45</td>
<td>15.8</td>
</tr>
<tr>
<td>Declined to respond</td>
<td>4</td>
<td>1.4</td>
</tr>
<tr>
<td>Annual household income</td>
<td></td>
<td></td>
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<tr>
<td>Below $10,000</td>
<td>64</td>
<td>22.5</td>
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<td>$10,000–$20,000</td>
<td>70</td>
<td>24.6</td>
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<tr>
<td>$20,000–$30,000</td>
<td>30</td>
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</tr>
<tr>
<td>$30,000–$50,000</td>
<td>44</td>
<td>15.5</td>
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<tr>
<td>Over $50,000</td>
<td>46</td>
<td>16.2</td>
</tr>
<tr>
<td>Declined to respond</td>
<td>30</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Note: Percentages are rounded.

the assessing clinician (n = 7). Two women who did not report relationshipships characterized by IPV were also excluded. Finally, one woman who had been separated from her abuser for 40 years, and whose ability to accurately recall conflict patterns in the abusive relationship was questionable given the time elapsed since the IPV, was excluded. This resulted in a sample of 284 women in the present study.

Mean age in our sample was 37.84 years (SD = 12.08). Most women (approximately 90%) had been separated from their abusive partner for eight years or less at the time of assessment (Med = 12 months elapsed since IPV, IQR = 2.5–43.5 months). Other sample characteristics, including race/ethnicity, educational background, annual income, and type(s) of IPV experienced, can be found in Table 1. Notably, women in our sample reported elevated rates of exposure to stressful life events other than IPV as reported on the Life Events Checklist (see below; M = 3.71 events, SD = 2.30).

2.2. Measures

2.2.1. IPV interview

A semi-structured interview developed by the last author was used to assess the nature and severity of IPV experienced by participants. Modeled after a similar interview for motor vehicle accident survivors (Blanchard & Hickling, 2004), this omnibus assessment was used to obtain details regarding significant romantic relationships and any IPV experienced in the context of those relationships, time since separation from the most recent abuser, status of the relationship (ongoing, or separated or divorced), and current living situation. The IPV interview was administered by a trained clinician.

2.2.2. Adverse events

The Life Events Checklist (LEC; Gray, Litz, Hsu, & Lombardo, 2004) is a 19-item measure of exposure to potentially traumatic events (e.g., natural disaster, car accident). Individuals indicated whether each event was experienced directly, by watching it happen to someone else, by learning about it from someone else, by watching it on TV, or not at all. In the present study, number of adverse events was computed as the total number of directly-experienced events endorsed on the LEC that were not IPV-related.

2.2.3. IPV type and severity

The Conflict Tactics Scale — Revised Version (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used to assess physical abuse severity. Specifically, the 12-item partner physical aggression subscale was used to assess prevalence of experiences of physical abuse in the context of the participant’s most abusive relationship. Sample items from the physical aggression subscale include “My partner punched or hit me with something that could hurt” and “My partner twisted my arm or hair”. Response options on the CTS-2 range from 0 (this has never happened) to 6 (more than 20 times in the past year) or 7 (not in the past year, but it did happen before). Scores were collapsed to reflect never happened (0) or ever happened (1) and were summed. Good reliability was found for the partner physical aggression subscale in the present study (Cronbach’s alphas = 0.89).

The Psychological Maltreatment of Women Inventory—Short Form (PMWI-SF, Tolman, 1989) was used to assess psychological abuse. This measure yields two 7-item subscales: an emotional-verbalsubscale encompassing verbal attacks, demeaning behavior, and emotional withholding; and a dominance-isolation subscale encompassing isolation from resources, demands for obedience and subservience, and rigid adherence to stereotyped sex roles. Sample emotional-verbaland dominance-isolation subscale items include “My partner blamed me for his problems” and “My partner used our money or made important financial decisions without talking to me about it”, respectively. Participants were instructed to respond to items with regard to their most abusive relationship. Response options on the PMWI-SF range from 1 (never) to 5 (very frequently) or not applicable. Item scores are summed. Excellent reliability was found for both the emotional-verbal and dominance-isolation subscales in the present study (Cronbach’s alphas = 0.94 and 0.90, respectively).

2.2.4. Conflict patterns

The Communication Patterns Questionnaire (CPQ; Christensen & Sulaway, 1984) was used to assess partner demand/self withdraw communication during relational conflict. Specifically, we used the 7-item partner demand/self withdraw (D/W) subscale reported by Crenshaw et al. (2016) to assess the extent to which each participant’s most abusive romantic partner initiated discussion, nagged, demanded, and chastised her, while she responded by avoiding or refusing discussion, withdrawing, staying silent, and defending herself. Sample items include “Man tries to start a discussion while Woman tries to avoid a discussion” and “Man nags and demands while Woman withdraws, becomes silent, or refuses to discuss the matter further”. Response options on the CPQ range from 1 (very unlikely) to 9 (very likely) and are averaged. Reliability of the D/W subscale in the present study was 0.67.

2.2.5. IPV-related PTSD symptoms

IPV-related PTSD symptoms, based on Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association [APA], 2000) criteria, were assessed with the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990), the gold-standard clinician measure for PTSD. This interview-style assessment includes 17 items that assess the three symptom clusters of PTSD (re-experiencing, avoidance and numbing, hyperarousal). Prompts, specifically anchored to the experience of IPV, were used to obtain ratings of past-month symptom frequency and intensity. Symptom frequency ratings range from 0 (not at all) to 4 (nearly every day), and symptom intensity ratings range from 0 (no distress) to 4 (extreme distress). Frequency and intensity ratings are summed to produce a total severity score ranging from 0 to 136.

Interviews were administered by trained, graduate and doctoral-level clinicians. A subset of these videotaped interviews (n = 56, 2 Data collection for this study began prior to the publishing of the DSM-5.
Model fit was evaluated using the following fit indices per the recommendations of Kline (2011): $\chi^2$ test of model fit, Steiger-Lind root mean square error of approximation (RMSEA; Steiger, 1990), Bentler comparative fit index (CFI; Hu & Bentler, 1999) and standardized root mean square residual (SRMR). Lower model $\chi^2$ values indicate better model fit. RMSEA values less than or equal to 0.05 indicate close approximate fit, values between 0.05 and 0.08 suggest reasonable error of approximation, and RMSEA values greater than equal to 0.10 suggest poor fit (Browne & Cudeck, 1993). CFI values greater than 0.90 indicate adequate fit, and values greater than 0.95 indicate good fit (Hu & Bentler, 1999). SRMR values of zero reflect perfect model fit, and values less than 0.08 indicate good fit (Hu & Bentler, 1999).

### 3. Results

Means, standard deviations, and bivariate correlations are presented in Table 2. All forms of IPV were significantly associated with one another and with D/W. PTSD symptoms were associated with physical and emotional-verbal IPV and time elapsed since IPV. The association between PTSD symptoms and adverse events approached significance ($p = 0.054$), as did the association between GAD symptoms and D/W ($p = 0.063$).

#### 3.1. Associations between IPV, demand/withdraw, and PTSD symptoms

Model fit indices initially suggested poor to adequate fit for the first PTSD model (model $\chi^2$ ($2$) = 7.91, $p = 0.019$; RMSEA = 0.10, 95% CI (0.04, 0.18), $p > 0.05$; CFI = 0.72; SRMR = 0.05), indicating that the model should be respecified. Both empirical evidence (Dutton, 2009) and the bivariate correlations we obtained suggested an association between physical IPV and PTSD symptoms. Accordingly, we tested a modified model that allowed the association between physical IPV and PTSD symptoms to be estimated freely. Fit indices for the modified model indicated excellent fit (Fig. 1a; model $\chi^2$ ($1$) = 0.21, $p > 0.05$; RMSEA = 0.00, 95% CI (0.00, 0.12), $p > 0.05$; CFI = 1.00; SRMR = 0.01). Emotional-verbal IPV was significantly associated with D/W ($b = 0.20$, $SEb = 0.08$, $p = 0.012$, $\beta = 0.21$). Physical IPV was significantly associated with PTSD symptoms ($b = −0.72$, $SEb = 2.35$, $p = 0.004$, $\beta = −0.24$) and time elapsed since IPV ($b = −5.16$, $SEb = 2.07$, $p = 0.013$, $\beta = −0.16$). No other associations were significant ($p > 0.05$).

Model fit indices initially suggested poor to adequate fit for the second PTSD model as well (model $\chi^2$ ($2$) = 6.64, $p = 0.036$; RMSEA = 0.09, 95% CI (0.02, 0.17), $p > 0.05$; CFI = 0.77; SRMR = 0.04). We also respecified this model so that the association between physical IPV and PTSD symptoms could be estimated freely. Fit indices for the modified model indicated excellent model fit (Fig. 1b; model $\chi^2$ ($1$) = 0.00, $p > 0.05$; RMSEA = 0.00; 95% CI (0.00, 0.00), $p > 0.05$, CFI = 1.00; SRMR = 0.00). Domination-isolation IPV was significantly associated with D/W ($b = 0.19$, $SEb = 0.08$, $p = 0.011$, $\beta = 0.12$). Physical IPV was significantly associated with PTSD symptoms ($b = −6.43$, $SEb = 2.43$, $p = 0.008$, $\beta = −0.23$) and time elapsed since IPV ($b = −5.21$, $SEb = 2.08$, $p = 0.012$, $\beta = −0.17$). No other associations were significant ($p > 0.05$).

#### 3.2. Associations between IPV, demand/withdraw, and GAD symptoms

Model fit indices indicated excellent model fit for the first GAD model (Fig. 1c; model $\chi^2$ ($2$) = 0.58, $p > 0.05$; RMSEA = 0.00, 95% CI (0.00, 0.08), $p > 0.05$; CFI = 1.00, SRMR = 0.01). The association between D/W and GAD symptoms approached significance

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3 We also evaluated models with paths between sexual IPV (assessed using the CTS-2) and D/W. Including sexual IPV in our structural models did not change the overall pattern of the results presented in this report, although sexual IPV was additionally significantly associated with D/W. However, model fit statistics indicated poor fit of these models to the data, particularly when GAD was modeled as the dependent variable of interest. Fit statistics suggested that the models presented in this report provided better fit to the data than modified models including paths between sexual IPV and D/W, and sexual IPV and GAD.
The present study examined the relationships between physical and psychological IPV, partner demand/self withdraw, and PTSD and GAD, in a sample of women seeking mental health assistance following IPV. Addressing a number of gaps in the extant literature, we assessed three types of IPV: physical; emotional-verbal; and dominance-isolation. We used clinician-administered assessments of PTSD and GAD symptoms to ensure valid and precise measurement of psychological symptoms. With this methodology, we identified a number of unique associations. The first notable finding to emerge was the association between two forms of psychological IPV, emotional-verbal IPV and dominance-isolation IPV, and demand/withdraw (Fig. 1), contrasted with nonsignificant findings for physical IPV. The second notable finding to emerge was the association between demand/withdraw and GAD symptoms (Fig. 1d), contrasted with nonsignificant findings for PTSD. These results are the first to suggest a unique association between psychological IPV and demand/withdraw in female IPV survivors no longer romantically involved with their abusive partners. They are also the first to suggest that certain psychological sequelae of IPV may be associated with the demand/withdraw conflict pattern.

4. Discussion

The results of this study extend earlier between-groups findings by using a within-group design involving women who had experienced IPV. As women in our study predominantly experienced both physical and psychological IPV (85%), we were able to shed light on the specific features of violent relationships that may give rise to partner demand/self withdraw, controlling for variance explained by other concurrent forms of abuse. It appears that demand/withdraw is particularly fostered by a pattern of behavior in which abusers verbally attack their partners and make concerted efforts to isolate, demean, and control them. Although physical IPV was associated with partner demand/self withdraw at the bivariate level, our results suggest that physical IPV, and demand/withdraw (Fig. 1), contrasted with nonsignificant findings for physical IPV. The second notable finding to emerge was the association between demand/withdraw and GAD symptoms (Fig. 1d), contrasted with nonsignificant findings for PTSD. These results are the first to suggest a unique association between psychological IPV and demand/withdraw in female IPV survivors no longer romantically involved with their abusive partners. They are also the first to suggest that certain psychological sequelae of IPV may be associated with the demand/withdraw conflict pattern.

4.1. Differential associations between types of IPV and demand/withdraw

The results of this study extend earlier between-groups findings by using a within-group design involving women who had experienced IPV. As women in our study predominantly experienced both physical and psychological IPV (85%), we were able to shed light on the specific features of violent relationships that may give rise to partner demand/self withdraw, controlling for variance explained by other concurrent forms of abuse. It appears that demand/withdraw is particularly fostered by a pattern of behavior in which abusers verbally attack their partners and make concerted efforts to isolate, demean, and control them. Although physical IPV was associated with partner demand/self withdraw at the bivariate level, our results suggest that physical IPV, and demand/withdraw (Fig. 1), contrasted with nonsignificant findings for physical IPV. The second notable finding to emerge was the association between demand/withdraw and GAD symptoms (Fig. 1d), contrasted with nonsignificant findings for PTSD. These results are the first to suggest a unique association between psychological IPV and demand/withdraw in female IPV survivors no longer romantically involved with their abusive partners. They are also the first to suggest that certain psychological sequelae of IPV may be associated with the demand/withdraw conflict pattern.

Fig. 1. Structural equation models depicting associations between IPV, partner demand/self withdraw, and psychological outcome symptoms.

Note: IPV = intimate partner violence. PTSD = posttraumatic stress disorder symptoms. GAD = generalized anxiety disorder symptoms. Inverse square root transformations were performed for physical, emotional-verbal, and dominance-isolation IPV, and partner demand/self withdraw prior to analyses. Nonsignificant associations are represented by dashed lines ($p > 0.05$). Significant associations are represented by solid lines and are presented with their standardized coefficients. Paths from control variables (time elapsed since IPV and adverse events) to PTSD and GAD, and their covariances with exogenous variables and partner demand/self withdraw, were included in these analyses but are not depicted here for simplicity.

$p < 0.05$

**$p < 0.10$

***$p < 0.001$
violence does not have the same associations with this particular conflict pattern among women who have been involved in abusive relationships after accounting for psychological IPV exposure.

Findings in the present study converge with Babcock et al.’s (1993) initial observations in that both sets of correlational analyses resulted in the same pattern of associations between IPV and partner demand/self-withdraw; our study, however, offers a nuanced perspective with the inclusion of multivariate analyses. Further, in contrast to the present endeavor which sampled only female IPV survivors who had left their abusive partners, associations reported by Babcock et al. (1993) were observed in a heterogeneous sample of participants still married at the time of their assessment (i.e., happy nonviolent, distressed nonviolent, and domestically violent marital dyads). In Babcock et al.’s study (1993), couples varied widely in their reported levels of relational distress and violence. Historically, it has been theorized that, in non-violent heterosexual relationships, being in the position of withdrawing represents being in the position of greater relational power, as those who seek to maintain the status quo are more powerful than those who desire and demand change, intimacy, or engagement (Christensen & Heavey, 1990; Jacobson, 1989). As noted previously, withdrawal in violent relationships may be understood better as a strategic response behavior used by IPV-exposed women to secure their safety (Byrne et al., 2004); accordingly, it is not clear that demand/withdraw should be conceptualized as a power process in the context of IPV.

Cohort effects might also be relevant when considering the different results between the 1993 study and the present report. Two or more decades ago, withdrawal from physical violence by a partner may have been maintained by norms that were relatively more permissive of men’s physical violence toward women. Today, however, physical violence might be met with other strategies due to more progressive contextual factors. If so, our findings underscore the necessity of including of multivariate analyses. Further, in contrast to the present endeavor which sampled only female IPV survivors who had left their abusive partners, associations reported by Babcock et al. (1993) were observed in a heterogeneous sample of participants still married at the time of their assessment (i.e., happy nonviolent, distressed nonviolent, and domestically violent marital dyads). In Babcock et al.’s study (1993), couples varied widely in their reported levels of relational distress and violence. Historically, it has been theorized that, in non-violent heterosexual relationships, being in the position of withdrawing represents being in the position of greater relational power, as those who seek to maintain the status quo are more powerful than those who desire and demand change, intimacy, or engagement (Christensen & Heavey, 1990; Jacobson, 1989). As noted previously, withdrawal in violent relationships may be understood better as a strategic response behavior used by IPV-exposed women to secure their safety (Byrne et al., 2004); accordingly, it is not clear that demand/withdraw should be conceptualized as a power process in the context of IPV.

Cohort effects might also be relevant when considering the different results between the 1993 study and the present report. Two or more decades ago, withdrawal from physical violence by a partner may have been maintained by norms that were relatively more permissive of men’s physical violence toward women. Today, however, physical violence might be met with other strategies due to more progressive views on violence toward women, greater condemnation of physical IPV in women’s social networks, or increased community resources for survivors. In contrast, cultural shifts over the same period of time have not as well illuminated the prevalence and effects of psychological IPV. Prescriptions against psychological IPV have been relatively slower to surface, and research on its consequences has been slower to evolve (Dutton, 2009). Withdrawal in the context of such behavior may continue to be the predominant response today because of these socio-contextual factors. If so, our findings underscore the necessity of increasing outreach to the public on the signs and consequences of psychological IPV.

4.2. Demand/withdraw and psychological outcomes

As we know that IPV is associated with poor psychological outcomes, a critical aim of this study was to clarify if aspects of psychological functioning were associated with partner demand/self-withdraw in our sample. Although both of our outcome variables, PTSD and GAD symptoms, are elevated in IPV-exposed samples (Caldwell et al., 2012; Suglia et al., 2011; Tolman & Rosen 2001) and share common features (e.g., irritability, sleep disturbance), it appears that GAD symptoms are more likely to be associated with the pattern of partner demand/self-withdraw. These results build on those of Malis and Roloff’s (2006), reinforcing the relationship between demand/withdraw and individual psychological functioning. They raise interest in a potential role for demand/withdraw in fostering cardinal GAD processes such as excessive and uncontrollable worry in IPV survivors.

Considering our models in their entirety, our results suggest that women who have, understandably, withdrawn from conflict in response to their abusive partners’ demands to control and isolate them experience excessive and uncontrollable worry characteristic of GAD. These relationships were significant even after controlling for relevant factors such as time elapsed since the IPV and history of exposure to adverse events. It appears that withdrawal in response to emotional-verbal IPV may also be linked to symptoms of GAD; however, our analyses have been underpowered to detect this association, as we only observed a marginally significant relationship between partner demand/self-withdraw and GAD when evaluating this association in the context of physical IPV and emotional-verbal IPV (Fig. 1c). We did not find that PTSD symptoms were associated with domineering, controlling, verbally aggressive, or demeaning behavior met with withdrawal by female IPV survivors. Finally, we did not find evidence to suggest that physical violence was linked with demand/withdraw and the experience of excessive and uncontrollable worry.

4.3. Future directions for research on demand/withdraw in IPV survivors

Future work should seek to clarify the function of demand/withdraw in violent relationships. Clarification on this point may be particularly important when attempting to identify the consequences of a high incidence of this communication pattern in violent relationships. For instance, a better understanding of demand/withdraw’s function might provide insight into the mechanisms linking this communication pattern and symptoms of GAD in IPV survivors. Potentially, demand/withdraw may be indicative of a general avoidance coping style, as avoidance coping has been linked with distress in interpersonal trauma survivors (Littleton, Horsley, John, & Nelson, 2007). However, avoidance coping has also been shown to be associated with PTSD in IPV survivors (Krause, Kaltman, Goodman, & Dutton, 2008); thus we would have expected a significant association between demand/withdraw and PTSD if demand/withdraw was indicative of a general avoidance coping style. Given the unique association with GAD, alternative functions of demand/withdraw, and other processes specific to GAD, should be considered.

Potentially, demand/withdraw may be related to negative problem-solving orientation, rather than maladaptive problem-solving skills. Research has demonstrated an association between GAD-like worry and negative problem-solving orientation (i.e., low confidence in problem-solving ability and perceived control over problem-solving; Dugas, Freeston, & Ladouceur, 1997), but no association between worry and problem-solving skill (e.g., problem identification and solution implementation; Dugas, LeFevre, Rhéaume, Freeston, & Ladouceur, 1995). Derived from this research, the Intolerance of Uncertainty Model of GAD (IUM; Dugas, Gagnon, Ladouceur, & Freeston, 1998) emphasizes chronic worry related to uncertain or ambiguous situations. It implicates beliefs about worry that promote cognitive avoidance and low problem-solving confidence (Behar, DiMarco, Mohlman, & Staples, 2009; Koerner & Dugas, 2006). Extending from this theoretical framework, experiences of psychological IPV may contribute to the development of a negative problem-solving orientation, leading to withdrawal and GAD. Alternatively, psychological IPV exposure may exacerbate already low confidence in one’s problem-solving ability, developed in response to prior trauma exposure (Borkovec, Alcaine, & Behar, 2004). Longitudinal designs that address partner demand/self-withdraw in the context of psychological IPV, GAD symptoms, and prior trauma history would be helpful in clarifying in these relationships.

As previously noted, demand/withdraw in the context of IPV may functionally represent a strategic act in service of securing a woman’s safety and wellbeing. Although withdrawal may not be successful in preventing abuse, potentially, it allows women to retain psychological autonomy in the face of controlling or isolating behavior. Its enactment might explain why demand/withdraw is not associated with PTSD; demand/withdraw may prevent the type of severe loss of psychological autonomy or “mental defeat” that contributes to the development of this disorder (Brewin & Holmes, 2003; Ehlers & Clark, 2000; Ehlers, Maercker, & Boos, 2000). A better understanding of the benefits and costs of demand/withdraw and other coping strategies employed by women in abusive relationships could inform how providers and community leaders could advise women to respond to their abusive partners.
4.4. Limitations

The cross-sectional design of this study limits our ability to make causal inferences regarding the impact of IPV on partner demand/self-withdraw and subsequent associations with mental health outcomes. We could not determine, in our sample, if IPV predated demand/self-withdraw or vice versa; however, distressed and IPV-exposed women have previously reported that they withdraw in response to violence and other forms of aggression (Byrne et al., 2004). Another possibility that could not be tested with this study’s cross-sectional data is whether GAD symptoms predate IPV and demand/self-withdraw. Additional studies employing longitudinal designs would be best equipped to address such issues of temporal sequence. It is also possible that another, unmeasured variable, such as attachment style, may have influenced the observed relationships in our models (Schoedt et al., 2014; Woodward et al., 2013). Another methodological limitation to our study was the use of self-report measurement of communication patterns. Women with more severe psychological symptomatology may have a tendency to recall communication more negatively and report more frequent use of demand/self-withdraw communication. Further, demand/self-withdraw, as well as IPV, were reported by the woman partner only in this study. Although other studies suggest that partners’ reporting of demand/self-withdraw are significantly correlated (e.g., Babcock et al., 1993), future research might obtain reports from both parties. Concern regarding truthful or accurate self-reporting of demand/self-withdraw could be addressed by using behavioral observations of the conflict pattern in the future (e.g., Holtzworth-Munroe et al., 1998, Study 2).

4.5. Conclusion

Over two decades ago, Babcock et al. (1993) suggested that husband demand/wife withdraw deserved “further exploration as possibly one of the basic interactive dynamics in [violent] couples” (p. 47). In light of emerging evidence of this conflict pattern’s harmfulness (Malis & Rolfou, 2006; Schoedt et al., 2014), this study represents an overdue examination of the relationships between IPV, demand/self-withdraw, and psychological outcomes. Our results suggest that GAD symptoms experienced by IPV-exposed women are associated with their partners’ demands and their withdrawal, specifically when their partners aim to dominate or isolate them. If supported by longitudinal designs, it is critical that IPV-exposed women and their allies become aware of these associations. It is essential that they be equipped with the appropriate resources, referrals, and support they need to promote alternative behaviors for maintaining autonomy and to protect their well-being.

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References


