Association between Intimate Partner Violence and Women's Mental Health: Survey Evidence from Thailand

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Abstract: There is increasing recognition that mental health issues are a problem affecting women experiencing intimate partner violence. We report part of a larger study that investigated intimate partner violence, health consequences, and coping patterns among 532 Thai women who had gynecological problems. The purposes of this study were to: (1) compare mental health (stress, depression, self-esteem, and social support) among non-abused and abused women, (2) examine the specific types of violence (physical, sexual, and emotional violence) on the mental health of abused women, and (3) identify the influence of specific types of violence on stress, depression, self-esteem, and social support. Data was obtained from seven instruments: the Demographic Characteristics Questionnaire, the Abuse Assessment Screen, the Index of Spouse Abuse, the Stress Test, the Center for Epidemiologic Studies Depression Scale, The Rosenberg's Self-Esteem Scale, and the Multidimensional Scale of Perceived Social Support. Results revealed that abused women reported significantly higher stress and depression and had lower self-esteem and social support than non-abused women. Women who experienced emotional violence had significantly higher stress and depression but lower self-esteem and social support than those experiencing physical and sexual violence. Only emotional violence had a significant effect on stress. Sexual violence was the strongest predictor of depression, self-esteem, and social support. Physical violence had no effect on mental health.

Our findings emphasize that different types of intimate partner violence are independently associated with women's mental health. Correlates of these can be useful for nursing professionals in Thailand to help identify women exposed to such violence so as to provide proper care and treatment, including mental health treatment. Thus, examination protocols need to be inclusive of routine assessment for intimate partner violence so that this is part of the standard care of all women with gynecological problems.

Key Words: intimate partner violence, abused women, mental health, Thailand, women

Introduction

Intimate partner violence (IPV) is a serious public health and social problem that affects women's short-term and long-term health sequelae.[1] Results from developing countries have consistently shown a significant association between IPV and negative

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health, such as injuries, adverse pregnancy outcomes, and poor physical health.[2-4] However, the majority of studies on the mental health effects of IPV has been undertaken in Western and developed countries.[2-5] In Thailand, although there is substantial evidence from previous studies linking IPV and mental health, most studies have mainly focused on pregnant and postpartum women.[6-8] To date, there has been only one published study among women with gynecological problems in Thailand investigating the association between IPV and risk factors.[9] As a result, there is limited information on the course of mental health among Thai women with gynecological problems exposed to IPV. This evidence is important given the lack of attention to the psychosocial contexts of mental health problems among females who experience a wider range of poor mental health outcomes compared to males.[10]

This study examined the mental health consequences of IPV, by (1) comparing the mental health of non-abused and abused women (e.g., stress, depression, self-esteem, and social support), (2) identifying the specific types of IPV affecting the mental health of abused women (i.e., physical, sexual, and emotional violence), and (3) identifying the influence of specific types of IPV on stress, depression, self-esteem, and social support among Thai women with gynecological problems.

Literature Review

Intimate partner violence (IPV), which includes physical, sexual, and emotional abuse by a current or former partner, is a form of gender-based violence that is a violation of women's rights.[11] The prevalence of IPV has been increasingly documented and recognized as an important public health issue worldwide.[12] The prevalence of IPV during pregnancy across 19 countries ranges from 3.9-8.7%.[13] However, results from a Nordic cross-sectional study across five countries found the ranges of lifetime prevalence in patients visiting gynecology clinics were 38-66% for physical violence,

19-37% for emotional violence, and 17-33% for sexual violence.[14] In a German study, almost half of women (n=479, 44.6%) seeking gynecologic care reported that they had been the subject of unwanted sexual attention.[15] Recently, about 40% of 424 females in an outpatient sample with gynecological-psychosomatic symptoms reported experiencing violence during their lifetime, including 25.2% for physical violence, 13% for sexual violence, and 23.8% for psychological violence.[16]

In Thailand, it has been estimated that the prevalence of psychological, physical, sexual and economical violence among 337 women with gynecological problems was 65.3%, 40.4%, 38.6%, and 36.2%, respectively.[9] Although the prevalence of IPV among women admitted to a gynecology ward (20.5%) was lower than women attending a gynecology clinic (45.7%), those who were inpatients experienced IPV more frequently than those who were outpatients, especially, for physical violence (49.64%), sexual violence (46.15%), and economical violence (47.12%).

Not only is IPV a substantial health problem by virtue of its direct effects on physical and sexual dimensions, it also contributes to the overall burden of disease as a risk factor for women's mental health. Recent studies have consistently shown a significant association between IPV and mental health in women, including depressive symptoms, anxiety, hostility, borderline personality disorder, antisocial personality disorder, psychotic experiences, post-traumatic stress disorder (PTSD), suicidal thoughts, and suicide attempts.[4,5,10] Although mental disorders are estimated to constitute 14% of the global burden of disease and disability,[17] women are about 1.5-3.0 times more likely than men to experience depression.[18] Among depressed women, approximately 60% were found to have histories of abuse.[19] In turn, experience of IPV can lead to feelings of depression, stress, anxiety, and lower levels of self esteem[8,10,20] Stress has been conceptualized as an imbalance between mental demands and individual resources[21] which can enhance stress perception and

maladaptive emotional responses, leading either directly or indirectly to adverse health outcomes.[2,17]

To date, only a few published studies have examined the negative mental health correlates of IPV among women with gynecological problems.[14-16] Most studies have only considered physical or sexual violence, and have neglected emotional violence.[15,22,23] Specifically, what types of IPV affect the mental health of women remains unclear due to a lack of research focus and limited systematic studies. A review of past literature on mental health and IPV victimization among women reveals a substantial overlap in their types of IPV, indicating a need to explore whether there are relationships between physical, sexual, and emotional violence exists between IPV victimization and poor mental health.

This study extended research on the mental health consequences of IPV among Thai women with gynecological problems. Specific hypotheses included: (1) abused women will report more mental health problems, and (2) women who have experienced emotional violence will be more likely to report adverse mental health than those who have experienced physical violence or sexual violence.

Methods

Design: This study used a predictive correlational design and was a part of a larger study that investigated intimate partner violence, health consequences, and coping patterns among inpatient Thai women with gynecological problems.

Sample and Setting: Convenience sampling was used to recruit participants from two gynecology wards of a large university hospital in Bangkok, Thailand. This healthcare setting was selected because it contained a large number of women with gynecological problems. The inclusion criteria were: being a Thai woman who was an inpatient with a gynecological problem diagnosed by gynecologist; 15-65 years of age; currently having or leaving an intimate partner relationship; not having a serious physical or mental illness; and able to understand spoken and written Thai.

We used Hancock and Freeman's power analysis for Structural Equation Modeling (SEM)[24] in this study since it provides the sample size requirement tables for the Root Mean Square Error of Approximation (RMSEA) goodness of fit using model degrees of freedom, effect size and power. Using this would yield power of at least 80%, with 80 degrees of freedom, RMSEA = 0.02 with 0.5 significance level. The estimated sample size for this study was at least 250 participants each for abused and non-abused groups. To allow for 10% attrition, 550 potential participants were approached. A total of 562 participants joined the study, however, 30 (5.6%) were excluded because of missing data, resulting in 532 for data analysis. Prior to analysis, the data were evaluated for normality. Data collection occurred July 2011 to December 2012.

Ethical Considerations: Study approval was obtained from the institutional review board of the hospital used as study site. Each potential participant was informed about: the purposes of the study; what study involvement entailed; voluntary participation; confidentiality and anonymity issues; the right to refuse to participate; and the right to withdrawn from the study, without the risk of incurring any penalties or prejudicial treatment at any time without repercussions. All participants were asked to sign a consent form. However, for safety and confidentiality reasons, each participant could either sign a consent form or give a verbal consent instead of a written consent.[25]

Data Collection: A staff nurse in each gynecology ward identified eligible women and provided the information participation sheet and consent form without coercion. The principle investigator (PI) recruited potential participants who met the selection criteria at each setting without any activity by the respective physicians or nurses. For safety and privacy reasons, the participants were invited to stay in the private area that was at their bedsides or in the health consulting room at each setting and complete the set

of questionnaires. If a participant needed assistance, as a result of illness or visual problems, the participant was approached in the health consulting room instead. Then the PI read the content of the questionnaires and asked the participants to either verbally or non-verbally respond to each question asked. Completing the questionnaires took approximately 30 minutes. All participants received a list of services related to IPV as well as information on mental health services during the initial interaction. To ensure confidentiality, a serial number was used in the questionnaires instead of participants' names. After completion, participants put their completed questionnaires in a sealed box provided at nurses' station. The PI picked up these questionnaires daily for data entry.

Instruments: Seven instruments were used for data collection: a *Demographic Characteristics Questionnaire; The Abuse Assessment Screen*[26]; *The Index of Spouse Abuse*[27]; *The Stress Test*[28]; *The Center for Epidemiologic Studies Depression Scale*[29]; *The Rosenberg's Self-Esteem Scale*[30]; *and The Multidimensional Scale of Perceived Social Support.*[31] All instruments (except for the Stress Test) were a Thai version of the original English version. Approval to use the copyrighted instruments was obtained from the authors of the respective instruments, as well as from those who had originally translated the English version of each instrument into Thai. A pilot test of all instruments was conducted with 30 Thai women in-patient with gynecological problems, similar to the study participants, to determine if the instruments were clear and understandable.

The Demographic Characteristics Questionnaire (DCQ) was developed by the PI and used in the aforementioned larger study. It contains 15 items that seek information regarding the participants and their partner, namely: age, marital status, second marriage, length of marriage, educational level, career, income, socioeconomic status, family structure, family relationships, smoking, drinking, drug abuse, and gambling.

The Abuse Assessment Screen (AAS)[6,26] consists of three questions which require a dichotomous

answer (Yes=1, No=0): "Within the last year, have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?"; "Within the last year, has anyone forced you to have sexual activities?"; and "Are you afraid of your partner or anyone you listed above?" An affirmative response to at least one of three screening questions is considered positive to IPV. The content validity of the AAS was derived from the literature and a panel of experts, and has acceptable sensitivity to detect abused status.[32] The AAS has been widely used in research on IPV across cultures.[26]

The Index of Spouse Abuse (ISA)[7,8,27] contains 30-items with a 5-point Likert scale ranging from 1=never to 5=very frequently. It is used to measure severity of three forms of IPV, physical, emotional, and sexual violence, in the past year. The original ISA includes two scales measuring 11 items of physical violence (ISA-P, α = 0.91) and 19 items of nonphysical violence (ISA-NP, α = 0.93). Examples items are: "My partner slaps me around my face and head" (ISA-P) and "My partner acts like I am his personal servant" (ISA-NP). In this study, the original ISA was modified into three subscales: physical violence (ISA-P), sexual violence (ISA-S), and emotional violence (ISA-E); therefore, each subscale was scored by averaging the responses. The possible range of scores for each scale is 0-5, with lower scores indicating the relative absence of abuse and higher scores representing increasing severity of violence. Cronbach's alpha value of total scale was 0.97, and the three modified subscales were 0.87, 0.92, and 0.93, respectively.

IPV was measured in two ways. The AAS was used for identifying IPV experience (yes or no) whereas the ISA was used to analyze IPV frequency and severity, and correlation between IPV and mental health. The ISA can assess a wider range of physical, sexual, and emotional violence with a Likert scale allowing more variability in responses. Women may not identify themselves as abused on the AAS for many reasons, but might be willing to report behaviors on the ISA

because it does not self-identify them as abused.[6]

The Stress Test[28] is a 20-item self-administered instrument used to screen individuals at risk for stress by assessing signs, behaviors, or feelings during the last two months. It utilizes a 4-point Likert scale ranging from 0=none of the time to 3=almost or all of the time. Examples of items are: "I can't do anything due to so much stress." and "I feel very exhausted". A total score, ranging from 0-60, is obtained by summing across each item score. Higher scores reflect a greater level of stress. Reliability of the scale has been found > 0.70.[33] The alpha coefficient for this sample was 0.94.

The Center for Epidemiologic Studies Depression Scale (CES-D)[29] is a 20-item Likert scale used to screen individuals at risk for depression, by assessing the frequency and duration of depressive symptoms. Examples of the CES-D items are: "I was bothered by things that usually don't bother me." and "I had crying spells." Respondents are asked to choose from four possible responses, where 0="rarely or none of the time (less than 1 day)" to 3="almost or all of the time (5-7 days). Four items are reverse-coded for establishing scores. A total score (range from 0 to 60) is obtained by summing across each item score. Higher scores reflect a greater level of depressive symptoms. A score of 16-29 indicates mild to moderate depressive symptoms, while scores > 30 suggest severe depressive symptoms. In this study, those with a CES-D 16 of greater were considered having depressive symptoms. The CES-D has been tested in various settings and found to have a high internal consistency and adequate test-retest reliability.[8,34,35] The Thai translated version of the CES-D, used in previous studies, has been found to have a Cronbach's alpha of 0.85-0.90.[34,35] The Cronbach's alpha value of the translated CES-D was 0.96.

The Rosenberg Self-Esteem Scale (RSE)[30,36] is a 10-item, self-administered instrument, consisting of two dimensions: a feeling of self-worth and self-respect; and a feeling of competence and ability. Feelings of self-worth and self-acceptance are measured using eight items, while competence and ability are assessed using two items. Examples of one question from each of the two dimensions of the scale are: "I feel that I am a person of worth at least on an equal plane with others" and "I am able to do things as well as most other people." For each of the 10 items, a participant rates how much she has valued herself in the last month on a scale of 1=strongly disagree to 4=strongly agree. A total score (ranging from 10-40) is obtained by summing across each item score. The higher the score, the higher one's self-assessed self-esteem. Reliability of the Scale has been found to range from 0.77 to 0.88.[35,37] The Cronbach's alpha value of the RSE in this study was 0.94.

The Multidimensional Scale of Perceived Social Support (MSPSS)[31,38] is a 12-item instrument designed to measure the perceived amount of social support one receives from three separate sources: family, friends, and significant others. Each of these three sources is assessed using four respective questions. Examples of two items are: "There is a special person who is around when I am in need" and "My family really tries to help me." The instrument utilizes a 7-point Likert scale range from 1=very strongly disagree to 7=very strongly agree. A score for each of the three subscales is obtained by summing across the respective items. A total score is obtained by summing across all 12 items. Scores for each subscale range from 4-28, with higher scores indicating a higher level of perceived social support received from the respective subscale as listed, whereas low scores suggest decreased levels of perceived social support. The MSPSS has been used in Thailand to measure perceived social support in adolescents and adults, with a reliability range of 0.89-0.96.[35] The Cronbach's alpha value of the MSPSS in this study was 0.92.

Data Analysis: Demographic characteristics data were analyzed using descriptive statistics (frequency distribution, mean, and standard distribution). Participants were allocated to either the non-abused or abused group. Independent t-tests were used to compare the mean differences of mental health (e.g., stress, depression, self-esteem, and social support) between non-abused

and abused Thai women with gynecological problems. Pearson's correlation analyses were conducted to examine the relationship between types of IPV and mental health. Multiple regressions were used to identify the best predictor, that is physical, sexual, or emotional violence of stress, depression, self-esteem, and social support. An alpha of 0.05 was set for significance.

Results

As shown in Table 1, the participants' mean age was 42.46 years (SD=12.174) and their partners' mean age was 44.5 (SD=12.937). The majority were married (n=380, 71.4%) and about one third (34.1%) had been married previously. The mean length of marriage was about 15.24 years (SD=11.021). The education level was diverse; however, almost half of participants (n=221, 41.6%) had obtained less than high school education, and most (n=393, 73.8%) were employed. The household income of participants was commonly <10,000 Thai baht per month (n=262, 49.3%). Almost half (n=243, 45.6%) had insufficient incomes or were in debt. Most (62%) had some arguments with their partners (Table 1). Of the participants, 9.4% (n=50) smoked, 22.4% (n=119) drank alcohol, 2.3% (n=12) had drug abuse, and 6.4% (n=34) gambled. The prevalence of IPV in this study was 21.1% and 17.3% reported physically abuse, 11.5% sexual abuse, and 13.2% emotionally abuse (see **Table 1**). Furthermore, the rate of having one type, two types, and three types of IPV during the past year were 7.7%, 5.6%, and 7.7%, respectively. In terms of perpetrators, 15% had experienced abuse by their former partners, 4.7% had experienced abuse by their current partners, and 1.3% had been in more than one abusive partner relationship.

Table 1: Demographic Characteristics of Women and the Prevalence of IPV (N = 532)

Characteristics	N	%
Age of participants	Mean = 42.46 (SD = 12.174)	
15 to 24	50	9.5
25 to 34	90	16.9
35 to 44	137	25.7
45 to 54	168	31.6
55 and above	87	16.3
Marital status		
Married	380	71.4
Divorced / separated	91	17.1
Widowed	43	8.1
Cohabiting	18	3.4
Number of marriage		
First marriage	351	66
Second marriage	128	24.1
Third marriage	39	7.3
≥ Fourth marriage	14	2.7
Length of marriage	Mean = 15.24 (SD = 11.021)	
Education		
No education	22	4.1
Less than high school	221	41.6
High school	159	29.9
College	38	7.1
University	92	17.3

Table 1: Demographic Characteristics of Women and the Prevalence of IPV (N = 532) (Continued)

Characteristics	N	*%*
Employment		
Unemployed	59	11.1
Employed	393	73.8
Housewife	63	11.8
Student	17	3.2
Household income (Thai baht)		
0–10,000	262	49.3
10,001–20,000	132	24.7
20,001–30,000	59	11.1
30,001–40,000	31	5.8
> 40,000	48	9.1
Socioeconomic status		
Sufficient	289	54.4
Insufficient	122	22.9
In debt	121	22.7
Family structure		
Living with husband and children	416	78.2
Living with family members	99	18.6
Living with others/friends	10	1.9
Living alone	7	1.3
Family relationship		
Good relationship	115	21.6
Poor communication	9	1.7
Some arguments	339	62
Marital conflict	78	14.7
Experienced IPV in the past year		
No	420	78.9
Yes	112	21.1
Physical abuse		
No	440	82.7
Yes	92	17.3
Sexual abuse		
No	471	88.5
Yes	61	11.5
Emotional abuse		
No	462	86.8
Yes	70	13.2

Independent sample t-tests were conducted to compare mean difference of mental health between non-abused and abused groups. The results showed that the mean scores of mental health between two groups were statistically different (**Table 2**). Results indicated that women who experienced sexual violence had the highest mean score of stress and depression, but the lowest mean score of self-esteem and social support compared to those experienced physical or emotional violence. Importantly, women who experienced sexual and emotional violence reported poorer mental health than those who experienced physical and sexual violence or those who experienced physical and emotional violence (**Table 3**).

From **Table 4**, the results indicated that three types of IPV were significantly related to mental health. To identify the influence of specific types of IPV on mental health, the three predictors (i.e., physical, sexual, and emotional violence) were regressed on stress, depression, self-esteem, and social support, using the enter method. The least square method was used to estimate parameter. Results revealed that three predictors significantly accounted for 17.6% of the variability in stress, 13.7% of the variability in depression, 6.7% of the variability in self-esteem, and 8.1% of the variability in social support (**Table 5**). Specifically, emotional violence was the strongest predictor of stress, indicating significant positive effect of .409 (p = .000), whereas the remaining two predictors had no significant effect. Sexual violence was the strongest predictor of depression, self-esteem, and social support. The results indicated significant positive effect of .171 (p = .002) on depression, negative effect of −.131 (p = .019) on self-esteem, and negative effect of −.163 (p = .004) on social support, whereas the remaining two predictors had no significant effect. In addition, physical violence had no significant effect on all mental health.

Table 2 Means and Standard Deviations of Women's Mental Health between Non-Abused and Abused Groups (N = 532)

Mental Health	Non-abused gr. (n =420)		Abused gr. (n = 112)		t	p
	$\overline{X}$	SD	$\overline{X}$	SD		
Stress	6.89	7.702	14.98	11.518	−7.030	.000*
Depression	4.69	7.442	12.05	11.807	−6.276	.000*
Self-esteem	30.33	4.200	26.98	4.648	6.915	.000*
Social support	55.25	14.933	45.73	16.113	5.896	.000*

* $p < .05$

Table 3 Mean and Standard Deviations of Abused Women's Mental Health (N = 112)

Mental Health	PV (N=27)		SV (N=10)		EV (N=4)		PV + SV (N=6)		PV + EV (N=20)		SV + EV (N=6)		PV + SV + EV (N=39)	
	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD	$\overline{X}$	SD
− Stress	11.96	10.113	16.40	10.834	8.25	9.251	12.50	9.566	12.30	10.408	24.50	12.422	17.69	12.574
− Depression	8.93	8.227	13.00	10.781	7.50	9.000	10.17	10.647	8.70	11.221	24.00	9.879	14.62	13.825
− Self-esteem	27.48	4.98	26.50	5.061	27.75	5.560	26.33	3.011	28.15	3.977	24.00	4.899	26.64	4.771
− Social support	47.15	13.702	43.80	21.091	52.00	7.303	52.67	17.603	50.20	14.244	40.00	24.495	42.12	16.00

Note: PV = Physical violence, SV = Sexual violence, EV = Emotional violence

Table 4 The Association of Types of IPV and Mental Health (N = 532)

Types of IPV	Stress	Depression	Self-esteem	Social support
PV	.372**	.321**	−.265**	−.222**
SV	.323**	.325**	−.239**	−.238**
EV	.413**	.348**	−.258**	−.225**

** *p* < .01

Table 5 Predictors of Types of IPV on Stress, Depression, Self-esteem, Social Support (N = 532)

Mental Health Predictor	Stress			Depression			Self-esteem			Social-support		
	β	t	p	β	t	p	β	t	p	β	t	p
PV	−.059	−.561	.575	.016	.151	.880	−.209	−1.871	.062	−.118	−1.046	.296
SV	.090	1.715	.087	.171	3.189	.002	−.131	−2.362	.019	−.163	−2.914	.004
EV	.409	3.597	.000	.220	1.893	.059	.022	.185	.853	−.009	−.076	.939
R^2	.176			.137			.067			.081		

Discussion

The findings from this analysis add to our knowledge of the relationship between IPV and mental health. The prevalence rates of IPV reported in the past year in this study was found to be over 21.1%, which was higher than the rate of IPV reported in obstetric settings (3.9–8.7%).[13] The prevalence of physical violence found in this study (17.3%) was higher than a population-based study that have been reported 10–14%.[39] In addition, the percentage of sexual violence reported in this study (11.5%) was also higher than a previous population-based study that reported the ranges from 8% to 9%.[40] A possible explanation for the higher rates of physical and sexual violence in this sample may be due to the anonymous nature of the data collection. Additionally, physical and sexual violence are frequently associated with injury, thus women sampled in the medical settings would be expected to have a higher prevalence than women sampled in population settings. However, the prevalence of emotional violence in this study (13.2%) was lower than in those previously reported studies.[14-16] This

possibly could be that women who participated in this study may have under-reported their experiences of emotional violence because they may be less likely to view the incident as abusive. Self-selection bias is plausible given that women with a history of abuse may be less likely to take part in a survey.

Consistent with previous research, this study found that each type of IPV was significantly associated with mental health, thereby supporting the hypotheses that abused women will report more mental health problems. First, women who experienced sexual violence reported significantly higher stress and depression but lower self-esteem and social support compared to those women who experienced other types of IPV. Second, women who experienced sexual violence were vulnerable to stress and depression, and women who experienced sexual and emotional violence were at the greatest risk of stress and depression. Finally, women who experienced a combination of three types of IPV were also vulnerable to those mental health issues. Thus, assessing for mental health within abusive relationships has important implications for healthcare providers.

While our findings about significant IPV-poor mental health association are broadly consistent with previous studies from other developing countries, we also identified several important results. These findings support previous research in that emotional violence was more strongly associated with having a mental health problem than was physical violence.[4] We argue that the dynamics of the experience of emotional violence in conjunction with physical and/or sexual violence are distinctly different from the experience of just one form of violence. However, types of IPV can be mutually correlated with each other, thus the combination of all three forms of IPV is a marker for more severe violence of all sorts.[8,41] Therefore, strategies to reduce women's mental health problems should include efforts to ensure early identification and prevention of IPV. In addition, research and implementation of IPV prevention programs that include stress management and empowerment are required to help improve women's mental health and help them deal with IPV in an assertive and positive way.

Limitations

We have a number of limitations to this study and recommendations for future research. First, since the study's design was not a longitudinal, and we could not determine if there were sustained long-term mental health effects for abused women with gynecological problems. So future studies should be longitudinal and also use a random sample so as to be able to generalize findings with confidence. To determine the casual relationship between IPV and mental health, future research should analyze episodes of IPV collected at multiple time points. In this study our sample was restricted to women who currently had or were leaving an intimate partner relationship, and we suggest that future research of mental health consequences of IPV should also include women in dating relationships who were never married. The AAS is a screening test that measures each type of IPV from only one item, so care needs to be taken not to use the AAS alone as a standard screening

tool until more evidence is gathered.[32] Recall bias was also a potential problem in this study but the participants needed to recall in the previous year only, therefore, there were no substantial differences in the findings. Finally, data was collected solely using self-report questionnaires, therefore, clinical interviews should be used in conjunction with self-reports in future research.

Conclusions and Implications for Nursing Practice

In summary, this study was the first to our knowledge to examine the specific types of IPV on mental health among Thai women who were inpatients with gynecological problems. We strongly suggest that women with gynecological problems should be screened for mental health issues and asked about their history of IPV, particularly women with the episode of sexual and/or emotional violence. If women are not assessed for IPV, abuse will likely remain undetected and untreated, placing women at risk for escalating mental health problems. Thus, training programs for health professionals, including nurses, in hospitals and educational institutions should address issues such as common definitions, statistics regarding IPV, the cycle of violence, the health impact of IPV, how to screen for IPV, how to deal with IPV in the health care setting, and how to work with existing resources. Importantly, health care systems in Thailand need to develop policies and practices that support health care providers in assessing women for IPV. Routine assessment for IPV must be standard care for all women with gynecological problems. Also, strategies to engage the health care system in providing social supports and increasing self-esteem, especially for women who experienced sexual and emotional violence are needed.

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ความสัมพันธ์ระหว่างความรุนแรงที่เกิดจากคู่สมรสกับภาวะสุขภาพจิต ของสตรี:การสำรวจข้อมูลจากประเทศไทย

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บทคัดย่อ: เป็นที่ทราบดีว่าสตรีที่ได้รับความรุนแรงที่เกิดจากคู่สมรสมักจะมีปัญหาสุขภาพจิต การศึกษา ครั้งนี้เป็นส่วนหนึ่งของโครงการวิจัยเรื่องความรุนแรงที่เกิดจากคู่สมรสผลกระทบต่อสุขภาพและ แบบแผนการแก้ปัญหาจากสตรีไทยที่มีปัญหาทางนรีเวชจำนวน 532 คน วัตถุประสงค์ของการศึกษา เพื่อ (1) เปรียบเทียบผลกระทบทางสุขภาพจิต (ได้แก่ ความเครียด ภาวะซึมเศร้า ความรู้สึกมีคุณค่าใน ตนเอง และการสนับสนุนทางสังคม) ในกลุ่มสตรีที่ถูกทำร้ายและไม่ถูกทำร้าย (2) ตรวจสอบชนิดของ ความรุนแรงที่เกิดจากคู่สมรส (ทางกาย ทางเพศ และทางจิตใจ) ที่มีผลต่อสุขภาพจิตของสตรีที่ ถูกทำร้าย และ (3) ค้นหาว่าความรุนแรงที่เกิดจากคู่สมรสชนิดใดมีอิทธิพลต่อความเครียด ภาวะซึมเศร้า ความรู้สึกมีคุณค่าในตนเอง และการสนับสนุนทางสังคม เก็บข้อมูลโดยใช้แบบสอบถามจำนวน 7 ชุด ได้แก่ แบบสอบถามข้อมูลส่วนบุคคล แบบคัดกรองความรุนแรง แบบวัดระดับความรุนแรงของการถูก ทำร้าย แบบวัดความเครียด แบบสอบถามภาวะซึมเศร้า แบบสอบถามความรู้สึกมีคุณค่าในตนเอง และแบบสอบถามความช่วยเหลือทางสังคมแบบพหุมิติ

ผลการวิจัยพบว่า สตรีที่ถูกทำร้ายมีความเครียดและภาวะซึมเศร้าสูง มีความรู้สึกมีคุณค่าใน ตนเองและการสนับสนุนทางสังคมต่ำกว่าสตรีที่ไม่ได้ถูกทำร้ายอย่างมีนัยสำคัญทางสถิติ สตรีที่ถูก ทำร้ายทางจิตใจมีความเครียดและภาวะซึมเศร้าสูง มีความรู้สึกมีคุณค่าในตนเองและการสนับสนุน ทางสังคมต่ำกว่าสตรีที่ถูกทำร้ายทางกายและทางเพศอย่างมีนัยสำคัญทางสถิติ ความรุนแรงทางจิตใจ เพียงชนิดเดียวที่มีอิทธิพลต่อความเครียดอย่างมีนัยสำคัญทางสถิติความรุนแรงทางเพศเป็นตัวทำนาย ที่แรงที่สุดต่อภาวะซึมเศร้า ความรู้สึกมีคุณค่าในตนเองและการสนับสนุนทางสังคม ส่วนความรุนแรง ทางกายไม่พบว่ามีอิทธิพลต่อภาวะสุขภาพจิต

ผลศึกษาครั้งนี้ชี้ให้เห็นว่า ชนิดของความรุนแรงที่เกิดจากคู่สมรสมีความสัมพันธ์กับภาวะ สุขภาพจิตของสตรี ความสัมพันธ์ดังกล่าวนับว่าเป็นประโยชน์แก่วิชาชีพการพยาบาลในประเทศไทย เพื่อค้นหาสตรีที่ถูกทำร้ายและให้การดูแลรักษาอย่างเหมาะสม ตลอดจนการให้บริการทางสุขภาพจิต ดังนั้น คู่มือการดูแลผู้ป่วยควรจัดให้มีการคัดกรองความรุนแรงควบคู่ไปกับงานประจำเพื่อแสดงถึง มาตรฐานในการดูแลสตรีทุกคนที่มีปัญหาทางนรีเวช

คำสำคัญ: ความรุนแรงที่เกิดจากคู่สมรส, สตรีที่ถูกทำร้าย, ภาวะสุขภาพจิต, ประเทศไทย, สตรี

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