Sexual Abuse in Thai Children: A Qualitative Study

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Objective: *To understand sexual abuse in the Thai context, the impact of abuse, and the health problems of abused children.*

Material and Method: *This is a qualitative research. Sixty substantiated cases of child sexual abuse were recruited (56 girls and 4 boys). Participants were interviewed with a semistructured interview instrument. Data were coded and content analysis was done to identify common themes.*

Results: *Most children were first-born and came from families with multiple psychosocial stressors. About 77% were abused by family members. Most abuse was chronic and occurred when caretakers were not available or did not closely supervise the children due to economic and work-hour problems. Sixty-three percent of the children made purposeful disclosures. After disclosure, 65% of the children were placed in rehabilitation centers. At least 16.7% of the sample had intellectual limitations, and 28.3% had physical problems resulting from abuse. Frequent mental health problems included guilt feelings and aggressive behavior.*

Conclusion: *Family dysfunction and cultural factors place many children at risk for sexual abuse. Important preventive strategies include empowering families so they can take better care of their children, as well as educating parents and professionals about child sexual abuse.*

Keywords: *Sexual abuse, Child abuse, Child maltreatment, Asian children, Mental health problems*

J Med Assoc Thai 2008; 91 (9): 1461-7
Full text. e-Journal: *http://www.medassocthai.org/journal*

Child sexual abuse (CSA) is considered a serious crime in any society and is a major risk factor for mental health problems. In the United States in 2004, approximately 872,000 children were determined to be victims of child maltreatment, and about 10% of these victims were sexually abused[1]. In Thailand, there is no data system that collects information on CSA. However, the report from the Center for the Protection of Children's Rights revealed that between 2004-2005, 151 girls and 5 boys suffered from sexual abuse[2].

Sexual abuse has been referred to as the "tip of the iceberg" since a substantial proportion of abuse cases are not reported. In Thailand CSA is a widespread problem but only a minority of victims are referred for assessment. A study by Trangkasombat in 1992 found that sexual abuse cases accounted for only 0.36% of total referral to a regional child mental health center[3]. Moreover, the information on the subject of CSA in Thai population is minimal as sexual abuse usually occurs behind closed doors, and it is difficult to obtain a certain picture of what occurs, especially in an Asian society such as Thailand. The present study was conducted with the aim to understand CSA in the Thai context, the impact that it has on the lives of the children, and the problems and needs of these children.

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Material and Method

Participants

Participants were recruited from five sites: two regional medical centers and three rehabilitation centers located in Bangkok, the north, the northeast, and the south of the country. Only cases of substantiated sexual abuse were included. Participants with recent abuse who were in acute physical or psychological distress were excluded from the present study. In the period between the year 2000 and 2003, 60 CSA cases were recruited. The present study was approved by the Research Ethics Committee of the Faculty of Medicine, Chulalongkorn University.

Instrument

Since the aim of the study was to understand in depth various elements of abusive experiences, an exploratory study using the semistructured interview was conducted. The interview instrument consisted of items/questions focusing on the following issues: demographic information, abuse-specific variables such as the types of abusive behavior and the dynamics of the relationship between the child and the abuser, the situations leading to abuse, disclosure-related information, psychosocial stressors, life circumstances after abuse, health problems of the child and his/her perceptions about the future. Items concerning mental health problems were based on the Diagnostic and Statistical Manual of the Mental Disorders, 4th edition[4]. The questions were mostly open-ended and were intended to be used as a guide to explore or capture as much as possible the child's thoughts and feelings about his/her experiences.

Procedure

After the researcher explained about the aim and the procedure of the present study, informed consent was obtained from the caretaker. If the child stayed at a facility, permission was asked from the caseworker who acted as a guardian of the child.

Separate interviews were conducted with the caretaker and/or caseworker first, and later with the child. For the caretaker or caseworker questions focused on the background information of the child and the family, the impact of abuse on the family unit, the reaction from the community, the family's perception of the situation and the perception of the caretaker about the child's adjustment. As for the child, questions focused on how he or she experienced the abuse. Each interview lasted 60-90 minutes on the average. In addition to the interview, case records or medical records were also reviewed.

Data analysis

Data from the interview and relevant documents were coded. Content analysis was used to identify common themes related to the objectives of the present study.

Results

Demographic characteristics

The sample consisted of 56 girls and four boys. Most were first-born and in the age range of 11 to 15 years. In 61.7% of the cases, parents were divorced or separated. Details are shown in Table 1.

Table 1. Demographic characteristics (n = 60)

	No.	%
Age:		
≤5 years	1	1.7
6-10	21	35.0
11-15	30	50.0
16-18	8	13.3
Education:		
Never been to school	5	8.3
Kindergarten	2	3.3
Grade 1-6	19	31.7
Grade 7-9	28	46.7
Grade 10-12	6	10.0
Birth place:		
Central	21	35.0
North	15	25.0
East	4	6.7
South	7	11.7
Bangkok	13	21.7
Parents' marital status:		
Married	16	26.7
Divorced/separated	37	61.7
Widowed	5	8.3
Single (child adopted by single parent)	1	1.7
No information	1	1.7
No. of children in family:		
1	9	15.0
2	27	45.0
3-4	16	26.7
5-7	8	13.3
Birth order:		
Only child	9	15.0
First-born	26	43.3
Youngest	15	25.0
Other position	10	16.7

Family psychosocial stressors

All families had multiple psychosocial stressors. Frequent stressors were family breakdown (divorce, separation or parental death; 43 cases, 71.3%), poverty (33 cases, 55%) and substance abuse in parents (23 cases, 38.3%). Others included poor family relationship (22 cases, 36.7%), marital discord/violence (17 cases, 28.3%), and psychiatric illness in family members (9 cases, 15%).

Abuse-related characteristics

Abusers: All abusers were male. Forty-six cases (77%) were abused by family members. The three most frequent types of relationships to the children were stepfather (12 cases), uncle (10 cases),

and biological father (9 cases). Others included cousin (8), brother (3), grandfather (2),and brother-in-law (2). Abuse by other people occurred in 37 cases (61.7%). This included neighbor (15 cases), total stranger (8), friend (4), parent's friend (4), teacher (2), monk (2), police (1), and servant (1). Many children were abused by more than one abuser.

Types of abuse: Penetrative abuse occurred in 52 cases (86.7%) and contact nonpenetrative abuse in five cases (8.3%). In three cases, no definite information was available. Some children were physically abused and forced to take amphetamine or sniff glue during abusive episodes.

Age of first abuse: Abuse occurred most frequently between 12-13 years (Table 2). Four children with mental retardation could not tell exactly when abuse started or how long it continued.

Chronicity: In 25% of the cases, abuse happened only once and the children were referred immediately or shortly afterwards. In 75%, abuse occurred repeatedly and in 53.3%, it continued for a year or more (Table 2). Reasons for chronicity were as follows:

- The abuser was a family member and lived in the same house with the child.

- The abuser had significant role in the family. For example, the mother did not report that the father abused the child, as he was the only breadwinner of the family.

- The abuser was powerful in the community (school principal, police, monk, etc.).

- The abuser had a good relationship with the parents (e.g., parents' friend) and had easy access to the child.

- The child had poor relationship with parents and no action was taken to protect the child after disclosure.

Situations leading to abuse: Situations leading to abuse varied as in Table 3. (In chronic abuse, the interview focused on the last incident.) In most cases, abuse occurred when parents were not available or did not closely supervise the child, and the abuser was someone the child trusted. Common reasons why parents could not take care of the children were economic and work-hour problems.

Disclosures

Thirty-eight children (63.3%) made purposeful disclosures. Seventeen cases disclosed to the parents, especially the mothers. Other people included relatives (8 cases), schoolteachers (6 cases), friends (3 cases), doctors (2 cases), a nun, and a neighbor.

Table 2. Age at first abuse and chronicity of abuse (n = 60)

	No.	%
Age at first abuse		
4-5 years	9	15.0
6-7	10	16.7
8-9	9	15.0
10-11	6	10.0
12-13	15	25.0
14-15	7	11.7
Undefined	4	6.7
Chronicity of abuse		
Abuse happened once	15	25.0
Many times within one month	4	6.7
More than one month but less than 1 year	9	15.0
1-2 years	6	10.0
2-3 years	12	20.0
> 3 years	6	10.0
Very long time but couldn't define how long	8	13.3

Table 3. Situations leading to abuse (n = 60)

	No.	%
1. Stepfather/biological father abused child when mother was away	14	23.3
2. Relative abused child	11	18.3
3. Caretaker was not around, neighbor came into the home and abused child	7	11.7
4. Child knew abuser and went with him to his place or to buy candy	4	6.7
5. Single father abused child	4	6.7
6. Stranger broke in and abused child by force	2	3.3
7. Parents left child unattended, abuser abducted child from home	2	3.3
8. Child visited friend's house, and was abused by friend/stranger (In one case the child was drugged)	2	3.3
9. Child and father were inappropriately close	2	3.3
10. Parents were away, babysitter abused child	2	3.3
11. Child went to play in isolated place, and abused by stranger	2	3.3
12. Teacher abused child in school	2	3.3
13. Senior student abused child in school	1	1.7
14. Child ran away, abused while roaming the street	1	1.7
15. Mother was a prostitute, planned for client to abuse child	1	1.7
16. Child had severe mental retardation, biological father abused her while helping with routine self-care	1	1.7
17. Mother sent child to abuser's place on purpose	1	1.7
18. Unsafe school environment. Stranger abused child in school toilet	1	1.7

In 22 cases (36.7%), the disclosures were "accidental". That is, family members (relatives, 5 cases and parents, 4 cases), and professionals working with children (doctors and teachers, 5 cases each, social worker, 1 case) noticed the problems and investigated the case. Other people included the police and a neighbor.

Life after abuse

Living arrangements: At the time of the interview, 21 cases (35%) stayed with their families and 39 cases (65%) were placed in rehabilitation centers. Two children were re-abused while in placement.

Family support: In 19 cases (31.7%), the families had a negative attitude. They blamed the children and protected the abusers. In such cases, the abusers were family members, powerful people in the community or parents' friends. In 41 cases (68.3%), the families supported the children in many ways such as by visiting them or writing them letters while they were in placement.

Health problems

Seventeen children (28.3%) had problems resulting from sexual abuse. The list included pregnancy (7 cases), sexually transmitted diseases (gonorrhea and syphilis, 5 cases), genital tears (3 cases), pneumoperitoneum (1 case), and HIV infection (1 case).

The I.Q. test was done in 28 cases. Ten were found to have I.Q. below 90. This means that at least 16.7% (10 out of 60) of the children in the present study had intellectual problems.

Common mental health problems are shown in Table 4. Thirty-three cases (55%) had disturbing psychological problems and needed continued counseling.

Perceptions of the future

The sample's outlook for future is shown in Table 5. Most were hopeful and expected a better future. They had strong ambition for further education and vocational training. However, some had not yet recovered from traumatic experiences and refused to talk about the future.

Table 4. Mental health problems (n = 34)*

	No.	%
Emotional problems		
Feel guilty	18	52.9
Fear	14	41.2
Anxious	13	38.2
Irritable	13	38.2
Depressed	12	35.3
Crying spell	11	32.4
Lonely	10	29.4
Hopeless	9	26.5
PTSD symptoms	9	26.5
Feel worthless	8	23.5
Dislike self	5	14.7
Poor concentration	3	8.8
Dissociative symptoms	1	2.9
Behavioral problems		
Aggressive	13	38.2
Seductive	10	29.4
Self-injury	9	26.5
Suicidal attempt	9	26.5
Withdraw	6	17.6
Runaway from home/centers	6	17.6
Lying	4	11.8
Suicidal idea	4	11.8
Overactive	3	8.8
Agitate	3	8.8
History of drug abuse	3	8.8
Stealing	2	5.9
Abused other children	1	2.9

* Some cases were excluded due to young age, intellectual limitations and not being psychologically ready to talk about feelings

Table 5. Perceptions of the future (n = 60)

	No.	%
Children's thoughts of the future, *"My future will be..."*		
Better	36	60.0
Worse	1	1.7
The same as before abuse	1	1.7
Hopeless, did not want to talk about it	9	15.0
Never thought about it	1	1.7
Unable to give opinion due to young age/ intellectual limitations	12	20.0

Discussion

Many findings in the present study are similar to previous studies both in Thailand and in other Asian countries[3,5-7]. The majority of victims were abused by the people they knew. An interesting point in the sample's profile is that most were first-born (43.3%). In Thai culture, there is a lot of pressure in being the first-born. Parents put high responsibilities on first-born children and expect them to take care of

younger siblings. In some families, there are role reversals, and first-born children have to take on parental responsibilities. Some parents think that their children have grown enough to take care of themselves. The result is that first-born children do not receive appropriate care and parents are not available for them, both physically and emotionally. This puts them at high-risk for sexual abuse.

A review by Putnam found gender to be a risk factor for sexual abuse[8]. In the present study, as in other studies of CSA in Asia, girls were victimized more than boys[6,7]. One reason that may explain this is the son preference. Some papers argue that son preference is very strong in some Asian countries such as in China, South Korea and India, but is minimal in Southeast Asia[9,10]. The present study found strong son preference, especially in rural areas where most samples came from. Many parents perceived sons as more valuable than daughters as it is the son who carries the family name and continues family lineage. In Buddhism, it is the son who enters monkhood, and there is a belief that by touching his holy gown, parents can accompany him to heaven. All these contribute to the differences in the ways rural parents treat their children. Daughters have to do many household chores, while sons just play around. As a result, many girls felt unloved and uncared for. They may unconsciously seek inappropriate attachment with potential abusers in order to gain love and care.

CSA occurs more frequently in children from socially deprived and disorganized family backgrounds[8,11-15]. About 60% of the samples came from broken families. Growing up in broken families increased the chance of neglect. The analysis of situations leading to abuse revealed that neglect, lack of supervision, and parental unavailability contributed most to abuse. Inadequate supervision leaves the child exposed to the approaches of molesters. In stepfamilies, bonding between the child and the stepfather is not strong and incest easily occurs. In light of this, an important preventive strategy is to help families function better and decrease the rate of family breakdown.

Parental substance abuse is associated with increased risk of abuse[16]. In the present study many episodes of abuse occurred when the fathers got drunk. Poverty is also a major factor. Many families lived in severe poverty level, which was characterized by crowded living space and inappropriate sleeping arrangements.

Non-disclosure contributes to the chronicity of abuse. Many children kept it 'secret' for years. Besides many reasons for nondisclosure such as being threatened, fear of disbelief, or causing the family trouble, cultural factors may play an important role. In dealing with adults most Thai children are less assertive compared to Western children. They are taught to respect adults and, in some way, respect means keeping silent. This attitude may inhibit them from voicing their needs. A study of sexual abuse in Britain found that South Asian children disclosed less frequently compared with the British cohort[17]. Almost 40% of abuse in this sample was accidentally disclosed through the child's physical problems observed by caretakers or doctors, and behavioral changes observed by teachers. The findings that schoolteachers were the 'outside people' the children confided in most was significant in terms of prevention. Educational program should be provided to schoolteachers so they have a higher index of suspicion regarding abuse.

Abuse brings many changes into the child's life. Many children could not live at home because of family and community rejection or the risk of re-abuse. Children who have been removed from home tend to feel rejected and to view the removal as punishment. They also suffer from emotional and behavioral problems[18]. Beside being placed in alternative care points, they have other problems. People in the community label them as "problem child". This stigma contributes to behavior that is more inappropriate.

Previous studies found that children who grow up in abusive homes have delayed cognitive development[19-21]. In the present study, at least 16.7% of children had IQ below 90. Intellectual limitations may contribute to the risk of abuse as the child may bring herself into risky situation. The finding in the present study suggested that there may be association between intellectual limitations and CSA. It also underlines the need to have an IQ test as part of the routine assessment.

Studies found that most sexually abused children develop psychological problems that can persist into adulthood[11,12,15]. Children who grew up in abusive homes also suffered from impairment in basic trust and self-esteem, and are prone to serious psychopathology as adults[20,22,23]. Psychological problems attributed to abuse may, therefore, be related as much to the disrupted childhood background as to the abuse itself[11,12]. As most children in the present study came from disadvantaged families, it is difficult to differentiate out how much the upbringing experience and how much the abusive experience contributed to their mental health problems.

Despite traumatic experiences, most children were hopeful for their future. Those who were in placement found the centers to be safer and more peaceful than home. A study in sexually abused children found that at six month follow-up, the quality of life of the children removed to alternative care improved, compared to those who remained at home[24]. Higher quality of life may account for the hopeful attitudes of this sample.

One of the serious consequences of CSA is the risk of prostitution[5-7,25]. A study in maltreated children found that their narratives contained more negative self-representations than controls[26]. From the interviews, some children reported that they hated themselves and felt 'rotten' or as 'damaged goods'. Negative self-image contributes to many victimized children's decision to enter prostitution. A study by Trangkasombat found that 31% of child prostitutes had a previous history of sexual abuse, especially incest[5]. Long-term rehabilitation focusing on improving school and work opportunities is important to help children regain their self-esteem and reintegrate them into society.

Conclusion

Sexual abuse occurs on the background of family dysfunction and cultural factors. The findings underscore the need to support parents so they can take better care of their children. Treatment should be individualized to meet the needs of each child. Further research is needed to clarify the issues of risk and protective factors in the Thai context.

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การละเมิดทางเพศในเด็กไทย: การศึกษาเชิงคุณภาพ

อุมาพร ตรังคสมบัติ

วัตถุประสงค์*: เพื่อศึกษาปัญหาการละเมิดทางเพศในบริบทของสังคมไทย ผลกระทบของการละเมิด และปัญหาสุขภาพของเด็กที่ถูกละเมิด*

วัสดุและวิธีการ*: เป็นการศึกษาเชิงคุณภาพในเด็กและวัยรุ่นจำนวน 60 รายที่ถูกละเมิดทางเพศ (เด็กหญิง 56 ราย และเด็กชาย 4 ราย) เครื่องมือในการวิจัยคือ แบบสัมภาษณ์ semistructured interview วิเคราะห์ข้อมูลโดยวิธี content analysis*

ผลการศึกษา*: เด็กส่วนใหญ่เป็นลูกคนโต มาจากครอบครัวที่มีปัจจัยเครียดทางจิต-สังคมหลายอย่าง ประมาณร้อยละ 77 ถูกละเมิดโดยสมาชิกในครอบครัว การละเมิดส่วนใหญ่ดำเนินอยู่นานและมักเกิดขึ้นเมื่อผู้ปกครองไม่ได้ดูแลเด็กอย่างใกล้ชิดเนื่องมาจากปัญหาเศรษฐกิจหรือเวลาในการทำงาน เด็กร้อยละ 63 เปิดเผยเรื่องการละเมิดโดยตรง ภายหลังการเปิดเผยร้อยละ 65 ถูกส่งไปยังสถานบำบัดฟื้นฟู อย่างน้อยร้อยละ 16.7 มีปัญหาทางสติปัญญา และร้อยละ 28.3 มีปัญหาทางสุขภาพกายซึ่งเป็นผลมาจากการละเมิดทางเพศ ปัญหาทางสุขภาพจิตที่พบบ่อยคือ ความรู้สึกผิด และพฤติกรรมก้าวร้าว*

สรุป*: การปฏิบัติหน้าที่อย่างไม่เหมาะสมของครอบครัว รวมทั้งปัจจัยทางวัฒนธรรมทำให้เด็กหลายคนเสี่ยงต่อการถูกละเมิดทางเพศ กลยุทธ์ในการป้องกันที่สำคัญคือ การเสริมสร้างครอบครัวให้เข้มแข็งเพื่อครอบครัวจะดูแลเด็กได้ดีขึ้น รวมทั้งการให้ความรู้เรื่องการละเมิดทางเพศแก่พ่อแม่และบุคลากรที่ทำงานกับเด็ก*