INFLUENCE OF BULLY VICTIMIZATION ON DEPRESSIVE MOOD WITH SELF-COMPASSION AND RESILIENCE AS MEDIATORS

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อิทธิพลของการตกเป็นเหยื่อการกลั่นแกล้งรังแกต่อภาวะซึมเศร้า โดยมีความเมตตากรุณาต่อตนเองและความสามารถในการฟื้นพลังเป็นตัวแปรส่งผ่าน

น.ส.อันชิษฐา บวรกิตติกุล

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาศิลปศาสตรมหาบัณฑิต
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อันชิษฐา บวรกิตติกุล : อิทธิพลของการตกเป็นเหยื่อการกลั่นแกล้งรังแกต่อภาวะซึมเศร้า โดยมีความเมตตากรุณาต่อตนเองและความสามารถในการฟื้นพลังเป็นตัวแปรส่งผ่าน. (INFLUENCE OF BULLY VICTIMIZATION ON DEPRESSIVE MOOD WITH SELF-COMPASSION AND RESILIENCE AS MEDIATORS) อ.ที่ปรึกษาหลัก : ผศ. ดร. กุลยา พิสิษฐ์สังฆการ, อ.ที่ปรึกษาร่วม : อ. ดร.สมบุญ จารุเกษมทวี

งานวิจัยครั้งนี้ทำการทดสอบสมมุติฐานของโมเดลเส้นทางของตัวแปรส่งผ่านที่สร้างขึ้นตามทฤษฎี ในกลุ่มตัวอย่าง นักเรียนชั้นมัธยมศึกษาตอนต้นในเขตกรุงเทพมหานคร จำนวน 371 คน กลุ่มตัวอย่างมีอายุเฉลี่ย 12.95 ปี โดยส่วนใหญ่เป็นเพศชาย และเข้าร่วมการศึกษาผ่านช่องทางออนไลน์ ข้อมูลที่ได้รับถูกนำมาวิเคราะห์โมเดลเส้นทางของตัวแปรส่งผ่านด้วยโปรแกรมเอมอส ผลการวิเคราะห์ข้อมูลแสดงว่า สมมุติฐานของโมเดลเส้นทางของตัวแปรส่งผ่านนั้นไม่ได้รับการสนับสนุน จึงมีการปรับโมเดล ผลการปรับโมเดลได้รับการสนับสนุนจากข้อมูลเชิงประจักษ์ (X^2 (2, N=371) =2.42, p=.09) ทั้งนี้ แม้จะไม่พบความสัมพันธ์ที่ความสามารถในการฟื้นพลังมีกับการตกเป็นเหยื่อการกลั่นแกล้งรังแกโดยตรง แต่ความเมตตากรุณาต่อตนเองเป็นตัวแปรส่งผ่านในความสัมพันธ์นี้ ผลการศึกษาครั้งนี้สามารถนำไปประยุกต์ใช้เป็นแนวทางในการป้องปรามหรือลดภาวะซึมเศร้าในวัยรุ่นได้

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The present study was purposed to explore a theoretical model hypothesized to explain the relationship between bullying victimization and depressive mood with self-compassion and resilience as mediators. Participants were 371 junior high school students in the Bangkok metropolitan area. The participants' mean age was 12.95 years old. Participants were predominantly males and responded to the study measures online. Data obtained were analyzed using a path analysis on SPSS AMOS. The proposed theoretical model did not fit with the empirical data; hence, a model modification was conducted. Results indicated a good fit, (X^2 (2, N=371) =2.42, p=.09). Self-compassion and resilience mediated the relationship between bullying victimization and depressive mood. Findings implications were discussed in terms of the therapeutic preventions and intervention for reducing depression in adolescents.

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Anchidtha Bowornkittikun

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

Chapter 1
Introduction

Rationales and statements of the problem

Adolescence is a critical period of our life as it is a crossroads going from childhood into adulthood. It plays a vital role for the youth to begin making their way towards adult life and acing challenges in the transition such as becoming an independent individual and building up social life (Lerner & Steinberg, 2009). School is where the adolescents spend most of their youth and become a place that influences, motivates, and assists with development (Lerner & Steinberg, 2009). Thus, schools and educational institutions should be safe places for adolescents to develop into adulthood. However, the recent violence and aggression in schools are increasing rapidly worldwide, and bullying is one of the significant concerns among them. Being exposed to bullying during adolescence in the school setting is a negative experience for the adolescent, leading to physical pain, social pain, emotional pain, and other psychological issues (Ekasawin & Phothisut, 2017; Vaillancourt, Hymel, & McDougall, 2013). Being bullied by peers is a humiliating experience of peer rejection that could not be forgotten and could become prolonged grief into adulthood (Vaillancourt et al., 2013). Hence, it is crucial to study, understand, and explore potential interventions to reduce the damage that bullying could cause for a lifetime.

Bullying refers to a form of aggression where an individual or group of people came in contact with another vulnerable individual with the intention to repeatedly harm, attack, humiliate or isolate (Salmivalli, 2010). Those who become bullying victimization are at the receiving end of the attack and find the experience unpleasant. Bullying victimization has become a concern in society, as research had

revealed that the prevalence rate of experiencing bullying victimization is at 15% to 30% (Modecki, Minchin, Harbaugh, Guerra, & Runions, 2014). While a study on Thai students examining the relationship between bullying victimization and psychiatric disorders suggested a prevalence rate of 21% for bullying victimization, and 60.1% of the bullying victimization was diagnosed with at least one psychiatric disorder (Ekasawin & Phothisut, 2017). The experience of bullying is a significant concern. Studies have shown that children and adolescents who had been bullied have a significantly higher risk of developing psychosomatic problems than students who have not been bullied (Gini & Pozzoli, 2013). The psychosomatic complaints from bullying victimization include insomnia, headaches, dizziness, poor appetite, self-harm behavior, and poor academic achievement (Karatas & Ozturk, 2011; Ladd, Ettekal, & Kochenderfer-Ladd, 2017; McMahon, Reulbach, Keeley, Perry, & Arensman, 2012; van Geel, Goemans, & Vedder, 2016). These negative outcomes can disrupt the victim's lifestyles and had a major impact on their life, which can last a lifetime. However, the main concern in regarding negative outcomes from falling as bully victimization is the depressive mood that may follow suit (Stapinski, Araya, Heron, Montgomery, & Stallard, 2015).

Depressive mood in adolescents is a significant concern. The study shows that 80% of the youth report depressive symptoms alone in the United States (Saluja et al., 2004). While in Thailand, Depressive moods were found among students as well. For instance, a study on 1,230 adolescents between the ages of 12-19 years old found that 24.15% of the participants with depressive moods (Kotnara, Kittiwatanapaisan, & Rungreangkulki, 2015). Depression in adolescents can lead to a significantly higher risk of suicide, self-harm, substance abuse, and smoking (Audrain-McGovern, Rodriguez, & Kassel, 2009; de Araújo Veras, Ximenes, de Vasconcelos, & Sougey, 2016; Hernandez et al., 2016). It is crucial to note that adolescence is a risk

period for developing depression due to the development reorientation of social engagement (Nesi, Miller, & Prinstein, 2017). This is the period where adolescents seek more peer relationships and develop self-identity (American Psychological Association, 2002; Harter, Stocker, & Robinson, 1996). Thus, adolescents experience more interpersonally conflict (Nesi et al., 2017). Studies had shown that depressive symptoms could predict poor peer relationships, and depressed individuals are more likely to engage in excessive reassurance-seeking behavior (Joiner Jr & Metalsky, 2001; Kochel, Ladd, & Rudolph, 2012). Additionally, it was revealed that depressed youth might lack social skills, leading them to become a target for bullying (Saluja et al., 2004). Hence, depression in adolescents is a significant health concern; and one of the causes of peer relationships is bullying, which could cause twice as depressive symptoms compared with adolescents who were not involved in bullying (Saluja et al., 2004).

A study on the association between bullying and depression in adolescents revealed that bullying victimization could lead to depression and impact an individual into adulthood. For intense, a self-report survey conducted on 2,342 high school students in New York through 2002 to 2004 found that frequency of exposure to bullying behavior or bullying victimization was related to a higher risk of depression, ideation, and suicidal attempts when compared to adolescents who are not involved (Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2007). Additionally, research on 5,030 students from the United Kingdom with a self-report method for 12 months revealed that not only did the bullying victimization may exert an immediate effect on depressive mood, but it can also be a delayed effect (Stapinski et al., 2015). Additionally, a longitudinal study on 1,420 participants on the impact of bullying victimization by assessing the participants 4-6 times throughout the study during the ages of 9-16 years old to categorize them into the bully, bullying

victimization, and both (Copeland, Wolke, Angold, & Costello, 2013). Then, the participants were assessed again during the ages of 19,21, 24-26 years. The result demonstrated that the depressive symptoms could persist into adulthood for those who had experience bullying during early childhood (Copeland et al., 2013). Furthermore, it was found that female participants who had experienced bullying victimization were at a higher risk of developing agoraphobia, and male participants are at higher risk of suicide (Copeland et al., 2013). Thus, being bullied during adolescence can lead to several physical injuries to psychological health significantly; depressive symptoms could be long-term effects and increase risk in other aspects of the victims.

School bullying is a widespread phenomenon that occurs worldwide, and numerous studies indicate that bullying should become a significant international public health concern due to the impact it holds on adolescents' lives (Gini & Pozzoli, 2013). Hence, it is crucial to understand the robust association between bullying victimization and depressive mood to reduce them. Additionally, the purpose of this study will be a focus on testing the model of the influence of bullying victimization on depressive mood. At the same time, simultaneously explore the role of protective factors such as self-compassion and resilience as mediators for the relationship. The understanding obtained could identify factors relevant to depressive moods in junior high school students and explore potential intervention.

In addition to bullying victimization, self-compassion has been demonstrated to be related to depressive moods. Self-compassion refers to an act of being touch and aware of one is suffering by embracing them with the desire to alleviate the pain, and such action would heal oneself with kindness (Neff & Davidson, 2016). Self-compassion allows one to provide personal warmth and support during the challenging experience and emotional resources to help endure the challenge and

bounce back quicker (Neff & Davidson, 2016). Studies had shown that self-compassion is associated with psychological maladjustments such as depression and social anxiety (Gill, Watson, Williams, & Chan, 2018; Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013). For instance, a study on 109 adolescents found that self-compassion partially mediated the relationship between psychological maladjustment and victimization and reduced adverse consequences on adolescents who reported being bullied (Játiva & Cerezo, 2014). While, research on self-compassion on mental health suggested a negative correlation between self-compassion and depression (Neff, 2003). The negative correlation between self-compassion and depressive mood was also found when conducted with adolescents (Muris, Meesters, Pierik, & de Kock, 2016; Neff & McGehee, 2010). These findings suggested that self-compassion could be an effective intervention for adolescents who suffer from negative self-views, which could lead to depression (Neff & McGehee, 2010).

The effectiveness of self-compassion on mental health and psychological well-being was explained by Blatt and colleagues (1982) that self-compassionate individuals should have better mental health because their experiences of pain and suffering were not amplified and perpetuated (as cited in Neff, 2003). Additionally, self-compassionate individuals are less likely to judge themselves, feel isolated, and over-identification (Neff, 2003). Hence, the component of self-compassion had helpful in combating depression in adolescents. Moreover, the study suggested that self-compassion was the highest among the Thai population compared to the United States and Taiwan (Neff, Pisitsungkagarn, & Hsieh, 2008). The results were due to Thais' culture, religion, and lifestyle that live close to the teaching of self-compassion (Neff et al., 2008). Thus, self-compassion could potentially play a role as a mediator for the relationship between bullying victimization and depressive mood.

Resilience refers to a situation in which an individual can overcome stress in an uneventful event (Rutter, 1999). Overcoming a stressful life event is crucial as the situation could increase higher risk of developing depressive symptoms (Shapero et al., 2014). Hence, a higher level of resilience in individuals facing adversity could potentially reduce the impact on mental health-related issues. Studies had suggested that higher resilience scores on adolescents could predict lower depression, anxiety, and stress (Hjemdal, Vogel, Solem, Hagen, & Stiles, 2011; Moore & Woodcock, 2017). Additionally, resilience could be considered a protective factor against depression for adolescents at a higher risk of developing the symptoms (Carbonell et al., 2002; Sapouna & Wolke, 2013). Protective factors from resilience could include family, peers, and a positive environment around the individual, which could help overcome the stressful life event. For instance, a study on primary school students who had become victims due to bullying found that maternal warmth, sibling supports. A positive atmosphere at home was associated with less depression and aggression (Bowes, Maughan, Caspi, Moffitt, & Arseneault, 2010), as well as a study on peer relationships suggesting that bullying victimization individuals with high-level support from peers are more likely to have a more minor problem with academic achievement than those who receive less peer support (Wang, Iannotti, & Luk, 2011).

Furthermore, a longitudinal study on bullying victimization as a predictor for depression found that adolescents who reported low depression despite experiencing bullying victimization had higher self-esteem, a lower feeling of isolation, and a low level of conflict at home (Sapouna & Wolke, 2013). This show that an individual with a higher level of resilience from social, family, and peer supports are less likely to develop depression despite facing stressful life event such as bullying victimization. Thus, suggesting that resilience from social, family, and peer

support could play a crucial role in mediating the relationship between bullying victimization and depressive mood in adolescents.

As can be seen, there are negative impacts of bullying victimization on depressive mood in adolescents. Therefore, the researcher is interested in variables such as self-compassion and resilience role in reducing the negative consequences. The Literature review suggested that higher levels of self-compassion and resilience should result in a lower level of depressive mood. In contrast, a higher level of bullying victimization could lead to a higher score of depressive mood. Hence, the current study proposed is to develop and test a path analysis model to examine the effect of bullying victimization on depressive mood with self-compassion and resilience as mediators in Thai junior high school students. The current study is beneficial, as it will fill the research gap regarding bully victimization and self-compassion that are understudied both internationally and in Thailand. As well as the understudy of resilience and self-compassion as mediators for the relationship. Additionally, findings regarding these relationships could potentially lead to future study interventions for adolescents who become victims of bullying in school.

The objective of the study

The objective of the current study is to test the model of the impact of bullying victimization on the depressive mood among Thai junior high school students with self-compassion and resilience as mediators.

Research Question

Will the model of the impact of bullying victimization on the depressive mood among Thai junior high school students with self-compassion and resilience as mediators fit with the empirical data?

Hypothesis

The model of the impact of bullying victimization on the depressive mood among Thai junior high school students with self-compassion and resilience as mediators will fit with the empirical data.

Scope of the study

The current study focused on the influence of bullying victimization on depressive mood in Thai junior high school students in the Bangkok metropolitan area with self-compassion and resilience as mediators. Thus, due to the scope of the study, the limitation of the model proposed in the current study is that the findings will only be able to generalize to junior high school students in the ages between 12-16 years old in Thailand.

Study Variables

1. There is one independent variable for the current study, which is bullying victimization.
2. There is one dependent variable for the current study, which is depressed mood.
3. There are two mediators for the current student, which are the following:
   3.1. Self-compassion
   3.2. Resilience

Operational Definition

1. **Bullying** is defined as a form of aggressive behavior where an individual or group of people repeatedly harms, attacks, humiliates, or isolates another vulnerable individual. The forms of bullying commonly found are physical bullying, verbal bullying, relational bullying, and cyber-bullying.
2. **Bullying Victimization** is defined as the situation in which an individual had been exposed to repeated bullying that inflicted pain or discomfort over time by at least one or more perpetrators. An individual will be considered bullying

victimization if the bullying occurs during the two months as indicated in the measurement. In the current study, bullying victimization will be measured using the Thai version of *Olweus's Revised Olweus Bully/Victim Questionnaire* by Tapanya (2007).

3. **Depression mood** is defined as the presence of sadness, feeling of emptiness, or irritable mood that could significantly affect the average human capacity to function. In the current study, the depressed mood will be measured with the Thai version of the *Children's Depression Inventory* (CDI) by Likanapichitkul and Trangkasombat (1996).
4. **Self-compassion** is defined as an act of being touch and aware of one's own suffering by embracing them with a desire to alleviate the pain and perceive the situation as an ordinary human experience; such an act would heal oneself with kindness. In the current study, self-compassion will be measured with the Thai version of *Self-compassion Scale Short Form* (SCS-SF) by Pornkosonsirilert, Audboon, and Laemsak (2017).
5. **Resilience** is defined as a universal capacity that allows an individual or group of individuals to prevent, diminish, or overcome the damage that may impact oneself from adversity. In the current study, resilience will be measured using the Thai version of the *Resilience Scale* (SRC) developed by Kittisunthorn (2016).

Theoretical Framework

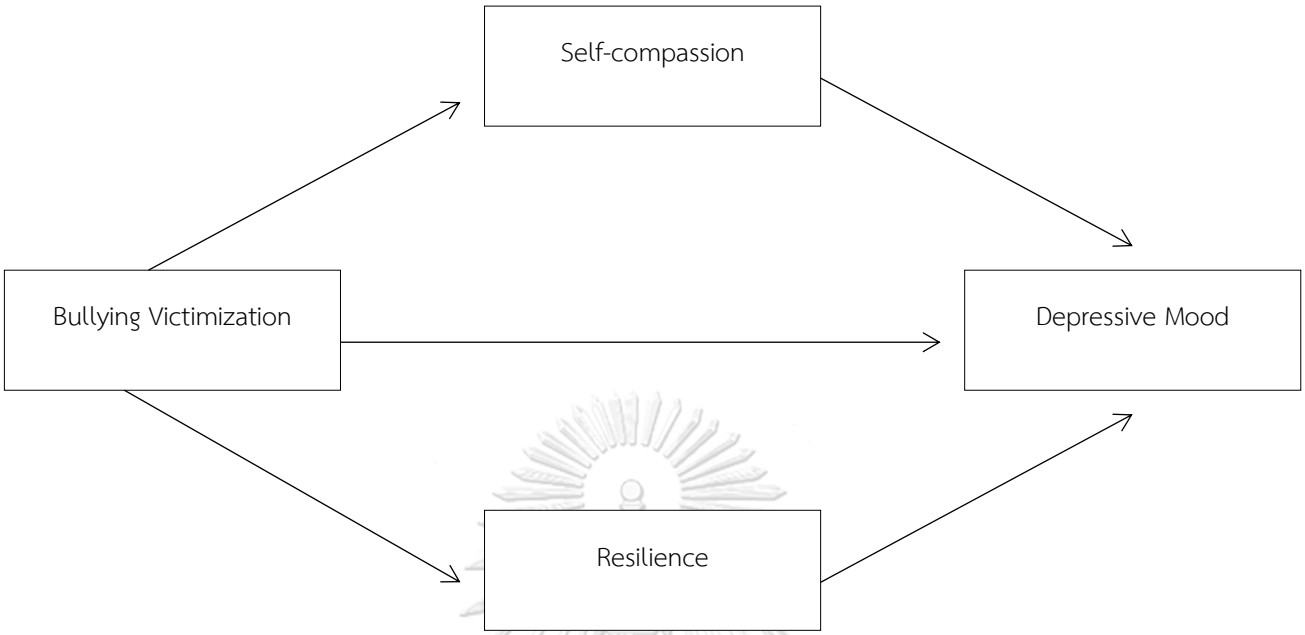


Figure 1: Show the theoretical conceptualize for the current study

Chapter 2

Literature Review

In this chapter, the critical component variables relevant to this study are reviewed to allow further empirical evidence to support and assist in conceptualizing the framework of the study. Therefore, the following variables will be review in order:

1. Bullying in a school setting
2. Depression mood
3. Self-compassion
4. Resilience

1. Bullying in a school setting

1.1. Operational Definition

The Oxford dictionary defined the term bully as “a person who habitually seeks to harm or intimidate those whom they perceive as vulnerable.” (Oxford University Press, n.d.-a). The most commonly used definition for a bully is an individual who intentionally harms another individual perceived as vulnerable.

On the other hand, the *American Psychological Association* (APA) defined *bullying* as “a form of aggressive behavior in which someone intentionally and repeatedly causes another person injury or discomfort” (American Psychological Association, 2014). This definition corresponds with Salmivalli (2010), which described bullying as a form of aggressive behavior where an individual or group of people repeatedly harms, attacks, humiliates, or isolates another vulnerable individual (Salmivalli, 2010). From the two definitions, it is crucial to note that the primary vital components to bullying are aggressive behavior, repeatedly and intentionally to hurt

another vulnerable individual. Additionally, to define the situation as bullying according to Dan Olweus (1994), the three characteristics should be as follows: an imbalance in power, repetition, and intentionally (Olweus, 1994). With this definition, it is clearly shown that bullying is a form of abuse, which is set apart from child abuse due to the context and the relationship characteristic (Olweus, 1994). Thus, to consider the situation as bullying, the three main characteristics needed to be met.

With one of the most commonly used definitions of bullying victimization by Dan Olweus (1973) as a situation in which a student is being bullied (as cited in Olweus, 1994), school/education context is one of the most commonly referred to for the study of bullying victimization. The victimization occurred when an individual had been exposed to repeatedly adverse action over time by at least one or more perpetrators (Olweus, 1994). It is a harmful action when an individual intentionally or attempts to inflict pain or discomfort on another (Olweus, 1994). Hence, bullying victimization is an individual who falls as a victim of the bullying situation, which the bully inflicts.

These definitions will be used in this research paper, as they can encompass all forms of bullying (Kljakovic & Hunt, 2016) and had been commonly used by other researchers such as the APA and the National Association of School Psychologists (Ekasawin & Phothisut, 2017). However, for the clearer understanding, this paper shall use the term “bullies” or “bully” to refer to the perpetrator of these negative actions, bullying as the aggressive behavior of intention to cause harm or discomfort, and “victims” or “bullying victimization” will refer to those who are exposed to negative actions (Kljakovic & Hunt, 2016). The following definitions are shown below in table 1:

Table 1: Operational definition for bully use in the study

Term	Definition
Bully	An individual intentionally harms another individual who is perceived as vulnerable through the use of negative behavior.
Bullying	A form of aggressive behavior where an individual or group of people repeatedly harms, attacks, humiliates or isolates another vulnerable individual.
Bullying victimization	An individual had been exposed to repeatedly adverse action over time by at least one or more perpetrators.

1.2. Types of bullying

The types of bullying consisted of direct and indirect forms of adverse action (Shetgiri, 2013). The direct forms consist of physical and verbal aggression, which is a form of imbalance and overt expression of power (Shetgiri, 2013). In contrast, the indirect forms are relational aggression, such as gossiping, exclusion from the group, and ignoring (Shetgiri, 2013). Additionally, the researchers have separated forms of bullying into traditional (physical, verbal, relational) and cyberbullying (Kowalski & Limber, 2013). It was suggested that cyberbullying is a continuation of traditional bullying with new means (Kowalski & Limber, 2013). The types of bullying are as shown in table 2 (Shetgiri, 2013):

Table 2: Form of bullying found in the literature review

Types of Bullying	Forms	Traditional	Method/ behavior
Physical	Direct	Traditional	Hitting, punching, kicking, pushing, pulling, choking
Verbal	Direct	Traditional	Threatening, name-calling, teasing, malicious, taunting
Relational	Indirect	Traditional	Ignoring, exclude from the group, gossiping, slandering, sabotage, manipulating
Cyber bullying	Indirect	Non-traditional	Harassing, threatening, malicious through electronic medium

1.2.1. Physical bullying

Physical bullying is a form of overt aggression through behaviors of intention to harm and causes a direct bruise, injury, or pain to another individual (Shetgiri, 2013). A study on physical aggression as a direct form of bullying suggested that a greater frequency of bullying could result in a greater frequency of injury in the victims (Dukes, Stein, & Zane, 2010). Additionally, this could also predict the greater frequency of the adolescents carrying weapons to school with both genders (Dukes et al., 2010). The greater frequency of carrying a weapon could be due to self-protection against violence. On the other hand, studies had pointed out that there

was more frequently physical bullying among the male students when compared with female students, and there was more male bullying victimization with physical bullying (Dukes et al., 2010; Turner, Exum, Brame, & Holt, 2013). The physical aggression in male students could be due to establishing dominance in the peer group and trying to gain access to social resources (Marini, Dane, Bosacki, & CURA, 2006). Whereas, with female students, the physical aggression is non-normative and may receive peer disapproval from peers and parents (Marini et al., 2006). Additionally, the direct form of bullying such as physical bullying was shown to peak higher in the seventh grade suggesting that technology may be limited in this age group (Turner et al., 2013).

1.2.2. Verbal bullying

Verbal aggression refers to the behavior of name-calling, threatening, or teasing and could be considered a form of direct aggression (Wolke, Woods, Bloomfield, & Karstadt, 2000). The study obtained from Health Behavior in School-Aged Children (HSBC) in the United States with 7,182 revealed that the most prevalent rate of bullying during the last two months is verbal bullying with 51.4% (Wang, Iannotti, & Nansel, 2009). The result shows that verbal bullying is one of the most common forms of bullying in adolescents. Verbal bullying can be motivated by the physical appearance of the victims, such as obesity, race, religion, and gender (Serra-Negra et al., 2015). A study on 366 Brazilian adolescents on verbal school bullying found that most of the bullies were males who have satisfied family life, and the victims exhibited a lower prevalence of non-violence (Serra-Negra et al., 2015). This form of traditional bullying on the victims leads to a strong association with depression (Hawker & Boulton, 2000). While, a meta-analysis conducted on bullying victimization with the traditional form of bullying suggested that the greater the bullying victimization, the more frequently the individual experience poor emotional adjustment, relationship problems with peers, mental health-related issue, and other internalizing problems (Cook, Williams, Guerra, Kim, & Sadek, 2010; Gini &

Pozzoli, 2013). In contrast, another study suggested; otherwise, the result shows that direct forms of traditional bullying such as hitting, threatening, or teasing were not a significant predictor for poor mental health and somatic health (Baldry, 2004). At the same time, the indirect form of traditional bullyings, such as spreading rumors, seems to a more significant impact on the victims (Baldry, 2004).

1.2.3. Relational bullying

Less attention was focus on relational bullying. This could be due to the perception of the form being less harmful or could be view as a form of normative female behavior (Bauman & Del Rio, 2006). Crick (1996) had defined relational bullying as a method to harm victims through manipulation or damaging the relationships with peers (as cited in Bauman & Del Rio, 2006). In order to be considered as relational bullying, the behavior has to happen repeatedly and is inflicted directly on victims who are perceived as vulnerable (Bauman & Del Rio, 2006). The characteristics of relational bullying include excluding social group activities, spreading rumors/gossip, and withholding friendship (Bauman & Del Rio, 2006). This indirect bullying is covert social manipulation, which allows the perpetrator to behave aggressively without being detected (Marini et al., 2006). Relational bullying and victimizations are more noticeable in adolescence due to peer relationships and social resources being the center of attention of this development period (Dukes et al., 2010). It was suggested that this form of bullying was more frequent in female children and adolescents (Crick & Nelson, 2002; Salmivalli & Kaukiainen, 2004). According to other researchers, the indirect form of aggression was frequent in females due to more substantial distress with close friend and peer relationships than males (Bjorklund & Pellegrini, 2000). As such, disrupting the female rivals could enhance social status and access to other vital social resources (Dukes et al., 2010). In contrast, another study suggested that both males and females reported indirect bullying, with males adolescents having a behavior of

spreading rumors four more times than females (Baldry, 2004). Thus, showing that the indirect form could be found with both male and female adolescents.

A study on teacher education programs has found that when the participants are shown with scenarios describing physical, verbal, and relational bullying situations, the participants rated relational bullying as less severe and felt the slightest empathy when comparing to other forms of bullying (Bauman & Del Rio, 2006). However, it was shown that relational bullying could potentially cause more consequence than what it seems. For intense, the massacre shootings in Virginia Tech and Columbine had reported that before the incident occurred, the perpetrators had to experience relational bullying such as teasing and mocking from peers (Dukes, Stein, & Zane, 2009). The situation shows that relational bullying could lead to higher consequences when it is not paid attention to (Dukes et al., 2009). A study on bullying among adolescence found that relational bullying holds a more substantial influence on violent behavior and weapon-carrying behavior (Dukes et al., 2010). On the other hand, another research found that adolescents involved in indirect bullying as bully/victims and victims have processed more significant social anxiety issues, relationships with friends, and antisocial behavior (Marini et al., 2006). Additionally, indirect bullying was shown to be a strong predictor for withdrawal behaviors, somatic health issues, anxiety, and depression (Baldry, 2004).

1.2.4. Cyberbullying

Cyberbullying is a new form of bullying emerging from the rise of electronic device usage and had become a global concern. The term cyberbullying was defined as a form of aggressive behavior that is carried out by an individual or group of people using a form of electronic contact repeatedly over time against an individual who cannot defend themselves (Smith et al., 2008). This new form of bullying can occur through mobile devices and the Internet (Smith et al., 2008). It was reported that text messages and phone calls are the most prevalent form of cyberbullying (Fredstrom, Adams, & Gilman, 2011; Smith et al., 2008). Cyberbullying had similar

characteristics to the traditional form as it may be repeated over time due to a single incident that could repeat itself, such as e-mail to various individuals or online posts that can be viewed by multiple individuals (Waasdorp & Bradshaw, 2015). Although cyberbullying commonly shares features with traditional bullying, it also differs from traditional bullying due to aspects such as the inability to identify the perpetrator and the differences in a different group of individuals (Kowalski & Limber, 2013).

The emergence of cyberbullying in adolescence could be due to increased electronic usage, online society, and less supervision online (Waasdorp & Bradshaw, 2015). The Mobile Life Report (2006) found that in the United Kingdom alone, more than 91% of the 12 years old own a mobile phone device (Smith et al., 2008). With the growth of electronic devices, there is a rise in online risk as well. Microsoft research has revealed that in 2016 then 65% of the participants from 14 countries had been victims of at least one risk online (Beauchere, 2017). Thus, the new phenomena have been of concern to society.

Studies on cyberbullying phenomena have shown that the emerging of electronic devices and the online community could put adolescents at risk. A study on 28,104 adolescents in 58 high schools in the United States found that 23% of the youth had reported as victims of bullying within the last month, and 25.6% of the victims report being cyberbullied (Waasdorp & Bradshaw, 2015). While, in Thailand, a study on 1,200 secondary and vocational students in Bangkok revealed that more than half of the students had witnessed cyberbullying happening to their peers, and 11% of the students had witnessed the form of bullying more than six times in a month (Songsiri & Musikaphan, 2011). Similar to the traditional form of bullying, cyberbullying reported consequences on the psychological health of the victims. Research on cyberbullying with 802 students found that adolescents who had reported as victims through experiences with cyberbullying from computers such as email, chat room, and online post were associated with higher rates of stress, anxiety, depressive symptoms, low self-esteem, and external locus of control

(Fredstrom et al., 2011). In contrast, adolescents who experienced cyberbullying through mobile devices were found to have no significant psychological and psychosocial adjustment differences compared to non-victims (Fredstrom et al., 2011).

1.3. Bullying in adolescents

A school is a place where most of us spend our youth and should be a safe place for adolescents; however, research shows otherwise. A study by the World Health Organisation (WHO) on the student between the ages of 11-15 from 38 countries in 2008-2013 revealed that 9-13% had become victims of aggressive behavior in the school known as 'bully' (Ekasawin & Phothisut, 2017). This shows that bullying is a problem in various countries. On the other hand, study on the prevalence of bullying experience in Thailand on 3,376 Thai students in the ages between 13-17 years old to examine the relationship between bully victimization and psychiatric disorders; it was revealed that 21% of the participant had been exposed to bullying as a victim at one point (Ekasawin & Phothisut, 2017). Additionally, it was found that 60.1% of the bullying victimization was diagnosed with at least one psychiatric disorder, with the three most common psychiatric disorders as disruptive behavior disorders, anxiety disorders, and mood disorders (Ekasawin & Phothisut, 2017). Thus, students who experience bullying have a 2.6 times higher chance of developing psychiatric disorders than other students (Ekasawin & Phothisut, 2017).

On the other hand, studies had indicated that gender differences in male and female adolescents on bullying victimization are inconclusive. Several studies had noted that physical bullying is more progressive among male students (Dukes et al., 2010; Turner et al., 2013). In comparison, some suggested that females are more likely to be the perpetrator of relational bullying (Crick & Nelson, 2002), and some

suggested that there are no differences (Baldry, 2004). Thus, gender differences for bullying victimization for adolescents would need to be further study.

Bullying victimization has become a severe issue in society, and the victims often experienced physical damage and psychological health issue, such as headaches, insomnia, and self-harm behavior (Gini & Pozzoli, 2009; Povedano, Cava, Monreal, Varela, & Musitu, 2015; van Geel, Goemans, & Vedder, 2015; van Geel et al., 2016). These adverse outcomes can disrupt the victim's lifestyles and had a significant impact on their life. Thus, showing how important it is to research and understand the mechanism behind bullying victimization to potentially find an intervention to reduce the problem that follows sue. To further understand bullying phenomena, it is essential to define bullying and victimization, which shall be used in this paper.

1.4. Factors that cause bullying

Studies have shown that numerous factors could lead to bullying in adolescents. The research below highlights some of the examples of factors that lead to bullying and bullying victimization.

1.4.1. High status and dominant

Researchers have theorized that bullying behavior could be motivated by the strive for higher status and dominant position in the group hierarchy (Peets, Hodges, & Salmivalli, 2008). Although they strive for status as individual motivation, it is pointed out that it is group-related due to the individual standing position in group hierarchy and group decided upon the members status (Salmivalli, 2010). Thus, the bullies needed to depend on the group to realize their status goal (Salmivalli, 2010). A study found that children are more likely to become involved in bully when there was an association with a higher status goal, especially in male adolescents (Sijtsema, Veenstra, Lindenberg, & Salmivalli, 2009). Additionally, a classic study by Björkqvist,

Ekman, and Lagerspetz (1982) found that by showing images of ego, ideal ego, and normative ego to adolescents, the bullies perceived themselves as being dominant and also had high ideals relating to dominance (as cited in Salmivalli, 2010). This further shown that bullying behaviors are related to striving for power in peer groups, especially during adolescence. If bullying were associated with status, it would be more common during the lifespan where peer status is essential (Salmivalli, 2010). Thus, a study has shown that the peak of prioritizing in status happened during early adolescence. It was found that one-third of the participants had chosen status enhancement more than friendship (LaFontana & Cillessen, 2010).

Additionally, several researchers believe that bullies saw their behaviors to enhance their status in a group. Studies have found that aggressive children, including the bullies, could be perceived as powerful, cool, and popular (Caravita, Di Blasio, & Salmivalli, 2009), for intense a study found that the change in bullying behaviors and status were associated with the peer perception of coolness (Juvonen, Wang, & Espinoza, 2013). Hence, one factor that could lead to bullying behaviors was an enhancement in status and being perceived as cool in the peer group.

1.4.2. Parenting attachment

Parents play the most crucial role in developing children's socialization through interactions with parents (Cho & Lee, 2018). Studies have shown that maltreatment by parents, such as physical punishment, emotional abuse, and absence of love and warmth from parents, are associated with children's negative emotions and lessen the parental bond, which could lead to the child becoming a bully or victim (Lereya, Samara, & Wolke, 2013). Another study conducted with 601 Greek preadolescents found that both bully and bullying victimization was related to how the participants perceived parenting (Kokkinos, 2013). The result suggested a positive association with rejection and negative with emotional warmth (Kokkinos,

2013). Hence, the children who are insecurely attached to their parents are more likely to be involved with bullying behavior and becoming a victim (Kokkinos, 2013). Additionally, a meta-analysis on bullying and parenting style has revealed that negative parenting behaviors are associated with children who bully and become victims of bullying (Cho & Lee, 2018). Thus, the studies have shown that parents play an important role in bullying behavior and bullying victimization among children and adolescents.

1.4.3. Self-esteem

Researches have suggested that there is a strong association between self-esteem and bullying (Tsaousis, 2016). Importantly, it was noted that the relationship between self-esteem and bullying victimization is negatively correlated (Tsaousis, 2016). For intense, Egan and Perry (1998) found that individuals with lower self-esteem are at a higher risk of being victimized than those with higher self-esteem (as cited in Tsaousis, 2016). Additionally, a study on a sample of 1,963 middle school students found that students who experienced cyberbullying had significantly lower-self esteem than those who were not involved (Patchin & Hinduja, 2010). A meta-analysis also revealed an association between bullying victimization and self-esteem (Tsaousis, 2016). Hence, it was suggested that there is an association between self-esteem and bullying. Olweus (1992) has suggested that individuals with low self-esteem may attract negative attention from peers and provoke bullying behavior (as cited in Tsaousis, 2016). Children with low self-esteem may be view as more accessible targets for bullying, as they are unlikely to defend themselves (Garandeau & Cillessen, 2006). However, the nature of the relationship has remained unclear. Whether being victimized by a bully decreases the individual self-esteem or an individual with lower self-esteem is at higher risk of becoming a target for bullying (Patchin & Hinduja, 2010). For intense, a longitudinal study on 115 children on

bullying and bullying victimization found that bullying victimization predicts changes in self-esteem (Boulton, Smith, & Cowie, 2010). Furthermore, it was suggested that the relationship is bidirectional natural, meaning that bullying victimization leads to lower self-esteem, and lower self-esteem leads to a higher risk for victimization (Boulton et al., 2010). Hence, children and adolescents with low self-esteem could be at higher risk of bullying victimization due to an inviting behavior.

1.4.4. Social skill problems

Social skill problems could potentially be one of the factors that lead an individual to become bullying victimized. Merrell and Gimpel (1888) defined a social skill individual as a person who can maintain a friendship, resolved social problems, and had less to no problem with social (as cited in Fox & Boulton, 2005). In contrast, those deficient in social skills are likely to have a problem with interpersonal issues (Fox & Boulton, 2005). Hence, it was suggested that bullying victimization is socially unskilled (Fox & Boulton, 2005). For intense, a study on 330 adolescents in the United Kingdom found that the victims of bullying have significantly more pronounced social skills issues when comparing with non-victims (Fox & Boulton, 2005). It was suggested that specific behavior characteristics could lead to poor social skills and, in turn, put children at higher risk for bullying victimization (Fox & Boulton, 2005). While, another study found similar results that the victims of bullying were perceived as having a higher social skill problem than non-victims (Perren & Alsaker, 2006).

Additionally, research on 345 children also found that social behaviors of bullying victimization such as less sociable, more isolated, and less cooperative put the children at higher risk of becoming victimized (Crawford & Manassis, 2011). It was pointed out that the lack of social skills and friendships could put the children in a more vulnerable situation and more prone to becoming targets (Crawford & Manassis,

2011). Thus, the social skills problems could also be one of the internalizing causes for bullying victimization.

1.5. Consequences of bullying

1.5.1. Depression

Studies have shown that students who had fallen as victims of bullying had to face various debilitating consequences. It was revealed that bullying victimization may lead to depressive symptoms and may further develop into major depression (Klomek et al., 2007). For intense, research on 5,030 students from the United Kingdom with a self-report method for 12 months revealed that not only did the bullying victimization may exert an immediate effect on depressive symptoms, but it can also be a delayed effect (Stapinski et al., 2015). Additionally, a longitudinal study on 1,420 participants who had been assessed 4-6 times during the ages of 9-16 years old to categorize them into the bully, bullying victimization, and both (Copeland et al., 2013). Then assessed again during the ages of 19,21, 24-26-year-olds showed that the depressive symptoms could persist into adulthood for those who had experience bullying during early childhood (Copeland et al., 2013).

The four forms of bullying (physical, verbal, relational, and cyberbully) are associated with depression (Wang et al., 2011). The result also revealed that cyberbullying reported a higher level of depression than any other form of bullying (Wang et al., 2011). It is essential to point out that bullying victimization leads to a higher risk of adolescents developing depressive symptoms and depression, leading to other consequences. Bullying victimization and depressive symptoms could further increase the higher risk of the individual having suicide ideation and suicide attempts (Klomek et al., 2007). Additionally, studies had also shown that the depressive symptoms induced by bullying could increase the risk of substance abuse and suicidal ideation (Luk, Wang, & Simons-Morton, 2010; Reed, Nugent, & Cooper,

2015). Hence, studies have shown that there is a significant association between bullying victimization and depressive mood.

1.5.2. Other consequences

Other negative consequences that could happen to the bullying victims are anxiety, poor academic performance, and psychosomatic complaints (headaches and abdominal pain) (Shetgiri, 2013). As found by one study, this could lead to absence from school that 7% of students in the US had been absent from school at least once a month due to bullying victimization (Shetgiri, 2013). Other long-term consequences also include lower self-esteem and adjustment problems into adulthood. Additionally, a study on school homicides in the 1990s suggested that over 20% of the perpetrators had been bullying victimization and had a twice higher risk of causing school shootings than those who did not experience bullying (Shetgiri, 2013). Thus, being bullied during adolescence can lead to several physical injuries to psychological health, especially; depressive symptoms that could be long-term effects and increase risk in other aspects of the victims. As well as affecting the bullying victimization with long-term consequences. It is crucial to understand the robust association between bullying victimization and depressive symptoms mechanisms that are understudy as well.

2. Depressive mood

2.1. Operational Definition

Depression is a common mental health problem that affects the population worldwide and has been a global health concern for the last decade. The American Psychiatric Association defined depression or depressive disorder as a severe medical illness that negatively affects an individual's feelings, thinking process, and behavior (Torres, 2020). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), depression's common features include the presence of sadness, feeling of

emptiness, or irritable mood that could significantly affect the average human capacity to function (American Psychiatric Association, 2013). Depression is characterized by episodes of duration that last at least two weeks and apparent change in cognition and neuro-vegetative functions (American Psychiatric Association, 2013). To be diagnosed with Major Depression Episode (MDE), an individual will be required to have at least five or more symptoms during two weeks (American Psychiatric Association, 2013). One of the symptoms presented is either depressed mood (DM) or loss of interest or pleasure (American Psychiatric Association, 2013). According to DSM-5, the depressive symptoms include (American Psychiatric Association, 2013):

1. Depressed mood or irritable mood almost every day with the feeling of hopelessness, sadness, and emptiness
2. Disinterest in pleasant activities
3. Significant weight loss or weight gain
4. Decrease or increase in appetite
5. Lack of sleep due to insomnia or intensive sleeping period due to hypersomnia
6. Psychomotor agitation or retardation
7. Loss of energy and feeling of fatigue
8. The feeling of worthlessness or inappropriate guilt
9. Less ability to concentrate and think
10. Recurrent thoughts on death and suicide idealization

On the other hand, it was suggested that there are three approaches regarding assessment and classification for adolescent depression, which are depressed mood, depressive syndromes, and clinical depression (Petersen et al., 1993). The three approaches reflect differences in assumptions about the

psychopathology, purposes, and the difference in the level of depressive phenomena (Petersen et al., 1993). For intense, depressed mood during adolescence was studied with the adolescent development, whereas the clinical depression approach is based on the assumption regarding disease or disorder (Petersen et al., 1993).

Depressive mood or depressed mood is referred to as the experience of sadness and unhappiness during a specific period, which can be experienced by everyone (Petersen et al., 1993). The depressed mood can occur in response to adverse situations such as losing significant ones or becoming a failure in certain things (Petersen et al., 1993). The depressive mood can last for a brief period to a certain extent of time (Petersen et al., 1993). The research on depressed mood concerns depression as a symptom (Petersen et al., 1993). Hence, a depressed mood can be considered a negative emotion of sadness and unhappiness during a specific period in response to an adverse life event and concerned with the depression symptoms.

On the other hand, symptoms of depression refer to the biased interpretations of an event that can trigger negative representations of oneself, the personal world, and the future (Beck, 2005). These dysfunctional beliefs put an individual at a higher risk of depression (Beck, 2005). Hence, it is noted that there are differences in terms of assumption and definition of depression. In this study, depression mood or depressed mood will be used to refers to the dysfunctional beliefs in a negative event that lead to negative emotion and symptoms.

2.2. Theoretical conceptualization of Depression

Various explanations and theories could be used to conceptualize depression. With the cognitive-behavior approaches, two cognitive-behavioral

explanations for depression could be explained through the learned helplessness and cognitive model of depression.

2.2.1. Learned Helplessness

The learned helplessness referred by Seligman (1972) as “the interference with adaptive responding produced by inescapable shock” (p. 408) (Seligman, 1972). The theory was the first form when Seligman was studying the laboratory dogs and found that when the dogs were given inescapable shocks, over time the dog learned that they have no control over the unpleasant reinforcement and learned that it is helplessness in a negative situation (Comer, Gould, & Furnham, 2013; Seligman, 1972). It was pointed out that the learned helplessness found with laboratory dogs resembled the depression symptoms found with humans. Thus it was theorized that humans became depressed over time after developing a belief that they have no control over the situation in their lives (Comer et al., 2013; Seligman, 1972).

2.2.2. Cognitive Model of Depression

The cognitive model of depression developed by Beck (1976) evolved through empirical research and experience over time (as cited in Beck, 1979). The model proposed three specific concepts to explained depression, as follows:

2.2.2.1. Cognitive triad

The cognitive triad consisted of three major cognitive patterns, which induced individuals to regard themselves, their future, and experience in a peculiar manner (Beck, 1979). The first components concern the individual's negative perception of themselves, such as seeing themselves as defective and inadequate (Beck, 1979). Hence, when a negative situation arises, the individual perceives their moral, psychological, or physical defects as the cause of the situation (Beck, 1979). Thus, the individual believes that they are

worthless and undesirable, leading the individual to view themselves through critical eyes.

The second component consisted of the individual tendency to perceive experiences negatively (Beck, 1979). The individual believes that the world is making high demands on themselves and presenting an impossible obstacle for reaching their life goals (Beck, 1979). Additionally, the individual misinterpreted their interaction with the environment as representing deprivation (Beck, 1979). Hence, a depressed individual is often biases and negatively construes the situation when there are alternative interpretations (Beck, 1979).

The third component consisted of individual negative perceptions of the future. The depressed individual believes that the current suffering and difficulties are infinite (Beck, 1979). Hence, they expect hardship, and trends expect failure in future tasks (Beck, 1979). The cognitive model of depression views that depression symptoms are the consequences of active negative cognitive patterns.

2.2.2.2. Schemas

The concept of schemas can explain why a depressed person maintains their pain-inducing and self-defeating attitudes when there is evidence of positive aspects in their life (Beck, 1979). When a person faces a situation, the schema related to that specific circumstances activated itself. Thus, the schema screen out differentiates and codes the stimuli (Beck, 1979). Hence, an individual will evaluate and categorize the experiences according to the matrix of the schema (Beck, 1979). In a depressed individual, matching an appropriate schema to specific stimuli is disrupted by the overly idiosyncratic schemas (Beck, 1979). The more idiosyncratic schemas are activated, the

individual becomes less logical and loses control of the thinking process, enabling the more appropriate schemas (Beck, 1979).

2.2.2.3. Faulty information process

The systemic errors in the thinking of a depressed person maintain belief in the validity of their negative thinking despite evidence that suggests the opposite (Beck, 1979). The faulty information process includes six components overgeneralization, selective abstraction, arbitrary inference, magnification and minimization, personalization, and dichotomous thinking (Beck, 1979). An example of the faulty information process is an overgeneralization. The individual draws a conclusion based on isolated experiences and generalizes it across all other situations (Beck, 1979).

2.3. Depressive mood in adolescents

Depression in adolescents has become a global health concern. According to the National Institute of Mental Health, around 2.2 million adolescents in the United States of America (USA) alone have been found to have at least one major depressive symptom (Jatchavala & Chan, 2018). Depressions in adolescents are concerned as depression could be persistent life-long and associated with other problems such as interpersonal maladjustment (Jatchavala & Chan, 2018). A study on 479 adolescents in Thailand also revealed that the prevalence rate of depression in young Thais was 14.9%, and factors are often associated with poor relationships with friends, family authoritarian, parenting style, and stressful life events (Chaveepojnkamjorn, Pichainarong, Adthasangsri, Sativipawee, & Prasertsong, 2016).

It is essential to point out that adolescence is an important duration for development, such as physical appearance, emotion, and understanding of healthy relationships (Clayborne, Varin, & Colman, 2019). Thus, adolescences are crucial for transition, and experiencing depression during this period can ultimately impact the

individual life-long (Clayborne et al., 2019). Therefore, it is important to explore factors that could potentially lower the risk of depression in adolescents. According to various studies, it was revealed that numerous factors could lead to depression, including biological, social, and cognitive aspects.

2.4. Risk factors for depressive mood

The triple vulnerability model proposed by Balow (2000, 2002) suggested that three vulnerabilities contribute to increasing the risk of developing emotional disorders such as anxiety and depression (as cited in Brown & Naragon-Gainey, 2013). The three vulnerabilities are biological vulnerability, psychological vulnerability, and disorder-specific psychological vulnerability (Brown & Naragon-Gainey, 2013). Various factors have been shown to be predictive of depression. These include biological factors, biochemistry, personality styles, cognitive patterns, and social support. Still, the factors relevant to the individuals' environment or their live events are consistently linked to depression.

2.4.1. Environment

Studies pointed out that stressful life events could increase the risk of depressive mood and develop into major depression (Shapero et al., 2014). Meanwhile, other studies had revealed that an individual who had been exposed to a stressful life event such as childhood trauma, sexual abuse, bullying victimization, and becoming a cancer patient had an association and higher risk of showing depressive mood or being diagnosed with major depression (Hartung et al., 2017; Musliner & Singer, 2014; Negele, Kaufhold, Kallenbach, & Leuzinger-Bohleber, 2015; Perales-Blum et al., 2015). Children with major depression were found to have twice the number of stressful life events than other children (Mayer et al., 2009). It was shown that 26% of the children who have major depression are more likely to have been abuse, 56% related to teasing in school, and 3.5% to history with police (Mayer

et al., 2009). Hence, suggesting that various stressful life events and the frequency could lead to depression in children and adolescents.

According to Post (1992), the stress sensitization or the *kindling* hypothesis explained that the first episode of depression could sensitize an individual when faced with life events. Later on, even when faced with minor stress events, the depression episode could reoccur (as cited in Shapero et al., 2014). Thus, the theory could suggest that the individual's reactions to stress could change or become scared after having an episode of depression (Shapero et al., 2014). A study on 281 adults on early stressful life events suggested associations between stressful life events during childhood and a lower threshold for the severity of stress that could trigger depressive responses (Shapero et al., 2014).

Another component that could lead to depression is the cognitive approach. Beck's cognitive theory (1967, 1983) hypothesizes that the increase in negative thought during stressful life events could lead to depression (as cited in McGinn, 2000). It was highlighted that individuals with negative self-schemata on negative views are more prone to depression (McGinn, 2000). Thus, individuals who view themselves as a failure or negatively could be at a higher risk of developing depression (Abela & D'Alessandro, 2002).

2.4.2. Biological factors

On the other hand, the biological approach suggested that genetics can explain 30-40% of the factor that causes depression (Hasler, 2010). A longitudinal assessment and using the prospective cohort study from the bipolar family study found that an individual with a high genetic risk of mood disorder is highly associated with depression in later life (Papmeyer et al., 2016). This suggested that genes might play a role in depression as well. Additionally, studies had revealed that neuroendocrine factors such as the feeling of stress caused by the Hypothalamic-

pituitary-adrenal (HPA) axis could also explain the symptoms of depression (Hasler, 2010). A study on the individual with major depression reported an association between depression and dysregulation in the HPA axis hormones (Parker, Schatzberg, & Lyons, 2003). The activation of HPA hormones happened during emotion or physical stress, such as stressful life events, which causes the hypothalamus to secrete corticotrop-releasing hormone (CRH) and arginine vasopressin (AVP), which increase andrenocorticotropin hormone (ACTH) that activated the secretion of cortisol or the stress hormones (Pariante & Lightman, 2008; Varghese & Brown, 2001). The secretion of CRH and the increase in ACTH has been shown by studies to be associated with depression (Parker et al., 2003; Varghese & Brown, 2001). Hence, biological factors such as genetics and dysregulation in hormones could also be used to explain the depressive mood and how the emotional stress from stressful life events could lead to prolonged hypersecretion of cortisol and result in depression.

2.4.3. Personality

It has been suggested that personality traits may play a role individual differences in developing depression. Studies have shown that the personality trait of neuroticism puts an individual at higher risk for depression (Jourdy & Petot, 2017). Neuroticism is one of the personality traits concerned with psychopathology, especially depression and anxiety (Roelofs, Huibers, Peeters, & Arntz, 2008). Neuroticism refers to an individual's tendency to experience more intense and negative emotions (Jourdy & Petot, 2017). Thus, the characteristic of neuroticism often increases the higher risk of depression due to the frequency of intense feelings of worry and insecurity. The study has suggested significant associations between neuroticism and depressive symptoms and the relationship maintained by rumination (Roelofs et al., 2008). Additionally, a meta-analysis also found that patients with depression significantly score higher on neuroticism and lower on extraversion and

conscientiousness (Kotov, Gamez, Schmidt, & Watson, 2010). The similarity was also found in a group of Asian participants the neuroticism personality increase the risk of lifetime major depression disorder (Xia et al., 2011).

2.5. Treatment and Intervention

There are various treatments available for depression ranging from medicine and numerous treatments. It was pointed out before that one of the causes for depression was the dysregulation in the HPA axis; thus, it was suggested that tricyclic antidepressants could be a suitable treatment (Anacker, Zunszain, Carvalho, & Pariante, 2011). The antidepressants would restore the glucocorticoid receptor (GR) feedback inhibitor found in the HPA axis. Studies have shown that antidepressants can modulate GR (Anacker et al., 2011). Thus, targeting GR could provide a possible way to overcome depression. However, the use of antidepressants on GR is still understudied (Anacker et al., 2011).

On the other hand, new wave treatment such as cognitive behavior therapy (CBT) has shown to be on level one for treating depression. Studies have suggested that CBT is an effective treatment plan for depression as it deals with negative thoughts directly (Zadeh & Lateef, 2012). Research on the depressed female university in Pakistan found that 12 sessions of CBT intervention significantly alleviate depression (Zadeh & Lateef, 2012). At the same time, another meta-analysis on CBT had suggested that CBT is probably the most effective way to treatment of major depression (Cuijpers, Cristea, Karyotaki, Reijnders, & Huibers, 2016).

Self-compassion was suggested to become a buffer for self-coldness factors associated with depression with the attitude of self-caring, kindness, and forgiving oneself (Körner et al., 2015). A study on 48 participants who meet major depression disorder found that after mood induction, the response of accepting negative emotion and reappraise the situation in a self-compassion manner can reduce the

depressed mood significantly when comparing to the control group (Diedrich, Grant, Hofmann, Hiller, & Berking, 2014). Hence, self-compassion may become another alternative treatment for depression as well.

3. Self-compassion

Expressions on pursuing happiness are different in the western and eastern philosophical worlds (Neff & Davidson, 2016). In the west, the idea has been expressed as hedonism, in which the belief that the ultimate motivation for humans is to seek happiness and avoid the feeling of pain (Neff & Davidson, 2016). Whereas, in the eastern philosophical, the idea has been expressed as eudaimonic. Buddhist belief that painful experience is a natural part of being a human and one should be ready to embrace rather than run away from them (Neff & Davidson, 2016). These differences lead researchers in the west to study well-being and pursue one's happiness as part of positive psychology more. However, recently the eudaimonic happiness is more entail to study and come in line with self-compassion; positive psychology that becomes more mainstream recently (Neff & Davidson, 2016).

3.1. Operational Definition

Self-compassion deals directly with one's painful experience and suffering from personal failure or difficulties by proposing that one should embrace suffering with kindness (Neff & Davidson, 2016). By doing so, the painful experience could be transformed and enhance well-being, resilience, and a way to cope with difficulties (Neff & Davidson, 2016). To understand the definition of self-compassion, it is crucial to understand the aspect of 'compassion.' Wispe (1991) defined compassion as the sensitivity to the painful or suffering experience by which one has become aware of the pain that others had felt and acted without avoiding by expression kindness towards others who are suffering (as cited in Neff & Davidson, 2016). As such, the act of compassion involves placing oneself in the shoes of the other and expressing

understanding of others during the time they face mistakes or have been in a difficult situation. Thus, as defined by Lewis and Short (1879), compassion can be translated as “to suffer with” (Neff & Davidson, 2016). The act of compassion can help ease the pain of those who suffer in some way. It was pointed out that compassion can also be extended towards oneself when we experience pain and suffering due to personal mistakes, failures, and other personal issues. Therefore, self-compassion is an act of being touch and aware of one’s own suffering by embracing them with the desire to alleviate the pain, and such an act would heal oneself with kindness (Neff & Davidson, 2016).

3.2. Components of self-compassion

Self-compassion ideals were originated from Buddhism; however, Neff (2003) was able to conceptualize the terms within the scientific framework and separated self-compassion into three components as follows:

1. Self-kindness: An individual often becomes harsh at oneself with self-criticism and shame when making mistakes or feel like a failure (Neff & Davidson, 2016). However, the act of self-compassion shows that mistakes and difficulties are part of human beings that shall not be denied or resisted but should be embraced with kindness, forgiveness, and acceptance (Neff & Davidson, 2016). An individual with high self-compassionate would take time to reflect on the situation, emotions that occur and give oneself time to comfort or soothing in a difficult situation (Neff & Davidson, 2016). As such, it results in better well-being.
2. Common humanity: Harsh self-judgment during difficulties often results in the feeling of isolation, loneliness, and believing that the struggles are abnormally comparing to others who seem to be having fewer difficulties (Neff & Davidson, 2016). Self-compassion expresses that imperfections are a common shared experience among humans. Realizing that the pain is something that everyone

had experience will make an individual feel less isolated and lonely (Neff & Davidson, 2016).

3. Mindfulness: Brown and Ryan (2003) stated that mindfulness involves an individual awareness of the experience of being in the present moment, one neither avoids nor ruminates that aspect of the experience (as cited in Neff & Davidson, 2016). Thus, first, an individual must acknowledge the extent of the pain and suffering of self-criticism. Additionally, the mindfulness aspect helps with the "over-identification" where one exaggerates the negative thoughts and emotions to the point where they are not aware of it clearly and could develop into self-concept or belief about self (Neff & Davidson, 2016). Mindfulness allows one to become aware of the thoughts and emotions that they are just that and help them gain balance about themselves (Neff & Davidson, 2016).

3.3. Effectiveness of self-compassion on psychological problems

Self-compassion allows one to provide personal warmth and support during the challenging experience and emotional resources to help endure the challenge and bounce back quicker (Neff & Davidson, 2016). Studies on self-compassion and well-being have been researched intensively and have supported the effectiveness of self-compassion during a stressful life event. The studies often utilize the Self-Compassion Scale (SCS) developed by Neff (2003) to assess self-compassion as a trait level, and a higher score on SCS indicated that an individual possesses a higher level of happiness (as cited in Neff & Germer, 2017). For instance, a study on using self-compassion as a key to help people adjust to life after divorce found that participants who expressed greater self-compassion when talking about the divorce for a 4-minutes stream of consciousness recording have a more significant psychological adjustment (Sbarra, Smith, & Mehl, 2012). The evidence also showed that the participants have better psychological adjustments during the study and

nine-month follow-up (Sbarra et al., 2012). This shows that self-compassion enables an individual in difficult situations to adjust better to changes.

On the other hand, self-compassion can benefit one's well-being as awareness, the act of kindness, acknowledgment of shared and connected allows human to do so. A study on social anxiety with 316 adolescents revealed that self-compassion was inversely correlated with social anxiety and partially mediated by the fear of being judged and cognitive avoidance (Gill et al., 2018). It was pointed out that lower self-compassion could potentially predict social anxiety more effectively than the symptoms themselves (Gill et al., 2018). Thus, the intervention that focuses on self-compassion could potentially benefit adolescents who suffer from social anxiety (Gill et al., 2018). Further evidence from a meta-analysis with 20 studies on self-compassion and psychopathology found a large effect size that supports the benefit of self-compassion focus therapy (MacBeth & Gumley, 2012). In other words, the aspect of less self-criticism in self-compassion plays the primary role in lessening anxiety and depression (Neff & Davidson, 2016).

On the contrary, it was found that self-compassion could also be associated with other positive aspects. A study on self-compassion and optimism found that online exercises on self-compassion can significantly increase the level of happiness up to six months follow up and significantly decrease depression up to three months (Shapira & Mongrain, 2010). At the same time, a study on self-compassion, hope, and life satisfaction in Chinese adults revealed that self-compassion was positively associated with higher hope and life satisfaction (Yang, Zhang, & Kou, 2016). Thus, self-compassion can also be associated with other positive aspects in the well-being of an individual.

3.4. Self-compassion and depression

A study has found that individuals with higher SCS scores tend to have lesser feelings of isolation and anxiety when reflecting on their problems (Leary, Tate, Adams, Allen & Hancock, 2007). Additionally, self-compassion has been shown to associate with less depression and anxiety. For instance, a study of 142 depressed outpatients found that participants with depressive symptoms had a lower level of self-compassion when compared to 120 control participants who never have depression (Krieger et al., 2013). Additionally, participants with depression have shown to have symptom-focused rumination, cognitive, and behavior avoidance that mediated the relationship between self-compassion and depressive symptoms (Krieger et al., 2013). Studies have suggested that SCS can also positively and negatively related to depressive symptoms. The SCS negative subscales of self-judgment, isolate, and overidentification has shown to have moderate to a strong association with depressive symptoms, whereas the positive subscale of self-kindness, common humanity, and mindfulness showed to have weaker associations (Garcia-Campayo et al., 2014; Krieger et al., 2013; López, Sanderman, & Schroevers, 2018). Additionally, it was shown that isolation components are most strongly associated with depressive symptoms (Lopez, Sanderman, & Schroevers, 2018). Hence, studies have shown that individuals with self-compassion are associated with depression, and individuals with low self-compassion are more prone to depressive symptoms.

The association between self-compassion and depression could be explained through self-criticism. It was pointed out that individual with depression tends to blame oneself and self-criticism as explain previous with a cognitive triad (Beck, 1979). Hence, the nature of self-compassion could protect against self-judgment and help an individual to self-soothing (Huaiyu Zhang et al., 2019). A study with 147

participants who recently attempted suicide found that self-criticism was positively correlated with depressive symptoms and negatively associated with self-compassion (Huaiyu Zhang et al., 2019). Furthermore, it was revealed that self-compassion is a mediator for the link between self-criticism and depressive symptoms (Huaiyu Zhang et al., 2019). This finding suggested that self-compassion may able to reduce the negative impact that self-criticism has on depressive symptoms. Therefore, an intervention on self-compassion could potentially be beneficial for those with depressive symptoms.

As pointed out by Neff (2003), self-compassion is a trait that can be enhanced and modified with training (as cited by Neff & Germer, 2017). Thus, intervention on self-compassion could be beneficial to increase self-compassion and may, in turn, decrease depression. A systematic review and meta-analysis revealed that self-compassion-related therapies are effective as they can increase self-compassion while reducing depression and anxiety (Wilson, Mackintosh, Power, & Chan, 2019). For intense, an 8-week group intervention known as Mindful Self-Compassion (MSC) was developed by Neff and Germer (2013) to teach people about becoming self-compassion (Neff & Germer, 2013). The MSC includes exercises such as guided meditation, informational practices, and interpersonal exercises (Neff & Germer, 2013). The study results found that participants who take part in MSC reported a significant increase in self-compassion and a significant decrease in depression (Neff & Germer, 2013).

Additionally, the MSC results can be maintained up to one year after participating in showing the effectiveness of the intervention (Neff & Germer, 2013). On the other hand, another intervention designed to teach skills of self-compassion to 52 female college students found that compared to the controls group, those whom participants have shown to have a significant increase in self-compassion, as

well as, decrease in rumination (Smeets, Neff, Alberts, & Peters, 2014). The decrease in rumination is associated with depressive symptoms, and reducing rumination can decrease depression (Smeets et al., 2014). The invention of self-compassion for adolescents was found to be effective in reducing depression as well. A study using the Mindfulness-Based Stress Reduction for adolescents conducted with 20 junior high school students for eight sessions found a significant increase in the score for self-compassion and a significant decrease in depression (Edwards, Adams, Waldo, Hadfield, & Biegel, 2014). Hence, the studies have shown that various types of self-compassion interventions are effective in increasing self-compassion and reducing depression in adults and adolescents. Therefore, the use of self-compassion is beneficial for those with depressive symptoms.

3.5. Self-compassion as a mediator

Although self-compassion as a mediator for the relationship between bullying victimization and depressive mood is understudy, several studies could indirectly explain these relationships indirectly. For instance, a study on 109 African Americans who attempted suicide revealed that self-compassion mediated the relationship between shameful experience and depressive symptoms (Huaiyu Zhang et al., 2018). This can be explained that shame is a painful feeling caused by the humiliation of one's awareness of doing something wrong, and self-compassion ability of self-kindness and common humanity could reduce these aspects of shame or self-criticism (Huaiyu Zhang et al., 2018). Thus, depressive symptoms could be reduced with higher self-compassion, and the experience of shame could potentially predict depressive symptoms (Huaiyu Zhang et al., 2018). In this case, bullying victimization could be considered as the experience of shame, as a study has suggested that the victim can feel ashamed of themselves for the experience (Beduna & Perrone-McGovern, 2019; Duarte, Pinto-Gouveia, & Rodrigues, 2015). Thus, self-compassion

could potentially mediate the relationship between bullying victimization and depressive mood. Additionally, a study on various types of victimization, including bullying victimization on a group of adolescents also found that self-compassion partially mediated the relationship between victimization and psychological maladjustment (Játiva & Cerezo, 2014). Participants with higher levels of self-compassion were found to have lower levels of psychological maladjustment (Játiva & Cerezo, 2014). Hence, suggesting the self-compassion could reduce the negative consequences of victimized adolescents, helps adolescents recover from painful experience, and could be included in an intervention for adolescents (Játiva & Cerezo, 2014). However, studies on self-compassion as a mediator for bullying victimization and depressive symptom is still understudied. Therefore, the current study could be beneficial to examine these aspects.

4. Resilience

4.1. Operational Definition

During the past two to three decades, there is raise interest in the concept of protective factors (Rutter, 1987). The protective factors have been filmy established in psychology and stem from the notion of resilience (Rutter, 1987). The term resilience originated from the Latin word resilire, which means “to leap back” (Hu, Zhang, & Wang, 2015). The Oxford English Dictionary defined it as “being able to withstand or recover quickly from difficult conditions” (Oxford University Press, n.d.-b). In the psychology field, the term resilience refers to the phenomenon of overcoming stress in uneventful situations or adversity. These situations were often shown to be a major risk of the development of psychopathology (Rutter, 1999). On the other hand, Grotberg (1995) defined resilience as a “universal capacity, which allows a person, group or community to prevent, minimize or overcome the

damaging effects of adversity" (Grotberg, 1995). Hence, resilience could be used to refers to a capacity that helps an individual to overcome difficulties.

4.2. Theoretical conceptualization

4.2.1. Lack of uniform definition

The applications of resilience have been of interest in numerous psychology fields. Due to the lack of uniform operational definitions of resilience, it often hindered the application of resilience in association with mental health (Hu et al., 2015). There are currently three orientations of resilience definitions found in studies: trait, outcome, and state. The trait resilience approach views resilience as a personality trait that helps individuals cope with a negative situation and adjust to them (Hu et al., 2015). While, the outcome perspective suggests resilience as a function or behavioral outcomes that help individual conquer or recover from adversity (Hu et al., 2015). Lastly, the state approach view resilience as a process over time where an individual adapts to and recover from an adverse life event (Hu et al., 2015).

It is important to note that there is debate concerning the definition of resilience; various approaches shape the theoretical framework, direction, and the method of the studies differently (Hu et al., 2015). Thus, in this research paper, the term resilience will be view as a state and could change over time.

4.2.2. Resilience Model

There are various models for resilience, which contribute to the research of resilience. There are three significant models of resilience that have been identified, which are compensatory, protective, and challenge (Fergus & Zimmerman, 2005). The models can explain how certain factors can alter the negative outcomes from difficult situations (Fergus & Zimmerman, 2005).

1. The compensatory model refers to when the promotive factors (environment, social, and individual) counteracts in a different direction as the risk factor (Fergus & Zimmerman, 2005). Resilience is seen as a factor that neutralizes the negative outcomes to risk (Ledesma, 2014). Hence, there are direct effects of the promotive factor on the outcome (Fergus & Zimmerman, 2005).
2. Garmezy and colleagues (1984) explain the protective factor model or immunity-versus-vulnerability that there is a conditional relationship between individual stress and personal attributions (as cited in Zolkoski & Bullock, 2012). Personal attributes can either dampen or amplify the impact that stress has on an individual. Hence, protective factors can help in reducing any risk factors that could cause negative outcomes (Zolkoski & Bullock, 2012). It was indicated that the protective factors could lead to positive outcomes and healthy characteristics (Ledesma, 2014). For example, the relationship between child poverty and violence could be reduced with higher-level parental supports (Fergus & Zimmerman, 2005).
3. The challenge model explained that if an infidel is exposed to a moderate level of risk, it could lead to fewer negative outcomes or event positive outcomes that could enhance an individual adaption (Fergus & Zimmerman, 2005; Ledesma, 2014).

4.2.3. Three sources of resilience

Grotbergy (1995) proposed the three primary sources of resilience for an International Resilience Project that could be considered as protective factors against adversity (Grotberg, 1995). The components are highlighted below:

1. I HAVE referred to external supports and resources that could help promote resilience. It was noted that before the children become aware of other factors, they must be aware of the external supports and resources for a sense of safeness. For example, resilient children will be aware of trusting relationships from peers, parents, and the community.
2. I AM refers to the individual internalizing and personal strengths, which are the feelings, attitudes, and beliefs that the individual possesses. For intense, individuals will become aware of how they are an important person and feel pride. By feeling proud about oneself, an individual will not be bothered by others that degrade them.
3. I CAN refer to the individual social and interpersonal skills, which can be learned through interaction with others. For example, the individual can realize that they have effective communication skills to express thoughts or feelings to others.

It was pointed out that resilient child does not have posses all of the three features; however, they need to have at least two of the features to become resilience (Grotberg, 1995). It is not easy to become resilient; the study revealed that only 38 percent of the participant's responses to the International Resilience Project indicate that the promotion of resilience (Grotberg, 1995). Children and adolescents need to become resilient to overcome difficulties and adversities throughout their lifetime.

4.3. Resilience as a protective factor from mental health-related issues

Meta-Analysis conduct with trait resilience and mental health indicated that the two components were negatively correlated with each other (Hu et al., 2015).

Thus, an individual with a low level of resilience had a higher rate of mental health-related issues such as depression, anxiety, and life satisfaction (Hu et al., 2015). On the other hand, numerous researchers view resilience as a process that developed over time with parents and peers in an individual's life. Garmezy (1985) theoretical framework was pointed out to be influential on the research on resilience (as cited in Sapouna & Wolke, 2013). Germezy (1985) suggested that the importance of a positive relationship between family and communities could potentially foster resilience (Sapouna & Wolke, 2013). Thus, he had distinguished them into three fundamental factors of protection (Sapouna & Wolke, 2013):

1. Individual characteristic such as self-esteem and how an individual view themselves
2. The family environment has been defined as a positive relationship with the family that is characterized by warmth and lack of neglect
3. The community which are characterized by trust, support, and lack of conflict among peer interactions

4.4. Resilience in adolescents

Research on children and adolescents established that it is crucial for an individual to become resilient to overcome adversities. Studies on resilience indicated that adolescents with a higher level of resilience could cope with negative life events more and are at lower risk of developing a mental health-related issue. Research on adolescents who had experienced sexual abuse suggested that teens with higher resilience scores were less likely to report post-traumatic disorder (PTSD) (Hébert, Lavoie, & Blais, 2014). It was suggested that resilience, maternal warmth, and peer interactions could predict the symptoms of PTSD (Hébert et al., 2014).

On the other hand, a study on 3,136 adolescents found that adolescents who reported a low level of depression despite experiencing bully victimization are those

who obtain a higher level of self-esteem, are less isolated with peers, and low conflict with family members (Sapouna & Wolke, 2013). Thus, the finding suggested that with three primary factors of individual characteristic, family environment, and community being met, the individual who experiences adversity would receive a lower impact on psychopathology. Hence, the resilience was able to help them cope with the uneventful situation in life.

Meanwhile, a study on bullying in school increases the risk of adjustment problems found that females seem to have higher resilience when the male (McVie, 2014). Additionally, the study on 4,300 adolescents in Scotland indicated that resilience could predict violence and psychological distress in late adolescents between the bullying perpetrator and bullying victimization (McVie, 2014). The study indicated that bullying victimization with higher resilience experiences lower psychological distress (McVie, 2014). It was suggested that individual factors such as higher self-esteem could protect against anxiety and depression (McVie, 2014). While, the family factor suggests that warmth family had a more substantial effect on reducing later on aggression and violence in the bullying perpetrator when comparing with psychological distress (McVie, 2014). The community factor indicated that it only had little impact on the overall model; however, the adolescent who lives in the least deprived area of Edinburgh was shown to have reduced risk in psychological distress (McVie, 2014). On the other hand, a study on 393 adolescents in India also indicated that resilience could buffer the potential negative effect that could impact bullying victimization (Narayanan & Betts, 2014). Thus, these studies suggested that the resilience in three levels outcomes could predict the negative outcome of individuals who have experienced bullying victimization and bullying perpetrator.

Additionally, the use of resilience may not only be in uneventful events but can also be related to academics. A study on the association between resilience,

self-efficacy, and thinking styles in 130 Italian middle adolescents revealed that adolescent with a higher level of resilience was able to cope with life in educational context more and was able to use various of thinking style to adapt to academic (Sagone & De Caroli, 2013).

4.5. Resilience and depression

Studies have shown an association between resilience and depression (Anyan & Hjemdal, 2016; Moljord, Moksnes, Espnes, Hjemdal, & Eriksen, 2014). A cross-sectional survey on 533 Ghanaian adolescents found that resilience partially mediated the relationship between depression symptoms (Anyan & Hjemdal, 2016). On the other hand, another study conducted on Norwegian adolescents also found a negative association between resilience factors and depression (Moljord et al., 2014). Additionally, study research into adverse childhood experiences such as abuse and neglect on risk factors of developing depression found that resilience moderated the relationship between the adverse childhood experiences and depression (Poole, Dobson, & Pusch, 2017). Hence, suggesting that a higher level of resilience could potentially act as protective factor against depression. Studies on adversities experience such as bullying victimization also suggested that resilience partially mediated the relationship between bullying victimization and depressive symptoms in children (Zhou, Liu, Niu, Sun, & Fan, 2017). Therefore, studies have shown that there is an association between resilience and depression.

Research indicated the positive effect of resilience on psychological distress, violence, and the academic context of adolescents; numerous interventions were explored to build or increase the level of resilience in adolescents to help them cope when facing adversity. For intense, a study on resilience-focused interventions to help to strengthen resilience and reduce mental health problems in adolescents found that it is an effective intervention (Dray et al., 2017).

The resilience-focused intervention to measure the effectiveness of the school-based intervention indicated that the resilience-focused intervention was effective in reducing depressive symptoms, personal problems, externalizing the problem, and other psychological distress (Dray et al., 2017). Suggesting that interventions for increasing resilience could potentially be helpful for adolescents coping with adversity.

4.6. Resilience as a mediator

Several studies have shown that resilience can mediate the relationship between bullying victimization and psychological well-being. For intense, a study on Chinese grade school students found that resilience partially mediated the relationship between bullying victimization and depressive symptoms in the group of participants (Zhou et al., 2017). The finding suggests that early intervention for increasing resilience and mindfulness among the children will be beneficial to combat the negative impact the bullying victimization may have in the future (Zhou et al., 2017). On the other hand, another study on employed adults in Romania also found that resilience mediated the relationship between workplace bullying and depressive symptoms (Maidaniuc-Chirila, 2015). It was pointed out that employees with higher levels of resilience had lower levels of depressive symptoms, suggesting that resilience could potentially be used as an intervention for bullying and depressive symptoms (Maidaniuc-Chirila, 2015). Hence, this shows that resilience as a mediator for the impact of bullying victimization on depressive mood was found in both children and adults; thus, it could potentially be found with adolescents as well.

Additionally, there are several studies for social support as a mediator for bullying victimization and depression. A study on Dutch primary school students found that social support mediated the relationship between bullying victimization

and depressive feeling (Pouwelse, Bolman, Lodewijkx, & Spaa, 2011). While a study on 8th-grade students also found that social support partially mediated the relationship between bullying victimization and clinical maladjustment (Malecki, Demaray, & Davidson, 2008). This shows that the component of resilience, such as social support, could function as a mediator for bullying victimization and other psychological adjustments. However, resilience as a mediator for the relationship between bullying victimization and the depressive mood is still under study, therefore, the model proposed by this study could fill in the research gap as well.

In summary, the literature review suggested that bullying victimization is a painful experience for adolescents that could lead to negative consequences, especially depressive moods. Hence, it is crucial to study variables that could become protective factors against the impact of bullying victimization. The research suggested that the key aspect of self-compassion could reduce depressive symptoms due to the nature of self-kindness, common humanity, and mindfulness. While resilience also plays a crucial role in overcoming adversities such as bullying victimization through internalizing self and external supports. Therefore, the current study focused on testing the path analysis model for the influence of bullying victimization on the depressive mood among Thai junior high school students with self-compassion and resilience as mediators.

Chapter 3

Methodology

The following chapter presents the research methodology and description of the research design for the current study. The purpose of the study is to test the path analysis model of the influence of bullying victimization on the depressive mood among Thai junior high school students with self-compassion and resilience as mediators. Thus, the study employed a correlational research design with self-compassion and resilience tested as mediators between bullying victimization and depressive mood.

Participants

The current study participants are Thai junior high school students (12-16 years old). This decision was made due to literature review that junior high school students reported the highest rates for bullying, and the rates often decline with the increase in ages across various countries (Bellmore, Huang, Bowman, White, & Cornell, 2017; Due et al., 2005; Scheithauer, Hayer, Petermann, & Jugert, 2006). Additionally, a study has pointed out that older adolescents who are in high school had more knowledge and confidence in dealing with bullying victimization due to competence with the increasing of age (Sittichai & Smith, 2018). Hence, the current study focuses on junior high school students as the researcher is interested in testing a model for possible intervention for bullying victimization. Thus, the age group with the highest prevalence rate of bullying was selected.

The number sample size was calculated by G Power 3.1 using medium effect size as suggested by Cohen (1988) with an alpha of .05 and power of .95. The result suggested that the sample size was 62 (as cited in Cohen, 2013). Additionally, to determine the most suitable sample size for this study, the researcher follows the

suggestion by Hair and colleagues (2010), which suggests using 20 samples per each variable (Hair Jr, Babin, & Anderson, 2010). Thus, the suggested sample size would be 60 participants. However, for data completeness and to reduce the risk of insufficient data due to the participant's withdrawal or data collection error, the researcher decided to collect a minimum of 210 participants in the study. Therefore, this study will employ a minimum of 210 Thai junior high school students from Bangkok metropolitan area. Data collection process happened at an all-girls public school, an all-boys school, and a mixed public school in the inner Bangkok metropolitan area.

1. Inclusion criteria

1.1. Participants are Thai junior high school students from Thai schools

2. Exclusion criteria

2.1. Participants who have reading comprehension difficulty

2.2. Students were diagnosed with mental illness or receiving pharmaceutical/ psychological/therapeutic intervention at the time of the data collection.

Research instruments

1. Demographic information

1.1. Whether the participant receive mental illness diagnosis or is receiving pharmaceutical/psychological/therapeutic intervention for mental illness during the time of data collection

1.2. Gender

1.3. Ages

1.4. Grade level

2. Bullying victimization

The Olweus Bullying/Victim Questionnaire (OBVQ) is one of the most commonly used bullying self-report measures and has been translated into various languages (T. Lee & Cornell, 2009). The first version of OBVQ was developed by Dan

Olweus (1983). The questionnaire was designed in such a way to be coherent with the definition of bullying as given by Dan Olweus (1994), which included the three main aspects of intentionally, repetition, and imbalance in power (Olweus, 2012; Solberg & Olweus, 2003). The Revised Olweus Bully/Victim Questionnaire released in 1996 expanded to include the specifics forms of bullying and distinguished the differences between teasing and bullying (Solberg & Olweus, 2003). The Revised Olweus Bully/Victim Questionnaire also included the definition of bullying for the instructor to read to the students before completing the questionnaire (Solberg & Olweus, 2003). The questionnaire consisted of 39 items, some of which also had additional sub-questions (Olweus, 2012). The questions address various aspects of a bully and bullying victims (Solberg & Olweus, 2003) and cover various forms of bullying (verbal, physical, relational, and cyberbullying). The older version of the Revised Olweus Bully/Victim Questionnaire did not include the items on cyberbullying; however, it was later added on since 2015 with two sub-questions regarding Internet or mobile phone devices (Olweus, 2012). Hence, in this study, the cyberbullying items will be included as well.

The Thai version of the Revised Olweus Bully/Victim Questionnaire was translated by Tapanya (2007) and consisted of 38 items (Tapanya, 2007). The Thai version of the Revised Olweus Bully/Victim Questionnaire by Tapanya was widely used in Thailand. For instance, a study on participants in the ages of 10-18 years old was diagnosed with ADHD and was found to be bullying victims (Buttabote, 2011). Additionally, a study on primary school students who had been found to be bullying victims (Puranachaikere, Punyapas, & Kaewpornsawan, 2015). Thus, this suggested the effectiveness of the Thai version of the Revised Olweus Bully/Victim Questionnaire on Thai adolescents. However, the translated version does not include the question item regarding cyberbullying. The current study employed ten items from the first

session of the Revised Olweus Bully/Victim Questionnaire by Tanpaya (2007), including one general item and nine items regarding bullying victimization. Only the first ten items of the questionnaire will be used as it is more congruent with the purpose of the study on bullying victimization. Several studies on bullying also used only ten items from the questionnaire to determine the victimization (Buttabote, 2011; Puranachaikere et al., 2015). Additionally, the researcher will further develop the questionnaire to include the cyberbullying item due to the increase in this form of bullying.

The Revised Olweus Bully/Victim Questionnaire included five different responses to determine the bullying victimization frequency. The respond includes: “It hasn’t happened to me in the past couple of months,” “Only once or twice,” “2 or 3 times a month”, “About once a week,” and “Several times a week.” The Revised Olweus Bully/Victim Questionnaire did not include any reverse item and consisted of three parts. The example of question includes “I was bullied with mean or hurtful messages, calls, or pictures, or in others way on my mobile phone or over the internet (computer).” The items will be used to examine the form of bullying and the frequency of the victims' bullying.

The psychometric properties of the Revised Olweus Bully/Victim Questionnaire have been investigated. For instance, a study on 202 middle school students in central Virginia revealed that the Revised Olweus Bully/Victim Questionnaire had modest support for concurrent validity (T. Lee & Cornell, 2009). While a study at Greek Cypriot primary schools suggested that the instrument has satisfactory psychometric properties (Kyriakides, Kaloyirou, & Lindsay, 2006). The combination of bullying victimization and bullied together yield a total value of Cronbach's alpha higher than 0.80 (Kyriakides et al., 2006). Additionally, in Thailand, the translated version by Tapanya (2007) was tested with 235 participants found that

the reliability of Cronbach alpha is at 0.75 (Tapanya, 2007). Thus, the psychometric properties of the Revised Olweus Bully/Victim Questionnaire were at the modest to a satisfactory level.

3. Self-compassion

The current study used Self-compassion Scale Short Form (SCS-SF) to measure the level of self-compassion in the participants. Raes and colleagues (2011) developed the short form of self-compassion from the original Self-compassion Scale (SCS) developed by Kristin Neff (2003) to shorten the extended version of SCS, which employ 26 items (Raes, Pommier, Neff, & Van Gucht, 2011). The short version was developed, as it might be beneficial to use in settings with time constraints (Raes et al., 2011). In addition, the Thai version of SCS-SF developed by Pornkosonsirilert and colleagues (2017) for measuring the level of self-compassion in Thai adolescents was used in this study (Pornkosonsirilert, Audboon, & Laemsak, 2017). The Thai version of SCS-SF consisted of 12 items, which are in a similar manner as the SCS-SF by Raes (2011) and was found to be satisfactory when used with Thai students (Pornkosonsirilert et al., 2017).

The SCS-SF consisted of 12 items, which, similarly to the SCS, measure six various components of self-compassion (Raes et al., 2011). The subscales reflecting positive statements are for the key components of self-kindness, common humanity, and mindfulness. Sample items subscale for self-kindness includes a question such as “When I’m going through a very hard time, I give myself the caring and tenderness I need,” the sample items for common humanity include “I try to see my failings as part of the human condition,” and the sample items for mindfulness include “When something painful happens I try to take a balanced view of the situation.” In contrast, the negative subscale statements are self-judgment, isolation, and over-identification. Sample items subscale for self-judgment includes a question such as

“I’m intolerant and impatient towards those aspects of my personality I don’t like,” the sample items for isolation include “When I fail at something that’s important to me, I tend to feel alone in my failure,” and sample items for over-identification include “When I fail at something important to me I become consumed by feelings of inadequacy.”

The 5-point Likert scale consisted of 5 responses, which indicated the self-compassion level for each key component. The response includes “almost never” (1) to “almost always” (5), indicating how well the statements match with the participants.

The negative subscale statements are Self-Judgment, Isolation, and over-identification; they entail the reverse scores include 1,4, 8, 9, 11, and 12. While the subscale reflecting positive statements Self-Kindness, Common Humanity, and Mindfulness, entailing ordinary scoring items include 2, 3, 5, 6, 7, and 10. After scoring reversal, the total score is calculated based on the score on each item. It can be calculated by adding all the item scores together, and the scores can be between 12 (no sign of self-compassion) to 60 (self-compassion are present) (Raes et al., 2011). The total score of SCS-SF was used as an overall score for self-compassion levels, and there is no cut-off point, but a higher score indicated a higher level of self-compassion (Raes et al., 2011). In this study, the scores of SCS-SF were calculated in a similar manner. The normal scoring and reverse scoring are shown below in the table:

Table 3: Respond, normal scoring, and reverse scoring for SCS-SF

Respond	Normal Scoring	Reverse Scoring
Almost never	1	5
Hardly never	2	4
Sometimes	3	3
Often	4	2
Almost always	5	1

The psychometric properties of SCS-SF were tested with two Dutch samples and validated in English (Raes et al., 2011). The internal consistency of the SCS-SF was adequate with Cronbach's alpha ≥ 0.86 in all samples and demonstrated that it is highly correlated with the original SCS, r ≥ 0.97 in all samples (Raes et al., 2011). Additionally, a confirmatory factor analysis suggested that the SCS-SF supported the six components, similar to the long-form (Raes et al., 2011). While, for the Thai version developed by Pornkosonsirilert and colleagues (2017), the psychometric properties are adequate with Cronbach's alpha of 0.803 when conducted on a pilot study with 72 students and the Cronbach's alpha of 0.789 when conducted with the research study (Pornkosonsirilert et al., 2017). Thus, the Thai version of SCS-SF demonstrated to be a reliable and valid measurement to use as an alternative for the original SCS and was used in the current study for determining the level of self-compassion in Thai students.

4. Resilience

In this study, the Thai version of the State Resilience Scale (SRC) developed by Kittisunthorn (2016) was used to measure the level of resilience found in adolescents. The State Resilience Scale (SRC) from the full State-Trait Resilience Scale (STRI) developed by Hiew and colleagues (2000) (Hiew, Mori, Shimizu, &

Tominaga, 2000). The original SCR was modified from Grotberg's Resilience Checklist (1995), which is congruent with the definition of resilience as given by Grotberg (Hiew et al., 2000). The original SRC includes 15 items to measure the individual's current state of resilience behavior, whereas the TRC was used to measure childhood resilience (Hiew et al., 2000).

The Thai version of SCR developed by Kittisunthorn (2016) was used in the study, as the SRC allows the researcher to examine how the students cope with life stressors and the factors of resilience that reduce the stress (Hiew et al., 2000). The Thai version of SCR by Kittisunthorn (2016) was developed from the translated version of SCR by Chawsilpa (2003) for students aged between 10 to 12 years old (Kittisunthorn, 2016). The Thai version of SCR consisted of 14 items, and the language was developed to be suitable for adolescents. However, the current study target at the participant ages between 12 to 16 years old, thus, further development and adjustment will be made to the Thai version of SCR by Kittisunthorn (2016) to be more suitable for the population of the study.

The SRC was measured using a 5-point Likert rating from "strongly disagree" (1) to "strongly agree" (5), and the score ranges between 14 to 75 (Kittisunthorn, 2016). The original version of SRC consisted of 15 items, which included three items relating to the subscale for "I have" such as "I have someone who loves me," 7 items for the subscale of "I am," such as "I believe things will turn out alright," and five items for the subscale of "I can" such as "I can focus on a task and stay with it" (Hiew et al., 2000).

The total score of the SRC was calculated by summing up the total score from the given response, and there is no cut-off point, but a higher score indicated higher resilience (Hiew et al., 2000). Thus, the scoring criteria for the SRC, according to Hiew (2002) and Kittisunthorn (2016), are as follows:

Table 4: Respond and scoring for SRC

Respond	Scoring
Strongly disagree	1
Disagree	2
Neutral	3
Agree	4
Strongly agree	5

The psychometric properties for the SRC were evaluated with samples of Canadian college students by Hiew (1999) and were found that the internal reliability of SRC has Cronbach's alpha levels of 0.76 (as cited in Hiew et al., 2000). Additionally, the sample of Japanese college students was also tested by Hiew and Matchett (2002) with the Cronbach's alpha of 0.77 (Hiew et al., 2000). While, in Thailand, the SRC by Chowsilpa (2003) on samples of college students found high internal reliability for Cronbach's alpha of 0.73 (Hiew et al., 2000). The Thai version of SRC by Kittisunthorn (2016) has an internal consistency of 0.755 for Thai adolescents (Kittisunthorn, 2016). Hence, the SRC is an effective instrument for measuring the level of state resilience.

5. Depressive mood

In this study, the researcher decided to use The Children's Depression Inventory (CDI) developed by Maria Kovacs (1981) from Beck Depression Inventory (as cited in Muris et al., 2016). The questionnaire aims to measure depressives symptoms found in children and adolescents between the ages of 7-17 years old (Muris et al., 2016). The questionnaire is a self-report survey with 27 items dealing with the aspect of sadness, self-blame, loss in appetite, sleep problems, interpersonal relationships, and adjusting to school (Muris et al., 2016).

In this study, a translated version of CDI into the Thai language was used. The translated version of CDI was developed by Likanapichitkul and Trangkasombat (1996) to determine whether the children or adolescents are presented with depression symptoms (as cited in Leelatrakarnkun & Trangkasombat, 2012). The Thai version of CDI has 27 items and was developed for children between the ages of 10-15 years old (Leelatrakarnkun & Trangkasombat, 2012).

CDI is designed as a three-point Likert scale rating to determine the level of depression symptoms found in adolescents for the past two weeks. The response included “not true” (0) to “very true” (2) to indicate the agreeableness of the statements. The sample items are “I am sad all the time” and “I feel like crying every day” (Muris et al., 2016).

The total score of CDI can be calculated by adding all the item scores together, and the scores can be between 0 (no sign of depressive symptoms) to 54 (all signs of depressive symptoms are present) (Muris et al., 2016). The cut-off point to consider the adolescent to have depressive moods as examine in a group of adolescents in Thai should be at 15 or above (Leelatrakarnkun & Trangkasombat, 2012). The scoring for each of the responses is shown below:

Table 5: Respond and scoring for CDI

Respond	Scoring
Not true	0
Somewhat true	1
Very true	2

The psychometric properties for the CDI were evaluated with samples of 132 adolescents between the ages between 12 to 17 years old, and were found that the

internal reliability of CDI has Cronbach's alpha levels of 0.93 (Muris et al., 2016). At the same time, the translated version of CDI was analyzed for the reliability and validity to use with Thais adolescents. It was found that there is significant discrimination p < 106 for separating adolescents who are normal and those with depression symptoms (Leelatrakarnkun & Trangkasombat, 2012). Additionally, the sensitivity of the Thai version of CDI is at 78.7, the specificity is at 91.3, and the accuracy is at 87. Overall, Cronbach's alpha coefficient is at 0.83, which is considered a reasonable level. Thus, the Thai version of CDI developed by Dusit Likanapichitkul and Umaporn Trangkasombat (1996) was used as it was appropriated for the participants' age group in the study and were shown to be an effective tool in measuring depressives symptoms found in children and adolescent.

Instrument development and evaluation of psychometric properties

Prior to the data collection process, further adjustment was made to the revised Thai version of Revised Olweus Bully/Victim Questionnaire translated by Tapanya (2007), Self-compassion Scale Short Form (SCS-SF) translated by Pornkosonsirilert and colleagues (2017), State Resilience Scale (SRC) developed by Kittisunthorn (2016), and The Children's Depression Inventory (CDI) by Likanapichitkul and Trangkasombat (1996). In addition, the revision and adjustments were made to become more age-appropriate for junior high school students. Seventy junior high school students who share similar characteristics as the study participants completed the first pilot testing. However, only the Revised Olweus Bully/Victim Questionnaire had satisfactory psychometric properties. As such, SCS-SF, SRC, and CDI items were revised and adjusted for the second pilot study with 110 junior high school students. The process and result are as follows.

1. Revised Olweus Bully/Victim Questionnaire

The adjustment made to the revised Olweus Bully/Victim Questionnaire was an additional item on cyberbullying added to the questionnaire. Item 11 was translated to Thai language and was back-translated to English by an expert before being review by another expert in the psychology field. The result of the first pilot study on 70 junior high school students revealed satisfactory psychometric properties for the revised Olweus Bully/Victim Questionnaire. The result reports the Cronbach's alpha of .87 and Item-total Correlation Coefficient (CITC) ranging between .30 to .80, which are satisfactory when comparing with Critical r of Pearson Product-Moment Correlation Coefficient of .195. Additionally, discriminate analysis using the T-test reports significant differences in all item scores for bullying victimization between low and high groups. Hence, the Revised Olweus Bully/Victim Questionnaire was found to be satisfactory.

2. Self-compassion Scale Short Form (SCS-SF)

The adjustment made to the Self-compassion scale short form was the language to become more suitable for junior high students. The adjusted version was evaluated for content validity according to the Index of item objective congruence (IOC) by a panel of three experts until satisfactory. The result of the first pilot study on 70 junior high school students revealed satisfactory psychometric properties for Cronbach's alpha. However, Item-total Correlation Coefficient (CITC) was not satisfied. Thus, the Self-compassion scale short form was revised and adjusted for the second pilot study with 110 junior high school students. The result revealed satisfactory psychometric properties with Cronbach's alpha of .75 and Item-total Correlation Coefficient (CITC) ranging from .10 to .70. In addition, the discriminate analysis reported that there are significant differences in all items in the self-compassion questionnaire between low and high groups.

3. State Resilience Scale (SRC)

State resilience scales were revised and adjusted for the junior middle-high school students. Then it was evaluated for content validity by a panel of three experts until satisfactory. However, the result from the first pilot study was not satisfactory, as some of the items did not meet the critical r of .195 for the Item-total Correlation Coefficient (CITC). Hence, the state resilience scale was re-evaluated for the second pilot with 110 junior high school students. The second pilot study was found to be satisfactory with Cronbach's alpha of .83 and Item-total Correlation Coefficient (CITC) ranging from .20 to .80. Additionally, the T-test analysis reported significant differences in all items in the state resilience scale questionnaire between low and high groups. Therefore, the state resilience scale is found to have satisfactory psychometric properties.

4. The Children's Depression Inventory (CDI)

The result from the first pilot study for The Children's Depression Inventory was not satisfactory, as item 23 did not meet the critical r value for item-total Correlation Coefficient (CITC). Thus, for the second pilot study, item 23 was revised and adjusted. The second pilot study was found to be satisfactory for the Children's Depression Inventory with Cronbach's alpha of .91 and Item-total Correlation Coefficient (CITC) ranging from .10 to .70. Furthermore, the T-test analysis revealed significant differences in all items Children's Depression Inventory between low and high groups. Therefore, the Children's Depression Inventory had satisfactory psychometric properties for junior high school students.

Data collection

After receiving approval from the Institutional Ethical Review Board, the data collection process began. The researcher employed two data collection methods for the study. In the first method, the researcher contacted junior high schools for permission for students to participate in the study and obtain approval from the school board. The first data collection method took place in a classroom, and the student completed the paper-and-pencil questionnaires. As for the second method, the researcher collected the data online using the survey created in Google form. The four questionnaires use in this method were similar to the first method and completed by the voluntary participants who found the shared links for the research online. Both methods of data collection took approximately 15 to 20 minutes to complete.

The researcher planned to collect data from three schools, including an all-girls school, an all-boys school, and a mixed school in the inner Bangkok metropolitan area. The decision was made due to potential gender differences in bullying victimization and depression (Klomek et al., 2007). Additionally, the data collection method was initially planned to be a paper-and-pencil method. However, due to the COVID-19 pandemic, the data collection plan has to be adjusted. The access to participants came mainly from the all-boys school. Participants mainly responded online.

Protection of human rights

The data collection process will commence after gaining approval from the Institutional Ethical Review Board (IRB). Before starting the process, the participants were given a written form of information and a comprehensive explanation of the study's objective, procedure, implication, and potential risk of concern. Additionally, the participants were informed regarding the process of withdrawal and the

confidentiality nature of the research. As well as, written information regarding when the participants feel psychological distress where they could seek further help.

Statistical analysis

Data obtained from the current study were analyzed for path analysis to examine the influence of bullying victimization on depressive mood with self-compassion and resilience as mediators using Statistical Package for Social Science (SPSS) version 22 for mac. The following statistical analyses were conducted:

1. Descriptive statistics to describe the demographic information regarding the participants and the key variables (i.e., bullying victimization, self-compassion, resilience, depression symptoms).
2. The path analysis model was tested with bullying victimization as a predictor and depressive mood as an outcome with self-compassion and resilience as mediators using path analysis.

Chapter 4

Result

The purpose of this study was to analyze and test the proposed model on the impact of bullying victimization on depressive moods among Thai junior high school students with self-compassion and resilience as mediators. Hence, the SPSS AMOS was used to explore the goodness of fit for the hypothesized path analysis model. The statistical analyses were separated into the four following categories:

1. Demographic variables
2. Descriptive statistics
3. Path analysis model
4. Model modification

1. Demographic variables

After removing the multivariate outliers, data for the current study were composed of responses from 371 Thai junior high school students who voluntarily completed the questionnaires from either a paper-and-pencil method (11.6%) or an online one (88.4%). Participants' age ranged between 12-16 years old, and their average age was 12.95 (*SD* = .89). Most of the participants were students from Grade 7 (66.60%) and are male (74.1%). See table 6 below for the demographic variables in the study.

Table 6: Demographic characteristics (N = 371)

Variable	Characteristic	Frequency	Percentage
Age (years old)	12	121	32.61
	13	180	48.52
	14	38	10.24
	15	30	8.08
	16	2	0.55
		371	100
		(*M* = 12.95, *SD* = .89)	
Gender	Male	275	74.1
	Female	96	25.9
Grade Level	Grade 7	247	66.60
	Grade 8	81	21.80
	Grade 9	43	11.60

2. Descriptive Statistics

Prior to conducting the path analysis, preliminary analyses were conducted. First, an outlier examination was conducted (Ghorbani, 2019). Among various outlier detection methods, the Mahalanobis distance was used in this data set. The Mahalanobis distance method was known for the ability to detect multivariate outliers and take accountability for correlations between variables that were not found in other methods, such as Euclidean distance (Ghorbani, 2019). Here, data that the preliminary analyses suggested a large Mahalanobis distance were removed from the data set (Ben-gal, 2005). A total of 34 participants was removed as multivariate outliers using the Mahalanobis distance for the four study variables.

The key study variables of bully victimization, depressive mood, self-compassion, and resilience were analyzed for the normality of the data. According to Kim (2013), the formal normality tests such as the Shapiro-Wilk test and Kolmogorov-Smirnov test were not suitable for sample sizes larger than 300 (Kim, 2013). However, the number of participants in this study was 371. Hence, the method of assessing normality assumptions with histograms, skewness, and kurtosis suitable for both large and small sample sizes was used (Kim, 2013). It was suggested that sample sizes larger than 300, absolute skewness value between -2 to 2, and absolute kurtosis values between -7 to 7 indicated normality (Kim, 2013). If the absolute skewness value and absolute kurtosis value are greater than these values, there was a likelihood of non-normality. In this study, all four variables met the assumptions of normality as the absolute skewness values were between -2 to 2 and the absolute kurtosis values were between -7 to 7. Therefore, non-normality was not found in the data obtained.

The mean average, standard deviation, minimum, maximum, and possible range for bullying victimization, depressive mood, self-compassion, and resilience are shown below in table 7. The mean average score for these variables were 17.07 (*SD* = 5.83), 14.76 (*SD* = 7.59), 39.76 (*SD* = 6.57), and 52.42 (*SD* = 8.85), respectively.

Table 7: Descriptive statistics of the study variables

Variables	***M***	***SD***	***Min***	***Max***	***Possible Range***
Bullying victimization	17.07	5.83	11	36	11-55
Depressive mood	14.76	7.59	1	36	0-81
Self-compassion	39.76	6.57	19	54	12-60
Resilience	52.42	8.85	26	69	14-70

The relationships between bullying victimization, depressive mood, self-compassion, and resilience were analyzed using Pearson correlation. Table 8 displayed the intercorrelation between each study variable with Cronbach's alphas reported on the diagonal. A significant positive correlation was found between bullying victimization and depressive mood (r = .28, p < .01). In contrast, bullying victimization had a significant negative association with self-compassion (r = -.23, p < .01). There was a significant negative medium correlation between depressive mood and self-compassion (r = -.61, p < .01) as well as a negative medium association between depressive mood and resilience (r = -.46, p < .01). Self-compassion was positively correlated with resilience (r = .47, p < .01). However, there was no significant relationship between bullying victimization and resilience (r = -.01, p = 0.82).

Table 8: Correlations between study variables with Cronbach's alpha reported in the diagonal

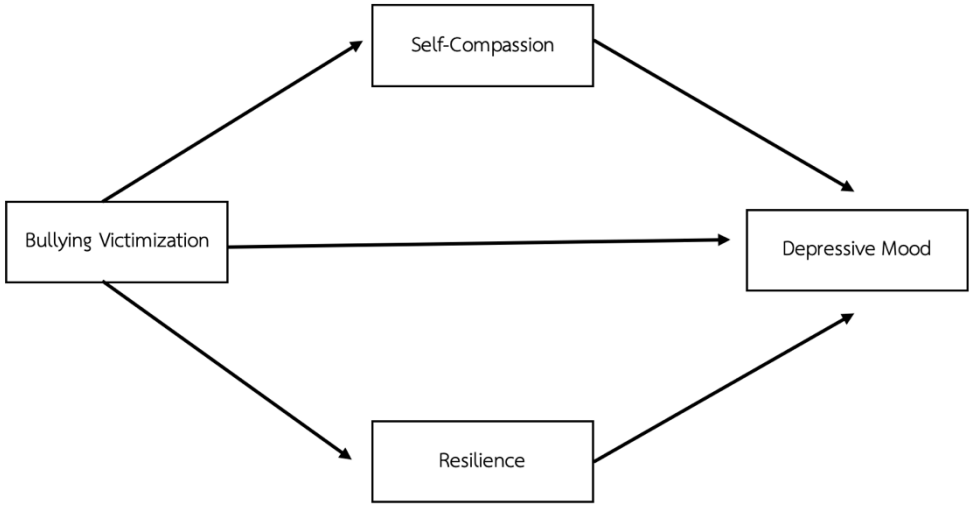
Variables	**1**	**2**	**3**	**4**
Bullying victimization	(.80)			
Depressive mood	.28**	(.87)		
Self-compassion	-.23**	-.61**	(.63)	
Resilience	-.01	-.46**	.47**	(.85)

**p<.01

3. Path analysis model

The SPSS Analysis Moment Structure (AMOS) version 22 was used to analyze and test the goodness-of-fit of the data with the hypothesized theoretical model, shown in Figure 2.

Figure 2: The Proposed theoretical model of depressive mood bullying victimization self-compassion, resilience, and depressive mood and resilience.



Path analysis was performed on the proposed theoretical model. According to Hooper, Coughlan, and Mullen (2008), multiple goodness-of-fit were used as indicators to determine whether the model fit was confirmed (as cited in Hooper, Coughlan, & Mullen, 2008). The most reported fit indices, as suggested by McDonald and Ho (2002), were Comparative Fit Index (CFI), Goodness of fit (GFI), Normed-Fit Index (NFI), and Non-Normed-Fit Index (NNFI) (Hooper, Coughlan & Mullen, 2008). However, it was noted that referring to the most used fit indices was not recommended on occasions when some of the statistics, namely the GFI, was problematic (Hooper et al., 2008). Hence, the researcher used the fit statistics in accordance with Hu and Bentler's suggestion (1999) on a two-index presentation strategy which includes the SRMR together with Tucker Lewis index (TLI) and Root Mean Square Error of Approximation (RMSEA) (as cited in Hooper et al., 2008). In addition, Kline (2005) strongly suggested using the Chi-Square test, RMSEA, CFI, and SRMR (Hooper et al., 2008; Kline, 2015). Hence, the model fit statistics reported in

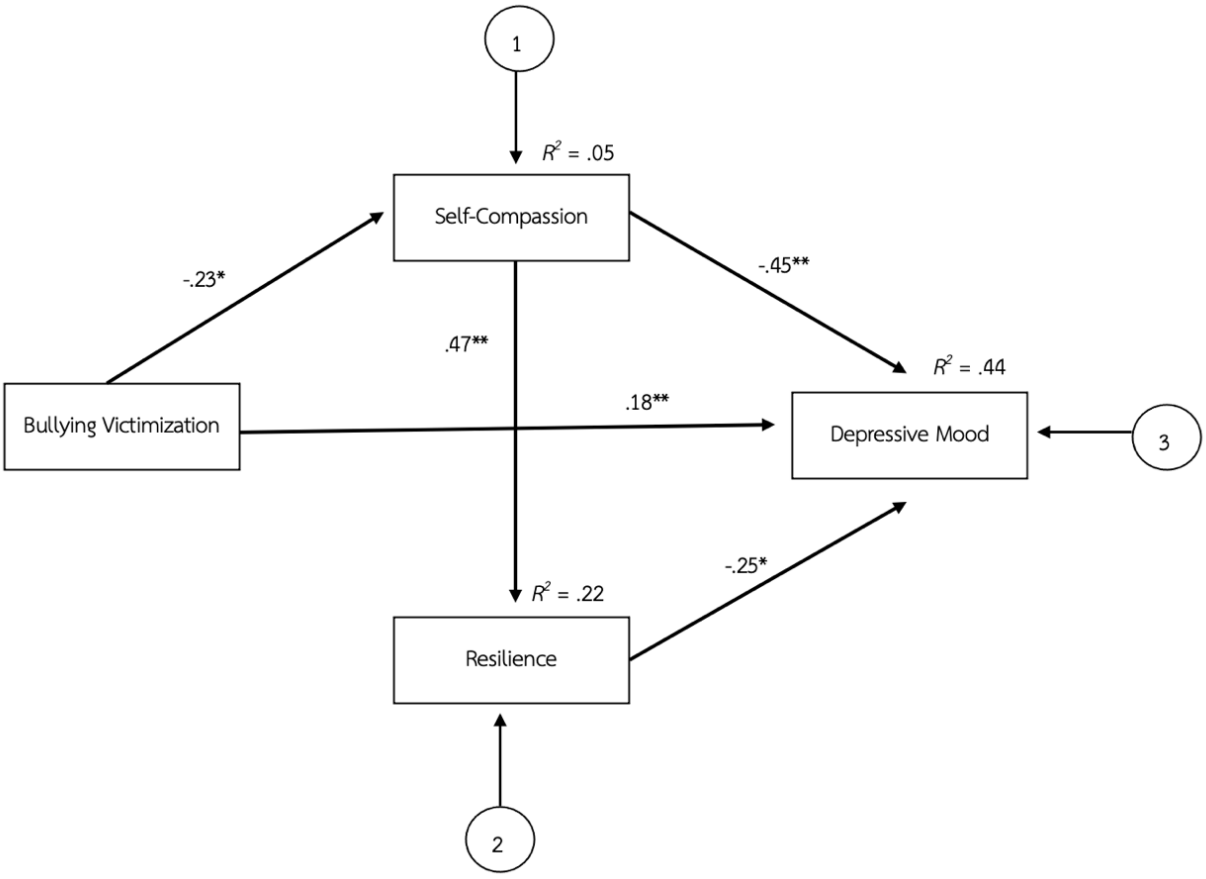
this study are model Chi-square (X^2), TLI, RMSEA, CFI, and SRMR, along with p-value, a relative of X^2/df. The recommended acceptable thresholds for each fit index are as following: the TLI values must be greater than .95, RMSEA values must be .06 or lower, CFI values must be greater than .95, SRMR must be lesser than .08, and the Chi-Square test must be insignificant (Hooper et al., 2008).

However, the path analysis for the proposed theoretical model revealed that it does not fit past the thresholds for fit indices, X^2 (2, N=371) =49.43, p <.01. As shown in Table 9, the proposed theoretical model did not meet the thresholds as mentioned above of the fit indices (i.e., p <.01, CFI < .95, TLI < .95, SRMR > .08, SMSEA >.06) the Chi-Square test significant, and the CFI, TLI, SRMR, and SMSEA were not within the ranges recommended. Hence, the proposed theoretical model did not meet the acceptable thresholds for goodness-of-fit, suggesting that the model did not fit statistically. Therefore, a model modification was conducted.

4. Model modification

A model modification was conducted. This entailed removing the path coefficient direct effect between bullying victimization and resilience and the addition of the path coefficient direct effect between self-compassion and resilience. Figure 3 displayed the modified model with the standardized indirect and direct effects.

Figure 3: Modified model with the indirect and direct effects and standardized path estimates of bullying victimization, self-compassion, and resilience on depressive mood



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

Data analysis suggested that the modified model fit well with the data, X^2 (2, N=371) =2.42, p=.09. The Chi-Square test was insignificant, being within the acceptable thresholds for goodness-of-fit. In addition, as displayed in Table 9, other fix indices also met the thresholds mentioned by Hooper et al. (2005) (i.e., TLI and CFI of beyond 0.95, RMSEA at .06, SRMR lesser than .08). Therefore, after the model modification, the goodness-of-fit indices met the recommended thresholds and suggested a good fit.

Table 9: Goodness-of-fit indices for mediation path models 1 and 2 of depressive mood

	X^2	df	*p*	X^2/df	CFI	TLI	SRMR	RMSEA
Model 1	98.86	2	.00	49.43	.70	.10	.16	.36
Model 2	4.83	2	.09	2.42	.99	.97	.03	.06

Note: threshold for goodness fit (p >.05, CFI > .95, TLI > .95, SRMR <.08, SMSEA <.06)

A mediation analysis was performed using the bootstrap method to investigate the role of self-compassion and resilience as a mediator for bullying victimization and depressive mood. The standardized indirect effect of bullying victimization on depressive mood was found statistically significant [β= .13, *p* = .006, *S.E* = .02, 95% C.I. (.09, .19)]. The result suggested that, together, self-compassion and resilience mediated the relationship between bullying victimization and depressive mood.

As displayed in Table 10, there was a significant total effect, direct effect, and indirect effect for each exogenous variable. For depressive mood, the model indicated a direct significant positive effect from bullying victimization (β = .18, *p* = .008, *S.E* = .04) and direct significant negative effect from self-compassion (β = -.45, *p* = .005, *S.E* = .05), and resilience (β = -.25, *p* = .021, *S.E* = .05). There was also significant indirect effect on depressive mood from bullying victimization (β = .13, *p* = .006, *S.E* = .023) and self-compassion (β = -.12, *p* = .015, *S.E* = .026). For resilience, self-compassion had a significant direct effect (β = .47, *p* = .003, *S.E* = .04) and there was a significant indirect effect from bullying victimization (β = -.11, *p* = .006, *S.E* = 0.19). For self-compassion, bullying victimization was a direct negative significant predictor (β = -.23, *p* = .012, *S.E* = .04). The explained variance in depressive mood, resilience and self-compassion was 44%, 22%, and 5% respectively. Overall, bullying victimization, self-compassion, and resilience explained 44% of the variance in depressive mood.

Table 10: *Standardized direct, indirect, and total effect*

Path	Direct effect	Indirect effect	Total effect	R^2
To depressive mood from:				
Bully Victimization	.18**	.13**	.31*	.44
Self-compassion	-.45**	-.12*	-.56**	
Resilience	-.25*	-	-.25*	
To Resilience from:				
Bully Victimization	-	-.11**	-.11**	.22
Self-compassion	.47**	-	. 47**	
To Self-compassion from:				
Bully Victimization	-.23*	-	-.23*	.05

*p<.05,**p<.01

Chapter 5

Discussion

The present study was proposed to fill in the research gap regarding resilience and self-compassion as mediators between bullying victimization and depressive mood. Given past empirical studies that suggested bullying victimization could lead to adolescent depressive mood (Stapinski et al., 2015), understanding potential protective factors were beneficial. Furthermore, obtaining a path analysis model that helped illustrate the mediating roles of self-compassion and resilience in the relationship between bullying victimization and depressive mood in junior high school students should help clarify the roles and relationships of these potential protective factors.

The theoretical model on the impact of bullying victimization on the depressive mood among Thai junior high school students with self-compassion and resilience as mediators was proposed and hypothesized to fit empirical data. The model was tested in 371 Thai junior high school students aged 12-16 years old. The participants' mean age was 12.95 years, and they were predominantly males (i.e., 74.1%). Participants voluntarily responded to a set of questionnaires, using either an online method (88.4%) or a paper-and-pencil method (11.6%). Data obtained were analyzed using a path analysis method on SPSS AMOS. The proposed theoretical model did not meet the assumption for the goodness-of-fit test; hence, a model modification was conducted. The modified model fit well with the data, X^2 (2, N=371) =2.42, p=.09, and accounted for 44% of the variances in the depressive mood. Overall, despite a lack of the association between bully victimization and resilience, self-compassion and resilience together mediated the relationship

between bullying victimization and depressive mood. The effect that resilience had on depressive mood was through self-compassion.

Further findings will be discussed in the relevance of the associations between 1) bullying victimization and depressive mood, 2) bullying victimization and depressive mood with self-compassion as a mediator, and 3) bullying victimization and depressive mood with resilience as a mediator.

1. Bullying victimization and depressive mood

Findings from the current study of the association between bullying victimization and depressive mood are consistent with past empirical studies (Alba, Calvete, Wante, Van Beveren, & Braet, 2018; Ekasawin & Phothisut, 2017; Klomek et al., 2007). Results from path analyses also revealed a significant positive direct effect, indirect, and total effects of bullying victimization on depressive mood. In addition, participants reporting higher frequencies of being bullied by their peers were more likely to score higher in a depressive mood. The findings mentioned above could be drawn from Beck's cognitive model of depression (1976).

The first explanation can be drawn from the cognitive triad component in the cognitive model of depression (Beck, 1979), which suggested that individuals' negative views about themselves, the world, and the future (Beck, 1979) could lead to depression (Beck, 1979). Past studies suggest that the model is well applied to children and adolescents (Braet, Wante, Van Beveren, & Theuwis, 2015; Emam, Abdelrasheed, & Omara, 2019; Stark, Schmidt, & Joiner, 1996). In particular, the view of themselves and the future particularly significant in predicting depressive symptoms (Braet et al., 2015). In addition, as reported in past findings (Graham & Juvonen, 1998), bullying victimization has been associated with self-blamed, loneliness, and anxiety. These senses of inadequacies that these individuals experienced appear consistent with the negative self-views. These could lead to the

perception of themselves as unworthy and unlovable, which could escalate into self-criticism and depression (Beck & Bredemeier, 2016). Similarly, past studies demonstrated that bullying victimization could lead individuals to develop negative views of the world; exposure to repeated victimization could lead to hopelessness (Bauman, Toomey, & Walker, 2013).

When encountering bullying victimization, some adolescents attribute the act to their own personal shortcomings (Graham, Bellmore, Nishina, & Juvonen, 2009). This could aggravate the sense of shame, given the threat of victimization to the individuals' social status (Strøm, Aakvaag, Birkeland, Felix, & Thoresen, 2018). Furthermore, with the victimization, some of the adolescents reportedly view themselves as unworthy of love and could not be kind to themselves (Jiang et al., 2016; Huiping Zhang, Chi, Long, & Ren, 2019). Subsequently, these negatives viewed on self from bullying victimization experiences could potentially explain the increase in depressive mood (Braet et al., 2015). As such, this second worldview could leave those experiencing the victimization to increase the hopelessness and aggravate vulnerability to depressed mood.

Secondly, bullying victimization can intimidate the security of attachment relationships and activated maladaptive schema, particularly those relevant to negative relationship-related beliefs and the sense of peer rejection (Alba et al., 2018; Calvete, Fernández-González, González-Cabrera, & Gámez-Guadix, 2018). As proposed by Beck (1976), the schema is the perpetuating factor of depression. Such factor contributes to the maintenance of pain-inducing and self-defeating attitudes even though individuals experience other positive aspects in their life (as cited in Beck, 1979). Consisting of dysfunctional beliefs about oneself, interaction with others, and the world (Alba et al., 2018), schemas become activated when an individual encounters stressors consistent with their schematic beliefs and, in turn, also impact

the information processing progress (Beck & Bredemeier, 2016). With increased exposure to bullying victimization, the degree to which individuals develop their negative schema is likely to increase. Being automatic (Beck, 1979), maladaptive schemas could lead to increased negative biases that the individuals have toward their social relationship and the degree to which they will experience negative views toward their social relationship and depressive mood (Alba et al., 2018; Calvete et al., 2018).

The current findings are in line with past findings that students reporting being bullied by peers are twice more likely to be screened positive for depression when compared with those with no such reports (Williams, Langhinrichsen-Rohling, Wornell, & Finnegan, 2017). In addition, previous findings indicated that both traditional bullying victimization (i.e., physical, verbal, and relational) and cyberbullying victimization were positively associated with depressive symptoms, which could escalate into suicidal ideations in adolescents (Strohacker, Wright, & Watts, 2019). Past experiences of bullying victimization could predict depressive and anxiety symptoms in young adults (J. Lee, 2021).

2. Bullying victimization and depressive mood with self-compassion as a mediator

The overall result indicated that bullying victimization was positively associated with depressive mood through self-compassion. It was suggesting that self-compassion mediated the relationship between the two variables. This indicated that students with a high level of self-compassion when facing bullying victimization are less likely to be reported with depressive symptoms.

The characteristics of self-compassion could explain the mediating role of self-compassion in the association between bullying victimization and depression. With its three components (i.e., self-kindness, common humanity, and mindfulness),

adolescents who reported higher self-compassion are more likely to take a more balanced approach in perceiving the bullying victimization experiences, become kinder to themselves after the experience, and successfully avoiding maladaptive coping behavior such as self-injury (Jiang et al., 2016). The characteristics of each component of self-compassion appeared to contribute to these benefits.

Neff (2003) proposed that the first component of self-compassion is self-kindness is beneficial for well-being (as cited in Neff & Davidson, 2016). Such characteristic helps prevent the use of a maladaptive coping method such as self-criticism, self-shaming, self-injury or self-blaming reports in various studies in relevance to those experiencing bully victimization (Graham & Juvonen, 1998; Greene, Britton, & Fitts, 2014; Jiang et al., 2016; Huiping Zhang et al., 2019). Consequently, the nature of self-compassion could act as a protective factor against self-judgment and comfort self during difficulties. Studies have suggested a negative association between self-criticism and self-compassion (Huaiyu Zhang et al., 2019). In addition, a study found that self-compassion mediated the relationship between self-criticism and depression, indicating that self-compassion can reduce the negative impact self-criticism have on depression (Huaiyu Zhang et al., 2019). This can be explained that being kind to oneself during difficulties could potentially reduce the opposing views on oneself, such as self-blame, shame, and self-criticism. Henceforth, the impact of bullying victimization on depressive mood could be reduced with a higher self-compassion level.

The role that self-compassion mediates the association between bullying victimization and depression could be viewed from its second component, common humanity (Neff & Davidson, 2016). Past empirical research had suggested that bullying victimization could lead to a sense of loneliness and social alienation, which could, in turn, result in a depressive mood (Andreou, Didaskalou, & Vlachou, 2015; Cao et

al., 2020; Olenik-Shemesh, Heiman, & Eden, 2012; Rudolph et al., 2014). Under those circumstances, individuals with high self-compassion could benefit from the sense of common humanity to reduce isolation (Leary, Tate, Adams, Batts Allen, & Hancock, 2007). It was explained that adolescents with a higher level of self-compassion are more likely to perceive bullying victimization as a commonly shared experience and treated themselves with more kindness (Q.-Q. Liu, Yang, Hu, & Zhang, 2020).

Lastly, the third component of self-compassion or mindfulness is likely to mediate the association between bullying victimization and depression. The act of being present without avoiding the experiences, mindfulness has been reported to help individuals gain a more balanced perspective on their situations (Neff & Davidson, 2016). Most importantly, self-compassion has been shown to reduce rumination, which plays a mediating and moderating role in the relationships between bullying victimization and depressive symptoms (Chu, Fan, Liu, & Zhou, 2019; Feinstein, Bhatia, & Davila, 2014; Mathieson, Klimes-Dougan, & Crick, 2014). With its mindfulness component, self-compassion should help vulnerable individuals reduce ruminate and overwhelmed moods and negative experiences (Odou & Brinker, 2014).

The current result was consistent with the past studies, which suggested that, when examined together, the positive association between bullying victimization and depression could be explained by self-compassion (Huiping Zhang et al., 2019; Huiping Zhang & Wang, 2019). Furthermore, relevant studies reported similar results where self-compassion helps mediate the relationships between bully victimization and psychological maladjustment (Játiva & Cerezo, 2014) and non-suicidal self-injury (Jiang et al., 2016). Overall, these studies suggest that the association between bullying victimization and depression becomes weakened when the individuals experience a higher level of self-compassion.

3. Bullying victimization and depressive mood with resilience as a mediator

The result indicated that bullying victimization was positively associated with depressive mood through indirect resilience role. Suggesting that resilience mediated the relationship between the two variables indirectly through self-compassion. Overall, indicating that students with a high level of resilience when facing victimization are less likely to be reported with depressive symptoms.

Past findings regarding the relationships between bullying victimization and resilience remain inconsistent. Findings from the present study result were inconsistent with some past findings of direct associations between bullying victimization and resilience (Baldry & Farrington, 2005; McVie, 2014; Sapouna & Wolke, 2013). However, it is worth noting that, when it was reported, such associations were relatively weak (Andreou, Roussi-Vergou, Didaskalou, & Skrzypiec, 2020; Hinduja & Patchin, 2017; Villora, Larrañaga, Yubero, Alfaro, & Navarro, 2020). Based on the current findings, the associations shown here occurred through self-compassion. The current results align with past reports of no relationships between bullying victimization and resilience (Narayanan & Betts, 2014) and mental health issues (Andreou et al., 2020; Narayanan & Betts, 2014).

That inconsistencies remain in the complex relationships between resilience and bullying victimization can be viewed in relation to differences in definition and methodological aspects among relevant studies (Sapouna & Wolke, 2013). Moreover, the association between resilience and bullying victimization was generally investigated indirectly through variables such as self-esteem, family support, and social connection (Malecki et al., 2008; Sapouna & Wolke, 2013). The relationship between resilience and self-compassion is generally not included in these investigations. Hence, the association was investigated in a different context than the current one, where self-compassion was examined concurrently, and resilience was

found to indirectly affect the relationship between bullying victimization and depressive mood via self-compassion.

Still, the current findings lend support, to some degree, past studies which reported the mediating role, albeit indirect, of resilience in the relationships between bullying victimization and depressive symptoms (Maidaniuc-Chirila, 2015; Zhou et al., 2017). As previously mentioned, the role occurred through self-compassion. These findings resonated with past reports of a positive association between resilience and self-compassion in adolescents (Bluth, Mullarkey, & Lathren, 2018). Indeed, resilience was posited to be promoted by self-compassion (Nery-Hurwit, Yun, & Ebbeck, 2018; Trompetter, de Kleine, & Bohlmeijer, 2017). With mindfulness and common humanity, the individuals are less likely to be consumed by their negative emotions but become better equip during difficult situations (Nery-Hurwit et al., 2018), including bullying victimization.

Past empirical research indicated that the components of self-compassion facilitated resilience during adversities. For example, albeit with different sample characteristics, research on the individual under challenging situations such as breast cancer and epilepsy reported self-compassion contributed to resilience (Alizadeh, Khanahmadi, Vedadhir, & Barjasteh, 2018; Baker, Caswell, & Eccles, 2019). Furthermore, those kinder to themselves and reported less self-judgment were found with a higher level of resilience (Alizadeh et al., 2018; Baker et al., 2019). Additionally, mindfulness in self-compassion in past empirical studies was associated with promoting resilience (Bajaj & Pande, 2016; Zhou et al., 2017). Furthermore, studies had suggested that the relationship between bullying victimization and depressive symptoms was mediated by resilience with mindfulness as a moderator (Zhou et al., 2017). Hence, providing information that mindfulness could lead to a higher level of resilience (Bajaj & Pande, 2016).

The association between self-compassion and resilience was demonstrated empirically in an intervention program. The 3-week self-compassion group intervention and 8-week mindfulness self-compassion course were shown to successfully enhance the participants' resilience and well-being (Bluth & Eisenlohr-Moul, 2017; Smeets et al., 2014). The mechanism behind the relationship was explained that awareness and acceptance components in mindfulness potentially promoted the development of resilience (Bajaj & Pande, 2016). Individuals with high mindfulness levels could maintain a balanced attitude and worldview towards difficult circumstances and foster resilience (Bajaj & Pande, 2016). Therefore, past empirical studies suggested that there was a positive association between self-compassion and resilience. Moreover, self-compassion could enhance resilience. The association could potentially explain how bullying victimization and the depressive mood were mediated by resilience through self-compassion.

One key component of resilience, the perception of social support, which is particularly beneficial for adolescents experiencing bullying victimization (Malecki et al., 2008; Pouwelse et al., 2011), should be considered as another potential explanation for decreasing depressive mood. Social support was associated with lower depression in the adolescent who was facing bullying victimization (Sapouna & Wolke, 2013). A study found that maternal and sibling warmth plays essential roles in reducing stress and effective coping mechanisms for bullied children (Bowes et al., 2010). Additionally, a good relationship between children and parents could result in parents' involvement in guiding children on coping with bullying victimization (Bowes et al., 2010). Another study found that facilitate parenting, peer acceptance, and the child's friendliness play crucial roles in depression over time (Healy & Sanders, 2018). It was found that facilitating parents with warmth and supporting good peer relationships predicted lower depression over time (Healy & Sanders, 2018). Overall,

it was suggested that perception of social support, a component of resilience, contributed to reducing depressive mood.

Another component of resilience that could contribute to lower depression was internalizing strength (Grotberg, 1995), such as self-esteem. Studies have found that despite being bullied by peers, students with high self-esteem reported lower depression when comparing with those with less self-esteem (Sapouna & Wolke, 2013). Overall, suggesting that components of resilience do act as a mediating role for bullying victimization on depressive mood.

Limitations

Similar to other studies, cautions should be exercised in viewing the current findings. One of the limitations was related to participants' characteristics. The majority of the participants were predominantly males (i.e., 74.1%). Based on past reports, gender role could potentially influence the association between bullying victimization and depression (Klomek et al., 2007). Thus, the findings in the current study could be limited in generalization.

Secondly, the present study relied on cross-sectional data, and a conclusion could not be drawn from the results. Additionally, data collection occurred during the pandemic COVID-19; this could impact the circumstances of the participants' social interactions, relationships, and thus experiences of bully victimization. The subsequent lockdown and school closure due to the pandemic could impact the participants' well-being and moods (Duan et al., 2020; Y. Liu et al., 2021). Furthermore, it is feasible that cyberbullying could be a more common occurrence than other types of bullying during the lockdown. However, the revised OBVQ questionnaire for bullying victimization focuses on face-to-face bullying (i.e., physical, verbal, and relational) more than cyberbullying. Hence, it is not feasible to rule out that this circumstantial factor could interfere with the current findings.

Future directions and Implications

Future studies could address the limitations of the current study by considering gender proportion during the data collection process and replicate similar processes during a non-pandemic situation. Additionally, the findings that resilience mediates the association of bullying victimization and depressive mood through self-compassion help pave the way for further investigation of relevant constructs. Mechanisms in which the relevant concepts (e.g., schema and information that could explain the association between bullying victimization and depressive mood, social support and internalizing strengths inherent in resilience) could be further investigated in future studies.

The current findings highlight the importance of self-compassion. The construct is first instrumental in directly reducing the negative impact of bullying victimization on depressive mood. Secondly, the indirect effect on depressive mood via resilience was evident. The three components of self-compassion allow feelings of self-acceptance and self-kindness which should lead to less self-criticism and self-judgment (Neff & McGehee, 2010). Hence, therapeutic planning, self-compassion should not be overlooked.

Self-compassion-related intervention program has been shown to effectively reduce depression mood (Neff & Germer, 2013; Wilson et al., 2019). Studies have shown that individuals who are more kind to themselves during adversities have a higher level of resilience and showed fewer symptoms of anxiety and depression (Alizadeh et al., 2018). As such, intervention promoting self-compassion, such as writing about a difficult situation in a self-compassionate way, could be beneficial (Odou & Brinker, 2014). Furthermore, writing in a self-compassionate attitude allows the individual to acknowledge it is a commonly shared experience, and the process promoted mindfulness as well (Odou & Brinker, 2014). Hence, intervention such as

writing or group program that allows the individual to be kind to themselves, acknowledge common shared experienced, and promoted mindfulness could be beneficial in increasing resilience in adolescents, which could reduce the negative impact on bullying victimization on adolescents adolescent psychological well-being. However, these interventions are yet to involve adolescents bullying victimization and are still understudy directly. Therefore, potentially future studies could examine and apply relevant intervention for adolescents bullied by their peers.

Conclusion

In conclusion, the present study objective was to explore and tested the proposed theoretical model for the impact of bullying victimization on depressive mood with self-compassion and resilience as mediators among Thai junior high school students. The study's result partially consisted of past empirical studies suggesting that self-compassion and resilience together mediated the relationship between bullying victimization and depressive mood. Therefore, self-compassion and resilience together could potentially act as protective factors against the negative impact bullying victimization has on depressive mood. Therefore, a future intervention targeting to increase self-compassion and resilience, particularly the former, could benefit adolescents.

REFERENCES

Abela, J. R., & D'Alessandro, D. U. (2002). Beck's cognitive theory of depression: A test of the diathesis-stress and causal mediation components. *British Journal of Clinical Psychology, 41*(2), 111-128.

Alba, J., Calvete, E., Wante, L., Van Beveren, M.-L., & Braet, C. (2018). Early maladaptive schemas as moderators of the association between bullying victimization and depressive symptoms in adolescents. *Cognitive Therapy and Research, 42*(1), 24-35.

Alizadeh, S., Khanahmadi, S., Vedadhir, A., & Barjasteh, S. (2018). The relationship between resilience with self-compassion, social support and sense of belonging in women with breast cancer. *Asian Pacific journal of cancer prevention: APJCP, 19*(9), 2469-2474.

American Psychiatric Association. (2013). DSM 5. *American Psychiatric Association, 70*.

American Psychological Association. (2002). A reference for professionals: Developing adolescents. *Retrieved from http://www.apa.org/pi/families/resources/develop.pdf, 11*, 5.

American Psychological Association. (2014). Bullying. from Retrieved from https://www.apa.org/topics/bullying

Anacker, C., Zunszain, P. A., Carvalho, L. A., & Pariante, C. M. (2011). The glucocorticoid receptor: pivot of depression and of antidepressant treatment? *Psychoneuroendocrinology, 36*(3), 415-425.

Andreou, E., Didaskalou, E., & Vlachou, A. (2015). Bully/victim problems among G reek pupils with special educational needs: associations with loneliness and self-efficacy for peer interactions. *Journal of Research in Special Educational Needs, 15*(4), 235-246.

Andreou, E., Roussi-Vergou, C., Didaskalou, E., & Skrzypiec, G. (2020). School bullying, subjective well-being, and resilience. *Psychology in the Schools, 57*(8), 1193-1207.

Anyan, F., & Hjemdal, O. (2016). Adolescent stress and symptoms of anxiety and

depression: Resilience explains and differentiates the relationships. *Journal of affective disorders, 203*, 213-220. doi:https://doi.org/10.1016/j.jad.2016.05.031

Audrain-McGovern, J., Rodriguez, D., & Kassel, J. D. (2009). Adolescent smoking and depression: evidence for self-medication and peer smoking mediation. *Addiction, 104*(10), 1743-1756.

Bajaj, B., & Pande, N. (2016). Mediating role of resilience in the impact of mindfulness on life satisfaction and affect as indices of subjective well-being. *Personality and Individual Differences, 93*, 63-67.

Baker, D. A., Caswell, H. L., & Eccles, F. J. (2019). Self-compassion and depression, anxiety, and resilience in adults with epilepsy. *Epilepsy & Behavior, 90*, 154-161.

Baldry, A. C. (2004). The impact of direct and indirect bullying on the mental and physical health of Italian youngsters. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression, 30*(5), 343-355.

Baldry, A. C., & Farrington, D. P. (2005). Protective factors as moderators of risk factors in adolescence bullying. *Social psychology of education, 8*(3), 263-284.

Bauman, S., & Del Rio, A. (2006). Preservice teachers' responses to bullying scenarios: Comparing physical, verbal, and relational bullying. *Journal of Educational Psychology, 98*(1), 219-231.

Bauman, S., Toomey, R. B., & Walker, J. L. (2013). Associations among bullying, cyberbullying, and suicide in high school students. *Journal of adolescence, 36*(2), 341-350.

Beauchere, J. (2017). Microsoft releases Digital Civility Index, challenges people to be more empathetic online. from Retrieved from https://blogs.microsoft.com/on-the-issues/2017/02/07/microsoft-releases-digital-civility-index-challenges-people-empathetic-online/#_ftn1

Beck, A. T. (1979). *Cognitive therapy of depression*: Guilford press.

Beck, A. T. (2005). The current state of cognitive therapy: a 40-year retrospective. *Archives of general psychiatry, 62*(9), 953-959.

Beck, A. T., & Bredemeier, K. (2016). A unified model of depression: Integrating clinical, cognitive, biological, and evolutionary perspectives. *Clinical Psychological*

Science, 4(4), 596-619.

Beduna, K. N., & Perrone-McGovern, K. M. (2019). Recalled childhood bullying victimization and shame in adulthood: The influence of attachment security, self-compassion, and emotion regulation. *Traumatology, 25*(1), 21.

Bellmore, A., Huang, H.-c., Bowman, C., White, G., & Cornell, D. (2017). The trouble with bullying in high school: issues and considerations in its conceptualization. *Adolescent research review, 2*(1), 11-22.

Bjorklund, D. F., & Pellegrini, A. D. (2000). Child development and evolutionary psychology. *Child development, 71*(6), 1687-1708.

Bluth, K., & Eisenlohr-Moul, T. A. (2017). Response to a mindful self-compassion intervention in teens: A within-person association of mindfulness, self-compassion, and emotional well-being outcomes. *Journal of adolescence, 57*, 108-118.

Bluth, K., Mullarkey, M., & Lathren, C. (2018). Self-compassion: A potential path to adolescent resilience and positive exploration. *Journal of child and family studies, 27*(9), 3037-3047.

Boulton, M. J., Smith, P. K., & Cowie, H. (2010). Short-term longitudinal relationships between children's peer victimization/bullying experiences and self-perceptions: Evidence for reciprocity. *School Psychology International, 31*(3), 296-311.

Bowes, L., Maughan, B., Caspi, A., Moffitt, T. E., & Arseneault, L. (2010). Families promote emotional and behavioural resilience to bullying: evidence of an environmental effect. *Journal of child psychology and psychiatry, 51*(7), 809-817.

Braet, C., Wante, L., Van Beveren, M.-L., & Theuwis, L. (2015). Is the cognitive triad a clear marker of depressive symptoms in youngsters? *European child & adolescent psychiatry, 24*(10), 1261-1268.

Brown, T. A., & Naragon-Gainey, K. (2013). Evaluation of the unique and specific contributions of dimensions of the triple vulnerability model to the prediction of DSM-IV anxiety and mood disorder constructs. *Behavior therapy, 44*(2), 277-292.

Buttabote, P. (2011). The relationship between bullying behavior and self-esteem in

attention deficit/hyperactivity disorder patients. *Journal of Psychiatric Association Thailand, 56*(2), 93-102.

Calvete, E., Fernández-González, L., González-Cabrera, J. M., & Gámez-Guadix, M. (2018). Continued bullying victimization in adolescents: Maladaptive schemas as a mediational mechanism. *Journal of Youth and Adolescence, 47*(3), 650-660.

Cao, Q., Xu, X., Xiang, H., Yang, Y., Peng, P., & Xu, S. (2020). Bullying victimization and suicidal ideation among Chinese left-behind children: Mediating effect of loneliness and moderating effect of gender. *Children and Youth Services Review, 111*, 104848.

Caravita, S. C., Di Blasio, P., & Salmivalli, C. (2009). Unique and interactive effects of empathy and social status on involvement in bullying. *Social Development, 18*(1), 140-163.

Carbonell, D. M., Reinherz, H. Z., Giaconia, R. M., Stashwick, C. K., Paradis, A. D., & Beardslee, W. R. (2002). Adolescent protective factors promoting resilience in young adults at risk for depression. *Child and Adolescent Social Work Journal, 19*(5), 393-412.

Chaveepojnkamjorn, W., Pichainarong, N., Adthasangsri, V., Sativipawee, P., & Prasertsong, C. (2016). Depression and its associated factors among Senior High School students in Nonthaburi Province, Thailand: a cross-sectional study. *Journal of Public Health in Developing Countries, 2*(3), 224-234.

Cho, S., & Lee, J. M. (2018). Explaining physical, verbal, and social bullying among bullies, victims of bullying, and bully-victims: Assessing the integrated approach between social control and lifestyles-routine activities theories. *Children and Youth Services Review, 91*, 372-382.

Chu, X.-W., Fan, C.-Y., Liu, Q.-Q., & Zhou, Z.-K. (2019). Rumination mediates and moderates the relationship between bullying victimization and depressive symptoms in Chinese early adolescents. *Child Indicators Research, 12*(5), 1549-1566.

Clayborne, Z. M., Varin, M., & Colman, I. (2019). Systematic review and meta-analysis: adolescent depression and long-term psychosocial outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry, 58*(1), 72-79.

Cohen, J. (2013). *Statistical power analysis for the behavioral sciences*: Academic press.

Comer, R. J., Gould, E., & Furnham, A. (2013). *Psychology*: Wiley.

Cook, C. R., Williams, K. R., Guerra, N. G., Kim, T. E., & Sadek, S. (2010). Predictors of bullying and victimization in childhood and adolescence: a meta-analytic investigation. *School psychology quarterly, 25*(2), 65.

Copeland, W. E., Wolke, D., Angold, A., & Costello, E. J. (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA psychiatry, 70*(4), 419-426.

Crawford, A. M., & Manassis, K. (2011). Anxiety, social skills, friendship quality, and peer victimization: An integrated model. *Journal of anxiety disorders, 25*(7), 924-931.

Crick, N. R., & Nelson, D. A. (2002). Relational and physical victimization within friendships: Nobody told me there'd be friends like these. *Journal of abnormal child psychology, 30*(6), 599-607.

Cuijpers, P., Cristea, I. A., Karyotaki, E., Reijnders, M., & Huibers, M. J. (2016). How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta‐analytic update of the evidence. *World Psychiatry, 15*(3), 245-258.

de Araújo Veras, J. L., Ximenes, R. C. C., de Vasconcelos, F. M. N., & Sougey, E. B. (2016). Prevalence of suicide risk among adolescents with depressive symptoms. *Archives of psychiatric nursing, 30*(1), 2-6.

Diedrich, A., Grant, M., Hofmann, S. G., Hiller, W., & Berking, M. (2014). Self-compassion as an emotion regulation strategy in major depressive disorder. *Behaviour research and therapy, 58*, 43-51.

Dray, J., Bowman, J., Campbell, E., Freund, M., Wolfenden, L., Hodder, R. K., . . . Bailey, J. (2017). Systematic review of universal resilience-focused interventions targeting child and adolescent mental health in the school setting. *Journal of the American Academy of Child & Adolescent Psychiatry, 56*(10), 813-824.

Duan, L., Shao, X., Wang, Y., Huang, Y., Miao, J., Yang, X., & Zhu, G. (2020). An investigation of mental health status of children and adolescents in china during the outbreak of COVID-19. *Journal of affective disorders, 275*, 112-118.

Duarte, C., Pinto-Gouveia, J., & Rodrigues, T. (2015). Being bullied and feeling ashamed: Implications for eating psychopathology and depression in adolescent girls. *Journal of adolescence, 44*, 259-268.

Due, P., Holstein, B. E., Lynch, J., Diderichsen, F., Gabhain, S. N., Scheidt, P., & Currie, C. (2005). Bullying and symptoms among school-aged children: international comparative cross sectional study in 28 countries. *European journal of public health, 15*(2), 128-132.

Dukes, R. L., Stein, J. A., & Zane, J. I. (2009). Effect of relational bullying on attitudes, behavior and injury among adolescent bullies, victims and bully-victims. *The Social Science Journal, 46*(4), 671-688.

Dukes, R. L., Stein, J. A., & Zane, J. I. (2010). Gender differences in the relative impact of physical and relational bullying on adolescent injury and weapon carrying. *Journal of School Psychology, 48*(6), 511-532.

Edwards, M., Adams, E. M., Waldo, M., Hadfield, O., & Biegel, G. M. (2014). Effects of a mindfulness group on Latino adolescent students: Examining levels of perceived stress, mindfulness, self-compassion, and psychological symptoms. *The Journal for Specialists in Group Work, 39*(2), 145-163.

Ekasawin, S., & Phothisut, C. (2017). Prevalence of bullying experiences and psychiatric disorders in Thai students. *Journal of Mental Health of Thailand, 25*(2), 96-106.

Emam, M. M., Abdelrasheed, N. S. G., & Omara, E. (2019). Negative Cognition, Emotional and Behavioural Difficulties, Negative Life Events and Depressive Symptoms among Adolescents in Oman. *Current Psychology*, 1-10.

Feinstein, B. A., Bhatia, V., & Davila, J. (2014). Rumination mediates the association between cyber-victimization and depressive symptoms. *Journal of interpersonal violence, 29*(9), 1732-1746.

Fergus, S., & Zimmerman, M. A. (2005). Adolescent resilience: A framework for understanding healthy development in the face of risk. *Annu. Rev. Public Health, 26*, 399-419.

Fox, C. L., & Boulton, M. J. (2005). The social skills problems of victims of bullying: Self, peer and teacher perceptions. *British Journal of Educational Psychology, 75*(2), 313-328.

Fredstrom, B. K., Adams, R. E., & Gilman, R. (2011). Electronic and school-based victimization: Unique contexts for adjustment difficulties during adolescence. *Journal of Youth and Adolescence, 40*(4), 405-415.

Garandeau, C. F., & Cillessen, A. H. (2006). From indirect aggression to invisible aggression: A conceptual view on bullying and peer group manipulation. *Aggression and violent behavior, 11*(6), 612-625.

Garcia-Campayo, J., Navarro-Gil, M., Andrés, E., Montero-Marin, J., López-Artal, L., & Demarzo, M. M. P. (2014). Validation of the Spanish versions of the long (26 items) and short (12 items) forms of the Self-Compassion Scale (SCS). *Health and quality of life outcomes, 12*(1), 1-9.

Ghorbani, H. (2019). Mahalanobis distance and its application for detecting multivariate outliers. *Facta Univ Ser Math Inform, 34*, 583-595.

Gill, C., Watson, L., Williams, C., & Chan, S. W. (2018). Social anxiety and self-compassion in adolescents. *Journal of adolescence, 69*, 163-174.

Gini, G., & Pozzoli, T. (2009). Association between bullying and psychosomatic problems: A meta-analysis. *Pediatrics, 123*(3), 1059-1065.

Gini, G., & Pozzoli, T. (2013). Bullied children and psychosomatic problems: A meta-analysis. *Pediatrics, 132*(4), 720-729.

Graham, S., Bellmore, A., Nishina, A., & Juvonen, J. (2009). "It must be me": Ethnic diversity and attributions for peer victimization in middle school. *Journal of Youth and Adolescence, 38*(4), 487-499.

Graham, S., & Juvonen, J. (1998). Self-blame and peer victimization in middle school: an attributional analysis. *Developmental psychology, 34*(3), 587.

Greene, D. C., Britton, P. J., & Fitts, B. (2014). Long-term outcomes of lesbian, gay, bisexual, and transgender recalled school victimization. *Journal of Counseling & Development, 92*(4), 406-417.

Grotberg, E. H. (1995). *A guide to promoting resilience in children: Strengthening the human spirit* (Vol. 8): Bernard van leer foundation The Hague.

Hair Jr, J. F., Babin, B. J., & Anderson, R. E. (2010). *Multivariate Data Analysis: A Global Perspective*. London: Pearson Education.

Harter, S., Stocker, C., & Robinson, N. S. (1996). The perceived directionality of the link between approval and self-worth: The liabilities of a looking gladd self-orientation among young adolescents. *Journal of Research on Adolescence, 6*(3), 285–308.

Hartung, T., Brähler, E., Faller, H., Härter, M., Hinz, A., Johansen, C., . . . Weis, J. (2017). The risk of being depressed is significantly higher in cancer patients than in the general population: prevalence and severity of depressive symptoms across major cancer types. *European Journal of Cancer, 72*, 46-53.

Hasler, G. (2010). Pathophysiology of depression: do we have any solid evidence of interest to clinicians? *World Psychiatry, 9*(3), 155.

Hawker, D. S., & Boulton, M. J. (2000). Twenty years' research on peer victimization and psychosocial maladjustment: A meta-analytic review of cross-sectional studies. *Journal of child psychology and psychiatry, 41*(4), 441-455.

Healy, K., & Sanders, M. (2018). Mechanisms through which supportive relationships with parents and peers mitigate victimization, depression and internalizing problems in children bullied by peers. *Child Psychiatry & Human Development, 49*(5), 800-813.

Hébert, M., Lavoie, F., & Blais, M. (2014). Post Traumatic Stress Disorder/PTSD in adolescent victims of sexual abuse: resilience and social support as protection factors. *Ciencia & saude coletiva, 19*, 685-694.

Hernandez, L., Cancilliere, M. K., Graves, H., Chun, T. H., Lewander, W., & Spirito, A. (2016). Substance use and depressive symptoms among adolescents treated in a pediatric emergency department. *Journal of child & adolescent substance abuse, 25*(2), 124-133.

Hiew, C. C., Mori, T., Shimizu, M., & Tominaga, M. (2000). Measurement of resilience development: Preliminary results with a State-Trait resilience inventory. *Journal of Learning and Curriculum Development, 1*, 111-117.

Hinduja, S., & Patchin, J. W. (2017). Cultivating youth resilience to prevent bullying and cyberbullying victimization. *Child abuse & neglect, 73*, 51-62.

Hjemdal, O., Vogel, P. A., Solem, S., Hagen, K., & Stiles, T. C. (2011). The relationship

between resilience and levels of anxiety, depression, and obsessive–compulsive symptoms in adolescents. *Clinical psychology & psychotherapy, 18*(4), 314-321.

Hooper, D., Coughlan, J., & Mullen, M. (2008). Structural equation modelling: guidelines for determining model fit. Electron J Bus Res Methods 6: 53–60. In.

Hu, T., Zhang, D., & Wang, J. (2015). A meta-analysis of the trait resilience and mental health. *Personality and Individual Differences, 76*, 18-27.

Jatchavala, C., & Chan, S. (2018). Thai Adolescent Depression: Recurrence Prevention in Practice. *Journal of Health Science and Medical Research, 36*(2), 147-155.

Játiva, R., & Cerezo, M. A. (2014). The mediating role of self-compassion in the relationship between victimization and psychological maladjustment in a sample of adolescents. *Child abuse & neglect, 38*(7), 1180-1190.

Jiang, Y., You, J., Hou, Y., Du, C., Lin, M.-P., Zheng, X., & Ma, C. (2016). Buffering the effects of peer victimization on adolescent non-suicidal self-injury: The role of self-compassion and family cohesion. *Journal of adolescence, 53*, 107-115.

Joiner Jr, T. E., & Metalsky, G. I. (2001). Excessive reassurance seeking: Delineating a risk factor involved in the development of depressive symptoms. *Psychological Science, 12*(5), 371-378.

Jourdy, R., & Petot, J.-M. (2017). Relationships between personality traits and depression in the light of the "Big Five" and their different facets. *L'évolution Psychiatrique, 82*(4), 27-37.

Juvonen, J., Wang, Y., & Espinoza, G. (2013). Physical aggression, spreading of rumors, and social prominence in early adolescence: Reciprocal effects supporting gender similarities? *Journal of Youth and Adolescence, 42*(12), 1801-1810.

Karatas, H., & Ozturk, C. (2011). Relationship between bullying and health problems in primary school children. *Asian Nursing Research, 5*(2), 81-87.

Kim, H.-Y. (2013). Statistical notes for clinical researchers: assessing normal distribution (2) using skewness and kurtosis. *Restorative dentistry & endodontics, 38*(1), 52.

Kittisunthorn, D. (2016). *Effective of cognitive behavior therapy group on resilience and emotional regulation in middle childhood* (Master's Disseration), Chulalognkorn University, Bangkok.

Kline, R. B. (2015). *Principles and practice of structural equation modeling*: Guilford

publications.

Kljakovic, M., & Hunt, C. (2016). A meta-analysis of predictors of bullying and victimisation in adolescence. *Journal of adolescence, 49*, 134-145.

Klomek, A. B., Marrocco, F., Kleinman, M., Schonfeld, I. S., & Gould, M. S. (2007). Bullying, depression, and suicidality in adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(1), 40-49.

Kochel, K. P., Ladd, G. W., & Rudolph, K. D. (2012). Longitudinal associations among youth depressive symptoms, peer victimization, and low peer acceptance: An interpersonal process perspective. *Child development, 83*(2), 637-650.

Kokkinos, C. M. (2013). Bullying and victimization in early adolescence: Associations with attachment style and perceived parenting. *Journal of school violence, 12*(2), 174-192.

Körner, A., Coroiu, A., Copeland, L., Gomez-Garibello, C., Albani, C., Zenger, M., & Brähler, E. (2015). The role of self-compassion in buffering symptoms of depression in the general population. *PloS one, 10*(10), 1-14.

Kotnara, I., Kittiwatanapaisan, W., & Rungreangkulki, S. (2015). Prevalence and Predictive Factors Influence Depression among Secondary School Students: Sex Difference Analysis. *Journal of Nursing Science and Health, 38*(1), 63-72.

Kotov, R., Gamez, W., Schmidt, F., & Watson, D. (2010). Linking "big" personality traits to anxiety, depressive, and substance use disorders: a meta-analysis. *Psychological bulletin, 136*(5), 768.

Kowalski, R. M., & Limber, S. P. (2013). Psychological, physical, and academic correlates of cyberbullying and traditional bullying. *Journal of adolescent health, 53*(1), 13-20.

Krieger, T., Altenstein, D., Baettig, I., Doerig, N., & Holtforth, M. G. (2013). Self-compassion in depression: Associations with depressive symptoms, rumination, and avoidance in depressed outpatients. *Behavior therapy, 44*(3), 501-513.

Kyriakides, L., Kaloyirou, C., & Lindsay, G. (2006). An analysis of the Revised Olweus Bully/Victim Questionnaire using the Rasch measurement model. *British Journal of Educational Psychology, 76*(4), 781-801.

Ladd, G. W., Ettekal, I., & Kochenderfer-Ladd, B. (2017). Peer victimization trajectories

from kindergarten through high school: Differential pathways for children's school engagement and achievement? *Journal of Educational Psychology, 109*(6), 826.

LaFontana, K. M., & Cillessen, A. H. (2010). Developmental changes in the priority of perceived status in childhood and adolescence. *Social Development, 19*(1), 130-147.

Leary, M. R., Tate, E. B., Adams, C. E., Batts Allen, A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: the implications of treating oneself kindly. *Journal of personality and social psychology, 92*(5), 887.

Ledesma, J. (2014). Conceptual frameworks and research models on resilience in leadership. *Sage Open, 4*(3), 1-8.

Lee, J. (2021). Pathways from childhood bullying victimization to young adult depressive and anxiety symptoms. *Child Psychiatry & Human Development, 52*(1), 129-140.

Lee, T., & Cornell, D. (2009). Concurrent validity of the Olweus bully/victim questionnaire. *Journal of school violence, 9*(1), 56-73.

Leelatrakarnkun, K., & Trangkasombat, U. (2012). The Association between depression and family functioning in seventh grade students in Ubonratchathani province. *Journal of the Psychiatric Association of Thailand, 57*(1), 29-38.

Lereya, S. T., Samara, M., & Wolke, D. (2013). Parenting behavior and the risk of becoming a victim and a bully/victim: A meta-analysis study. *Child abuse & neglect, 37*(12), 1091-1108.

Lerner, R. M., & Steinberg, L. (2009). *Handbook of adolescent psychology, volume 1: Individual bases of adolescent development* (Vol. 1): John Wiley & Sons.

Liu, Q.-Q., Yang, X.-J., Hu, Y.-T., & Zhang, C.-Y. (2020). Peer victimization, self-compassion, gender and adolescent mobile phone addiction: Unique and interactive effects. *Children and Youth Services Review, 118*, 105397.

Liu, Y., Yue, S., Hu, X., Zhu, J., Wu, Z., Wang, J., & Wu, Y. (2021). Associations between feelings/behaviors during COVID-19 pandemic lockdown and depression/anxiety after lockdown in a sample of Chinese children and adolescents. *Journal of*

affective disorders, 284, 98-103.

López, A., Sanderman, R., & Schroevers, M. J. (2018). A close examination of the relationship between self-compassion and depressive symptoms. *Mindfulness, 9*(5), 1470-1478.

Luk, J. W., Wang, J., & Simons-Morton, B. G. (2010). Bullying victimization and substance use among US adolescents: Mediation by depression. *Prevention Science, 11*(4), 355-359.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical psychology review, 32*(6), 545-552.

Maidaniuc-Chirila, T. (2015). Mediation roles of resilience and coping strategies on the relationship between workplace bullying and Romanian employees' depressive symptoms. *Romanian Journal of Experimental Applied Psychology, 6*(3), 84-101.

Malecki, C. K., Demaray, M. K., & Davidson, L. M. (2008). The relationship among social support, victimization, and student adjustment in a predominantly Latino sample. *Journal of school violence, 7*(4), 48-71.

Marini, Z. A., Dane, A. V., Bosacki, S. L., & CURA, Y. (2006). Direct and indirect bully-victims: Differential psychosocial risk factors associated with adolescents involved in bullying and victimization. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression, 32*(6), 551-569.

Mathieson, L. C., Klimes-Dougan, B., & Crick, N. R. (2014). Dwelling on it may make it worse: The links between relational victimization, relational aggression, rumination, and depressive symptoms in adolescents. *Development and psychopathology, 26*(3), 735-747.

Mayer, L., Lopez-Duran, N. L., Kovacs, M., George, C. J., Baji, I., Kapornai, K., . . . Vetró, Á. (2009). Stressful life events in a clinical sample of depressed children in Hungary. *Journal of affective disorders, 115*(1-2), 207-214.

McGinn, L. K. (2000). Cognitive behavioral therapy of depression: Theory, treatment, and empirical status. *American Journal of Psychotherapy, 54*(2), 257-262.

McMahon, E. M., Reulbach, U., Keeley, H., Perry, I. J., & Arensman, E. (2012). Reprint of:

Bullying victimisation, self harm and associated factors in Irish adolescent boys. *Social science & medicine, 74*(4), 490-497.

McVie, S. (2014). The impact of bullying perpetration and victimization on later violence and psychological distress: a study of resilience among a Scottish youth cohort. *Journal of school violence, 13*(1), 39-58.

Modecki, K. L., Minchin, J., Harbaugh, A. G., Guerra, N. G., & Runions, K. C. (2014). Bullying prevalence across contexts: A meta-analysis measuring cyber and traditional bullying. *Journal of adolescent health, 55*(5), 602-611.

Moljord, I. E., Moksnes, U. K., Espnes, G. A., Hjemdal, O., & Eriksen, L. (2014). Physical activity, resilience, and depressive symptoms in adolescence. *Mental Health and Physical Activity, 7*(2), 79-85.

Moore, B., & Woodcock, S. (2017). Resilience, bullying, and mental health: Factors associated with improved outcomes. *Psychology in the Schools, 54*(7), 689-702.

Muris, P., Meesters, C., Pierik, A., & de Kock, B. (2016). Good for the self: Self-compassion and other self-related constructs in relation to symptoms of anxiety and depression in non-clinical youths. *Journal of child and family studies, 25*(2), 607-617.

Musliner, K. L., & Singer, J. B. (2014). Emotional support and adult depression in survivors of childhood sexual abuse. *Child abuse & neglect, 38*(8), 1331-1340.

Narayanan, A., & Betts, L. R. (2014). Bullying behaviors and victimization experiences among adolescent students: The role of resilience. *The Journal of genetic psychology, 175*(2), 134-146.

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and identity, 2*(3), 223-250.

Neff, K. D., & Davidson, O. (2016). Self-compassion: Embracing suffering with kindness. In *In Mindfulness in Positive Psychology* (pp. 47-60): Routledge.

Neff, K. D., & Germer, C. (2017). Self-Compassion and Psychological. *The Oxford handbook of compassion science*, 371.

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of clinical psychology, 69*(1), 28-44.

Neff, K. D., & McGehee, P. (2010). Self-compassion and psychological resilience among adolescents and young adults. *Self and identity, 9*(3), 225-240.

Neff, K. D., Pisitsungkagarn, K., & Hsieh, Y.-P. (2008). Self-compassion and self-construal in the United States, Thailand, and Taiwan. *Journal of Cross-Cultural Psychology, 39*(3), 267-285.

Negele, A., Kaufhold, J., Kallenbach, L., & Leuzinger-Bohleber, M. (2015). Childhood trauma and its relation to chronic depression in adulthood. *Depression research and treatment*.

Nery-Hurwit, M., Yun, J., & Ebbeck, V. (2018). Examining the roles of self-compassion and resilience on health-related quality of life for individuals with Multiple Sclerosis. *Disability and Health Journal, 11*(2), 256-261.

Nesi, J., Miller, A. B., & Prinstein, M. J. (2017). Adolescents' depressive symptoms and subsequent technology-based interpersonal behaviors: A multi-wave study. *Journal of Applied Developmental Psychology, 51*, 12-19.

Odou, N., & Brinker, J. (2014). Exploring the relationship between rumination, self-compassion, and mood. *Self and identity, 13*(4), 449-459.

Olenik-Shemesh, D., Heiman, T., & Eden, S. (2012). Cyberbullying victimisation in adolescence: Relationships with loneliness and depressive mood. *Emotional and behavioural difficulties, 17*(3-4), 361-374.

Olweus, D. (1994). Bullying at school: basic facts and effects of a school based intervention program. *Journal of child psychology and psychiatry, 35*(7), 1171-1190.

Olweus, D. (2012). Cyberbullying: An overrated phenomenon? *European journal of developmental psychology, 9*(5), 520-538.

Oxford University Press. (Ed.) (n.d.-a) Bully. Retrieved from https://www.lexico.com/definition/bully.

Oxford University Press. (Ed.) (n.d.-b) Resilient Retrieved from https://www.lexico.com/definition/resilient.

Papmeyer, M., Sussmann, J. E., Stewart, T., Giles, S., Centola, J. G., Zannias, V., . . . McIntosh, A. M. (2016). Prospective longitudinal study of subcortical brain volumes in individuals at high familial risk of mood disorders with or without

subsequent onset of depression. *Psychiatry Research: Neuroimaging, 248*, 119-125.

Pariante, C. M., & Lightman, S. L. (2008). The HPA axis in major depression: classical theories and new developments. *Trends in neurosciences, 31*(9), 464-468.

Parker, K. J., Schatzberg, A. F., & Lyons, D. M. (2003). Neuroendocrine aspects of hypercortisolism in major depression. *Hormones and behavior, 43*(1), 60-66.

Patchin, J. W., & Hinduja, S. (2010). Cyberbullying and self-esteem. *Journal of school health, 80*(12), 614-621.

Peets, K., Hodges, E. V., & Salmivalli, C. (2008). Affect-congruent social-cognitive evaluations and behaviors. *Child development, 79*(1), 170-185.

Perales-Blum, L., Juárez-Treviño, M., Capetillo-Ventura, N., Rodríguez-Gutiérrez, G., Valdés-Adamchik, M., Trevino-Trevino, J., & Cáceres-Vargas, M. (2015). Association between bullying and major depressive disorder in a psychiatric consultation. *Medicina universitaria, 17*(67), 75-79.

Perren, S., & Alsaker, F. D. (2006). Social behavior and peer relationships of victims, bully-victims, and bullies in kindergarten. *Journal of child psychology and psychiatry, 47*(1), 45-57.

Petersen, A. C., Compas, B. E., Brooks-Gunn, J., Stemmler, M., Ey, S., & Grant, K. E. (1993). Depression in adolescence. *American psychologist, 48*(2), 155-168.

Poole, J. C., Dobson, K. S., & Pusch, D. (2017). Childhood adversity and adult depression: the protective role of psychological resilience. *Child abuse & neglect, 64*, 89-100.

Pornkosonsirilert, T., Audboon, S., & Laemsak, O. (2017). *The relationship among self-compassion, stress, self- efficacy, subjective well-being and school burnout in high school students: Senior project psychology*. Bangkok: Faculty of Psychology, Chulalongkorn University.

Pouwelse, M., Bolman, C., Lodewijkx, H., & Spaa, M. (2011). Gender differences and social support: Mediators or moderators between peer victimization and depressive feelings? *Psychology in the Schools, 48*(8), 800-814.

Povedano, A., Cava, M.-J., Monreal, M.-C., Varela, R., & Musitu, G. (2015). Victimization,

loneliness, overt and relational violence at the school from a gender perspective. *International Journal of Clinical and Health Psychology, 15*(1), 44-51.

Puranachaikere, T., Punyapas, S., & Kaewpornsawan, T. (2015). Coping Strategies of Grade 4-6 Primary School Students in Response to Being Bullied. *Journal of the Psychiatric Association of Thailand, 60*(4), 275-286.

Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the self-compassion scale. *Clinical psychology & psychotherapy, 18*(3), 250-255.

Reed, K. P., Nugent, W., & Cooper, R. L. (2015). Testing a path model of relationships between gender, age, and bullying victimization and violent behavior, substance abuse, depression, suicidal ideation, and suicide attempts in adolescents. *Children and Youth Services Review, 55*, 128-137.

Roelofs, J., Huibers, M., Peeters, F., & Arntz, A. (2008). Effects of neuroticism on depression and anxiety: Rumination as a possible mediator. *Personality and Individual Differences, 44*(3), 576-586.

Rudolph, K. D., Lansford, J. E., Agoston, A. M., Sugimura, N., Schwartz, D., Dodge, K. A., . . . Bates, J. E. (2014). Peer victimization and social alienation: Predicting deviant peer affiliation in middle school. *Child development, 85*(1), 124-139.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American journal of orthopsychiatry, 57*(3), 316-331.

Rutter, M. (1999). Resilience concepts and findings: Implications for family therapy. *Journal of family therapy, 21*(2), 119-144.

Sagone, E., & De Caroli, M. E. (2013). Relationships between resilience, self-efficacy, and thinking styles in Italian middle adolescents. *Procedia-Social and Behavioral Sciences, 92*, 838-845.

Salmivalli, C. (2010). Bullying and the peer group: A review. *Aggression and violent behavior, 15*(2), 112-120.

Salmivalli, C., & Kaukiainen, A. (2004). "Female aggression" revisited: Variable-and person-centered approaches to studying gender differences in different types of

aggression. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression, 30*(2), 158-163.

Saluja, G., Iachan, R., Scheidt, P. C., Overpeck, M. D., Sun, W., & Giedd, J. N. (2004). Prevalence of and risk factors for depressive symptoms among young adolescents. *Archives of pediatrics & adolescent medicine, 158*(8), 760-765.

Sapouna, M., & Wolke, D. (2013). Resilience to bullying victimization: The role of individual, family and peer characteristics. *Child abuse & neglect, 37*(11), 997-1006.

Sbarra, D. A., Smith, H. L., & Mehl, M. R. (2012). When leaving your ex, love yourself: Observational ratings of self-compassion predict the course of emotional recovery following marital separation. *Psychological Science, 23*(3), 261-269.

Scheithauer, H., Hayer, T., Petermann, F., & Jugert, G. (2006). Physical, verbal, and relational forms of bullying among German students: Age trends, gender differences, and correlates. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression, 32*(3), 261-275.

Seligman, M. E. (1972). Learned helplessness. *Annual review of medicine, 23*(1), 407-412.

Serra-Negra, J. M., Paiva, S. M., Bendo, C. B., Fulgêncio, L. B., Lage, C. F., Corrêa-Faria, P., & Pordeus, I. A. (2015). Verbal school bullying and life satisfaction among Brazilian adolescents: Profiles of the aggressor and the victim. *Comprehensive Psychiatry, 57*, 132-139.

Shapero, B. G., Black, S. K., Liu, R. T., Klugman, J., Bender, R. E., Abramson, L. Y., & Alloy, L. B. (2014). Stressful life events and depression symptoms: the effect of childhood emotional abuse on stress reactivity. *Journal of clinical psychology, 70*(3), 209-223.

Shapira, L. B., & Mongrain, M. (2010). The benefits of self-compassion and optimism exercises for individuals vulnerable to depression. *The Journal of Positive Psychology, 5*(5), 377-389.

Shetgiri, R. (2013). Bullying and victimization among children. *Advances in pediatrics, 60*(1), 33-51.

Sijtsema, J. J., Veenstra, R., Lindenberg, S., & Salmivalli, C. (2009). Empirical test of

bullies' status goals: Assessing direct goals, aggression, and prestige. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression, 35*(1), 57-67.

Sittichai, R., & Smith, P. K. (2018). Bullying and cyberbullying in Thailand: Coping strategies and relation to age, gender, religion and victim status. *Journal of New Approaches in Educational Research, 7*(1), 24-30.

Smeets, E., Neff, K., Alberts, H., & Peters, M. (2014). Meeting suffering with kindness: Effects of a brief self-compassion intervention for female college students. *Journal of clinical psychology, 70*(9), 794-807.

Smith, P. K., Mahdavi, J., Carvalho, M., Fisher, S., Russell, S., & Tippett, N. (2008). Cyberbullying: Its nature and impact in secondary school pupils. *Journal of child psychology and psychiatry, 49*(4), 376-385.

Solberg, M. E., & Olweus, D. (2003). Prevalence estimation of school bullying with the Olweus Bully/Victim Questionnaire. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression, 29*(3), 239-268.

Songsiri, N., & Musikaphan, W. (2011). Cyber-bullying among secondary and vocational students in Bangkok. *Journal of Population and Social Studies [JPSS], 19*(2), 235-242.

Stapinski, L. A., Araya, R., Heron, J., Montgomery, A. A., & Stallard, P. (2015). Peer victimization during adolescence: Concurrent and prospective impact on symptoms of depression and anxiety. *Anxiety, Stress, & Coping, 28*(1), 105-120.

Stark, K. D., Schmidt, K. L., & Joiner, T. E. (1996). Cognitive triad: Relationship to depressive symptoms, parents' cognitive triad, and perceived parental messages. *Journal of abnormal child psychology, 24*(5), 615-631.

Strohacker, E., Wright, L. E., & Watts, S. J. (2019). Gender, bullying victimization, depressive symptoms, and suicidality. *International journal of offender therapy and comparative criminology*, 0306624X19895964.

Strøm, I. F., Aakvaag, H. F., Birkeland, M. S., Felix, E., & Thoresen, S. (2018). The mediating role of shame in the relationship between childhood bullying victimization and adult psychosocial adjustment. *European journal of*

psychotraumatology, 9(1), 1418570.

Tapanya, S. (2007). Study to develop a sustainable violence prevention model in children. *National health foundation supported by Thai health promotion foundation*.

Torres, F. (2020). What Is Depression? , from Retrieved from https://www.psychiatry.org/patients-families/depression/what-is-depression

Trompetter, H. R., de Kleine, E., & Bohlmeijer, E. T. (2017). Why does positive mental health buffer against psychopathology? An exploratory study on self-compassion as a resilience mechanism and adaptive emotion regulation strategy. *Cognitive Therapy and Research, 41*(3), 459-468.

Tsaousis, I. (2016). The relationship of self-esteem to bullying perpetration and peer victimization among schoolchildren and adolescents: A meta-analytic review. *Aggression and violent behavior, 31*, 186-199.

Turner, M. G., Exum, M. L., Brame, R., & Holt, T. J. (2013). Bullying victimization and adolescent mental health: General and typological effects across sex. *Journal of Criminal Justice, 41*(1), 53-59.

Vaillancourt, T., Hymel, S., & McDougall, P. (2013). The biological underpinnings of peer victimization: Understanding why and how the effects of bullying can last a lifetime. *Theory into Practice, 52*(4), 241-248.

van Geel, M., Goemans, A., & Vedder, P. (2015). A meta-analysis on the relation between peer victimization and adolescent non-suicidal self-injury. *Psychiatry research, 230*(2), 364-368.

van Geel, M., Goemans, A., & Vedder, P. H. (2016). The relation between peer victimization and sleeping problems: A meta-analysis. *Sleep medicine reviews, 27*, 89-95.

Varghese, F. P., & Brown, E. S. (2001). The hypothalamic-pituitary-adrenal axis in major depressive disorder: a brief primer for primary care physicians. *Primary care companion to the Journal of clinical psychiatry, 3*(4), 151.

Villora, B., Larrañaga, E., Yubero, S., Alfaro, A., & Navarro, R. (2020). Relations among poly-bullying victimization, subjective well-being and resilience in a sample of late adolescents. *International journal of environmental research and public*

health, 17(2), 590.

Waasdorp, T. E., & Bradshaw, C. P. (2015). The overlap between cyberbullying and traditional bullying. *Journal of adolescent health, 56*(5), 483-488.

Wang, J., Iannotti, R. J., & Luk, J. W. (2011). Peer victimization and academic adjustment among early adolescents: Moderation by gender and mediation by perceived classmate support. *Journal of school health, 81*(7), 386-392.

Wang, J., Iannotti, R. J., & Nansel, T. R. (2009). School bullying among adolescents in the United States: Physical, verbal, relational, and cyber. *Journal of adolescent health, 45*(4), 368-375.

Williams, S. G., Langhinrichsen-Rohling, J., Wornell, C., & Finnegan, H. (2017). Adolescents transitioning to high school: Sex differences in bullying victimization associated with depressive symptoms, suicide ideation, and suicide attempts. *The Journal of School Nursing, 33*(6), 467-479.

Wilson, A. C., Mackintosh, K., Power, K., & Chan, S. W. (2019). Effectiveness of self-compassion related therapies: a systematic review and meta-analysis. *Mindfulness, 10*(6), 979-995.

Wolke, D., Woods, S., Bloomfield, L., & Karstadt, L. (2000). The association between direct and relational bullying and behaviour problems among primary school children. *Journal of child psychology and psychiatry, 41*(8), 989-1002.

Xia, J., He, Q., Li, Y., Xie, D., Zhu, S., Chen, J., . . . Chen, C. (2011). The relationship between neuroticism, major depressive disorder and comorbid disorders in Chinese women. *Journal of affective disorders, 135*(1-3), 100-105.

Yang, Y., Zhang, M., & Kou, Y. (2016). Self-compassion and life satisfaction: The mediating role of hope. *Personality and Individual Differences, 98*, 91-95.

Zadeh, Z. F., & Lateef, M. (2012). Effect of cognitive behavioural therapy (CBT) on depressed female university students in Karachi. *Procedia-Social and Behavioral Sciences, 69*, 798-806.

Zhang, H., Carr, E. R., Garcia-Williams, A. G., Siegelman, A. E., Berke, D., Niles-Carnes, L. V., . . . Kaslow, N. J. (2018). Shame and depressive symptoms: Self-compassion and contingent self-worth as mediators? *Journal of clinical psychology in medical settings, 25*(4), 408-419.

Zhang, H., Chi, P., Long, H., & Ren, X. (2019). Bullying victimization and depression among left-behind children in rural China: Roles of self-compassion and hope. *Child abuse & neglect, 96*, 104072.

Zhang, H., & Wang, Y. (2019). Bullying victimization and depression among young Chinese adults with physical disability: Roles of gratitude and self-compassion. *Children and Youth Services Review, 103*, 51-56.

Zhang, H., Watson-Singleton, N. N., Pollard, S. E., Pittman, D. M., Lamis, D. A., Fischer, N. L., . . . Kaslow, N. J. (2019). Self-criticism and depressive symptoms: Mediating role of self-compassion. *OMEGA-Journal of Death and Dying, 80*(2), 202-223.

Zhou, Z.-K., Liu, Q.-Q., Niu, G.-F., Sun, X.-J., & Fan, C.-Y. (2017). Bullying victimization and depression in Chinese children: A moderated mediation model of resilience and mindfulness. *Personality and Individual Differences, 104*, 137-142.

Zolkoski, S. M., & Bullock, L. M. (2012). Resilience in children and youth: A review. *Children and Youth Services Review, 34*(12), 2295-2303.

APPENDIX

Appendix A

IRB Approval Documents

คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน กลุ่มสหสถาบัน ชุดที่ 1 จุฬาลงกรณ์มหาวิทยาลัย
254 อาคารจามจุรี 1 ชั้น 2 ถนนพญาไท เขตปทุมวัน กรุงเทพฯ 10330
โทรศัพท์: 0-2218-3202, 0-2218-3049 E-mail: eccu@chula.ac.th

COA No. 046/2563

ใบรับรองโครงการวิจัย

โครงการวิจัยที่ 254.1/62 : อิทธิพลของการตกเป็นเหยื่อการกลั่นแกล้งรังแกต่อภาวะซึมเศร้าโดยมีความเมตตากรุณาต่อตนเองและความสามารถในการฟื้นพลังเป็นตัวแปรส่งผ่าน

ผู้วิจัยหลัก : นางสาวอันชิษฐา บวรกิตติกุล

หน่วยงาน : คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย

คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน กลุ่มสหสถาบัน ชุดที่ 1 จุฬาลงกรณ์มหาวิทยาลัย ได้พิจารณาโดยใช้หลักของ Belmont Report 1979, Declaration of Helsinki 2013, Council for International Organizations of Medical Sciences (CIOM) 2016, มาตรฐานคณะกรรมการจริยธรรมการวิจัยในคน (มคจค.) 2556, นโยบายแห่งชาติและแนวทางปฏิบัติการวิจัยในมนุษย์ 2558 อนุมัติให้ดำเนินการศึกษาวิจัยเรื่องดังกล่าวได้

ลงนาม.....
(รองศาสตราจารย์ นายแพทย์ปรีดา ทัศนประดิษฐ)
ประธาน

ลงนาม.....
(รองศาสตราจารย์ ดร.นันทรี ชัยชนะวงศาโรจน์)
กรรมการและเลขานุการ

วันที่รับรอง : 4 กุมภาพันธ์ 2563 **วันหมดอายุ** : 3 กุมภาพันธ์ 2564

เอกสารที่คณะกรรมการรับรอง

1) โครงการวิจัย
2) เอกสารข้อมูลสำหรับผู้มีส่วนร่วมในการวิจัยและหนังสือแสดงความยินยอมของผู้มีส่วนร่วมในการวิจัย (โครงการวิจัยนี้ได้รับการยกเว้นการลงนามแสดงความยินยอมเข้าร่วมงานวิจัยจากผู้มีส่วนร่วมในการวิจัย)
3) ผู้วิจัย
4) แบบสอบถาม
5) ใบประชาสัมพันธ์

เลขที่โครงการวิจัย 254.1/62
วันที่รับรอง - 4 ก.พ. 2563
วันหมดอายุ - 3 ก.พ. 2564

เงื่อนไข

1. ข้าพเจ้ารับทราบว่าเป็นการฝิดจริยธรรม หากดำเนินการเก็บข้อมูลการวิจัยก่อนได้รับการอนุมัติจากคณะกรรมการพิจารณาจริยธรรมการวิจัยฯ
2. หากใบรับรองโครงการวิจัยหมดอายุ การดำเนินการวิจัยต้องยุติ เมื่อต้องการต่ออายุต้องขออนุมัติใหม่ล่วงหน้าไม่ต่ำกว่า 1 เดือน พร้อมส่งรายงานความก้าวหน้าการวิจัย
3. ต้องดำเนินการวิจัยตามที่ระบุไว้ในโครงการวิจัยอย่างเคร่งครัด
*4. ใช้เอกสารข้อมูลสำหรับกลุ่มประชากรหรือผู้มีส่วนร่วมในการวิจัย ใบยินยอมของกลุ่มประชากรหรือผู้มีส่วนร่วมในการวิจัย และเอกสารเชิญเข้าร่วมวิจัย (ถ้ามี) **เฉพาะที่ประทับตราคณะกรรมการเท่านั้น***
5. หากเกิดเหตุการณ์ไม่พึงประสงค์ร้ายแรงในสถานที่เก็บข้อมูลที่ขออนุมัติจากคณะกรรมการ ต้องรายงานคณะกรรมการภายใน 5 วันทำการ
6. หากมีการเปลี่ยนแปลงการดำเนินการวิจัย ให้ส่งคณะกรรมการพิจารณารับรองก่อนดำเนินการ
7. โครงการวิจัยไม่เกิน 1 ปี ส่งแบบรายงานสิ้นสุดโครงการวิจัย (AF 02-14) และบทคัดย่อผลการวิจัยภายใน 30 วัน เมื่อโครงการวิจัยเสร็จสิ้น สำหรับโครงการวิจัยที่เป็นวิทยานิพนธ์ให้ส่งบทคัดย่อผลการวิจัย ภายใน 30 วัน เมื่อโครงการวิจัยเสร็จสิ้น

บันทึกข้อความ

ส่วนงาน คณะกรรมการพิจารณาจริยธรรมการวิจัยในคน กลุ่มสหสถาบัน ชุดที่ 1 โทร.0-2218-3202
ที่ จว. 142 /2563 วันที่ 26 มิถุนายน 2563
เรื่อง แจ้งผลอนุมัติการแก้ไขเพิ่มเติมโครงการวิจัย

เรียน คณบดีคณะจิตวิทยา

สิ่งที่ส่งมาด้วย 1.บันทึกแจ้งผลการอนุมัติแก้ไขเพิ่มเติมโครงการวิจัย

2. เอสารข้อมูลกลุ่มประชากร

3. แบบสอบถาม

ตามที่ **นางสาวอันชิษฐา บวรกิตติกุล** นิสิตระดับมหาบัณฑิต คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ได้เสนอโครงการวิจัยที่ 254.1/62 เรื่อง **อิทธิพลของการตกเป็นเหยื่อการกลั่นแกล้งรังแกต่อภาวะซึมเศร้า โดยมีความเมตตากรุณาต่อตนเองและความสามารถในการฝึกพลังเป็นตัวแปรส่งผ่าน** (INFLUENCE OF BULLY VICTIMIZATION ON DEPRESSIVE MOOD WITH SELF-COMPASSION AND RESILIENCE AS MEDIATORS) เพื่อให้กรรมการผู้ทบทวนหลักพิจารณาการแก้ไขเพิ่มเติมโครงการวิจัย ความละเอียดแจ้งแล้วนั้น

การนี้ กรรมการผู้ทบทวนหลัก ได้เห็นสมควรอนุมัติการแก้ไขเพิ่มเติมโครงการวิจัยเมื่อวันที่ 21 มิถุนายน 2562

จึงเรียนมาเพื่อโปรดทราบ

เรียน ผอ.ฝ่ายวิชาการ
จึงเรียนมาเพื่อโปรด
ø ทราบ
O พิจารณา
ลงชื่อ.....

(รองศาสตราจารย์ ดร.นันทรี ชัยชนะวงศาโรจน์)
กรรมการและเลขานุการคณะกรรมการ
พิจารณาจริยธรรมการวิจัยในคน
กลุ่มสหสถาบัน ชุดที่ 1 จุฬาลงกรณ์มหาวิทยาลัย

เรียน คุณวัลลภ
เพื่อโปรดแจ้ง นิสิต/อาจารย์

(น.ส.เวณิกา บวรสิน)
ผู้อำนวยการฝ่ายวิชาการ
20 ก.ค. 2563

Appendix B

Permission to use the instruments

ศูนย์ประเมินทางจิตวิทยา คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย

แบบฟอร์มขอใช้มาตรวัด

① เรียน คณบดี คณะจิตวิทยา

ข้าพเจ้า นางสาว อันธิฐา บวโกศลกุล

☑ นิสิตนักศึกษา เลขประจำตัว 6077142138 ระดับการศึกษา ☐ปริญญาตรี ☑ ปริญญาโท ☐ ปริญญาเอก

คณะ จิตวิทยา มหาวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย

อาจารย์ที่ปรึกษา ผศ. ดร. กุลยา พิสิษฐ์สิงฆกาย

☐ อาจารย์ คณะ มหาวิทยาลัย

☐ ผู้สนใจ หน่วยงาน

ที่อยู่ปัจจุบัน เลขที่ 259/17 ถนน ประดิษฐ์มนูธรรม ซอย ตำบล/แขวง ลาดพร้าว

อำเภอ/เขต ลาดพร้าว จังหวัด กรุงเทพฯ รหัสไปรษณีย์ 10230

โทรศัพท์ที่ติดต่อได้ 085-9451545 อีเมล์ anchidha.kat@gmail.com

มีความประสงค์จะขอใช้มาตรวัด

ชื่อมาตรวัด มาตรวัดความสามารถในการฟื้นพลัง ชื่อผู้พัฒนามาตรวัด ณรงค์ กิตติสุนทร

จากวิทยานิพนธ์/งานวิจัยเรื่อง ผลของกลุ่มการปรึกษาเชิงจิตวิทยาแนวปัญญาพุทธต่อการเพิ่มความสามารถในการฟื้นพลัง และความสามารถในการทำงานอย่างมีประสิทธิผลในวัยเด็กตอนกลาง

ชื่ออาจารย์ที่ปรึกษาของผู้พัฒนามาตรวัด (ในกรณีที่มาจากวิทยานิพนธ์ โปรดระบุชื่ออาจารย์ที่ปรึกษาวิทยานิพนธ์ของผู้พัฒนามาตรวัด) ผศ. ดร. กุลยา พิสิษฐ์สิงฆกาย ปี พ.ศ. 2559

วัตถุประสงค์ของการใช้งาน ☐ โครงงานทางจิตวิทยา ☐ การวิจัย ☑ วิทยานิพนธ์

☐ การเรียนการสอน ☐ อื่น ๆ โปรดระบุ .....

จึงเรียนมาเพื่อขอความอนุเคราะห์ จักเป็นพระคุณยิ่ง

ขอแสดงความนับถือ

ลงนามผู้ขอใช้มาตรวัด อันธิฐา

วันที่ 25 / 10 / 2019

② อาจารย์ที่ปรึกษาของผู้ขอใช้มาตร (ในกรณีที่ผู้ขอใช้มาตรเป็นนิสิตนักศึกษา)

ให้ผ่านการพิจารณา

ลงนาม

วันที่ 25 / 10 / 2019

③ ศูนย์ประเมินทางจิตวิทยาตรวจสอบ

☑ สมควรดำเนินการ

☐ ไม่สมควรดำเนินการ เพราะ .....

ลงนาม

วันที่ 30 ต.ค. 2562

④ อาจารย์ที่ปรึกษาของผู้พัฒนามาตรวัด (ในกรณีที่เป็นวิทยานิพนธ์) / เจ้าของผลงาน (ในกรณีที่เป็นงานวิจัย)

☑ อนุญาต

☐ ไม่อนุญาต เพราะ .....

ลงนาม

วันที่ 25 / 10 / 2019

⑤ คณบดี คณะจิตวิทยา

☑ อนุมัติ

☐ ไม่อนุมัติ

ลงนาม

วันที่ 30 ต.ค. 2562

สัญญาขอใช้มาตรวัดทางจิตวิทยา

คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ประจำปีงบประมาณ พ.ศ. 2562

สัญญาฉบับนี้ทำขึ้น ณ คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ตั้งอยู่ที่อาคารบรมราชชนนีศรีศตพรรษ ชั้น 7 ถนนพญาไท แขวงวังใหม่ เขตปทุมวัน กรุงเทพมหานคร เมื่อวันที่ 25 เดือน ตุลาคม พ.ศ. 2562 ระหว่าง คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย โดย ผู้ช่วยศาสตราจารย์ ดร.พรรณระพี สุทธิวรรณ ตำแหน่ง คณบดีคณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ซึ่งต่อไปในสัญญาฉบับนี้ จะเรียกว่า "ผู้อนุมัติให้ใช้มาตรวัด" ฝ่ายหนึ่งกับ (นาย/นาง/นางสาว) อันชิษฐา บวงกิตติกุล เลขประจำตัวนิสิต 6037626338 ระดับปริญญา ไท คณะ จิตวิทยา มหาวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย อาจารย์ที่ปรึกษา ผศ.ดร. กุลยา พิสิษฐ์สังฆการ เข้าศึกษาเมื่อปีการศึกษา 2560 สาขาวิชา จิตวิทยาการปรึกษา เลขประจำตัวประจำตัวประชาชน 1103701452374 ที่อยู่ปัจจุบัน 259/1 หมู่ 4 ถนน ประชาชื่นพัฒนา แขวง/ตำบล ลาดพร้าว เขต/อำเภอ ลาดพร้าว จังหวัด กรุงเทพฯ รหัสไปรษณีย์ 10230 หมายเลขโทรศัพท์ 085-9451545 ซึ่งต่อไปในสัญญานี้ จะเรียกว่า "ผู้ขอใช้มาตรวัดทางจิตวิทยา" อีกฝ่ายหนึ่ง มีความประสงค์จะขอใช้มาตรวัด ชื่อมาตรวัด ความสามารถในการฟื้นพลัง

ชื่อผู้พัฒนามาตรวัด ดวงพร กิตติสุนทร

จากวิทยานิพนธ์/งานวิจัยเรื่อง ผลของกลุ่มการปรึกษาเชิงจิตวิทยาแนวปัญญาพฤติกรรมนิยมต่อความสามารถในการฟื้นพลัง และความสามารถในการกำกับตนเองในวัยเด็กตอนกลาง

ชื่ออาจารย์ที่ปรึกษาของผู้พัฒนามาตรวัด (ในกรณีที่มาจากวิทยานิพนธ์ โปรดระบุชื่ออาจารย์ที่ปรึกษาวิทยานิพนธ์ของผู้พัฒนามาตรวัด) ผศ.ดร. กุลยา พิสิษฐ์สังฆการ ปี พ.ศ. 2559

วัตถุประสงค์ของการใช้งาน ☐ โครงงานทางจิตวิทยา ☐ การวิจัย ☑ วิทยานิพนธ์ ☐ การเรียนการสอน

☐ อื่น ๆ โปรดระบุ .....

ผู้ขอใช้มาตรวัดทางจิตวิทยายินยอมตามข้อตกลง ดังนี้

1. มาตรวัดทางจิตวิทยาเป็นลิขสิทธิ์ของคณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย

2. ผู้ขอใช้มาตรวัดทางจิตวิทยาได้รับต้นฉบับและ/หรือไฟล์ต้นฉบับของมาตรวัดและวิธีคิดคะแนน และยินดีปฏิบัติตามข้อตกลงในสัญญา ดังนี้

2.1 ผู้ขอใช้มาตรวัดทางจิตวิทยาจะต้องนำมาตรวัดทางจิตวิทยานี้ไปใช้เพื่อประโยชน์ในการศึกษาวิจัยเท่านั้น

2.2 การอนุญาตให้ใช้มาตรวัดอนุญาตเฉพาะครั้งนี้เท่านั้นที่ขอมา

2.3 ผู้ขอใช้มาตรวัดทางจิตวิทยาจะไม่เปิดเผยหรือนำมาตรวัดทางจิตวิทยานี้ไปใช้ประโยชน์ต่อ ไม่ว่าจะนำไปใช้ประโยชน์ทางตรงหรือทางอ้อม เพื่อประโยชน์ของตนเองหรือผู้อื่น นำไปใช้ในเชิงพาณิชย์ หรือนำไปใช้เพื่อการอื่นใด ซึ่งข้อมูลหรือเอกสารใดๆ ไม่ว่าจะเป็นบันทึกหรือจัดเก็บในรูปแบบใด

2.4 ผู้ขอใช้มาตรวัดทางจิตวิทยาจะต้องระบุรายการอ้างอิงของมาตรวัดนี้ที่ได้รับอนุญาตจากคณะจิตวิทยาให้ถูกต้องในรายงานการวิจัยและ/หรือวิทยานิพนธ์ ตลอดจนการตีพิมพ์ผลงานลงในเอกสารใดๆ ที่นำมาตรวัดนี้ไปใช้ และส่งสำเนาหรือไฟล์ .pdf มาทางอีเมล์ โดยแจ้งให้ศูนย์ประเมินทางจิตวิทยา คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ทราบเป็นลายลักษณ์อักษรทุกครั้ง

2.5 หลังจากนำมาตรวัดนี้ไปใช้ในการเก็บข้อมูลและรวบรวมข้อมูลสำหรับวิทยานิพนธ์และ/หรืองานวิจัยในครั้งนี้เสร็จสิ้นแล้ว เพื่อให้คณะจิตวิทยามีข้อมูลเกี่ยวกับมาตรวัดที่นำไปใช้และไว้ใช้ประโยชน์ในการศึกษามาตรวัดนี้ต่อไป ผู้ขอใช้มาตรวัดทางจิตวิทยาจะต้องส่งรายงาน 1 เล่ม ในรูปแบบของไฟล์ word และรูปเล่ม 1 ฉบับ ที่ศูนย์ประเมินทางจิตวิทยา ประกอบด้วย

2.5.1 ข้อมูลพื้นฐานของกลุ่มตัวอย่างที่ได้นำมาตรวัดนี้ไปใช้

2.5.2 การหาคุณภาพของเครื่องมือ ความเที่ยงและความตรง (หากมี)

2.6 การอ้างอิงมาตรวัดทางจิตวิทยานี้ในเล่ม ส่วนของภาคผนวก ไม่อนุญาตให้ผู้ขอใช้มาตรวัดทางจิตวิทยานำมาตรวัดฉบับเต็มไปใส่ในเล่มวิทยานิพนธ์และ/หรืองานวิจัย อนุญาตให้ใส่เพียงตัวอย่างเป็นข้อ ๆ ด้านละไม่เกิน 3 ข้อ

3. การระงับการขอใช้มาตรวัดทางจิตวิทยา จะระงับเมื่อ

3.1 ผู้ขอใช้มาตรวัดทางจิตวิทยาไม่ปฏิบัติตามข้อตกลงในสัญญาฉบับนี้ ตามข้อ 1- ข้อ 3 โดยไม่มีเหตุอันสมควรและไม่ได้แจ้งให้ศูนย์ประเมินทางจิตวิทยา คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ทราบเป็นลายลักษณ์อักษร

3.2 คณะกรรมการบริหารศูนย์ประเมินทางจิตวิทยาพิจารณาเห็นสมควรให้ระงับ

4. คณะจะไม่รับผิดชอบการละเมิดลิขสิทธิ์ทางปัญญา และคณะจะดำเนินการตามกฎหมายต่อไปจนถึงที่สุด

สัญญาฉบับนี้ทำขึ้นเป็น 3 ฉบับ มีข้อความตรงกันทุกประการ ต้นฉบับเก็บที่ผู้ขอใช้มาตรวัดทางจิตวิทยา คู่ฉบับ 1 ฉบับ เก็บที่ศูนย์ประเมินทางจิตวิทยา คู่ฉบับอีก 1 ฉบับ ให้อาจารย์ที่ปรึกษาของนิสิต/นักศึกษา

ข้าพเจ้าได้รับทราบข้อความข้างต้นโดยตลอดแล้ว และยินดีจะปฏิบัติตามทุกประการ หากข้าพเจ้าไม่ปฏิบัติตามข้อตกลงที่ให้ไว้ ข้าพเจ้ายินดีให้คณะจิตวิทยาดำเนินการระงับการอนุญาตให้ใช้มาตรวัดทางจิตวิทยาได้

ลงนาม [illegible] ผู้ขอใช้มาตรวัด

([illegible])

วันที่ 25 เดือน ตุลาคม พ.ศ. 2562

ลงนาม ______________

อาจารย์ที่ปรึกษาของผู้ใช้มาตรวัด

([illegible])

วันที่ 25 เดือน ตุลาคม พ.ศ. 2562

(กรณีนำไปใช้ในวิทยานิพนธ์)

ลงนาม ______________ คณบดี

(ผู้ช่วยศาสตราจารย์ ดร.พรรณระพี สุทธิวรรณ)

30 ต.ค. 2562

วันที่ ____ เดือน ____ พ.ศ. ____

ศูนย์ประเมินทางจิตวิทยา คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย

แบบฟอร์มขอใช้มาตรวัด

① เรียน คณบดี คณะจิตวิทยา

ข้าพเจ้า นางสาว อันธิษฐา บวงโกฏกุล

☑ นิสิตนักศึกษา เลขประจำตัว 6077624338 ระดับการศึกษา ☐ปริญญาตรี ☑ ปริญญาโท ☐ ปริญญาเอก

คณะ จิตวิทยา มหาวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย

อาจารย์ที่ปรึกษา ผศ. ดร. กุลยา พิสิษฐ์สังฆการ

☐ อาจารย์ คณะ มหาวิทยาลัย

☐ ผู้สนใจ หน่วยงาน

ที่อยู่ปัจจุบัน เลขที่ 2541/7 ถนน ประดิษฐ์มนูธรรม ซอย ตำบล/แขวง ลาดพร้าว

อำเภอ/เขต ลาดพร้าว จังหวัด กรุงเทพฯ รหัสไปรษณีย์ 10230

โทรศัพท์ที่ติดต่อได้ 085-9451545 อีเมล์ anchid.ba.kat@gmail.com

มีความประสงค์จะขอใช้มาตรวัด

ชื่อมาตรวัด มาตรวัดความสามารถในการฟื้นพลัง ชื่อผู้พัฒนามาตรวัด ดร.พร ภิญโญกุลชาย

จากวิทยานิพนธ์/งานวิจัยเรื่อง ผลของกลุ่มการปรึกษาเชิงจิตวิทยาแนวปัญญาพฤติกรรมนิยมต่อความสามารถในการฟื้นพลัง และความสามารถในการกำกับอารมณ์ในวัยเด็กตอนกลาง

ชื่ออาจารย์ที่ปรึกษาของผู้พัฒนามาตรวัด (ในกรณีที่มาจากวิทยานิพนธ์ โปรดระบุชื่ออาจารย์ที่ปรึกษาวิทยานิพนธ์ของผู้พัฒนามาตรวัด) ผศ. ดร. กุลยา พิสิษฐ์สังฆการ ปี พ.ศ. 2559

วัตถุประสงค์ของการใช้งาน ☐ โครงงานทางจิตวิทยา ☐ การวิจัย ☑ วิทยานิพนธ์

☐ การเรียนการสอน ☐ อื่น ๆ โปรดระบุ .....

จึงเรียนมาเพื่อขอความอนุเคราะห์ จักเป็นพระคุณยิ่ง

ขอแสดงความนับถือ

ลงนามผู้ขอใช้มาตรวัด อันธิษฐา

วันที่ 25 / 10 / 2019

② อาจารย์ที่ปรึกษาของผู้ขอใช้มาตร
(ในกรณีที่ผู้ขอใช้มาตรเป็นนิสิตนักศึกษา)

เห็นควรให้ดำเนินการ

ลงนาม

วันที่ 25 / 10 / 2019

③ ศูนย์ประเมินทางจิตวิทยาตรวจสอบ

☑ สมควรดำเนินการ

☐ ไม่สมควรดำเนินการ เพราะ.....

ลงนาม

วันที่ 30 ต.ค. 2562

④ อาจารย์ที่ปรึกษาของผู้พัฒนามาตรวัด (ในกรณีที่เป็นวิทยานิพนธ์) / เจ้าของผลงาน (ในกรณีที่เป็นงานวิจัย)

☑ อนุญาต

☐ ไม่อนุญาต เพราะ.....

ลงนาม

วันที่ 25 / 10 / 2019

⑤ คณบดี คณะจิตวิทยา

☑ อนุมัติ

☐ ไม่อนุมัติ

ลงนาม

วันที่ 30 ต.ค. 2562

สัญญาขอใช้มาตรวัดทางจิตวิทยา

คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ประจำปีงบประมาณ พ.ศ. .....2562.....

สัญญาฉบับนี้ทำขึ้น ณ คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ตั้งอยู่ที่อาคารบรมราชชนนีศรีศตพรรษ ชั้น 7 ถนนพญาไท แขวงวังใหม่ เขตปทุมวัน กรุงเทพมหานคร เมื่อวันที่ 25 เดือน ตุลาคม พ.ศ. 2562 ระหว่าง คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย โดย ผู้ช่วยศาสตราจารย์ ดร.พรรณระพี สุทธิวรรณ ตำแหน่ง คณบดีคณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ซึ่งต่อไปในสัญญาฉบับนี้ จะเรียกว่า "ผู้อนุมัติให้ใช้มาตรวัด" ฝ่ายหนึ่งกับ (นาย/นาง/นางสาว) อันธิฐา บวงกิตติกุล เลขประจำตัวนิสิต 6037626338 ระดับปริญญา โท คณะ จิตวิทยา มหาวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย อาจารย์ที่ปรึกษา ผศ.ดร. กุลยา พิสิษฐ์สังฆการ เข้าศึกษาเมื่อปีการศึกษา 2560 สาขาวิชา จิตวิทยาการปรึกษา เลขประจำตัวประจำตัวประชาชน 1103701452374 ที่อยู่ปัจจุบัน 259/7 หมู่ 4 ถนน ประดิษฐ์มนูธรรม แขวง/ตำบล ลาดพร้าว เขต/อำเภอ ลาดพร้าว จังหวัด กรุงเทพฯ รหัสไปรษณีย์ 10230 หมายเลขโทรศัพท์ 085-9451545 ซึ่งต่อไปในสัญญานี้ จะเรียกว่า "ผู้ขอใช้มาตรวัดทางจิตวิทยา" อีกฝ่ายหนึ่ง มีความประสงค์จะขอใช้มาตรวัด ชื่อมาตรวัด ความสามารถในการฟื้นพลัง ชื่อผู้พัฒนามาตรวัด ดวงพร กิตติสุนทร จากวิทยานิพนธ์/งานวิจัยเรื่อง ผลของกลุ่มการปรึกษาเชิงจิตวิทยาแนวปัญญาพุทธิกรรมนิยมต่อความสามารถในการฟื้นพลังและความสุขในการทำงานของพยาบาลในวันเด็กตอนกลาง ชื่ออาจารย์ที่ปรึกษาของผู้พัฒนามาตรวัด (ในกรณีที่มาจากวิทยานิพนธ์ โปรดระบุชื่ออาจารย์ที่ปรึกษาวิทยานิพนธ์ของผู้พัฒนามาตรวัด) ผศ.ดร. กุลยา พิสิษฐ์สังฆการ ปี พ.ศ. 2559

วัตถุประสงค์ของการใช้งาน ☐ โครงงานทางจิตวิทยา ☐ การวิจัย ☑ วิทยานิพนธ์ ☐ การเรียนการสอน

☐ อื่น ๆ โปรดระบุ .....

ผู้ขอใช้มาตรวัดทางจิตวิทยายินยอมตามข้อตกลง ดังนี้

1. มาตรวัดทางจิตวิทยาเป็นลิขสิทธิ์ของคณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย

2. ผู้ขอใช้มาตรวัดทางจิตวิทยาได้รับต้นฉบับและ/หรือไฟล์ต้นฉบับของมาตรวัดและวิธีคิดคะแนน และยินดีปฏิบัติตามข้อตกลงในสัญญา ดังนี้

2.1 ผู้ขอใช้มาตรวัดทางจิตวิทยาจะต้องนำมาตรวัดทางจิตวิทยานี้ไปใช้เพื่อประโยชน์ในการศึกษาวิจัยเท่านั้น

2.2 การอนุญาตให้ใช้มาตรวัดอนุญาตเฉพาะครั้งนี้เท่านั้นที่ขอมา

2.3 ผู้ขอใช้มาตรวัดทางจิตวิทยาจะไม่เปิดเผยหรือนำมาตรวัดทางจิตวิทยานี้ไปใช้ประโยชน์ต่อ ไม่ว่าจะนำไปใช้ประโยชน์ทางตรงหรือทางอ้อม เพื่อประโยชน์ของตนเองหรือผู้อื่น นำไปใช้ในเชิงพาณิชย์ หรือนำไปใช้เพื่อการอื่นใด ซึ่งข้อมูลหรือเอกสารใดๆ ไม่ว่าจะเป็นบันทึกหรือจัดเก็บในรูปแบบใด

2.4 ผู้ขอใช้มาตรวัดทางจิตวิทยาจะต้องระบุรายการอ้างอิงของมาตรวัดนี้ที่ได้รับอนุญาตจากคณะจิตวิทยาให้ถูกต้องในรายงานการวิจัยและ/หรือวิทยานิพนธ์ ตลอดจนการตีพิมพ์ผลงานลงในเอกสารใดๆ ที่นำมาตรวัดนี้ไปใช้ และส่งสำเนาหรือไฟล์ .pdf มาทางอีเมล์ โดยแจ้งให้ศูนย์ประเมินทางจิตวิทยา คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ทราบเป็นลายลักษณ์อักษรทุกครั้ง

2.5 หลังจากนำมาตรวัดนี้ไปใช้ในการเก็บข้อมูลและรวบรวมข้อมูลสำหรับวิทยานิพนธ์และ/หรืองานวิจัยในครั้งนี้เสร็จสิ้นแล้ว เพื่อให้คณะจิตวิทยามีข้อมูลเกี่ยวกับมาตรวัดที่นำไปใช้และไว้ใช้ประโยชน์ในการศึกษามาตรวัดนี้ต่อไป ผู้ขอใช้มาตรวัดทางจิตวิทยาจะต้องส่งรายงาน 1 เล่ม ในรูปแบบของไฟล์ word และรูปเล่ม 1 ฉบับ ที่ศูนย์ประเมินทางจิตวิทยา ประกอบด้วย

2.5.1 ข้อมูลพื้นฐานของกลุ่มตัวอย่างที่ได้นำมาตรวัดนี้ไปใช้

2.5.2 การหาคุณภาพของเครื่องมือ ความเที่ยงและความตรง (หากมี)

2.6 การอ้างอิงมาตรวัดทางจิตวิทยานี้ในเล่ม ส่วนของภาคผนวก ไม่อนุญาตให้ผู้ขอใช้มาตรวัดทางจิตวิทยานำมาตรวัดฉบับเต็มไปใส่ในเล่มวิทยานิพนธ์และ/หรืองานวิจัย อนุญาตให้ใส่เพียงตัวอย่างเป็นข้อ ๆ ด้านละไม่เกิน 3 ข้อ

3. การระงับการขอใช้มาตรวัดทางจิตวิทยา จะระงับเมื่อ

3.1 ผู้ขอใช้มาตรวัดทางจิตวิทยาไม่ปฏิบัติตามข้อตกลงในสัญญาฉบับนี้ ตามข้อ 1- ข้อ 3 โดยไม่มีเหตุอันสมควรและไม่ได้แจ้งให้ศูนย์ประเมินทางจิตวิทยา คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย ทราบเป็นลายลักษณ์อักษร

3.2 คณะกรรมการบริหารศูนย์ประเมินทางจิตวิทยาพิจารณาเห็นสมควรให้ระงับ

4. คณะจะไม่รับผิดชอบการละเมิดลิขสิทธิ์ทางปัญญา และคณะจะดำเนินการตามกฎหมายต่อไปจนถึงที่สุด

สัญญาฉบับนี้ทำขึ้นเป็น 3 ฉบับ มีข้อความตรงกันทุกประการ ต้นฉบับเก็บที่ผู้ขอใช้มาตรวัดทางจิตวิทยา คู่ฉบับ 1 ฉบับ เก็บที่ศูนย์ประเมินทางจิตวิทยา คู่ฉบับอีก 1 ฉบับ ให้อาจารย์ที่ปรึกษาของนิสิต/นักศึกษา

ข้าพเจ้าได้รับทราบข้อความข้างต้นโดยตลอดแล้ว และยินดีจะปฏิบัติตามทุกประการ หากข้าพเจ้าไม่ปฏิบัติตามข้อตกลงที่ให้ไว้ ข้าพเจ้ายินดีให้คณะจิตวิทยาดำเนินการระงับการอนุญาตให้ใช้มาตรวัดทางจิตวิทยาได้

ลงนาม .... ผู้ขอใช้มาตรวัด
(อันชิษา นวรกิตติกุล)
วันที่ 25 เดือน ตุลาคม พ.ศ. 2562

ลงนาม ....
อาจารย์ที่ปรึกษาของผู้ใช้มาตรวัด
([illegible])
วันที่ 25 เดือน ตุลาคม พ.ศ. 2562
(กรณีนำไปใช้ในวิทยานิพนธ์)

ลงนาม .... คณบดี
(ผู้ช่วยศาสตราจารย์ ดร.พรรณระพี สุทธิวรรณ)
วันที่ 30 เดือน ต.ค. พ.ศ. 2562

Appendix C

Instruments Development

Table 11: The Revised Olweus Bully/Victim Questionnaire and its psychometric properties

Items	Pilot study 1 (n = 70)		The study (n = 371)	
	Discrimination	CITC	Discrimination	CITC
1	✓	.545	✓	.619
2	✓	.726	✓	.551
3	✓	.545	✓	.396
4	✓	.617	✓	.417
5	✓	.432	✓	.429
6	✓	.353	✓	.413
7	✓	.653	✓	.449
8	✓	.588	✓	.521
9	✓	.667	✓	.372
10	✓	.699	✓	.492
11	✓	.396	✓	.433
α		.87		.80

Table 12: Self-compassion Scale Short Form and its psychometric properties

Items	Pilot study 1 (*n* = 70)		Pilot study 2 (*n* = 110)		The study (*n* = 371)	
	Discrimination	CITC	Discrimination	CITC	Discrimination	CITC
1	✓	.352	✓	.490	✓	.280
2		-.186	✓	.160	✓	-.053
3	✓	.515	✓	.316	✓	.336
4	✓	.442	✓	.306	✓	.266
5	✓	.508	✓	.520	✓	.300
6	✓	.440	✓	.422	✓	.236
7	✓	.255	✓	.427	✓	.241
8	✓	.641	✓	.193	✓	.485
9	✓	.636	✓	.170	✓	.467
10		-.031	✓	.586	✓	.119
11	✓	.188	✓	.638	✓	.386
12	✓	.457	✓	.396	✓	.258
α		.72		.75		.63

Table 13: State Resilience Scale and its psychometric properties

Items	Pilot study 1 (*n* = 70)		Pilot study 2 (*n* = 110)		The study (*n* = 371)	
	Discrimination	CITC	Discrimination	CITC	Discrimination	CITC
1	✓	.296	✓	.283	✓	.183
2	✓	.440	✓	.471	✓	.486
3	✓	.252	✓	.268	✓	.561
4	✓	.515	✓	.716	✓	.574
5		.055	✓	.322	✓	.499
6	✓	.636	✓	.591	✓	.581
7	✓	.572	✓	.574	✓	.549
8	✓	.431	✓	.373	✓	.600
9	✓	.667	✓	.566	✓	.562
10	✓	.453	✓	.425	✓	.531
11	✓	.518	✓	.513	✓	.533
12	✓	.694	✓	.602	✓	.540
13	✓	.379	✓	.443	✓	.487
14	✓	.316	✓	.290	✓	.408
α		.81		.83		.85

Table 14: The Children's Depression Inventory and its psychometric properties

Items	Pilot study 1 (*n* = 70)		Pilot study 2 (*n* = 110)		The study (*n* = 371)	
	Discrimination	CITC	Discrimination	CITC	Discrimination	CITC
1	✓	.686	✓	.644	✓	.550
2	✓	.574	✓	.489	✓	.345
3	✓	.717	✓	.575	✓	.488
4	✓	.406	✓	.600	✓	.452
5	✓	.481	✓	.519	✓	.357
6	✓	.472	✓	.507	✓	.459
7	✓	.663	✓	.633	✓	.610
8	✓	.441	✓	.527	✓	.231
9	✓	.468	✓	.658	✓	.501
10	✓	.588	✓	.668	✓	.352
11	✓	.621	✓	.552	✓	.518
12	✓	.321	✓	.406	✓	.419
13	✓	.285	✓	.348	✓	.345
14	✓	.416	✓	.591	✓	.376
15	✓	.237	✓	.529	✓	.276
16	✓	.366	✓	.588	✓	.405
17	✓	.620	✓	.648	✓	.519
18	✓	.463	✓	.418	✓	.360
19	✓	.427	✓	.321	✓	.325
20	✓	.553	✓	.534	✓	.514
21	✓	.296	✓	.368	✓	.424
22	✓	.362	✓	.389	✓	.374
23	✓	.203	✓	.426	✓	.375
24	✓	.517	✓	.592	✓	.436
25	✓	.507	✓	.571	✓	.479
26	✓	.245	✓	.135	✓	.302
27	✓	.686	✓	.283	✓	.429
α		.89		.91		.87

Appendix D

Instruments

Demographic Information

อันชิษฐา บวรกิตติกุล สาขาจิตวิทยา คณะจิตวิทยา
โทร. 085-945-1545 Email: anchidtha.kat@gmail.com

ข้อมูลทั่วไป

กรุณาอ่านข้อความด้านล่างและกากบาทเครื่องหมาย X ลงในกล่องสี่เหลี่ยมข้างล่างในช่องที่ตรงกับนักเรียนมากที่สุด

1. นักเรียนกำลังได้รับการวินิจฉัยว่าเป็นโรคทางจิตเวชโดยผู้เชี่ยวชาญหรือรับการปรึกษาเชิงจิตวิทยาในช่วงการเข้าร่วมการศึกษาหรือไม่

☐ ใช่

☐ ไม่ใช่

เลขที่โครงการวิจัย 254.1 | 62
วันที่รับรอง - 4 ก.พ. 2563
วันหมดอายุ - 3 ก.พ. 2564

Demographic Information

ข้อมูลทั่วไป

กรุณาอ่านข้อความด้านล่างและกากบาทเครื่องหมาย X ลงในกล่องสี่เหลี่ยมข้างล่างในช่องที่ตรงกับนักเรียนมากที่สุด

1. โปรดระบุเพศ

☐ ชาย

☐ หญิง

2. โปรดระบุอายุ

☐ 12 ปี

☐ 13 ปี

☐ 14 ปี

☐ 15 ปี

☐ 16 ปี

3. โปรดระบุชั้นปีการศึกษา

☐ มัธยมศึกษาปีที่ 1

☐ มัธยมศึกษาปีที่ 2

☐ มัธยมศึกษาปีที่ 3

เลขที่โครงการวิจัย 254.1/62

วันที่รับรอง - 4 ก.พ. 2563

วันหมดอายุ - 3 ก.พ. 2564

The Revised Olweus Bully/Victim Questionnaire

แบบสอบถามการกลั่นแกล้งรังแก

คำถามที่เกี่ยวกับการถูกรังแกโดยนักเรียนคนอื่น

ต่อไปนี้จะอธิบายคำถามเกี่ยวกับการถูกรังแกโดยนักเรียนคนอื่นๆ ตอนแรกเราคงจะต้องให้คำจำกัดความหรืออธิบายความหมายของคำว่า "การรังแก" เสียก่อน เราจะบอกนักเรียนที่ถูกรังแกเมื่อมีเพื่อนคนนึงหรือมากกว่าทำสิ่งต่อไปนี้กับเขา เช่น

- ใช้คำพูดที่ทำร้ายจิตใจเขา เหยียดหยาม หรือล้อเลียนเขา หรือตั้งชื่อที่เขาฟังแล้วทำให้ไม่สบายใจ เพื่อให้คนอื่นเรียกหรือร่วมล้อเลียนเขาด้วย
- เพิกเฉย ละเลย ไม่สนใจเขาโดยสิ้นเชิง หรือกีดกันเขาไม่ให้เข้ากลุ่มเพื่อน หรือแกล้งลืมเขาโดยมีเจตนาไม่ให้เข้าร่วมกิจกรรมต่างๆ
- ชก เตะ ตบ ตี ทุบ ข่วน ผลักเขาแรงๆ ทำร้ายร่างกายเขาด้วยวิธีอื่นๆ ขังเขาไว้ในห้องหรือจำกัดการเคลื่อนไหวของเขา
- ทำอะไรอย่างอื่นๆ ที่ทำให้เขาต้องเจ็บปวดในทำนองเดียวกัน

การรังแกกันนี้มักจะเป็นสิ่งที่เกิดขึ้นซ้ำๆ และคนที่ถูกรังแกมักจะป้องกันตัวเองไม่ค่อยได้ แม้กระทั้งการที่นักเรียนคนใดคนหนึ่งล้อเลียนเพื่อนซ้ำแล้วซ้ำเล่า โดยมีเจตนาทำร้ายจิตใจเขาให้อับอายหรือช่ำใจ ก็ถือว่าเป็นการรังแกเหมือนกัน

แต่ถ้าการล้อเลียนนั้น ทำเพียงนิดหน่อย ในลักษณะที่เป็นมิตรและเป็นการเล่นสนุกเท่านั้น เราจะไม่เรียกว่าเป็นการรังแกกัน และถ้านักเรียนสองคนที่มีรูปร่างหรือกำลังพอๆกัน ทะเลาะหรือชกต่อยต่อสู้กัน เราก็จะไม่ถือว่าเป็นการรังแกเช่นกัน

1.	ในสองเดือนที่ผ่านมานี้ เธอเคยถูกรังแกที่โรงเรียนบ่อยแค่ไหน	☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง

เธอเคยถูกรังแกที่โรงเรียนในสองเดือนที่ผ่านมานี้โดยวิธีต่างๆ ดังต่อไปนี้หรือเปล่า?

โปรดตอบคำถามทุกข้อ

2.	มีคนเคยใช้คำพูดหยาบคายกับฉัน ล้อเลียนฉันใน ลักษณะที่ทำให้ฉันเจ็บใจหรือเสียใจ	☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง

3.	มีเพื่อนบางคนที่เคยไม่ชวนให้ฉันเล่นหรือทำกิจกรรมด้วย ไม่ยอมให้เข้ากลุ่มเพื่อน หรือแกล้งเมิน ไม่สนใจฉันเลย	☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง
4.	ฉันเคยถูกชก เตะ ต้น ผลักแรงๆ หรือถูกขังไว้ในห้อง	☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง

เธอเคยถูกรังแกที่โรงเรียนในสองเดือนที่ผ่านมานี้โดยวิธีต่างๆ ดังต่อไปนี้หรือเปล่า?

โปรดตอบคำถามทุกข้อ

5.	มีเพื่อนบางคนเคยสร้างเรื่องโกหกหรือปล่อยข่าวลือในทางไม่ดีเกี่ยวกับตัวฉัน และพยายามทำให้คนอื่นๆไม่ชอบฉัน	☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง
6.		☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง
7.		☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง
8.		☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง
9.		☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง

10.		☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง ถ้าตอบว่า "เคย" โปรดระบุว่าเคยถูกรังแกโดยวิธีไหน: _____
11.		☐ ไม่เคยเลย ☐ เคย 1-2 ครั้งเท่านั้น ☐ เดือนละ 2-3 ครั้ง ☐ สัปดาห์ละครั้ง ☐ สัปดาห์ละ 3-4 ครั้ง

Self-compassion Scale Short Form (SCS-SF)

แบบสอบถามความเมตตากรุณาต่อตนเอง

คำชี้แจง ขอให้นักเรียนทำเครื่องหมาย ✓ ในช่องที่ตรงกับนักเรียนมากที่สุดเพียงคำตอบเดียว คำตอบที่นักเรียนเลือกตอบในแต่ละข้อนั้นไม่มีข้อถูกและผิด และขอความกรุณาให้นักเรียนตอบคำถามให้ครบทุกข้อ

1 หมายถึง พฤติกรรมนั้น **ไม่เคยตรงเลย**
2 หมายถึง พฤติกรรมนั้น **แทบจะไม่ตรง**
3 หมายถึง พฤติกรรมนั้น **ตรงบางครั้ง**
4 หมายถึง พฤติกรรมนั้น **ตรงบ่อยครั้ง**
5 หมายถึง พฤติกรรมนั้น **ตรงแทบทุกครั้ง**

	ข้อความ	ไม่เคยตรงเลย 1	แทบจะไม่ตรง 2	ตรงบางครั้ง 3	ตรงบ่อยครั้ง 4	ตรงแทบทุกครั้ง 5
1.	เมื่อฉันทำบางสิ่งที่มีความสำคัญกับตนเองล้มเหลว ฉันจะจมอยู่กับความรู้สึกว่าตนเองไม่ดีพอ					
2.	ฉันพยายามเข้าใจและอดทนต่อนิสัยตนเองที่ฉันไม่ชอบ					
3.	เมื่อมีเรื่องที่ทำให้ฉันเจ็บปวดเสียใจ ฉันพยายามที่จะไม่มองเพียงด้านร้ายๆ แต่ฉันพยายามมองหาแง่มุมดีๆ ที่อาจเกิดจากเรื่องนั้นด้วย					
4.	เมื่อฉันรู้สึกเศร้าใจ ฉันมักจะมีความรู้สึกว่าคนอื่นๆ น่าจะมีความสุขมากกว่าฉัน					
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

State Resilience Scale (SRC)

แบบสอบถามความสามารถในการฟื้นพลัง

คำชี้แจง ขอให้นักเรียนอ่านและพิจารณาข้อคำถามในแต่ละข้อ จากนั้น **ทำเครื่องหมาย X ทับบนตัวเลขที่ตรงกับนักเรียนมากที่สุดเพียงคำตอบเดียว** เพื่อแสดงถึงความคิดของนักเรียนที่มีต่อตนเอง**ในปัจจุบัน** โดยตัวเลขแต่ละตัวมีความหมายดังต่อไปนี้

1 หมายถึง พฤติกรรมนั้น**ไม่ตรง**กับนักเรียน**มากที่สุด**
2 หมายถึง พฤติกรรมนั้น**ไม่ตรง**กับนักเรียน
3 หมายถึง พฤติกรรมนั้น**ตรงและไม่ตรงพอๆ กัน**
4 หมายถึง พฤติกรรมนั้น**ตรง**กับนักเรียน
5 หมายถึง พฤติกรรมนั้น**ตรง**กับนักเรียน**มากที่สุด**

ข้อ	ข้อความ	ไม่ตรงมากที่สุด	ไม่ตรง	ตรงและไม่ตรงพอๆ กัน	ตรง	ตรงมากที่สุด
1	ฉันมีคนอื่นนอกเหนือจากคนในครอบครัวที่ฉันสามารถคุยด้วยได้ในเวลาที่ไม่สบายใจ	1	2	3	4	5
2	ฉันสามารถขอให้คนในครอบครัวช่วยเหลือฉันได้ในเวลาที่ต้องการ	1	2	3	4	5
3	ฉันอยากจะประสบความสำเร็จในสิ่งที่ฉันทำ	1	2	3	4	5
4	ฉันเชื่อว่าสิ่งต่างๆจะลงเอยด้วยดี	1	2	3	4	5
5	ฉันมีบุคคลที่ฉันชื่นชมและอยากจะประสบความสำเร็จเหมือนเขา	1	2	3	4	5
6		1	2	3	4	5
7		1	2	3	4	5
8		1	2	3	4	5
9		1	2	3	4	5
10		1	2	3	4	5
11		1	2	3	4	5
12		1	2	3	4	5
13		1	2	3	4	5
14		1	2	3	4	5

เลขที่โครงการวิจัย 254.1 62
วันที่รับรอง - 4 ก.พ. 2563
วันหมดอายุ - 3 ก.พ. 2564

Children's Depression Inventory (CDI)

แบบสอบถามภาวะซึมเศร้า

เลือกประโยคที่ตรงกับความรู้สึกหรือความคิดของนักเรียนมากที่สุดในระยะ 2 สัปดาห์ที่ผ่านมา โดยกา √ ลงใน ☐

1. ☐ ก. ฉันรู้สึกเศร้านานๆ ครั้ง ☐ ข. ฉันรู้สึกเศร้าบ่อยครั้ง ☐ ค. ฉันรู้สึกเศร้าตลอดเวลา	7.
2. ☐ ก. อะไรๆ ก็มีอุปสรรคไปเสียหมด ☐ ข. ฉันไม่แน่ใจว่าสิ่งต่างๆ จะเป็นด้วยดี ☐ ค. สิ่งต่างๆ จะเป็นไปด้วยดีสำหรับฉัน	8.
3. ☐ ก. ฉันทำอะไรๆ ได้ค่อนข้างดี ☐ ข. ฉันทำผิดพลาดหลายอย่าง ☐ ค. ฉันทำอะไรผิดพลาดไปหมด	9.
4. ☐ ก. ฉันรู้สึกสนุกกับหลายสิ่งหลายอย่าง ☐ ข. ฉันรู้สึกสนุกเฉพาะกับบางสิ่งบางอย่าง ☐ ค. ไม่มีอะไรสนุกสนานเลยสำหรับฉัน	10.
5. ☐ ก. ฉันทำตัวไม่ดีเสมอ ☐ ข. ฉันทำตัวไม่ดีบ่อยครั้ง ☐ ค. ฉันทำตัวไม่ดีนาน ๆ ที	11.
6.	12.

เลขที่โครงการวิจัย 254.1/62
วันที่รับรอง - 4 ก.พ. 2563
วันหมดอายุ - 3 ก.พ. 2564

13.	19.
14.	20.
15.	21.
16.	22.
17.	23.
18.	24.

25.	27.
26.	

เลขที่โครงการวิจัย 254.1/62
วันที่รับรอง - 4 ก.พ. 2563
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VITA

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