Examining Mediators of Intimate Partner Violence and Depressive Symptoms among Thai Women with Gynecological Problems

Nanthana Thananowan, Nopporn Vongsirimas

Abstract: Although associations among intimate partner violence, stress, social support, self-esteem, and depressive symptoms are well documented, the mechanism of these links has not been fully explored. This study is part of a larger research project that investigated intimate partner violence, health consequences, and coping patterns among 532 Thai women with gynecological problems. The aim of this study was to examine the potential mediators (e.g., stress, social support, and self-esteem) of the relationship between intimate partner violence and depressive symptoms by using a structural equation modeling approach. Data were collected from self-reported questionnaires, including the: Demographic Characteristics Questionnaire, Abuse Assessment Screen, Index of Spouse Abuse, Stress Test, Multidimensional Scale of Perceived Social Support, Rosenberg's Self-Esteem Scale, and Center for Epidemiologic Studies Depression Scale.

Results revealed that 21.1% of participants experienced intimate partner violence within the previous year and 17.1% had depressive symptoms. Intimate partner violence was significantly positively correlated with stress and depressive symptoms but negatively correlated with social support and self-esteem. Intimate partner violence exhibited indirect effect on depressive symptoms through stress, social support, and self-esteem. The model fitted the empirical data and accounted for 92% of the variance of depressive symptoms. Therefore, intervention programs that include the role of these factors may be effective in preventing depressive symptoms among abused Thai women with gynecological problems.

Pacific Rim Int J Nurs Res 2014; 18(3) 216-227

Keywords: depression, gynecological problems, intimate partner violence, mediator, Thai women

Introduction

Although intimate partner violence (IPV) has long been seen as a private family matter in many countries, in the past few years it has been recognized as both a public health problem and a human rights violation.[1] Not only is IPV a substantial health consequence by nature of its direct effects, such as physical and sexual, but it also contributes to women's

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mental health, including fear, anxiety, stress, hostility, self-esteem, depressive symptoms, posttraumatic stress disorder, suicidal thoughts, and suicide attempts.[1-4] Although there is evidence documenting the link between IPV and increased risk for mental health, less is known about the mechanisms or pathways responsible for the risk among Thai women. Understanding these pathways is important to the development of effective interventions.

Literature Review

The prevalence of IPV has been increasingly documented and recognized as an important public health issue worldwide. Over 25% of U.S. adult women report having been a victim of sexual assault or rape, physical assault, or stalking at some point in their lives.[1] According to the WHO multi-country study on women's health and violence against women in Thailand, 23% of ever-partnered women in Bangkok and 34% in Nakhonsawan reported physical violence by their intimate partner at some time in their life; and 30% in Bangkok and 29% in Nakhonsawan reported that they had experienced sexual violence by an intimate partner.[5] Combining these data, 41% of ever-partnered women in Bangkok and 47% in Nakhonsawan had experienced physical or sexual violence by an intimate partner.[5]

IPV often results not only in serious physical or sexual injury but also puts women at risk for the development of mental disorders.[2] There is some evidence of the relationship between IPV and depression. A meta-analysis by Golding[6] found that abused women were 3.8 times more likely to experience depression when compared to women in general. Rhodes and colleagues[7] reported that women presenting to the emergency department who disclosed IPV were 2.5 times more likely to have depressive symptoms than women who did not screen positive for IPV. Sixty per cent of women with depression were more likely to have a history of IPV.[8] In Thailand, abused pregnant women had significantly higher levels of depressive symptoms than non-abused pregnant women.[9] A recent investigation of mental health among Thai women with gynecological problems found that women who experienced emotional violence had significantly higher levels of depressive symptoms than those experiencing physical and sexual violence.[4]

Risk factors for depression include substance abuse, chronic physical illness, stressful life events, social isolation, a family history of depression, and a history of physical or sexual abuse.[10] Research has revealed that moderate to severe depressive symptoms were predicted by physical abuse coupled with daily stress among abused women.[11] Chang and colleagues stated that IPV is a chronic stressor that predominantly affects women of reproductive age.[12] In fact, stress from IPV causes an imbalance between mental demands and individual resources, which in turn places abused women at risk to have maladaptive emotional responses to high level of stress, resulting in either direct or indirect negative health consequences.[13] Consistent with previous research, a local study in Thailand indicated that stress was significantly associated with depressive symptoms experienced by abused women.[4]

Recent research suggests that social support is another factor that related to mental health for abused women. For example, perceived social support was associated with higher quality of life and lower depression.[14] Effects of physical abuse on quality of life and depression were mediated by satisfaction with social support, perhaps because physical abusers isolate abused women from friends and other sources of support, which in turn causes a negative effect on mental health. Thus, social support is a potential protective factor that can buffer mental health in several ways, such as reducing stressful events and depressive symptoms, increasing coping strategies, and enhancing levels of self-esteem.[15]

Besides social support, self-esteem was considered to be one of the psychosocial processes through which victimization may affect mental health.[16] Interpersonal victimization has been associated with low levels of self-esteem.[4,16] At the same time, low levels of self-esteem have been correlated with depressive symptoms and other mental disorders. However, previous research has examined the potential mediating effects of self-esteem with inconsistent results,[17,18] perhaps because this mechanism is complex and far from understood.[19]

Despite an increasing focus on mental health among abused women, the role of stress, social support, and self-esteem in mediating depressive symptoms has been under investigated. Taken together, IPV and these factors may contribute to depressive symptoms. Although there is substantial evidence linking IPV and depression in emergency medical samples,[20] community samples,[21] and obstetric samples,[22] less is known about the pathways responsible for the risk among gynecological samples. Therefore, the purpose of this study was to examine stress, social support, and self-esteem as mediators of IPV and depressive symptoms among Thai women with gynecological problems.

Methods

Design: A predictive correlational design was used in this study.

Sample and Setting: A convenience sampling technique was used to find potential participants and the inclusion criteria were: Thai women between 15 and 65 years of age at time of recruitment, currently had or have left an intimate partner relationship, had any gynecological problem that was diagnosed by a gynecologist, did not have an urgent healthcare need, and could read and write in Thai. The two gynecology wards of a university hospital in Bangkok, Thailand were selected because they served a large number of women with gynecological problems, including menstrual disorders, sexually transmitted infections (STIs), benign tumor (e.g., myoma uteri), and gynecological cancer (e.g., cervical cancer).

Based on power analysis for structural equation modeling (SEM), the sample size requirement which would yield power of at least 80%, with 80 degrees of freedom, was RMSEA=0.02 with 0.05 significance level,[23] so the required sample size was at least 250 participants each for non-abused and abused groups. With 10% attrition rate, 550 potential participants were expected. A total of 562 participants consented. Unfortunately, 30 cases (5.6%) were excluded due to missing data, leaving a final sample size of 532. Data collection occurred July 2011-December 2012.

Ethical Considerations: Recruitment strategies included a staff nurse at each gynecology ward to identify eligible inpatient Thai women. The principal investigator (PI) in each setting provided potential participants with an information sheet and a consent form. For participants younger than 18, formal permission was obtained from their guardians. Participants were informed that this study was approved by an institutional review board of the hospital, the purpose, and the risks and benefits of the study. Participation in this study was on voluntary basis. Serial code numbers instead of participants' names were used to maintain the confidentiality and anonymity. For safety and confidentiality reasons, a participant could choose either sign an informed consent or give a verbal consent to participate in this study.[24]

Data Collection: After consenting, the participants were invited to stay at their bedsides or in the health consulting room at each site to complete the set of structured questionnaires. If a participant needed help due to their illness or visual problem, the PI read the content of the questionnaires and asked the participant to provide a verbal or non-verbal response to each question asked. After completion, participants

put their questionnaires in a sealed box provided at nurses' station. All participants received a list of services related to IPV and information about mental health services of the hospital if they wished. Questionnaire administration averaged 30 minutes in length.

Instruments: Seven instruments were used for data collection. The first two scales (The Abuse Assessment Screen and the Index of Spouse Abuse) were published for public use while the rest were used with the authors' permission and from those who had originally translated the English version of each instrument into Thai. All instruments (except for the Stress Test) were translated from English to Thai using a forward-backward translation method. The revised instruments were pilot-tested for internal consistency reliabilities by 30 Thai women with gynecological problems.

The Demographic Characteristics Questionnaire (DCQ) included age (women and their partners), marital status, number of marriage, length of marriage, education, career, income, socioeconomic status, family structure, and family relationship.

Experiences of IPV were measured by two instruments: the Abuse Assessment Screen (AAS)[25] and the Index of Spouse Abuse (ISA).[26] This is because some women may feel uncomfortable and stigmatized to identify themselves as abused on the AAS questions, but they might be willing to report the severity of their abusive relationship on the ISA instead.

The AAS is used to screen physical, sexual, and emotional abuse by answering yes (1) and no (0) of three questions including: (1) "Within the last year, have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?"; (2) "Within the last year, has anyone forced you to have sexual activities?"; and, (3) "Are you afraid of your partner or anyone you listed above?" Participants were categorized as exposed to IPV if they reported at least one of three screening questions. The AAS yielded a higher detection of violence in all three categories compared with a standard interview.[27] Cronbach's alpha for this sample was 0.84.

The ISA was used to measure the intensity of past physical (11 items) and non-physical (19 items) violence while a woman was living with the intimate partner. Women were asked to indicate the frequency of abusive acts ranging from 1 *(never)* to 5 *(very frequently)*. Examples of items were presented in a previous publication.[4] Scores were computed by summing individual items for a possible range from 30 to 150. The alpha coefficient for this sample was 0.97.

The Stress Test (ST)[28] has 20 items for screening women at risk for stress by assessing signs, behaviors, or feelings during the last two months. This instrument includes response alteration ranging from 0 *(none of the time)* to 3 *(almost or all of the time)*. The Stress Test is scored on a scale from 0 to 60. The higher the score, the more the woman is stressed. Content validity and reliability of the scale has been accepted.[4] The alpha coefficient for this sample was 0.94.

The Multidimensional Scale of Perceived Social Support (MSPSS)[29] measured woman's amount of social support received from family, friends, and significant others. The scale included response alternatives ranging from 1 *(very strongly disagree)* to 7 *(very strongly agree)*. A total score is calculated by summing across all 12 items with a possible range from 4 to 28. The higher the scores, the more the woman has a higher level of social support as listed. The MSPSS has been used in Thailand to measure perceived social support in adolescents and adults, with a reliability range of 0.89 to 0.96.[4,30] The alpha coefficient for this sample was 0.92.

The Rosenberg's Self-Esteem Scale (RSE)[31] is a well-validated instrument composed of two

subscales: a feeling of self-worth and self-respect (8 items); and a feeling of competence and ability (2 items). A woman rates how much she has valued herself in the last month ranged from 1 (*strongly disagree*) to 4 (*strongly agree*). A total score is obtained by summing across each item score ranging from 10 to 40 (negatively stated items were reverse scored). The higher the score, the higher woman's self-assessed self-esteem. Reliability of the scale ranged from 0.77 to 0.88.[4,32] Cronbach's alpha value for this sample was 0.94.

The Center for Epidemiologic Studies Depression Scale (CES-D),[33] having 20 items, is used to screen depression by assessing the frequency and duration of depressive symptoms. The instrument has response alternative ranging from 0 *(rarely or none of the time)* to 3 *(almost or all of the time)*. A total score is obtained by summing across each item score ranging from 0 to 60. The higher the score, the greater level of depressive symptoms with a score of 16-29 indicates mild to moderate depressive symptoms, while scores more than 30 suggest severe depressive symptoms.[4] For Thai culture, a woman with a CES-D 16 of greater was considered to be experiencing depressive symptoms.[30] Therefore, the cut off score of CES-D used in this study was ≥ 16. Cronbach's alpha value for this sample was 0.96.

Data Analysis: Prior to analysis, all variables in the model satisfied the assumptions of normality and multicollinearity. Descriptive analysis was conducted with SPSS 13.0 to determine the characteristics of participants and the prevalence of IPV. Differences between non-abused and abused groups were compared using independent sample t-tests for continuous variables (i.e., age and length of marriage) and chi-square tests for categorical variables (i.e., marital status, number of marriage, education, career, income, socioeconomic status, family structure, and family relationship). After Pearson's correlation analyses, the proposed mediators (i.e., stress, social support, and self-esteem) were correlated significantly with IPV and were therefore included in the analysis. By using structural equation modeling (SEM),[34] the hypothesized model was tested to estimate the relationships between observed and latent variables (the measurement model) and among latent variables themselves (the construct model), as well as direct and indirect effects. Maximum Likelihood (ML) using LISREL version 8.72 was used for data analysis.

Results

Overall, the 532 Thai women's age ranged from 15-65 years, with a mean of 42.46 (SD=12.174) and their partners' age ranged from 15-80 years, with a mean of 44.50 (SD=12.937). The majority (n=380; 71.4%) were married and about 34% had been remarried. The average length of marriage was about 15.24 years (SD=11.021). Almost half (n=289; 40%) had obtained more than high school education. The majority (n=393; 73.8%) were employed. The household income was commonly less than 10,000 Thai baht per month (n=262; 49.3%). Almost half (n=243; 45.6%) had insufficient incomes or were in debt. The majority (n=416; 78.2%) lived with their husbands and children. Most (n=339; 62%) had some arguments with their partners.

From Chi-square analyses, all categorical variables as listed were significantly different between non-abused and abused groups (Table 1). However, there was no difference between groups on age and length or marriage. Prevalence of past IPV was 21.1% (n=112). With respect to types of IPV, physical abuse in the past year was most frequently reported (17.3%). Sexual abuse in the past year (11.5%) and emotional abuse (13.2%) were also found. Of the 112 abused women, 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 partners.

Table 1 Sample Characteristics of Women with Gynecological Problems (n=532)

	Total (*n*=532)	**Non-Abused gr. (*n*=420, 78.9%)**	**Abused gr. (*n*=112, 21.1%)**	***P***
Women's age, mean (SD)	42.46 (12.174)	42.61 (12.108)	41.92 (12.460)	.595[a]
Partners' age, mean (SD)	44.50 (12.937)	44.60 (13.002)	44.10 (12.740)	.713[a]
Marital status				.000[b]
- married	71.4	74.0	61.6	
- separated	12.4	10.3	20.5	
- divorce	4.7	3.8	8.0	
- widow	8.1	8.8	5.4	
- cohabitating	3.4	3.1	4.5	
Number of Marriages	1.51 (1.142)	1.38 (.679)	2.00 (2.049)	.000[b]
- one	66	71	47	
- remarried	34	29	53	
Length of marriage	15.24 (11.021)	15.56 (11.001)	14.06 (11.068)	.203[a]
Education				.000[b]
≤ high school	60	56.4	73.2	
> high school	40	43.6	26.8	
Career				.000[b]
- unemployed	14.4	12.9	19.7	
- employed	73.8	74.3	72.4	
- housewife	11.8	12.8	7.9	
Income/month (Thai baht)				.000[b]
< 10,000	49.3	45.5	63.3	
10,001-20,000	24.7	26.4	18.8	
20,001-30,000	11.1	10.7	12.5	
> 30,001	14.9	17.4	5.4	
Socioeconomic status				.000[b]
- sufficient	54.4	60.4	31.2	
- insufficient	22.9	20.2	33.0	
- in debt	22.7	19.4	35.8	
Family structure				.000[b]
- with husband or children	78.2	78.5	76.7	
- with family members	18.6	19.3	16.1	
- with others/friends	1.9	1.7	2.7	
- live alone	1.3	0.5	4.5	
Family relationship				.000[b]
- good relationship	21.6	24.5	10.7	
- poor communication	1.7	1.9	0.9	
- some arguments	62.0	67.6	41.1	
- marital conflict	14.7	6.0	47.3	

a = T-test statistic, b = Chi-square statistic

Table 2 shows the results of Pearson's correlational analyses of IPV (i.e., ISA), mediator variables, and depressive symptoms. Statistically significant mild relationships were found between the severity of violence (ISA) and women's stress (ST) (r=.410, p < .01). Most results were in the expected direction, that is, a higher level of ISA was positively correlated with stress and depressive symptoms, but negatively correlated with social support and self-esteem.

Table 2 Bivariate Correlation of the Study Variables (n=532)

Scales	ISA	ST	MSPSS	RSE	CES-D
1. ISA	1.000	.410**	-.234**	-.269**	.351**
2. ST		1.000	-.335**	-.637**	.871**
3. MSPSS			1.000	.567**	-.341**
4. RSE				1.000	-.693**
5. CES-D					1.000

*Note: * p < .05, ** p < .01*
ISA = Index of Spouse Abuse
ST = Stress Test
MSPSS = Multidimensional Scale of Perceived Social Support
RSE = Rosenberg's Self-Esteem Scale
CES-D = Center for Epidemiologic Studies Depression Scale

To explore the extent to which IPV was associated indirectly with depressive symptoms, data analysis using structural equation modeling (SEM) approach revealed a significant fit with chi-square=68.29; df=54; p-value=0.091; RMSEA=.022, GFI=.980; AGFI=.960. The results in Table 3 and Figure 1 indicated that not only did IPV exhibit direct effects on stress (β= .50, p < .01), social support (β= -.13, p < .05), and self-esteem (β= .14, p < .01), but it also had a significant, positive, total effect on depressive symptoms (β= .42, p < .01). Importantly, the indirect effect of IPV through the mediating variables (i.e., stress, social support, and self-esteem) was statistically significant (β= .44, p < .01). The model fitted very well to the empirical data and explained 92% of the variance of depressive symptoms. This may because the relationship between stress and depressive symptom is very high (.87) (Table 2).

Table 3 Direct, Indirect, and Total effects of Latent Variables in the Model

Causal Variables	Effected Variables											
	Stress			Social Support			Self-Esteem			Depressive Symptoms		
	DE	IE	TE	DE	IE	TE	DE	IE	TE	DE	IE	TE
IPV	.50**	-	.50**	-.13*	-.22**	-.35**	.14**	-.45**	-.31**	-.02	.44**	.42**
Stress				-.45**	-	-.45**	-.44**	-.29**	-.74**	.85**	.13*	.98**
Social Support							.65**	-	.65**	.22*	-.20	.02
Self-Esteem										-.31**	-	-.31**
Structural Equation Fit	R^2 = .25			R^2 = .28			R^2 = .81			R^2 = .92		

*Note: * p < .05, ** p < .01*
DE = Standardized direct effect, IE = Standardized indirect effect, TE = Standardized total effect

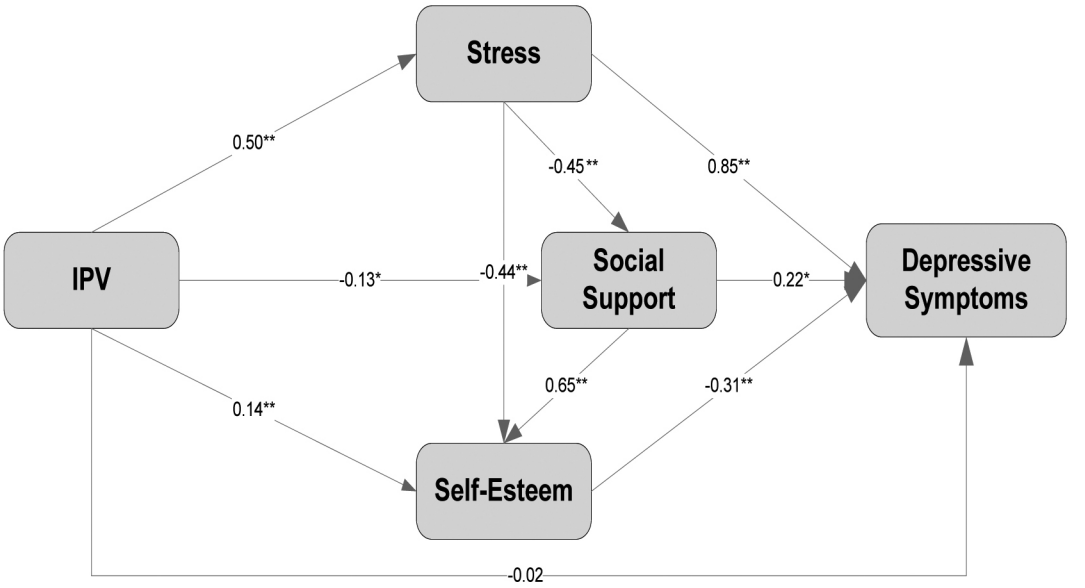

Figure 1 Mediators of IPV and depressive symptoms among Thai women

*Note: * p < .05, ** p < .01*

Discussion

The findings of this study add to our knowledge of the prevalence of IPV and the multiple mediators of IPV and depressive symptoms among Thai women with gynecological problems. The prevalence of IPV among these women was substantial (21.1%) and comparable to the U.S. study among women who were patients in a gynecology ward (20.5%).[35] However, these prevalence rates were approximately five times higher than that found in pregnant women (3.9-8.7%).[36] Additionally, the prevalence of physical abuse (17.3%) and sexual abuse (11.5%) in this study were higher than a population-based study that reported physical and sexual violence in the past year about 5.7% and 3.7%, respectively.[37] A possible explanation for the higher rate of IPV in this study may involve the study design. The questionnaires were a self-administered anonymous approach about intimate relationship, enabling women to feel more comfortable revealing their information about abusive relationship. Due to the sensitive nature of this issue, obtaining consent in this study was done either verbally or in writing. This is because asking for a signature of the potential participant may not appropriate in Thai culture and can possibly place a woman at risk. A third possible explanation was abused women may come to the hospital with injuries or somatic symptoms from physical or sexual abuse, thus the prevalence of IPV from women in hospital settings would be expected to have a higher prevalence than women in population settings.

Consistent with previous research,[38,39] the findings confirmed that IPV have different effects on women's mental health. Despite this, since depressive symptoms was found to be strongly correlated with stress, it is probable that an increase in depressive symptoms could aggravated by stress, which in turn could lead to worsening of depressive symptoms. It is important not to overlook depressive symptoms in abused women with stress. Therefore, efforts to identify women with depressive symptoms should include screening of IPV and assessing for stress.

However, Thai women are traditionally not supposed to talk about their episodes of violence and/or mental health because talking is labeled as deviant and it disrupts family harmony. Thus, health care protocols for abused women should include not only screening of IPV, but also investigating any stressful life event and source of social support as well as level of self-esteem to prevent depressive symptoms.[40]

In order to identify the mediating variables, the results of SEM revealed that there was a statistical significant indirect effect of IPV on depressive symptoms, without significant direct effect. This finding indicated that the mediation model was supported because the direct path between IPV and depressive symptoms did not provide a better fit to the data (i.e., the direct path between the predictor and the outcome was not significant). This result also showed casual relationships among mediators (stress, social support, and self-esteem). This implied that the relationship between IPV and depressive symptoms was completely mediated by variables including stress, social support, and self-esteem. Results suggested that the mediators could resist the effect of IPV on depressive symptoms. Therefore, stress relief strategy as well as enhance social support and self-esteem need to be designed for abused Thai women with gynecological problems.

Limitations

The results of this study should be interpreted in light of the following limitations. First, the use of a convenience sampling from a university hospital limits the generalizability of the findings to women outside this population. Further work examining a representative sample of women from diverse hospital settings is important for a better understanding. Second, the cross-sectional design does not allow an evaluation of the causal relationship among the study variables. Longitudinal studies are essential for verifying the causal link between IPV and depressive symptoms. Third, the use of self-report measures may still be subject to bias and/or limited recall with the participants underreporting the extent of their IPV experience and/or mental health problems. Future studies might consider the use of multiple data collection methods, including the patient's chart or the biological measures (e.g., salivary cortisol level).[12] Finally, qualitative studies may also be conducted to explore the context within which IPV takes place so that a more comprehensive picture of the women's experiences IPV and mental health can be elicited and better understood.

Conclusion and Implications for Nursing Practice

This study was the first to examine IPV associated with depressive symptoms within a mediation model framework among Thai women with gynecological problems. The findings highlight not only the high prevalence of IPV among this population, but also the complex interrelationships between IPV and mental health. Prevention programs that incorporate hospital services, including mental health counseling, stress reductions, and empowerment programs, as well as social supports should be multidimensional with equal time placed on violence prevention strategies. Importantly, screening of IPV and identifying women's mental health during a gynecological admission should be intervened to prevent a woman at risk for further abusive relationships and mental health problems.

Acknowledgement

Authors thank to the China Medical Board (CMB) by the Faculty of Nursing, Mahidol University for their financial support of this study. Also thanks to the women whose valuable contributions to this study have enlightened our understanding of the complexity of IPV and mental health.

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การศึกษาตัวแปรส่งผ่านของความรุนแรงที่เกิดจากคู่สมรสกับภาวะซึมเศร้าในสตรีไทยที่มีปัญหาทางนรีเวช

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บทคัดย่อ: ถึงแม้ว่าจะพบรายงานวิจัยที่แสดงความสัมพันธ์ของความรุนแรงที่เกิดจากคู่สมรส ความเครียด การสนับสนุนทางสังคม ความรู้สึกมีคุณค่าในตนเอง และภาวะซึมเศร้าก็ตาม กลไกของความสัมพันธ์ดังกล่าวยังไม่ได้มีการศึกษาเท่าที่ควร การวิจัยครั้งนี้เป็นส่วนหนึ่งของโครงการวิจัยที่ศึกษาความรุนแรงที่เกิดจากคู่สมรส ผลกระทบต่อสุขภาพและแบบแผนการแก้ปัญหาจากสตรีไทยที่มีปัญหาทางนรีเวช จำนวน 532 คน วัตถุประสงค์ของการวิจัยเพื่อค้นหาตัวแปรส่งผ่าน (ในที่นี้ได้แก่ ความเครียด การสนับสนุนทางสังคม และความรู้สึกมีคุณค่าในตนเอง) ระหว่างความสัมพันธ์ของความรุนแรงที่เกิดจากคู่สมรสกับภาวะซึมเศร้าด้วยวิธีการวิเคราะห์สมการเชิงโครงสร้าง การเก็บข้อมูลเป็นการให้กลุ่มตัวอย่างตอบแบบสอบถามด้วยตนเองซึ่งประกอบด้วย แบบสอบถามข้อมูลส่วนบุคคล แบบคัดกรองความรุนแรง แบบวัดระดับความรุนแรงของการถูกทำร้าย แบบวัดความเครียด แบบสอบถามความช่วยเหลือทางสังคมแบบพหุมิติ แบบสอบถามความรู้สึกมีคุณค่าในตนเอง และแบบสอบถามภาวะซึมเศร้าตามลำดับ

ผลการวิจัยพบว่า กลุ่มตัวอย่างร้อยละ 21.1 ได้รับความรุนแรงที่เกิดจากคู่สมรสและร้อยละ 17.1 มีภาวะซึมเศร้า ความรุนแรงที่เกิดจากคู่สมรสมีความสัมพันธ์เชิงบวกกับความเครียดและภาวะซึมเศร้า แต่มีความสัมพันธ์เชิงลบกับการสนับสนุนทางสังคมและความรู้สึกมีคุณค่าในตนเอง ความรุนแรงที่เกิดจากคู่สมรสมีอิทธิพลทางอ้อมต่อภาวะซึมเศร้าโดยผ่านตัวแปรความเครียด การสนับสนุนทางสังคมและความรู้สึกมีคุณค่าในตนเอง โมเดลนี้สอดคล้องกับข้อมูลเชิงประจักษ์และตัวแปรอิสระทั้งหมดในโมเดลร่วมกันอธิบายความแปรปรวนของภาวะซึมเศร้าได้ถึงร้อยละ 92 ดังนั้น โปรแกรมการป้องกันภาวะซึมเศร้าในสตรีที่ถูกทำร้ายควรคำนึงถึงบทบาทของตัวแปรส่งผ่านเหล่านี้ด้วย

Pacific Rim Int J Nurs Res 2014 ; 18(3) 216-227

คำสำคัญ: ภาวะซึมเศร้า, ปัญหาทางนรีเวช, ความรุนแรงที่เกิดจากคู่สมรส, ตัวแปรส่งผ่าน, สตรีไทย

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