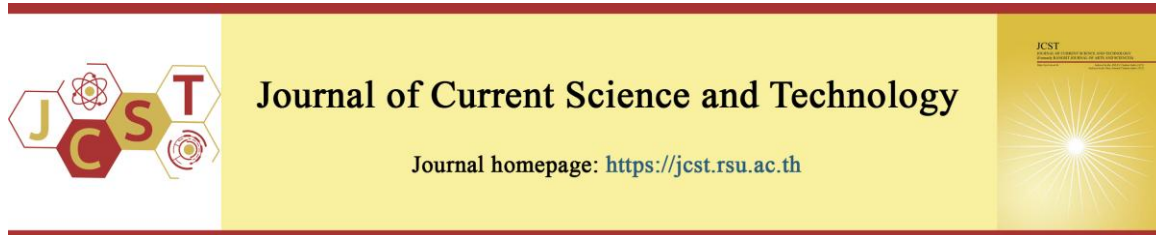


Cite this article: Dechboon, P., Jumneansuk, A., & Arsa, R. (2026). Relationship between family violence and psychological stress among Thai young people: A mixed-methods study in Pathum Thani Province. *Journal of Current Science and Technology*, 16(3), Article 198. <https://doi.org/10.59796/jcst.V16N3.2026.198>



Relationship between Family Violence and Psychological Stress Among Thai Young People: A Mixed-Methods Study in Pathum Thani Province

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Received 16 January 2026; Revised 27 March 2026; Accepted 14 April 2026; Published 25 June 2026

Abstract

Family violence among young people remains a significant public health concern, yet primary care screening remains inconsistent in Thailand. To understand which specific types of violence most strongly predict adolescent stress and why these problems remain hidden during healthcare visits, we enrolled 350 young people aged 13 – 24 years from Pathum Thani Province between February and April 2025. Participants completed surveys measuring six types of violence, psychological stress using the ST-5 instrument, and family relationship quality. The 138 participants scoring ST-5 ≥ 8 subsequently completed in-depth interviews. Associations were analyzed using Pearson correlations and stepwise regression, and interview transcripts were then coded thematically.

Of the 365 young people approached, 350 participated, yielding a response rate of 95.9%. Violence exposure affected 46% of participants, while 39.5% demonstrated high-to-severe stress levels. Stepwise regression revealed that witnessing parental arguments was the only violence-related predictor independently associated with stress, accounting for 23.6% of the variance ($\beta = .486, p < .001$). Shared family activities provided modest protection ($\beta = -.127, p = .007$), increasing the total explained variance to 25.2%. Paradoxically, 57.1% of violence-exposed participants described their family relationships positively overall, reflecting the coexistence of violence and support within Thai family systems. Based on these findings, brief ST-5 screening combined with culturally adapted indirect inquiry about parental conflict may represent a promising direction for improving the detection in primary care settings, although prospective evaluation is required. Clinicians must recognize that violence and support can coexist within Thai families, requiring interventions that validate young people's distress while preserving essential family bonds.

Keywords: family violence, psychological stress, young people, mental health, interparental conflict, mixed-methods research

1. Introduction

Psychological stress in adolescents represents both a common health complaint and an early warning sign for serious mental health disorders. Approximately 14% of 10–19-year-olds worldwide experience mental health problems, with stress symptoms often preceding major depression, anxiety disorders, or suicidal ideation (World Health

Organization, 2021). In Thailand specifically, suicide ranks as the third leading cause of death among adolescents, with 17.6% of those aged 13–17 having seriously considered suicide (UNICEF, 2022a), underscoring the urgency of addressing stress and mental health in this population. Studies in Thai university populations have demonstrated that psychological distress manifests through measurable

physiological changes, including alterations in autonomic nervous system functioning and stress hormone levels (Noiprasert et al., 2024). These figures were corroborated by the 2021 Global School-based Student Health Survey, which confirmed the severity of suicide ideation among Thai adolescents aged 13–17 years (World Health Organization, 2022).

Despite substantial research on academic pressure and peer relationships as adolescent stressors (Ruangkanchanasetr et al., 2005; Peltzer & Pengpid, 2015), family violence remains a critical blind spot in clinical practice. Worldwide, 20–60% of adolescents experience some form of family violence, including verbal attacks, physical punishment, psychological manipulation, or witnessing interparental conflict (Hillis et al., 2016; Norman et al., 2012), with physical abuse alone affecting approximately 26.6% of children in China (Fang et al., 2015). In Thailand specifically, family violence affected 42.2% of households during the COVID-19 pandemic (Napa et al., 2023). Yet young people rarely disclose family problems during healthcare visits, often presenting with non-specific complaints rather than directly reporting family concerns. Family violence among young people has been investigated primarily through self-report questionnaires, structured interviews, and official records, with self-report tools being the most feasible in community settings (Straus et al., 1996).

Primary care settings theoretically offer ideal opportunities for early detection, as they serve as adolescents' first point of healthcare contact and enable longitudinal follow-up (Hagan et al., 2017). However, multiple barriers impede systematic screening, including time constraints during appointments, limited availability of brief validated tools, and insufficient training in culturally appropriate ways to discuss family issues (Miller & McCaw, 2019; Thackeray et al., 2010). Previous studies have employed multidimensional instruments such as the Perceived Stress Scale (PSS; Cohen et al., 1983) and the General Health Questionnaire; GHQ (Goldberg, 1972) to measure stress broadly across multiple domains. Unlike these multi-item tools, the Stress Test-5 (ST-5), developed by Thailand's Department of Mental Health, assesses five stress indicators in 2–3 minutes: sleep disturbance, concentration difficulty, irritability, loss of interest, and social withdrawal (Department of Mental Health, Ministry of Public Health, 2016). Recent psychometric validation studies have established that culturally adapted brief screening instruments demonstrate acceptable reliability and validity for identifying mental health

risks in Thai populations (Kaewjanta et al., 2024). Moreover, although prior studies have examined associations between family violence and mental health outcomes, they have generally not disaggregated findings by specific types of violence. Therefore, evidence on which specific types of family violence most strongly predict psychological distress among young people in Thai cultural contexts remains limited (Hillis et al., 2016; Norman et al., 2012). A further critical gap concerns cultural context: Thai young people often do not seek formal help for mental health concerns, partly due to cultural norms around privacy and family matters, suggesting that culturally adapted approaches are needed in clinical and community settings (UNICEF, 2022b).

Theoretical Framework

This research integrates ecological systems theory (Bronfenbrenner, 1979) and emotional security theory (Davies & Cummings, 1994). The ecological perspective positions the family as the most proximal and powerful influence on adolescent development. Emotional security theory suggests that exposure to interparental conflict threatens children's fundamental need for a stable family context, creating fear of family dissolution. However, these Western-derived frameworks may not fully capture Thai cultural norms emphasizing family harmony and privacy, which likely shape stress appraisal and help-seeking behaviors differently.

This study contributes to the literature in four ways:

- 1) To the authors' knowledge, it provides one of the first examinations of how specific types of family violence differentially predict psychological stress among Thai young people.
- 2) It documents the coexistence of violence and family support within Thai collectivist family systems.
- 3) Through qualitative analysis, it identifies strategic differentiation and cultural normalization as underlying mechanisms explaining this paradox.
- 4) It provides preliminary evidence that family-related concerns may not always be addressed during healthcare visits, highlighting a potential area for strengthening family-informed care in Thai primary care settings.

2. Objectives

This mixed-methods study aimed to: 1) examine the relationships between different types of family violence and psychological stress among Thai

young people aged 13–24 years; 2) identify which aspects of family violence and family relationships most strongly predict stress; and 3) explore young people's lived experiences of family violence, its psychological impact, and healthcare visits within Thai cultural contexts.

3. Materials and Methods

3.1 Study Design and Setting

This convergent mixed-methods study combined cross-sectional surveys and qualitative interviews conducted simultaneously in Pathum Thani Province, Thailand, between February and April 2025. Potential participants were recruited through schools and universities in Pathum Thani Province. Research assistants visited each institution to provide information about the study and invite eligible students to participate. Surveys were administered in closed, private rooms within each institution, with participants completing questionnaires individually under supervised conditions. In-depth interviews were conducted one-to-one in separate private rooms to ensure confidentiality and comfort. The inclusion criteria were: (1) aged 13–24 years; (2) currently enrolled in a school or university in Pathum Thani Province for at least one year; (3) able to read, write, and communicate in Thai; and (4) no hearing or visual impairment. The exclusion criteria were: (1) diagnosed with a psychiatric disorder such as major depressive disorder or obsessive-compulsive disorder; (2) currently receiving tricyclic medication; or (3) currently under psychiatric treatment. The study employed a single-wave cross-sectional survey design ($n = 350$) followed by one wave of in-depth interviews ($n = 138$) with participants who reported family violence exposure.

3.2 Sample Size

1) Quantitative phase: The sample size was calculated using G*Power 3.1 software for correlation analysis with $\alpha = .05$, power = .80, and an anticipated effect size of $r = .30$, selected based on medium effect size conventions for correlation analysis in social science research (Cohen, 1988). Power analysis indicated a minimum required sample of $n = 342$. However, to account for potential incomplete responses, 350 participants were recruited from 365 individuals approached, yielding a response rate of 95.9%.

2) Qualitative phase: All 138 participants who met high-stress criterion ($ST-5 \geq 8$) were invited for in-depth interviews. The interview completion rate

was 100%. Data saturation was assessed inductively throughout the analysis process. The research team independently reviewed each interview transcript and discussed emerging themes after each set of interviews. Saturation was considered achieved when subsequent interviews produced no new themes or substantively new information, which was confirmed by the final interviews in the dataset.

3.3 Variables and Measurements

1) Outcome: Psychological stress was measured using the ST-5 (0 – 15 score range), which assesses five stress symptoms over 2 – 4 weeks: sleep problems, concentration difficulties, irritability, loss of interest, and social withdrawal. Scores ≥ 8 indicate high stress (Cronbach's $\alpha = .77$).

2) Exposures: Six violence subtypes experienced in the prior 6 months were assessed on 5-point scales (1 = never to 5 = very often): harsh verbal communication, physical threats before others, violence causing injury, witnessing parental arguments, home confinement, and being struck or having objects thrown. This 6-item scale was developed by the research team based on established family violence typologies. It was validated through a content validity assessment by three academic experts, yielding an Item-Objective Congruence (IOC) value of 0.78, and was then pilot-tested with 30 young people in Pathum Thani Province (Cronbach's $\alpha = .72$).

3) Predictors: Five dimensions of the quality of family relationships were assessed using a 5-item researcher-developed scale: receiving care and concern, receiving advice, following parental guidance, family outings together, and shared activities among family members. This scale was validated through content validity assessment by three academic experts (IOC = 0.72) and pilot-tested with 30 young people in Pathum Thani Province (Cronbach's $\alpha = .72$).

4) Covariates: Age, sex, level of education, family structure, and living condition were collected for descriptive analyses but were not adjusted in the primary models due to multicollinearity.

5) Qualitative procedures: Two psychologists conducted semi-structured interviews in Thai, covering family violence experiences, stress impact, and healthcare disclosure barriers.

6) Data treatment: No transformations were applied. No missing data were found across the primary variables.

3.4 Data Sources and Measurement

1) *Quantitative Instruments*

Participants self-reported basic characteristics, including age, sex, education level, family structure, and current living arrangements.

For family violence exposure, participants answered questions about six different types of violence that they might have faced in the previous 6 months. Each item used a 5-point response format, ranging from never (1) to very often (5). Reliability and validity information for this scale is reported in Section 3.3.

Stress level was measured using the ST-5, a validated screening questionnaire developed by Thailand's Department of Mental Health (Department of Mental Health, Ministry of Public Health, 2016). It assesses five common stress symptoms experienced over the past 2–4 weeks: sleep problems, difficulty concentrating, irritability, loss of interest, and social withdrawal. Participants rated how often they experienced each symptom on a 4-point scale, ranging from "rarely or never" to "regularly," producing total scores from 0 to 15. Scores of 8 or higher indicate high stress. Score interpretation follows four levels: low stress (0–4), moderate stress (5–7), high stress (8–9), and very high stress (10–15). Reliability information is reported in Section 3.3.

To assess family relationships, five items asked about receiving care and concern, receiving advice, following parental guidance, family outings, and shared activities using 5-point Likert scales. Reliability information is reported in Section 3.3.

All three instruments were pilot-tested with 30 young people with characteristics similar to those of the study sample in Pathum Thani Province before the main data collection. Completed questionnaires were checked by the principal investigator for missing responses; any questionnaire with incomplete primary variable data was excluded from the analysis. For the qualitative component, all interview recordings were transcribed verbatim in Thai by the principal investigator. Thematic coding was conducted manually by the principal investigator, with independent verification by a second team member. Inter-coder agreement was assessed using Cohen's kappa ($\kappa = .82$), indicating substantial agreement.

2) *Qualitative Procedures*

Two psychologists conducted semi-structured interviews lasting 30–45 minutes, all of which were conducted and recorded in Thai. The interviews covered participants' sources of stress, family

dynamics, experiences of family violence, experiences with healthcare providers, and stress management strategies. All participant quotes included in this paper were originally spoken in Thai.

3.5 Statistical Methods

1) *Quantitative Analysis*

Descriptive statistics were used to characterize the sample. Pearson correlations were used to examine bivariate associations. Stepwise multiple regression was used to identify independent predictors of stress. Variables were entered into the model if they met the inclusion criterion of $p \leq .05$ and removed if they no longer met the retention criterion of $p \geq .10$. All 11 candidate variables (six violence subtypes and five family relationship dimensions) were considered for entry. Qualitative data were analyzed using Braun and Clarke's thematic analysis (Braun & Clarke, 2006). Inter-coder agreement was substantial ($\kappa = .82$).

2) *Data Integration*

In accordance with convergent design principles, quantitative and qualitative data were analyzed independently before integration. Systematic comparison during interpretation revealed patterns of convergence, expansion, and divergence.

3.6 Bias

Selection bias was minimized through stratified random sampling across three educational levels: junior high school, senior high school, and university. Within each stratum, participants were randomly selected to ensure representation across the age range of 13–24 years. Social desirability bias was addressed through the use of validated instruments, participant anonymity ensured by the absence of identifying information on questionnaires, private individual survey rooms, one-to-one private interview settings, and abbreviated recall periods (6 months for violence exposure and 2–4 weeks for stress symptoms).

3.7 Ethics Statement

This study was approved by the Institutional Review Board of Valaya Alongkorn Rajabhat University under the Royal Patronage (REC No. 0059/2024 and COA No. 0002/2025, approved January 13, 2025). All participants provided written informed consent; parental consent was obtained for minors under 18 years of age. All procedures followed the Declaration of Helsinki.

4. Results

4.1 Sample Characteristics

All 350 participants completed the surveys (response rate of 95.9% among the 365 young people approached). The mean age was 18.1 ± 3.3 years, and 50.6% were male. Education levels included junior high school (33.7%), senior high school (26.0%), and university students/graduates (40.3%). Family structures included living with both parents (57.4%), separated parents (30.0%), and a deceased parent (12.6%). The mean ST-5 score was 6.20 ± 4.72 , and 39.5% showed high-to-severe stress ($ST-5 \geq 8$).

4.2 Violence Exposure and Stress Prevalence

Violence exposure was common: 161 participants (46%) reported experiencing at least one type of violence “often” or “very often” during the prior 6 months. Individual violence types ranged from 26.3% to 30.3% (Table 1). Stress levels were elevated: the mean ST-5 score was 6.20 ± 4.72 , with 39.5% ($n = 138$) showing high-to-severe stress ($ST-5 \geq 8$). Notably, specific stress symptoms varied in prevalence: irritability affected 32.3%, sleep problems 29.4%, and depressed mood 27.7% of participants.

A striking finding emerged: despite widespread violence exposure, 57.4% described family relationships positively overall. Among the 161 violence-exposed adolescents, 57.1% still rated family bonds favorably nearly identical to the 57.7% among non-exposed participants (Table 1). This paradox warranted deeper qualitative exploration.

4.3 Associations Between Violence, Relationships, and Stress

All six violence types were significantly correlated with stress ($r = .378-.486$, all $p < .001$), with witnessing parental arguments showing the strongest association ($r = .486$). As is arithmetically expected in simple regression, this Pearson correlation ($r = .486$) is identical to the standardized regression coefficient reported in Model 1 ($\beta = .486$), given that only one predictor was entered at that stage. Violence types were highly intercorrelated ($r = .756-.916$), suggesting clustering, as adolescents rarely faced only one form of violence. Better family relationship quality was correlated with lower stress, although the associations were modest ($r = .067$ to

.132). Violence exposure was inversely correlated with receiving support (advice $r = -.215$, care $r = -.168$; Table 2).

Table 1 Prevalence of Family Violence Exposure and Psychological Stress ($n = 350$)

Variable	Mean	n (%)
PSYCHOLOGICAL STRESS:		
ST-5 total score (0-15)	6.20 ± 4.72	
Low (0 – 4)		137 (39.1)
Moderate (5 – 7)		75 (21.4)
High (8 – 9)		32 (9.1)
Very high (10 – 15)		106 (30.3)
FAMILY VIOLENCE EXPOSURE^a		
Harsh verbal communication	2.53 ± 1.49	106 (30.3)
Home confinement	2.42 ± 1.45	106 (30.3)
Being struck or having objects thrown	2.47 ± 1.53	103 (29.4)
Witnessing parental arguments	2.40 ± 1.44	101 (28.9)
Physical threats before others	2.35 ± 1.44	98 (28.0)
Physical violence causing injury	2.38 ± 1.50	92 (26.3)
Any violence (frequent exposure)		161 (46.0)
FAMILY RELATIONSHIP QUALITY^b		
Receiving care/concern	4.15 ± 0.87	
Receiving advice	4.11 ± 0.91	
Following parental guidance	4.05 ± 0.89	
Family outings	3.89 ± 1.02	
Shared activities	3.79 ± 1.03	
Good overall relationships		201 (57.4)
Among violence-exposed ($n = 161$)		92 (57.1)
Among non-exposed ($n = 189$)		109 (57.7)

Values are presented as mean $\pm$ standard deviation or n (%).

^aFrequent exposure was defined as reporting “often” or “very often” (score ≥ 4 on the 5-point scale) for at least one violence type during the prior 6 months. ^bGood overall relationship quality was defined as a mean score of ≥ 3.41 across the five family relationship items, consistent with standard interpretation criteria for 5-point Likert scales.

4.4 Regression Analysis: Independent Predictors

Stepwise regression tested 11 candidate variables. Witnessing parental arguments entered first, accounting for 23.6% of the stress variance ($\beta = .486$, $p < .001$). Shared family activities added 1.6% of the variance ($\beta = -.127$, $p = .007$). No other variables met the inclusion criteria due to multicollinearity. The final model explained 25.2% of the variance ($F(2,347) = 58.42$, $p < .001$; $f^2 = 0.34$, large effect; Table 3).

Table 2 Pearson Correlations Between Study Variables (n = 350)

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Psychological stress	1											
Family violence												
2. Harsh verbal	.378**	1										
3. Physical threats	.450**	.806**	1									
4. Physical injury causing	.467**	.776**	.916**	1								
5. Parental arguments	.486**	.772**	.870**	.887**	1							
6. Confinement	.402**	.756**	.839**	.874**	.888**	1						
7. Hit/thrown	.447**	.784**	.839**	.856**	.875**	.886**	1					
Family relationships												
8. Receive care	-.067	-.168**	-.096	-.136	-.176**	-.166**	-.140**	1				
9. Receive advice	-.121*	-.215**	-.091	-.177**	-.197**	-.200**	-.205**	.680**	1			
10. Follow guidance	-.124*	-.143**	-.127**	-.152**	-.179**	-.152**	-.154**	.594**	.583**	1		
11. Outings	-.089	-.142**	-.078	-.137*	-.127*	-.136*	-.132*	.364**	.492**	.451**	1	
12. Activities	-.132*	-.035	-.008	.024	-.010	-.011	-.045	.240**	.200**	.229**	.424**	1

Note: * $p < .05$. ** $p < .01$ (two-tailed)

ST-5 scores range from 0 to 15 (higher scores indicate greater stress). Violence and relationship items were rated on 5-point scales (1 = never/strongly disagree to 5 = very often/strongly agree). High intercorrelations among violence types ($r = .76-.92$) were addressed through stepwise regression (Table 3)

Table 3 Stepwise Multiple Regression Predicting Adolescent Stress (n = 350)

Model and Predictors	B	SE	β	t	95% CI	P	R ²	Adj R ²	ΔR^2
Model 1							.236	.234	-
Constant	0.364	0.598	-	0.61	-0.813, 1.541	.543			
Parental arguments	1.594	0.154	.486	10.36	1.291, 1.897	<.001			
Model 2 (Final)							.252	.2478	.016
Constant	2.583	0.994	-	2.60	0.629, 4.537	.010			
Parental arguments	1.590	0.152	.484	10.43	1.290, 1.890	<.001			
Family activities	-.581	0.212	-.127	-2.73	-0.998, -0.163	.007			

Model 1: $F(1,348) = 107.36, p < .001$; Cohen's $f^2 = 0.31$ (large effect)

Model 2: $F(2,347) = 58.42, p < .001$; Cohen's $f^2 = 0.34$ (large effect)

Change: $\Delta R^2 = .016, F \text{ change } (1,347) = 7.48, p = .007$

Note: In Model 1, the standardized regression coefficient ($\beta = .486$) is mathematically equivalent to the Pearson correlation coefficient ($r = .486$) because only one predictor is included in the model. This equivalence is an expected arithmetic property of simple linear regression and does not indicate circularity in the analysis

4.5 Qualitative Findings: Understanding the Paradox

Thematic analysis of 138 interviews identified three interconnected themes explaining the violence–stress relationship and detection barriers. These themes help resolve the quantitative paradoxes observed earlier.

1) Theme 1: Verbal Conflict Causes Deeper Psychological Impact Than Physical Discipline

Adolescents consistently characterized verbal attacks and witnessed arguments as more psychologically damaging than physical punishment, which many normalized as parental training. One participant explained the lasting impact of harsh words: “Mother’s words are sometimes harsh. They

hurt” (P077-F-18). Another described feeling caught in parental disputes: “*Sometimes when they fight, they take it out on me despite my non-involvement*” (P013-M-16). The sense of being misunderstood by parents emerged frequently: “*I wish mother would understand me more. She never adjusts for me*” (P007-F-15). These accounts align with the quantitative findings showing parental arguments as the strongest stress predictor ($\beta = .486$), explaining why verbal conflict matters more than frequency alone suggests.

2) Theme 2: Strategic Differentiation and Cultural Normalization Enable Positive Family Perceptions

This theme directly explains the quantitative paradox, namely how 57.4% of violence-exposed adolescents maintained positive family views.

Participants revealed two simultaneous processes. First, strategic differentiation occurred when adolescents selectively sought support from less-harsh family members rather than seeking uniform support. One participant explained: *"For life matters, I talk with grandmother. She gives good advice. Neither father nor grandmother pressure me"* (P110-F-20). Another described this selective relationship maintenance: *"Usually when problems arise, I seek counsel from siblings and mother"* (P081-M-19).

Second, cultural normalization occurred when harsh discipline was interpreted as parental training rather than rejection. Even those experiencing harsh treatment described unconditional family support: *"Family doesn't pressure me. They always support"* (P027-M-18). Deep family bonds created both stress and motivation. Worry about ill parents emerged frequently: *"Very stressed about mother's illness. I worry because mother is household center"* (P036-F-17). These dual processes, strategic differentiation and cultural normalization, allowed adolescents to maintain positive overall family views despite measurably reduced support in violence-exposed homes.

3) Theme 3: Systematic Absence of Healthcare Inquiry with Cultural Barriers to Disclosure

Despite 60.9% reporting moderate-to-severe stress, participants consistently reported that healthcare providers never inquired about family circumstances. Two barriers emerged. Fear of repercussions kept adolescents silent: *"If I told the doctor, what if they report it? My parents would blame me"* (P081-M-19). Cultural privacy norms made disclosure feel inappropriate: *"Discussing family problems with outsiders is embarrassing. Family matters should stay private"* (P125-F-20). These accounts reveal why systematic screening combined with culturally adapted inquiry approaches might improve detection rates.

5. Discussion

This mixed-methods study of 350 Thai young people revealed three key findings with important theoretical and clinical implications. First, interparental conflict emerged as the strongest observed predictor of stress in this sample, accounting for 23.6% of the explained variance ($\beta = .486$, $p < .001$), and was stronger than Western meta-analytic estimates ($r = .25-.35$) (Harold et al., 2016). Second, violence and positive family perceptions coexisted through strategic differentiation (seeking support

from less-harsh relatives) and cultural normalization (viewing harsh discipline as training). Third, despite 46% violence exposure and 39.5% high stress, participants consistently reported that healthcare providers did not inquire about family circumstances.

5.1 Interpretation within Theoretical Framework

Our findings provide both empirical support for and important extensions to Western theoretical frameworks. Emotional security theory (Davies & Cummings, 1994) posits that interparental conflict threatens children's sense of a stable family context. The present qualitative findings offer partial support for this mechanism, as adolescents described chronic worry, helplessness, and role confusion consistent with theoretical expectations. However, the theory does not fully explain the observed paradox in which 57.4% of violence-exposed adolescents maintained positive family perceptions, suggesting that the assumption of uniform threat appraisal may not hold across cultural contexts. Ecological systems theory (Bronfenbrenner, 1979) conceptualizes the family as the most proximal influence on development. The regression results, with 23.6% of the variance explained by a single family-related factor, provide empirical support for this proposition within a Thai context. Nevertheless, the theory does not explicitly address how collectivist cultural norms shape the nature of family influence, nor does it account for the process of strategic differentiation identified in the qualitative analysis, whereby adolescents selectively engaged supportive family members while distancing themselves from harmful ones. These findings indicate that ecological models may require cultural adaptation to adequately capture the heterogeneous dynamics within Thai family microsystems.

However, findings also reveal cultural-ecological complexity that these Western frameworks underspecify. The coexistence of violence with positive family perceptions through strategic differentiation and cultural normalization suggests that adolescents navigate family microsystems more dynamically than simple exposure–outcome models acknowledge. Rather than family violence uniformly predicting negative outcomes, adolescents actively construct meaning and selectively engage family members within heterogeneous environments where specific individuals provide harsh discipline while others offer warmth and guidance. These findings challenge traditional risk–protection models that treat violence and support as opposing forces, suggesting that they coexist within collectivist family systems

(Chao, 1994) where families represent the primary, and often only, available support network. Figure 1 illustrates these complex dynamics, depicting the dual role of the family as both a stressor (through violence exposure) and support system (through strategic differentiation and shared activities) within Thai collectivist contexts. Thai cultural emphasis on family harmony and collectivist values shapes how adolescents perceive family relationships (Junla & Yotanyamaneewong, 2024); consistent with Theme 2, this cultural orientation appeared to intensify both the psychological impact of family violence and the motivation to preserve family bonds, as adolescents simultaneously experienced violence while maintaining positive family perceptions through strategic differentiation and cultural normalization.

5.2 Comparison with Existing Literature

The observed correlation between parental conflict and adolescent stress ($r = .486$), compared with Western estimates ($r = .25 - .35$) (Harold et al., 2016), may reflect multiple contextual factors. Collectivist family systems, in which the family represents a central component of identity-may amplify perceived threats to family integrity (Chao, 1994). In the Thai context, cultural emphasis on family harmony may render such conflicts particularly salient, a pattern consistent with findings from other East Asian collectivist contexts. For example, research with Chinese early adolescents has shown that interparental conflict predicts depressive symptoms, with cultural processes such as family loyalty and intergenerational dynamics shaping how conflict affects young people differently than in Western samples (Wang et al., 2024). Such cross-cultural evidence supports the proposition that collectivist family systems may amplify the psychological impact of interparental conflict through heightened family enmeshment and identity interdependence.

5.3 Clinical and Policy Implications

Universal ST-5 screening (under 3 minutes) appears feasible given the 95.5% response rate and its ability to identify 39.5% of high-stress cases. However, screening alone is insufficient without systematic family inquiry (Thombs et al., 2014). It is important to acknowledge, however, that the regression model explained only 25.2% of the stress variance ($R^2 = .252$), leaving 74.8% unexplained. This indicates that family violence and relationship quality, while clinically meaningful, represent only one subset

of factors contributing to adolescent psychological stress. Additional unmeasured variables, including academic pressure, peer relationships, individual temperament, and socioeconomic stressors - likely account for a substantial portion of the remaining variance. Clinicians implementing ST-5 screening combined with family violence inquiry should therefore recognize that this approach captures one important dimension of stress, not its full complexity. A comprehensive assessment addressing multiple domains remains essential for effective clinical practice. Given the predictive strength of conflict, specific questions about parental fighting deserve priority. Phrasing matters; culturally adapted indirect approaches such as "How does your family handle disagreements?" may work better than direct "abuse" terminology, although validation is required.

Family activities, although statistically modest ($\beta = -.127$), offer accessible intervention targets that do not require resolution of deep conflicts. Qualitative data suggest that these moments, such as shared meals, temple visits, and recreation, temporarily restore a sense of normalcy despite ongoing tensions, creating spaces where family relationships function differently. Interventions must navigate this complexity by validating adolescent distress while recognizing that families can provide essential support, even when imperfect (Diamond et al., 2012). Approaches that vilify families risk severing adolescents from their primary coping resource, particularly in settings where mental health services remain limited. Trauma-informed principles that acknowledge cultural context and values of family preservation may enhance intervention, acceptability and effectiveness (Substance Abuse and Mental Health Services Administration, 2014). It is also important to note that the clinical recommendations presented here are based on the characteristics of this study's sample, which consisted of school-enrolled young people in Pathum Thani Province. Additional contextual factors not examined in this study, including health insurance coverage, geographic accessibility to healthcare providers, and household income - may substantially influence young people's ability to access mental health and primary care services. These structural barriers may be particularly salient for lower-income families or those in more rural areas and should be considered in any policy or clinical implementation efforts.

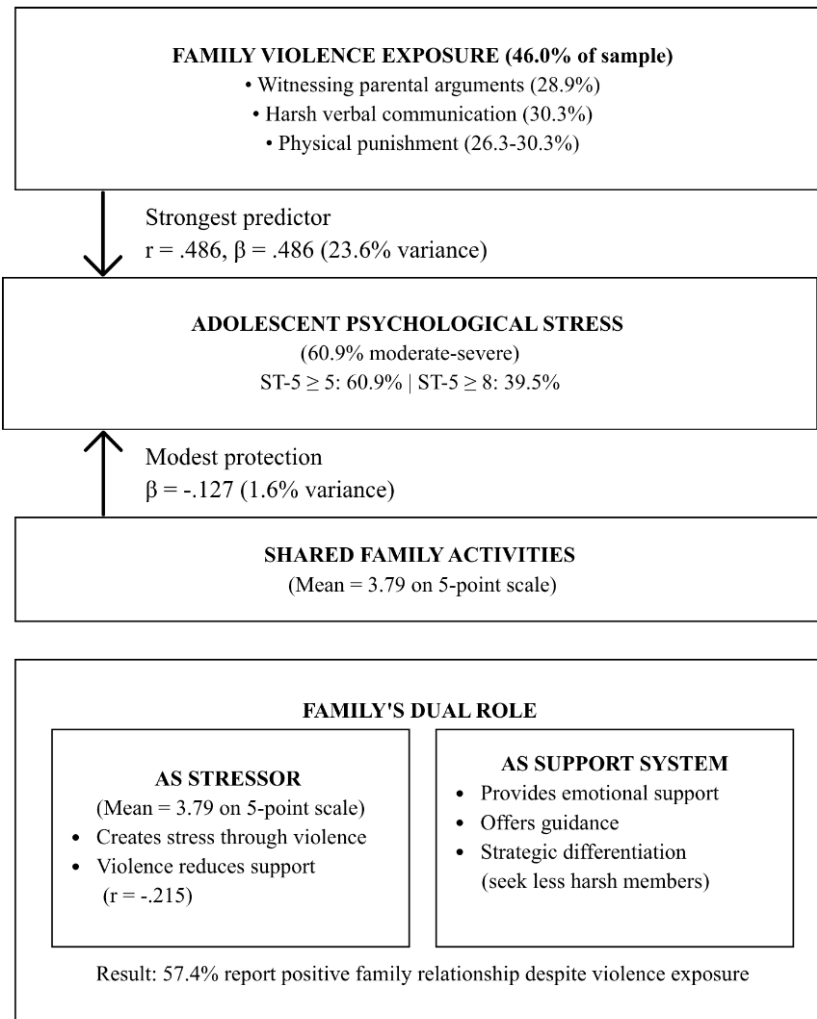


Figure 1 A conceptual model of stress–family violence in Thai adolescents
(Original conceptual model based on study findings)

5.4 Limitations

The cross-sectional design prevents causal inference; therefore, we cannot determine whether violence causes stress or vice versa. School-based sampling excludes high-risk populations, such as dropouts and institutionalized youth, producing conservative estimates. Self-report may underestimate violence through social desirability and cultural normalization. The 6-month recall period introduces memory bias. The ST-5 screens symptoms but does not constitute a diagnosis. As a self-report instrument, ST-5 scores may be subject to response bias, and no additional objective or clinician-administered measure was used to validate stress levels in this study. Future research would benefit from incorporating multimethod assessment of stress, including clinician

ratings or physiological indicators, to strengthen measurement validity. Qualitative sampling only of high-stress participants (ST-5 ≥ 8) missed low-stress perspectives that might reveal protective factors. High multicollinearity ($r = .756-.916$) prevented estimation of the unique contributions of violence types. Single-site sampling limits geographic generalizability. Unmeasured confounders, such as academic pressure, peers, temperament, and socioeconomic stress, likely explain the 74.8% unexplained variance. Additionally, the researcher-developed scales measuring family violence exposure and family relationship quality were not subjected to exploratory or confirmatory factor analysis, which represents a psychometric limitation. Formal factor analytic validation of these instruments is recommended for future research.

Future research should address these limitations by employing longitudinal designs to establish causal directionality, including multi-site sampling across Thailand to enhance geographic generalizability, and incorporating validated multimethod stress assessment. Comparative studies across developmental stages (early, middle, and late adolescence) would also help clarify whether the identified mechanisms differ by age. Additionally, testing the feasibility and effectiveness of culturally adapted family inquiry protocols within Thai primary care settings would provide the empirical evidence needed to move from these exploratory findings toward evidence-based clinical recommendations.

6. Conclusion

The mixed-methods design revealed insights that neither method alone could capture: quantitative data identified the dominance of parental conflict and documented the violence–support paradox, while qualitative data explained the mechanisms through strategic differentiation and cultural normalization. Based on these findings, brief ST-5 screening combined with culturally adapted inquiry about parental conflict may represent a promising direction for improving the detection of violence-related stress in Thai primary care settings, although this was not empirically tested in this study. This represents an evidence-informed recommendation rather than a tested intervention and requires prospective evaluation before clinical implementation. Effective interventions must recognize the complex coexistence of violence and support within collectivist family systems, validating distress while preserving essential family bonds that serve as young people’s primary, and often only, source of support and resilience.

7. Acknowledgements

We extend our sincere gratitude to all adolescent participants who generously shared their experiences and perspectives, without whom this research would not have been possible. We are deeply appreciative of their willingness to discuss sensitive family matters with courage and openness. We thank the school and university administrators, teachers, and educational institutions in Pathum Thani Province for facilitating participant recruitment and providing research spaces.

8. Funding

This research was funded by Valaya Alongkorn Rajabhat University under the Royal

Patronage and supported by Thailand Science Research and Innovation (TSRI) through the Fundamental Fund, fiscal year 2024 (Grant number VRU-FF67/013).

9. CRediT Statement

Pitchasuda Dechboon: Conceptualization, Formal analysis and data interpretation, Funding acquisition, Investigation, Tool development, Methodology, Formal analysis and data interpretation, Resources, Visualization, Project administration, Read and approved the final manuscript.

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10. Abbreviations

Abbreviation	Full Term
ST-5	Stress Test-5
WHO	World Health Organization
UNICEF	United Nations Children's Fund
SAMHSA	Substance Abuse and Mental Health Services Administration
PSS	Perceived Stress Scale
GHQ	General Health Questionnaire
IOC	Index of Item-Objective Congruence
GSHS	Global School-based Student Health Survey

11. References

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. London, UK: Harvard University Press.
- Chao, R. K. (1994). Beyond parental control and authoritarian parenting style: Understanding Chinese parenting through the cultural notion of training. *Child Development*, 65(4), 1111-1119. <https://doi.org/10.1111/j.1467-8624.1994.tb00806.x>

- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). New Jersey, US: Lawrence Erlbaum Associates.
- Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24(4), 385-396. <https://doi.org/10.2307/2136404>
- Davies, P. T., & Cummings, E. M. (1994). Marital conflict and child adjustment: An emotional security hypothesis. *Psychological Bulletin*, 116(3), 387-411. <https://doi.org/10.1037/0033-2909.116.3.387>
- Department of Mental Health, Ministry of Public Health, Thailand. (2016). *Department of mental health screening test for stress 5 (ST-5)*. Retrieved from <https://dmh.go.th/test>
- Diamond, G. M., Diamond, G. S., Levy, S., Closs, C., Ladipo, T., & Siqueland, L. (2012). Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings. *Psychotherapy*, 49(1), 62-71. <https://doi.org/10.1037/a0026247>
- Fang, X., Fry, D. A., Ji, K., Finkelhor, D., Chen, J., Lannen, P., & Dunne, M. P. (2015). The burden of child maltreatment in China: A systematic review. *Bulletin of the World Health Organization*, 93, 176-185C. <https://doi.org/10.2471/BLT.14.140970>
- Goldberg, D. P. (1972). *The detection of psychiatric illness by questionnaire*. Oxford, UK: Oxford University Press.
- Hagan, J. F., Shaw, J. S., & Duncan, P. M. (Eds.). (2017). *Bright Futures: Guidelines for health supervision of infants, children, and adolescents* (4th ed.). Washington, DC, US: American Academy of Pediatrics.
- Harold, G. T., Acquah, D., Sellers, R., & Chowdry, H. (2016). *What works to enhance inter-parental relationships and improve outcomes for children*. London, UK: Early Intervention Foundation.
- Hillis, S., Mercy, J., Amobi, A., & Kress, H. (2016). Global prevalence of past-year violence against children: A systematic review and minimum estimates. *Pediatrics*, 137(3), Article e20154079. <https://doi.org/10.1542/peds.2015-4079>
- Junla, D., & Yotanyamaneewong, S. (2024). Cultural values, parenting and child adjustment in Thailand. *International Journal of Psychology*, 59(4), 559-567. <https://doi.org/10.1002/ijop.13111>
- Kaewjanta, N., Kabkumba, C., Rungreangkulkij, S., & Rice, S. (2024). Psychometric evaluation of the Thai Male Depression Risk Scale (MDRS-TH): psychometric properties of MDRS Thai version. *Journal of Current Science and Technology*, 14(2), Article 44. <https://doi.org/10.59796/jcst.V14N2.2024.44>
- Miller, E., & McCaw, B. (2019). Intimate partner violence. *New England Journal of Medicine*, 380(9), 850-857. <https://doi.org/10.1056/NEJMra1807166>
- Napa, W., Neelapaichit, N., Kongsakon, R., Chotivitayataragorn, S., & Udomsubpayakul, U. (2023). Impacts of COVID-19 on family violence in Thailand: Prevalence and influencing factors. *BMC Women's Health*, 23(1), Article 294. <https://doi.org/10.1186/s12905-023-02440-x>
- Noiprasert, S., Buttagat, V., Sittiprapaporn, P., Sivaphongthongchai, A., & Hongsing, P. (2024). Effects of acupuncture on autonomic nervous system parameters and salivary cortisol level among mental stress university students: A pilot randomized controlled trial. *Journal of Current Science and Technology*, 14(2), Article 25. <https://doi.org/10.59796/jcst.V14N2.2024.25>
- Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLoS Medicine*, 9(11), Article e1001349. <https://doi.org/10.1371/journal.pmed.1001349>
- Peltzer, K., & Pengpid, S. (2015). Depressive symptoms and social demographic, stress and health risk behaviour among university students in 26 low-, middle-and high-income countries. *International Journal of Psychiatry in Clinical Practice*, 19(4), 259-265. <https://doi.org/10.3109/13651501.2015.1082598>
- Ruangkanchanasetr, S., Plitponkarnpim, A., Hetrakul, P., & Kongsakon, R. (2005). Youth risk behavior survey: Bangkok, Thailand. *Journal of Adolescent Health*, 36(3), 227-235. <https://doi.org/10.1016/j.jadohealth.2004.01.013>
- Straus, M. A., Hamby, S. L., Boney-McCoy, S. U., & Sugarman, D. B. (1996). The revised conflict tactics scales (CTS2) development and preliminary psychometric data. *Journal of*

- Family Issues*, 17(3), 283-316.
<https://doi.org/10.1177/019251396017003001>
- Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. SMA 14-4884). Author. Retrieved from https://www.nctsn.org/sites/default/files/resources/resource-guide/samhsa_trauma.pdf
- Thackeray, J. D., Hibbard, R., Dowd, M. D., & Committee on Child Abuse and Neglect, and the Committee on Injury, Violence, and Poison Prevention. (2010). Intimate partner violence: the role of the pediatrician. *Pediatrics*, 125(5), 1094-1100.
<https://doi.org/10.1542/peds.2010-0451>
- Thombs, B. D., Ziegelstein, R. C., Roseman, M., Kloda, L. A., & Ioannidis, J. P. (2014). There are no randomized controlled trials that support the United States Preventive Services Task Force guideline on screening for depression in primary care: a systematic review. *BMC Medicine*, 12(1), Article 13.
<https://doi.org/10.1186/1741-7015-12-13>
- UNICEF. (2022a). *Alarming poor mental health trend among children and adolescents in Thailand requires urgent investment in services*. Retrieved from <https://www.unicef.org/thailand/press-releases/alarming-poor-mental-health-trend-among-children-and-adolescents-thailand-requires>
- UNICEF. (2022b). *Strengthening mental health and psychosocial support systems and services for children and adolescents in East Asia and Pacific Region: Thailand country report 2022*. Retrieved from <https://www.unicef.org/eap/media/11806/file/Thailand%20Country%20Report.pdf>
- Wang, M., Sun, S., Liu, X., Yang, Y., Liu, C., Huang, A., & Liu, S. (2024). Interparental conflict and early adolescent depressive symptoms: parent-child triangulation as the mediator and grandparent support as the moderator. *Journal of Youth and Adolescence*, 53(1), 186-199.
<https://doi.org/10.1007/s10964-023-01923-2>
- World Health Organization. (2021). *Mental health of adolescents*. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health>
- World Health Organization. (2022). *Global school-based student health survey (GSHS): Thailand 2021 fact sheet*. Retrieved from <https://cdn.who.int/media/docs/default-source/ncds/2021-thailand-gshs-fact-sheet.pdf>