THE RELATIONSHIP BETWEEN INTIMATE PARTNER VIOLENCE AND QUALITY OF LIFE AMONG THAI WOMEN: THE MODERATING EFFECTS OF FAMILY SUPPORT AND FRIEND SUPPORT

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by

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Abbreviations

CI	Confidence interval
DQOL	Domains of quality of life
EIPV	Extent of intimate partner violence
HIV	Human immunodeficiency virus
HRQOL	Health-related quality of life
IPV	Intimate partner violence
ML	Maximum likelihood
MSPSS	Multidimensional Scale of Perceived Social Support
OLS	Ordinary least squares
PMWI	Psychological Maltreatment of Women Inventory
QOL	Quality of life
STI	Sexually transmitted infection
SVAWS	Severity of Violence Against Women Scales
VIF	Variance inflation factor
WHOQOL-BREF	World Health Organization Quality of Life-Brief version
WIPV	Women who have experienced intimate partner violence

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THE RELATIONSHIP BETWEEN INTIMATE PARTNER VIOLENCE AND QUALITY OF LIFE AMONG THAI WOMEN: THE MODERATING EFFECTS OF FAMILY SUPPORT AND FRIEND SUPPORT

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Intimate partner violence (IPV) is a critical social issue and impacts female victims' health circumstances and quality of life (QOL). IPV includes physical, psychological, and sexual violence. In Thai women, rates of psychological, physical, and sexual violence have been estimated at 89.8%, 61.3%, and 25.4%, respectively. Family and friends have been reported as playing an important role in reducing the impact of IPV on QOL. Nevertheless, little is known about the effect of having support from family and friends as it applies to domains of QOL (DQOL) among Thai women experiencing one or more types of IPV. The research findings of this study will increase the understanding of the relationships among the extent of IPV (EIPV), family support, friend support, and DQOL. This understanding may facilitate the promotion of effective family and friend support interventions in this vulnerable population.

The overall aim was to determine whether family support and friend support moderate the relationship between EIPV (conceptualized as the number of types of IPV experienced) and DQOL among Thai women. An adapted Cohen and McKay's Stress-Buffering Model (SBM) was the theoretical framework used to guide this study. The SBM posits that negative outcomes can be mitigated when IPV, as a stressful event, interacts with appropriate social support. This study was a descriptive, cross-sectional analysis of an existing dataset collected from Thai

female patients between 18 and 60 years of age from OB/GYN units in a large hospital in northeast Thailand.

Among the 283 participants, the rates of EIPV, classified as no abuse, one-type, two-types, and all three-types, were 9.9%, 25.8%, 42.0%, and 22.3%, respectively. The results show both family support and friend support moderated between EIPV and psychological health. The buffering effects were stronger for women who experienced multiple types of IPV. The more IPV types experienced and the less family and friend support received, the lower the score of psychological health. Neither family nor friend support moderate the relationships among EIPV and the other four DQOL.

The study findings revealed both family and friend support are advantageous for minimizing the adverse effect of EIPV on women's psychological health. These findings suggest screening for a history of IPV in female clients receiving hospital services may enable early detection of abuse. The findings could also provide a better understanding of female victims' perception of available social support and aid in the development and testing of interventions for victims in Thailand and possibly other Southeast Asian countries with similar cultural contexts.
Key words: intimate partner violence, family support, friend support, quality of life

Chapter I

Introduction

Background and Significance

Intimate partner violence (IPV) is the most common form of violence women experience and a significant public health concern worldwide. About one-third of ever- partnered women globally have experienced physical and/or sexual violence by their intimate partners during their lives (García-Moreno et al., 2013). According to the World Health Organization (WHO), high-income countries such as the United States, Canada, Denmark, and Australia have the lowest rate of IPV (23.2%), while the highest rate is in Southeast Asia (37.7%), followed closely by the Eastern Mediterranean region (37.0%) and Africa (36.6%) (García-Moreno et al., 2013). In East Asia and the Pacific, more than 16 % of ever-married girls aged 15-19 years had experienced some form of physical, sexual, or psychological violence as committed by their partners (United Nations, 2014).

Although IPV can take a number of forms, most researchers have focused on physical, psychological, and sexual violence (Ross, Stidham, Saenyakul, & Creswell, 2015; Stöckl, March, Pallitto, & García-Moreno, 2014; WHO, 2012). The different forms of IPV often overlap. For example, WHO (2005) conducted a multi-country study and found that 23 to 56% of women who had experienced intimate partner violence (WIPV) were exposed to both physical and sexual violence. Surveys conducted in 12 countries within Latin America and the Caribbean revealed the rate of WIPV who were exposed to both physical and psychological violence in the previous 12 months ranged from 61.1% to 92.6%. (Bott, Guedes, Goodwin, & Mendoza, 2012). In Thailand, a country in Southeast Asia, the rates of psychological, physical, and sexual

violence among Thai female participants in a study by Ross et al. (2015) were 89.8%, 61.3%, and 25.4%, respectively. Some participants reported experiencing one form of IPV, while others reported exposure to multiple forms.

Factors associated with IPV are age, economic status, and education. A WHO survey on women's health and domestic violence conducted in nine countries found young women to be the most at risk for experiencing IPV (Stöckl et al., 2014). Poverty is well-documented as being another factor contributing to IPV (Ali, Asad, Mogren, & Krantz, 2011; Babu & Kar, 2009; Stöckl et al., 2014). Additionally, women with limited formal education are more likely to accept IPV than those with higher levels of education (Tran, Nguyen, & Fisher, 2016).

IPV has been identified as the leading cause of both short-term and long-term negative health outcomes for WIPV (Alsaker, Moen, & Kristoffersen, 2008; Black, 2011; WHO, 2016). IPV has resulted in fatal outcomes such as homicides and suicides (Banks, Crandall, Sklar, & Bauer, 2008; García-Moreno et al., 2013; Sabri, Campbell, & Dabby, 2016). IPV is also associated with increased incidences of physical injuries, post-traumatic stress, anxiety, depression, and sexually transmitted infections (Gao & Jacka, 2012; García-Moreno et al., 2013; Kamimura, Christensen, Tabler, Ashby, & Olson, 2014; WHO, 2016). IPV during pregnancy increases the likelihood of miscarriage (Taft & Watson, 2007), stillbirth (García-Moreno et al., 2013), preterm delivery (Rodrigues, Rocha, & Barros, 2008), low birth weight (García-Moreno et al., 2013; Valladares, Ellsberg, Peña, Högberg, & Persson, 2002), and antepartum depression (Martin et al., 2006). Some WIPV turn to unhealthy behaviors such as using illegal drugs, smoking, and/or drinking alcohol as a way of coping with the abuse (Macy, Ferron, & Crosby, 2009).

The negative health impacts of IPV generate an economic burden for victims as well as society, including the cost of medical and mental health services and lost productivity (Rivara et al., 2007; Roldós & Corso, 2013; Snow Jones et al., 2006; WHO, 2012). Researchers found health care costs for WIPV were higher than for the general female population (Wisner, Gilmer, Saltzman, & Zink, 1999). Australian women who had experienced a combination of severe physical, emotional, and sexual violence used more medications, counseling, and IPV services and were more likely to take time off work due to emotional health issues than those who had experienced less severe and fewer types of abuse (Hegarty et al., 2013). The cost of violence in England including additional financial burdens on housing, social and civil legal services, and the criminal justice system were reported at nearly £4 billion (approximately $5.5 billion) (Walby, 2009). The researcher also reported the cost of lost economic output, restricted to time off due to injuries from IPV, at £1.92 billion (approximately $2.2 billion). Cadilhac et al. (2015) estimated that a 5% absolute reduction in the prevalence of IPV in the Australian female population in 2008 would have led to total cost savings of AUD 377 million (approximately $292 million).

Studies have revealed a significant negative association between women's exposure to IPV and their quality of life (QOL) (Dindas & Ege, 2009; Ghasemi, Reshadat, Rajabi-Gilan, Salimi, & Norouzi, 2015; Leung, Leung, Ng, & Ho, 2005; Ross et al., 2015; Tavoli, Tavoli, Amirpour, Hosseini, & Montazeri, 2016). QOL is a subjective, complex, multidimensional concept involving an individual's perception of life (Meeberg, 1993), satisfaction with life (Cummins, 2005), and well-being (Ferrans, 1996; Haas, 1999). Domains of QOL include physical health, psychological health, social relationships, and environmental health (The

WHOQOL Group, 1996). Research has identified IPV as one factor that threatens WIPV's QOL across all four domains (Leung et al., 2005; Sotskova, Coghlan, & Woodin, 2011). Several studies focused on the relationship between IPV and health-related quality of life (HRQOL) involving the physical and psychological health domains. Women who experienced psychological, physical, or sexual abuse reported poor physical and psychological health (Asadi, Mirghafourvand, Yavarikia, Mohammad-Alizadeh-Charandabi, & Nikan, 2016; Costa et al., 2015; Dillon, Hussain, Loxton, & Rahman, 2013; Kamimura, Parekh, & Olson, 2013; Saito, Creedy, Cooke, & Chaboyer, 2012; Tavoli et al., 2016).

Exposure to IPV was found to also impact victims' QOL in the non-health related domains of social relationships and environmental health (Huang, Wu, & Frangakis, 2006). Some studies revealed that WIPV reported low scores in the social relationship domain along with negative physical, psychological, and environmental health (Ghasemi et al., 2015; Leung et al., 2005; Ross et al., 2015; Sotskova et al., 2011).

Not all studies support the association between IPV and QOL domains. Helfrich, Fujiura, and Rutkowski-kmitta (2008) found that no statistically significant differences in physical functioning existed between WIPV residing in a shelter and females in the general U.S. population. Mean scores of subscales related to physical health in Hispanic female victims who experienced physical, psychological, or sexual violence were similar to non-Hispanic victims (Chen, Rovi, Vega, Jacobs, & Johnson, 2009). No statistically significant differences in physical and psychological health between non-victims and those who experienced psychological abuse alone were found (Chen et al., 2009).

Age, educational level, duration of abuse, and economic status have been identified as reliable predictors of QOL among WIPV. Costa et al. (2015) reported that older victims experienced poorer physical health than younger ones. The researchers also found that WIPV with higher levels of education were likely to have better physical and mental health than those with less education. A longer duration of IPV was associated with lower HRQOL (Alsaker et al., 2008; Wai & Tsai, 2012). Job instability resulting from IPV, unemployment, and financial dependency affected both the economic well-being and QOL of participants in several studies (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012; Gharaibeh & Oweis, 2009; Wuerch, 2015).

Research findings have demonstrated that social support correlates closely with better physical and mental health (Beeble, Bybee, Sullivan, & Adams, 2009; Coker et al., 2002; Goodkind, Gillum, Bybee, & Sullivan, 2003; Kamimura et al., 2013; Ross et al., 2015). Social support refers to the social resources that individuals perceive are available when they need such aid (Cohen, Underwood, & Gottlieb, 2000). Social support consists of four types: instrumental, informational, emotional, and companionship (Taylor, 2011). Both informal and formal supporters are significant sources of social support. Social support has been shown to be beneficial for the health and well-being of WIPV (Beeble et al., 2009; Cohen et al., 2000; Cohen & Wills, 1985; Coker et al., 2002; Coker, Watkins, Smith, & Brandt, 2003; Goodkind et al., 2003; Kamimura et al., 2013; Ross et al., 2015; Taket, O'Doherty, Valpied, & Hegarty, 2014). American women who perceived high emotional support had better physical and mental health, including lower levels of psychological distress and a greater sense of mastery and higher self-esteem (Coker et al., 2003; Mitchell & Hodson, 1983).

A beneficial relationship between IPV and social support from family members and friends was not however indicated in all studies. Some women experiencing IPV reported that friends tended to be dismissive of their feelings and circumstances (Lewis, Henriksen, & Watts, 2015). Wright (2015) found friend support was related to a higher rate of revictimization, whereas family support significantly reduced the prevalence of revictimization. In Muslim societies, birth family members believe married women should not expect to receive support from them due to cultural beliefs regarding the traditional roles of males and females (Gharaibeh & Oweis, 2009). Some female victims in New Zealand reported they had refused support because they perceived the violence to be normal, not serious, or shamefully embarrassing, while others reported fearing the consequences of seeking help (Fanslow & Robinson, 2010).

Thailand is a country in the Eastern region of the globe where the people have adopted specific societal belief systems and values as influenced by Theravada Buddhist principles (Limanonda, 2000; Norsworthy, 2003; Ross & Ross, 2013). Even though Buddhism does not directly cause IPV, some of its principles can promote gender inequality. Hierarchical order is a vital characteristic of Thai society and is based on the Buddhist teaching that supports a vertical social relationship structure where dominance over others is recognized and accepted (Limanonda, 2000; Ross & Ross, 2013). A formalized superordinate-subordinate relationship or respect pattern is an integral component of Thai society (Limanonda, 2000). A younger person is expected to be subordinate to an older person, and a woman is expected to be subordinate to a man because of the requisite respect for elders and males (Ross & Ross, 2013). This also applies to relationships among children. If a child is nine, he is automatically subordinate to a 10-year-old.

The Buddhist concept of a hierarchical order also applies to the relationship structure of married couples (Limanonda, 1995). A husband dominates his family and makes all the decisions, while a wife is expected to respect her husband without expressing any superiority in either action or speech (Ho, 1990). This belief is clearly represented in the Thai metaphor that a husband is the elephant's forelegs (leader), while a wife is the elephant's hind legs (follower and supporter) (Limanonda, 1995; Ross & Ross, 2013). Many Thai men view their partners as personal property; Charoensuthipan (2017) reported more than 40% hold this view. Assavarak (2007) also found that women victims typically acquiesce to their partners' abusive behaviors due to this patriarchal belief.

Traditionally, Thai women have perceived their roles as the givers to husbands and children. They willingly sacrifice for the well-being of their family members (Coyle & Kwong, 2000). Women have been taught being a good wife means taking care of the entire family, maintaining harmony within the family, and preventing "loss of face" (Ho, 1990). "Loss of face" can occur when one member puts the other family members to shame or causes the family to lose respect in the community. The duty to conserve family well-being is more important than one's own happiness (Ho, 1990). Based on these traditional values, many Thai women view IPV as a private matter. Disclosure of abuse to others can result in shame and guilt for not being a good wife, or even an escalation in the severity of IPV (Chuemchit & Perngparn, 2014; Ross et al., 2015; Rujiraprasert, Sripichyakan, Kantaruksa, Baosoung, & Kushner, 2009; Saito, Cooke, Creedy, & Chaboyer, 2009). Some women keep silent as a strategy to protect their family members from any additional emotional burdens. Further, some mentioned they want their

husbands to be seen as good people (Ross et al., 2015) even though they were at risk for IPV (Rujiraprasert et al., 2009).

Since married life is highly preferred in Thai culture, WIPV view divorce as a stigma and failure (Assavarak, 2007; Hirschman & Teerawichitchainan, 2003; Limanonda, 1995). Divorced or separated women are more likely to be questioned by society as compared to men (Boonmongkon, Kovindha, Thurston, & Sanhajariya, 2005). Divorces and remarriages are culturally acceptable for men but not for women (Sricamsuk, 2006). Charoensuthipan (2017) reported around 77% of Thai female respondents stated they believed women must have a monogamous relationship.

Research regarding IPV in Thai women has focused on examining the relationship between IPV and health outcomes primarily in antenatal and postnatal populations. Pregnant WIPV reported significantly poorer health in emotional role functioning, vitality, bodily pain, mental health, and social functioning compared to those in non-abusive situations (Saito, Creedy, Cooke, & Chaboyer, 2013; Sricamsuk, 2006). Pregnant WIPV were more likely to have higher levels of depressive symptoms than those in non-abusive relationships (Thananowan & Heidrich, 2008). Additionally, IPV positively associated with pregnancy complications and negative physical as well as psychological health outcomes (Punsomreung, 2012).

Some researchers included social support in their examination of IPV and health outcomes. Thananowan and Kaesornsamut (2010) learned that IPV during pregnancy associated negatively with social support and self-esteem. Other studies indicated that social support mediates the relationship between IPV and antenatal depression (Thananowan, Vongsirimas, Kedcham, & Kaesornsamut, 2012). About 21% of pregnant women with IPV wanted support

from family and/or friends, while 39% preferred to solve problems themselves (Pengpid, Peltzer, McFarlane, & Puckpinyo, 2016). Saito et al. (2012) reported rates of psychological, physical, and sexual violence at 35.4%, 13.1%, and 11.3%, respectively in women from childbirth to six weeks postpartum. All forms of violence negatively affected the well-being of these postpartum victims. Psychological violence impacted physical functioning, social functioning, and mental health, while sexual violence significantly affected emotional well-being.

Few studies focused specifically on IPV, social support, and health outcomes among Thai women in the general population. WHO's multi-country study on health and domestic violence against women revealed that Thai women who were exposed to physical and/or sexual partner violence were significantly more likely to report poorer physical health and higher levels of emotional distress than non-abused women (WHO, 2005). Half of these WIPV had not disclosed their abusive experiences to anyone. Some WIPV who chose to disclose to family members and friends reported that they did not feel supported (WHO, 2005). Chuemchit and Perngparn (2014) found IPV among Thai women in the general population associated closely with depression, anxiety, phobias, and post-traumatic stress disorder.

Only one study examined IPV, social support, and QOL in Thai women. Ross et al.'s (2015) mixed-methods study identified an association among IPV, social support, and health outcomes (depression, physical symptoms, and QOL). Support from family members, friends, and significant others weakly mediated the relationship between IPV and health outcomes ($z = -2.16$, $p = .031$). Qualitative results revealed most victims disclosed IPV in order to seek help from family and/or friends but not from partners (Ross et al., 2015). The authors reported

social support was helpful for some women, whereas others indicated they received no benefit. This suggests the role of family and friend support among Thai women remains unclear.

In addition, the instrument used by Ross et al. (2015) to measure QOL was the World Health Organization Quality of Life-Brief version (WHOQOL-BREF) which includes four domains (physical, psychological, environmental health, and social relationship) and considers support to be a mediator. Since WHOQOL-BREF Thai version was validated among community dwellers, it may not be applicable to WIPV in hospital settings (Ross, 2017). Consequently, Ross, Shahrour, Stidham, and Delahanty (2017) reanalyzed the data regarding QOL using exploratory factor analysis which resulted in the generation of five domains of QOL (physical health, psychological health and relationship, self and spirituality, safety and environment, and medical care needs). The fifth domain may enable Thai healthcare professionals to assess QOL in Thai WIPV who receive services in the hospital. Thai nurses have a limited time to provide care to each patient as a result of a nursing shortage in the public healthcare system (Sawaengdee et al., 2016). Screening initially for the number of types of IPV that women have experienced would be more efficient than using long questionnaires.

The Gap in Knowledge

Because Ross et al.'s study (2015) examined the IPV of Thai women receiving care in the hospital by classifying physical, psychological, and sexual abuse as continuous variables, little is known about the extent of IPV (EIPV) conceptualized as the number of types of IPV the women had experienced (no IPV experience, one-type IPV, two-type IPV, and three-type IPV). Additionally, the authors tested the mediating effect of support from family, friends, and spouse as a single variable and found only a weak statistical effect on the relationship between IPV and

QOL. Although qualitative data revealed participants perceived they received support from family and friends, the moderating effects of these two kinds of support on EIPV and QOL remain unknown. Since QOL was determined using the total scores of the four domains of WHOQOL-BREF, limited information is known about how the interaction of EIPV and family/friend support impacts the score of each of the domains of QOL as modified by Ross et al. (2017).

Overall Aims

The overarching aim of the current study was to examine the moderating effects of family support and friend support on the relationships between EIPV and each of the five domains of QOL among Thai women. Thus, the specific aims are as follows:

Aim 1. Explore the relationships between EIPV and DQOL as moderated by family support.

H1: Family support will function as a moderator for the relationships between EIPV and DQOL when controlling for age, education, and income.

Aim 2. Explore the relationships between EIPV and DQOL as moderated by friend support.

H2: Friend support will function as a moderator for the relationships between EIPV and DQOL when controlling for age, education, and income.

Theoretical Framework

Intimate partner violence is conceptualized as a stressor in WIPV's lives that can negatively impact their health and well-being. The current study focused specifically on determining the moderating effects of family support and friend support on the relationships

between EIPV and each DQOL. Since WIPV who are exposed to multiple types of abuse can suffer adverse consequences to their health and well-being, this study proposed that family and friend support could act as protective factors and positively influence their DQOL.

The theoretical underpinning of the current study is the Stress-Buffering Model proposed by Cohen and McKay (1984) (see Figure 1) which posits that the presence of social support helps buffer or protect individuals from the potential harm of stressful events (Cohen et al., 2000; Cohen & Wills, 1985). This theoretical model is aligned with the Stress and Coping Theor*y* which states that social support protects people from the negative health effects of stressful events by influencing thought and coping ability (Lazarus & Folkman, 1984). When individuals with little or no social support encounter psychological stress, their health and well-being will most likely be negatively impacted. The negative consequences of stress may be minimized or eliminated for those with stronger perceived support (Cohen & McKay, 1984).

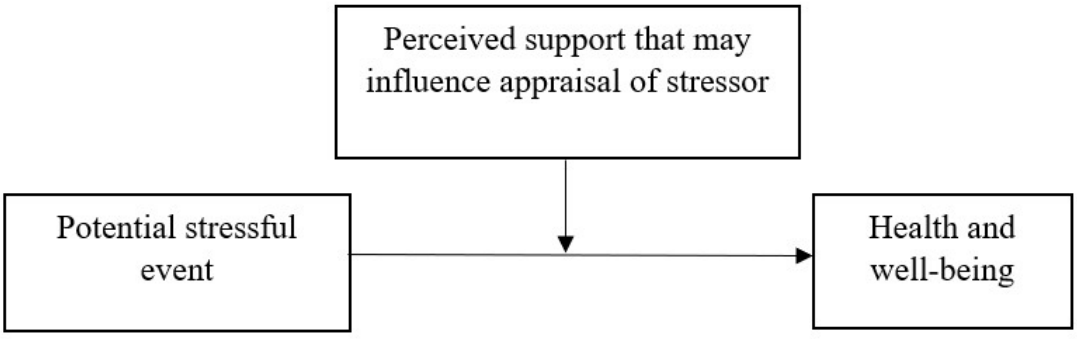

Figure 1. The Conceptual Model of Social Support and the Buffering Hypothesis Adapted from "Stress, Social Support, and the Buffering Hypothesis," by S. Cohen and T. A. Wills, 1985, *Psychological Bulletin, 98*, p. 313.

The stress-buffering mechanism of social support can intervene at two points during the process that links stressful events to adverse health outcomes (Cohen & McKay, 1984; Cohen & Wills, 1985). First, social support can intervene between a stressful event and stress by preventing a stress response. Second, social support can play an important role between the experience of stress and the onset of pathological outcomes by lessening or eradicating stress reactions. Social support could mitigate the impact of stress in several ways, such as by suggesting solutions to the problem, reducing the perceived importance of stressful situations, facilitating healthy behavior (House, 1981), and encouraging the avoidance of risky behavior (Wills & Ainette, 2012).

Cohen and Wills (1985) described two patterns of buffering interaction between stress and social support. First, partial buffering effect is present when high social support reduces the impact of life stress, but a significant amount of stress remains present. Individuals with high stress and high social support who experience partial buffering may still have more negative health outcomes than those with low stress and high social support. The second pattern is complete buffering which is present when higher social support completely eradicates the effect of life stress. In such cases, individuals with high stress and high social support may have similar health outcomes as those with low stress and high social support (Cohen & Wills, 1985; Wills & Ainette, 2012).

Social support that operates as stress buffers can be classified into four types: emotional support; information support; social companionship; and instrument support (Cohen & Wills, 1985; Heaney & Israel, 2008). The support can come from a variety of sources including a partner, relatives, friends, co-workers, and community ties (Taylor, 2011). Cohen and Wills

(1985) posit that available support must match the individual's coping needs in order for buffering to take place. Evidence suggests that emotional support and informal support provide protection against a wide range of stressful events (Cohen & McKay, 1984).

Based upon the model, the current study hypothesized that negative health outcomes would be mitigated when a stressful event (IPV) interacts with appropriate family and friend support, resulting in better QOL (see Figure 2).

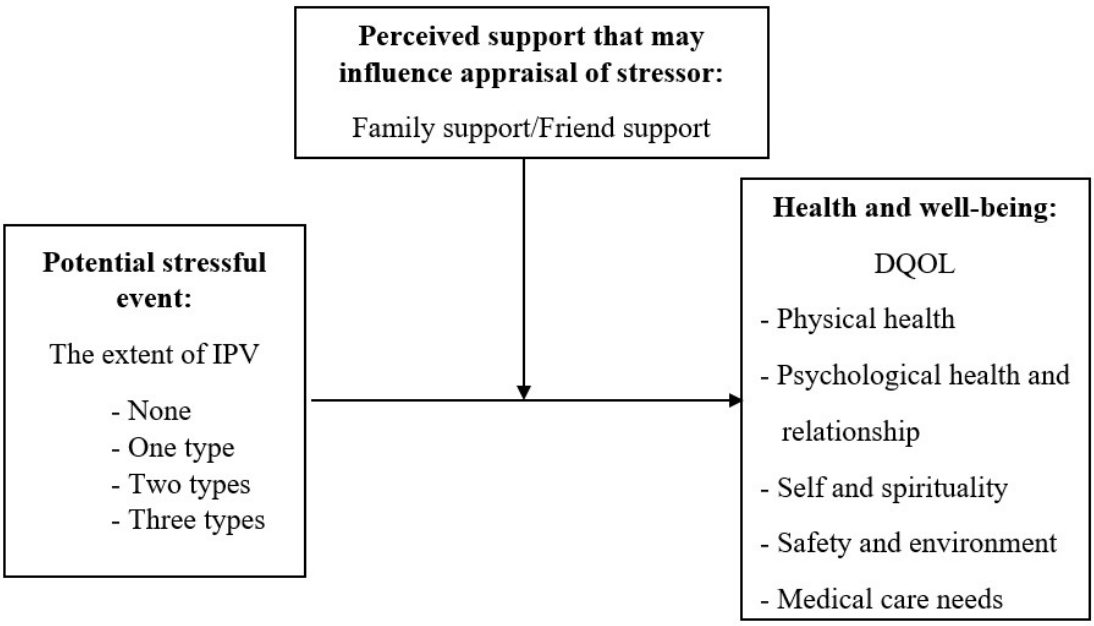

Figure 2. The Study Model of the Extent of IPV on Domains of QOL, with Family and Friend Support as Moderators

Conceptual Definition of the Study Variables

The Extent of IPV

Conceptual Definition. EIPV is defined as the number of types of IPV experienced by the woman throughout her intimate relationship. EIPV in this study included having experienced: 1) no IPV; 2) one type of IPV –physical or psychological or sexual abuse; 3) two types of IPV – physical and psychological; sexual and psychological; or physical and sexual, and 4) all three types of IPV.

Operational Definition. EIPV is separated into four categories: no IPV experience is coded 0; experienced one type of IPV is coded 1; experienced two types of IPV is coded 2; and experienced all three types of IPV is coded 3.

Family Support

Conceptual Definition. Family support is defined as a victimized woman's perception about the extent to which she is cared for, feels loved, and is understood by her family members.

Operational Definition. Family support was measured by an interval rating representing the degree to which a woman perceived support from family members using the family support subscale of the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley, 1988).

Friend Support

Conceptual Definition. Friend support is defined as a victimized woman's perception about the extent to which she is cared for, feels loved, and is understood by her friend(s).

Operational Definition. Friend support was measured by an interval rating representing the degree to which a woman perceived support from friend(s) using the friend support subscale of the MSPSS (Zimet et al., 1988).

Domains of Quality of Life

Conceptual Definition. QOL is a woman's perception of her position in life based on the context of the culture and value systems in which she lives and in relation to her goals, expectations, standards and concerns (The WHOQOL Group, 1996).

Operational Definition. QOL was represented by an interval rating representing the degree to which a woman perceived her wellness measured by the WHOQOL-BREF (The WHOQOL Group, 1998a). In this study, DQOL focuses on the domains of physical health, psychological health and relationship, self and spirituality, safety and environment, and medical care needs based on the psychometric properties of the WHOQOL-BREF among Thai WIPV from the study by Ross et al. (2017).

Chapter II

Literature Review

This chapter presents a literature review of three major topic areas: 1) IPV including the definition, prevalence, and adverse consequences of this type of violence; 2) QOL composed of the definition and an examination of QOL in WIPV; and 3) family and friend support including the context of family and friend support in Thailand as well as family and friend support among WIPV.

Intimate Partner Violence

Definition of Intimate Partner Violence

The terms "intimate partner violence" or "IPV," "violence against women," and "domestic violence" are often used interchangeably. All three involve abusive and coercive behaviors; however, their meanings differ slightly. WHO (2016) defines IPV as any abusive behavior including acts of physical aggression, sexual coercion, psychological abuse, and controlling manners by a spouse, partner, or ex-partner that causes physical, psychological, or sexual harm to a person in a couple relationship. Violence against women, known as gender-based violence or gender oppression, refers to acts of violence perpetrated against women expressly because they are women (UN Women, 2017a). Domestic violence, also called family violence, refers to abuse by one person against another within the family setting. This type of violence can take place in heterosexual or homosexual family relationships and encompasses partner, child, and elder abuse, as well as abuse by any member of a household (WHO, 2012).

This study uses the term "IPV" which occurs between two people in an intimate relationship during dating, cohabitating, or marriage and can happen in or outside the home

(Howe, 2012). Both men and women can be the abuser or the victim in IPV situations (Truman & Morgan, 2015; WHO, 2012). In the role of abuser, men are more likely to commit long-term abuse, while women are more likely to act violently in self-defense and are generally less violent than men (Fernandez, 2010). Female victims have a higher rate of prevalence and experience more severe abuse than male victims (Breiding et al., 2014; Chan, 2011; Truman & Morgan, 2015).

Prevalence of IPV in Thailand

Before the 1990s , IPV was a major problem despite the lack of prevalence, largely due to the Thai culture norm of women's silence (Han & Resurreccion, 2008). Results of an ethnographic study in the central region of Thailand showed a lack of wife victimization (Levinson, 1989). In contrast, news stories involving violence against women were reported on the front page of the top five daily newspapers including *Thairath*, *Dailynews*, *Mathichon*, *Khosod*, and *Bangkokbiznews* between 1997 and 1999 (Grisurapong, 2004). Later, Charoenyooth, Serisathien, Priyatruk, Dherabatana, and Malitong (1999) conducted a study in 188 non-pregnant married women age 20-39 who sought care at emergency units at two hospitals in Bangkok, the capital of Thailand and found that rate of IPV was 77%. Moreover, WHO (2005) conducted the survey in 10 countries, including two study sites in Thailand, and found that about 41% of Thai women residing in urban areas and 47% from rural areas had experienced physical or sexual violence or both types by their intimate partners.

When classified into each type of IPV, nearly 34% of women living in rural areas and 23% from urban Thailand had experienced physical violence at least once in their lifetimes. Furthermore, 29% in rural and 30% in urban areas had experienced sexual violence (WHO,

2005). Correspondingly, data collected from 471 women victims receiving services at One Stop Crisis Center (OSCC) in Bangkok revealed that rates of physical, psychological, and sexual violence were 83%, 9.1%, and 5.9%, respectively (Chuemchit & Perngparn, 2014). From these studies, it can be concluded that sexual violence took place less frequently than physical violence.

Ross et al. (2015) examined the prevalence of IPV in 284 women from northeast Thailand. They found that psychological violence had the highest rate at around 89.8%, followed by physical abuse at 61.3% sexual abuse at about 25.4%. Similar to the results to Ross et al., the results of a qualitative study of 35 non-pregnant women in northern Thailand, the rates of psychological, physical, and sexual abuse were 100%, 80%, and 44%, respectively (Sripichyakan, 1999). The Women and Men Progressive Movement Foundation (WMP) conducted a survey of 1,608 women aged 17-40 in the capital of Thailand, and the results showed that 42.2% of respondents reported being forced into sexual acts with their husbands or partners, 41.1% reported being they were forced to have an abortion, and the rest experienced physical and psychological violence (Charoensuthipan, 2017). It is interesting to note that the prevalence of each form of IPV varies from one area to another.

Forty-eight percent of abused Thai women reported experiencing one type of IPV, whereas 42% reported multiple types of IPV (Ross et al., 2015). Moreover, nearly 50% of victimized women experienced violence at least twice in their lifetimes and about 70% of WIPV who married or cohabited had been revictimized (Chuemchit & Perngparn, 2014). The young partner and insufficient household income associated significantly with IPV (Charoenyooth et

al., 1999). Pregnancy status, illicit drug use, gambling, and alcohol consumption also significantly predicted the likelihood of IPV (Ross et al., 2015).

The prevalence of IPV in Thailand has changed from place to place and has increased over time. Evidence showed that Thai women concealed abusive relationships in order to protect their senses and safety, husband's image, and family well-being (Rujiraprasert et al., 2009). The cultural and religious beliefs in the concept of "being a good wife" who should sacrifice for her family also strongly influences women to accept an inferior status. After the Thai legislature passed the Protection Domestic Violence Victims Act in 2007, the incidence of IPV has been continually reported. Since 2009, Her Royal Highness Princess Bajrakitiyabha Mahidol of Thailand, has served as the UN Women's Goodwill Ambassador for the Ending Violence Against Women; as a result, she has launched the "Say No to Violence Against Women" campaign to increase public awareness of IPV, the Act, and its benefits (UN Women, 2017b). Thai women now tend to disclose abuse and seek support.

Adverse Consequences of Intimate Partner Violence for Women

Exposure to IPV contributes to substantial health burdens among women worldwide (Beck et al., 2014; Hegarty et al., 2013; Ross et al., 2015). Abused women need medical care more frequently due to experiencing not only mental health problems but also physical health issues (Black, 2011; Gao & Jacka, 2012; Rees et al., 2011; Ross et al., 2015)

Psychological sequelae commonly occur in female IPV victims. IPV is associated with depression, anxiety, phobias, and posttraumatic stress disorder (PTSD) (Chuemchit & Perngparn, 2014; Fernbrant, Emmelin, Essen, Ostergren, & Cantor-Graae, 2014). Ross et al. (2015) found IPV significantly predicted depression in their study's sample of Thai women. It also had a

significant positive direct effect on antenatal depression (Thananowan et al., 2012). Rates of sadness or anxiety and major depression among the U.S. women victims residing in shelter were higher than those in general (Helfrich et al., 2008). Similarly, the 75 studies published from 2006 to 2012 that concerned Western as well as developing countries showed that IPV was related to depression, PTSD, anxiety, and self-harm (Dillon et al., 2013). This results in negative physical health outcomes such as poor functional health, somatic disorders, sleep disorders, chronic pain, gynecological problems, and increased risk of sexually transmitted diseases also result from IPV (Dillon et al., 2013).

Incidentally, physical injuries are the most visible consequences of IPV (Black, 2011; Vung, Ostergren, & Krantz, 2009), ranging from relatively minor injuries such as bruises and pain to more severe injuries which include broken bones, burns, and knife wounds (Bott et al., 2012). Injuries to women's heads, necks, and faces are common (Wong et al., 2014). More than one in four female victims need medical care, and one in three women experience a loss of consciousness at least once as the result of IPV (Chrisler & Ferguson, 2006). Some women experience an increased risk of memory loss, disability, pain, discomfort, and death compared to those with no IPV experiences (Bott et al., 2012; Vung et al., 2009). Additionally, physical or sexual IPV associates with increased risk of sexually transmitted infections (STI)/human immunodeficiency virus (HIV), particularly in case of unprotected vaginal sex (AOR 1.93, 95% CI [1.52, 2.44]) (Decker et al., 2014). Correspondingly, Hess et al. (2012) reported that being a victim of IPV was significantly related with a greater likelihood of having a prevalent STI (OR= 2.1, 95% CI [1.0, 4.2]).

Women victims who had experienced one type of IPV often endure exposure to other types of abuse (WHO, 2005, 2012). Evidence suggests that the more that the frequency and severity of IPV increases, the greater its impact on victims' health also becomes progressively severe (Campbell et al., 2002). Besides, although physical, sexual, and psychological violence can lead to mental and physical health consequences, those who have experienced multiple types of IPV are more likely to develop poor health outcomes (Black, 2011; Hegarty et al., 2013), which in turn can impact victims' QOL.

Quality of Life

Definition of Quality of Life

QOL and HRQOL are used interchangeably in the literature concerning IPV; nevertheless, each has its own meaning and purpose. QOL consists of a multidimensional concept involving how persons assess the goodness of their lives, and it is often referred to as well-being (Theofilou, 2013). The WHOQOL Group (1996) defined QOL as "people's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (p. 1). Because of the concern about how individuals broadly perceived the effects of diseases or health conditions on their lives, QOL does not focus on measuring symptoms, severity of illness or health circumstance (The WHOQOL Group, 1996). QOL is a broad concept affected in a multifaceted way by the persons' physical health, psychological state, social relationships, and the relationship to the features of their environment (The WHOQOL Group, 1996, 1998a).

Quality of Life in Women Experiencing Intimate Partner Violence

The literature review revealed that previous studies have most frequently examined QOL and HRQOL using the Short Form Heath Survey (SF-36) or the 12-item version (SF-12) among women experiencing IPV. The results of most studies revealed the negative association between IPV and HRQOL (Dillon et al., 2013). When considering the impacts of each form of IPV on physical health and mental health components of HRQOL, evidence shows that women who experienced physical abuse have significantly lower physical component summary scores compared with never-abused women (Bonomi, Anderson, Rivara, & Thompson, 2007; Costa et al., 2015; Tavoli et al., 2016). Women involved in physical violence also have a low mental component HRQOL summary score (Costa et al., 2015), whereas those exposed to sexual violence with or without physical violence have significantly lower mental health summary scores compared to those who never experienced partner violence (Bonomi et al., 2007; Costa et al., 2015).

Notably, female victims exposed to psychological IPV have lower mental health summary scores than those who have not experienced IPV (Asadi et al., 2016; Tavoli et al., 2016). For example, Iranian pregnant women who had experienced physical abuse have significantly lower scores for role physical, bodily pain, and general health than those exposed to psychological abuse, except for social functioning and mental health domain of HRQOL (Tavoli et al., 2016). American women with sexual abuse had lower scores in social functioning and mental health compared with those exposed to physical violence (Bonomi et al., 2007).

The differences in health outcomes between women who have experienced more than one type of IPV remain substantial. Kelly (2010) found Latino women who experienced various

types of IPV correlated highly with bodily pain, sleeping difficulty, and lower HRQOL. This concurs with the findings of Bonomi and colleagues' study (2007), where American women who experienced physical abuse and sexual abuse have lower mental health and social functioning scores compared to those who endure physical violence. Exposure to high levels of both physical and psychological abuse also correlate highly with poorer physical and mental health outcomes (Straus et al., 2009).

Despite such results, inconsistent findings regarding the association between IPV and physical health outcome appear in two studies. In the first study conducted by Chen et al. (2009), Hispanic women who exposed to physical violence have less vitality, decreased mental health, and lower role emotional scores than non-Hispanic victims, but no significant difference in physical and mental component summary scores occurred between these groups. The small number of victims (n = 31) compared to non-victims (n = 115) can affect the results of the statistical analysis. The second study reported that physical health did not differ statistically among WIPV residing in a short-term domestic violence shelter in a Midwest city of Chicago compared with the general American population (Helfrich et al., 2008).

Domains of Quality of Life

Physical, psychological, environmental health and social relations domains of WHOQOL-BREF had been used to measure QOL in WIPV and a significantly inverse correlation between IPV and QOL was found. In support of this, Ghasemi et al. (2015) reported that overall IPV negatively correlated to both total scores and every single domain of QOL in Iranian female victims. Similar to emotional violence, physical abuse was inversely significant related to psychological, environmental, social domain, and total QOL, while the study found no

significant association between physical violence and the physical health domain (Ghasemi et al., 2015). On the contrary, Sotskova et al. (2011) reported that psychological violence significantly predicted all four domains of QOL in Canadian women when controlling for age and income.

For the effects of the severity and combination of IPV, Australian women with severe combined abuse had poorer QOL in all domains, although they made more use of medications, counseling, and IPV services (Hegarty et al., 2013). Likewise, women with physical and psychological abuse reported lower QOL on the social dimension compared to those without abuse. Besides, these abused groups had more possibility of visiting a counselor or psychologist and experiencing at least one day off from work than other abusive types (Hegarty et al., 2013) .

In Thailand, only two studies aimed to determine HRQOL or QOL in Thai women. Saito et al. (2013) examined HRQOL in 421 Thai women during pregnancy, and the findings revealed that women with any recent IPV exposure reported having lower scores in mental health, role emotional, vitality, and bodily pain components compared to non-abused women. In the other study, Ross et al. (2015) collected from 284 Thai women, the results of which indicated the negative association between IPV and QOL. In addition, the authors examined the effect of IPV on depression and the QOL, finding that psychological violence has a direct effect on the QOL while physical and sexual violence had an indirect effect on QOL through depression.

Some demographics contribute to IPV and victims' QOL. Age, low economic household income, and education, associated closely with IPV (Fowler & Hill, 2004; Jewkes, 2002; Pengpid et al., 2016; Vung et al., 2009). Marital, unskilled worker or unemployment status also relate significantly to IPV (Ali et al., 2011; Thananowan & Heidrich, 2008; Wuerch, 2015).

Thus, these demographic characteristics should be carefully considered as confounding variables that can affect the study findings.

Family and Friend Support

Social support refers to an individual's perception or experience that others love or care for him or her (Taylor, 2011). It also includes useful resources and interactions from others to help individuals deal with their problems (Cohen & Syme, 1985; Wills & Fegan, 2001). Informal support can be provided by a partner, family members, relatives, friends, neighbors, or coworkers; conversely, formal support consists of seeking help from police, the legal system, a social service agency, health professionals and staff, crisis hotline workers, or staff at women shelters (Liang, Goodman, Tummala-Narra, & Weintraub, 2005). Social support can also involve the perception of available resources needed (Cohen & Wills, 1985). Therefore, social support means specific transactions whereby a person obtains assistances and perceives the availability of help and support from another, which is termed received and perceived support (Wethington & Kessler, 1986).

Cohen and Wills (1985) categorized social support into four different forms, including informal, instrument, and emotional support. First, informational support means the extent to which one person helps another to define, understand, and cope with problematic situations through providing information, advice, or suggestion on actions. Second, instrument support, usually called tangible or material support, occurs when another offers concrete assistance, such as financial aid, needed goods, or other specific service to another person. Third, emotional support, referred to as esteem support, relates to the nurturance expression of caring, concern, sympathy, and reassuring that offers the individual a sense of value, esteem, acceptance, and

affection. Lastly, social companionship support consists of the presence of another person who provides a sense of belonging and engagement by helping to distract a person from stressful situations.

The Cultural and Religious Beliefs of Family and Friend Support in Thailand

Social support proves valuable for persons to diminish the undesirable impact of stressful events (Cohen & Wills, 1985). Since social support inherently involves interpersonal relationships, people from diverse cultural contexts can differ in perspective and use of social support. Research in cultural psychology has shown that Westerners are more likely than Easterners to use social support for coping (Taylor et al., 2004). Consistent with this finding, Liang and Bogat (1994) reported that social support had negative stress-buffering effect among Asians.

Similarly, a study of Asian Americans indicates that they are more likely to seek friend support instead of family support with the purpose of maintaining harmonious family relationships (Wang, Shih, Hu, Louie, & Lau, 2010). Culture amounts to a considerable factor that affects the nature of the relationship between the support seeker and the support provider. Asking for assistance is subject to an understanding about appropriateness and efficacy of seeking support (Kim, Sherman, & Taylor, 2008). It is vital to understand how persons view the self and relationships with others that can influence using social support as a coping strategy, no matter in individualistic or collectivistic cultures (Uchida, Kitayama, Mesquita, Reyes, & Morling, 2008).

In individualism, people tend to view the self as independent from others and act upon personal beliefs to accomplish their own goals and desires (Kitayama & Markus, 2014). This

perspective of the self can be found in Western countries, especially European-American, middle-class contexts. Individualistic persons might pay attention to the notions of good life, well-being, and happiness that are personal instead of interpersonal. The relationships influenced by the individualistic view rest on the assumptions that persons can choose freely with relatively few obligations (Adams & Plaut, 2003).

To the contrary, persons in collectivist countries such as found in several Asian countries, including Thailand, view the self as interdependent because of connecting with others in social groups and considering group goals as opposed to individual goals (Kitayama & Markus, 2014; Uchida et al., 2008). Social relationship, norms, and group harmony emerge as more necessary for family and community than personal beliefs and needs (Taylor, Welch, Kim, & Sherman, 2007). Under the relationships within this context, people try not to share their personal difficulties with others to avoid diluting harmony within these social groups (Guan & Fuligni, 2016; Kim, Sherman, Ko, & Taylor, 2006).

In the Thai cultural context, the view of self as interdependent has its historical roots in some Buddhist teachings, particularly social hierarchy, which is the heart of traditional beliefs (Kitayama & Markus, 2014). For example, concept of *kreng-jai* consists of a polite attitude of respect and consideration for others, particularly one who has a higher social rank or is older (Sandhu, 1999). Hurting others' feelings or causing discomfort to someone should be avoided in order that all relationships be pleasant and relaxed (Vathanaprida, MacDonald, & Rohitasuke, 1994).

As to family and friend support, Thai citizens might consider seeking support from close confidants while facing personal problems. Thais could also be concerned with the sensitivity of

others' perceptions that possibly cause fears such as being a burden, loss of face, and greater potential for negative relational consequences (Ho, 1990; Kim et al., 2008). More specifically, disclosure of family matter to outsiders amounts to a violation of family privacy and place WIPV in the position of embarrassment, shame, or even being blamed for the results (Midlarsky, Venkataramani-Kothari, & Plante, 2006; Ross et al., 2015). Married women bear the responsibility of upholding family harmony (Limanonda, 1995). It can be noted that people are more likely to be cautious to convey private issues to others because of a concern about producing an obstacle within the social group (Kim et al., 2008).

Family and Friend Support among Women Experiencing Intimate Partner Violence

In the case of IPV in Thailand, seeking support can bring either benefits or trouble to WIPV due to collectivism. Some people, including female victims, perpetrators, relatives, neighbors, police, or even the village itself, view IPV as a private issue and a non-serious matter (Chuemchit & Perngparn, 2014; Pengpid et al., 2016; Rujiraprasert et al., 2009; Saito et al., 2009; Sricamsuk, 2006). Approximately 70% of Thai women exposed to IPV reported that they felt ashamed to ask for assistance and believed that no one cannot help them (Sricamsuk, 2006). Similarly, they perceived that seeking help would bring shame to them and their families (Rujiraprasert et al., 2009). Thus, in all likelihood they concealed abuse in order to protect the self and safety, the husband's image, and family harmony (Rujiraprasert et al., 2009).

Also, outsiders sometimes believed that women experienced IPV because of doing something inappropriate to their husbands (Punsomreung, 2012). If women victims decide to disclose their abuse, they might be regarded by others as a "bad wife" that possibly makes them feel worthless or guilty, and that they only have themselves to blame (Rujiraprasert et al., 2009).

Some women keep silent and manage their own problem themselves without any assistance from outsiders (Chuemchit & Perngparn, 2014; Pengpid et al., 2016; Rujiraprasert et al., 2009). Others reported that keeping silent can lighten family members' burdens. For example, one woman victim mentioned that she did not tell her parents or relatives about her abuse experiences because she did not want to worry them (Rujiraprasert et al., 2009).

Despite these notions, some find disclosure and seeking support helpful, especially women enduring re-victimization and worsening abusive relationships (Pengpid et al., 2016; Ross et al., 2015; Rujiraprasert et al., 2009; Saito et al., 2009). Sharing stressful situations with someone helps release tension. In one instance, WIPV who viewed support as a helpful strategy mentioned that they wished to have someone listen to them because they are about to lose their composure (Rujiraprasert et al., 2009). Respectively, one informant mentioned that her neighbors, parents, brother, sister, and relatives are important resources of support to deal with her abuse experience (Saito et al., 2009). It can be summarized that the inconsistent findings regarding social support in Thai WIPV readily appear (Beeble et al., 2009). Even though they can receive social support from many people, such as family members, friends, health professionals, or community members, most studies point to the beneficial effect of family and friend support on IPV (Goodkind et al., 2003; Ross et al., 2015; Taket et al., 2014; Wright, 2012).

Family Support and Intimate Partner Violence

Family members can provide instrumental, emotional, or companionship support to victimized women, which would assist them in coping with abusive relationships. Family support can influence them in various ways. Taket et al. (2014) found 31% of Australian women

specified that the family of origin more frequently provides support than the family of an abusive partner. A great deal of family support for WIPV occur not only to allow women to cope emotionally with IPV but also actively protect themselves and their children (Krishnan, Hilbert, & VanLeeuwen, 2001; Saito et al., 2009). They could perceive affirmation, appreciation, encouragement, and positive regard from family as exemplified in this quote: "My eldest sister is fantastic. She will listen without judgment although I know it hurts her that I am not in a great relationship. Of enormous value is her encouragement, telling me how proud she is of me and that I am a wonderful person" (Taket et al., 2014, p. 987).

Women victims who received family support had less likelihood of being victimized and lower frequency of IPV (Wright, 2015). Family support is also helpful as the findings of Ross et al. (2015) revealed that some WIPV feel better because their mothers always listen to and support them. Older women appeared more likely to seek help from family members than younger women (Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). Leone, Johnson, and Cohan (2007) reported, however, that young female victims were more likely to disclose to the birth family members than others.

Conversely, family ties could promote accepting violence or subordinate notions of gender that might not protect women from IPV situations (Agoff, Herrera, & Castro, 2007). Assistance from family does not always result in help (Fanslow & Robinson, 2010). Some WIPV reported their mothers and siblings who did not get along with abusers blame them about getting married to their partners (Ross et al., 2015). Abused women would receive negative reactions from family members, including avoiding the victims, blaming them, expressing frustration when victims ignored their advice (Goodkind et al., 2003).

Friend Support and Intimate Partner Violence

Friends can also serve as an important source of support. WIPV disclose the abusive experience to friends who respond to them with listening, compassion, and respect (Rujiraprasert et al., 2009; Taket et al., 2014). They also prefer disclosure to friends who are accessible and usually available to talk. Some seek support and potential advice from friends who had similar experiences. For instance, a quote from a victim explained that "my friend's words can make me feel better. She didn't tell me to take actions like suing my husband, but she gave me encouragement and told me to be patient" (Rujiraprasert et al., 2009, p. 339). Some women who experienced lower frequency of physical violence were more likely to disclose to friends than family members or relatives, and those experiencing more severe abuse could be the least likely to seek support from others (Yoshioka et al., 2003). Remarkably, some women victims sought help from female friends more often than from family members (Rose & Campbell, 2000).

Others perceived that they felt ashamed and guilty because of being blamed, re-victimized, and gossiped about as negative consequences of disclose abuse to others (Rujiraprasert et al., 2009; Taket et al., 2014). Wright (2015) found friend support related to higher frequencies of IPV. Negative reaction from family and friends associated significantly with low QOL among American women (β = -.20, p = .05), while offering a place to stay related positively to women's QOL (r = .23, p < .05) (Goodkind et al., 2003). Given the spectrum of what female victims consider helpful, it remains unclear whether family and friend support always help WIPV.

Some studies revealed that female friends and family members are the most supportive resources for WIPV, and social support obtained following disclosure relates to better QOL

(Barrett & Pierre, 2011; Sylaska & Edwards, 2014). Among positive social reactions, emotional support is the most common form of support provided by family and friends (Bosch & Bergen, 2006; Goodkind et al., 2003). Although negative reactions to disclosure of IPV experienced occur less frequently than positive reactions, they significantly decrease QOL of WIPV (Goodkind et al., 2003).

In summary, a review of the existing literature demonstrated that IPV is a significant issue and affects female victims' QOL. Research evidence about whether family and friend support can help diminish the negative consequences of IPV evidence is inconsistent. Further, little is known about the moderating effect of family and friend support on DQOL in WIPV, especially in the Thai culture. The purpose of this study is to examine the moderating effects of family support and friend support on the relationship between EIPV and domains of QOL among Thai WIPV. The findings of this study expand our understanding of social support in Thai cultural contexts and help inform nurses when developing interventions to improve the QOL among Thai female victims.

Chapter III

Method

Study Design

A descriptive, cross-sectional analysis took place to determine if family support or friend support moderates the relationship between EIPV and DQOL among Thai women. This study used existing data extracted from the parent study, "*Intimate Partner Violence, Emotional Support, and Health Outcomes among Thai Women: A Mixed Methods Study*" by Ross et al. (2015) funded by Fulbright Foundation and the U.S. Department of State. For the current study, the dissertation proposal was submitted to the Kent State University Institutional Review Board (IRB) for approval.

The main objectives of the parent study were to examine predictors of IPV; the relationships between IPV and health outcomes including depression, physical symptoms, QOL; emotional support as a mediator between IPV and health outcomes; and IPV experiences in the Thai context (Ross et al., 2015). Two hundred and eighty-four Thai women 18 to 60 years of age, able to read and write in Thai, and receiving care at Obstetrics/Gynecologic units at a large hospital in northeast Thailand.

The differences between the parent study and the current study are shown in Table 1. The research findings would inform nurses to screen for a history of IPV, which help to early detect abusive experiences prior to the development of negative consequences resulting from IPV. A better understanding of family and friend support could enable nurses to develop nursing interventions for WIPV.

Table 1

The Comparison between the Parent Study and a Current Study

Topic	Ross et al. (2015)	The Current Study	Rationale
IPV	IPV included three variables: physical, psychological, and sexual abuse as continuous variables	EIPV includes categorical variables: no IPV experience, one-type IPV, two-type IPV, and three-type IPV	To make it more feasible for clinical practice
Support	Tested the mediating effect of support from family, friends, and spouse	Tested the moderating effect of support from family and friends.	In the parent study, the mediation effect of social support was very weak and all WIPV disclosed their abusive experiences to only family and friends.
QOL	Used total score of all 4 domains of WHOQOL-BREF	Focused on each of the 5 domains of QOL based on Ross et al. (2017)'s psychometric study of WHOQOL-BREF	Understanding the influence of EIPV on each domain of the QOL would be beneficial to guide clinical management.
Theory	Bell and Naugle's theory contextualized IPV, and Lazarus and Folkman's theory of coping	Cohen and McKay's Stress-Buffering Model	The Stress-Buffering Model posits that the presence of social support helps buffer or protect individuals from the potential harm of stressful events (Cohen & Wills, 1985).

Sample Size

Although this study includes the entire available sample (n = 284), power analysis had been computed to determine the necessary number of subjects to detect an effect of a given size. Power analysis refers to the probability to find significant effects of predictors and outcome variables (Tabachnick & Fidell, 2013). A large enough sample size can produce a significant relationship between predictors and outcomes (Tabachnick & Fidell, 2013). For this study, a

priori power analysis for multiple regression using G*Power 3.1.9.2 (Faul, Erdfelder, Buchner, & Lang, 2009; Faul, Erdfelder, Lang, & Buchner, 2007) were calculated, assuming medium effect size (f^2) .15, a significance level of .05, a power .80, and six predictors. The total sample size requires at least 98. The available data had 284 participants, or nearly 3 times the number needed.

Variables and Instruments

Six independent variables were included EIPV, family support, and friend support, age, education, income with five outcome variables, DQOL. Family support, friend support, and each domain of QOL variables were measured at interval or ratio level of measurement, while EIPV, education, and income are in ordinal level.

The Extent of Intimate Partner Violence

A 14-item, short version of the Psychological Maltreatment of Women Inventory (PMWI), developed by Tolman (1999), was used in the Thai version with back translation (Saito et al., 2012) to obtain information on psychological abuse allegedly perpetrated by women's partners in the six months prior to the parent study. The PMWI-short version requires responses on a 5-point Likert scale of 1 = never to 5 = very frequently. Item ratings are summed, and they range from 14 to 70. Higher scores reflect greater psychological abuse. Based on Saito et al.'s study, Cronbach's alpha reliability coefficient was 0.86.

The Severity of Violence Against Women Scales (SVAWS) (Marshall, 1992) is composed of 46 items that described a woman's experience in physical abuse (40 items) and sexual abuse (6 items) from her partner. The SVAWS translated into Thai with back translation (Saito et al., 2012) is a 4-point Likert scale ranging from 1= never to 4 = many times. Item

ratings are coded and summed. Total scores for physical abuse range from 40 to 160, while total scores of sexual violence range from 6 to 24. Higher score indicates more experiences of physical and/or sexual violence. An alpha coefficient for the internal validity of this instrument was 0.96 (Saito et al., 2012). In this study, women's experiences in psychological, physical, and sexual violence are recoded into four categories as EIPV, containing no IPV experience = 0, experienced one type of IPV = 1, experience two types of IPV = 2, and experienced all three types of IPV = 3. Total scores of physical, psychological, and sexual abuses were summed and dummy coded as dichotomous variables separately. The total score of physical abuse was coded: scores $\leq$ 40 = 0 (no physical abuse), while scores > 40 = 1 (experience physical abuse). Total score of psychological abuse was also coded: scores $\leq$ 14 = 0 (no psychological abuse), while scores > 14 = 1 (experience psychological abuse). The total score of sexual abuse less than or equal 6 was coded as 0 (no experience sexual abuse), while scores more than 6 were coded as 1 (experience sexual abuse). Then, coded scores of three types of IPV were summed and recoded to EIPV as mentioned above.

Family Support

The Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988) with a Thai back translation (Wongpakaran, Wongpakaran, & Ruktrakul, 2011) was designed to assess a woman's perception of the adequacy of the support she receives from family members, friends, and significant other. The MSPSS/Thai version has been widely used in both clinical and non-clinical settings, such as medical students, persons with depression, WIPV, individuals living with HIV, elder persons, and pregnant women (Ross, Sawatphanit, & Zeller, 2009; Thananowan & Vongsirimas, 2014; Thananowan et al., 2012; Wongpakaran & Wongpakaran,

2010; Wongpakaran et al., 2011; Wongpakaran, Wongpakaran, Sirirak, Arunpongpaisal, & Zimet, 2017). The MSPSS is a 12-items, a 7-point Likert-like scale with scores ranging from 1 = very strongly disagree to 7 = very strongly agree. The overall Cronbach's alpha of the MSPSS in a previous WIPV study was .92 (Thananowan & Vongsirimas, 2014). Family support subscale contains four items. Item ratings are summed, and they range from 4 to 28 for total scores. Higher scores indicated greater family support. The Cronbach's alpha of family support was 0.84 (Wongpakaran et al., 2011). The total scores of a family support subscale calculated from a 4-item Likert like scale were analyzed.

Friend Support

Four-items of the MSPSS (Zimet et al., 1988) with a Thai back translation (Wongpakaran et al., 2011) were used to assess each woman's perception of the adequacy of the support she receives from friends. A 7-point Likert-like scale ranged from 1 = very strongly disagree to 7 = very strongly agree. Item ratings were summed, and they ranged from 4 to 28 for total scores. Higher scores indicate greater friend support. The Cronbach's alpha of friend support subscale was 0.85 (Wongpakaran et al., 2011). The total scores of a friend support subscale were used to analyze in this study.

Domains of Quality of Life

As noted, the World Health Organization Quality of Life-Brief version (WHOQOL-BREF) developed by The WHOQOL Group (1998a) is an abbreviated version that was extracted from the WHOQOL-100 (The WHOQOL Group, 1995). The WHOQOL-100 had been collaboratively established in 15 different countries worldwide, including Thailand, by working in their own national languages to assess individuals' quality of life across cultural perspectives

(The WHOQOL Group, 1998b). Because of its length in practical use, the WHOQOL-BREF was introduced and translated in multiple different languages (Skevington, Lotfy, & O'Connell, 2004; The WHOQOL Group, 1996, 2004).

The Thai version of WHOQOL-BREF is comprised of 26 items with 5-point Likert responses (Li, Kay, & Nokkaew, 2009; The WHOQOL Group, 1998a, 1998c). The WHOQOL-BREF has two generic items covering overall perceptions of QOL and general health, and 24 other items classified into four domains, including physical, psychological, environmental health, and social relationship. Items inquire as to "how healthy," "how satisfied," "how well," or "how safe" the respondent has felt over the last four weeks. The subscale scores were calculated by summing up the scores of each subscale (The WHOQOL Group, 1996). Higher scores indicate greater QOL (The WHOQOL Group, 1998a).

According to the study by Ross et al. (2015), the WHOQOL-BREF was used to assess QOL among 284 Thai WIPV. Ross et al. (2017) later reanalyzed existing data to examine the psychometric properties of the WHOQOL-BREF. Five subscales were generated, resulting from exploratory factor analysis. These subscales include physical health (7 items), psychological health and relationship (5 items), self and spirituality (5 items), safety and environment (5 items), and medical care needs (2 items). The overall Cronbach's alpha was .87 and five subscales generated good Cronbach's alphas ranging from .74 to .80 (Ross et al., 2017) as shown in Appendix F. Key reasons of using the WHOQOL-BREF for this study is that Thailand was one of fifteen international field centers where the WHOQOL group developed and tested this instrument in order to be applicable to assess QOL cross-culturally. Studies conducted by Ross et al. (2015) and Ross et al. (2017), also indicated good reliability and validity of this instrument

among Thai WIPV. The participants in a current study were the same group as those in Ross et al.' studies. Thus, the WHOQOL-BREF would be appropriate for the current study.

Demographic Data

The Background Information Questionnaire by Ross et al. (2015) was used to obtain personal information of participants. Information collected consisted of age, educational level, and household income. These demographic characteristics will be considered as covariate variables because of their possible relation to both EIPV and domains of QOL.

Procedure

After obtaining IRB approval and the extracted, de-identified data; the processes of screening for missing data, replacing missing values, recoding variables, testing statistical assumptions, and running moderation analysis were performed as follows:

1. The processes of screening missing data were comprised of: running "frequencies" and "descriptive statistics" to determine missing values within each variable; checking pattern of missing data; and making decision for handling missing values (Mertler & Vannatta, 2013; Soley-Bori, 2013). Outliers were identified using descriptive statistics looking for extreme values, boxplots, and Mahalanobis distances (Mertler & Vannatta, 2013).
2. Data regarding number of types of IPV that participants experienced were recoded into four categories: including no IPV experience = 0, experienced one type of IPV = 1, experience two types of IPV = 2, and experienced all three types of IPV = 3.

3. The scores of each domain of QOL, involving physical health, psychological health and relationship, self and spirituality, safety and environment, and medical care needs were summed separately.
4. Assumptions of multiple regression analysis, including multivariate normality, linearity, homoscedasticity, and multicollinearity were tested.
5. Two study hypotheses were addressed using the Statistical Package for the Social Sciences (SPSS) along with PROCESS MACRO

Data Analysis

The SPSS version 24 was used for descriptive statistics. Moderation analysis was computed using the PROCESS MACRO version 3.0 to test moderating effects of family support and friend support on the relationships between EIPV and each domain of QOL. The PROCESS MACRO version 3.0 was developed by Hayes (2017) to test moderating effect with better rigor (Bolin, 2014) than using the normal regression analysis because it 1) centered predictor, 2) computed the interaction term automatically, and 3) created simple slopes analysis (Field, 2013). PROCESS MACRO requires complete data; seeing this, screening for missing values is crucial. The screening processes involved several steps. First, descriptive statistics and frequencies were run in order to checking whether there were missing values and if data had been entered correctly. Missing value analysis (MVA) with expectation maximization (EM) were assessed to determine whether variables were missing completely at random (MCAR), called Little's MCAR test (Argyrous, 2011). Third, multiple imputation was conducted to explain overall summary of missing values, pattern of missing. Finally, imputation missing values were performed.

The results of data screening indicated that all data were accurately entered. Around 67.5% of variables and 9% of cases contained incomplete data. Only 0.7% of overall values were missing as shown in Figure 3. Data regarding Family and friend support were completed. Nevertheless, 1.8% of age, 0.4% of educational level, and 0.4% to 2.5% of variables applied to five domains of QOL. The Little's MCAR test obtained for this study's data resulted in a chi-square = 658.30 (df = 525; p < .001), which indicated that the data was indeed not missing completely at random. It is insecure to listwise delete cases with missing values or singly impute missing values because these methods are proper for data with MCAR (Garson, 2015). Multiple imputation (MI) would be appropriate if the number of missing values is not high (Garson, 2015). Because of this, MI was the prevailing method of estimating missing values in this study. Then, paired *t*-test analysis was conducted to compare whether there were significant differences in the means of variables with missing values and those after valued replacement. The study revealed no significant differences of the means between two data sets.

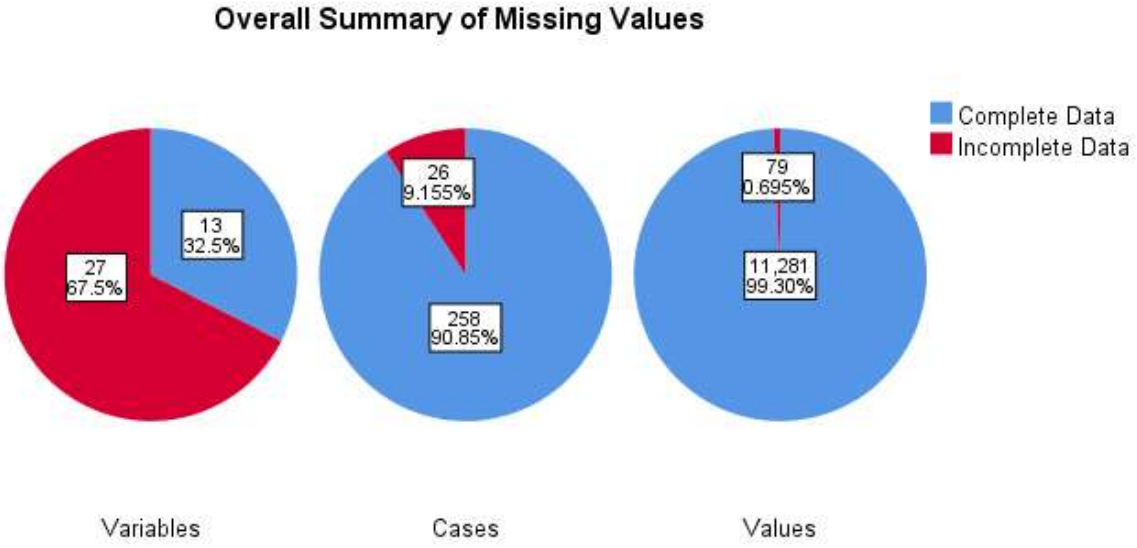

Figure 3. Overall Missing Values

By identifying multivariate outliers by calculating Mahalanobis distance, the critical value of chi-square at $p < .001$ and $df = 6$ is 22.458 (Mertler & Vannatta, 2013). Cases with Mahalanobis distance greater than 22.458 were considered multivariate outliers for age, education, income, family support, friend support, and domains of QOL. One case was identified as an outlier. An outlier often represents an interesting case, and the decision whether it should be deleted or not may involve further statistical analysis (Mertler & Vannatta, 2013).

Testing statistical assumptions for moderation analysis, all assumptions of multiple regression including normality, linearity, multicollinearity, and homoscedasticity were tested. Firstly, multivariate normality of standardized residual indicated histograms with normal-distributed curves. Secondly, linearity assumption was investigated with residual plots, and the result indicated the straight-line relationship between the predictors and an outcome (each domain of QOL). According to multicollinearity testing, the correlation among six predictors ranged between -.12 and .69, an acceptable intercorrelation ($r < .90$). Values of collinearity tolerance (.48 - .93) and variance inflation factor (1.07 - 2.11) for each predictor also indicated low intercorrelation. Last, the residual scatterplots between all predictors and an outcome were approximately the same width across all values with some bulging toward the middle, indicating homoscedasticity. In summary, four assumptions for regression analysis were met (see Appendix H-K).

Descriptive statistics such as frequency, mean, *SD*, and percent were employed to identify participants' demographic characteristics. To address research hypotheses 1 and 2, a moderation analysis was computed using the PROCESS MACRO version 3.0. The interaction effect between EIPV (an independent variable) and family/friend support (the moderators) and

whether such an effect significantly predicts each of the five domains of QOL (the dependent variables) when controlling for age, education, and income (covariates) were analyzed using a simple moderation model (Model 1). The options were selected before performing analysis, entailing: 1) mean center for products that centered the predictors and moderator; 2) heteroscedasticity-consistent (HC) inference using HC0 to test heteroscedasticity in the model; 3) generate code for visualizing interaction for simple slop analysis; 4) covariance matrix of regression coefficients; 5) Johnson-Neyman output to obtain a significant zone of the moderator; 6) 95% confidence interval; and 7) the number of bootstrap samples =1000.

The results of moderation analysis for the data set which included the outlier revealed friend support was not a significant moderator for the relationship between EIPV and the domain of psychological health and relationship. Conversely, a statistical significance was found in the same domain when the data set was analyzed without the outlier. Because of these results, it was statistically appropriate to drop the outlier, resulting in a total sample of 283 cases in this study.

Chapter IV

Results

A descriptive, cross-sectional analysis aimed to examine whether family and friend support moderated the relationships between EIPV and each domain of QOL, including physical health, psychological health and relationship, self and spirituality, safety and environment, and medical care needs when controlling for age, education, and income. Existing data of 283 Thai women who have experienced intimate partner violence were analyzed. This chapter designates data analysis results. The SPSS version 24 along with PROCESS MACRO version 3.0 was used to analyze descriptive statistics and moderating effects. The results were presented as follows:

Part I: Descriptive statistics of participants

Part II: Descriptive statistics of key variables

Part III: Moderation analysis

Descriptive Statistics of Participants

Table 2

Descriptive statistics of Thai WIPV (n=283)

Characteristics	Frequency	Percent
Age (years)		
≤ 20	14	5.0
21-40	184	65.0
> 40	85	30.0
Marital status		
Married with marriage certificate	177	62.5
Married without marriage certificate	65	23.0
Separate, divorce, or widow	13	4.6
Unclear relationship	28	9.9
Highest educational level		
Did not attend school	1	0.4
Grade 6 or below	49	17.3
Middle or high school	109	38.5
Diploma/associate degree	29	10.2
Bachelor degree	80	28.3
Graduate degree	15	5.3
Household income		
Less than 1,000 Baht	9	3.2
1,000-5,000 Baht	69	24.4
5,001-9,000 Baht	50	17.7
9,001-20,000 Baht	83	29.3
More than 20,000 Baht	72	25.4
Experienced IPV classified by each type		
Psychological violence	254	89.8
Physical violence	174	61.5
Sexual violence	72	25.4
Experienced EIPV		
No experience	28	9.9
One type	73	25.8
Two types	119	42.0
Three types	63	22.3

Table 2 showed that majority of participants' age (65%) ranged between 21 and 40 years. Sixty-two percent of participants were married and produced a marriage certificate. Around 28% of the participants had completed a bachelor's degree as the highest educational level, followed by grade 12 (20.5%). About 29% reported that they had household income 9,001-20,000 Thai Bahts ($273-$606), while 25.4% earned more than 20,000 Thai Bahts (> $606). Approximately 42% had experienced two types of IPV, followed by one type (25.85%), and three types (22.3%), respectively. Only 9.9% had never been exposed to IPV.

Descriptive Statistics of Key Variables

Table 3

Descriptive Statistics of Key Variables

variable	Mean	*SD*
Age (18-58 years)	36.03	9.04
Family support (4-28)	22.99	5.07
Friend support (4-28)	19.77	5.32
Domains of QOL		
Physical health	27.41	3.57
Psychological health and relationship	19.73	2.49
Self and spirituality	19.51	2.90
Safety and environment	16.54	3.15
Medical care needs	7.46	1.95

SD = Standard Deviation

Participants' age ranged from 16 to 58 years (mean 36.03, *SD* = 9.04). The mean of perceived family (22.99, *SD* = 5.07) was higher than that of friend support (19.77, *SD* = 5.32). The mean of physical health domain of quality of life was 27.21 (*SD* = 3.57), followed by

psychological health and relationship 19.73 (*SD* = 2.49), self and spirituality 19.51 (*SD* = 2.90), safety and environment 16.4 (*SD* = 3.15), and medical care needs 7.46 (*SD* = 1.95).

Moderation Analysis

Table 4

Results from a Regression Analysis Examining the Moderation of the Effect of Family and Friend Support on the Relationship between EIPV and Physical Health

	b	Beta	*SE*	*t*	*p*
Constant	25.73	-	0.79	32.53	<.001
EIPV	-1.16	-0.29	0.23	-5.06	<.001*
Family support	0.15	0.21	0.05	3.22	.001*
EIPV x Family support	0.07	0.10	0.06	1.12	.218
Age	0.02	0.05	.023	0.82	.414
Education	-0.09	-0.04	-0.16	-0.57	.567
Income	0.41	0.14	.22	1.90	.059
$R^2 = 0.17$, $MSE = 10.78$, $F(6, 276) = 8.08$, $p < .001$					
Constant	25.84	-	0.823	31.39	<.001
EIPV	-1.17	-0.30	0.24	-4.92	<.001*
Friend support	0.08	0.12	0.04	1.94	.053
EIPV x Friend support	0.04	0.05	0.04	0.87	.384
Age	0.02	0.04	0.02	0.70	.487
Education	-0.09	-0.04	0.16	-0.58	.560
Income	0.40	0.14	0.21	1.89	.060
$R^2 = 0.15$, $MSE = 11.16$, $F(6, 276) = 8.65$, $p < .001$					

According to Table 4, the results indicated that EIPV negatively affected physical health ($p < .001$). The first model, family support positively associated with physical health domain of

QOL (b = 0.15, t(6, 276) = 3.22, p < .01), whereas friend support did not influence physical health in the second model (b = 0.08, t(6, 276) = 1.94, p = .053). Family support was not a moderator for the relationship between EIPV and physical health (b = 0.07, t(6, 276) = 1.12, p = .218). Similarly, friend support did not moderate the relationship between EIPV and physical health (b = 0.04, t(6, 276) = 0.87, p = .384).

Table 5

Results from a Regression Analysis Examining the Moderation of the Effect of Family Support on the Relationship between EIPV and Psychological Health and Relationship

	b	Beta	*SE*	*t*	*p*
Constant	18.70	-	0.70	26.58	<.001
EIPV	-1.03	-0.038	0.15	-6.71	<.001**
Family support	0.06	0.12	0.03	2.08	.039*
EIPV x Family support	0.07	0.12	0.03	2.17	.031*
Age	0.01	0.32	0.02	0.50	.616
Education	0.06	0.04	0.14	0.41	.682
Income	0.15	0.72	0.18	0.82	.412
R^2 = 0.19, MSE = 5.14, F(6, 276) = 11.15, p < .001					

The overall model of the moderating effect of family support on EIPV and psychological health and relationship was significant when controlling age, education, and income (R^2 = 0.19, F(6, 276) = 11.15, p < .001). This model accounted for 19% of the variance in psychological health. Every unit increased in EIPV, and participants had a 1.03 unit decrease in psychological health and relationship (b = -1.03, t(6, 276) = -6.71, p < .001). For every unit of increase in family support, participants had a 0.06 unit increase in psychological health and relationship (b =

0.06, $t(6, 276) = 0.03$, $p < .05$). Family support significantly moderated the relationship between EIPV and psychological health and relationship ($b = 0.07$, $t(6, 276) = 2.17$, $p < .05$).

Table 6

The Conditional Effect of EIPV on Psychological Health and Relationship at the Different Values of Family Support

Family support	Effect	*SE*	*t*	*p*	95%CI
-5.07	-1.37	.22	-6.20	<.001	[-1.81, -0.94]
.000	-1.03	.15	-6.71	<.001	[-1.33, -0.73]
5.00	-0.69	.22	-3.21	.002	[-1.12, -.27]

*Note** Values for quantitative moderators are the mean and plus/minus one SD from mean

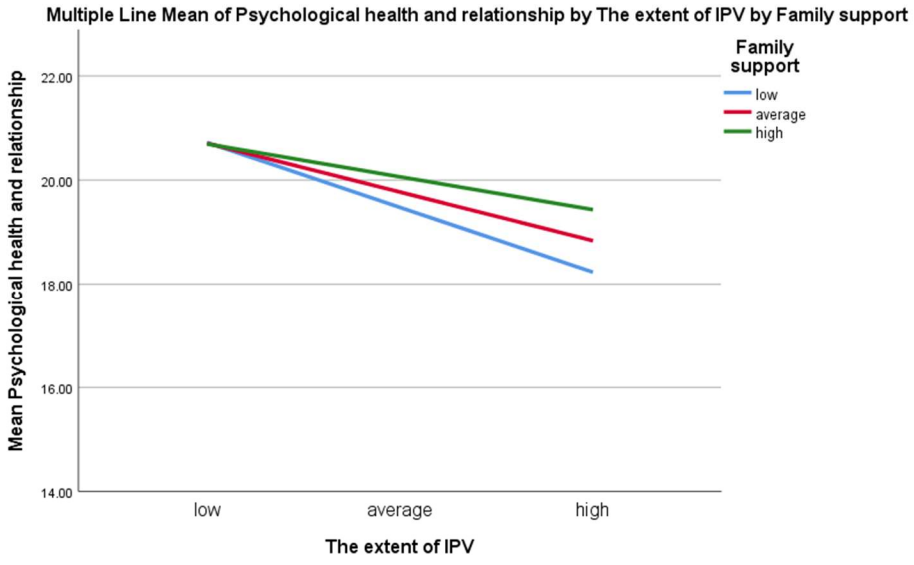

Figure 4. The Impact of EIPV on Psychological Health and Relationship under the Influence of Family Support

From Table 6 and Figure 4, the results revealed that women with high levels of EIPV had lower psychological health at all levels of family support. However, women experiencing high level of EIPV were much closer in terms of psychological health to those women with and average levels of EIPV, if they had high family support. Family support had a much weaker buffering effect for psychological health for women at low and average exposure to EIPV and a much stronger effect for women experiencing high levels of EIPV. An alternative way to say it was that the relationship between EIPV and psychological health was different for women with low, average, and high family support. Level of family support did not seem to matter much for psychological health at low and average exposure to EIPV. However, women experiencing high level of EIPV were much better off psychologically as the level of family support increased.

Table 7

Results from a Regression Analysis Examining the Moderation of the Effect of Friend Support on the Relationship between EIPV and Psychological Health and Relationship

	b	Beta	*SE*	*t*	*p*
Constant	18.80	-	0.69	27.09	<.001
EIPV	-1.02	-0.37	0.15	-6.82	<.001 **
Friend support	0.06	0.12	0.03	1.72	.086
EIPV x Friend support	0.06	0.13	0.03	2.08	.038*
Age	0.01	0.03	0.02	0.46	.644
Education	0.04	0.02	0.13	0.27	.786
Income	0.16	0.08	0.17	0.92	.360

$R^2 = 0.20$, $MSE = 5.10$, $F(6, 276) = 11.46$, $p < .001$

Table 7 revealed that an overall model of the moderating effect of friend support on EIPV and psychological health and relationship was significant (R^2 = 0.20, F(6, 276) = 11.46, p < .001). The model accounted for 20% of the variance of psychological health. By controlling age, education, and family monthly income, every unit increased in EIPV, participants had a 1.02 unit decrease in psychological health and relationship (b = -1.02, t(6, 276) = -6.82, p < .001). For every unit increased in friend support, psychological health and relationship did not significantly change (b = 0.06, t(6, 276) = 1.72, p = .086). Nonetheless, friend support was a significant moderator for the relationship between EIPV and psychological health and relationship (b = 0.06, t(6, 276) = 2.08, p < .05).

Table 8

The Conditional Effect of EIPV on Psychological Health and Relationship at the Different Values of Friend Support

Friend support	Effect	*SE*	*t*	*p*	95%CI
-5.321	-1.37	.22	-6.13	<.001	[-1.80, -0.93]
.000	-1.02	.15	-6.82	<.001	[-1.32, -0.73]
5.32	-.68	.22	-3.06	.002	[-1.12, -0.24]

*Note** Values for quantitative moderators are the mean and plus/minus one SD from mean

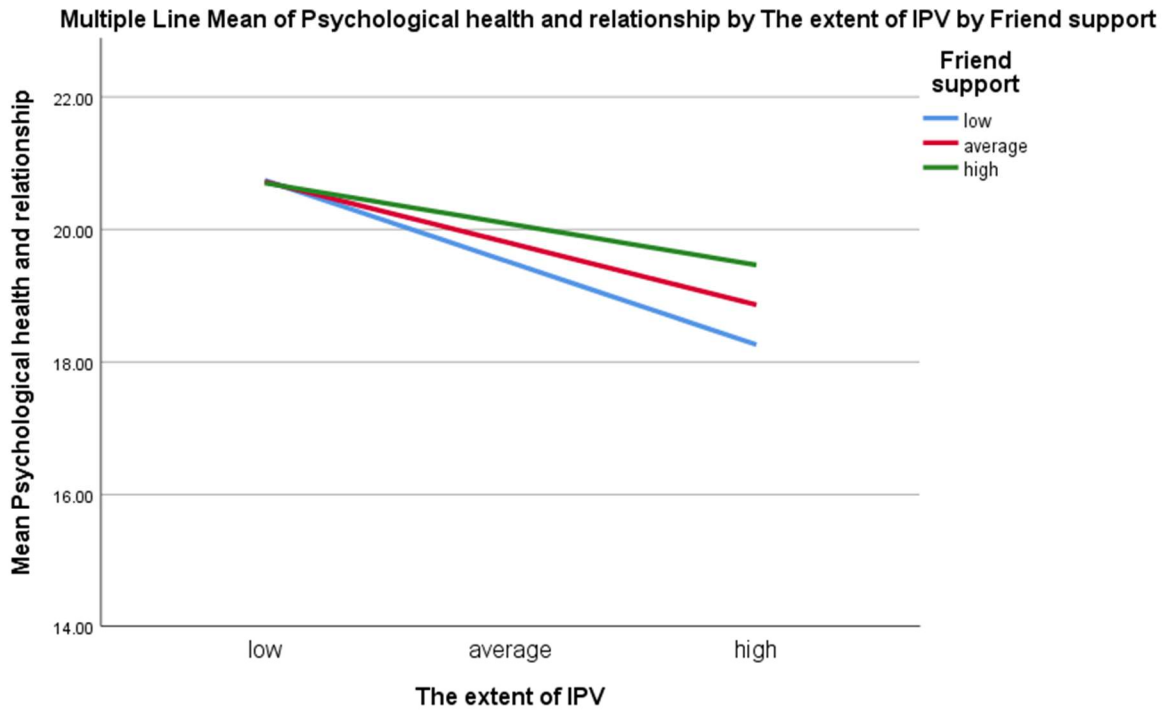

Figure 5. The Impact of the EIPV on Psychological Health and Relationship under the Influence of Friend Support

Based on Table 8 and Figure 5, the results indicated that women with high levels of EIPV had lower psychological health at all levels of friend support. Nevertheless, women who had experienced a high level of EIPV were much closer in terms of psychological health to those women with and average levels of EIPV, if they had high friend support. Friend support had a much weaker buffering effect for psychological health for women at low and average levels of EIPV and a much stronger effect for women who exposed to high levels of EIPV. To sum up, participants who had experienced all three types of IPV and perceived the high levels of friend support reported the better psychological health than those who perceived low and average friend supports.

Table 9

Results from a Regression Analysis Examining the Moderation of the Effect of Family and Friend Support on the Relationship between EIPV and Self and Spirituality

	b	Beta	*SE B*	*t*	*p*
Constant	17.69	-	0.77	22.98	<.001
EIPV	-0.92	-0.29	0.19	-4.93	<.001**
Family support	0.13	0.22	0.03	3.73	<.001**
EIPV x Family support	0.07	0.11	0.04	1.52	.129
Age	-0.01	-0.03	0.02	-0.49	.624
Education	0.02	0.01	0.13	0.12	.902
Income	0.61	0.25	0.19	3.27	.001**
R^2 = 0. 23, *MSE* = 6.63, $F(6, 276) = 14.32$, $p < .001$					
Constant	17.812	-	0.78	22.80	<.001
EIPV	-0.91	-0.28	0.20	-4.59	<.001**
Friend support	0.09	0.16	0.03	2.60	.010 *
EIPV x Friend support	0.03	0.05	0.04	0.81	.417
Age	-0.01	-0.04	0.02	-0.60	.548
Education	0.001	0.001	0.13	0.01	.993
Income	0.61	0.25	0.19	3.29	.001**
R^2 = 0.20, *MSE* = 6.83, $F(6, 276) = 13.79$, $p < .001$					

Table 9 indicated that EIPV negatively impacted on personal self and spirituality domain of QOL ($p < .01$). Family support (($b = 0.13$, $t(6, 276) = 3.73$, $p < .001$) and friend support ($b = 0.09$, $t(6, 276) = 2.60$, $p < .05$) positively associated with self and spirituality. Still, family support did not moderate among the relationship between EIPV and self and spirituality ($b = 0.07$, $t(6, 276) = 1.52$, $p = .129$). In the same way, friend support did not moderate the

relationship between EIPV and personal self and spirituality ($b = 0.03$, $t(6, 276) = 0.81$, $p = .417$). Income, but not age or education, was a significant predictor of self and spirituality ($p < .01$).

Table 10

Results from a Regression Analysis Examining the Moderation of the Effect of Family and Friend Support on the Relationship between EIPV and Safety and Environment

	b	Beta	*SE B*	*t*	*p*
Constant	13.99	-	0.84	16.75	<.001
EIPV	-1.20	-0.35	0.20	-6.14	<.001**
Family support	0.10	0.17	0.03	3.25	.001**
EIPV x Family support	0.03	0.04	0.05	0.59	.558
Age	0.01	0.01	0.02	0.25	.801
Education	0.23	0.12	0.15	1.58	.114
Income	0.40	0.15	0.20	2.01	.046*
$R^2 = 0.25$, $MSE = 7.62$, $F(6, 276) = 17.37$, $p < .001$					
Constant	14.14	-	0.85	16.59	<.001
EIPV	-1.15	-0.33	0.21	-5.47	<.001**
Friend support	0.11	0.18	0.04	3.05	.003**
EIPV x Friend support	0.01	0.02	0.05	0.31	.759
Age	0.003	0.01	0.02	0.14	.885
Education	0.20	0.14	0.14	1.41	.158
Income	0.41	0.16	0.20	2.09	.038*
$R^2 = 0.25$, $MSE = 7.58$, $F(6, 276) = 16.90$, $p < .001$					

Table 10 presented EIPV negatively associated with safety and environment domain of QOL ($p < .001$). Family support ($b = 0.10$, $t(6, 276) = 3.25$, $p < .001$) and friend support ($b =$

0.11, $t(6, 276) = 3.05$, $p < .01$) positively related to safety and environment. Quite interestingly, family support did not moderate among the relationship between EIPV and safety and environment ($b = 0.03$, $t(6, 276) = 0.59$, $p = .558$). Likewise, friend support failed to moderate the relationship between EIPV and safety and environment ($b = 0.01$, $t(6, 276) = 0.31$, $p = .756$). Income significantly predicted safety and environment ($p < .05$).

Table 11

Results from a Regression Analysis Examining the Moderation of the Effect of Family and Friend Support on the Relationship between EIPV and Medical Care Needs

	b	Beta	*SE*	*t*	*p*
Constant	7.59	-	0.50	15.16	<.001
EIPV	-0.23	-0.11	0.13	-1.77	.078
Family support	-0.03	-0.07	0.03	-1.10	.271
EIPV x Family support	-0.05	-0.11	0.03	-1.39	.166
Age	-0.04	-0.17	0.01	-3.05	.002*
Education	0.17	0.14	0.11	1.55	.123
Income	0.13	0.08	0.14	0.93	.353
$R^2 = 0.09$, $MSE = 3.56$, $F(6, 276) = 4.72$, $p < .001$					
Constant	7.63	-	0.51	14.93	<.001
EIPV	-0.17	-0.08	0.14	-1.27	.206
Friend support	0.03	0.07	0.03	1.00	.316
EIPV x Friend support	-0.04	-0.09	0.03	-1.14	.255
Age	-0.04	-0.17	0.01	-3.04	.003*
Education	0.14	0.12	0.11	1.32	.188
Income	0.15	0.09	0.14	1.09	.278
$R^2 = 0.09$, $MSE = 3.56$, $F(6, 276) = 4.73$, $p < .001$					

Table 11 revealed that EIPV did not relate to medical care needs ($p > .05$). Neither family ($b = -0.03$, $t(6, 276) = -1.10$, $p = .271$) nor friend support ($b = 0.03$, $t(6, 276) = 1.00$, $p = .316$) was a predictor of medical care needs. Family support was not a moderator for the relationship between EIPV and medical care needs ($b = -0.05$, $t(6, 276) = -1.39$, $p = .166$), neither did friend support moderate the relationship between EIPV and medical care needs ($b = -0.04$, $t(6, 276) = -1.14$, $p = .255$). Age proved itself a substantial predictor of medical care needs ($p < .01$).

Table 12

Additional Regression Analysis Examining the Moderation of the Effect of Family and Friend Support on the Relationship between Psychological Violence and Medical Care Needs

	b	*SE*	*t*	*p*
Constant	7.542	0.511	14.760	.000
Psychological violence	-0.936	0.336	-2.782	.005*
Family support	-0.019	0.025	-0.759	.448
Psychological health x Family support	0.034	0.056	0.605	.545
Age	-0.037	0.012	-3.066	.002**
Education	0.180	0.107	1.687	.092
Income	0.138	0.135	1.019	.309
$R^2 = 0.09$, $MSE = 3.55$, $F(6, 276) = 4.91$, $p < .001$				
Constant	7.619	0.517	14.751	.000
Psychological violence	-0.882	0.395	-2.232	.026*
Friend support	0.023	0.025	0.933	.351
Psychological x Friend support	0.017	0.079	0.209	.834
Age	-0.037	0.012	-3.065	.002**
Education	0.153	0.107	1.422	.156
Income	0.150	0.133	1.126	.261
$R^2 = 0.09$, $MSE = 3.55$, $F(6, 276) = 5.17$, $p < .001$				

When being coded as dichotomous variable (0 = no experience abuse, and 1 = experience abuse), the results indicated that physical and sexual violence did not relate to medical care needs. Yet, psychological violence significantly associated with medical care needs ($p < .01$ in the first model and $p < .05$ in the second model as shown in Table 12). Age was an important predictor of medical care needs ($p < .01$). Comparable to previous results, family and friend support did not moderate between psychological violence and medical care needs (family support: $b = 0.034$, $t(6, 276) = 0.605$, $p = .545$, and friend support: $b = 0.017$, $t(6, 276) = 0.209$, $p = .834$).

Summary Results

Table 13

Summary Results of the Direct Association and Interaction Effect of Family/Friend Support on Each Domain of QOL

Domains of QOL	Family support		Friend support	
	Direct association	Interaction effect (EIPV X family support)	Direct association	Interaction effect (EIPV X family support)
Physical health	significant	nonsignificant	nonsignificant	nonsignificant
Psychological health and relationship	significant	significant	nonsignificant	significant
Self and spirituality	significant	nonsignificant	significant	nonsignificant
Safety and environment	significant	nonsignificant	significant	nonsignificant
Medical care needs	nonsignificant	nonsignificant	nonsignificant	nonsignificant

Chapter V

Discussion

Discussion of Findings

This chapter provides a discussion of the findings, conclusion, strengths and limitations, nursing implications, and recommendations for future research. The primary focus of the current study was to determine the moderating effects of family support and friend support on the relationship between EIPV and each of the five domains of QOL among Thai women, adjusting for age, education, and income. Based on the Stress-Buffering Model (Cohen & McKay, 1984), it was hypothesized that both friend support and family support would mitigate the negative effects of IPV on physical health, psychological health and relationship, self and spirituality, safety and environment, and medical care needs. The overall results obtained from a moderation analysis revealed both kinds of support significantly moderated the relationship between EIPV and the psychological health and relationship domain. Contrary to the predictions, however, family/friend support did not moderate the relationships between EIPV and the remaining domains of physical health, self and spirituality, safety and environment, and medical care needs. An explanation of these findings is offered based on the study hypotheses.

Hypothesis 1: Family support will function as a moderator for the relationship between EIPV and each domain of QOL when controlling for age, education, and income.

An analysis of the data revealed IPV was negatively associated with psychological health and relationship, while family support was positively associated with this domain. Family support was also found to significantly moderate the relationship between EIPV and the domain of psychological health and relationship. Family support at all three levels (low, average, and

high) reduced the impact of EIPV on psychological health. Its buffering effect was stronger among participants with multiple types of IPV and weaker among those with fewer types of IPV. These findings support the Stress-Buffering Model which indicates that individuals who receive more emotional and tangible support from family members and friends are in better health than those with less support (Cohen & McKay, 1984; Cohen & Wills, 1985).

The findings are consistent with the literature review which revealed numerous studies linking exposure to violence, family support, and psychological health. IPV was found to be related to poor psychological health (Fernbrant et al., 2014; Pengpid et al., 2016). Houry, Kemball, Rhodes, and Kaslow (2006) found exposure to multiple types of IPV in African American women was associated with the greatest risk of poor psychological health, including depression, post-traumatic stress disorder (PTSD), and suicidal ideation. Higher emotional support from family was associated with a lower risk of negative psychological health among women experiencing IPV (Coker et al., 2002; Coker et al., 2003; Ross et al., 2015; Thompson et al., 2000). A deficit in family support led to lower psychological health conditions in victimized women, whereas an increase in support improved psychological health outcomes (Panaghi, Ahmadabadi, Ghahari, & Mohammadi, 2012). Supportive family members protected WIPV from psychological health problems by listening to their problems and providing them with a safe place to stay and relax (Clark, Silverman, Shahrouri, Everson-Rose, & Groce, 2010).

A majority of the items on the MSPSS-family subscale contain wording that appears to measure emotional support. Examples are “I get the emotional help and support I need from my family,” “I can talk about my problems with my family,” and “My family is willing to help me make decisions.” The emphasis on emotional support may help explain why family support is a

substantial moderator for the interaction between EIPV and psychological health. Additionally, the mean score of family support in this study is 22.99 (scores ranged from 4 to 28) indicating women perceived high emotional support (mean score > 20). A quote from Ross et al. (2015) which demonstrates how emotional support from family positively impacted the psychological health of a victim is "My mom is always there for me. She listens and consoles me which helps me to feel better every time." Conversely, the lack of diversity in social support items may help to explain why family support did not reduce the impact of EIPV on the other four domains of QOL.

An analysis of the relationships between predictors and outcomes showed EIPV was negatively associated with physical health, self and spirituality, safety and environment but not medical care needs. Family support, on the other hand, was positively related to physical health, self and spirituality, and safety and environment but not to medical care needs. As mentioned, the current study did not find family support moderated the relationship between EIPV and these four domains. These analyses are further explained below.

For the domain of physical health, family support was found to be positively associated with perceived physical health. This finding supports a previous study conducted by Coker et al. (2003), which revealed that family support positively associated with better physical health perceptions. Several studies found family members often serve as the primary source of emotional, financial, and material support (Ross et al., 2015; Rujiraprasert et al., 2009; Saito et al., 2009). Additionally, prior studies asserted that women who experienced multiple types of abuse were more likely to report poor physical health including decreased sleep quality and working ability (Hegarty et al., 2013; Lacey, McPherson, Samuel, Powell Sears, & Head, 2013).

Regarding the moderating effect on physical health, family support was not found to reduce the impact of IPV. A possible explanation of this finding is that many Thai women consider IPV or fighting a normal part of married life, and since "men can do no wrong", the women accept the violence (Ross et al., 2015). Some WIPV may fear they will be revictimized if they disclose the abuse to family members. WIPV may therefore perceive family support is less likely to benefit them.

As for the self and spirituality domain, family support was found to have a positive impact; however, it was not protective against IPV within this domain. Self and spirituality involves life enjoyment, meaningful life, concentration, energy, and body appearance (Ross et al., 2017). IPV is considered a family matter in Thai culture as presented in the quote "It is disgraceful to tell people about your 'mosquito tent' matter. Then everyone will know what's going on in your family" (Ross et al., 2015, p. 20). Women may also feel ashamed of their inability to maintain family harmony and may be concerned their abuse experience will cause parents and siblings to feel worried, ashamed, and uncomfortable (Ross et al., 2015; Rujiraprasert et al., 2009). A quote from a victim supporting this claim is "I don't tell my parents about what's going on because I'm afraid that they will feel shameful." (Ross et al., 2015, p. 20). The burden of being abused, maintaining family harmony, and protecting relatives and themselves from "loss of face" may diminish WIPV's capacity to enjoy life and to have a positive sense of self.

Although family support was significantly associated with safety and environment, it did not buffer the effect of IPV on this domain, which includes the perception of safety, economics, leisure activities, and physical environment. A possible explanation of this finding is that WIPV

who share details of this private matter with family may experience revictimization as a result of the sharing (Wright, 2015). WIPV who make this choice tend to have increased anxiety about their safety as well as the safety of the family members who assist them (Rujiraprasert et al., 2009). Since half of the participants in the current study reported having low-income, it would be difficult for them to leave their abuser. WIPV often seek financial support from their family members; however, these supporters may be struggling with economic problem themselves. Thai female victims in Rujiraprasert et al.'s study (2009) were unlikely to receive financial support from their birth families when they did not have enough money to share.

Neither EIPV nor family support was found to be associated with the domain of medical care needs which Ross et al. (2017) described as physical pain and medical attention needs. When physical, psychological, and sexual violence were categorized as "no abuse experienced" and "abuse experienced," each type of abuse functioned separately as a main predictor of medical care needs. Further analysis revealed psychological violence positively associated with medical care needs; no association was found for the other two types. This is consistent with the study by Thananowan and Kaesornsamut (2010) which indicated psychological violence was a strong predictor of mental health problems, such as stress, depression, and suicidal behavior. Even so, family support was not found to be a significant moderator for the relationship between psychological violence and medical care needs. A possible explanation for this finding is participants were recruited from a hospital where they were receiving formal support from healthcare professionals which lessened the need for support from family members.

Hypothesis II: Friend support will function as a moderator for the relationship between EIPV and each domain of QOL when controlling for age, education, and income.

Similar to family support, study findings showed friend support was a significant moderator for the relationship between EIPV and the domain of psychological health and relationship. All levels of friend support reduced the impact of IPV on mental health. High friend support was associated with improved mental health when WIPV experienced multiple types of abuse. The following explanation is offered for this significant finding.

Although the literature review is limited regarding the moderating effect of friend support on the relationship between IPV and psychological health, the impact of friend support on psychological health is addressed in the literature. Some studies suggest female friends are often the most vital source of mental support for WIPV (Rose, Campbell, & Kub, 2000; Rujiraprasert et al., 2009). Afro-Trinidadian WIPV reported friends listened to their problems, gave advice, and served as a safety net when an alternative place to live or financial support was needed (Hadeed & El-bassel, 2006). Levendosky et al. (2004) reported high emotional support from friend(s) was associated with fewer symptoms of depression and anxiety in women living in the mid-Michigan area. These findings reflect a rising awareness that friend(s) can be an additional source of support for WIPV.

The four items of the MSPSS-friend scale may have affected the findings since they focused only on perceived emotional support rather than asking about the diversity of support from friends. Examples of these items include: “I have friends with whom I can share my joys and sorrows,” “I can talk about my problems with my friends,” and “I can count on my friends when things go wrong.” The mean score of 19.77 for friend support (scores ranged from 4 to 28)

also demonstrates women perceived moderate support (scores 15-20). These factors may help explain why the interaction of EIPV and friend support improved the psychological health of WIPV but not the other four domains.

No significant interactions were found between friend support and EIPV on the domains of physical health, self and spirituality, safety and environment, and medical care needs. EIPV negatively associated with physical health, self and spirituality, safety and environment, but not medical care needs. Friend support positively related to self and spirituality, safety and environment, but not to physical health and medical care needs.

A moderation analysis showed no association between friend support and physical health. Additionally, friend support did not buffer the impact of IPV on physical health. Rujiraprasert et al. (2009) reported that some Thai women view sharing their abusive experiences to outsiders as a way to help relieve tension, while others believe abuse is a private problem a couple should resolve themselves. WIPV may perceive the disclosure of their story to friend(s) to be pointless or harmful to their physical well-being. Feelings of guilt and embarrassment which can occur when they receive negative responses from friends, such as gossip or blame, rather than support, may lead to physical symptoms including headache and lack of energy. In contrast, Coker et al. (2003) found American women with greater emotional support from friends reported better physical health. Hadeed and El-bassel (2006) also reported that friends helped to relieve the abusive situation by talking to the perpetrator or to both partners in the abuse situation about finding a resolution.

Friend support positively related to self and spirituality; however, it was not a moderator for the relationship between EIPV and this domain. The finding was congruent with a study by

Barnett, Martinez, and Keyson (1996) which found WIPV who perceived high friend support had lower levels of self-blame, while those with severe and multiple types of violence reported higher levels of self-blame. Older women were more likely to report higher friend support than younger ones because of having more opportunities to develop friendship networks. The more frequently women were exposed to IPV, the more likely they were to retaliate and experience self-blame (Overholser & Moll, 1990). Self-blame associated negatively with self-esteem in the aftermath of IPV (Catherine et al., 2014). Chronic abusive experiences and stigmatization affected WIPV's perception of self and self-esteem, resulting in increased psychological distress and social isolation (Fernbrant et al., 2014; Thananowan & Kaesornsamut, 2010).

Nonsignificant interaction was noted for friend support and EIPV in association with self and spirituality in this study. A possible explanation for the finding is that women who experienced abuse might believe friend support would not diminish the likelihood of ongoing violence on sense of self. Some Thai women concealed abusive experiences in order to protect their feelings (Ross et al., 2015). Rujiraprasert et al. (2009) found Thai WIPV connected their abuse to negative views of themselves; being a "bad women" generated feelings of shame and embarrassment, self-worthlessness, guilt and self-blame. These feelings lead to the destruction of self when their abuse stories are disclosed to others.

Friend support was positively related to safety and environment but did not moderate the relationship between EIPV and this domain. A possible explanation of the finding is that WIPV often turn outward in their efforts to find safety, thereby seeking help from informal supporters, including friends. Hadeed and El-bassel (2006) reported close female friends appeared to have a personal interest in WIPV. In another study, friends talked to perpetrators to try to stop the

abusive behaviors, and took their friends' children out of the abusive situations (Hadeed & El-bassel, 2006). Goodman, Dutton, Vankos, and Weinfurt (2005) also found the stronger friend support was, the less likely women would experience IVP. Some studies found that seeking friend support can trigger negative consequences. Some friends responded to disclosures and requests for help with negative reactions such as judgment, disbelief, fear, anger, or blaming (Liang et al., 2005; Sylaska & Edwards, 2014). These responses, in turn, can trigger shame, embarrassment, self-isolation, and a reluctance to disclose abuse on the part of WIPV (Latta & Goodman, 2011; Liang et al., 2005; Sylaska & Edwards, 2014). A study by Thomas, Goodman, and Putnins (2015) revealed that around 62% of American women reported having to give up sharing their experiences to remain safe, and over 50% reported safety concerns led to new or unexpected problems for themselves and their loved ones.

Results indicated that friend support was not a moderator for the relationship between EIPV and medical care needs. After three types of IPV were coded as categorical variables, psychological violence associated with medical care needs, while friend support did not relate to this domain. Friend support did not decrease the effect of psychological violence on this domain. When WIPV experience multiple types of IPV and perceive IPV has reached a certain level of severity, friend support is unlikely to buffer or stop it. Women who experienced particularly poor physical and mental health required support from healthcare professionals rather than from friends. A longitudinal study examined secondary stress including family responsibility and loss of job in post-sheltered women and revealed that women with high levels of violence were more likely to remain in or even undergo increases in depression over time (Anderson, Saunders, Yoshihama, Bybee, & Sullivan, 2003). Even though friend support may be helpful in some

abusive situations, the findings of this study suggest it may not alleviate the impact of IPV on medical care needs.

Conclusion

This study found both friend and family support are beneficial for significantly reducing the impact of EIPV on psychological health among Thai women who have been exposed to intimate partner violence. The associations between EIPV, family/friend support, and QOL may enable nurses and other healthcare professionals to develop interventions or support networks for promoting women's psychological health and preventing the negative impacts of IPV.

Strengths and Limitations

This study has several strengths. First, this is the first study to examine the five domains of QOL based on Ross et al. (2017). Second, this study is the first to test the interactions of family/friend support and EIPV on each DQOL among Thai women who received health care services at a hospital. Third, the use of categorical IPV can be beneficial to future feasible clinical practice. Fourth, a data analysis was completed by using the PROCESS MACRO program to determine the moderating effects with more rigor than if the normal multiple regression had been used. The benefits of using this program are that it 1) centers predictors which helps reduce multicollinearity, 2) computes the interaction term between predictors automatically, and 3) does simple slopes analysis to explain the relationships among predictor variables and an outcome.

Three limitations to this study can be identified. First, the findings may not be generalized to all women experiencing intimate partner violence in Thailand since the participants were from only one hospital in the country's northeast region. Second, the study was

a cross-sectional design which limits the ability to determine the long-term effect of IPV and family/friend support as it applies to DQOL. Third, this study relied on self-reports, which may cause under or over reporting as a result of recall bias.

Implications for Nursing

The current study findings add to knowledge about the benefits of family and friend support on the relationship between EIPV and the psychological health domain of quality of life and may guide both nursing education and nursing practice in Thailand. Since women with undetected IPV are at risk for escalating health and non-health related problems, nursing programs in Thailand should incorporate IPV content into their curriculums. Nursing instructors should prepare nursing students about how to clinically manage WIPV by teaching them how to screen for EIPV and available supporters such as family members and/or friends to promote female victims' QOL.

Although high rates of EIPV have been reported, screening for a history of IPV in female patients is not done routinely on OB/GYN or other hospital units in Thailand. The findings of this study suggest that screening for IPV as part of their routine health assessment would enable early detection of abuse for these patients. Because nurses have a limited time to provide care to each patient due to a nursing shortage, screening using categorical IPV would be more efficient than using long questionnaires. To accomplish this, nurses should develop protocols for providing effective EIPV screening as standard care for female clients. They could use the Satellite Guide developed by Ross, Roller, Rusk, Martsolf, and Draucker (2009) to design appropriate strategies for assessment of abusive experiences in this vulnerable group. Additionally, available sources of support for WIPV should be explored when EIPV experiences

are found. Nurses may need in-service training to inform them about IPV and to ensure they know how to effectively screen for EIPV and how to provide initial assistance. Nursing interventions should also be developed to minimize the negative consequences of EIPV and then tested for their feasibility and usefulness. The results of these interventions may have positive impact on Thai WIPV's quality of life.

Recommendations for Future Research

Although this study is an analysis of an existing data set collected seven years ago, findings most likely still hold true for the current situation due to the deep roots of the patriarchal system in Thai culture. A replicate study may be helpful to add new information. In particular, a longitudinal study should be conducted to examine any causal relationship among IPV, family and friend support, and DQOL. Participants should be recruited from multiple settings across all regions of Thailand to increase the generalizability of study findings. If the additional data collected support the current study's findings, interventions to improve perceived support, such as family-focused programs, friend-focused programs, or peer support groups, could be developed and tested to determine their feasibility in Thai culture.

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Appendix A

Background Information Questionnaire

Please answer all questions by filling in the space provided or by selecting the answer as indicated.

Personal Information	For Researcher Only
About yourself 1. If you are pregnant, how many weeks are your pregnant?.....	□
2. You are……. years old.	□
3. What is your highest educational level? □ Did not attend school □ Grade 6 or below □ Junior High School □ High School □ Diploma/Associate degree □ Bachelor's degree □ Master's or Doctoral degree	□
4. What is your occupation? □ Unemployed □ Cooperation employee □ Laborer □ Professional □ Farmer □ Small business employee □ Government employee □ Other, specify……..	□
5. What is your family monthly income? □ Less than 1,000 Baht □ 1,000-5,000 Baht □ 5,000-9,000 Baht □ 9,001-20,000 Baht □ More than 20,000 Baht	□
6. What is your marital status? □ Married with marriage certificate □ Married without marriage certificate □ Separate, divorced, or widowed □ De facto relationship	□
7. Do you drink alcohol? □ Yes, rarely (about once a month) □ Yes, occasionally (about every other week) □ Yes, frequently (at least once a week) □ No	□

About your partner 8. Your husband/partner is ……years old.	□
9. What is your husband/partner's highest education level? □ Did not attend school □ Grade 6 or below □ Junior High School □ High School □ Diploma/Associate degree □ Bachelor's degree □ Master's or Doctoral degree	□
10. What is your husband/partner's occupation? □ Unemployed □ Cooperation employee □ Laborer □ Professional □ Farmer □ Small business employee □ Government employee □ Other, specify……..	□
11. Does your husband/partner drink alcohol? □ Yes, rarely (about once a month) □ Yes, occasionally (about every other week) □ Yes, frequently (at least once a week) □ No	□
12. Does your husband illicit drugs? □ Yes, please specify type…….. □ No	□
13. Does your husband gamble? □ Yes, please specify type of gambling……... How often do he gamble?..... How much money did he spend on gambling each time?.....Baht □ No	□
Family information 14. Number of family numbers living in the household……	□
15. How many children do you have?.....	□
16. How long have you been in the relationship? …….. years	□
17. Does your family have any debt? □ Yes □ No	□

Appendix B

Psychological Maltreatment of Women Inventory

Please tick (√) the response that most accurately describes how your husband/partner acted toward you

Your partner/husband's behaviors	Never	Rarely	Occasionally	Frequently	Very Frequently
1. My partner called me names					
2. My partner swore at me					
3. My partner yelled and screamed at me					
4. My partner treated me like an inferior					
5. My partner monitored my time and made me account for where I was					
6. My partner used our money or made important financial decisions without talking to me about it					
7. My partner was jealous or suspicious of my friends					
8. My partner accused me of having an affair with another man					
9. My partner interfered in my relationships with other family members					
10. My partner tried to keep from doing things to help myself					
11. My partner restricted my use of the cellphone					
12. My partner told me that my feelings were irrational or crazy					
13. My partner blamed me for his problems					
14. My partner tried to make me feel crazy					

Appendix C

Severity of Violence against Women Scale

During the past year, you and your partner have probably experienced anger or conflict. Below is a list of behaviors your partner may have done. Describe how often your partner has done each behavior by tick (√) at the appropriate box.

My partner behaviors:	Never	Once	A few times	Many times
1. Kicked a wall, door, or furniture				
2. Threw, smashed, or broke an object				
3. Drove dangerously with me in the car				
4.Threw an object at me				
5. Shook finger at me				
6. Made threatening gestures at me				
7. Shook fist at me				
8. Acted like a bully toward me				
9. Destroyed something belonging to me				
10. Threatened to harm or damage things I cared about				
11. Threatened to destroyed property				
12. Threatened someone I cared about				
13. Threatened to hurt me				
14.Threatened to kill himself				
15. Threatened to kill me				
16. Threatened me with a weapon				
17. Threatened me with a club-like object				
18. Acted like he wanted to kill me				
19. Threatened me with a knife or gun				
20. Held me down, pinning me in place				
21. Pushed or shoved me				
22. Grabbed me suddenly or forcefully				
23. Shock or roughly handled me				
24. Scratched me				
25. Pulled my hair				
26. Twisted my arm				
27. Spanked me				
28. Bit me				
29. Slapped me with the palm of his hand				
30. Slapped me with the back of his hand				
31. Slapped me around the face and head				
32. Hit me with an object				
33. Punched me				
34. Kicked me				

My partner behaviors:	Never	Once	A few times	Many times
35. Stomped on me				
36. Choked me				
37. Burned me with something				
38. Used a clublike object on me				
39. Beat me up				
40. Used a knife or gun on me				
41. Demanded sex whether I wanted to or not				
42. Made me have oral sex against my will				
43. Made me have sexual intercourse against my will				
44. Physically forced me to have sex				
45. Made me have anal sex against my will				
46. Used an object on me in a sexual way				

Appendix D

The Multidimensional Scale of Perceived Social Support

Instructions

We are interested in how you feel about the following statements.

Read each statement carefully. Indicate how you feel about each.

Please circle the 1 if you very strongly disagree

the 2 if you strongly disagree

the 3 if you mildly disagree

the 4 if you are neutral

the 5 if you mildly agree

the 6 if you strongly agree

the 7 if you very strongly agree

	Very strongly disagree	Strongly disagree	Mildly disagree	Neutral	Mildly agree	Strongly agree	Very strongly agree
1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joy and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help and support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7

	Very strongly disagree	Strongly disagree	Mildly disagree	Neutral	Mildly agree	Strongly agree	Very strongly agree
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my join and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feeling.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

Appendix E

WHOQOL-BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures, and concerns. We ask that you think about your life **in the last four weeks**.

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How Satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
4.	How much do you need any medical treatment to function in your daily life?	5	4	3	2	1
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	An extreme amount
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things **in the last four weeks**.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet you need?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
19.	How satisfied are you with yourself?	1	2	3	4	5
20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

Appendix F

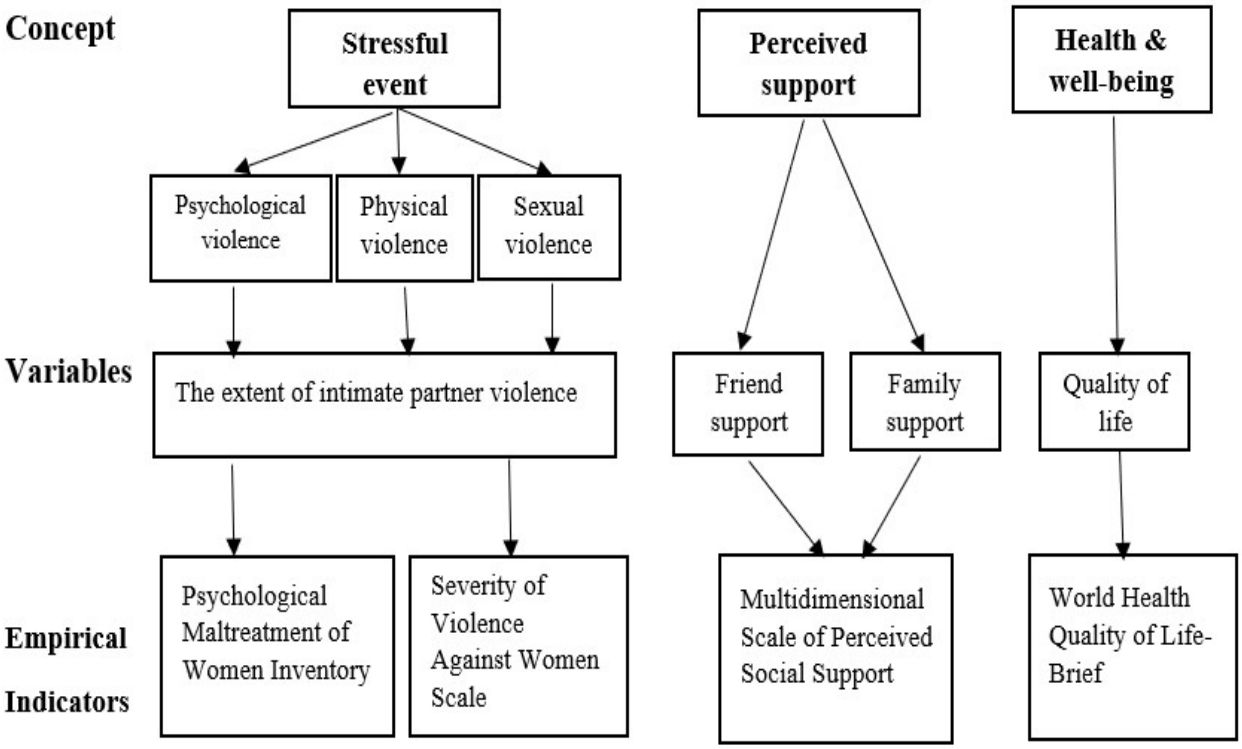
Comparison of Factors and Alphas Resulting from the World Health Organization Original Study and the Ross et al. (2017)

	The WHOQOL's findings		Ross et al. (2017)	
No.	Factor	Alpha	Factor	Alpha
1	Physical health (7 items): 3. Physical pain 4. Medical attention needs 10. Energy 15. Getting around 16. Sleep 17. Daily living activities 18. Work capacity	.80	Physical health (7 items): 15. Getting around 16. Sleep 17. Daily living activities 18. Work capacity 23. Living conditions 24. Access to health care 25. Transportation	.79
2	Psychological health (6 items): 5. Life enjoyment 6. Meaningful life 7. Concentration 11. Body appearance 19. Satisfaction with self 26. Despair, anxiety, depression	.76	Psychological health and relationship (5 items): 19. Satisfaction with self 20. Personal relationship 21. Sex life 22. Friend support 26. Despair, anxiety, depression	.74
3	Social relationships (3 items): 20. Personal relationship 21. Sex life 22. Friend support	.66	Self and spirituality (5 items): 5. Life enjoyment 6. Meaningful life 7. Concentration 10. Energy 11. Body appearance	.75
4	Environment (8 items): 8. Safety 9. Physical environment 12. Finance 13. Information 14. Leisure activities 23. Living conditions 24. Access to health care 25. Transportation	.80	Safety and environment (5 items): 8. Safety 9. Physical environment 12. Finance 13. Information 14. Leisure activities	.80
5	N/A	N/A	Medical care needs (2 items): 3. Physical pain 4. Medical attention needs	.77

Note. N/A= not applicable.

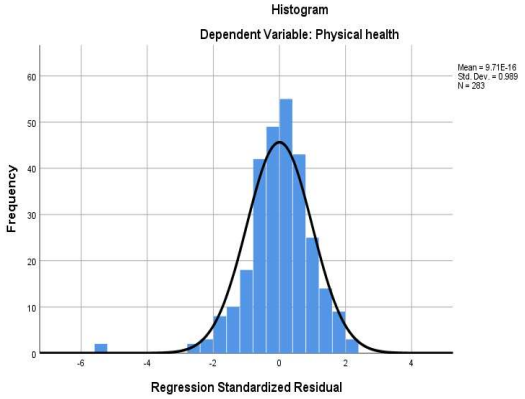
Appendix G

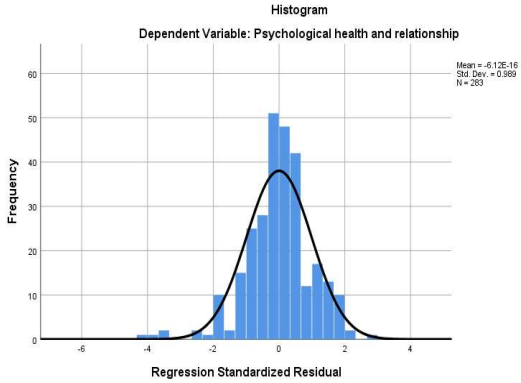
The Theoretical Substruction

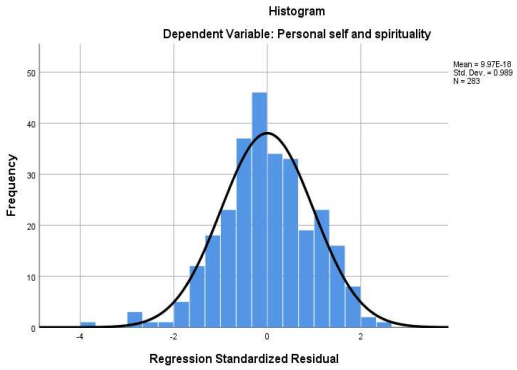


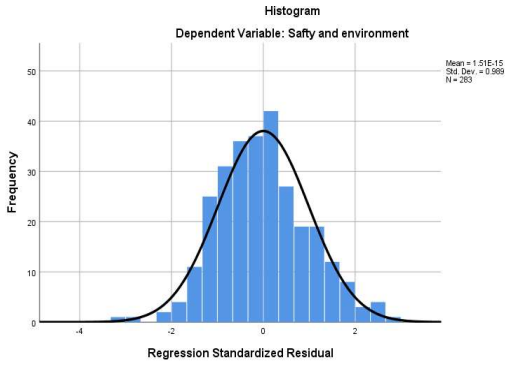
Appendix H

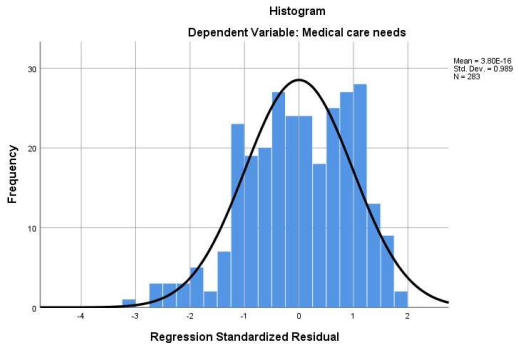
The Results of Multivariate Normality Testing





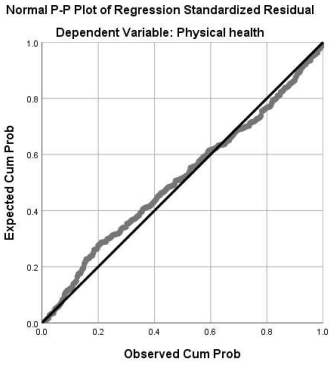


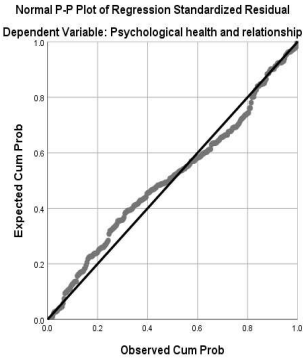


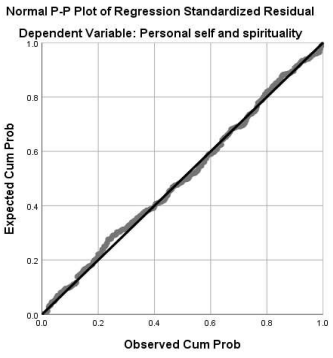


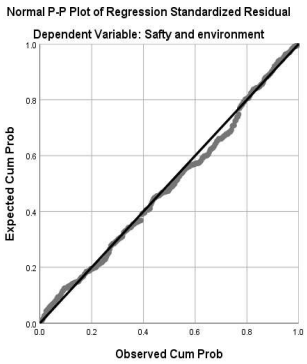
Appendix I

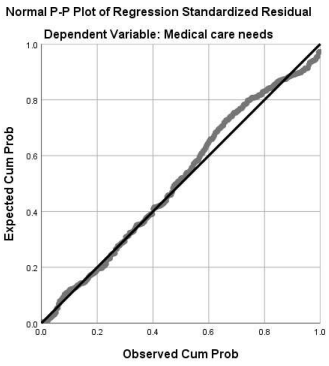
The Results of Linearity Testing





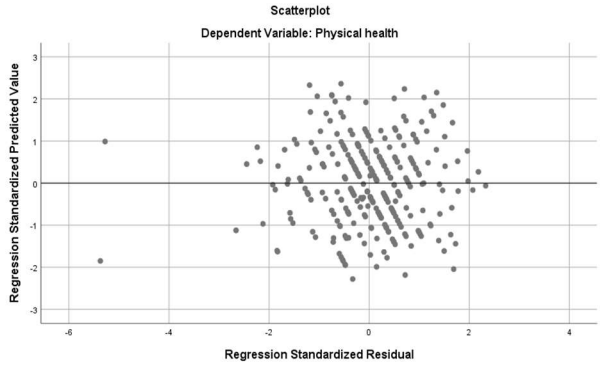


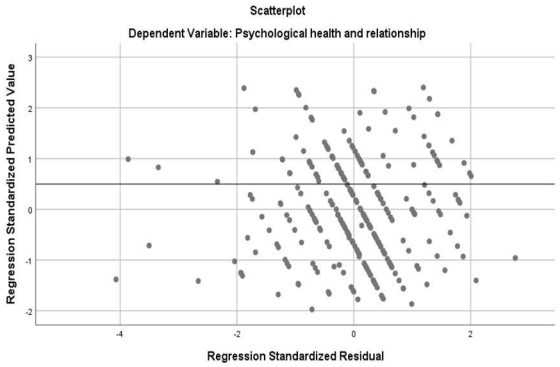


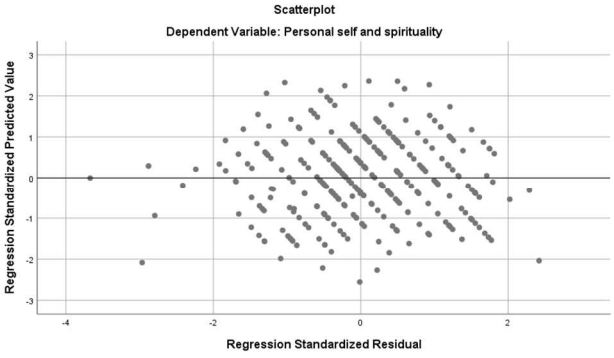


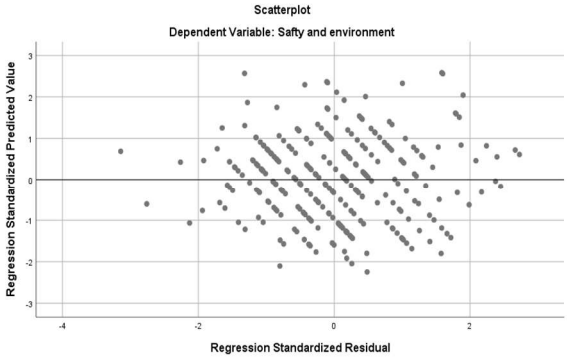
Appendix J

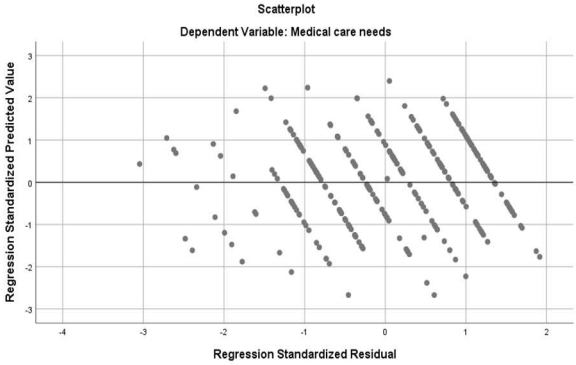
The Results of Homoscedasticity Testing











Appendix K

The Results of Multicollinearity Testing

	age	education	income	Family Support	Friend Support	EIPV	Physical	Psycho	Self	Safety	Medical
age	1	-0.024	.164**	-0.025	0.014	-.122*	0.101	0.084	0.041	0.074	-.143*
education	-0.024	1	.698**	.119*	.153**	-0.024	0.073	0.092	.204**	.248**	.204**
income	.164**	.698**	1	0.046	0.077	-.128*	.158**	.147*	.293**	.287**	.165**
Family Support	-0.025	.119*	0.046	1	.632**	-.120*	.233**	.150*	.250**	.230**	-0.019
Friend Support	0.014	.153**	0.077	.632**	1	-.187**	.183**	.202**	.230**	.275**	0.105
IPV	-.122*	-0.024	-.128*	-.120*	-.187**	1	-.335**	-.396**	-.336**	-.389**	-0.097
Physical	0.101	0.073	.158**	.233**	.183**	-.335**	1	.644**	.598**	.549**	0.064
Psychological	0.084	0.092	.147*	.150*	.202**	-.396**	.644**	1	.527**	.488**	.118*
Self	0.041	.204**	.293**	.250**	.230**	-.336**	.598**	.527**	1	.621**	0.103
Safety	0.074	.248**	.287**	.230**	.275**	-.389**	.549**	.488**	.621**	1	0.059
Medical	-.143*	.204**	.165**	-0.019	0.105	-0.097	0.064	.118*	0.103	0.059	1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	24.530	1.460		16.796	.000		
	Family SS Items 3 4 8 11	.134	.049	.190	2.722	.007	.621	1.611
	Friend SS Items 6 7 9 12	.008	.047	.013	.178	.859	.600	1.667
	Forms of IPV	-1.127	.223	-.287	-5.044	.000	.933	1.072
	1. Client age	.019	.023	.047	.827	.409	.928	1.078
	2. What is your highest education level?	-.111	.176	-.050	-.630	.529	.481	2.077
	4. What is your family monthly income?	.409	.237	.137	1.724	.086	.475	2.107

a. Dependent Variable: Physical item# 15,16,17,18,23,24,25 (7items)