

Qual Life Res
DOI 10.1007/s11136-014-0766-9

Intimate partner violence and health-related quality of life in European men and women: findings from the DOVE study

Diogo Costa · Eleni Hatzidimitriadou · Elli Ioannidi-Kapolou · Jutta Lindert · Joaquim Soares · Örjan Sundin · Olga Toth · Henrique Barros

Accepted: 21 July 2014
© Springer International Publishing Switzerland 2014

Abstract

Purpose Little is known on the specific relation between being a perpetrator or both a victim and perpetrator of intimate partner violence (IPV) and health-related quality of life (HRQoL). We assessed the association between HRQoL and abuse, considering men and women as victims, perpetrators or reciprocally.

Methods Participants were adult men and women ($n = 3,496$), randomly selected from the general population of six European cities. The Revised-Conflict-Tactics-Scales and the Medical-Outcomes-Study 36-item Short-Form Health Survey (SF-36) were used to measure IPV and HRQoL. The age-, education-, and city-adjusted mean scores[standard error] of the physical and of the mental SF-

36 component summaries were used to compare victims-only, perpetrators-only, and those involved in both (bidirectional or reciprocal cases) with those not involved in past-year and lifetime physical assault and/or sexual coercion.

Results The physical component summary was significantly lower in women involved in past-year bidirectional physical assault compared with non-abused women. The mental component summary in women not involved in IPV was significantly higher than in those physically abused, regardless of type of involvement. Women victims-only of past-year sexual coercion and victims or involved in bidirectional concomitant physical and sexual IPV also presented lower scores in the mental component summary than women not involved in IPV. In men, significantly lower scores in the mental component summary were found in the past-year bidirectional physically assaulted group and among those involved bidirectionally in both physical and sexual IPV compared with men not involved in IPV.

Electronic supplementary material The online version of this article (doi:10.1007/s11136-014-0766-9) contains supplementary material, which is available to authorized users.

D. Costa (✉) · H. Barros
Institute of Public Health, University of Porto, Rua das Taipas,
135, 4050-600 Porto, Portugal
e-mail: dmcosta@med.up.pt

D. Costa · H. Barros
Department of Clinical Epidemiology, Predictive Medicine and
Public Health, University of Porto Medical School, Porto,
Portugal

E. Hatzidimitriadou
Faculty of Health and Social Care Sciences, Kingston University
and St George's, University of London, London, UK

E. Ioannidi-Kapolou
Department of Sociology, National School of Public Health,
Athens, Greece

J. Lindert
University of Emden, Emden, Germany

J. Lindert
Brandeis University, Waltham, MA, USA

J. Soares
Institution for Health Sciences, Mid Sweden University,
Sundsvall, Sweden

Ö. Sundin
Department of Psychology, Mid Sweden University, Östersund,
Sweden

O. Toth
Institute of Sociology, Hungarian Academy of Sciences,
Budapest, Hungary

Conclusion Experiencing physical and sexual IPV is negatively associated with HRQoL. Lower scores in the mental component summary of the SF-36 are evident among female victims and among males and females involved in intimate partner violence as both victims and perpetrators when compared to females and males not involved in violence.

Keywords Intimate partner violence · Europe · Multicenter study · Health-related quality of life

Introduction

Quality-of-life is an important outcome measure in routine clinical practice and in research [1]. More specifically, health-related quality-of-life (HRQoL) involves perceptions of well-being and functioning in physical, mental, social, and daily life activities that comprise a summary quantification of perceived health [2]. Health-related quality of life is a quantitative summary measure of the effect of a condition on individual's lives, and it provides an estimate of the potential benefit of interventions. Health-related quality of life is useful in decision making on prioritization of resources across competing programs and interventions [3].

Intimate partner violence (IPV) is a human rights violation. It is a major public health problem [4], defined as any physical, sexual, or psychological harm inflicted by a current or former partner. Worldwide, more than 30 % of women are victims of IPV [5]. Less is known about male victimization, but the published data, mainly from English speaking populations, pointed to a 25 % prevalence [6].

Short- and long-term adverse physical and mental health consequences of IPV [4, 7], including a decreased HRQoL [8, 9], have often been reported, but focused only in victims [9–11]. However, reciprocal or bidirectional violence, defined as involvement as both a victim and perpetrator, is thought to be the most commonly identified profile of IPV when dealing with general population samples [12], although previous studies looking at bidirectional IPV mainly dealt with university student samples or adolescent samples from the US [13, 14]. Studies performed with clinical samples suggested that bidirectional IPV is more strongly associated with adverse health outcomes than unidirectional violence [15, 16]. Exploring the experiences of victims and perpetrators might also elucidate different sex patterns of associations, as shown in a large Canadian cross-sectional telephone survey, where depressive symptoms were more often reported by female victims and male perpetrators [17].

The association between HRQoL and the type of involvement in IPV remains poorly described, and to the best of our knowledge, it was never assessed using a multiple country sample. With the present investigation,

we explored in a general population sample of men and women living in six European cities how experiencing abuse as victims, perpetrators or reciprocally is associated with HRQoL.

Methods

Participants

We used data collected as part of the DOVE project (<http://doveproject.eu>), a European multinational research project designed to evaluate the frequency of IPV and health-related associated factors. In the present study, participants were non-institutionalized adult men and women (aged 18–65), national citizens or documented migrants, sampled from the general population of six cities (Athens—Greece, Budapest—Hungary, London—United Kingdom, Östersund—Sweden, Porto—Portugal and Stuttgart—Germany) although two other cities (Ghent, Granada) were initially thought but could not reach the targeted sample size [18].

Random sample lists were obtained through city's municipality registries in Stuttgart, through the electoral registry in Porto and London and through the state person address registry in Östersund. Additional sampling strategies included random-digit dialing in Porto and a via-public approach in London. Random route was used in Athens and Budapest. We previously described and discussed the design, methods, procedures, and characteristics of the samples in comparison with the resident population [18]. The final sample comprised 3,496 participants, 1,470 men and 2,026 women.

A questionnaire was developed, comprising information on socio-demographic characteristics, intimate relationships, physical, and mental health. In all cities, the IPV section was self-administered and, except for Östersund, face-to-face interviews were conducted for the remaining topics. In Östersund, the local ethics committee required all questionnaires to be mailed with a prepaid envelope for return. In Porto, London, and Stuttgart, if participants were otherwise unreachable or explicitly asked for it, questionnaires were also mailed to their homes following the same procedure. The World Health Organization (WHO) ethical and safety guidelines for the conduct of research on violence against women were followed [19]. In the case of posted questionnaires, a letter was sent detailing the study objective, the participant's selection procedures, and explaining the anonymous character of responses. It also included the full names and contacts of the research team (telephone, e-mail), institution, funding agency, and project website. The study protocol was approved by a Research Ethic Committee in each center. Data collection lasted approximately 9 months and ended in May 2011.

Outcome measure

The outcome measure was the physical and mental component summaries derived from the eight domains of the Medical-Outcomes Study 36-item Short-Form Health Survey (SF-36) [20]. The SF-36 as a measure of health-related quality of life refers to functional health and well-being in the previous 4 weeks and has been widely tested and used in several countries, namely in all the countries represented in this study [21–26].

The physical and mental component summaries of SF-36 were computed following recommendation for their use in multinational comparisons [27]: All eight domains of the SF-36 (physical functioning, physical role functioning, bodily pain, general health, vitality, social functioning, emotional role functioning, and mental health) were standardized using a linear *z*-score transformation obtained by subtracting domain means for the general US population from each domain score in our sample and dividing the difference by the standard deviation of the US population; these *z*-scores were then multiplied by the component factor score coefficient for physical and mental health summaries as obtained from the factorial analysis extracted for the US population and summed over the eight domains; the resulting physical and mental summary scales sums were then *t*-scored (multiplied by 10 and added 50). The higher the scores, the better expected HRQoL.

Exposure measure

The physical assault and sexual coercion subscales of the Revised Conflict Tactics Scales (CTS2) were used to define exposure to physical and/or sexual IPV [28]. The CTS2 was originally developed in English and has been used in more than 100 studies, including in multinational comparisons. It was previously validated to Portuguese, German, and Swedish populations [29, 30]. Translations to Greek and Hungarian followed a standard protocol: forward translation, expert panel revision, back-translation, new expert panel revision, and piloting. The internal consistency of the CTS2 (Cronbach alpha) in our sample was 0.903 for victimization (ranging from 0.825 in Budapest to 0.956 in London) and 0.896 for perpetration (ranging from 0.748 in Östersund to 0.953 in London), in line with previous reliability analysis [30].

The CTS2 physical assault and sexual coercion subscales comprise, respectively, 12 and 7 specific acts or behaviors. It include minor acts (examples: “I threw something at my partner that could hurt,” “I made my partner have sex without a condom”) and severe acts (examples: “I used a knife or a gun on my partner,” “I used force (like hitting, holding down, or using a weapon to make my partner have oral or anal sex”). For each act,

participants are asked whether they have been victims or perpetrators and they are given an 8-options scale to mark if it happened: never, once in the past year, twice, 3–5, 6–10, 11–20, more than 20 times or ever but not in the past year. When all items describing each type of violence were answered as “never,” the participant was coded as a never victim or never perpetrator. To overcome the skewed time frequency response distribution, participants were recoded as victims-only, perpetrators-only or as involved in bidirectional violence.

Socio-demographic factors

Age was classified in 5 years groups: 18–24, 25–34, 35–44, 45–54, 55–64, and educational level in three: primary level, secondary level, university degree, according to completed stage of schooling.

Statistical analysis

T test and ANOVAs were used to compare mean scores (standard deviation) of the physical and mental component summaries of the SF-36 according to sex, age-groups, educational level, and city of residence. Chi-square test was used to compare the proportions.

The mean (standard errors) of the physical and mental component summaries of the SF-36 by type of involvement in violence were computed by fitting linear regression models. Models were adjusted for age, education, and city of residence and computed for physical assault, sexual coercion, and for concomitant physical assault and sexual coercion. We considered separately the experiences of past-year IPV and of having ever experienced IPV. We tested the interaction of sex and IPV by including the interaction term for each violence type. As there was a statistically significant interaction, we stratified the analysis by sex.

We then performed a pair-wise comparison of each estimated mean with the group declaring “no violence” using a Bonferroni correction.

From the 3,496 participants, there was missing information for physical assault in 182 (5.2 %), for sexual coercion in 183 (5.2 %) and 2 (0.1 %) did not provided the SF-36 evaluation. Only participants with complete information were used in the regression models, and no imputation was made for missing data.

An additional analysis was performed considering a measure of chronicity of abusive acts and is provided as supplementary material. Among participants who engaged in one or more acts of violence in the previous year, we added the midpoints for the frequency categories chosen and summed these acts for each type of violence. The midpoints considered were accordingly: one, two, four,

Table 1 Sample characteristics and mean scores for the SF-36 physical and mental component summaries according to socio-demographics

	Women <i>n</i> (%)	Men <i>n</i> (%)	Physical health		Mental health	
			Women Mean (SD)	Men Mean (SD)	Women Mean (SD)	Men Mean (SD)
Age						
18–24	253 (12.5)	181 (12.3)	54.15 (5.61)	56.14 (5.39)	48.07 (10.71)	51.93 (8.15)
25–34	396 (19.5)	315 (21.4)	53.43 (6.60)	54.33 (6.65)	47.66 (9.77)	50.22 (9.53)
35–44	436 (21.5)	341 (23.2)	51.66 (7.77)	54.11 (5.65)	49.10 (9.35)	49.88 (8.63)
45–54	433 (21.4)	314 (21.4)	49.82 (8.07)	50.78 (8.21)	47.48 (10.63)	49.29 (10.20)
55–64	508 (25.1)	319 (21.7)	46.55 (9.99)	48.51 (7.63)	49.37 (10.61)	51.52 (8.95)
<i>p</i> *			<0.001	<0.001	0.014	0.004
Education						
Primary	171 (8.7)	86 (6.0)	44.24 (10.15)	48.53 (9.61)	46.44 (12.20)	48.66 (11.50)
Secondary	933 (47.3)	749 (52.5)	50.39 (8.64)	52.03 (8.12)	47.90 (10.73)	49.89 (9.51)
University	869 (44.0)	593 (41.5)	52.22 (7.17)	53.68 (6.26)	49.33 (9.17)	51.39 (8.36)
<i>p</i> *			<0.001	<0.001	<0.001	0.002
City						
Athens	276 (13.6)	272 (18.5)	51.05 (7.54)	53.48 (7.26)	48.99 (9.71)	49.17 (8.62)
Budapest	356 (17.6)	248 (16.9)	50.72 (9.75)	53.68 (7.51)	50.09 (10.37)	51.97 (8.94)
London	298 (14.7)	273 (18.6)	51.72 (8.19)	50.86 (9.36)	46.72 (10.14)	49.27 (9.50)
Östersund	370 (18.3)	222 (15.1)	50.97 (9.20)	52.45 (7.29)	49.32 (9.88)	52.18 (8.99)
Porto	408 (20.1)	227 (15.4)	48.20 (7.69)	51.35 (6.12)	46.27 (11.39)	49.59 (10.32)
Stuttgart	318 (15.7)	228 (15.5)	51.93 (8.48)	53.08 (7.16)	49.31 (8.72)	50.81 (8.54)
<i>p</i> *			<0.001	<0.001	<0.001	<0.001
Total			50.64 (8.48)	52.48 (7.63)	48.41 (10.23)	50.44 (9.23)
<i>p</i> †			<0.001		<0.001	

SD standard deviation

* *p* value ANOVA comparing mean scores of the SF-36 component summaries

† *p* value for *T* test comparing mean scores of the SF-36 component summaries in women versus men

eight, 15, and 25, as suggested by the original scale' author [31]. The mean number (standard deviation) of violent acts was computed according to violence involvement and severity subscales. *T* test was used to compare the mean number of minor and severe acts by sex. Correlations between the number of acts and the physical and mental component summaries of the SF-36 were also estimated separately for minor and severe acts of violence among participants reporting victimization, perpetration, and bidirectional involvement. The analyses were conducted using SPSS v20.

Results

In general, mean SF-36 physical and mental component summaries were higher in men than women (Table 1) and increased with the educational level in both sexes. The physical component summary mean score also significantly decreased with age in both sexes.

Statistically significant differences were found according to city of residence: The lowest mean scores for the physical component summary were observed in Porto for women (48.20 [7.69]) and in London for men (50.86

[9.36]), while the highest were observed in Stuttgart for women (51.93 [8.48]) and in Budapest for men (53.68 [7.51]); for the mental component summary, the lowest mean was observed in Porto for women (46.27 [11.39]) and in Athens for men (49.17 [8.62]), while the highest were observed in Budapest for women (50.09 [10.37]) and in Östersund for men (52.18 [8.99]).

As shown in Table 2, the past-year prevalence of victimization-only, perpetration-only and bidirectional physical assault in women was 3.5, 4.2 and 10.0 %, respectively, while the corresponding figures for men were 4.1, 3.8 and 11.9 %, with no sex differences. For sexual coercion, 7.7 % of women and 3.0 % of men declared to be only victims, 1.6 % of women and 7.5 % of men declared only perpetration, and 9.7 % of women and 12.5 % of men declared bidirectional involvement ($p < 0.05$). The observed frequency of concomitant involvement in physical assault and sexual coercion was 1.2 % in women and 0.5 % in men for victimization only, 0.2 % in women and 0.8 % in men for perpetration only, and 4.0 % in women and 5.1 % in men for bidirectional involvement ($p < 0.05$).

After adjustment for age, education, and city of residence, women involved in bidirectional physical assault presented a significantly lower physical component

Table 2 Adjusted mean scores for the SF-36 physical and mental component summaries, in women and men according to directionality of involvement in past-year physical assault and sexual coercion as types of intimate partner violence

	Women <i>n</i> (%)	Men <i>n</i> (%)	Physical health		Mental health	
			Women Adjusted mean (SE) ^a	Men Adjusted mean (SE) ^a	Women Adjusted mean (SE) ^a	Men Adjusted mean (SE) ^a
Physical assault						
No	1,592 (82.4)	1,108 (80.2)	49.75 (0.26)	51.96 (0.30)	49.09 (0.34)	50.25 (0.40)
Victim	67 (3.5)	56 (4.1)	49.09 (0.99)	52.15 (0.96)	42.05 (1.26)*	49.31 (1.27)
Bidirectional	193 (10.0)	165 (11.9)	48.00 (0.58)*	50.48 (0.59)	42.86 (0.73)*	46.34 (0.78)*
Perpetrator	81 (4.2)	52 (3.8)	48.76 (0.88)	51.96 (0.98)	45.46 (1.11)*	50.07 (1.30)
Sexual coercion[‡]						
No	1,566 (81.0)	1,063 (77.0)	49.64 (0.26)	51.71 (0.30)	48.26 (0.34)	50.04 (0.40)
Victim	149 (7.7)	41 (3.0)	49.27 (0.67)	53.81 (1.10)	44.74 (0.86)*	48.94 (1.47)
Bidirectional	187 (9.7)	173 (12.5)	48.01 (0.61)	51.70 (0.58)	46.85 (0.79)	48.14 (0.77)
Perpetrator	31 (1.6)	103 (7.5)	49.92 (1.44)	52.03 (0.71)	48.30 (1.87)	49.09 (0.95)
Physical assault and sexual coercion[‡]						
No	1,371 (94.6)	916 (93.6)	49.46 (0.29)	51.41 (0.34)	49.11 (0.36)	50.62 (0.43)
Victim	18 (1.2)	5 (0.5)	49.86 (1.90)	53.89 (3.12)	41.43 (2.36)*	45.97 (3.95)
Bidirectional	58 (4.0)	50 (5.1)	47.21 (1.04)	49.31 (1.03)	43.34 (1.30)*	46.17 (1.30)*
Perpetrator	3 (0.2)	8 (0.8)	39.57 (4.49)	54.29 (2.47)	48.42 (5.59)	51.98 (3.12)

* $p < 0.05$ for comparison with the “no-violence” group (Bonferroni correction was used in pair-wise comparison)

[‡] $p < 0.05$ for chi-square test comparing the prevalence of violence by sex

^a Adjusted for age, education, and city of residence; *SE* standard error

summary mean score (48.00 [0.58]) than those declaring no physical assault (49.75 [0.26]). No other significant difference was observed regarding the physical component summary.

A statistically significant lower mean score in the mental component summary of the SF-36 was found in the group of women involved in physical assault as victims and also in the group involved in bidirectional physical assault and in the group reporting perpetration of physical assault, compared with women reporting no past-year physical assault. The scores were also significantly lower among women only victims of sexual coercion compared with those who did not report past-year sexual coercion. Women who were victims only and who were involved in bidirectional physical and sexual IPV also presented lower mental component summary mean scores than those reporting no violence. In men, significant lower mental component summary scores were observed among those involved in bidirectional physical assault, and in bidirectional concomitant physical assault and sexual coercion, compared with those not involved in IPV.

Table 3 shows the results for ever experiencing physical assault and sexual coercion. In women, 5.6 % reported having ever been victims or perpetrators of physical assault and 15.9 % reported ever being involved in bidirectional physical assault. In men, these proportions were 5.4 %

victims, 5.4 % perpetrators, and 18.4 % for bidirectional involvement. Lifetime victimization-only of sexual coercion was declared by 11.3 % of women and 3.5 % of men, bidirectional sexual coercion was 13.9 % in women and 18.9 % in men, and the prevalence of having ever perpetrated sexual coercion was 1.7 % in women and 8.9 % in men ($p < 0.05$). Victims-only of both physical assault and sexual coercion were 2.8 % in women and 0.8 % in men, perpetrators-only were 0.2 % in women and 1.7 % in men, and bidirectional involvement was 7.5 % in women and 11.4 % in men ($p < 0.05$).

In the models adjusted for age, education, and city of residence, we observed a lower mean score in the physical component summary of the SF-36 among women involved in violence bidirectionally. The difference was statistically significant when compared to women who declared no lifetime experience of the two types of violence considered. For the mental component summary, mean scores were lower for those involved in violence compared with those who never experienced it. Statistically significant differences when compared to those never involved in IPV were observed for women involved in physical assault (victims, perpetrators, and bidirectionally), women victims-only of sexual coercion, women victims and involved in bidirectional concomitant physical assault and sexual coercion, and for men involved in bidirectional physical

Table 3 Adjusted mean scores for the SF-36 physical and mental component summaries, in women and men according to directionality of involvement in lifetime physical assault and sexual coercion as types of intimate partner violence

	Women <i>n</i> (%)	Men <i>n</i> (%)	Physical health		Mental health	
			Women Adjusted mean (SE) ^a	Men Adjusted mean (SE) ^a	Women Adjusted mean (SE) ^a	Men Adjusted mean (SE) ^a
Lifetime physical assault						
No	1,407 (72.8)	978 (70.8)	49.83 (0.28)	51.99 (0.31)	49.54 (0.35)	50.62 (0.41)
Victim	109 (5.6)	75 (5.4)	49.79 (0.77)	52.47 (0.84)	44.82 (0.98)*	49.85 (1.11)
Bidirectional	308 (15.9)	254 (18.4)	48.03 (0.47)*	51.14 (0.49)	43.05 (0.59)*	46.56 (0.65)*
Perpetrator	109 (5.6)	74 (5.4)	49.30 (0.76)	50.91 (0.83)	46.92 (0.96)*	48.65 (1.09)
Lifetime sexual coercion [‡]						
No	1,415 (73.2)	948 (68.7)	49.74 (0.27)	51.83 (0.31)	48.49 (0.35)	50.40 (0.42)
Victim	218 (11.3)	48 (3.5)	49.54 (0.56)	53.59 (1.03)	45.03 (0.73)*	48.71 (1.37)
Bidirectional	268 (13.9)	261 (18.9)	48.01 (0.51)*	51.20 (0.50)	46.65 (0.66)	47.84 (0.66)*
Perpetrator	32 (1.7)	123 (8.9)	49.45 (1.41)	51.92 (0.65)	48.26 (1.83)	48.77 (0.86)
Lifetime physical assault and sexual coercion [‡]						
No	1,137 (89.5)	752 (86.0)	49.70 (0.32)	51.60 (0.37)	49.73 (0.40)	50.90 (0.46)
Victim	36 (2.8)	7 (0.8)	50.51 (1.32)	53.18 (2.80)	44.69 (1.66)*	46.12 (3.51)
Bidirectional	95 (7.5)	100 (11.4)	46.71 (0.82)*	50.05 (0.76)	43.06 (1.03)*	46.35 (0.96)*
Perpetrator	3 (0.2)	15 (1.7)	39.71 (4.46)	50.53 (1.78)	48.20 (5.59)	48.79 (2.24)

* $p < 0.05$ for comparison with the “no-violence” group (Bonferroni correction was used in pair-wise comparison)

[‡] $p < 0.05$ for chi-square test comparing the prevalence of violence by sex

^a Adjusted for age, education, and city of residence; *SE* standard error

assault, bidirectional sexual coercion, and accumulating the latter two experiences.

Discussion

We found that HRQoL is associated with physical and sexual abuse and that it varied with sex and role in the victim/perpetrator process, being especially evident for the mental component summary of the SF-36. In models adjusted for age, education, and residence, women victims-only of lifetime or past-year physical assault and sexual coercion presented lower scores in the mental component summary of the SF-36 compared with women not experiencing violence, which was not observed among men victims-only. Declared past-year and lifetime victimization and perpetration of physical assault and of physical assault and sexual coercion cumulatively were associated with a decreased mental component summary in both men and women. Female perpetrators-only of physical assault presented a lower mental component summary, compared with those not involved in any type of violence for both lifetime and past-year periods.

The results found in the present study and concerning victims are in line with the findings in a Norwegian sample

of battered women, assessed in shelters, which showed a marked decrease in the mental health domains of the SF-36 [11]. Similarly, results from two Danish nationally representative, cross-sectional health interview surveys, revealed that victims of physical violence scored lower in HRQoL, and the effect was more pronounced in women than in men [10]. In our study, the accumulation of physical assault and sexual coercion in women victims represented a decrease in the mental component summary, as in a previous Australian study of the general population of women, for whom cumulative types of gender-based violence represented impaired quality of life [8]. Women victims of IPV present increased levels of depressive symptoms [32] and somatic complaints [33], have lower social support [34], all of which directly affect their health perception. Furthermore, physical assaults may directly increase the risk of injuries or predispose and aggravate some chronic diseases [35]. Although the severity of abuse impacts directly the physical health perception of a victim, the psychological stress associated with less severe types of IPV may also affect other acute or chronic health conditions through more indirect paths [36]. Etiologic studies are only in their beginnings, but the emotional suffering derived from any type of abuse is likely to affect the immune system as it responds to prolonged stress [37].

We also observed lower scores in the mental component summary of the SF-36 for men and women involved in bidirectional physical assault and in bidirectional concomitant physical assault and sexual coercion. This is in line with studies documenting that bidirectional violence might entail more severe acts [12, 38] and is associated with depressive symptoms [39], thus affecting the health perception of both men and women, particularly the domains linked to their mental health.

A significantly lower score in the physical component summary was only present in women involved in bidirectional violence during the previous year and lifetime compared with those not involved in IPV, which supports previous accounts of more deleterious health effects of IPV in women than in men [10] as a result of the physical conflict, and that considering the lifetime period helps elucidate sex differences present in factors associated with IPV experiences [40]. It has been suggested that women suffer more intimate partner violence victimization than men during their lifetime [40] and report more severe acts [41, 42]. An analysis of the chronicity of minor and severe acts of IPV in our sample (Supplementary Table 1) showed that women involved in past-year IPV reported more minor bidirectional physical assault acts and suffered more minor sexual coercion acts compared with men. No statistically significant sex difference was observed for the mean number of severe abusive acts, and the chronicity of IPV presents, essentially, negative correlations with the physical and mental component summaries of the SF-36.

In women, perpetration only of physical assault was also represented by a lower score in the mental component summary. Although the debate over the motivations of women's perpetration is still unresolved [43], previous studies linking depression with IPV perpetration in women suggest that feelings of guilt, shame, or regret might explain why women who perpetrate feel more depressed than non-perpetrators [17]. It has been suggested that depressive symptoms experienced by women who perpetrate are the result of a reaction to an event perceived as unusual to them, since their usual role is one of nurturing [44]. Thus, the same mechanism might explain the results found for the mental component summary of the SF-36, which includes domains linked to the individual's social functioning and emotional well-being, important characteristics of a depressive state.

Less is known about the impact of sexual coercion acts in HRQoL. It must be acknowledged that various types of violence generally coexist in the same violent intimate relationship [4, 45, 46], which increases the difficulty of disentangling the particular impact of each type of violence in HRQoL domains, should they prove to affect these domains differently. In women victims of past-year sexual coercion, we found a significantly lower score in the

mental component summary, which is in line with a previous Italian study documenting the impact of sexual IPV victimization to be greater for female student victims (compared with male), with higher odds for panic attacks, alcohol use, eating problems, and suicide ideation [47]. It has been suggested that sexual coercion against men is qualitatively different, less severe, and that men are more likely to accept force in their sexual relationships, while women find it unacceptable more often [48].

The fact that no significant difference in the physical and mental component summaries of men was found for past-year IPV may also be due to a social desirability bias, with men tending to demonstrate a tougher posture [47]. A 1988 study performed in college students already reported that among 22 men victims of sexual coercion, 25 % felt "good" about being forced to have sex, 50 % felt "neutral," and 25 % felt "bad," whereas none of the 32 women victims assessed felt "good" and 88 % felt "bad or very bad" after a sex incident [49]. Men victims of sexual coercion may perceive their situation as positive, thus not feeling harmed or violated, but rather see it as an opportunity for sexual intimacy, which would result in better health perceptions. Nevertheless, the effects of male sexual coercion victimization should be the focus of further explorations [50].

The main strengths of this study include the large sample size, the geographical diversity, and the measurement of both the exposure and outcome with two reliable and commonly used instruments: the CTS2 [28] and the SF-36 [2, 20]. However, the cross-sectional nature of our study does not allow inferences on causality. As in all studies assessing sensitive topics, the potential bias imposed by social desirability is a limitation [51]. Our samples were drawn from the general population of adults living in urban centers, but we used different sampling procedures, which might have led to selection bias. However, the age distribution of the study samples was close to the resident population in Athens, London, and Stuttgart, but in Budapest, Östersund, and Porto, participants were older, and the educational level in all cities was generally higher than the resident population, which might translate into underestimation of violence [18]. It was not possible to collect information on non-responses in all cities. However, registry-based sampling (municipal or electoral) and random route are expected to provide acceptable coverage of the target population [18]. The past experience of the research consortium determined the choice for the particular cities assessed based on the region where institutions were established. The sites included in this study are representing cultural and social features that were not considered in the analysis. These European urban centers are different regarding IPV campaigns, gender equality initiatives, laws, action plans, and support mechanisms, all

expected to influence prevalence rates and attitudes toward disclosure. Some of the differences might still reflect the effect of unmeasured social and cultural characteristics of the different sampling locations.

Although IPV experience was disclosed using self-administered questionnaires, it is plausible to think that victims of severe violence might reject participation or answer in a more socially acceptable way, especially regarding males from more “patriarchal” societies [52]. Also, using individual data (compared with couple) to assess IPV may lead to underreporting, both in men and women, but even more in men for IPV perpetration [53, 54], although support for underreporting was not found in posterior results obtained in representative sample of USA adolescents [12]. However, the assessment of couples may increase the risk of violence, thus relying in individual data is a safer option.

For clarity and because they are the most commonly measured types of violence, we only analyzed physical assault and sexual coercion reports. Further analysis should also consider the other violence types (e.g., psychological, injury).

In summary, the results of this study provide empirical evidence for an association between IPV and the HRQoL and that the influence of violence in HRQoL depends on the type of involvement in violence. Lower scores were consistently observed in the mental component summary of the SF-36 in female victims of physical assault or sexual coercion. However, women and men reporting bidirectional violence also presented lower scores in the mental component summary of the SF-36, which calls for a particular focus on the bidirectional nature of IPV when intervention strategies are designed.

Acknowledgments The authors would like to thank all men and women who generously participated in the DOVE project in the different cities across Europe. This work was supported by the Executive Agency for Health and Consumers—European Commission [Contract Number: 20081310] and the Portuguese Foundation for Science and Technology [SFRH/BD/66388/2009 and PTDC/SAU-SAP/122904/2010].

Conflict of interest None declared.

Ethical standard The manuscript does not contain clinical studies or patient data.

References

- Testa, M. A., & Simonson, D. C. (1996). Assessment of quality-of-life outcomes. *New England Journal of Medicine*, *334*(13), 835–840.
- Fayers, P. M., & Sprangers, M. A. (2002). Understanding self-rated health. *Lancet*, *359*(9302), 187–188.
- Wittenberg, E., Joshi, M., Thomas, K. A., & McCloskey, L. A. (2007). Measuring the effect of intimate partner violence on health-related quality of life: A qualitative focus group study. *Health and Quality of Life Outcomes*, *5*, 67.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet*, *359*(9314), 1331–1336.
- WHO. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and nonpartner sexual violence*. Geneva: World Health Organization.
- Desmarais, S., Reeves, K., Nicholls, T., Telford, R., & Fiebert, M. (2012). Prevalence of physical violence in intimate relationships: Part 1. Rates of male and female victimization. *Partner Abuse*, *3*(2), 1–6.
- Reid, R. J., Bonomi, A. E., Rivara, F. P., Anderson, M. L., Fishman, P. A., Carrell, D. S., et al. (2008). Intimate partner violence among men prevalence, chronicity, and health effects. *American Journal of Preventive Medicine*, *34*(6), 478–485.
- Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., et al. (2011). Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *Journal of the American Medical Association*, *306*(5), 513–521.
- Soares, J. J. F., Viitasara, E., & Macassa, G. (2007). Quality of life among lifetime victimized men. *Violence and Victims*, *22*(2), 189–204.
- Sørensen, J., Kruse, M., Gudex, C., Helweg-Larsen, K., & Brønnum-Hansen, H. (2012). Physical violence and health-related quality of life: Danish cross-sectional analyses. *Health and Quality of Life Outcomes*, *10*, 113.
- Alsaker, K., Moen, B. E., Nortvedt, M. W., & Baste, V. (2006). Low health-related quality of life among abused women. *Quality of Life Research*, *15*, 959–965.
- Whitaker, D. J., Haileyesus, T., Swahn, M., & Saltzman, L. S. (2007). Differences in frequency of violence and reported injury between relationships with reciprocal and nonreciprocal intimate partner violence. *American Journal of Public Health*, *97*(5), 941–947.
- Johnson, W. L., Giordano, P. C., Longmore, M. A., & Manning, W. D. (2014). Intimate partner violence and depressive symptoms during adolescence and young adulthood. *Journal of Health and Social Behavior*, *55*(1), 39–55.
- Straus, M. A. (2004). Prevalence of violence against dating partners by male and female university students worldwide. *Violence Against Women*, *10*(7), 790–811.
- Palmetto, N., Davidson, L. L., Breitbart, V., & Rickert, V. I. (2013). Predictors of physical intimate partner violence in the lives of young women: Victimization, perpetration, and bidirectional violence. *Violence and Victims*, *28*(1), 103–121.
- Shneyderman, Y., & Kiely, M. (2013). Intimate partner violence during pregnancy: Victim or perpetrator? Does it make a difference? *British Journal of Obstetrics and Gynaecology*, *120*(11), 1375–1385.
- Graham, K., Bernards, S., Flynn, A., Tremblay, P. F., & Wells, S. (2012). Does the relationship between depression and intimate partner aggression vary by gender, victim-perpetrator role, and aggression severity? *Violence and Victims*, *27*(5), 730–743.
- Costa, D., Soares, J. J. F., Lindert, J., Hatzidimitriadou, E., Sundin, O., Toth, O., et al. (2013). Intimate partner violence in Europe: Design and methods of a multinational study. *Gaceta Sanitaria*, *27*(6), 558–561.
- Ellsberg, M., Heise, L., Pena, R., Agurto, S., & Winkvist, A. (2001). Researching domestic violence against women: Methodological and ethical considerations. *Studies in Family Planning*, *32*(1), 1–16.

20. Ware, J., & Sherbourne, C. (1992). The MOS 36-item short-form health survey (SF-36). I. Conceptual framework and item selection. *Medical Care, 30*(6), 473–483.
21. Sullivan, M., Karlsson, J., & Ware, J. E. J. (1995). The Swedish SF-36 Health Survey—I. Evaluation of data quality, scaling assumptions, reliability and construct validity across general populations in Sweden. *Social Science and Medicine, 41*(10), 1349–1358.
22. Severo, M., Santos, A. C., Lopes, C., & Barros, H. (2006). Fiabilidade e validade dos conceitos teóricos das dimensões de saúde física e mental da versão portuguesa do MOS SF-36. *Acta Médica Portuguesa, 19*, 281–288.
23. Pappa, E., Kontodimopoulos, N., & Niakas, D. (2005). Validating and norming of the Greek SF-36 Health Survey. *Quality of Life Research, 14*, 1433–1438.
24. Bullinger, M. (1995). German translation and psychometric testing of the SF-36 Health Survey: Preliminary results from the IQOLA Project. International quality of life assessment. *Social Science and Medicine, 41*(10), 1359–1366.
25. Bowling, A., Bond, M., Jenkinson, C., & Lamping, D. L. (1999). Short Form 36 (SF-36) Health Survey questionnaire: Which normative data should be used? Comparisons between the norms provided by the Omnibus Survey in Britain, the Health Survey for England and the Oxford Healthy Life Survey. *Journal of Public Health Medicine, 21*(3), 255–270.
26. Czimbalmos, A., Nagy, Z., Varga, Z., & Husztik, P. (1999). Páciens megelégedettségi vizsgálat SF-36 kérdőívvel, a magyarszági normál értékek meghatározása. *Népegészségügy, 1*, 4–19.
27. Ware, J., Gandek, B., Kosinski, M., Aaronson, N. K., Apolone, G., Brazier, J., et al. (1998). The equivalence of SF-36 summary health scores estimated using standard and country-specific algorithms in 10 countries: Results from the IQOLA project. *Journal of Clinical Epidemiology, 51*(11), 1167–1170.
28. Straus, M. A., Hamby, S. L., & Warren, W. L. (2003). *The Conflict Tactics Scales handbook. Revised Conflict Tactics Scales (CTS2). CTS: Parent-child version (CTSPC)*. Los Angeles: Western Psychological Services.
29. Straus, M. A., & Mickey, E. L. (2012). Reliability, validity, and prevalence of partner violence measured by the conflict tactics scales in male-dominant nations. *Aggression and Violent Behavior, 17*, 463–474.
30. Straus, M. A. (2004). Cross-cultural reliability and validity of the revised Conflict Tactics Scales: A study of university student dating couples in 17 nations. *Cross-Cultural Research, 38*, 407–432.
31. Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues, 17*(3), 283–316.
32. Bonomi, A. E., Thompson, R. S., Anderson, M., Reid, R. J., Carrell, D., Dimer, J. A., et al. (2006). Intimate partner violence and women's physical, mental, and social functioning. *American Journal of Preventive Medicine, 30*(6), 458–466.
33. Eberhard-Gran, M., Schei, B., & Eskild, A. (2007). Somatic symptoms and diseases are more common in women exposed to violence. *Journal of General Internal Medicine, 22*(12), 1668–1673.
34. Ruiz-Perez, I., Plazaola-Castano, J., Alvarez-Kindelan, M., Palomo-Pinto, M., Arnalte-Barrera, M., Bonet-Pla, A., et al. (2006). Sociodemographic associations of physical, emotional, and sexual intimate partner violence in Spanish women. *Annals of Epidemiology, 16*(5), 357–363.
35. Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *Lancet, 371*(9619), 1165–1172.
36. Corso, P. S., Edwards, V. J., Fang, X., & Mercy, J. A. (2008). Health-related quality of life among adults who experienced maltreatment during childhood. *American Journal of Public Health, 98*(6), 1094–1100.
37. Lokhmatkina, N. V., Feder, G., Blake, S., Morris, R., Powers, V., & Lightman, S. (2013). Longitudinal measurement of cortisol in association with mental health and experience of domestic violence and abuse: Study protocol. *BMC Psychiatry, 13*(13), 188.
38. Straus, M. A. (2008). Dominance and symmetry in partner violence by male and female university students in 32 nations. *Children and Youth Services Review, 30*(3), 252–275.
39. Anderson, K. L. (2002). Perpetrator or Victim? Relationships between intimate partner violence and well-being. *Journal of Marriage Family, 64*(4), 851–863.
40. Nybergh, L., Taft, C., Enander, V., & Krantz, G. (2013). Self-reported exposure to intimate partner violence among women and men in Sweden: Results from a population-based survey. *BMC Public Health, 13*(1), 845.
41. Ansara, D. L., & Hindin, M. J. (2010). Exploring gender differences in the patterns of intimate partner violence in Canada: A latent class approach. *Journal of Epidemiology and Community Health, 64*(10), 849–854.
42. Johnson, M. P., Leone, J. M., & Xu, Y. (2014). Intimate terrorism and situational couple violence in general surveys: Ex-spouses required. *Violence Against Women, 20*(2), 186–207.
43. Dixon, L., & Graham-Kevan, N. (2011). Understanding the nature and etiology of intimate partner violence and implications for practice and policy. *Clinical Psychology Review, 31*(7), 1145–1155.
44. Caetano, R., & Cunradi, C. (2003). Intimate partner violence and depression among Whites, Blacks, and Hispanics. *Annals of Epidemiology, 13*(10), 661–665.
45. Thompson, R. S., Bonomi, A. E., Anderson, M., Reid, R. J., Dimer, J. A., Carrell, D., et al. (2006). Intimate partner violence: Prevalence, types, and chronicity in adult women. *American Journal of Preventive Medicine, 30*(6), 447–457.
46. Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health*. Geneva: World Health Organization.
47. Romito, P., & Grassi, M. (2007). Does violence affect one gender more than the other? The mental health impact of violence among male and female university students. *Social Science and Medicine, 65*, 1222–1234.
48. Krahe, B., Bieneck, S., & Scheinberger-Olwig, R. (2007). The role of sexual scripts in sexual aggression and victimization. *Archives of Sexual Behavior, 36*(5), 697–701.
49. Struckman-Johnson, C. (1988). Forced sex on dates: It happens to men, too. *Journal of Sex Research, 24*, 234–241.
50. Platt, J. J., & Busby, D. M. (2009). Male victims: The nature and meaning of sexual coercion. *American Journal of Family Therapy, 37*(3), 217–226.
51. Eckhardt, C. I., Samper, R., Suhr, L., & Holtzworth-Munroe, A. (2012). Implicit attitudes toward violence among male perpetrators of intimate partner violence: A preliminary investigation. *Journal of Interpersonal Violence, 27*(3), 471–491.
52. Ullman, S. E., & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse and Neglect, 29*(7), 767–782.
53. Archer, J. (1999). Assessment of the reliability of the conflict tactics scales: A meta-analytic review. *Journal of Interpersonal Violence, 14*, 1263–1289.
54. Chan, K. L. (2011). Gender differences in self-reports of intimate partner violence: A review. *Aggression and Violent Behavior, 16*(2), 167–175.