Parenting, Parent and Child Mental Health in the Families of Maltreated Children Registered with the Child Protection Unit, Thammasat University Hospital

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Background: *Mental health outcomes of maltreated children can be various. There are mediated by several factors including parental and family variables. Less is known in Thailand on how these variables and children's mental health are related.*
Objective: *To study mental health of the maltreated children and their parents and to examine the relationships between parent mental health, parenting behaviors, family function and child mental health.*
Material and Method: *A sample of 48 parents who contacted mental health service via the child protection unit from October 2009 to 2010 was recruited in this cross-sectional study. Child mental health, parent mental health, parenting behaviors and family functions were measured by the Strength and Difficulties Questionnaires –parent version, General Health Questionaire-28, the Conflict Tactic Scale parent-child version and Chulalongkorn Family Inventory, respectively. Chi-square test was conducted to explore the associations between each independent variable and child mental health.*
Results: *Thirty-eight point six percent of the children and 56.8% of the parents had mental health problems. Poor family function (OR = 24.6; 95% CI = 2.8, 219.1) and negative parental behaviors (OR = 5.9; 95% CI = 1.3, 26.3) had statistically significant relationships with child mental health problem.*
Conclusion*: Mental health problems were prevalent among the maltreated children and their parents. Parent training programs focusing on positive parenting strategies and enhancing family function may be beneficial to maltreated children and their parents in order to improve their mental health.*

Keywords: *Child maltreatment, Child mental health, Parent mental health, Parenting, Family function*

J Med Assoc Thai 2011; 94 (Suppl. 7): S86-S94
Full text. e-Journal: *http://www.jmat.mat.or.th*

Child maltreatment, in other words, child abuse and neglect is an act of commission and/or omission resulting in actual or potential harm to the child's health, development or dignity[1]. Generally, it was classified into 4 types; physical abuse, sexual abuse, emotional abuse, and neglect. It is well known that child maltreatment is highly prevalent all around the world despite of under reporting. Different prevalent among the studies could be due to a broad definition of abuse, settings and socio-cultural acceptance in the degree of abuse.

Impacts of child maltreatment are well established. Psychological impacts include anxiety, depression, alcohol and substance use disorder, low self esteem, and other psychiatric disorders[2-8]. However, the psychological outcomes are various and can be mediated by several factors. Goodman[7] proposed that prognosis of child maltreatment depends on factors within the child, maltreatment's characteristics, attachment and family and parental factors. Not only in the context of child maltreatment, but parenting behaviors, parent mental health and family function also play a key role in child mental health in general as evidenced from previous studies[9-13].

To date, child protective services with multidisciplinary approach are accepted as gold standard and widely used for helping the affected children and their families. Unfortunately, only a small number of the services are available in several countries. Moreover, to the authors' knowledge, there is no research under the child protection services related

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to the psychological health of the maltreated children and its related factors in Thailand.

Therefore, the objectives of the present study were to explore a) mental health problems of the maltreated children and their parents b) parenting behaviors and c) family function, and to examine the relationships between parent mental health, parenting behaviors, family function and child mental health.

Material and Method

Setting

Child Protection Unit (CPU), Thammasat University Hospital, founded in 1998, is a pioneering effort for hospital based child protective services in Thailand. Aims of the services are to holistically help children aged 0-15years suffering from physical abuse, emotional abuse and neglect and extended to the age of 18 for sexual abuse cases. The present study was conducted in Child Psychiatric Unit which was a part of the CPU.

Participants

A sample of 48 parents who contacted child psychiatric clinic via child protection unit, Thammasat University from October 2009 to October 2010 was enrolled. The parents for each family in the present study included a father, a mother and an adult who is a key care-taker of the target child.

Methods

The present study employed cross-sectional design. Data were collected by means of semi-structured interview and self-report. A trained interviewer (clinical psychologist) conducted semi-structure interview to gather information related to children's and parent's demographic data including characteristics and details of child maltreatment. The parents completed self-report questionnaires.

Measures

Child mental health, parent mental health, parenting behaviors and family functions were assessed by the Strength and Difficulties Questionnaires-Parent Version (SDQ)[14], General Health Questionaire-28 (GHQ-28)[15], the Conflict Tactic Scale Parent-Child Version (CTS-PC)[16] and Chulalongkorn Family Inventory (CFI)[17], respectively. All of the selected measures were standard questionnaires and their details were as follows: 1) Strength and Difficulties Questionnaire (SDQ) was an international screening test for common behavioral and emotional problems in children (4-16 years). SDQ had 3 versions; parent, teacher and self. Each version had 25 items and consisted of 5 subscales, namely, hyperactivity, conduct problems, emotional problems, peer relationship problems, and prosocial behaviors (strengths). The study of SDQ Thai versions[18] provided normative data and showed promising psychometric properties. 2) General Health Questionnaire (GHQ) was an international screening test for common mental health problems in general populations. Several versions included GHQ-60, GHQ-30, GHQ-28 and GHQ-12. The GHQ-28 version provided 4 subscales; somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. The study of Thai GHQ versions[19] proved their desirable psychometric properties with high level of internal consistency (Cronbach's alpha coefficient 0.84-0.94), sensitivity (78.1-85.3) and specificity (84.4-89.7). 3) Conflict Tactic Scales-Parent Child Version (CTS-PC) was an international screening tool for parenting assessment. There were 35 items which are categorized into four subscales: non-violence discipline, psychological aggression, physical assault and neglect. Its psychometric properties were fair with the evidence of discriminant and construct validity. The scale was widely used despite its low to moderate range of reliability. The cause of rather poor reliability appeared reasonable because the severe assault items measured rare events which could affect calculation of internal consistency. 4) Chulalongkorn Family Inventory (CFI) was a 36-item scale measuring family function in 7 aspects; problem solving, communication, affective responsiveness, affective involvement, behavioral control, role, and general function. The scale was widely used in Thailand because of its favorable psychometric properties with high internal consistency (alpha = 0.88) and its evidence of discriminant validity.

Statistical analysis

Demographic data of the children and their parents, characteristics of child maltreatment, child and parent mental health, parenting behaviors and family function were presented descriptively. Then bivariate analysis using Chi-square test was conducted to examine the relationships between each independent variable, *i.e.* parent mental health, parenting behaviors, family function, and child mental health.

Results

According to the record of CPU, total cases registered with the CPU during the time conducted in

the present study were 105. However, only 51 children (48.6%) received services from the child psychiatric clinic, three of whom were from child care institution without their parents. Therefore, 48 children (45.7%) coming with their parents were eligible for the present study.

Demographic Data

A sample of 48 parents was the respondents, mainly the mothers (72.9%) followed by the others (14.6%) and the father (12.5%), respectively. Almost all of the maltreated children (97.9%) in the present study were female.

The children's age (n = 47) ranged from 3-17 years old with a mean age of 12.13 (SD 2.8). Regarding the children's education (n = 43), the majority of them (53.5%) was studying in secondary schools. Other demographic data of the children and their caretakers were illustrated in Table 1.

Characteristic of abuse & abusers

Prevalence of each type of child maltreatment in the present study were as follows (n = 43); sexual abuse (88.4%), physical abuse (8.3%), emotional abuse (8.3%) and neglect (4.2%). Regarding the numbers of maltreatment's type, one, two and three types were reported as 93%, 2.3% and 4.7%, respectively.

Almost all of the abusers (95.3%, n = 43) were male. The abuser's age (n = 42) ranged from 11 to 57 years old with the mean age of 24.16 (SD = 12.54). Most abusers (80.4%, n = 46) were not in the children's family.

Child mental health

Most of the maltreated children had the SDQ scores within normal range. They also had strength which was prosocial behavior. However, the number of children classified as at risk and abnormal was not small. Based on total difficulties score, approximately 40 % of the group had mental health problems. In the abnormal subgroup, the symptoms commonly found ranging from the most to the least were hyperactivity, emotional problems, conduct behaviors and peer relationship problems, respectively. A number of children in each subgroup classified by severity of mental health problems were demonstrated in Table 2.

Parent mental health

Mental health of the parents in the present study was classified as abnormal by having the mean score of the group above the cut-point for Thai norm. The mean scores ranging from highest to lowest were anxiety and insomnia, somatic symptoms, social dysfunction and severe depression, respectively. Nineteen parents (43.2%), which was the minority, had the total mean score below cut-point. Mean scores of each subscale were shown in Table 3.

Table 1. Demographic Data of the Children and Their Parents

	n (%)
Children	
Age (n = 47)	
3-10	11 (23.4%)
11-17	36 (76.6%)
Gender (n = 48)	
Female	47 (97.9%)
Male	1 (2.1%)
Level of education (n = 43)	
Uneducated	5 (11.6%)
Primary school	11 (25.6%)
Secondary school	23 (53.5%)
Vocational school	4 (9.3%)
Parents	
Relationship to the child (n = 48)	
Mother	35 (72.9%)
Father	6 (12.5%)
Others	7 (14.6%)
Age (n = 41)	
18-30	6 (14.6%)
31-40	15 (36.6%)
41-50	13 (31.7%)
51-60	7 (17.1%)
Gender (n = 45)	
Female	36 (80%)
Male	9 (20%)
Marital status (n = 42)	
Single	1 (2.4%)
Married	33 (78.6%)
Separated/Divorced/Widowed	8 (19%)
Level of education (n = 43)	
Uneducated	3 (7%)
Primary school	22 (51%)
Secondary school	12 (28%)
College	2 (4.7%)
Bachelor or Higher	4 (9.3%)
Family characteristics (n = 42)	
Nuclear family	23 (54.8%)
Extended family	19 (45.2%)
Number of children's caretakers (n = 41)	
One	10 (24.4%)
Two	22 (53.7%)
Three	4 (9.8%)
Four	4 (9.8%)
Five	1 (2.4%)

Table 2. Children's Mental Health

	n (%)		
	Normal range	Borderline	Abnormal
Conduct problems (n = 48)	32 (66.7)	6 (12.5)	10 (20.8)
Hyperactivity/inattention (n = 47)	27 (57.4)	4 (8.5)	16 (34)
Emotional symptoms (n = 46)	30 (65.2)	3 (6.5)	13 (28.3)
Peer problems (n = 46)	38 (82.6)	4 (8.7)	4 (8.7)
Total difficulties score (n = 44)	27 (61.4)	3 (6.8)	14 (31.8)
Prosocial behavior (n = 46)	42 (91.3)	-	4 (8.7)

Table 3. Parent's Mental Health

	Minimum	Maximum	Mean	Std. Deviation
Somatic symptoms (n = 48)	0	7	2.6	2.2
Anxiety and insomnia (n = 48)	0	7	3.0	2.5
Social dysfunction (n = 45)	0	5	1.5	1.5
Severe depression (n = 47)	0	7	1.1	1.8
Total score (n = 44)	0	25	8.4	6.9

Parenting strategies/behaviors

The parents used combinations of strategies to raise their children. The most commonly used strategy was nonviolence discipline (97.8%) followed by psychological aggression (87.2%), physical assault (64.4%) and neglect (46.8%), respectively. Regarding parenting behaviors, "explained why something was wrong" was the most frequent technique (93.6%), being used 13.2 times on average during the preceding year. The other two most frequent techniques were "shouted, yelled, or screamed at" (60.4%), being used 7.8 times and "threatened to spank or hit but did not actually do it" (56.2%), being used 8.9 times on average during the preceding year.

Among the modes of physical assault, the most severe form of parenting behaviors was "Grabbed around neck and chocked". However, this mean was the least life time prevalent (2.2%) compared to other means in the physical assault subscale. The three most frequently used methods were as follows; "Slapped on the hand, arm or leg" (46.8%), "Hit on the bottom with a belt, a hairbrush, a stick or some other hard object" (39.6%) and "Spanked on bottom with bare hand" (31.2%). The prevalent of each parenting behavior was shown in Table 4.

When classifying nonviolent discipline as positive parenting and psychological aggression, physical assault and neglect as negative parenting, a small number of the parents (9.1%) in the present study reported only using positive parenting techniques with their children. The vast majority (90.9%) used multiple negative parenting techniques ranging from 1-11. The mean number of these techniques was 4.2 (SD = 2.8).

Family function

Total mean score of CFI in this sample was 114.75 (SD 14.36) while the median was 116. Problem solving scale had the highest whereas behavioral control had the lowest mean scores compared to other subscales of family function as shown in Table 5.

Relationships between parent mental health, parenting behaviors, family function and child mental health

Results demonstrated that there were positive correlations between parenting behaviors, parent mental health, family function and child mental health with having all of odds ratio more than 1. However, statistically significant relationships ($p < 0.05$) were found only on parenting behaviors and family function variables as shown in Table 6.

Discussion

The findings illustrated that mental health problems in both children and their parents were common in the families of maltreated children. An

Table 4. Prevalence Rates per Hundred and Chronicity Estimates for CTSPC Scales and Items

Scale and Items	Prevalence n (%)		Year chronicity*
	One year	Lifetime	
Non-violence discipline (n = 46)	44 (95.7)	45 (97.8)	
Explained why something was wrong (n = 47)	41 (87.2)	44 (93.6)	13.2
Give him/her something else to do instead of what he/she was doing (n = 48)	21 (43.8)	22 (45.8)	10.7
Put in "time out" (or sent to room) (n = 47)	13 (27.7)	14 (29.8)	5.9
Took away privileges or grounded him/her (n = 48)	10 (20.8)	10 (20.8)	6.7
Psychological aggression (n = 47)	39 (83.0)	41 (87.2)	
Shouted, yelled, or screamed at (n = 48)	26 (54.2)	29 (60.4)	7.8
Threatened to spank or hit but did not actually do it (n = 48)	24 (50)	27 (56.2)	8.9
Called him/her dumb or lazy or some other name like that (n = 47)	23 (48.9)	23 (48.9)	6.9
Said you would send him/her away or kicked him/her out of the house (n = 48)	12 (25)	14 (29.2)	2.3
Swore or cursed at (n = 48)	6 (12.5)	8 (16.7)	2.7
Physical assault (n = 45)	28 (62.2)	29 (64.4)	
Slapped on the hand, arm or leg (n = 47)	20 (42.6)	22 (46.8)	2.5
Hit on the bottom with a belt, a hairbrush, a stick or some other hard object (n = 48)	16 (33.3)	19 (39.6)	2.2
Spanked on bottom with bare hand (n = 48)	12 (25)	15 (31.2)	3.4
Hit some other part of the body besides the bottom with a belt, a hairbrush, a stick (n = 48)	9 (18.8)	11 (22.9)	2.1
Shook him/her (n = 47)	5 (10.6)	5 (10.6)	4.2
Slapped on the face, head or ears (n = 48)	5 (10.4)	6 (12.5)	1.4
Pinched him/her (n = 48)	3 (6.2)	3 (6.2)	10.3
Threw or knocked down (n = 47)	2 (4.3)	2 (4.3)	13.5
Hit with a fist or kicked hard (n = 48)	2 (4.2)	2 (4.2)	1.5
Beat up, that is you hit him/her over and over as hard as you could (n = 48)	1 (2.1)	3 (6.2)	2.0
Grabbed around neck and chocked (n = 48)	-	1 (2.1)	-
Burned or scolded on purpose (n = 48)	-	-	-
Threatened with a knife or gun (n = 48)	-	-	-
Neglect (n = 47)	18 (38.3)	22 (46.8)	
Had to leave your child home alone, even when you thought some adult should be with him/her (n = 48)	11 (22.9)	14 (29.2)	18.5
Were not able to make sure your child got the food he/she needed (n = 48)	6 (12.5)	7 (14.6)	18.3
Were so caught up with problems that you were not able to show or tell your child that you loved him/her (n = 47)	5 (10.6)	8 (17)	18.8
Were not able to make sure your child got to a doctor or hospital when he/she needed it (n = 47)	5 (10.6)	6 (12.8)	16.0
Were so drunk or high that you had a problem taking care of your child (n = 48)	-	-	-

*Year chronicity is the mean number of times each act was reported among the subset of parents who reported at least one occurrence in the previous year

explanation would be simply because of the maltreatment itself. However, due to complex etiology of child abuse and neglect, there might be alternative explanations. The high prevalence of mental health problems in the families could represent a result of negative interaction between the children and their

Table 5. Family Function

	Mean	Median	SD
Problem solving (n = 48)	3.40	3.40	0.583
Communication (n = 47)	3.14	3.20	0.581
Affective responsiveness (n = 48)	3.22	3.20	0.454
Affective involvement (n = 48)	3.12	3.10	0.755
Role (n = 46)	3.20	3.25	0.542
Behavior control (n = 47)	2.73	2.75	0.638
General function (n = 48)	3.28	3.38	0.440
Total score (n = 44)	114.75	116	14.359

Table 6. Bivariate Model of Variables Associating Child Mental Health

	Likelihood ratio	Significant	Odds ratio	95% Confidence interval
Parent mental health	3.03	0.08	3.30	0.82-12.88
Parenting behaviors	6.16	0.01**	5.90	1.3-26.3
Family function	14.30	0.00**	24.56	2.75-219.09

** $p < 0.05$

parents preceding the incidence of child maltreatment or could be both the cause and effect relating to occurrence of child abuse.

According to the association between the two independent variables (parenting behaviors and family function) and child mental health, demonstrated 95% confident intervals which were above 1 even in small sample size indicated powerful effects of these two variables. The findings were in line with other previous research. For example, the GB national study[13] reported the strong association between negative parenting strategies and mental health problems in children. Dwairy M, Achoui M, Filus A, Rezvan Nia P, Casullo MM and Vohra N[12] also studied the relationships between parenting and child mental health in nine countries. They found that controlling mother, paternal and maternal inconsistency and rejection of children by their parents were associated with poor mental health in adolescent similarly among the countries. In addition, a study of Barry CT, Frick PJ and Grafeman SJ[20] pointed out the positive correlation between negative parenting patterns and emotional and behavioral difficulties in children.

Regarding others studies related to maltreated children, Paradise JE, Rose L, Sleeper LA and Nathanson M[21] proposed that parenting factors and family function had stronger effect than child maltreatment itself on long term adverse behavioral and academic outcomes. Moreover, the case-control study of Stern AE, Lynch DL, Oates RK, O'Toole BI and Cooney G[22] reported higher rate of family discord or breakdown and communication problems in the families of sexually abused children compared to their counterparts. These children also had more emotional and behavioral problems and lower self esteem.

As evidenced from many studies, multiple psychosocial risk factors *e.g.* poverty, high crime neighborhoods, parental alcoholism, parent mental illness and family breakdown are inter-related to child maltreatment and mental health problems in children and adolescents. For instance, a community study in Thailand[23] found high level of risk taking behaviors including depression in youths who experienced psychosocial adversities. Therefore, parenting strategies and family function may or may not be the factors directly affecting child mental health. In other words, in between child maltreatment and mental health outcomes, all the adversities could be either predisposing or mediating factors. However, in the present study, the majority had intact family, having at least one key care-taker and the perpetrators were outside the families. The findings then implied that structurally normal family had less meaningful influence over children's mental health than quality of parenting

and family function.

Limitations, implications and future research direction

There were a number of limitations in this study. First, only half of the families registered with the CPU participated in the project so the possibility of response bias cannot be excluded. In addition, several missing data were found and other confounding factors affecting child mental health such as severity, chronicity of child maltreatment and other psychosocial adversities had not been controlled. Moreover, some children had multiple care-takers which resulted in diversities of parenting strategies and might take different perspectives in viewing the child's and family's problems. Furthermore, a constraint from cross-sectional design caused a failure to establish a causal relationship between parenting and family function and child mental health. However, the findings had implications for child protection services planning family intervention. Training of positive parenting skills and improving family function should be provided for the targeted families in order to decrease mental health problems in the maltreated children and prevent the incident of repeated abuse. Future research should include other psychosocial risks factors, larger samples, correct the missing data, taking in also the children's perspective and conduct longitudinal study to expand our understanding of child maltreatment. Also investigations of maltreated children's characteristics and their families who did not receive services from mental health clinics could be useful for the child protective services planning to access more children and families in need.

Conclusion

In summary, mental health problems were prevalent among the maltreated children and their parents. The most common symptoms were hyperactivity for the children and anxiety for the parents. In addition, negative parenting strategies and low family function were strongly related to poor children's mental health. Parent training programs focusing on positive parenting strategies and enhancing family function are crucial to alleviate mental health problems of the maltreated children.

Acknowledgement

The authors are grateful to all the children and parents who took part in the present study. The present study project was funded and supported by a grant from the Faculty of Medicine, Thammasat University.

Potential conflicts of interest

None.

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การเลี้ยงดูสุขภาพจิตของผู้เลี้ยงดูและเด็กในครอบครัวเด็กถูกทารุณกรรมที่ขึ้นทะเบียนกับหน่วยคุ้มครองเด็กโรงพยาบาลธรรมศาสตร์เฉลิมพระเกียรติ

ศุภรา เชาว์ปรีชา, ติรยา เลิศหัตถศิลป์, กุลนรี พิมพ์สังกุล

ภูมิหลัง: *ผลลัพธ์ด้านสุขภาพจิตของเด็กที่ถูกทารุณกรรมมีความหลากหลายขึ้นอยู่กับหลายปัจจัยรวมถึงปัจจัยด้านการเลี้ยงดูและครอบครัว ในประเทศไทยยังมีความรู้น้อยเกี่ยวกับความสัมพันธ์ระหว่างปัจจัยดังกล่าวกับสุขภาพจิตของเด็ก*

วัตถุประสงค์: *เพื่อศึกษาสุขภาพจิต ของเด็กที่ถูกทารุณกรรมและของผู้เลี้ยงดูเด็กและเพื่อทดสอบหาความสัมพันธ์ระหว่างสุขภาพจิตผู้เลี้ยงดูพฤติกรรมการเลี้ยงดู การทำหน้าที่ครอบครัวกับสุขภาพจิตเด็ก*

วัสดุและวิธีการ: *กลุ่มตัวอย่างคือผู้ปกครองของเด็กจำนวน 48 ราย ที่มารับบริการในคลินิกจิตเวชเด็กผ่านทางหน่วยคุ้มครองเด็กตั้งแต่เดือนตุลาคม พ.ศ 2552–2553 ทำการศึกษารูปแบบภาคตัดขวางโดยทำการประเมินสุขภาพจิตเด็ก สุขภาพจิตผู้เลี้ยงดู พฤติกรรมการเลี้ยงดู และการทำหน้าที่ครอบครัวด้วย แบบประเมิน จุดแข็งและจุดอ่อนฉบับผู้ปกครอง (the Strength and Difficulties Questionnaires–parent version) แบบคัดกรองปัญหาสุขภาพจิต (General Health Questionaire-28) แบบวัดวิธีจัดการความขัดแย้ง ฉบับ ผู้ปกครองและเด็ก (the Conflict Tactic Scale parent-child version) และแบบวัดการปฏิบัติหน้าที่ของครอบครัว (Chulalongkorn Family Inventory) ตามลำดับ ทดสอบหาความสัมพันธ์ของแต่ละตัวแปรต้นกับสุขภาพจิตเด็ก ด้วยสถิติไคสแควร์*

ผลการศึกษา: *ร้อยละ 38.6 ของเด็กและ 56.8 ของผู้เลี้ยงดูมีปัญหาสุขภาพจิต การทำหน้าที่ของครอบครัวที่ไม่ดี (OR = 24.6; 95% CI = 2.8, 219.1) และ พฤติกรรมการเลี้ยงดูเด็กเชิงลบ (OR = 5.9; 95% CI = 1.3, 26.3) มีความสัมพันธ์อย่างมีนัยสำคัญทางสถิติกับปัญหาสุขภาพจิตเด็ก*

สรุป: *ปัญหาสุขภาพจิตพบได้บ่อยในเด็กที่ถูกทารุณกรรมและผู้เลี้ยงดูเด็ก การจัดฝึกอบรมวิธีการเลี้ยงดูเด็กโดยเน้นที่วิธีการเลี้ยงดูเชิงบวกและการส่งเสริมการทำหน้าที่ของครอบครัวมีความสำคัญสำหรับเด็กที่ถูกทารุณกรรม เพื่อช่วยให้เด็กมีสุขภาพจิตที่ดีขึ้น*