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Mental Health Literacy as a Predictor of Coping Strategies in Women Victims of Domestic Violence: A Cross-Sectional Study in Tehran, Iran

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Background and Objectives: Domestic violence severely impacts women's mental health and quality of life. Mental health literacy (MHL) may influence how women interpret and respond to violence, yet its specific role in predicting coping strategies remains underexplored, particularly in the Iranian context. This study aimed to determine the predictive role of MHL in coping strategies among women victims of domestic violence in Tehran, Iran.

Materials and Methods: This descriptive-analytical cross-sectional study was conducted on 138 women whose experience of domestic violence was confirmed by forensic medicine specialists at the central branch of the Tehran Province Forensic Medicine Organization. Participants were selected via convenience sampling. Data were collected using a demographic questionnaire, the standardized Mental Health Literacy Scale (MHLS), and the validated Coping with Domestic Violence against Women Questionnaire. The reliability of the instruments was re-evaluated in this study (Cronbach's alpha: MHLS =.89; Coping =.91). Data were analyzed using Spearman's correlation and linear regression in SPSS version 26.

Results: More than half of the participants (54.3%) exhibited moderate-to-low levels of MHL, with no participants in the high range. A significant positive correlation was found between MHL and total coping strategies ($r = .835$, $p < .01$). Regression analysis revealed that MHL was a significant positive predictor of both problem-focused ($R^2 = 0.515$, $\beta = .718$, $p < .001$) and emotion-focused coping ($R^2 = .416$, $\beta = 0.645$, $p < .001$). Higher education and employment were associated with greater MHL and coping.

Conclusion: Mental health literacy appears to be a significant and potentially modifiable factor associated with coping strategies among women experiencing domestic violence. Enhancing MHL through targeted educational initiatives may support women in adopting more adaptive coping responses. These findings highlight the importance of integrating MHL promotion into support programs for victims of domestic violence in Iran.

Keywords: Health Literacy; Mental Health; Coping Skills; Domestic Violence; Women's Health; Iran

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Introduction

Domestic violence against women is a major public health crisis and a fundamental violation of human rights worldwide (1, 2). Globally, nearly one in three women (approximately 840 million) have experienced physical or sexual violence in their lifetime, with rates remaining disturbingly stable over the past two decades (3). In Iran, domestic violence is critically underreported; official statistics show discrepancies, with social emergency centers registering 13,370 cases of spousal abuse nationwide in 2019, while the Forensic Medicine Organization documented only 9,500 cases in Tehran province alone (4). Systematic reviews report prevalence rates of 60–80% among Iranian women, with psychological violence being most common (5). A study during the COVID-19 quarantine found that 77.2% of women experienced violence, 91% psychological, 65% physical, 43% sexual, and 39% resulting in injury. Physical violence remains the most frequently documented form in official records (6).

The health consequences of domestic violence are profound, including PTSD, chronic pain syndromes, and adverse reproductive outcomes (7- 8). Furthermore, violence undermines women's reproductive health, leading to pregnancy complications and adverse fetal outcomes (5). Coping strategies particularly problem-focused and emotion-focused coping play a crucial role in women's psychological adjustment to violence (9-11). However, many women adopt passive or avoidant strategies due to fear, financial dependency, or cultural norms (12-13). Effective deployment of adaptive coping depends on awareness of available resources and psychological readiness to seek help (11,14).

Mental health literacy (MHL) may serve as a crucial determinant in this context. Originally defined by Jorm and colleagues as "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (15), MHL encompasses recognizing disorders, knowledge of risk factors, help-seeking, and attitudes toward mental illness (16-17). Higher MHL enables women to identify psychological symptoms and access support services (18), while limited MHL is a major barrier to help-seeking (15). Previous research suggests that improving mental health literacy can facilitate adaptive coping, reduce stigma, encourage self-management behaviors, and promote utilization of counseling and community resources (19).

The theoretical link between MHL and coping is well-established. MHL equips individuals with cognitive tools to appraise stressful situations and select adaptive responses. Women with higher MHL may better recognize the psychological impact of abuse and develop effective coping strategies (2, 20). Studies have shown positive associations between MHL and adaptive coping (2, 19-21). However, despite growing international recognition, the predictive role of MHL in coping strategies among Iranian women experiencing domestic violence remains underexplored. Most Iranian studies have focused on prevalence or qualitative descriptions of coping (12-13, 22-23), with no research specifically examining MHL as a predictor of problem-focused and emotion-focused coping in forensic settings.

To address this gap, the present study aimed to:

1. Assess the levels of mental health literacy and coping strategies among women victims of domestic violence in Tehran, Iran.
2. Examine the relationship between mental health literacy (including its subscales) and coping strategies (problem-focused and emotion-focused).
3. Determine the predictive power of mental health literacy for problem-focused and emotion-focused coping strategies.

By examining the predictive role of mental health literacy within a culturally specific and structurally relevant framework, this study seeks to provide empirical evidence that can inform targeted psychoeducational interventions, enhance women's access to mental health resources, and support the development of tailored support programs for survivors of domestic violence in Iran and similar cultural contexts.

Materials and Methods

Study Design and Setting

This study employed a descriptive-analytical cross-sectional design. It was conducted as part of a larger research project approved by the Islamic Azad University, Tehran Medical Sciences Branch. The study was carried out at the central branch of the Forensic Medicine Organization of Tehran Province, Iran, between January and March 2025.

Study Population and Sampling

The target population comprised all women victims of domestic violence referred to the Tehran Forensic Medicine Organization during the study period. Due to the sensitive nature of the topic and institutional protocols, a convenience sampling method was employed. Of the 146 eligible women approached, 138 agreed to participate, yielding a response rate of 94.5%. Reasons for non-participation included lack of time, acute emotional distress at the time of referral, or unwillingness to complete questionnaires. While this sample size facilitated access to a hard-to-reach population, the use of convenience sampling may introduce selection bias and limit generalizability, which is acknowledged in the limitations section.

Sample Size Calculation

The sample size was calculated using Cochran's formula for cross-sectional studies: $n = (Z^2 \times S^2) / d^2$, where Z = 1.96 (95% confidence level), S = 0.30 (population variance derived from previous studies), and d = 0.05 (margin of error). This yielded an initial estimate of 138 participants. As this study was derived from a larger modeling project employing Structural Equation Modeling (SEM), we also considered Kline's (2023) recommendation that a sample size of 100–150 is adequate for regression analyses with moderate effect sizes. Thus, the final sample of 138 participants was deemed sufficient for the primary analyses (24). Eligible

participants were women whose experience of domestic violence was officially confirmed by a forensic medicine specialist, with at least six months elapsed since the most recent violent incident, ability to read and write in Persian, and provision of written informed consent. Exclusion criteria were incomplete questionnaires, documented diagnosis of severe psychiatric conditions or active substance use disorders in forensic files, and observable cognitive impairment that could interfere with informed consent or accurate completion of questionnaires.

Data Collection Instruments

Three instruments were used for data collection: a sociodemographic questionnaire, the Mental Health Literacy Scale (MHLS) (17), and the Coping with Domestic Violence Against Women Questionnaire (25).

Sociodemographic Questionnaire: This researcher-developed instrument gathered data on age, marital status, education level, employment status, monthly income, duration of marriage, number of children, history of physical/mental illness, substance use, and perpetrator characteristics.

Mental Health Literacy Scale (O'Connor & Casey, 2015): This 35-item standardized scale measures six dimensions: ability to recognize disorders, knowledge of risk factors, knowledge of self-treatment, knowledge of professional help, knowledge of information sources, and attitudes toward mental illness. Items 1–15 are rated on a 4-point Likert scale, and items 16–35 on a 5-point Likert scale, with 12 items reverse-scored. Total scores range from 35 to 160, with higher scores indicating greater MHL. As the MHLS has no established cut-off points in the literature, and to facilitate interpretation of the findings, total scores were categorized into four groups based on the sample distribution, aiming for approximately equal group sizes. The cut-off points were determined as follows: low (35–60), lower-moderate (61–90), upper-moderate (91–120), and high (121–160). The Persian version of the MHLS has been validated in Iranian populations (26, 27). In the present study, Cronbach's α was 0.89, indicating excellent reliability.

Coping with Domestic Violence against Women Questionnaire (Mohammadian et al., 2018): This 32-item questionnaire assesses coping strategies in two dimensions: problem-focused coping and emotion-focused coping. Items are rated on a 5-point Likert scale from 0 (never) to 4 (always). Total scores range from 0 to 128, classified as poor (0–32), moderate (33–64), good (65–96), and excellent (97–128). These cut-off points were established by the original developers based on the score distribution and theoretical consideration. The instrument was developed and validated specifically for the Iranian population, with content validity index of 0.95 and reliability of 0.82 (25, 28). In the present study, internal consistency was excellent (Cronbach's α = 0.91).

Study Implementation and Ethical Considerations

Ethical approval was obtained from the Research Ethics Committee of Islamic Azad University, Tehran Medical Sciences Branch. Permission was also secured from the Forensic Medicine Organization. A trained female researcher approached eligible women individually in a private room, explained the study objectives, assured anonymity and confidentiality, and emphasized voluntary participation. Written informed consent was obtained from all participants. Questionnaires were self-administered, with the researcher present to clarify questions. Psychological support services were available for participants who experienced distress. All procedures adhered to the Declaration of Helsinki (29).

Statistical Analysis

Data were analyzed using SPSS version 26. Descriptive statistics (frequencies, percentages, means and standard deviations) were calculated for all variables. Normality was assessed using the Kolmogorov-Smirnov test and skewness/kurtosis values. Due to non-normal distribution of several variables, Spearman's rank-order correlation coefficient was used to examine bivariate relationships between MHL, coping strategies, and demographic factors. Simple linear regression analyses were conducted to test the predictive power of MHL on problem-focused and emotion-focused coping. Assumptions of linear regression (linearity, independence of errors, homoscedasticity and normality of residuals) were checked and met. A p-value of less than 0.05 was considered statistically significant.

Results

A total of 138 women with confirmed domestic violence participated in this study. The socio-demographic characteristics of the participants are presented in **Table 1.**

Table 1. Socio-demographic characteristics of the participants

Characteristic	Category	Frequency N (%)
Age (years)	18-25	15 (10.9%)
	26-33	28 (20.3%)
	34-41	61 (44.2%)
	42-50	28 (20.3%)
	Not reported	6 (4.3%)
Marital Status	Married	126 (91.3%)
	Divorced	9 (6.5%)
	Other	3 (2.2%)
Employment Status	Unemployed	69 (50%)
	Employee	30 (21.7%)
	Self-employed	39 (28.3%)
Education Level	No formal education	6 (4.3%)
	Below high school	12 (8.7%)
	High school diploma	39 (28.3%)
	Associate degree	18 (13%)
	Bachelor’s degree	39 (28.3%)
	Master’s degree	15 (10.9%)
	PhD	9 (6.5%)

Number of Children	No children	42 (30.45%)
	One child	42 (30.45%)
	Two children	45 (32.6%)
	Three children	6 (4.3%)
	More than three	3 (2.2%)
Duration of Marriage	Less than 1 year	12 (8.7%)
	1-5 years	30 (21.7%)
	5-10 years	24 (17.4%)
	More than 10 years	72 (52.2%)
Marital Satisfaction	Yes	108 (78.3%)
	No	30 (21.7%)
History of Physical Illness	Yes	6 (4.3%)
	No	132 (95.7%)
History of Psychiatric Disorders	Yes	6 (4.3%)
	No	132 (95.7%)
History of Substance Abuse	Smoking	9 (6.5%)
	None	129 (93.5%)
Financial Income	No income	69 (50%)
	Less than 5 million IRR	15 (10.9%)
	5-10 million IRR	15 (10.9%)
	10-15 million IRR	15 (10.9%)
	More than 15 million IRR	24 (17.4%)
Perpetrator of Violence	Husband	123 (89.2%)
	Father	6 (4.3%)
	Other	9 (6.5%)

Abbreviation: IRR: Iranian Rial

The majority were aged 34–41 years (44.2%), married (91.3%), and either unemployed or self-employed (78.3%). Educational attainment varied, with high school diploma and bachelor's degree each representing 28.3% of the sample. Most participants had been married for over ten years (52.2%), and interestingly, 78.3% reported initial satisfaction with their marriage at the time of union, despite subsequently experiencing violence. Economically, half of the participants (50%) had no personal income. In 89.2% of cases, the perpetrator of violence was the husband.

The mean total MHL score was 75.20 (SD = 17.79), and the mean total coping score was 50.33 (SD = 12.55). As shown in **Table 2**, none of the participants achieved a high level of mental health literacy.

Table 2. Descriptive Statistics of Mental Health Literacy and Coping Strategies

Main Variable	Score Category	Frequency N (%)
Total Coping Strategies Score	Poor (0-32)	12 (8.6%)
	Moderate (33-64)	111 (80.4%)
	Good (65-96)	15 (11%)
	Excellent (97-128)	0
	Low (35-60)	33 (24%)

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Total Mental Health Literacy Score	Lower Moderate (61-90)	75 (54.3%)
	Upper Moderate (91-120)	30 (21.7%)
	High (121-160)	0

Based on the categorization described in the Methods section, 33 participants (24%) were classified in the low MHL group, 75 (54.3%) in the lower-moderate group, and 30 (21.7%) in the upper-moderate group. Regarding coping strategies, the majority of participants (80.4%) demonstrated moderate levels, while 11% showed good levels and 8.6% poor levels. No participant reached the excellent level on the Coping with Domestic Violence Questionnaire. Spearman correlation analysis revealed a strong positive correlation between total MHL and total coping strategies (r=.835, p<.01). As shown in **Table 3**, all subscales of MHL were significantly correlated with both problem-focused and emotion-focused coping.

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Table 3. Correlation between Coping strategies and subscales of Mental Health Literacy

Spearman's Rank	Ability to Recognize Disorders	Awareness of Risk Factors and Causes	Awareness of Treatment	Awareness of Reliable Information Sources	Awareness of Available Professional Help	General Attitudes Toward People with Mental Illness	Total Mental Health Literacy
Problem-Focused Coping Strategies	0.535**	0.474**	0.373**	0.415**	0.590**	0.482**	0.700**
Emotion-Focused Coping Strategies	0.537**	0.279**	0.285**	0.679**	0.552**	0.278**	0.641**
Total Coping Strategies Score	0.630**	0.466**	0.387**	0.694**	0.729**	0.485**	0.835**

p < 0.01*

The strongest associations with total coping strategies were observed for awareness of professional help (r=.729, *p*<.01) and awareness of reliable information sources (r=.694, *p*<.01). Among demographic variables, education level showed significant positive correlations with both MHL (r=.366, *p*<.01) and coping strategies (r=.401, *p*<.01). Employment status was also positively associated with MHL (r=.250, *p*<.01) and coping (r=.187, *p*<.05). A history of mental illness was negatively correlated with both MHL (r = -.241, *p*<.05) and coping (r=-.185, *p*<.05). No significant associations were found between age, number of children, duration of marriage, or substance use and the main variables.

Simple linear regression analysis was conducted to examine the predictive role of MHL on coping strategies. As presented in **Table 4**, MHL was a significant positive predictor of problem-focused coping (β=0.718, *p*<.001), explaining 51.5% of its variance.

Table 4. Regression Results for Predicting Coping Strategies Based on Mental Health Literacy

Variable	B	SE	β	t	*p*	CI(95%)
Problem-Focused Coping Strategies						
Constant	1.339	2.261	-	0.592	0.555	-3.131-5.810
MHL	0.352	0.029	0.718	12.018	<0.001	0.294-0.410
Model Statistics	**R^2 = 0.515, R = 0.718, Adjusted R^2 = 0.511, F(1, 136) = 144.441, (p < 0.001), Durbin-Watson = 1.941. Confidence intervals were calculated based on 5000 bootstrap samples.**					
Emotion-Focused Coping Strategies						
Constant	3.145	2.023	-	1.554	0.122	-0.856-7.145
MHL	0.258	0.026	0.645	9.852	<0.001	0.206-0.305
Model Statistics	**R^2 = 0.416, R = 0.645, Adjusted R^2 = 0.412, F(1, 136) = 97.059, (p < 0.001), Durbin-Watson = 1.622. Confidence intervals were calculated based on 5000 bootstrap samples**.					

MHL also significantly predicted emotion-focused coping (β = 0.645, *p* <.001), accounting for 41.6% of its variance. The Durbin-Watson statistics (1.941 and 1.622) confirmed the independence of residuals in both models.

Discussion

This study examined the predictive role of mental health literacy in coping strategies among women victims of domestic violence in Tehran, Iran. The findings revealed that none of the participants achieved a high level of mental health literacy based on the categorization applied in this study, with the majority (54.3%) falling in the lower-moderate range. Similarly, most women (80.4%) demonstrated moderate coping strategies, and no participant reached the excellent level. A strong positive correlation was found between MHL and coping strategies (r = 0.835, p < 0.01). While this relatively high coefficient may partly reflect theoretical proximity between cognitive appraisal processes embedded in mental health literacy and adaptive coping behaviors, the constructs were assessed using distinct validated instruments, supporting their conceptual independence. Regression analysis confirmed that MHL significantly predicted both problem-focused (β = 0.718, explaining 51.5% of variance)

and emotion-focused coping (β = 0.645, explaining 41.6% of variance). Although the cross-sectional design of this study precludes causal inference, the magnitude of the explained variance indicates a substantial and meaningful association between MHL and coping strategies.

These findings suggest that MHL is a crucial cognitive resource that empowers women to employ more effective coping mechanisms when facing domestic violence (2). Similarly, Safaralinezhad and colleagues (2025), in their qualitative study developing a mental health literacy framework for Iranian women of reproductive age, identified "adapting to life challenges" as a core component of MHL, a dimension that directly parallels the concept of coping strategies examined in the present study (20). Song et al. (2023) demonstrated that MHL positively predicted positive coping styles among Chinese empty nesters, with resilience serving as a mediating mechanism (19). Mahapatro and Singh (2020), through an intervention study in India, showed that enhancing women's awareness of support resources strengthened positive coping strategies and ultimately improved psychological adjustment (21). Further support comes from qualitative research conducted in Iran. Noshirvani and colleagues (2022), in a grounded theory study exploring coping strategies among women victims of domestic violence in Yazd, found that women employed both maladaptive strategies (such as avoidance and surrender) and adaptive strategies (including realistic approaches, participatory strategies, and seeking practical support from family and social resources). Their identification of "getting rid of anonymity" as a core issue aligns with the present findings that awareness of professional help and reliable information sources factors that enable women to move beyond isolation were the strongest correlates of adaptive coping (30). This convergence of quantitative and qualitative evidence from the same cultural context strengthens the validity of our findings and highlights the importance of enhancing women's access to practical knowledge and support networks. On a broader scale, a recent systematic review by Verma and Pandey (2025) examining mental health literacy among rural women in low and middle-income countries (including India, Bangladesh, Nigeria, Turkey, and Ghana) reported consistently low levels of MHL, with stigma, supernatural attributions, and gender-based restrictions identified as major barriers to help-seeking. Their findings that community education and awareness campaigns can improve knowledge and reduce stigma resonate with the practical implications of the present study. The convergence of evidence across diverse settings from rural communities in developing countries to urban women seeking forensic services in Tehran underscores the universal importance of MHL as a modifiable determinant of women's psychological well-being and highlights the need for culturally tailored interventions that address both knowledge deficits and socio-cultural barriers (31). The consistency of these findings across different cultural contexts underscores the fundamental role of MHL in facilitating adaptive coping.

However, the relationship between mental health literacy and adaptive outcomes is not uniformly positive across all dimensions or contexts. A recent study by Kim et al. (2023) among

Asian international students with depressive symptoms found that while knowledge about mental disorders and campus services positively predicted help seeking, the ability to recognize disorders in others was negatively associated with seeking help (32). This counterintuitive finding suggests that certain components of MHL, particularly those involving identification of mental health problems in others, might inadvertently increase social distance rather than facilitate personal help-seeking. A similar pattern emerged in the present study when examining the differential contribution of MHL subscales. Although all subscales were significantly correlated with coping strategies, the strength of associations varied considerably. Awareness of treatment options ($r = 0.387$) showed a notably weaker correlation with coping compared to awareness of professional help ($r = 0.729$) or awareness of reliable information sources ($r = 0.694$). Moreover, the mean score for treatment awareness was the lowest among all MHL subscales ($M = 6.76$ out of 11), indicating that women in our sample had particularly limited knowledge about available treatments. This finding contrasts with previous studies that have emphasized the role of attitudes toward mental illness or ability to recognize disorders as primary predictors of coping (16). The relatively weaker role of treatment awareness in predicting coping may reflect the specific context of women experiencing violence in Iran, where practical knowledge of where and how to seek immediate help may be more urgently needed than knowledge about treatment modalities. These findings suggest that MHL is not a monolithic construct and that its different dimensions may have distinct effects on psychological outcomes depending on contextual factors. This internal variation underscores the importance of targeted interventions that prioritize specific, actionable components of MHL particularly awareness of professional help and reliable information sources rather than treating it as a single entity.

The positive associations between education, employment, and both MHL and coping suggest that socioeconomic empowerment plays a crucial role in enhancing women's cognitive and psychological resources. Educated and employed women likely have greater access to information, broader social networks, and higher financial independence, enabling them to develop more adaptive coping strategies. Conversely, the negative association between history of mental illness and both MHL and coping highlights a vicious cycle: women with prior mental health problems may have lower capacity to acquire mental health knowledge and employ effective coping strategies, which in turn exacerbates their psychological vulnerability. This finding underscores the need for integrated interventions that simultaneously address mental health symptoms and enhance mental health literacy. The particularly strong correlation between coping strategies and the subscales of "awareness of professional help" and "awareness of reliable information sources" indicates that practical, actionable knowledge is especially valuable for women facing violence. This aligns with the notion that MHL is not merely an abstract cognitive construct but a practical tool that empowers women to navigate complex support systems and make informed decisions about their mental health.

These findings have several practical implications for policy and practice. First, screening for MHL in forensic and healthcare settings could help identify women at risk of employing maladaptive coping strategies, enabling early intervention. Second, psychoeducational programs should be developed to enhance MHL, with a particular focus on practical knowledge such as recognizing psychological symptoms, understanding available treatment options, and accessing professional help. Given that awareness of professional help and reliable information sources showed the strongest associations with coping, these components should be prioritized in educational interventions. Third, given the significant associations between education, employment, and both MHL and coping, broader social policies that promote women's educational attainment and economic participation may indirectly strengthen their coping capacities. Fourth, training frontline staff in forensic, healthcare, and social services to provide basic mental health information could bridge the gap between victims and support systems, particularly for women with limited MHL. Finally, integrating MHL enhancement into existing domestic violence support programs could provide a cost-effective approach to improving psychological outcomes for survivors.

Study Limitations and Strengths: This study has several limitations that should be acknowledged. First, the cross-sectional design precludes causal inferences regarding the relationships between MHL and coping strategies. Longitudinal studies are needed to establish temporal directions and examine changes over time. Second, the use of convenience sampling from a single forensic center in Tehran limits the generalizability of findings to all women experiencing domestic violence in Iran, particularly those in rural areas or those who do not seek formal services. Third, self-report measures may be subject to recall bias and social desirability bias, especially given the sensitive nature of domestic violence. Fourth, while the sample size of 138 was adequate for regression analyses, a larger sample would have enhanced statistical power and allowed for more complex modeling. Fifth, the severity and frequency of violence, which could influence both MHL and coping, were not assessed in this study. Sixth, although the MHLS has been validated in Iranian populations, the lack of established cut-off points necessitated a data-driven categorization, which should be interpreted with caution.

Future research should address these limitations by employing longitudinal designs, recruiting larger and more diverse samples from multiple centers, and including detailed assessments of violence characteristics. Qualitative studies could provide deeper insights into how women with different levels of MHL experience and cope with violence. Intervention studies are needed to evaluate the effectiveness of MHL enhancement programs in improving coping strategies and mental health outcomes. Finally, cross-cultural comparisons could illuminate how contextual factors shape the relationship between MHL and coping in different societies.

Conclusion

The present study provides empirical evidence that mental health literacy is a significant predictor of coping strategies among women victims of domestic violence in Tehran, Iran. The findings revealed that none of the participants achieved a high level of MHL, with the majority falling in the lower-moderate range, and that MHL explained 51.5% and 41.6% of the variance in problem-focused and emotion-focused coping, respectively. These results underscore that MHL is not merely a cognitive construct but an empowering mechanism that enables women to employ more adaptive coping strategies when facing violence. Given that MHL is a modifiable factor, it represents a promising target for psychoeducational interventions aimed at enhancing women's psychological resilience and help-seeking behaviors. Based on these findings, screening for MHL should be integrated into forensic and healthcare services serving women experiencing domestic violence, enabling early identification of those at risk of employing maladaptive coping strategies. Psychoeducational programs should be developed with particular emphasis on practical knowledge components that showed the strongest associations with coping namely, awareness of professional help and awareness of reliable information sources and should be culturally tailored to address stigma and gender-based restrictions as highlighted in previous research (31). Training frontline staff in forensic and social services to provide basic mental health information could bridge the gap between victims and support systems, while broader social policies promoting women's education and economic participation may indirectly strengthen their coping capacities. Future research should employ longitudinal designs to establish causal relationships, recruit larger and more diverse samples from multiple centers, and conduct qualitative studies to gain deeper insights into how women with different levels of MHL experience violence. Intervention studies are needed to evaluate the effectiveness of MHL enhancement programs, and cross-cultural comparisons could illuminate how contextual factors shape the MHL-coping relationship across different societies.

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Conflicts of Interest: The authors declare no conflicts of interest.

Consent for publication: Not applicable.

Ethics Approval and Consent to Participate: This study was conducted in compliance with the ethical principles of research and in accordance with the Declaration of Helsinki. It was approved by the Ethics Committee of the Islamic Azad University (IR.IAU.TMU.REC.1403.102). All participants provided written informed consent after being fully informed about the study objectives. Participation was voluntary, and confidentiality was strictly maintained throughout the study.

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