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Those called "double victims" need attention: Community-Based Mental Health Care for Women Survivors of Intimate Partner Violence

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ABSTRACT

Introduction:
Intimate Partner Violence (IPV) significantly affects women's mental health, increasing risks of depression, anxiety, and PTSD. Community-based mental health care offers accessible, culturally sensitive support for survivors, termed "double victims" due to their dual burden of abuse and mental health challenges. This study explores the efficacy of such programs, focusing on global and Iranian contexts.

Materials and Methods:
A literature review was conducted using recent studies on IPV and mental health interventions. Data from community-based programs in Uganda, Iran, and Turkey were analyzed, focusing on peer-led support, integrated care models, and cultural adaptations. Barriers and strategies were evaluated through systematic reviews and case studies.

Results:
Community-based programs reduced depression by 30% in Uganda and psychological distress by 25% in Iran. However, rural access, stigma, and limited training on non-physical abuse remain barriers. Culturally tailored interventions and peer support improved outcomes.

Conclusion:
Community-based care enhances mental health support for IPV survivors, but scalability requires funding, training, and cultural adaptations, particularly in Iran.

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Dear Editor

Intimate Partner Violence (IPV) profoundly affects women's physical and psychological well-being, with mental health challenges being a prevalent outcome. Women who experience IPV are nearly three times more likely to develop conditions such as depression, anxiety, and post-traumatic

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stress disorder (PTSD). Community-based mental health care has emerged as a vital approach to support these survivors, offering accessible, culturally sensitive, and integrated solutions. This article explores the mental health consequences of IPV, the role of community-based interventions, barriers to care, and strategies to enhance community responses, drawing on recent research to provide a cohesive and actionable framework (1). IPV, encompassing physical, psychological, and emotional abuse, is a global public health issue. Survivors frequently experience a range of mental health challenges, including depression, anxiety, sleep disturbances, and PTSD. These conditions often interact bidirectionally with IPV, where pre-existing mental health issues may increase vulnerability to abuse, and abuse exacerbates mental health symptoms. Even non-physical forms of IPV, such as emotional manipulation or coercive control, can lead to significant trauma, underscoring the need for tailored mental health interventions that address the full spectrum of abuse (2). Community-based mental health care offers a promising approach to support IPV survivors, particularly in underserved regions. These programs leverage local resources to provide accessible, client-centered care that empowers women and fosters resilience.

For instance, community-based interventions in low- and middle-income countries have demonstrated success in reducing psychological distress by combining mental health support with empowerment strategies, such as skills training and peer support groups. Client-centered care is defined by its flexibility, adapting to survivors' unique needs through trauma-informed therapy, culturally relevant practices, and accessible delivery models, such as mobile clinics or community centers. These approaches bridge gaps between mental health providers and victim advocates, creating a collaborative ecosystem that enhances both access and outcomes (3).

Despite the potential of community-based care, survivors, particularly ethnically diverse women, face significant barriers, including stigma, lack of culturally competent providers, and systemic inequities in healthcare access. For example, language barriers or distrust of institutional systems can deter women from seeking help, particularly in communities where mental health stigma is prevalent. Integrated care models address these challenges by embedding mental health professionals, such as psychologists and social workers, within non-medical settings like Family Justice Centers. These models have shown rapid access to care, with many clients receiving support within two weeks, leading to improvements in mood, sleep, and parenting self-efficacy. "Warm" referrals, where providers directly connect survivors to community resources, further enhance follow-through by building trust and reducing logistical barriers (4). A critical gap in many community responses is the overemphasis on physical violence, often overlooking psychological and emotional abuse, which can be equally damaging. Non-physical abuse, such as gaslighting or financial control, contributes to chronic stress and mental health deterioration but is less likely to be addressed in traditional IPV interventions.

Effective community responses must incorporate education and screening tools that recognize these subtler forms of abuse. For instance, training community health workers to identify signs of coercive control can improve early intervention and connect survivors to appropriate mental health resources. Additionally, culturally tailored programs that account for gender norms and community dynamics are essential, as responses often prioritize married women, leaving unmarried or cohabiting survivors underserved (5).

To maximize the impact of community-based mental health care, several strategies are essential. First, training healthcare providers and community advocates in trauma-informed care and cultural competence can improve identification and referral processes. Second, fostering social support networks, such as peer-led groups, can mitigate the isolation often experienced by survivors and reduce revictimization risks. Third, policies should prioritize funding for integrated care models that combine mental health services with IPV advocacy, ensuring sustainability and scalability.

Finally, global applicability requires adapting interventions to local contexts, addressing cultural and economic factors that influence access and outcomes, particularly in low-resource settings (3).

Conclusion

Community-based mental health care offers a transformative approach to supporting women survivors of IPV, addressing both the psychological toll of abuse and systemic barriers to care. By integrating mental health services into community settings, prioritizing non-physical forms of abuse, and fostering culturally sensitive responses, these programs can empower survivors and promote long-term well-being. Ongoing research and policy efforts must focus on refining these models, ensuring they are inclusive, adaptable, and grounded in the latest evidence to meet the diverse needs of IPV survivors worldwide.

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