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Prevalence and Impact of Intimate Partner Violence (IPV) Among an Ethnic Minority Population

Journal of Interpersonal Violence

1–31

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DOI: 10.1177/0886260514563830

jiv.sagepub.com



Sabine Hellemans,¹ Tom Loeyts,¹ Ann Buysse,¹
and Olivia De Smet¹ [\[AQ2\]](#)[\[AQ3\]](#)

Abstract

The present study examined the prevalence of lifetime experiences of physical and psychological intimate partner violence (IPV) among members of the Turkish ethnic minority population in Flanders. In addition, this study explored how lifetime IPV victimization affects ethnic minority victims' current mental, relational, and sexual well-being. Using a population-based representative sample, data from 392 adult Turkish women and men were investigated. Lifetime experiences of physical violence were reported by 14.3% of the Turkish respondents, while 66.0% reported at least one incidence of psychological abuse. Women were much more likely than men to report physical IPV victimization, but no gender differences were found for psychological IPV. With regard to the impact of IPV, it was found that lifetime IPV experiences do not appear to affect victims' current mental health. However, higher levels of physical and/or psychological IPV victimization were related to increased levels of relationship dissatisfaction, anxious and avoidant attachment orientations, sexual dissatisfaction, sexual dysfunction (with distress), and to decreased levels of sexual communication. These adverse relational and sexual outcomes of IPV victimization were mainly present among women but were also, to a lesser degree, relevant for men.

¹Ghent University, Belgium

Corresponding Author [\[AQ1\]](#):

Sabine Hellemans, Department of Experimental-Clinical and Health Psychology, Ghent University, Henri Dunantlaan 2, B-9000 Ghent, Belgium.
Email: Sabine.Hellemans@UGent.be

Keywords

intimate partner violence, ethnic minority, well-being

The World Health Organization (WHO) defines intimate partner violence (IPV) as “behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours” (WHO & London School of Hygiene and Tropical Medicine, 2010, p. 11). IPV crosses all ethnic/racial, sociodemographic, religious, gender, and sexual orientation boundaries (Bent-Goodley, 2005; Rizo & Macy, 2011). IPV research in specific modern Western societies has led to the development of two opposing perspectives on violence between intimate partners (Archer, 2006; Johnson, 1995; Johnson & Ferraro, 2000). One perspective is referred to as “intimate terrorism” and typically describes one-sided, severe forms of aggression. The other perspective is referred to as “common couple violence” and typically consists of minor forms of aggression. Whereas intimate terrorism is mainly viewed as a way of dominating and maintaining control over the partner, common couple violence is predominantly viewed as a harmful way of coping with conflict within a relationship. Although it is not yet well known to what extent these patterns also fit in the context of IPV across non-Western ethnic minority populations (Archer, 2006; Field & Caetano, 2004), it has been argued that community samples mainly portray common couple violence and that clinical samples are more likely to reveal intimate terrorism (Archer, 2000; Johnson, 1995; Johnson & Ferraro, 2000).

Despite the recent wave of campaigning against IPV worldwide, violence within intimate relationships remains a significant problem for a number of people (WHO & London School of Hygiene and Tropical Medicine, 2010). To gain a full picture of this social concern, population-based research should represent all populations in society, including minority populations. However, a lack of diversity in ethnicity is often noted as an important limitation across studies (e.g., Follingstad, Rogers, & Duvall, 2012). Influenced, presumably, at least partially by cultural factors, ethnic minority victims often condone their experiences of violence, live with intense shame related to the stigma of IPV, or fear harming their family and community if they were to disclose their experiences. Consequently, ethnic minority victims often remain invisible, both in society and in research (Malley-Morrison & Hines, 2007; Raj & Silverman, 2002; Rizo & Macy, 2011; Yick, 2007). Because IPV prevention and intervention efforts require cultural knowledge to be successful (Bent-Goodley, 2005; Sokoloff & Dupont, 2005), several scholars have recently highlighted the importance of a better understanding of IPV among ethnic minorities (e.g., Field & Caetano, 2004;

Follingstad et al., 2012; Lacey, McPherson, Samuel, Powel Sears, & Head, 2013; Raj & Silverman, 2002; Tartakovsky & Mezhibovsky, 2012; Yick, 2007).

To date, empirical research on the prevalence of IPV among ethnic minorities, as well as on its impact on ethnic minority victims' well-being, is relatively sparse (Lacey et al., 2013). The small body of research that has been conducted in this area predominantly reports on ethnic minority populations in the United States (for an overview, see Taft, Bryant-Davis, Woodward, Tillman, & Torres, 2009). Furthermore, most cross-cultural studies on IPV victimization have only involved women, thereby excluding potential male victims of intimate violence (Archer, 2000, 2006). To fill these gaps in the research, the present study aimed to examine the prevalence of lifetime physical and psychological IPV victimization in a population-based representative sample of Turkish ethnic minority women and men in Flanders (i.e., the Dutch-speaking part of Belgium). Although immigration is often overlooked in Belgium, due to the small size of the country and the fact that its immigration history is not widely known, immigrants comprised almost 18% of the entire population in 2010. People of Turkish (5%) and Moroccan (10%) origin form the two largest non-Western ethnic minority groups (Levecque, Lodewycks, & Vranken, 2007 [\[AQ4\]](#); Timmerman, Vanderwaeren, & Crul, 2003; www.migrationinformation.org). For a detailed description of immigrants in Belgium, we refer the reader to Levecque and colleagues (2007) and to Timmerman and colleagues (2003). In addition, we aimed to examine how lifetime experience of IPV victimization is related to an individual's current mental well-being as well as to one's well-being on a relationship level. As we will outline below, it has not yet been properly assessed how lifetime IPV victimization affects victims' relational and sexual well-being within their current intimate partner relationship.

The Prevalence of IPV Among Ethnic Minority Women and Men

IPV Among Ethnic Minorities

Studies on IPV victimization among ethnic minorities in the United States have consistently revealed that immigrants are a high-risk group for intimate violence. That is, studies comparing IPV prevalence rates among ethnic minorities to the majority population consistently report higher IPV prevalence estimates in minority groups (e.g., Archer, 2006; Hien & Ruglass, 2009; Taft et al., 2009). Two main theoretical frameworks have been proposed to understand IPV among ethnic minorities, namely, the structural

inequality theory and the subculture of violence theory. The latter theory refers to the acceptance of violence by various cultural groups as a means of conflict resolution within intimate relationships (Field & Caetano, 2004). According to the structural inequality theory, intimate violence is a result of increased stress in intimate relationships due to institutionalized inequalities between groups (e.g., education, income, social support, racial discrimination; Field & Caetano, 2004; Gil, 1986). Strong empirical support has been found for the structural inequality theory as significant differences in IPV victimization between minority and majority groups decrease or disappear when sociodemographic factors such as education level, income, and social support are controlled for (e.g., Field & Caetano, 2004; Taft et al., 2009; Tartakovsky & Mezhibovsky, 2012). In contrast to the more stereotypical view of the subculture of violence theory, this theory stresses that societal structural factors, rather than cultural characteristics, of a specific group explain higher prevalence estimates among ethnic minority groups (Field & Caetano, 2004).

To date, no specific research on IPV among ethnic minority populations has been conducted in Belgium. However, based on the international literature, it is assumed that IPV among ethnic minority populations in Belgium is also highly prevalent. For instance, the Belgian national action plan 2010 to 2014 to combat intimate violence indicates that special attention should be paid to immigrants as they are—due to their lack of knowledge about Belgium support services, language barriers, the risk of isolation and ignorance of support organizations—a vulnerable group for IPV victimization (<http://igvm-iefh.belgium.be>). To expand the limited research in the area of IPV among ethnic minorities, we examined to what extent a representative sample of Turkish women and men in Flanders—recruited by means of a population-based survey—report lifetime experiences of physical and psychological IPV victimization (Research Question 1).

Ethnic Minority Women Versus Men

In Western community samples, evidence has been found for equal IPV victimization and perpetration rates among women and men (e.g., Archer, 2000). Yet, in non-Western community samples, men are more likely to perpetrate physical violence against women (Archer, 2006). The most popular theory to explain intimate violence against ethnic minority women fits with the intimate terrorism perspective detailed above (Johnson, 1995). That is, violence is the result of the maintenance of patriarchy and the dominant role of men over women in society. Indeed, historical and cultural traditions among ethnic minorities often indicate approval for a certain level

of male-to-female violence as a way of maintaining control (Archer, 2006; Bartholomew & Cobb, 2011). For instance, studies among Asian and Middle-Eastern immigrant communities demonstrate that both women and men are tolerant to the use of physical aggression when a woman does not follow the prescribed rules (Erez, Adelman, & Gregory, 2009; Raj & Silverman, 2002). In addition, immigrant women are more likely than immigrant men to alter their gender role ideologies to live according to the more egalitarian Western gender roles (Raj & Silverman, 2002). This implies that a sharp contrast might arise between the traditional values of men and the more modern values of women, which may in turn lead to a man attempting to increase his control over a woman, sometimes resorting to the use of violence (Archer, 2006; Colucci & Montesinos, 2013; Erez et al., 2009; Raj & Silverman, 2002). Laying the intimate terrorism perspective to one side, gender differences in IPV victimization among ethnic minorities can also be explained by means of the social role theory (Archer, 2006; Eagly & Wood, 1999). According to this theory, gender differences in physical aggression against partners are related to gender empowerment in a specific culture. In a compelling study that used data from 16 different nations, Archer (2006) revealed that male-to-female intimate violence is inversely related to women's societal power. Across nations, rates of victimization of women decrease the more empowered they are.

As the existing IPV literature reveals higher levels of intimate violence against immigrant women, we hypothesized that the Turkish women in our sample were more likely to report lifetime physical (Hypothesis 1a) as well as psychological (Hypothesis 1b) IPV victimization compared with Turkish men. To the best of our knowledge, no accurate data on IPV among this group was previously available for Flanders.

The Impact of IPV on Victims' Well-Being

Western clinical and/or community samples have provided clear evidence that experience of violence within a romantic relationship has detrimental effects on a victims' mental, relational, and sexual well-being (e.g., Caldwell, Swan, & Woodbrown, 2012; Campbell, 2002 [\[AOS\]](#); Coker et al., 2002; Krahe, Bieneck, & Möller, 2005). The relationship between IPV victimization and mental, relational, and sexual well-being has not been properly studied in ethnic minority populations, however (Taft et al., 2009). Therefore, this study examined whether, and to what extent, experiencing IPV affects the well-being of Turkish ethnic minority women and men.

Physical and psychological violence have consistently been linked to impaired mental health. Although there is no agreement on the specific

constellation of the symptoms, depression, post-traumatic stress disorder, and low self-esteem are the most reported mental health difficulties among both female and male victims (e.g., Caldwell et al., 2012). Several scholars have provided evidence for adverse mental health outcomes among all women, regardless of their racial/ethnic and social background (Hicks & Li, 2003; Lacey et al., 2013; Yick, Shibusawa, & Agbayani-Siewert, 2003). In accordance to these studies, we hypothesized that our current investigation would find that higher levels of physical (Hypothesis 2a) and psychological (Hypothesis 2b) IPV are associated with poorer mental well-being. Although we are not aware of studies focusing on male victims' mental health, we expected to find this association in both female and male respondents.

Both social learning theory and attachment theory are highly interesting concepts to explain the effects of negative relationship experiences, such as IPV, on a victim's cognitive and emotional responses in later intimate relationships. The social learning theory posits that relational outcomes are determined by couples' positive and negative interaction patterns (Bradbury & Karney, 2010). Over time, the accumulation of experience of conflict and violent interactions might influence the processing of social information and therefore people's judgments of intimate relationships, thus having a negative impact on their relationship satisfaction. Victims' relationship satisfaction has predominantly been examined in clinical samples, but some studies examining community samples have found that IPV victimization is related to higher levels of relationship dissatisfaction (e.g., Katz, Kuffel, & Coblenz, 2002; S. L. Williams & Frieze, 2005). According to attachment theory (Bowlby, 1969, 1973, 1982), past relationship experiences translate into mental representations and influence how individuals think about and behave toward attachment figures. Attachment orientations are relatively stable throughout the life span. However, given the fact that individuals have a variety of interpersonal experiences with their significant others, it is likely that new relationship experiences influence an individual's attachment orientation (Collins & Read, 1994; Fraley, Vicary, Brumbaugh, & Roisman, 2011). As such, a history of violence within a romantic relationship might contribute to negative mental representations of the self and others, triggering the development of insecure attachment orientations. In line with the two-dimensional model of adult attachment proposed by Brennan, Clark, and Shaver (1998), a series of clinical studies have found elevated levels of anxious and avoidant attachment among IPV victims (e.g., Doumas, Pearson, Elgin, & McKinley, 2008; Henderson, Bartholomew, Trinke, & Kwong, 2005; Weston, 2008).

IPV has been considered in the clinical literature to contribute to impaired sexual well-being (Coker, 2007). For example, significant associations have

been found between physical IPV victimization and sexual risk-taking behaviors, inconsistent condom use, unwanted pregnancies and abortions, and sexually transmitted diseases (for a detailed overview, see Coker, 2007). However, how experiences with intimate violence influence victims' sexual well-being and sexual communication within an intimate romantic relationship has not been systematically studied to date, especially with regard to satisfaction with the quality and frequency of sex and by the absence of sexual dysfunction (Bodenmann, Ledermann, & Bradbury, 2007). To the best of our knowledge, no studies have examined these associations for ethnic minorities in a community sample.

As there has been little research on relational and sexual responses to violence by an intimate partner in general, and among ethnic minorities in particular, it is difficult to make predictions about the potential impact of lifetime IPV victimization on ethnic minority victims' relational and sexual well-being in their relationship with their current partner. As considerable evidence has been gathered for cultural-related differences in thoughts, beliefs, and emotions (Markus & Kitayama, 1991) and intimate interactions with romantic partners (Bartholomew & Cobb, 2011; Marshall, 2008), it is likely that cultural differences will influence victims' responses to intimate violence. Despite the lack of supporting research, we hypothesized, based on logical reasoning, that higher levels of lifetime physical and psychological violence would be positively related to relationship dissatisfaction (Hypotheses 3a and 3b), the level of anxious (Hypotheses 4a and 4b) and avoidant (Hypotheses 5a and 5b) attachment orientation, sexual dissatisfaction (Hypotheses 6a and 6b), and sexual dysfunction (Hypotheses 7a and 7b). We also predicted that these experiences would be negatively related to the level of sexual communication (Hypothesis 8a and 8b) in the current intimate relationship. Differences between women and men were explored.

Method

Participants and Procedure

This study draws on data from the survey "Sexual Health of Ethnic Minorities in Flanders" (abbreviated to SEM). This survey includes extensive information on sexuality, sexual health, relationships, and biomedical, psychological, demographic, and socio-cultural correlates. Data were gathered in a population-based probability sample drawn from the two largest, non-Western, ethnic minorities in Flanders: people of Turkish or Moroccan descent. The sampling method in the SEM study followed a multi-

stage procedure. The first stage included the selection of Primary Sampling Units (PSUs), that is, the Flemish municipalities. By ordering and systematic sampling, we ensured that the chance of a municipality being selected was proportional to the number of inhabitants meeting the criteria for eligibility (i.e., between 14 and 59 years of age, of Belgian nationality, and with at least one parent born with either Turkish or Moroccan nationality). In a second stage, we selected respondents randomly from the Belgian National Register. As a very low response rate (26%) was obtained in the subsample of Moroccan descent, we only proceeded with the subsample of Turkish descent ($N = 432$, response rate = 57% of eligible respondents) in further analyses. After data collection, the data were weighted by gender and age to make them representative of the total population of Flemish residents of Turkish extraction, aged 14 to 59.

Data were gathered via face-to-face interviews. A mixed CAPI (Computer-Assisted Personal Interviewing) and CASI (Computer-Assisted Self-Interviewing) set-up was used to account for the (most) sensitive items in the questionnaire. In particular, a wide range of sexual health characteristics were gathered in a CASI set-up, so that respondents never had to share private information about their sexual health with an interviewer. To make sure that respondents would feel at ease with answering these sensitive questions, women were predominantly interviewed by bilingual Dutch–Turkish/Moroccan female interviewers and men by Dutch–Turkish/Moroccan male interviewers. Interviewers were given training on the topic of the questionnaire as well as on the contact and interview procedure. Respondents could fill out the questionnaire in Dutch, Turkish, or in Arabic.

In the present study, we specifically report on adult respondents of Turkish origin (≥ 18 years; $N = 392$). Respondents' country of birth was either Turkey (51.0%) or Belgium (49.0%). Almost all respondents' mothers (94.9%) and fathers (95.7%) were born in Turkey. Respondents' main reasons for moving to Belgium included accompanying their parents (37.4%), to marry their current partner (34.3%), to reunite their family (11.5%), or other reasons (16.8%; e.g., work, study, previous marriage, political refugee). The mean age of the women ($n = 197$) was 34.32 years ($SD = 10.74$, range = 18–60) and the mean age of the men ($n = 195$) was 34.71 years ($SD = 11.02$, range = 18–60). The majority of women (73.5%) and men (78.5%) were in a romantic relationship at the time of the survey. Respondents' current intimate partner's country of birth was Turkey (61.6%), Belgium (34.2%), or another country (4.2%). About 13% of the respondents were still studying, 54.8% held no educational degree or a secondary school degree, 8.5% had earned a secondary school degree, 8.5% held a bachelor's degree, and 4.2% had earned a higher-level university degree. Islamic religion was reported by

94.0% of the respondents, and this was viewed as very important by most respondents ($M = 4.36$, $SD = 0.97$ on a 5-point Likert-type scale ranging from 1 = *very unimportant* to 5 = *very important*).

Measures

Sociodemographic characteristics. In addition to the respondent characteristics described above, we examined several sociodemographic risk factors associated with IPV victimization. Although these factors have been shown to be risk markers for IPV victimization for a general population (see Stith, Smith, Penn, Ward, & Tritt, 2004), they have a particular link with IPV victimization among ethnic minorities (see Field & Caetano, 2004; Malley-Morrison & Hines, 2007): The frequency of social contact with family (0 = *not at all in the past 6 months* to 7 = *daily or almost daily*) and friends (0 = *not at all in the past 6 months* to 7 = *daily or almost daily*), whether their family income is above 2,000 euros a month (1 = *no* and 2 = *yes*), and how comfortable they found this income to live with (1 = *very uncomfortable* to 7 = *very comfortable*). In addition, social support was measured by five questions (e.g., “There are several people I can go to for a chat when I feel lonely”), each of which was rated on a 5-point Likert-type scale (1 = *totally disagree* to 5 = *totally agree*). A score for social support was computed by summing the scores for each item ($\alpha = .82$). Finally, we adapted concepts described by D. R. Williams, Yu, Jackson, and Anderson (1997) and assessed perceived racial discrimination (10 items; for example, “Have you been treated with less respect than others?”) on a 7-point Likert-type scale (1 = *never* to 7 = *daily*). A higher sum score reflects more perceived racial discrimination. This scale proved to be internally consistent in the current study ($\alpha = .92$).

IPV. To identify lifetime IPV victimization, respondents were asked about experiences of physical or psychological violence at the hands of a current or former partner. Physical IPV was assessed with one question measuring different acts of physical violence (adapted from the Conflict Tactics Scale [CTS]; Straus, 1979): “If you think about your current or former partner, has he/she ever hit you with the flat of their hand, hit you with their fist, kicked you, or physically hurt you in another way?” This item was rated on a 5-point Likert-type scale (0 = *never* to 4 = *very often*).

Seven items—adopted and modified from the WHO Multi-Country Study on Women’s Health and Domestic Violence Against Women (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006)^[AQ6]—were used to assess psychological IPV victimization. Specifically, respondents were asked,

"If you think about your current or former partner, has he/she ever . . ." followed by (a) "tried to limit the contact you have with your friends or family members?" (b) "insisted on knowing your whereabouts and who you are with at every moment of the day?" (c) "ignored you or treated you indifferently?" (d) "criticized you or ridiculed you for what you do or say?" (e) "belittled or humiliated you in front of other people?" (f) "intentionally done something to scare or intimidate you?" or (g) "threatened to hurt you or someone you love?" Each item was rated on a 5-point Likert-type scale (0 = *never* to 4 = *very often*). A principal component analysis based on the eigenvalues revealed a single factor solution with approximately equal weights for all items. A scale for psychological violence was computed by summing the scores for each item, with a higher score indicating more severe psychological victimization (range = 0-28). This seven-item measure proved to be internally consistent ($\alpha = .88$).

Mental health. A 5-item short version of the 18-item Mental Health Inventory (MHI; Veit & Ware, 1983) was used to assess respondents' current mental health. Each item (e.g., "During the past four weeks, how much of the time did you feel like a happy person?") was scored on a 5-point Likert-type scale (0 = *never* to 5 = *all the time*). A score for mental well-being was computed by summing the scores for all items, with a higher score reflecting a better level of mental well-being (range = 0-25). The alpha reliability for this 5-item measure was .79 in the present study.

Relationship satisfaction and sexual satisfaction. Respondents' relationship satisfaction and sexual satisfaction within their current relationship were assessed by means of the Maudsley Marital Questionnaire (MMQ; Arrindell, Boelens, & Lambert, 1983; Crowe, 1978; [AO71](#)). Whereas the original scale consists out of three subscales, the present study only used the Relationship Satisfaction (10 items; for example, "Regardless sex, how satisfied are you about the life with your partner?") and the Sexual Satisfaction (4 items¹; for example, "How much do you enjoy having sex with your partner?") subscales. Each item was rated on a 9-point Likert-type scale (0 = *very satisfied* to 8 = *very unsatisfied*). A total score for relationship satisfaction as well as for sexual satisfaction were computed by summing the scores of all items in each scale. Higher scores correspond with greater relationship *dissatisfaction* (range = 0-80) and greater sexual *dissatisfaction* (range = 0-40). The alpha reliabilities were .91 (Relationship Satisfaction) and .74 (Sexual Satisfaction).

Adult attachment style. To assess individual differences in respondents' attachment style toward their current partner, the 12-item short version of the Experiences in Close Relationships Scale (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007; Dutch version by Conradi, Gerlisma, van Duijn, & de Jonge, 2006) was used. The ECR-S is comprised of two scales, attachment anxiety (6 items; for example, "I worry that my partner won't care about me as much as I care about him/her") and attachment avoidance (6 items; for example, "I am nervous when my partner gets too close to me."). Each item was scored on a 5-point Likert-type scale (1 = *totally disagree* to 5 = *totally agree*). A higher score on each scale reflected greater attachment anxiety and greater attachment avoidance. The Cronbach's alpha was .47 for the anxiety scale and .66 for the avoidant scale. Dropping out 1 item of the anxiety scale increased the Cronbach's alpha to .60.

Sexual function and sexual distress. Impaired sexual function and sexual distress associated with impaired sexual function was assessed using the Sexual Functioning Scale (SFS; Enzlin et al., 2012). The SFS covers a range of sexual problems such as increased or decreased spontaneous/responsive sexual desire, arousal dysfunction, orgasmic dysfunction, dyspareunia, vaginismus, retrograde ejaculation, and lack of a forceful propulsive ejaculation. All sexual difficulties (e.g., "In the past 6 months, did you have the feeling that you had a decreased interest in sex, in sexual activities or decreased sexual fantasies or erotic thoughts?") were rated on a 4-point scale (1 = *none* to 4 = *severe or extreme*). To determine the clinical significance of these sexual difficulties, respondents who had scores of ≥ 2 on any of these items were asked to evaluate how any distress associated with each sexual difficulty: They were asked to what extent they experienced this sexual difficulty as a source of distress for themselves, for their partner, and for their relationship. Each type of distress was scored 1 = *no or mild distress*, 2 = *moderate distress*, or 3 = *severe or extreme distress*. Distress was considered to be present if they had a sum score of ≥ 5 (i.e., moderate levels of distress in at least two of three domains, namely, personal distress, partner distress, or relational distress). For this study, a sexual dysfunction scale was computed (0 = *no dysfunction*, 1 = *one or more dysfunctions without distress*, 2 = *one or more dysfunctions with distress*).

Sexual communication. Sexual communication within the current relationship was assessed by means of the 4-item short version of the 13-item Dyadic Sexual Communication Questionnaire (DSC; Catania, 1986 [AQ8]). Each item (e.g., "How often in the past 6 months did you find it difficult to discuss sexual matters with your partner?") was rated on a 5-point Likert-type scale

(1 = *never* to 5 = *almost always or always*) and a total score for sexual communication was computed by summing the scores for all items (range = 4-20). A higher score corresponds with experiencing a greater level of difficulty when discussing sexual topics with the partner. The Cronbach's alpha of this 4-item measure was .51 in the present study.

Results

Prevalence of IPV Among Turkish Ethnic Minorities

Before standardizing the continuous outcome variables, descriptive statistics and correlations were examined (see Table 1). Respondents reported on average a good level of mental health and relatively high levels of relationship satisfaction and sexual satisfaction. Moderate levels of attachment anxiety, attachment avoidance, and sexual communication were found. Overall, lifetime experiences of physical IPV were reported by 14.3% of the Turkish respondents. Sixty-six percent reported having experienced at least one act of psychological violence (Table 2). The most commonly reported act of psychological IPV among this Turkish sample was that a partner "insisted on knowing [your] whereabouts every moment of the day." In contrast, that a partner had "threatened to hurt either you or someone you love" was the least frequently reported act. Furthermore, according to the frequencies, low to moderate counts of physical and psychological IPV victimization were uncovered. In line with the IPV literature, a strong correlation was found between the two forms of aggression ($r = .54, p < .001$).

Sociodemographic characteristics of IPV victimization. Scores on physical and psychological IPV victimization were not normally distributed in this sample (see Figures 1 and 2). To handle the skewed distribution of experiences with physical and psychological IPV, researchers typically classify respondents in two or three categories (e.g., Romans Forte, Cohen, Du Mont, & Hyman, 2007) although this results in the loss of meaningful variance of the continuous dependent variable. Moreover, using categorical instead of continuous variables may result in different findings (e.g., Doumas et al., 2008). To appropriately analyze (right-) skewed count outcomes, several count models have been developed including Poisson regression, negative binomial (NB) regression, zero-inflated Poisson regression, and zero-inflated NB regression (see Atkins & Gallop, 2007; Karazsia & van Dulmen, 2010). As an alternative to the latter two zero-inflated models, researchers have recently developed the Poisson logit hurdle model and the hurdle NB model

Table 1. Descriptive Statistics and Pearson Correlations of the Main Variables Among the Turkish Respondents.

Variable	N	M (SD)	Minimum	Maximum	2	3	4	5	6	7	8
1. Physical IPV	378	0.24 (0.69)	0.00	4.00	.54**	-.06	.33**	.07	.25**	.28**	.11
2. Psychological IPV	313	2.77 (4.31)	0.00	28.00	—	-.19**	.47**	.22**	.37**	.26**	.14*
3. Mental health	380	17.69 (4.18)	0.00	25.00	—	—	-.33**	-.22**	-.13*	-.22**	-.19**
4. Relationship dissatisfaction	266	14.94 (12.71)	2.00	73.00	—	—	—	.27**	.51**	.51**	.28**
5. Anxious attachment	237	2.50 (0.74)	1.00	5.00	—	—	—	—	.36**	.27**	.09
6. Avoidant attachment	237	2.19 (0.74)	1.00	4.50	—	—	—	—	—	.41**	.41**
7. Sexual dissatisfaction	266	7.30 (5.80)	2.00	32.00	—	—	—	—	—	—	.35**
8. Sexual communication	234	9.92 (3.27)	4.00	20.00	—	—	—	—	—	—	—
9. Sexual dysfunctions	295	No SD = 61.6 %, without distress = 25.2%, with distress = 13.3 %									

Note. IPV = intimate partner violence; SD = sexual dysfunctions.

*p < .05. **p < .01.

Table 2. Descriptives and Frequencies of Lifetime IPV.

	<i>M</i> (<i>SD</i>)	%
Physical IPV		
Hit you with the flat of their hand, with their fist, kicked you, or physically hurt you in another way	0.24 (0.69)	14.3
Psychological IPV		
a. Tried to restrict your contact with family and friends	0.39 (0.78)	23.8
b. Insisted on knowing your whereabouts every moment of the day	0.66 (0.10)	37.7
c. Ignored you and treated you indifferently	0.50 (0.89)	29.6
d. Criticized you or ridiculed you for what you do or say	0.43 (0.86)	26.1
e. Belittled or humiliated you in front of other people	0.29 (0.72)	17.7
f. Intentionally done something to scare or intimidate you	0.17 (0.64)	8.7
g. Threatened to hurt either you or someone you love	0.13 (0.57)	6.3

Note. IPV = intimate partner violence.

(NBLH), which offer a more transparent split of the distribution into zero and non-zero counts (for a detailed explanation, see Loeys, Moerkerke, De Smet, & Buysse, 2012). Graphs and statistical tests (outlined in Atkins & Gallop, 2007; Loeys et al., 2012) revealed that the NB model best fitted for the dependent variable physical victimization, and the NBLH model best fitted for psychological victimization. In the NBLH model, the *probability* of all non-zero counts relative to all zero-counts (i.e., the zero-hurdle part) is modeled using a binary logistic regression. The *frequency* of all non-zero counts (i.e., the counts part) is modeled using a truncated NB regression. In the present study, the zero-hurdle part examined the effect of gender and the aforementioned sociodemographics on the *likelihood* of experiencing lifetime IPV, while the counts part examined the effect of gender and the other sociodemographics on the *frequency* of lifetime IPV experiences among victims. In each part, the regression coefficients were exponentiated (e^B) and, respectively, called odds ratios (ORs) and rate ratios (RRs). Converted to percentages ($100 \times (e^B - 1)$), ORs showed the percentage decrease ($OR < 1$) or increase ($OR > 1$) in the odds of experiencing IPV victimization, whereas RRs showed the percentage decrease ($RR < 1$) or increase ($RR > 1$) in the expected IPV frequencies for each unit increase in the independent variable, controlling for the other predictors in the model.

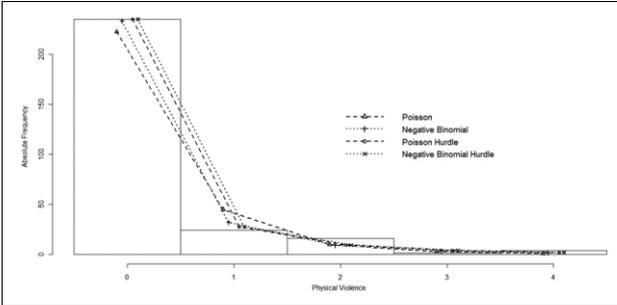


Figure 1. Histogram of physical IPV experiences among Turkish ethnic minorities with predicted frequencies from different types of count regressions. Note. IPV = intimate partner violence.

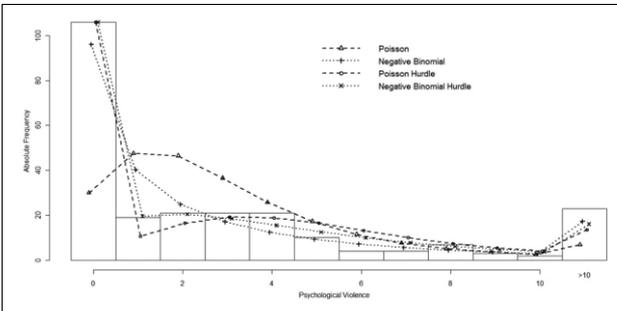


Figure 2. Histogram of psychological IPV experiences among Turkish ethnic minorities with predicted frequencies from different types of count regressions. Note. IPV = intimate partner violence.

Table 3 summarizes the results of the NB model for physical IPV victimization. As hypothesized (Hypothesis 1a), a significant effect was found for gender: Being a Turkish ethnic minority woman strongly increased the likelihood of physical aggression (603% increase relative to men). Furthermore, a higher level of education (relative to a low education level; $RR = 0.32$, a 68% decrease) and currently being in a romantic relationship

Table 3. Summary of Main Effects of the NB (Physical IPV) and NBLH (Psychological IPV) Models Testing Gender Differences and Sociodemographic Control Variables.

Variables	Physical IPV			
	RR (e^B)	95% CI		
Gender ^a	6.03***	[2.40, 18.55]		
Age	1.01	[0.98, 1.05]		
Education ^b	0.32**	[0.09, 0.93]		
Romantic relationship ^c	0.43**	[0.21, 0.84]		
Frequency contact friends	1.06	[0.78, 1.46]		
Frequency contact family	0.86	[0.66, 1.11]		
Social support	1.03	[0.62, 1.71]		
Racial discrimination	1.19	[0.66, 2.06]		
Religion	1.04	[0.70, 1.60]		
Income	1.90	[0.94, 3.85]		
Perception income	0.93	[0.74, 1.15]		

Variables	Psychological IPV			
	Zero-Inflation Part		Counts Part	
	OR (e^B)	95% CI	RR (e^B)	95% CI
Gender ^a	0.74	[0.40, 1.37]	1.23	[0.90, 1.70]
Age	0.96***	[0.93, 0.99]	1.01	[0.99, 1.02]
Education ^b	0.52	[0.24, 1.11]	1.27	[0.87, 1.84]
Romantic relationship ^c	0.83	[0.42, 1.63]	0.45***	[0.33, 0.60]
Frequency contact friends	1.05	[0.82, 1.35]	1.03	[0.91, 1.16]
Frequency contact family	0.98	[0.78, 1.23]	1.04	[0.94, 1.16]
Social support	0.68	[0.41, 1.10]	0.69***	[0.54, 0.87]
Racial discrimination	1.39	[0.88, 2.20]	1.13	[0.91, 1.40]
Religion	1.66***	[1.19, 2.32]	1.02	[0.84, 1.24]
Income	1.49	[0.75, 2.94]	1.09	[0.78, 1.53]
Perception income	1.06	[0.88, 1.28]	0.94	[0.86, 1.04]

Note. NB = negative binomial; IPV = intimate partner violence; NBLH = negative binomial logit hurdle; OR = odds ratios; RR = rate ratio; CI = confidence interval.

^aReference category is male.

^bEducation level was recoded into education level lower than high school degree (reference category) and a high school degree or above.

^cReference category is not being in a romantic relationship.

** $p < .01$, *** $p < .001$.

(relative to being single; RR = 0.43, a 57% decrease) were significantly related to lower levels of lifetime physical IPV victimization. No significant effect was found for age, the frequency of social contact with family or friends, social support, racial discrimination, religion, income, or the perception of income.

In contrast to our expectations (Hypothesis 1b), no significant effect was found for gender in either the zero-hurdle part or in the counts part of the NBLH model for psychological IPV. This implied that Turkish ethnic minority women were as likely as Turkish ethnic minority men to report lifetime experiences with psychological violence and that female and male victims reported no differences in frequency of experienced psychological aggression. Neither part revealed a significant effect for education level, frequency of social contact with family or friends, racial discrimination, income, and the perception of income. The zero-hurdle part only revealed a significant effect for age and religion: The odds of experiencing lifetime psychological violence decreased by 4% for every unit increase in age and increased by 66% for every unit increase in the importance an individual attached to religion. In the counts part, results revealed that victims who were in a romantic relationship (relative to singles; RR = 0.45; a 55% decrease) and those who mentioned higher levels of social support (RR = 0.69; a 31% decrease) reported less frequent acts of psychological violence.

IPV Victims' Mental, Relational, and Sexual Well-Being

Multivariate analysis of variance (i.e., MANOVA) was used to determine how lifetime IPV victimization affects victims' current mental, relational (i.e., relationship satisfaction, attachment anxiety, and avoidance) and sexual (i.e., sexual satisfaction and sexual communication) well-being to account for the interrelationships between all continuous dependent variables. Separate analyses were carried out for physical and psychological IPV, controlling for potential effects of gender, age, and education level. To explore whether intimate violence affects the mental, relational, or sexual well-being of Turkish women and men differently, interaction terms between gender and violence were included in both models. Table 4 demonstrates how IPV victimization is related to each of the six outcomes for women and men separately, and shows the differences in effects for both genders.

In contrast to our expectations, lifetime physical IPV victimization was unrelated to impaired mental health outcomes (Hypothesis 2a) in both Turkish men and women. In contrast to this, experiences with physical aggression were related to adverse relational outcomes, but gender differences were found: Women reported increased levels of relationship dissatisfaction (Hypothesis 3a) and avoidant attachment orientations (Hypothesis 5a), whereas men reported elevated levels of attachment anxiety (Hypothesis 4a). Furthermore, only women reported higher levels of sexual dissatisfaction (Hypothesis 6a) and no association was found with sexual communication (Hypothesis 7a).

Table 4. Summary of Univariate Analyses to Predict Male and Female Victims' Mental, Relational, and Sexual Well-Being from Physical and Psychological IPV Victimization.

Variables	Men			Women			Difference		
	B	SE	95% CI	B	SE	95% CI	B	SE	95% CI
Physical IPV^a									
Mental health	0.32	.31	[-0.29, 0.94]	-0.14	.15	[-0.43, 0.16]	0.46	.34	[-0.22, 1.14]
Relationship dissatisfaction	-0.22	.30	[-0.81, 0.37]	0.44**	.14	[0.16, 0.73]	-0.66*	.33	[-1.31, -0.01]
Anxious attachment	1.56***	.31	[0.94, 2.18]	-0.08	.15	[-0.38, 0.22]	1.64***	.35	[0.96, 2.32]
Avoidant attachment	0.63	.32	[-0.01, 1.26]	0.55***	.15	[0.25, 0.85]	0.08	.35	[-0.62, 0.78]
Sexual dissatisfaction	0.30	.30	[-0.29, 0.88]	0.31*	.14	[0.03, 0.59]	-0.01	.33	[-0.66, 0.64]
Sexual communication	0.45	.34	[-0.22, 1.11]	0.18	.16	[-0.13, 0.50]	0.26	.37	[-0.47, 0.99]
Psychological IPV^b									
Mental health	0.03	.04	[-0.06, 0.11]	-0.04	.03	[-0.10, 0.01]	0.07	.05	[-0.03, 0.17]
Relationship dissatisfaction	0.10*	.04	[0.02, 0.17]	0.14***	.03	[0.09, 0.19]	-0.05	.05	[-0.14, 0.04]
Anxious attachment	0.06	.04	[-0.03, 0.14]	0.04	.03	[-0.02, 0.09]	0.02	.05	[-0.08, 0.12]
Avoidant attachment	0.08	.04	[0.00, 0.16]	0.15***	.03	[0.09, 0.20]	-0.07	.05	[-0.17, 0.03]
Sexual dissatisfaction	0.05	.04	[-0.03, 0.13]	0.08**	.03	[0.03, 0.14]	-0.03	.05	[-0.12, 0.07]
Sexual communication	0.05	.04	[-0.03, 0.14]	0.08**	.03	[0.02, 0.14]	-0.03	.05	[-0.13, 0.08]

Note. B values are standardized regression coefficients. IPV = intimate partner violence.

^aMultivariate tests using Wilks's Λ revealed no significant effects for gender, $F(6, 177) = 1.37, p = .23$, education level, $F(6, 177) = 1.03, p = .41$, age, $F(6, 177) = 1.56, p = .16$. Significant effects were found for physical IPV, $F(6, 177) = 4.59, p < .001$, and Gender \times Physical IPV, $F(6, 177) = 6.77, p < .001$.

^bMultivariate tests using Wilks's Λ only revealed significant effects for psychological IPV, $F(6, 156) = 5.87, p < .001$. No significant effects were found for gender, $F(6, 156) = 0.69, p = .66$, education level, $F(6, 156) = 1.20, p = .31$, age, $F(6, 156) = 1.37, p = .23$, and Gender \times Psychological IPV, $F(6, 156) = 1.37, p = .53$.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Similar to lifetime physical IPV, lifetime experiences of psychological violence were not associated with victims' mental health scores (Hypothesis

2b). Whereas both victimized women and men reported increased levels of relationship dissatisfaction (Hypothesis 3b), only women reported more attachment avoidance (Hypothesis 5b), sexual dissatisfaction (Hypothesis 6b), and more difficulties with sexual communication (Hypothesis 7b). No effect was found for attachment anxiety (Hypothesis 4b).

The relationship between lifetime experiences with physical or psychological IPV and respondents' current sexual functioning (i.e., a three-leveled outcome variable) was assessed through two separate multinomial logistic regression analyses. No significant interaction terms were found, indicating that physical and psychological IPV victimization did not affect Turkish women and men's sexual functioning differently. Results showed that physical violence was not associated with sexual dysfunction without distress (compared with no dysfunction). In contrast, compared with no dysfunction, higher levels of physical IPV increased the odds of sexual dysfunction *with* distress by a factor of 4.58 (95% CI [2.39, 8.76]). More pronounced results were found for psychological IPV victimization. Compared with no dysfunction, higher levels of psychological violence increased the odds of sexual dysfunction without distress by a factor of 1.16 (95% CI [1.04, 1.29]) and the odds of sexual dysfunction *with* distress by a factor of 1.35 (95% CI [1.20, 1.51]).

Discussion

The present study aimed at a better understanding of IPV among ethnic minorities, a topic that has only rarely been investigated outside the United States. More specifically, this study examined the occurrence of lifetime physical and psychological IPV in a population-based representative sample of Turkish immigrants in Flanders. In addition, this study aimed to assess how experiences with intimate violence affect victims' mental well-being as well as their relational and sexual well-being within their current intimate relationship.

Prevalence of IPV Among Ethnic Minorities

Lifetime prevalence estimates for IPV indicate that one in seven respondents have experienced physical violence and that two thirds of the respondents have experienced psychological violence at some point at the hands of an intimate partner. The frequency of these acts of aggression tended to be low, however. In line with theoretical assumptions and previous studies (Archer, 2006; Field & Caetano, 2004), the Turkish women in our sample were much more likely to have been confronted with physical violence than men. In

contrast, women and men were equally likely to have experienced psychological violence. This pattern of results raises the question of whether IPV in this Turkish ethnic minority community sample reflects the same dynamics as in a Western community sample. As mentioned before, it is not clear whether the distinction between common couple violence and intimate terrorism is relevant for non-Western communities. In line with the common couple violence perspective, most of the incidences of physical and psychological aggression reported were minor and no gender difference was found for psychological IPV. However, the fact that there is clearly more male-on-female physical aggression suggests that physical violence might be a manifestation of a patriarchal culture, where men try to dominate and control their female partners (i.e., intimate terrorism perspective; Johnson, 1995). Alternatively, drawing from the social role theory, it can be hypothesized that the Turkish women in our sample were less empowered, leaving them more vulnerable to experiencing physical IPV (Archer, 2006; Eagly & Wood, 1999). Indeed, results from a nationally representative survey on IPV in Turkey revealed that although women and men have equal rights in law, women are less empowered than men in day-to-day life (Yüksel-Kaptanoglu, Türkyılmaz, & Heise, 2012). This latter statement requires careful interpretation, however, as it is not easy to generalize results from a community sample in Turkey to the current context in which Turkish respondents form a minority population. In fact, it might be that this minority status causes societal stress (i.e., minority stress) in Turkish men, which in turn generates frustration and anger against society and oneself. As these feelings of anger and frustration cannot be acted out in public because of fear of stigmatization, aggression could be acted out against intimate partners (Colucci & Montesinos, 2013; Taft et al., 2009). These dynamics are only hypothetical and deserve to be investigated more in depth in future research.

Some sociodemographic factors have been cited in the literature as increasing the likelihood of IPV victimization (see Field & Caetano, 2004; Malley-Morrison & Hines, 2007; Stith et al., 2004). In contrast to what has been reported in the past, the frequency of social contact, degree of experienced racial discrimination, income level, and income perception were not found to be risk markers for physical or psychological violence in the present study. However, as expected, having a lower education level and currently being single was associated with higher reports of past physical violence. The odds of experiencing psychological violence increased with the degree of importance a participant attached to religion and decreased with age. These findings are in line with the literature. For instance, research has clearly demonstrated that younger adults are at increased risk for IPV victimization (Stith et al., 2004). This might be due to recall bias (i.e., older

respondents do not remember or report their experiences because it was long time ago) or due to the fact that older respondents start to develop adequate coping strategies to avoid the violence. With regard to religion, Timmerman et al. (2003) revealed that the immigration context might be harmful to the patriarchal role of young men. Consequently, the lack of power or threat of losing power (see subculture of violence theory) combined with the fact that these Turkish couples have a lower socioeconomic position in Belgium (see structural inequality theory) might explain why couples who attach great importance to religion are at increased risk for IPV victimization and perpetration. Furthermore, victims of more severe psychological violence were more likely to be single and less likely to have a good social support network.

Impact of IPV Victimization on Ethnic Minorities' Well-Being

Neither physical nor psychological IPV victimization was related to negative mental health outcomes, which is an unexpected finding compared with the large majority of studies documenting mental well-being of IPV victims. A possible explanation for the absence of an effect on mental health could be the nature of the health outcome. Cross-cultural research on well-being has demonstrated that in response to distress, non-Western cultures have a tendency to somatize whereas Western cultures are likely to psychologize (Beirens & Fontaine, 2011; Keyes & Ryff, 2003). Indeed, Beirens and Fontaine (2011) found that both Turkish immigrants and Turkish majorities reported higher levels of somatization compared with Belgian majorities. Hence, it could be that in the current study, IPV had no effect on victims' mental well-being but was expressed in the form of somatic symptoms. Unfortunately, the current study did not incorporate a somatic complaints scale that could examine the effect of IPV on somatization. The lack of effect of IPV on mental health can additionally be explained by cultural differences regarding the shape, expression, and intensity of emotions (Markus & Kitayama, 1991). Emotional processes are influenced by the cultural view of the self (Kitayama, Park, Sevincer, Karasawa, & Uskul, 2009). Kitayama and colleagues (2009) have argued that Western cultures accentuate a view of the self as *independent* while non-Western cultural contexts emphasize a view of the self as *interdependent*. According to this interdependent view of the self, the expression of adverse individual feelings such as mental difficulties does not contribute to social harmony. Consequently, individuals are directed to restrain their inner feelings and to avoid the expression of negative emotions. We have to stress that the present study describes the results of a limited sample and not IPV among ethnic minorities in general, although there may

be some comparable and patterned similarities to other particular ethnic minorities.

The interpersonal context (i.e., the self in relation to the other) is focal among people with an interdependent idea of the self, and this becomes clear when examining how violence at the hands of an intimate partner affects a victim's relational well-being. In general, the results concerning the association between IPV and relationship satisfaction are in line with the literature (e.g., S. L. Williams & Frieze, 2005) and add to the body of knowledge on gender differences in IPV relational outcomes (Caldwell et al., 2012). That is, lifetime experiences of violence by an intimate partner appear to have a negative impact on victims' relationship satisfaction. Women were more likely to be dissatisfied with their current relationship if they had ever experienced physical and psychological violence. Men were only more dissatisfied when they had experience of psychological violence. The present study also revealed higher levels of avoidant attachment orientation among female victims of physical and psychological victimization, whereas men scored higher on attachment anxiety if they had ever experienced physical violence. Given that individuals from interdependent cultures are inclined to judge themselves in terms of highly valued others (Markus & Kitayama, 1991) and that they tend to report higher levels of preoccupied attachment orientations (i.e., positive model of Other and negative model of Self; Schmitt et al., 2004), it is not surprising that experiences with violence in a romantic relationship negatively affect attachment orientation.

Finally, we found evidence for impaired sexual well-being at the relationship level if the participant had ever experienced IPV. The effects were most pronounced among female victims reporting psychological aggression. These women reported decreased levels of sexual satisfaction and sexual communication, and increased levels of sexual dysfunction with and without distress. Physical IPV was associated with more sexual dissatisfaction and sexual dysfunction with distress among both women and men. To the best of our knowledge, this study is among the first to examine IPV victims' sexual well-being at the relationship level in a population-based sample of Turkish immigrants. The observed gender differences indicate that, as is generally reported in the literature for other groups (e.g., Birnbaum, Reis, Mikulincer, Gillath, & Opraz, 2006), the relational context is more important for determining sexual functioning of women than men. Furthermore, as no significant effect for sexual communication when experiencing physical violence was found for either men or women, this could possibly be explained from a cultural perspective on intimacy. It has been suggested that people in intimate relationships with more traditional gender roles are less likely to self-disclose on sexual matters (Marshall,

2008). Accordingly, it seems reasonable to assume that physical IPV experiences do not influence the extent to which IPV victims discuss their sexual wishes with their intimate partner. In conclusion, our findings indicate that IPV negatively affects victims' relational and sexual well-being within their current intimate relationship, and that the effect of IPV on the relational and sexual well-being is more negative for women than men.

Certain features of the present study are noteworthy. First, the prevalence estimates must be interpreted with caution. Prevalence numbers vary enormously according to the way data are collected. In line with most studies in this field, the present study reports on the findings of a self-report survey, and it is important to consider the limitations of this technique (Malley-Morrison & Hines, 2007). For this study, this implies that there might be an effect of community and cultural factors on the self-reporting rates of IPV victimization (White, Yuan, Cook, & Abbey, 2013). These include that the violence must first be considered as non-normative. From a culture-specific gender role perspective, some Turkish women may accept a certain level of violence and some Turkish men may refuse to consider themselves as victims and thus do not regard their experiences as problematic (White et al., 2013). In addition, some victims may have perceived themselves as victims but found it inappropriate to disclose this in a research context because IPV is a strictly private matter in certain cultures (e.g., Turkey; Yüksel-Kaptanoğlu et al., 2012), and not a topic of conversation (White et al., 2013). Furthermore, although many forms of aggression do not appear to differ between immigrants and non-immigrants, it has been shown that immigrant women might face additional forms of psychological aggression (e.g., prohibition of wearing Western clothes; see Raj & Silverman, 2002 for an overview). Therefore, to capture the full range of IPV experiences among ethnic minorities, some additional cultural-specific questions should be added to the standard measurements. Culture is not a static, homogeneous concept. It incorporates competitive and conflicting values. When comparing a majority group with a minority group, these nuances and differences within a culture are often ignored or forgotten. Therefore, we plead for a detailed examination of the context. Future research among ethnic minorities would therefore benefit from a mixed-methods approach (i.e., qualitative *and* quantitative research) to consider the cultural norms, perceptions, beliefs, and socially acceptable behaviors within the community (Sokoloff & Dupont, 2005; White et al., 2013). For instance, Western Turkey is more economically and socially advanced than Eastern Turkey, which might reflect internal different lifestyles between the Turkish respondents in our sample (Yüksel-Kaptanoğlu et al., 2012). Furthermore, research has clearly demonstrated that among dating couples, IPV patterns are similar across different cultures. However, a

different pattern is seen among married couples. That is, gender differences in IPV victimization rise when there is more gender inequality between both partners (Archer, 2006; Bartholomew & Cobb, 2011). These findings further underscore the importance of examining to what extent cultural aspects add to the larger context in which the violence takes place.

Second, the data relied on a population-based sample and therefore presents mainly mild forms of aggression. Additional data from clinical research is necessary to get an idea of the extent of more severe forms of aggression and to examine how severe abuse affects the well-being of members of ethnic minorities. Third, the study is cross-sectional. Therefore, it is unclear from this data whether IPV caused the health effects that are examined, whether the effects caused IPV, or—most probably—whether the relationship is reciprocal. However, given the temporal order of the measurements in the current study (i.e., IPV in current/former relationship vs. current mental, relational, and sexual well-being), we considered the health effects as outcomes. Fourth, despite their theoretical relevance, both the attachment scale (ECR-S) and the sexual communication scale (DSC) proved to be weakly internally consistent in this study. These shortened versions were used to save time, but future research would benefit from using the full versions of these scales.

Despite these limitations, the present study expands the scope of current research by addressing the occurrence of IPV, as well as different aspects of victims' well-being, in an ecologically valid, population-based sample of an ethnic minority population. A further exploration of the association between IPV victimization, mental health, and relational and sexual well-being within ethnic minority victims' intimate relationships is essential to deepen our understanding of IPV and well-being, for organizing adequate prevention campaigns, and for allocating sufficient resources for helping immigrant victims. By providing statistical evidence of the extent of IPV in this specific population, researchers play a pivotal role in making this a social issue (S. L. Williams & Frieze, 2005). Influenced at least partially by the prevalence estimates provided in surveys such as ours, policy makers address this issue on the societal or local level. In Belgium, these include a wide range of interventions such as, for instance, the development of a national action plan (NAP) to combat IPV within each legislation. The NAP of 2010 to 2014 to combat intimate violence indicates that special attention should be paid to immigrants as they are a vulnerable group for IPV victimization (due to their lack of knowledge about Belgium support services, language barriers, and risk of isolation). We hope that our study on IPV among Flemish people from Turkish origin supports the need to focus on this population.

Authors' Note

This research is the work of the “Sexpert II Project” on sexual health in Flanders at the Ghent University, Ghent University Hospital, and the University of Leuven (<http://www.sexpert-vlaanderen.be/>).

Acknowledgments

We thank all participants, team members, and promoters, and gratefully acknowledge the Agency for Innovation by Science and Technology in Flanders for supporting the project financially.

Declaration of Conflicting Interests [AQ10]

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Note

1. The original sexual satisfaction scale consists out of five items, but one item was dropped out in the computer program and could not be retrieved.

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Author Biographies **IAQI3**

Sabine Hellemans, a-PhD student, is a post-doctoral research assistant at the Faculty of Psychology and Educational Sciences, Department of Experimental-Clinical and Health Psychology, Research Group of Relationship and Family Studies at Ghent University, Ghent, Belgium. In her research, she focuses on intimate partner violence in heterosexual and same-sex relationships.

Tom Loeys, PhD, is a professor at the Faculty of Psychology and Educational Sciences, Department of Data Analysis at Ghent University, Ghent, Belgium. His research focuses on mediation analysis and dyadic data analysis with applications in clinical psychology.

Ann Buysse, PhD, is a professor at the Faculty of Psychology and Educational Sciences, Department of Experimental-Clinical and Health Psychology, Research Group of Relationship and Family Studies at Ghent University, Ghent, Belgium. She focuses on the integration of basic and applied research in the field of personal relationships, family studies, and marital and family therapy. More specifically, her research interests include the basic mechanisms that underlie both healthy and pathological relationships, including sexual health, divorce, and children and divorce in particular.

Olivia De Smet, PhD, is a post-doctoral research assistant at the Faculty of Psychology and Educational Sciences, Department of Experimental-Clinical and Health Psychology, Research Group of Relationship and Family Studies at Ghent University, Ghent, Belgium. Her research focuses on explanatory research within the domain of stalking. She is more specifically familiar with the examination of the occurrence and risk factors of unwanted relationship pursuit in populations of ex-partners.