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Violence, social support and mental health: a dual factor model approach

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ABSTRACT

Background: Although the impact of violence on mental health has been extensively studied, it has mainly focused on psychopathology and has overlooked well-being. Social support is a protective factor, but further evidence is lacking regarding its role when considering both psychopathology and well-being.

Aims: This study employed a cross-sectional retrospective design to explore the role of victimization and social support in mental health by applying a dual mental health approach.

Methods: A total of 581 adults (42.5% female,18–67 years; M = 34.55, SD = 11.68) completed self-report measures through an online survey.

Results: The results support the dual-factor model and significant differences were observed between the mental health groups in terms of participants' sex, victimization and social support. Specifically, the Troubled group reported the highest victimization scores and the worst scores on social support. Additionally, the Positive Mental Health group reported fewer victimization than the Troubled group, as well as greater social support from all sources than the Vulnerable group.

Conclusions: These results underpin the need for more comprehensive analysis of mental health, going beyond the classic perspective of the absence of symptoms as an indication of good health. The identification of different profiles might enable the design of targeted interventions addressing the victims' needs.

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Violence; mental health; social support; dual-factor model

Introduction

Violence is a pervasive global issue, a severe violation of human rights and a major public health concern (Ferreira et al., 2020; Krug et al., 2002). The individual and societal costs of violence include the detrimental impact on victims' well-being and the burden placed on health and welfare systems (Krug et al., 2002). Abusive acts are a significant risk factor for psychopathology (e.g. depression and anxiety) (Turanovic, 2022) and for well-being (e.g. self-acceptance or purpose in life) (Ferreira et al., 2020). The literature on this field has largely overlooked well-being while it has been mostly focused on psychopathology (Grych et al., 2015). However, the focus on psychopathology is restrictive, limiting the recognition of health as a complex, broad, and multifaceted process (Magalhães, 2024). According to Wang et al. (2011), this perspective contains two main risks: the overestimation of mental health in some cases, and its underestimation in others; while individuals without formal diagnostic criteria are generally considered mentally healthy, there is a risk of disregarding cases of subclinical illness. Even people reporting symptoms may have preserved specific well-being domains (e.g. life satisfaction, purpose in life) which are important not to disregard (Grych et al., 2020).

The dual-factor models (DFM) approach

The DFM conceptualizes mental health based on two distinct but co-occurring dimensions: psychopathology and well-being (Suldo & Shaffer, 2008). Instead of opposite poles of the same continuum, these two dimensions, although certainly distinct, co-occur and are required for a comprehensive understanding of mental health (Grych et al., 2020). This approach offers a more complete outline, allowing the identification of different (four) profiles of health organized around both dimensions: high/low psychopathology

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and high/low well-being (Magalhães, 2024). Despite some differences in the labels (Eklund et al., 2010), these groups could be described as: *Positive Mental Health* (PMH) (low psychopathology, high well-being), *Symptomatic but Content* (SBC) (high psychopathology, high well-being), *Vulnerable* (low psychopathology, low well-being) and *Troubled* (high psychopathology, low well-being). This taxonomy allows the identification of two groups that are traditionally overlooked: individuals with high levels of psychopathology but, simultaneously, high levels of well-being – *SBC*, and individuals without clinical scores of symptoms but also low levels of well-being – *Vulnerable* (Antaramian et al., 2010). Although these labels are familiar in literature, terms such as *Vulnerable* or *Troubled* may carry stigmatizing or disempowering connotations. Recent literature emphasizes the critical need for careful, non-stigmatizing language in mental health research (Haslam & Baes, 2024; Munari et al., 2021). While we maintained these labels for theoretical consistency and comparability with prior studies, we recognize these profiles strictly as descriptive categories of psychological functioning rather than definitive or disempowering traits.

Regardless of the terms, the empirical validity of this four-group taxonomy is well-supported by a growing body of research. Specifically, four profiles have been identified in studies of children and/or adolescents (Arslan & Allen, 2022), and adults (Jiang & Lu, 2019). Studies with community samples have reported inconsistent results regarding the prevalence in each group. Although most of them identify the *PMH* group as the most prevalent (Brailovskaia et al., 2022), others have reported a higher prevalence of the *Vulnerable* group (33%) (Suldo et al., 2014). The identification of these profiles of mental health is crucial as while some people might require therapeutic interventions focused on symptom reduction, others may benefit from interventions focused on endorsing psychological resources/well-being. By moving beyond a single-continuum approach, researchers and practitioners can develop tailored intervention and support systems.

Victimization and mental health: from risk to protection

The World Health Organization (WHO) defines violence as the intentional use of force or power likely to cause physical or psychological harm (Krug et al., 2002). While empirical evidence frequently isolates specific types of victimization (Amborski et al., 2022; Mento et al., 2023) and contexts (Treves-Kagan et al., 2024), these often co-occur (Bridges-Curry & Newton, 2025). Assessing the cumulative risk of violence across contexts is needed, given its psychological costs (higher depression and anxiety) (Semenza et al., 2021) and decreased well-being (Ferreira et al., 2020). This impact seems to be worse for victims of multiple forms of violence (Charak et al., 2020) and might vary according to the victims' gender (Schouler-Ocak & Brandl, 2022). Violence disproportionately impacts women due to gender-based sociocultural roles and power imbalances (Heise, 1998). Chronic abusive relationships often lead to betrayal trauma and severe mental health issues, while abuse-related stigma isolates victims and undermines their access to protective social support (Oram et al., 2017). Beyond gender, an intersectional perspective reveals that minority groups (e.g. LGBTQIA+, racialized, and disabled individuals) face compounded victimization risks due to systemic inequalities, harshly amplifying their health burden (Adeyeba et al., 2025; Espelage et al., 2018).

Despite this evidence, additional insights are needed into how victimization may undermine victims' mental health, using a DFM approach. Few studies have tested the role of victimization in mental health using a DFM, and most have been conducted with adolescents (Grych et al., 2020) or adults reporting victimization during childhood/adolescence (D'Eça et al., 2023). In a cross-sectional study involving 466 adolescents, Grych et al. (2020) found that the *Troubled* group reported significantly higher levels of victimization than any other group, and the *PMH* group reported less victimization than the *Troubled* and *SBC* groups but did not differ from the *Vulnerable*. D'Eça et al. (2023), based on a retrospective cross-sectional study with 274 adults, found that the *Complete Mental Health* group (equivalent to the *PMH* group) reported significantly fewer victimization than the *Troubled* group, but no significant differences were observed in the remaining groups. Nevertheless, to the best of our knowledge, no study has explored the differences in adult victimization among these four groups.

Furthermore, it is important to identify protective factors for victims' mental health. Social support is a protective factor for mental health, as it involves being cared for and loved, esteemed, and valued, as well as a sense of belonging to social networks (Cobb, 1976; Huang & Zhang, 2022). Different sources can provide social support (Baruch-Feldman et al., 2002; Zell & Stockus, 2025): informal social support includes individuals (e.g. family, friends) or associations that are likely to provide support in response to daily life events or difficulties. Formal social support

encompasses both social organizations (e.g. hospitals and police) and professionals who are intentionally focused on providing care (Carvalho et al., 2011). The chief role of informal social support has been more often analyzed (Nguyen et al., 2016), nonetheless, other sources should be considered (Carvalho et al., 2011).

The literature has pointed out the positive role of social support in mental health (Harandi et al., 2017), as it is a psychosocial resource that is mobilized to protect individuals' physical (Uchino, 2009) and psychological health (Harandi et al., 2017). In studies using DFM, lower levels of social support tend to be reported by participants reporting lower well-being, such as *Troubled* and *Vulnerable* groups (King et al., 2021). Specifically, Renshaw and Cohen's (2014), in their cross-sectional study, with a sample of 1356 undergraduate students, showed that the *Mentally Healthy* group (equivalent to the *Positive/Complete Mental Health* group) reported higher levels of interpersonal connectedness than both the *Mentally Unhealthy* group and the *Asymptomatic yet Discontent* group (equivalent to the *Troubled* and *Vulnerable* groups, respectively). Furthermore, also in a cross-sectional study involving 369 young people, Magalhães and Calheiros (2017) found that the *Complete Mental Health* group reported the highest levels of social support when considering different sources (formal and informal), while the *Troubled* group reported the lowest levels.

The present study

This study addresses existing gaps in literature by applying a DFM approach that provides an in-depth understanding of how victimization is associated with mental health profiles, and how specific sources of social support might differentiate these profiles. Based on these insights from the literature, this study employed a cross-sectional retrospective design to explore the role of victimization and social support on mental health. The following hypotheses will be tested: *H1* – The *Troubled* group reports more victimization and less social support than the others; *H2* – The *PMH* group reports fewer victimization and more social support than the others.

Method

Participants

In the current study we targeted a community sample in Portugal. Data were gathered from a nonrandom convenience sample using a retrospective cohort design. An online survey was used to collect data, and the link was released on social networks (i.e. posting on personal pages of Facebook or Instagram) and university mailing lists to recruit adults (aged 18 years or older) in the community.

Measures

Socio-demographic questionnaire

A sociodemographic questionnaire specifically developed for this study was used to measure individual characteristics (e.g. sex, age), educational and economic-financial status (e.g. education level, current employment status), family (e.g. number of children), and relational aspects (e.g. current relationship status) of our participants.

Adulthood victimization experiences questionnaire

Victimization was assessed using this questionnaire focused on the participants experiences during the last year (adapted from Lisboa et al., 2009 by Magalhães et al., 2019). Three dimensions were assessed: Psychological Violence (nine items), Physical Violence (five items) and Sexual Violence (five items). Items were rated on a five-point Likert scale ranging from 0 (*never*) to 4 (*often or frequently, more than 10 times*). In this study, all scales showed very good internal consistency (Psychological Violence ($\alpha.=84$), Physical Violence ($\alpha.=90$) and Sexual Violence ($\alpha.=88$)) as well as a very good fit to the data (CFI> .95; GFI >. 95; SRMR<.08).

Brief symptom inventory (BSI)

The BSI (Canavarro, 2007) is focused on mental health symptoms. In this study, only the 12 items related to depression (six items) and anxiety (six items) were selected, given that they are the most prevalent difficulties across countries (Davies et al., 2019). Participants responded using a five-point Likert scale ranging from 0 (*never*) to 4 (*often too)*. In the current study, both dimensions revealed a very good internal consistency (both $\alpha.=.87$). A one-dimensional CFA was performed for a global dimension of psychopathology to be able to create mental health groups, and very good fit to the data was found (CFI= .95; GFI=. 93; SRMR=.04) as well as an excellent internal reliability ($\alpha.=.92$).

Psychological well-being scales (PWBS)

The PWBS (Novo et al., 1997) assesses six dimensions of well-being and happiness (84 items; 14 per

dimension): autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. Participants responded using a Likert-type scale ranging from *Strongly Disagree* (1) to *Strongly Agree* (6). High scores indicate high psychological well-being. In this study, a global dimension of psychological well-being was used to create mental health groups, and a very good internal reliability was found ($\alpha. = .95$).

Multidimensional scale of perceived social support (MSPSS)

MSPSS (Carvalho et al., 2011) provides a subjective assessment of social support from three sources: family (4 items; $\alpha. = .95$), friends (4 items; $\alpha. = .95$), and significant others (4 items; $\alpha. = .95$). Participants responded to four items per each supportive source, using a 7-point Likert scale ranging from 1 (*Completely Disagree*) to 7 (*Completely Agree)*.

Ethics

This study was approved by the IRB of *Universidade Lusófona*, Faculty of Psychology and Education, Oporto, Portugal. Data were collected using an online survey, spread on social media and institutional mailing lists. All participants provided their informed consent prior to participation. No identifying information was collected and no compensation was provided. Given the sensitive topic, the informed consent explicitly acknowledged the possibility of emotional discomfort, and participants were given the option to stop their participation at any time without penalty. At the end of their participation, researchers' contact details were afforded for clarification of questions, for obtaining additional information or for possible referral to psychological support, if required.

Data analysis

Data analysis was performed using *IBM SPSS for Windows* (version 28.0). Participants with missing values for more than 10% of the items per measure were excluded. The percentage of missing values per item was below 2%, and the pattern of missing values was analyzed. Little's (1988) Missing Completely at Random test revealed that missing data were not random (*Little's MCAR test* $\chi^2 = 140.725$, $df = 58$, $p < .001$). Missing data were handled by multiple imputations to deal with missing data not at random (Pastor, 2003).

Similar to other studies (Magalhães, 2024; Santini et al., 2020), percentile analysis was used to determine which participants belonged to each mental health group based on high versus low/medium scores: high psychological well-being means a percentile of 70 (≥ 4.7024) and low/medium psychological well-being (< 4.7024); and high psychopathology means a percentile of 70 (≥0.83) and low/medium psychopathology (< 0.83). Psychopathology and well-being were crossed to create four groups of mental health consistent with the theoretical assumptions (Magalhães, 2024). Furthermore, two groups were created: victims (i.e. those who reported at least one experience of psychological, physical, or sexual victimization) and non-victims (i.e. those who reported no psychological, physical, or sexual victimization). First, we assessed normality distribution of our variables and only the victimization scales revealed skewness greater than 3 and kurtosis greater than 8 (Kline, 2016), which is plausible and expected. Non-parametric Kruskal-Wallis test was used to explore group differences in the three dimensions of victimization and Mann-Whitney test to explore these differences among gender. Furthermore, we explored whether the groups differed in social support from different sources by running a multivariate analysis of covariance (MANCOVA), controlling for victimization experience and a t-test student for exploring social support differences among men and women.

Patient and public involvement

This study is part of a broader project on victimization and mental health, in which several master's students collected data to complete their research aims, under the supervision of the authors. To avoid lengthy processes, participants were not consulted during the study design or data analysis. Nevertheless, after they have participated, they were allowed to obtain further details regarding the study design and conclusions, which expanded on the general information provided in the informed consent.

Results

Participants' characteristics

A total of 581 adults participated in this study (42.5% female, aged 18–67 years; $M = 34.55$, $SD = 11.68$). They were mostly single (48.2%), had completed high school (38.4%), and employed (73.6%). Analyzing the prevalence of victimization during the previous year, almost 38% of the participants reported psychological victimization, 8.6% reported sexual victimization, and 7.4% reported physical victimization. A complete sketch of these characteristics is presented in Table 1.

Table 1. Socio-demographic characteristics and victimization experiences of the sample.

		% (n[a]) / M (*SD*; *Min.*; *Max.*)
Sex	Male	57.5 (334)
	Female	42.5 (247)
Age		34.55 (11.68; 18; 67)
Marital Status	Single	48.2 (279)
	Married	43.9 (254)
	Divorced	6.4 (37)
	Widowed	1.2 (7)
Education	1st Cycle of primary School	5 (29)
	2nd cycle of primary School	5.7 (33)
	3rd cycle of primary School	15.4 (89)
	High school	38.4 (222)
	Graduation	20.6 (119)
	Master's degree	13.5 (78)
	Doctoral degree	0.7 (4)
	Other	0.5 (3)
Employment Status	Student	9 (52)
	Employed	73.6 (427)
	Student worker	12.4 (72)
	Unemployed	4.5 (26)
	Retired	0.5 (3)
Psychological Violence	No	62.1 (361)
	Yes	37.9 (220)
Physical Violence	No	92.6 (538)
	Yes	7.4 (43)
Sexual Violence	No	91.4 (531)
	Yes	8.6 (50)

[a]Total *N* varies slightly owing to missing values; therefore, valid percentages are reported.

Table 2. Mental health groups according to the dual-factor model.

		Psychological well-being	
Symptoms		High	Low/medium
	Low/medium	*Positive Mental Health* (*n* = 138; 23.8%) 61.6% non-victims 38.4% victims 39.9% Female 60.1% Male	*Vulnerable* (*n* = 269; 46.3%) 74.7% non-victims 25.3% victims 32.7% Female 67.3% Male
	High	*Symptomatic but Content* (*n* = 35; 6.0%) 37.1% non-victims 62.9% victims 80% Female 20% Male	*Troubled* (*n* = 139; 23.9%) 33.8% non-victims 66.2% victims 54.7% Female 45.3% Male

Mental health groups

The most prevalent group was *Vulnerable* (46%), which means that most of the participants did not have high symptoms, but did not have high levels of well-being (Table 2). Similarly, the *SBC* and *PMH* groups included less than 30% of the entire sample, which suggests that most of the participants in this study did not report high levels of psychological well-being. Most participants in the *SBC* and *Troubled* groups experienced at least one form of victimization in the last year (over 60%). A Chi-Square's test indicated statistically significant differences among the four groups in terms of participants' sex (χ^2 (3), $N = 581) = 39.508$, $p < .001$). Specifically, most participants in the *SBC* group are women and in the *Vulnerable* and *PMH* groups are men (Table 2).

Table 3. Mean rank of victimization experiences per group (mental health and sex).

Groups	Victimization (mean rank)		
Mental health	Psychological	Physical	Sexual
PMH	270.43	283.90	293.03
SBC	362.57	302.41	299.46
Vulnerable	242.76	283.39	273.24
Troubled	386.50	309.90	321.22
Sex			
Female	325.26	292.94	300.02
Male	265.66	289.57	284.33

Victimization differences according to participants' sex and mental health

A Mann-Whitney U test revealed statistically significant differences among women and men on psychological victimization ($U = 32786$, p <.001) and sexual victimization ($U = 39021$, $p = .022$). Non-significant differences were found on physical victimization ($U = 40771$, $p = .599$). Women significantly outscored men on psychological and sexual victimization, but not on physical victimization (Table 3).

A Kruskal-Wallis's test indicated statistically significant differences among the four groups in the three victimization subtypes: Psychological (χ^2 (3), $N = 581) = 99.932$, $p < .001$), Physical (χ^2 (3), $N = 581) = 12.220$, $p = .004$) and Sexual (χ^2 (3), $N = 581) = 32.231$, $p < .001$). Post-hoc comparisons using pairwise method indicated that, for psychological victimization, the mean rank of the *Troubled* group was significantly higher than that of the *Vulnerable* ($p < .001$) and the *PMH* ($p < .001$). Also, the mean rank of the *SBC* group was significantly higher than that of the *Vulnerable* ($p < .001$) and the *PMH* ($p < .001$). Regarding physical and sexual victimization, post-hoc comparisons using pairwise method indicated that the mean rank of the *Troubled* group was significantly higher than that of the *Vulnerable* ($p < .001$; $p < .001$) and that of *PMH* ($p = .005$; $p = .004$), respectively (Table 3).

Social support differences according to participants' sex and mental health

Statistically significant differences among women and men were found only on the significant others'

support ($t(577) = 1.979$, $p = .048$, $d = .17$), as women reported higher social support from this source (Table 4). Non-significant differences were found on family support ($t(573) = .212$, $p = .416$, $d = .02$) and friends support ($t(575) = 1.120$, $p = .132$, $d = .09$).

Furthermore, the results revealed significant multivariate effects on mental health for all sources of social support: Family ($F(3, 569) = 23780$; $p < .001$; $\eta^2 = .112$), Friends ($F(3, 569) = 21.480$; $p < .001$; $\eta^2 = .103$), and Significant Others ($F(3, 569) = 14.254$, $p < .001$, $\eta^2 = .071$). The *Post-hoc Tukey HSD test* revealed that the *Troubled* group reported significantly lower support from the three sources – Significant Others, Family and Friends–than did the other groups (all $p < .001$). In addition, the *PMH* group reported greater social support from the three sources: Significant Others ($p = .009$), Family ($p = .017$) and Friends ($p = .001$) - than the *Vulnerable* group (Table 4).

Discussion

Experiencing violence in adulthood can increase the risk of greater symptoms and lower well-being (Turanovic, 2022). However, research has focused mostly on psychopathology rather than well-being, and there is still a lack of studies that measure both dimensions. Thus, this study aimed to explore the role of victimization and social support on mental health (as encompassing both psychopathology and well-being). By identifying four profiles, our findings highlight that well-being is not simply the opposite of psychopathology. Rather, these results provided further empirical support for the DFM.

Most of our participants (46%) were classified as *Vulnerable* (i.e. low psychopathology and well-being), which is in line with previous evidence (Suldo et al., 2014). This finding is important for several reasons. The *Vulnerable* group is typically overlooked when considering the traditional perspective of mental health, which is more focused on individuals with high levels of psychopathology (i.e. *Troubled* and *SBC* groups) (Grych et al., 2020). Although often overlooked for interventions, individuals without high symptoms still require professional attention. Promoting their well-being acts as a protective buffer against future distress, improves daily functioning, and significantly reduces long-term public healthcare costs (Howell et al., 2016). Our findings highlight the need to mobilize meaningful supportive relationships for the *Vulnerable* group to optimize their individual functioning, as these participants reported less social support than those classified as *PMH*. This need is even more evident in the *Troubled* group.

Table 4. Means, standard deviations of social support per group (mental health and sex).

Groups	Social support (*M; SD*)		
Mental Health	Significant Others	Family	Friends
PMH	24.01(3.55)	23.70 (3.48)	23.01 (3.46)
SBC	25.08 (2.82)	24.31 (2.60)	22.68 (4.04)
Vulnerable	22.48 (4.38)	22.34 (3.83)	21.28 (3.96)
Troubled	20.63 (6.10)	19.03 (6.18)	18.40 (5.76)
Sex			
Female	22.99 (4.83)	22.07 (5.26)	21.38 (4.98)
Male	22.19 (4.81)	21.98 (4.26)	20.94 (4.34)

The *Troubled* group reported the greatest victimization scores, specifically with higher levels of psychological victimization than the other groups, and more physical and sexual violence than the *Vulnerable* and *PMH* groups. These results are in line with previous evidence suggesting that the *Troubled* group reported significantly more victimization than any other group (Grych et al., 2020). Specifically, psychological victimization seems to be detrimental to participants' mental health, including psychopathology and well-being. Psychological violence often involves persistent subtle ongoing manipulation, control, and humiliation, which can raise a permanent state of fear, anxiety, and insecurity (Dokkedahl et al., 2022). These processes might undermine the victims' sense of control over their own lives, leading to an increase in symptoms (Dokkedahl et al., 2022) and a decrease in well-being (Ferreira et al., 2020). Unlike other types of violence, psychological abuse is often invisible as there is no physical evidence, making it harder for victims to recognize these experiences and for others to validate them (Lagdon et al., 2014). Moreover, the *Troubled* group reported higher levels of psychological victimization, even when compared to individuals who, despite psychological difficulties, exhibited high levels of well-being (*SBC* group). Physical and sexual violence seem to be especially associated with psychopathology, since participants in the *Vulnerable* and in the *PMH* groups (both depicting low psychopathology) reported less physical and sexual violence.

Furthermore, our results also revealed that the *Troubled* group exhibited the worst scores for all sources of perceived social support, confirming our hypothesis and in line with previous evidence (Magalhães & Calheiros, 2017). Taken together, these results suggest that the *Troubled* group presents a cumulative risk of high levels of victimization and low levels of support, consistent with previous (Atkinson et al., 2015). The literature highlights several factors that explain why victims who perceive less social support exhibit poor mental health. Following victimization, victims tend to experience feelings of

isolation and loneliness, which can exacerbate their emotional difficulties, undermine effective coping strategies, and impair their capacity to seek formal and/or informal help (Green & Pomeroy, 2007; Jose & Novaco, 2016).

Our second hypothesis was partially supported, since the *PMH* group reported fewer victimization than the *Troubled* group, as well as more perceived social support than the *Vulnerable* group. This result suggests that victimization is particularly harmful in terms of psychopathology, as the *Troubled* group experienced significantly more adverse experiences than the *PMH* group. In addition, supportive relationships are particularly protective of well-being, as the vulnerable group reveals lower scores than the *PMH* group (Harandi et al., 2017). The lack of significant differences among the other mental health groups suggests the need for further research into the resilience portfolios of these groups (e.g. interpersonal or regulatory strengths) (Grych et al., 2020).

Regarding sex differences, women reported significantly higher psychological and sexual victimization, greater support from significant others, and a higher likelihood of belonging to the *SBC* group. These findings may reflect broader structural inequalities and gender-based power dynamics that increase women's risk of exposure to violence (Heise, 1998; Jewkes, 2002). Nevertheless, it is plausible to consider that interpersonal and supportive resources may positively foster women's well-being, even in the presence of high psychopathology. Taken together, these findings highlight the importance of gender-sensitive and trauma-informed interventions that consider the specificities of women's experiences of victimization and recognize the heterogeneity of mental health trajectories.

Despite these innovative findings, it is important to acknowledge some limitations. It was based on individuals' retrospective self-reported victimization, which might have led to some bias. However, official data or other reports tend to underestimate the prevalence of these experiences (Braga et al., 2019), and online surveys have benefits in terms of cost, time, visibility, and dissemination (Lages et al., 2018). Second, this study included a convenience, nonrandom, and nonrepresentative sample. A greater extent and variability in sample characteristics could provide more accurate evidence on mental health profiles. Third, as this was a cross-sectional retrospective study, causal inferences were unfeasible.

Regardless of these limitations, this study has several important implications. Beyond traditional approaches to mental health interventions based on a one-dimensional perspective, it is crucial to develop and implement psychosocial programs based on the specific needs and profiles of mental health groups (Magalhães, 2024). Symptom reduction only addresses one part of the victims' needs, which means that fostering their well-being is required on a regular and systematic basis (Antaramian, 2015). Specific real-world changes are required across applied psychological practice, public health messaging, and funding strategies. Intake protocols in victim support services should include a DFM on the mental health assessment to ensure that the typically overlooked *Vulnerable* profile is properly identified. Psychosocial interventions must move beyond standard symptom-reduction interventions to systematically incorporate well-being support, enhancing assets and resources, consistent with the resilience portfolio framework (Grych et al., 2020). While targeting emotion regulation mitigates distress, programs must also build distinct strengths (e.g. optimism, meaning-making) to effectively foster well-being, while simultaneously mobilizing social resources. Also, campaigns should evolve from solely focusing on psychopathology-related stigma reduction to promoting *mental health literacy* (Tay et al., 2018), by explicitly communicate that mental health entails not just the absence of psychopathology, but the presence of well-being. Finally, policymakers and funding agencies may fund programs targeting both psychopathology and well-being, ensuring resource allocation to interventions adopting a comprehensive approach to mental health.

Author contributions

Conceptualization: Célia Ferreira, Eunice Magalhães, Carla Antunes; Methodology: Célia Ferreira, Eunice Magalhães, Carla Antunes; Formal analysis and investigation: Eunice Magalhães; Writing - original draft preparation: Célia Ferreira, Eunice Magalhães; Writing - review and editing: Célia Ferreira, Eunice Magalhães, Carla Antunes.

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The data used in this study are available upon reasonable request by emailing the corresponding author.

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