ECOCULTURAL PERSPECTIVES ON PROBLEMATIC CHILD BEHAVIOR:

AN EXPLORATORY QUALITATIVE STUDY IN THE CONTEXT OF URBAN POVERTY IN EGYPT

by

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Abstract

Background: Disruptive behavioral problems (DBPs) are the most commonly identified mental health issues in children and have long-term health, social, and economic consequences. Community violence, lack of basic infrastructure, and inaccessibility to services in the context of urban poverty aggravate DBPs and their consequences. Most research around child behavior occurs in high-income countries and relies on a biomedical understanding of decontextualized disorders. Definitions and meaning ascribed to DBPs, however, vary by culture and context. In Egypt, child DBPs are a major reason for care-seeking. Like many developing countries, Egypt has an extremely low coverage of child psychiatric services, and limited research exists around the contextual influences on DBPs. This study addresses this gap in knowledge by examining how mothers in urban slums in Egypt define, describe causes of, and respond to DBPs.

Methods: We qualitatively assessed the definitions, responses, and care-seeking patterns for DBPs in Alexandria, Egypt. Up to two qualitative in-depth interviews were carried out with a sample of 37 mothers of 6-11-year-old children with DBPs, 17 who sought medical care and 20 who did not. Transcribed audio-recordings of IDIs, field notes, and observational notes were thematically analyzed.

Results: Thematic analysis of participants' accounts indicate a constant negotiation of the meaning of DBPs and their attribution as medical or criminal issues. Participants linked their child's DBPs in part to the extreme poverty and the physical and social environment

where they live. This construction impacted their perception and response to their child's problems and partially informed their care-seeking practices and expectations. Employing a gender lens, we found that perceptions of child DBPs were influenced by gender roles and expectations. Additionally, mothers described how maternal stressors, resulting from the burdensome expected gender roles and exposure to domestic violence, profoundly affected children's behavioral problems.

Conclusions: Our findings highlight the limitations of a western biomedical understanding and diagnosis of child DBPs. To design an intervention addressing DBPs in Egypt in urban slums, we need to consider the social construction of disruptive child behavior and the multifaceted influences at the environmental, cultural and structural levels that affect parents and children.

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Dedication

To mothers, who love, who teach, who give and do the best they can.

And to my mother, I owe you all that I am and hope to be. Without your unconditional love, unwavering support, and relentless prayers I would not achieve anything.

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List of terms and abbreviations

ADHD	Attention deficit hyperactive disorder
ASB	Antisocial behavioral
CAPMAS	Central Agency for Public Mobilization and Statistics
CD	Conduct disorder
CDC	Centre For Disease Control
DALYs	Disability Adjusted Life Years
DBDs	Disruptive behavioral disorder
DBPs	Disruptive behavioral problems
EDHS	Egyptian Demographic Health Survey
EF	Executive functions
ID	Intellectual disabilities
IDA	Iron deficiency anemia
IDIs	In-depth interviews
IPV	Intimate Partner Violence
IQ	Intelligence quotient
IRB	Institutional review board
KII	Key informant interviews
LD	Learning disabilities
LMIC	Low and Middle-Income Countries
MOE	Ministry of Education
MOHP	Ministries of Health and Population
ODD	Oppositional Defiance Disorder
SDQ	Strengths and Difficulties Questionnaire
SLI	Specific learning impairments
UNICEF	United Nations Child Emergency Fund
UAs	Unplanned areas
WHO	World Health Organization

Introduction and Study aims

Disruptive behavioral disorders (DBDs) are among the most common mental health issues identified in children worldwide and often have long-term health, social, and economic consequences into adulthood (1). According to Tolan and Leventhal, "Disruptive behavior" represents "a clinical syndrome that is characterized most significantly by engagement in repeated acts of aggression toward others that are often accompanied by little or no regard for the effects of such behavior on others nor the value of complying with directions, requests, and orders. Those disorders are usually defined through diagnostic criteria mandated by medical authorities" (2).

In 2015, a meta-analysis estimated the global prevalence of DBDs to be 5.7% among children aged 6-18 years, with evidence of under-diagnosis and under-treatment particularly in Low and Middle-Income Countries (LMICs) (3). The Global Burden of Disease report in 2010 indicates that at least one DBD, namely conduct disorder, is among the 15 leading contributors to disability-adjusted life years (DALYs) among 9 to 15-year old children (1).

An eco-cultural approach to understanding child development considers the social and physical environmental factors that shape child behavior, as well as the cultural factors like child-rearing norms and parental expectations. This approach aims to avoid treating childhood mental health as a study of a decontextualized universal child (4-7) and moves beyond the biomedical definitions of DBDs to incorporate mothers' experiences of disruptive behavioral problems (DBPs) as nonconforming behaviors in their context. The inclusion of ecocultural factors emphasizes the view of child behavioral psychopathology as the interaction between child behavior and how adults perceive and respond to said behavior (8). By shaping the

definition of and response to DBPs, these ecocultural factors ultimately dictate the course and consequences of childhood problems, that might include adult mental health disorders, poor socioeconomic trajectories, violence, drug use, and incarceration (9).

Despite behavioral problems being the most common mental health issues in school-age children in Egypt (10), little is known about the local understanding of such issues within urban settings. In addition, few studies explored the care-seeking patterns and experience of care in Egypt (11). A qualitative approach is necessary to generate the data needed to design locally informed interventions that are acceptable to the population and address context-specific strengths and weaknesses in care provision. To our knowledge, such an in-depth study has not been conducted in Egypt. This study also informs a larger body of research on ecocultural factors around child development that advances theory around childhood disruptive behaviors experiences and responses in a low resource setting. Given the limited resources of the medical system in this setting, this research contributes valuable data to advance policy efforts and community services.

The specific research aims, and research questions of this dissertation are:

Primary Research Aim 1:

To explore, among mothers of children ages 6-11 years, (a) the experiences, definitions, and perceived causes of problematic child behavior in an urban low-income setting; and (b) how ecocultural factors, such as the physical and social environment, parental factors, and child-rearing norms, are related to these definitions and models.

Primary Research Questions:

1. How do mothers define, classify, experience, and explain problematic child behavior, in the context of urban poverty in Egypt?

2. How are their definitions and ethno-psychological models affected by their surrounding environment, child-rearing norms, and caregiver characteristics?

Primary Research Aim 2:

To understand the contextual factors affecting responses to DBPs within the household and school.

Primary Research Questions:

1. What are the caregivers' responses to children's DBPs?
2. How are responses impacted by cultural norms around child-rearing in this setting?
3. How do the child-rearing practices described by caregivers compare to how they were raised by their own parents?
4. What is the response to child DBPs within the school, and how does it affect caregivers?

Primary Research Aim 3:

To explore patterns of caregivers' care-seeking behavior, treatment expectations, and engagement in care for problematic child behavior.

Primary Research Questions:

1. Do the ecocultural factors elicit in aim 1 affect care-seeking, treatment expectation, and engagement in care for problematic child behavior? And if so, how?
2. What kinds of care do they seek (formal and informal)?
3. What are the barriers and facilitators to care that they experience?
4. What is the caregivers' level of satisfaction or dissatisfaction with care?

Organization of the dissertation

This dissertation starts with an overview of the study aims. Chapter one provides the background literature and description of the study setting. Chapter two is a description of the theoretical grounding of the dissertation and the conceptual framework which informed the study design. Chapter three covers the methodological approach of the study.

Chapters Four through six present three separate, but linked, results chapters. Chapter four covers the definitions of DBPs and the perceived influences that impact child behavior among the study sample. Chapter five explores the responses of adults to childhood disruptive behaviors as well as a narrative illustration of maternal mental health issues and how they affect and are affected by the children's behavioral problems. Chapter six presents the care-seeking patterns and experiences of mothers of children with DBPs in this context.

After presenting the findings, chapter seven contains the discussion and conclusions. Chapter eight is dedicated to the implications and public health significance of this study, and recommendations for future research.

Chapter 1. Literature review and study setting

1.1 Definitions and Epidemiology of DBD:

Problematic behaviors occurring in childhood and adolescence are among the most common reasons for referral to mental health services among children worldwide (12). In this research, we studied DBDs from two distinct perspectives.

For the purposes of this study, DBDs refers to disruptive behavioral disorders within a biomedical perspective based on clinical research, diagnosis, and management. The diagnostic criteria for these disorders, mandated by medical authorities, usually address behavioral issues in children as universal and decontextualized., On the other hand, DBPs broadly refers to disruptive behavioral problems as a complaint or observation by mothers, school or society at large in response to child behavior that does not conform to expectations of 'normality' in their specific context. These two perspectives often overlap but are do not perfectly match. For example, disruption is often perceived by adults, such as mothers, in terms of aggression and oppositionality (13), which matches the Diagnostic Statistical Manual, 5th edition (DSM-5) criteria for a diagnosis of DBDs that focuses on impulse control and emotional regulation as mediators for aggression and violation of rights of others (14). On the other hand, many contextually important disruptive symptoms are not be captured by the DSM-5 criteria (15, 16).

This research addresses a distinct gap by examining both a biomedical diagnosis for mothers who sought formal medical care as well as mother's definitions and lived experiences of child behavioral problems regardless of care-seeking status. Hence, for most of the dissertation, we refer to children's behavioral issues as DBPs, except when in the context of medical diagnosis or previous research or literature which uses DBD diagnostic criteria.

The current and previous classifications of behavioral disorders in children in the medical context include a long list of disorders, such as Attention Deficit Hyperactive Disorder (ADHD) and Kleptomania. For this study, we only examined children with Conduct Disorder (CD), or Oppositional Defiance Disorder (ODD) as diagnosed by a psychiatrist for children recruited from the clinic. For mothers who did not seek formal medical care, we used the conduct subscale of the Strengths and Difficulties Questionnaire (SDQ) as a screening for CD or ODD symptoms (details of the screening and rationale for the use of SDQ are provided below).

While many mental disorders in children include exhibiting externalizing symptoms and may share a common pathway with CD and ODD, those two disorders are defined by their predominant behavioral aspects and often seen as synonymous or sequential (13). ODD is considered as a less severe presentation of disruptive behavior and usually identified earlier in life, typically around preschool and first grade (13). Symptoms of ODD include a pattern of "negativistic, defiant, noncompliant, and argumentative behavior, lasting for at least six months, and causing significant impairment in social or academic functioning" (14). Conduct disorder (CD) is usually first identified around first grade age (13, 14). CD symptoms include: "(1) aggression to people and animals, (2) destruction of property, (3) deceitfulness or theft, and (4) serious violation of rules." (13).

These disorders can be diagnosed clinically, and while there are promising strides in neurobiology that aim to explain them, they are still challenging to define, investigate, and manage (2, 13, 17). However, there are concerns regarding the validity of the definitions present in the DSM and other forms of 'objective' or 'agnostic' diagnostic criteria when it comes to mental health disorders in non-western cultures (18). This concern is particularly relevant to DBDs that are seen within the lens of 'social acceptability' of behavior by adults and authorities.

It also poses more problems given the variety of risk patterns and symptom configurations (phenotypes) of DBDs that warrant questioning whether they are a few distinct diagnoses or whether they exist as part of a broader range of disorders that fall under a disruptive behavioral umbrella (13).

It is challenging to accurately estimate the burden of DBDs in children given the variability in diagnosis and presentations. Population estimates in developed countries can vary between 5-25%, with most studies showing rates to be twice as high in males compared to females (13). In a systematic review in 2010, Canino et al. estimated the global prevalence of CD and ODD to be around 3.2% (19). However, only two of the 25 studies included in this report were conducted in Low- and Middle-Income Countries (LMICs). Another meta-analysis of global mental disorders among children in 2015 found the estimated prevalence of behavioral disorders to be around 5.7% (3). DBDs also pose a considerable burden of disability on children, families, and communities. In the World Health Organization (WHO)'s Global Burden of Disease report in 2010, CD was estimated to be the 15th contributor to DALYs in children 9-15, and the 7th contributor among mental disorders (1). The same report estimated the global burden of CD to be 113.3 DALYs per 100,000 among males and 47.6 DALYs per 100,000 among females (1).

1.2 The gap between need and care-seeking in Egypt

In Egypt, limited information is available on the nationwide prevalence of child mental health problems and particularly child behavior. However, a prevalence study in Upper Egypt in 2009 found that over 25% of elementary school children assessed by teachers or parents were estimated to have conduct problems on the Strengths and Difficulties Questionnaire (SDQ) (10). The same study found that 8.5% of children assessed had a probable behavioral, psychiatric

diagnosis based on a multi-informant algorithm, and 6.6% had a probable conduct disorder diagnosis.

On the other hand, Egypt has an extremely low coverage of mental health providers and facilities. In 2006 the WHO reported that 12% of the patients treated in the 62 outpatient mental health facilities in the country were children and adolescents, yet only two facilities exclusively served children and adolescents (20). The same report estimated there was a total of 1,000 psychiatrists in the country (1.44 per 100,000 population) and only 75 psychologists (0.11 per 100,000). Those numbers are expected to be even lower currently since the population had jumped from 69 million in 2004, when the numbers above were assessed, to almost 100 million in 2017, with no drastic change in numbers of medical graduates (21).

When it comes to care-seeking, a small clinical study in Cairo found that the most distressing mental health problems for parents were DBPs. Most parents consulted a pediatrician or a psychiatrist (68%) as their first point of contact for mental health problems with a considerable percentage seeking care from traditional healers (18%) (11). However, this quantitative study, as well as others reviewed above, did not consider the contextual factors around care-seeking or address issues regarding access, availability of, or satisfaction with available services. This dissertation provides an in-depth examination of these contextual factors through qualitative accounts of mothers who seek care, both within the formal healthcare system or other alternative routes like traditional and religious healers.

1.3 Child-rearing norms and practices

Parenting may be defined as the child-rearing behavior along with its related beliefs, knowledge, values, and attitudes (22). Childcare customs and practices include behaviors commonly practiced and accepted in response to children's developmental stages and actions (7).

Child-rearing behaviors and the family dynamics around them differ by culture. These cultural differences dictate who is responsible for the different childcare tasks, the level of autonomy expected of the child, the expectations of obedience and politeness, how parents react when these expectations are not met among many other aspects of parenting.

In Egypt, several studies over the past few decades have described parental practices in response to child misbehavior, but their focus was limited to the use and acceptance of corporal punishment and harsh disciplinary practices, with no broader understanding of other mitigation practices and responses (23-26). The Egyptian Demographic Health Survey (EDHS) in 2014 found that 94% of children nationwide were exposed to violent disciplinary behaviors, including psychological and physical punishment by their caregivers (27). In addition, 79% of children in the poorest income quintile were exposed to severe physical punishment involving hitting the child on the hand, arm, or leg (55%), shaking the child (46%) and hitting the child on the face, head, or ears (41%) (27). A study in Alexandria among elementary school children in poor neighborhoods found that over 76% of children were corporally punished, about 60% were frequently corporally punished (i.e., more than once a week) and that corporal punishment was significantly associated with poor child relationships with others (23). Corporal punishment is highly associated with child externalizing behaviors and violence worldwide (28, 29) and in Egypt, specifically (30).

These studies described norms around harsh disciplinary practices with the assumption that they only stem from cultural child-rearing norms. However, they rarely critically examine the rationale of parents for using harsh discipline and its perceived effectiveness in improving child behavior.

1.4 The importance of early intervention

The effects of nature versus nurture have been long debated in relation to child development (31-33). Child development can be more comprehensively seen as "a suite of cognitive, behavioral, and physical dispositions, sensitivities, predilections, and capacities that had been honed through evolutionary processes." and how those get further shaped within the broader physical, historical and cultural contexts (31). This understanding makes intervening early a cornerstone for behavioral and child developmental disorders. In a meta-analysis of the genetic etiology of DBDs in 2009, results showed that both genetic and environmental influences on aggressive versus nonaggressive behaviors were similar in early and middle childhood but were heightened by adolescence. There is also an abundance of research that early-onset delinquency problems, i.e., before 13 years of age, remarkably increases the risk of severe violence and criminal behavior later in life (34). Several studies indicate that early interventions at multiple levels are highly effective in decreasing those risks through adulthood (13, 34). For these reasons, this dissertation focused on the experiences of caregivers of elementary school children (6-11 years of age).

1.5 Urban Poverty and DBD

1.5.1 Definition and description of urban poverty and slum areas

The term slum is used in this proposal per the Millennium Developmental Goals (MDGs) definition as a context encompassing a wide range of low-income settlements and poor living conditions that exemplify the varied manifestations of poverty (35). Hence, slum, as used in this research, refers to 'a heavily populated urban area characterized by substandard housing and squalor' (35, 36). This umbrella term is used interchangeably with terms like decaying inner-city tenements, squatter settlements, informal settlements, and shantytowns, in addition to language-

and site-specific terms like Favelas of Brazil, Kampungs in Indonesia and Bidonvilles in France and North Africa (36, 37). In Egypt, slums are generally called 'Ashwa'iyyat' which literally means 'disordered' or 'haphazard'. It refers to informal settlements suffering from problems of access, narrow streets, lack of vacant land and open spaces, very high residential density, and deficiency in infrastructure and services (36).

In 2006, it was estimated that one-third of the urban population in Egypt lived in urban slums and that Cairo alone had four of the world's 30 mega-slums (i.e., housing more than a million people) (37). Alexandria, as the second-largest city has over 37 squatter areas which house over one-third of the city's population (38).

1.5.2 Relationship between urban poverty and DBD

In 2005, the State of the World's Children defined child poverty as: "Children living in poverty experience deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society" (39). Poverty has a myriad of effects on child development and DBDs, not only as etiological factors but also in controlling the course of disorder and responses to it. Children in poverty face deprivations related to nutrition, housing, quality of education, and health services (40). Besides, the physical environment of poverty can lead to heightened exposure to toxic substances that affect development and increase the likelihood of child behavioral disorders (41). The social environment is also affected by urban poverty through disruption of norms around child-rearing practices, and supervision and support by families, all of which further contribute to stressors around developing children (13, 41).

1.6 Study setting

1.6.1 Egypt

Egypt is a middle-income country in the North-East corner of Africa. Egypt is the second-most populous country in Africa and the 15th worldwide with an estimated population of over 95 million in 2019 (42). The annual growth rate is projected to remain over 2% until 2040, where the population is estimated to reach 116 million (43).

Almost half of the population if Egypt lives in urban areas, with the majority living in overcrowded conditions. With the fast rate of urbanization, there is an expansion in the population of slum areas which are dense pockets of poverty that are deficient in essential services such as infrastructure, including clean water and sewage, health, education, and roads.

1.6.2 Urban poverty in Egypt and DBP

Poverty further compounds the issue and impact of DBPs among Egyptian children, particularly in urban settings. While urban areas have traditionally fared better in terms of economic and health outcomes, the locus of global poverty is quickly shifting to cities with the growth of urban slums, a phenomenon known as 'urbanization of poverty' (35). In 2013, the Central Agency for Public Mobilization and Statistics (CAPMAS) estimated that almost half of Egyptians were living in poverty and that 28 percent were living in extreme poverty. Out of those numbers, 16.7 million children are living below the national poverty line, which was around US$54/month in 2016 (44, 45). Although overall poverty levels are higher in rural areas, these numbers hide pockets of extreme poverty and growing disparities within urban centers, with the number and population of slums increasing. In Alexandria, slums and informal areas cover 3.25% of the total area but house over one-third of the population, in around 37 squatter areas (38, 46). According to a household survey by UNICEF in 2012, 41.5% of children in slum areas live in

extreme poverty (estimated at less than US$36/month in 2016) (40), compared to 16% in other urban areas in Egypt in 2011 (45). The poverty facing children in urban slum areas constitutes an environmental injustice that impacts their neuro-cognition and behavioral outcomes due to a variety of exposures, including poor housing conditions, malnutrition, lack of access to clean water as well as exposure to environmental toxins (35, 47).

Despite the high prevalence of DBDs, the potential negative consequences of exposures to urban poverty related to child behavior and neurocognitive development, and the limited capacity of the medical system to respond to DBP, there is scarce research available on contextual factors affecting DBDs' experiences and responses in LMICs in general, and in Egypt specifically (48-50). Little understanding is available on how parents identify and respond to DBP, what factors they believe contribute to their development, and how parents in this context attempt to mitigate them. We also lack a clear understanding of culturally specific child-rearing customs, environmental factors, and parental characteristics that influence those definitions and responses, and would impact care-seeking, engagement in care, and acceptability of interventions.

1.6.3 Alexandria

Alexandria is the second-largest city in Egypt. It is located in the Northwest of Egypt along the Mediterranean Sea. The total population of the city is estimated at 5,315,559 with slums and informal areas covering an estimated 3.25% of the land while housing over one-third of the population, in around 37 squatter areas (38, 46). We chose two different kinds of settings for recruitment in this study to reflect a larger scope of experiences of caregivers living in urban poverty among those who sought medical care for DBPs and those who did not.

Hospital clinic

The Ma'amoura Psychiatric Hospital is a tertiary level government hospital that serves three governorates with a population of over ten million people. Located in the East of Alexandria, the Hospital provides both inpatient and outpatient specialized services for neuropsychiatric disorders and substance use.

The children's psychiatric clinic accepts referrals from schools and primary care facilities, as well as walk-ins. The clinic is staffed by physicians (mostly specialists holding a master in neuropsychiatry), nurses and psychologists and provide mostly free services.

Non-governmental organization

The study was conducted in collaboration with a local NGO, Sonaa' El Hayat, in Alexandria. This NGO has diverse programming in slum areas, including health, poverty alleviation, and educational support services. Volunteers, who are mainly middle-class college students and young professionals, carry out most of the NGO's work. Sonaa' El Hayat provides children-specific services in seven slum areas in Alexandria, three of which served as study sites for this dissertation. These services include educational programs targeting different age groups, poverty alleviation programs and financing of small projects, food drives, environmental 'beautification' efforts, and medical convoys. Over 80 children are served within a school year in the three locations. The school-age program involves several aspects, including assisting children struggling to stay in school, mentoring, and recreational activities. The number of volunteers, across programs, varying between 10-20 depending on site. Study participants were purposively sampled from among caregivers who had a child who receives the NGO services and who resides with their caregiver in one of the three chosen slum areas served by the NGO.

1.7 Contribution to public health

An in-depth contextual understanding of influences on and responses to problematic child behavior from the perspectives of mothers provide opportunities to identify local mitigation strategies and to develop culturally appropriate assessment and intervention approaches.

Despite behavioral problems being the most common mental health issue in school-age children, little is known about the local understanding of such problems within urban settings in Egypt. In addition, care-seeking and experience of care are not well described. A qualitative approach is necessary to generate the data needed to design locally informed interventions that are acceptable to the population and address context-specific strengths and weaknesses in care provision. To our knowledge, such an in-depth study has not been conducted in Egypt. In addition, this study informs a larger body of research on ecocultural factors around child development that advances theory around childhood disruptive behaviors perceptions and responses in a low resource setting. Given the limited resources of the medical system in this setting, this research contributes valuable data to advance policy efforts and community services.

Chapter 2. Theoretical grounding and Conceptual framework

This chapter presents the theoretical grounding of this study. It starts with an explanation of the epistemological stance for this work, followed by a commentary on reflexivity. It then discusses the two theoretical perspectives informing this dissertation and their relation to DBP in the urban poverty context. Finally, the chapter introduces the conceptual framework that is informed by the theoretical perspectives and which in turns informed study design and methods.

Theoretical grounding: Social construction of reality

2.1 Epistemology

This research is informed by a constructivist epistemology. Epistemology can be defined as "the theory of knowledge embedded in the theoretical perspective and thereby the methodology. It is a way of understanding and explaining how we know what we know" (51). Constructivism contends that reality is shaped by the context and considers the impact of both the researcher's and the participants' positions, background, and views (52). This approach is characterized by an understanding that there is no absolute truth to be examined, but that reality is shaped by the context and individual views and background. As applied in this research, the reality of DBPs is believed to be shaped by the context of the child within the family, community, and society at large, as well as shaped by the researcher's background, education and views around the topic. This constructivist epistemology is important to acknowledge as it informs the theoretical perspectives and conceptual framework used for this research. It also allows for the deconstruction of the idea of a decontextualized universal child which shapes most child-related and global mental health research (7).

2.2 Reflexivity

In qualitative research, the researcher is considered the research tool, who enters this relation with the research phenomenon, participants, or context (53-55). Recognizing the researcher's role is critical to understanding the methods selected to explore a specific interaction including what data is collected, where to start the analyses, and what is seen as relevant or important (53).

Additionally, the process of data analysis and interpretation involves a shift to a conceptual level away from the intricate details of the lives of participants and their shared daily experiences. This shift, while necessary for producing useful, digestible findings for the scientific community, can result in losing the participants' voices, who are already a marginalized and often a voiceless group. Hence, it is paramount to reflect on the researcher's role and to situate our interpretations within a historical, social and political realities which contextually root the interpretation and reduce the risk of losing the participants' voices.

As someone who has been primarily trained in the 'sciences', the task of talking about myself and my presuppositions in a researcher capacity is daunting. The imperative of modern science to be as 'objective' and distant from your research topic as possible to avoid 'bias' is ingrained in my training, especially prior to seeking a Ph.D. in the Social and Behavioral Interventions Program. Despite my training in qualitative methods and medical anthropology, which forced me to contend with issues of ontology, epistemology, and reflexivity, there is still a desire, which I share with many public health professionals, to neglect the researchers' involvement in the research process and its products.

However, this reflection as stated before is essential to understand the choices made from the conception of this study to the writing up of findings and interpretations.

Even though this research design and choice of topic, has been informed by my personal experience of working and living in Alexandria, Egypt for most of my life, I was constantly reminded of my presence as an 'other' in these settings. As a middle class educated woman living in the United States, my mere presence in a slum area looks foreign; As does the presence of the rest of the data collectors and the NGO volunteers, the majority of whom are middle-class college students and graduates. When asked where I came from, I answered 'here', meaning Alexandria, but the questioner was more interested in the neighborhood, usually to gauge where to place you in the social gradient.

This understanding of my paradoxical otherness while being from 'there', required constant reflection on the study goals, data collection methods, analysis approaches, and interpretation. What are we trying to learn? And to what end? Who will benefit from this study? And what are the greater societal risks of describing the experiences and responses to problematic child behaviors solely through the lens of mothers, possibly placing the blame on the least powerful actors? There are no easy answers to these questions and many others. Nevertheless, they are worth contemplating throughout the research process in an effort to align our study with the best interests of the population this work aims to serve.

In attempting to address these reflexivity issues, I was continuously in dialogue during the initial study phases with stakeholders in Alexandria during initial field visits. I had several meetings with officials in the Mental health secretariat in the Ministry of Health and Population (MoHP). I also spoke repeatedly with NGO educational volunteers in a slum area who have close contact with our target population. I carried out interviews with mental healthcare providers at different facilities to inquire about their experiences and in some instances, shadowed their work after approvals of hospital officials, and parents of children they served. During these visits, I

encountered many parents of children seeking care and had conversations about their experiences and needs.

During data collection and analysis, reflexivity was addressed through frequent debriefing sessions with research assistants, reviewing field notes, and reflexivity memo writing. This allowed for the documentation of the evolving perspectives, impressions, and ideas throughout data analysis.

During the writing process, preliminary findings were shared with other Egyptian researchers, practitioners, and team members on the ground to gain feedback and insight around our interpretations and ensure the continuation of dialogue on reflexivity issues during the entire research process.

2.3 Theoretical perspectives

The two theoretical perspectives that inform the study approach, methods, and choice of the conceptual framework are social constructionism and structural violence and are described in more detail below:

2.4 Social Constructionism

Social constructionism offers a theoretical orientation that emphasizes a critical view of our understanding of reality, and what we take for granted about the world and ourselves (52). In Berger and Luckmann's book, The Social Construction of Reality, they describe how the world is constructed by the social practices created by people, and at the same time experienced by them as the fixed nature of their world (52).

Berger and Luckmann’s work built on symbolic interactionism which originated as a sub-discipline at the University of Chicago by Blumer and Mead. According to Berger and

Luckmann's work, the world as we know it is a product of individual perceptions and social negotiations that allow individuals to construct their own and others' identities with every encounter (56). There is no inherent meaning that resides within the object or the action itself, but rather meaning is a product of human interaction and the concepts we ascribe to the object (52, 56). This approach is a clear contrast to positivism and objectivist approaches, which are typically associated with quantitative research and which proposes that "what exists is what we perceive to exist" (52). Social constructionism has been used frequently in mental illness research and continues to provide a theoretical grounding for interventional approaches like family therapy (57) and postmodern consultation/psychotherapy approaches (58).

When examining the perceptions of and responses to problematic child behavior in the context of poverty, we are looking at a complex interaction of biology, environment, and cultural factors. These interactions continuously shape what is problematic or normal and hence shape the way a child is perceived and treated within their home, school, and community.

Between Badness and Sickness: Construction of "problematic children"

Looking at the actions of 'troubling children' or children exhibiting DBP, several sociologists, including Conrad, argue that behavior is not inherently deviant, but rather authorities use a deviant label to identify behaviors that violate societal norms, as defined by political, religious or institutional values (59, 60). This label thus problematizes those externalizing behaviors and embarks on explaining, treating, or preventing these conditions (60). The reaction to a 'misbehaving' child in one school can be to send the child to a psychiatric consultation while the same action in another setting would be dealt with by calling the police. This example does not, in any way, intend to say that DBDs among children do not exist as a problem worth

addressing. Instead, the boundaries of 'malfunction', 'abnormality' and blameworthiness are socially constructed, both in their definition and the reaction to them (52, 59).

If we wanted to further deconstruct those notions of misbehavior as either 'badness' or 'sickness', we find that those two competing narratives of partial medicalization or partial criminalization of DBPs among children and youth do not account for troubled youth constantly negotiating designations of themselves and their behaviors as both bad and sick (59). It also does not account for the 'troubling' behavior itself being a normal, or even a healthy response, of youth to 'abnormal' environments in their households, neighborhoods, and schools (61, 62). Thus, a narrow definition of delinquency places the sole burden of the actions on the shoulders of the youth themselves without examining other cultural and societal factors (63). For example, violent acts are symbolic gestures which counteract more significant phenomena of disempowerment children in their social space, including exposures of violence, poverty, poor services, discrimination, and alienation (61).

In the context of urban poverty in Egypt, as well as many other developing countries, despite the severe social and physical deprivation of children, there is a tendency to address DBPs through a lens of 'badness' using harsh disciplinary actions or even using the criminal justice system to address youth delinquency in juvenile court systems. On the other hand, efforts to recognize those behavioral problems as a 'sickness' focus on providing specialized medical services that are not readily available, and if available, lack quality and effectiveness. Both approaches ignore contextual factors, including the ecocultural perspectives discussed above, and which this research examined.

2.5 Structural violence

Structural violence is another theoretical perspective that informs this study. Structural violence describes the social structures that stop individuals, communities, and societies from reaching their full potential (64). In this case, the violence is not necessarily physical but involves "avoidable impairment of fundamental human needs or the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible" (64). Structural violence helps researchers to examine the factors influencing behaviors and health from multiple levels, including the social and physical environments to laws and policies. In this study, the urban poverty setting, characterized by harsh environmental conditions and systematic impoverishment, are explicit forms of structural violence. These environments impair child development and behavior and block the ability of children and their mothers to reach their full potential or to improve their conditions.

The use of structural violence as a theoretical perspective permeates study design decisions from the conceptual framework, the design of tools, to sampling, data collection, and analysis. First, it allows for using a multilevel conceptual framework to examine how those structural violence factors impact child behavior not only at the structural societal level, but also at the individual, community, and organizational levels. Furthermore, the use of qualitative methods allows a marginalized group, namely mothers of children with DBPs who live in poverty in Egypt, a voice to share their experiences parenting a child with challenging needs in a context of limited resources, and with care-seeking for their children. Using this lens to examine the social and physical environment, as ecocultural factors, assumes that the harsh conditions and systematic impoverishment in the context of severe urban poverty are clear forms of structural violence and an environmental injustice which impairs child development and behavior and

blocks their ability to reach their full potential or to improve their conditions. Finally, it provided direction during analysis to examine the broader context of caregiving and how it impacts perceptions and responses to DBPs in children.

2.6 Conceptual Framework

Building on the theoretical perspectives described above which describe the construction and multi-level influences on child DBPs, this study was grounded in the social-ecological framework as well as the concept of a developmental niche, drawing on the extensive body of research around ecocultural aspects of child development and child behavioral outcomes.

In his foundational 1979 book, Uri Bronfenbrenner lays out the importance of emphasizing environment's role in the contexts of social and emotional development of children exposed to mass violence (32). His theory of the social ecology of child development conceptualizes the influences of the environment on various nested levels, from the micro or individual level (ontogenic system) to meso-, exo- and macro systems (33, 65). Working within an ecological framework is vital for both examining the ecocultural factors affecting child behavior at different levels, as well as using the finding for planning multilevel interventions that aim at improving long-term mental health and psychosocial outcomes of DBDs (65).

In applying Bronfenbrenner's social-ecological framework, we examined child development and mental health issues as being affected by various interacting factors at different socioecological levels from the individual, household, community, organizational and structural levels (6, 31) (Table 1). Super and Harkens' concept of the developmental niche focuses additionally on the dynamics that create childhood experiences growing up (7). Those dynamics are a result of the interacting microsystem of social and physical settings, child-rearing customs, and caregivers' characteristics which shape everyday experiences (7, 31). On the other hand, the

child is a dynamic agent in the face of the surrounding niche, who embodies the experience of development itself and shapes the microenvironment within which they live (31). In short, in this view, child behavioral outcomes are "individual-level biological predisposition, shaped and re-shaped over time through social interactions" (16).

Thus, the conceptual framework (Fig. 1) for this study draws upon Bronfenbrenner's ecological model and the Super and Harkens developmental niche as illustrated by Worthman in a review of the ecology of human development (6, 7, 16, 31).

At the meso-environmental level, the study aims to examine the child's interactions at the household, school, and neighborhood level. It also focuses on ecocultural factors including the social and physical environment of the child, child-rearing practices and customs as well the caregivers' characteristics, including age, marital status, education, occupation, and socioeconomic standards. The organizational level includes the surrounding organizational services and structures like the educational system, health services, and infrastructure that influence child development and behavior and interact with parental factors within the ecocultural level. On the structural level, which more broadly examines structural violence within this context, the study explored extreme poverty, discrimination, gender dynamics, and judiciary system as it concerns juvenile delinquency in urban Egypt. In addition to qualitative interviewing, poverty was assessed quantitatively using the wealth index employed by the EDHS in 2014 (27).

Models for child DBPs may cross all levels since mothers might attribute the child problems to different aspects of the child life from individual characteristics to family, community, and/or societal factors. This attribution also affects how they construct the child's problem through a medicalization or criminalization lens. Table 1 summarizes constructs that were explored at the different levels within the study.

While this framework provides a comprehensive view of all the different levels of influence on child behavioral problems, it does not provide a clear understanding of how they interact in this context and do not reflect pathways of attribution of DBP to various constructs within the different levels which would be beneficial for intervention design and policy change. Hence, even though this framework informed study design and methods, one of the key outputs was to adapt it based on findings to provide information for intervention design and which will be discussed in chapter 7.

Table 1. Levels in the ecological framework and their relation to the ecocultural perspective

Level	Description
Micro-environment (Individual)	Child characteristics, symptoms, and outcomes including age, gender, IQ, medical history, and temperament and behavioral symptoms as identified by the mother.
Meso-environmental (Ecocultural or community)	This includes relational, household, school, and neighborhood child interactions. It encompasses the ecocultural factors of interest, namely the social and physical environment of the child within the family, household, neighborhood, and school. It also encompasses the child-rearing customs and practices, as well as mother characteristics.
Organizational	Includes the surrounding organizational services and structures like the educational system, health services, and infrastructure all of which affect child development and behavior, and interact with parental factors within the ecocultural level
Structural	Those cover overall societal factors that affect all the subsequent levels like extreme poverty, discrimination, gender dynamics, and judiciary system as it concerns juvenile delinquency.

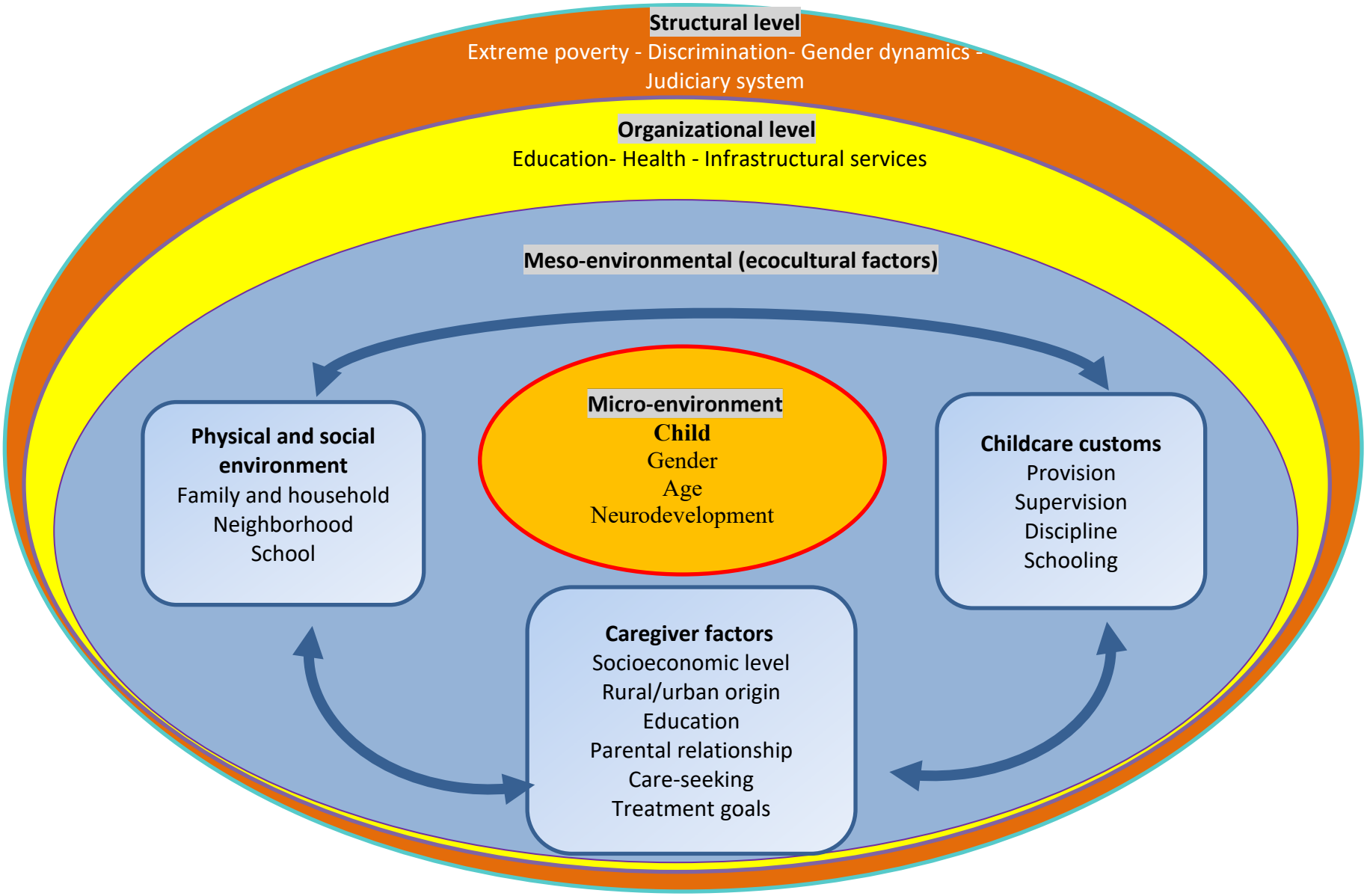

Figure 1. Conceptual framework of ecocultural influences on child behavior adopted from Bronfenbrenner (2009), Super and Harkens (1986) illustrated by Worthman (2010), and Burkey (2016)

Chapter 3. **Methodology**

This chapter provides an overview of the study methods, data collection, and analysis procedures.

3.1 Methods

3.1.1 Study population

We conducted in-depth interviews (IDIs) with 37 mothers of children ages 6-11 with DBPs living in slum areas of Alexandria. Child DBPs designations were based on clinical diagnosis for mothers enrolled in the Hospital or screening using the externalizing symptoms subscale of the Strengths and Difficulties Questionnaire (SDQ) for mothers enrolled through the NGO. The participants had to meet the following inclusion and exclusion criteria:

Inclusion and exclusion criteria

The inclusion criteria for caregivers recruited from the clinic were:

- Being the primary caregiver and reside in the same household as the child
- having a child who is between 6-11 years of age,
- residing in an urban area (either in an impoverished planned neighborhood or a slum area) within the clinic's catchment area,
- presenting to the clinic with a primarily disruptive behavioral complaint regarding their child,
- having received a diagnosis after assessment by a psychiatrist in the clinic for a DBD.

caregivers were excluded if they were:

- referred from a rural area (the catchment area for the clinic includes both rural and urban regions),
- are not the primary caregiver (i.e., do not live in the same house or do not see the child on a daily basis),
- or their child has a severe ID and/or is diagnosed with Autism Spectrum Disorder (ASD) given the specific needs and services required for neurodevelopmental disorders that might not correspond to the majority of mothers of children with chiefly behavioral complaints.

For caregivers recruited from the NGO educational support center, the inclusion criteria for them included:

- Being the primary caregiver of the child
- having a child who is between 6-11 years of age,
- residing in a slum area in Alexandria (or attend a school in one)
- a caregiver, a teacher or educational volunteer at the NGO complain of disruptive behavior(s) in the same child (i.e., Defying behavioral expectations of normality by exhibiting consistent disruptive behavior at home or school and/or violating rights of others)
- have not sought formal medical care for behavioral issues for this child before
- having a score of 3 or above on the conduct subscale of the Arabic version of the Parent-SDQ

They were excluded if they:

- Are not the primary caregiver (i.e., Do not live in the same house or do not see the child on a daily basis),

- Do not have a child who meets the criteria for diagnosis,
- The child has a diagnosis of severe ID or ASD
- Sought formal medical care for behavioral symptoms prior to recruitment.

We initially planned to interview each mother twice, to build rapport and elicit rich narratives. We ended up interviewing 29 out of the 37 mothers twice; the remaining mothers were interviewed once. Two mothers were excluded from follow-up since they did not fully meet the study inclusion criteria after preliminary analysis, and six mothers from the clinic setting were lost to follow-up.

In order to include both mothers who had and had not sought care for their children's symptoms, we recruited from two different sites. First, we purposively selected 17 mothers from the Ma'amoura Psychiatric Hospital, Child Mental Health Clinic, who had a child with a clinical diagnosis of a DBP.

Second, we recruited 20 mothers through the NGO Sona'a El Hayat's educational support centers in three slum areas: Al Tabya, Izbet Abis, and Houd 12. These mothers had a child with disruptive behaviors as observed by NGO staff or reported to the NGO staff by parents, teachers, or mothers, but the mothers had not previously sought formal medical care for behavioral issues for their child. To confirm DBP, study staff administered the strength and difficulties questionnaire (SDQ) to the children of selected mothers, and we only enrolled mothers of children who scored above average on this questionnaire (3 on conduct difficulty).

Within these two groups, we also sought variation in our sample in three additional characteristics: child gender (male or female), the severity of externalizing behavioral symptoms as identified by the SDQ (mild-moderate or severe), and current

dwelling (slum area or low-income planned neighborhood). These factors were selected given the gendered expression of behavioral problems and child-rearing practices, the close relationship between environmental exposures and DBDs, and the desire to explore a broad spectrum of the manifestations of DBPs and mother responses.

Maximum variation sampling is helpful when the researcher is interested in shared patterns across cases that emerge out of heterogeneity in their sample, which is relevant to this study given the diversity in dwelling conditions, gender expression of externalizing symptoms and severity of behavioral problems to address (66). It is described by Patton and Sandelowski as purposeful sampling techniques that focus on recruiting information-rich cases (55, 67, 68).

The recruitment took into consideration this diversity and aimed to include around eight. Sandelowski describes that maximum variation sampling is a common method of sampling in qualitative data collection. However, it is necessary for the researcher to choose the variation criteria carefully based on their research interest (67, 68). Although we were not able to get equal strata in each subgroup, each subgroup included 7-13 participants, which provided enough variation in characteristics for the analysis. This is except for dwelling among community-recruited mothers since the all three sites for this group were slum areas. Table 2 includes a breakdown of our sample by maximum variation criteria.

Table 2. Maximum variation criteria distribution in the study sample

Maximum variation Criteria	Clinic recruitment (N=17)	Community recruitment (N=20)
Gender		
- Male	10	13
- Female	7	7
Severity (SDQ Externalizing symptoms)		
- Mild-Moderate	8	12
- Severe	9	8
Dwelling		
- Planned poor neighborhood	11	0
- Slum area	6	20

3.1.1.1 The rationale for choosing maternal accounts

This dissertation focused on the mother-child dynamic as a microcosm that reflects the myriad of interacting factors influencing child DBPs at the individual, household, community, and structural levels. This study was conceptualized based on the view of DBD's psychopathology as the interaction between child behavior and how adults perceive and respond to said behavior (8). While we intended to enroll caregivers regardless of gender, our sample ended up being comprised of only mothers. This was reflective of the parenting context in this setting, where mothers carry the bulk of child-rearing responsibilities. Hence, exploring the maternal accounts in this study provided rich information regarding the mother's experiences and responses to DBPs. In addition, when it comes to care-seeking, children are dependent on the ability of adults around them to recognize their mental health issues as problems that warrant seeking care.

3.1.2 Research team

The field team consisted of six field interviewers and one field supervisor, all Egyptian and female with a medical degree, except for one male interviewer who was a medical student. All interviewers completed a seven-day training by the author before data collection. The training covered qualitative methodologies, interviewing techniques, research ethics, and the study protocol. Interviewers had significant experience in research in Alexandria, although none had conducted qualitative interviews prior to this study.

3.1.3 Recruitment

Recruitment occurred in October and November of 2018. This timeframe fell during the school year when most children are referred for behavioral issues, and the educational support centers are open but avoided the school exam season when parents are less likely to seek care.

In the clinical settings, psychiatrists introduced the study to mothers of children who fit the inclusion criteria. If the mother was interested and agreed to speak with a study team member, they were referred to the researcher to assess eligibility, explain the purpose of the study and an overview of what participation in the study entailed. If the mother was interested in participating, the researcher went through the informed consent process, including requesting permission to visit the mother in their home. Following consent, the first interview was conducted in a private room within the clinic. During the subsequent visit in the home, the consent was reread with the participant before the IDI started.

For mothers of children recruited from the NGO, potential participants were identified by NGO staff as mothers who complained of their child's disruptive behaviors, or the NGO staff observed potential disruptive behaviors when working with the child. The research team requested that NGO staff call potential participants who may be interested in research to come to the NGO service center while a research team member was present to assess eligibility and carry out screening using the parent version of the SDQ conduct subscale. If a mother's responses indicated a conduct subscale score of 3 or above (out of a maximum of 10) and fulfilled the eligibility criteria, a study team member conducted the informed consent process. The rationale for the use of SDQ conduct

subscale and the interpretation of scores are discussed below. If the potential participant consented to participate, the research team scheduled a time to carry out the first interview in a private space at the NGO service center, which occurred on the same day as the recruitment for all cases. Explicit consent was obtained before visiting the participants home for the follow-up interview.

Regardless of their enrollment, if a mother's reported SDQ score was 3 or higher, indicating a positive screen for elevated, high or very high conduct difficulty for their child, she was referred to the Maa'moura Psychiatric Hospital Child Outpatient Clinic for further evaluation and the study paid the transportation fees for the first appointment.

3.1.3.1.1 Use of SDQ conduct subscale for screening

Prior to enrollment, potential participants in the NGO setting were screened for conduct problems in their child using the Arabic version of parent completed Strengths and Difficulties Questionnaire (SDQ) for ages 4-17 years (25). This scale has been validated in the Egyptian context and is widely used for screening for mental health problems among children (69). SDQ consists of four difficulty subscales and one prosocial scale. To screen for DBP, we asked the conduct difficulty subscale questions only, which covers disruptive behavioral problems.

The scoring for the conduct difficulty subscale ranges between 0 and 10 and contains five questions total with scores ranging from 0-2 each. The four band scoring system divides scores on the Arabic version of SDQ into: Close to average (0-2), slightly elevated (3) or high conduct difficulty score (4-5) and very high score (6-10) (26). A member of the study team conducted the screening at the NGO service center prior to enrollment. If the mother's responses generated a slightly elevated or high score (3 or

above), they were considered to have a positive screen for mild-moderate DBPs for the purposes of the study. If they score very high on conduct difficulty, between 6 and 10, they were considered to have a positive screen for severe DBP. Mothers whose scores were less than three, indicating an average conduct difficulty SDQ score were excluded. If the SDQ screening indicated the child might have a probable externalizing behavioral problem, the team invited the mother to determine study eligibility based on inclusion and exclusion criteria detailed above. For all participants, oral consent for participation was obtained in the presence of a witness before the start of any data collection (ethical considerations are discussed below). The screening questions are included in appendix 1 with the interview guide.

3.1.4 Data Collection

IDI guides were designed to explore the mothers' experiences of child behavioral problems, how they defined these problems, and their etiological explanations for these problems. Interviews also allowed mothers to express their opinions about stigmatized issues such as mental health and DBPs in a private space, rather than in a group setting like a focus group. Finally, the IDIs allowed a marginalized population, mostly urban poor mothers, to express their opinions, experiences, and concerns using their own language. As our goal was to elicit local understanding and terminology, interviewers used lay language and avoided jargon that pre-labeled child behavior as disorderly or pathological. However, many mothers used clinical terms, particularly those attending the outpatient clinic, such as hyperactive or behavioral modification sessions, based on their care-seeking experiences.

The author initially developed the IDI guide in English. It was then translated into Arabic with feedback from the field team to ensure comprehension by the target population. Care was taken to include questions that can elicit narratives and parental models for childhood behavioral problems. The interview guide was further developed during the interviewers' training and based on feedback from the team after data collection started.

The first interview began by inviting participants to speak generally about problems mothers encounter with their children at home or school in this community. The interviewer then gradually shifted to what problems mothers encounter regarding their child behavior and how they first noticed them. Open-ended questions and probes were used to invite more extensive accounts of their understanding of their children's issues, its causes, and their own responses to them. Most interviews were around 60 minutes and ranged from 22 minutes to 125 minutes.

The initial interview guide contained a free listing exercise for childhood problems, the behavioral symptoms identified, and their severity and importance, as well as how mothers respond to DBP. However, after the first 12 interviews, we found the free listing exercise was mostly unsuccessful since mothers did not have a clear cover term for disruptive behaviors and found it hard to enumerate problems other than what they faced with their children which were already discussed in the interview. Hence, we decided to not include the free listing exercise in the subsequent interviews.

The interview guide also had a specific section on care-seeking behaviors that applied specifically to mothers who were recruited from the clinic regarding their experience in seeking formal medical care. We tailored the follow-up interviews to each

participant. The author listened to the initial interview and read the field notes. During the IDIs, interviewers took extensive notes on non-verbal communications by participants. They added these notes to field notes report that included further insights regarding the participant, and how the interview went and comments on reflexivity.

After the interview, the author held a debriefing session with the interviewers, during which possible issues to probe about and additional topics for the second interview were discussed. The follow-up interview was conducted two to four weeks after the initial interview. During the follow-up IDI, the interviewer probed further on factors discussed during the initial interview and provide an opportunity for the informant to share their narrative.

All follow-up interviews also included a structured wealth index questionnaire and a list of additional questions based on feedback from the team and the thesis advisory committee. Examples of additional questions include a description of a problematic behavioral episode that happened since the last interview and how the parent responded to it and describing how their parenting may be similar or different from the way they were raised.

Whenever possible, follow-up interviews were conducted in the participant home, and observational notes were recorded regarding the social and physical environment of the house. Observational notes also included photographs of the inside or outside of the home environment (for which specific oral consent was obtained during the initial interview and repeated during the follow-up). However, for mothers who declined to have the interview at home, oftentimes because of worries about having a stranger enter

their house or refusal of the participant's husband, the follow-up interview was conducted in a private space in the clinic or the NGO centers.

Observation notes also included observations on mother-child and -practitioner interactions, as well as the clinic setting for interviews carried out within the hospital. All interviews were digitally audio-recorded and subsequently transcribed verbatim in Arabic by Egyptian transcribers.

3.1.5 Data analysis

Data analysis was an iterative and interactive process. The analysis started during data collection, with frequent debriefings with the data collection team and preliminary reading and analysis of interviews as they occurred. Findings from the initial interviews helped strengthen the interview guide during the follow-up interviews. The lengthy transcription process and logistical constraints limited the extent to which a fully iterative approach could occur. For example, due to the relatively unsafe nature of the study site, data collectors had to do the interviews in a condensed time frame, visiting the field in groups and performing several interviews on the same day. This large volume of data did not allow for transcription and thorough analysis by the time of the follow-up interview occurred, or additional participants were recruited. However, field notes, listening to interviews, memo-ing and frequent debriefings helped the process of immersion in the data and context, as well as some level of iteration in the interview approaches and recruitment strategies when possible.

Coding of Arabic-language transcripts was done by the author, who has graduate-level training in public health and is fluent in Arabic. An initial codebook was developed deductively based on the study aims, interview guide, and initial field debriefings. This

codebook was refined through discussions with the field team and reflective memos. During the coding process, the lead author developed more codes based on themes and concepts arising inductively from the data. After the initial coding cycle, a secondary analysis was conducted to merge, delete, or modify codes. All coding was done using Atlas.ti 8 ®. The final set of codes was used to build themes and overarching categories that aided in the development of a conceptual framework of maternal perceptions and responses to DBPs in this setting. Finally, the author discussed codes and themes arising from the data with her Thesis Advisory committee members, drawing comparisons across sites, gender, and severity of symptoms to understand the texture and nuance of participant perspectives.

Note on transliteration

Because this research was conducted in colloquial Egyptian Arabic Dialect, the author attempts to transliterate words that possess cultural significance within findings and quotes. The Arabic letter hamza, a glottal stop, is signified by an apostrophe (’). The letter ‘ayn (ع)which represents a voiced pharyngeal fricative is signified by a superscripted inverted comma (‘). The hard H (ح) is represented by the letter h with a dot under it (ḥ). Stressed Arabic consonants are spelled out as Kh (خ), Sh (ش), Dh (ض). In the results, transliterated words are added between parentheses in italic

3.1.6 Ethics review

The study protocol, consent forms, and instruments were reviewed by the Ethical Committee at the Faculty of Medicine, Alexandria University, in accordance with standard research procedures. The protocol was also submitted to the Johns Hopkins Bloomberg School of Public Health’s Institutional Review Board, which withdrew the

application based on the presence of the Egyptian IRB approval and the presence of a Principal Investigator, Dr. Amira Seif Eldin, who is a professor of Community Medicine in Alexandria University. The consent forms and instruments were further reviewed and approved by the Mental Health Secretariat's research committee in the Egyptian Ministry of Health and Population (MOHP), to ensure cultural and scientific appropriateness.

Chapter 4. Maternal definitions of problematic child behavior

This chapter presents the behaviors children exhibit that mothers consider disruptive. This chapter also explores mothers' overarching understanding of DBPs and what they describe as the influences and causative factors of DBP, including the social and physical environment, and parental characteristics. These topics were developed both based on the study's aims and underlying theory but were impacted by emerging themes from the data. We begin by exploring how mothers defined problematic behaviors and what they saw as priorities. We then delve into the various influences they identified as impacting their child's behavior. More details regarding factors that might contribute to child behavior but are not necessarily identified by mothers as causative factors, including customs that govern childcare and discipline, maternal mental health as well as responses to problematic child behaviors, will be discussed in the next chapter.

4.1 Definitions of Behavioral Problems

Behavioral problems did not form a well-defined cognitive domain for most of the mothers interviewed. Mothers had a host of issues that they found "bothersome" or "worrisome" that led them to seek care either in the hospital or via reporting to NGO personnel. The research team attempted to elicit such issues using a variety of interviewing techniques and terms. The initial use of free listing as a technique did not prove effective given this lack of a defined domain. However, broad questions such as "can you describe a typical day with your son/daughter?" or "can you tell me about the last time your child did something that upset you?" proved the most effective in eliciting accounts and descriptions of problematic behaviors. We also used terms like manners,

actions, and doings to describe behaviors since the Arabic term for behaviors, *slokeyyat,* was not always well understood by the participants.

Some of the behaviors mothers described as problematic matched more universally recognized DBPs, including DSM-5 symptoms of conduct disorder (CD) and Oppositional defiance disorder (ODD) (14). For example, the most commonly reported problematic behavior was "not listening to talk" in reference to disobedience or defiance of parents. Other frequently mentioned behaviors that fit the DSM-5 definitions included easily getting angry or frequent shouting and screaming, lying, assaulting other children, fighting with siblings, not paying attention to school, disrespecting elders (including interrupting adults or answering back), using profanities, impulsive actions, hyperactivity or restlessness, and inattention. Other less commonly cited behaviors included stealing, abusing animals, carrying a knife, self-harm, and violence towards parents or adults. Cigarette smoking and use of drugs were only mentioned by three of the participants, perhaps due to the ages of these children.

There was another set of commonly mentioned problems that are not captured in the DSM-5 that is more specific to this setting. For example, "looking at others", implying jealousy of other kids, losing belongings, forgetfulness, and "blanking" or daydreaming were significant concerns for mothers. In addition, concerns about religious behaviors, including not praying regularly, not memorizing the Quran and insulting the religion or "*Sabb Eddin",* were commonly shared problems.

There was also a set of behaviors that concerned gender expectations and sexuality. For girls in the sample, mothers were concerned with a wide range of issues

including the girls' desire to wear revealing or tight clothing, talking or playing with boys, 'not walking right' or displaying 'boyish' behaviors.

*"She wants to talk to boys even though her father is strict. She wants to go play with guys' soccer, so I say, 'you don't know them [girl name], why would you go there?' she should not go out to play; she can play here at home with her brother. She goes to the window, and I tell her, 'do not talk to anyone'. There is a carpenter downstairs where she stands [by the window] ...but it is as if I am not talking" (*Mother of a 6-year-old girl, moderate symptoms, hospital recruit, planned neighborhood)

For the boys, mothers were more concerned when acts of sexual harassment occurred, including harassing family members and shouting 'obscene' comments at women and girls.

This gendered lens of problematic behaviors went beyond specific types of actions to include the perceived severity of the behavior depending on the child's gender. For example, mothers were more concerned with boys' school performance than they were of girls and hence saw it as a more severe problem. Some of that worry stemmed from the recognition that the boys need to be gainfully employed in the future and maybe jeopardizing their chances. Mothers also expressed the view that girls are already more concerned with schooling, and if they leave school, they will have other options. On the other hand, when discussing girls, mothers emphasized 'reputation' and good manners as priority issues. This quote exemplifies this gender lens as one mother discusses her variant expectations of her children by gender:

> *"I mean a girl can get there normally; I won't struggle with her to get to a better job. I might get her to college, and that is enough, she does not need a higher degree... it is not important. If she wants to do that in her husband's house, she is free… But a boy is different. I will keep at it till he is a good thing in society" (*Mother of 8-year-old boy, moderate symptoms, hospital recruit, living in slum area)

> *"Like at first teachers were praising him, and he memorized parts of the Quran. Come now, not even doing his homework or answering their questions. The thing that worries me the most is school… I was okay with the annoying actions, but when it reached schooling, I cannot just…I want him to be something good. A doctor, an officer... he wants to be like his father… a street seller [laughing]. I want him to succeed, to have an education." (*mother of a 9-year-old boy, mild symptoms, hospital recruit, living in a slum area)

In a few instances, mothers mentioned problematic behaviors of children that were developmentally appropriate. These behaviors included having a pet cat or dog, wanting to play all the time, watching too much TV or jumping around. When probed further why such behaviors were problematic, mothers often compared their child to other children or shared remarks made by other family members as the reason they found those behaviors concerning.

> *"I would be walking around and see kids walking upright, their clothes are clean, and they take care of their things. They listen to their mothers, even with just a look. A mother looks and the girl knows what her mother wants. But this one, no. She always wants to go out, run around and does not listen" (*Mother of a 6-year-old girl, moderate symptoms, hospital recruit, lives in a planned neighborhood)

The level of distress mothers experienced due to the problematic behaviors varied. This variation was often influenced by the level of embarrassment the child's behavior caused the mother in front of others. Mothers often shared feelings of shame and embarrassment when they felt judged by in-laws, neighbors, and teachers.

> *"When [child] talks to me, he gestures with his hand and does those facial expressions [implying rudeness]. I tell him, 'darling, you are disrespecting me with those gestures, don't get me angry'. He says he does not make disrespectful gestures. I know this is my son's nature, but if there is someone with us at home and I am talking to my son, and he does something like this, she will not know this*

> *is his nature, and I don't like my children to look bad in front of people. I want them to look polite and respectable. I have to explain to them that they cannot put me in an embarrassing situation. Thank Allah they usually honor me" (*mother of an 11-year-old boy, moderate symptoms, slum area recruit)

Mothers also struggled with whether the behaviors exhibited by the child represented criminal tendencies that cannot be helped or a medical condition for which they can seek care. This struggle was compounded by the views often expressed by extended family or neighbors. For instance, if a child is hurting others and carrying a weapon, the extended family sees the child in a negative light and tells the mother they are going to end up a criminal; whereas the mother sees her child's plight as a medical condition that needs help not judgment. As described by one mother of an 11-year-old boy with severe symptoms:

> *"He and I are totally isolated [from family and neighbors] because everyone is against him. They are not convinced that he is ill and they all pile on him thinking he is fine and that he just acts this way because he is ill-bred… no one is convinced he is ill… I am convinced he is ill, convinced that this behavior is not normal. No normal child, mentally and psychologically, would do the things that he does" (*Mother of an11-year-old boy, severe symptoms, CD diagnosis, hospital recruit, planned neighborhood)

4.1.1 Defining DPB in terms of severity

As mentioned above, mothers did not describe a clear unifying definition or domain of a 'disorder' or 'condition'. Instead, mothers would describe children in a variety of terms that were associated with the perceived severity of the behaviors. For example, the term 'naughty' (*Sha'y)* indicated a milder range of behaviors mostly around disobedience, profanity, and hyperactivity.

> *"Since he was born and became aware and he is Sha'y. As he gets older, he [is supposed to] understand better, but no, he becomes worse. Dirtier and dirtier in his naughtiness and less responsive. he stays in the street so much that he learned the words of street kids and profanities...he is not staying at home" (*Mother of an 8-year-old boy, moderate symptoms, slum area recruit)

The word 'criminal' kid or (*mogrem)* was associated with more severe actions like hurting others, stealing, or damaging property. Some words like 'thug' (*baltagy*), 'bum' (*saye'*) and 'lost' (*fa'ed*) also indicated a higher level of problems or fear of a negative trajectory that was often associated with a possible altercation with law enforcement.

> *"I do not see children doing what he does... what my son does... I see him as an older youth who is criminal (mogrem), deviant... I see him as a criminal (mogrem)… you cannot stand him. He does those criminal gestures and says stuff only a criminal would say… he brings a knife and gestures with it like this, and that then puts it in his pocket. I am worried he would sleep with it and it would [accidently] stab him in his side, so I search him at night and only let him sleep in his boxers"* (Mother of an11-year-old boy, severe symptoms, hospital recruit, lives in a slum area)

It is important to note that those terms were used interchangeably and could be even used endearingly in some settings. They did not necessarily indicate an explicit criminalization of the children's behavior in all cases.

> *"I don't want him one day to be saye'(laughing) with his friends so that I am picking him from jail… he is fighting or … I don't want him to be, excuse me...his abilities [are limited], (laughter), he cannot be an engineer, I just want him to be respectful in any profession that God intends for him" (* Mother of a 9-year-old boy, severe symptoms, hospital-recruit, lives in a slum area)

In terms of severity, the disclosed symptoms were more severe among hospital-recruits of both genders compared to the community-based sample. However, within the community-based sample, symptoms were more severe among boys compared to girls. Table 3 outlines the different categories of behaviors mothers identified as problematic and their predominance by gender.

Table 3. Categories of problematic behaviors and predominance by gender

Category	Signs and Symptoms	Predominant child gender
Physical violence	Beating and hurting siblings	Both
	Fighting with other children	Boys
	Hurting animals	Girls
Verbal violence	Vulgarity	Both
	Shouting and screaming	Girls
	Loud voice	Both
	Quarreling with siblings, peers, extended family, or neighbors	Both
Inattention	Losing stuff	Girls
	Forgetting	Girls
	"blanking" or daydreaming	Both
Activity and impulse control	Hyperactivity	Both
	Impulsivity	Both
	Restlessness	Both
School-related behaviors	Inattention at class	Both
	Not wanting to attend school	Boys
	Skipping school	Both
	Poor academic performance	Boys
	Disrupting class	Both
Disrespectful behavior	Anger	Both
	"not listening."	Both
	Answering back	Both
	Embarrassing mother	Both
Gender and sexuality	Talking to boys	Girls
	Revealing clothes	Girls

	Boyish behavior	Girls
	"Not walking" right	Girls
	Sexual harassment	Boys
	"vulgar" comments	Boys
Religion-related behaviors	Not praying	Boys
	Not memorizing Quran	Boys
	"insulting religion" *Sabb Eddin*	Boys
Substance-use related	Cigarettes	Boys
	Drugs	Boys
Other	Jealousy	Both
	Stealing	Both
	Destroying property	Both
	Arson	Both

4.1.1.1 Reflection on the context-specific disruptive behaviors

While many of the priority disruptive behaviors described by mothers, were consistent with more 'universally' described criteria for disorders like CD and ODD, mothers included a list of behaviors that were more specific to this context and are noteworthy for designing an intervention in this setting. These behaviors included jealousy, loss of belongings, forgetfulness, and daydreaming, profanity, "walking oddly" as well as sexuality- and religion-related behaviors.

Some of these context-specific symptoms were only shared by two studies of instrument development for DBDs in two LMICs, namely in Rwanda (15), and one in rural Nepal (16). The behaviors identified in those studies which could correspond to ours included "sexually deviant behaviors", "roaming around" and "being impolite".

The idea that jealousy would be associated with other disruptive behaviors was not unique to this setting (70), the frequency and intensity by which parents found it as a pressing behavioral issue were unique. This concern of parents about jealousy reflects a

set of cultural beliefs and values held by parents and often relate to expectations of conformity and future success. If children are jealous, they are more likely to be ungrateful and compare themselves to other children whose parents have better means, and thus get angry when their needs or wants are not met. It also has a religious connotation of displeasure with God's bounty.

Forgetfulness and loss of belongings meant that the already limited resources parents had to provide, were being squandered by children and meant the child did not appreciate how hard it was for the parent to provide the lost or forgotten item.

Finally, the religious behaviors such as not memorizing the Quran or using profanities that were seen as insulting of religious "*sabb Eddin*" was another defiance of values held by parents. Mothers had an expectation that children who grow up religious will be respectable and protected from other more severe behavioral problems in the future.

4.2 Influences and causes of problematic behaviors in children

4.2.1 The social and physical setting

This study was informed by Super and Harkens' concept of the developmental niche, which focuses on the dynamics that create childhood experiences growing up (Super & Harkness, 1986). Those dynamics are a result of the interacting microsystem of social and physical settings, child-rearing customs, and mothers' characteristics that shape everyday experiences (Super & Harkness, 1986; Worthman, 2010). Hence, we aimed to explore these interacting factors and how mothers described them in terms of influences on child behavior.

Although this framework shaped our study approach and design of tools, the participants' accounts gave rise to new elements within the framework that we have not anticipated as well as new understandings of what each factor means. Below we explore the findings regarding the aforementioned interacting microsystem and its building blocks.

4.2.1.1 Social environment

The social environment in which the child grows was an interest in this study from the beginning, and interviewers actively probed on this topic. There were several main themes that emerged from mothers, including the role of fathers, siblings, the extended family, the neighborhood, the school system, and peers.

Since the study was concerned with problematic behaviors, most of the accounts focused on the negative influence of the various actors on child behavior. However, there were instances where positive impacts of the people surrounding the child were also mentioned. Below we discuss the role of each element of the social environment separately.

4.2.1.1.1 Missing fathers

Most mothers described an overall absence of the father in raising children. Fathers were not in the home most of the day, leaving mothers alone to make most of the decisions about child-rearing. This reality was reinforced by the lack of fathers in our study sample despite our inclusion criteria that allowed both mothers and fathers to enroll as primary mothers.

Mothers often spoke of the primary role of the father in terms of child-rearing as a 'scarecrow' for children, since fathers could inflict harsher punishment and were more feared. Mothers also used words like "awe" to describe children's views of their father, indicating a mixed response of respect and fear in children. There were also instances where mothers expressed considerable skepticism that the father would willingly change their behavior with the child to engage more or participate in an intervention for the child's benefit.

> *"I went to ask about behavior modification sessions, but they said his mother, father, and brother have to be there. My husband would never agree to that... he won't go no. He does not go with the kids; he leaves anything about them to me… he does have a role of disciplining [child name] but to come with me to a doctor…no, never... he would say you go."(*Mother of a 7-year-old boy, moderate symptoms, slum area recruit)

Fathers were often seen as a causative factor of misbehavior in both girls and boys. For example, children modeled violent behavior or profanity displayed by the father. In many cases, this violent behavior on the part of the father was directed towards the mother. Mothers who disclosed issues of intimate partner violence (IPV) would link their child's disruptive behaviors to having witnessed them being demeaned by the father.

> *"Everything his father treats me when he is angry [influences the son's behavior]. [my husband] hits me, calls me horrible names… [son's name] once while we were fighting, me and his father, refused to live with us, he wanted to live with my mother. He does not want us because there is no family life… like I am taking care of them, and his father comes home and follows up, that never happens. [Child] is missing this. But I have to work because his father does not care. [child] does not love his father at all...he says I wish he was dead. His father beats him up, strangles him, and says I will kill you. I do not want you. I don't know what to do. I fix one thing; his father messes it up. He does not recognize his kids need*

> *parenting. His father has lots of problems with behavior." (*Mother of a 9-year-old boy, severe symptoms, hospital-recruit, living in a slum area)

In one instance, the child was displaying severe violence towards the father in an attempt to protect the mother.

> *"When he was younger, when his father would fight me, he would see this, and he got a 'complex'… since he was a nursing baby… it grew with him…now when his father and I are fighting, he would call his father names and once he held a knife to him. He would shout and cry and do things you would not expect from a child" (*Mother of an 8-year-old boy, severe symptoms, slum area recruit)

On the other hand, there were a few examples where the father was identified as a positive influence. In these cases, the father was able to 'negotiate' with the child and to talk them into improving their behavior, or the child just behaved better in the presence of the father. In situations where mothers felt that the child responded more to the directions of the father, mothers felt it was more likely that the father would participate in an intervention for the child.

The complete absence of the father, through death in two cases and abandonment in another, was also seen as influential on child behavior, since mothers felt the child was still traumatized by the loss of the father, especially in one case where the child witnessed the father passing away.

> *"She started acting out since her dad passed away…she started beating up people crying and saying 'he did not die; his heart is beating. Don't say my dad died.' She had a hysterical fit. Now she gets angry and shouts at everyone…she was really calm before because her father did everything, she wanted...the teacher pinched her and beat her on the wrist because she refuses to do her work. She says, 'I don't want to write because my dad is dead!' The teacher told me 'What does writing have to do with her*

*dad being dead?'"(*Mother of a 10-year-old girl, moderate symptoms, slum area recruit)

Fathers were seen as the protectors, providers, and authority figures in the child's life. Hence, having no father could expose the child to bullying or fear that if bullied, no one can stand up or care for them. Mothers shared their concern that the absence of the 'backing' of the father made the children lash out to protect themselves since they know no one else would. Fathers were the primary providers, and their absence means that the economic hardships are going only to worsen. Absent fathers also represented a source of 'pampering' or at least a buffer to the discipline of the mother, which children missed and affected their behavior.

*"She has been acting out since the ceiling fell off in [her room] ...she says why can't we have a nice house like others with a clean bed and finished floors? She has not been herself since the [death of] her father. She hasn't stopped talking about him for months. I sent her to a niqabi religion teacher who told me 'she is sensitive and looks at other girls with their fathers. They buy them stuff, or they play with them, and it affects her psychologically'. I told her many children don't have a father, but she said, 'not all children are the same.'"(*mother of an 8-year-old girl, moderate symptoms, slum area recruit)

In one case, the mother alleged that the absence of the father was due to him sexually molesting the child and that after obtaining a court-ordered divorce from the father she was able to prevent him from seeing the child.

4.2.1.1.2 The extended family

In relating their experience, mothers often emphasized the role of the extended family in affecting their child's behavior. Although there was no one pattern of influence described, either positively or negatively, the emphasis was on the father's family who

held power over the mother with frequent conflicts and interference in the way she raised her children and undermining her parenting efforts. On the other hand, there were cases where the mother described the grandparents' role in a positive light, helping in taking care of the child and providing a source of 'refuge' when parents used harsher discipline.

This extended family was not limited to child's grandparents, uncles and aunts only but also included spouses of uncles (*salayyef*), children's cousin's and even more distant relatives. Many of the participants lived in close proximity to the father's family, although rarely in the same housing unit. Mothers worried about embarrassment in front of the relatives and being judged as a bad parent. The relatives also held the power to agitate the husband against her or at least create problems within the household.

This is not a surprising finding or pattern. Extended family structures (*ahl*) have traditionally been powerful within Egyptian culture, particularly in rural areas. The family home (*beit-el- 'aila*) often includes the grandparents along with their sons and their wives and children, living in a shared household. This structure usually exerts massive influence on the wives who are expected to serve their mother-in-law and other female relatives of the husband, be dutiful and accept criticisms and directives on how to raise children. As families move from rural to urban settings, those structures partially dissolve as the family home (*beit-el-'aila*) does not exist in the same form, but we found in our study that they did not entirely disappear (71, 72). The husband's family still exerts that influence and puts pressure on the mother to conform. The children feel the tension, are affected by it, and occasionally exploit it.

> *"[child] told me, 'you don't want to let me out because my [paternal] aunt told you I am hanging in the street.' I told her no one told me what to do. She says 'don't say no one told you, why then you are not letting me out' she shouted.*

> *Her uncle heard her and came up to beat her up. She started tearing at her hair. 'you don't let me play in the street because my [paternal] aunt told you not to let me out to play and you listen to her. We are children, and we are supposed to play not be cooped up at home,' and she screamed again" (*Mother of an 8-year-old girl, mild symptoms, Slum area recruit)

It is important to note that these accounts are from the viewpoint of mothers who often struggle with the relationship with in-laws, as mentioned above. We did not take the accounts of children or fathers who might view the relation between the misbehaviors and the extended family differently.

4.2.1.1.3 Role of siblings

The conflict between siblings was a common distressing factor for mothers. Although some mothers acknowledged that it is normal for siblings to bicker and fight, it was still a prominent source of stress. The children often demanded attention from the mother constantly and with multiple children in small homes, mothers were struggling to address the needs of children or to be the perpetual arbitrator of their disputes.

Mothers also worried about siblings imitating the misbehaviors of each other or being affected by sibling misbehavior. In response, mothers often discussed being too hard on one child (usually the eldest) to prevent the behavior from influencing the siblings. Several mothers worried this focus on one child could be misconstrued as favoritism towards the other and were constantly battling to be just when treating all children.

> *"I am always in conflict with [child name]. He says, 'I didn't do it, it is [brother] who did'. [Child] is really kind, more than you can imagine. So even though he is (sha'y), his pros are more than cons. Especially when it comes to tenderness, love, and giving. He starts his day playing with*

> *his brother but always wants to control him, to dominate his brother's character. I try to break this in him. I want him to be the caring older brother. I don't want him to feel that I prefer his brother. I have to treat him well. But he gets angry and shouts and always starts problems with his father, who ends up beating him" (*Mother of an 11-year-old boy, moderate symptoms, slum area recruit)

4.2.1.1.4 Neighborhood and home surrounding environment

The role of the neighborhood played a paramount role in impacting child behavior, according to most participants. The description of the neighborhood was both physical and social. In this section, we focus on the social environment aspect, followed by a section on the physical environment. Participants usually described slum or poor areas as a 'low-class area'. They talked about loud neighbors who used drugs and/or a foul language and harassed the passersby. They described loitering youth whose behaviors their children would imitate. As a mother described:

> *"Yes, because we are in a low-class neighborhood (manti'a sha`bia) so it has everything…there are drugs, and youth is loitering on the corner abusing dogs and things like that. So of course, it has an impact" (*Mother of an 8-year-old boy, moderate symptoms, hospital recruit, living in slum area)

This mother, as did many others, longed to move to a better area where she could 'control' the child's surroundings and not be forced to interact with people she deemed to have a negative influence, but she had no means to do that.

> *"If you live in a 'sophisticated' neighborhood, your kids will grow up 'sophisticated' too, but a human being from a 'low class' neighborhood (manti'a sha`bia) cannot get to a sophisticated level… [noise meaning no] It is the hardest thing for a mother.. you see a home your son wants to live in and [the mother] does not have money to live there, he wants to go to a place that is large and clean, and he cannot take it. How can you provide him with the life you want when you cannot help it?"*

Mothers shared their worry that continuing to live in this neighborhood, whether a slum area or an impoverished planned neighborhood, would only result in their children growing up to be a neighborhood 'thug.'

Mothers worried that their children would imitate the people around them and that this impact would counteract any effort of discipline they might take. These exposures were contrasted with the rural background where most participants who lived in slum areas came from originally. They found the city to be more corrupting, and they were not able to raise their children according to the same values they received from their own parents.

> *"Because we are in an environment in the street, in the city, no matter how much you teach the kid, he will go out and forget what you taught them. In my street, we have kids; May God forgive me, are insulting religion all the time, totally normal. We did not have this in [rural town], but we came here [to the city], and there is no hope. He still does not say these bad things, but he doesn't listen because those around him don't listen. I tell their father 'when they grow up; we have to move somewhere else… I don't like it here…not the school, not the kids, I don't want my children to grow up like them'" (*mother of an 11-year-old boy, mild symptoms, slum area recruit)

4.2.1.1.5 Influence of school and peers

Schooling was another major issue for mothers in the sample. School and teachers were almost universally seen in a negative light. Schools were deficient of most resources, and children were in some cases illiterate despite passing to the following grade. This movement through grades was mostly achieved by paying teachers for 'tutoring' sessions so they can pass the child during the final examinations. Parents were forced to pay this tutoring fee even if it exceeded their financial capacity, which, for most

of the participants, was a challenge. Even though many parents sought private tutoring for their children out of their own volition, for the mothers in the sample whose children were in elementary school, the primary motivation was this 'passage fee'. Private classes, as they are literally translated, have been an integral part of life for Egyptians for several decades now, given the deficient support to public schools and the low wages of teachers (73, 74).

One mother of an 11-year-old child with mild DBP symptoms, who resides in a slum area, described her frustration with the schooling system as follows:

> *"I am sad when he does not know how to read, from the lack of attention at school. School comes first. The teacher does not explain anything. Teachers only want to be paid for tutoring and don't care about the circumstances of the students. For example, one subject is 50 pounds. A kid in fifth grade needs 300 or 350 pounds for tutoring and still does not know how to read… They just take the money and pass him… The teacher can have a great impact, but they don't have the consciousness to do their job for God's sake."*

This frustration with school and teachers extended beyond education to the role of schools in raising children and teaching them manners. Mothers felt the school was teaching the children to misbehave as children learned to imitate their peers or in some instances, their teachers. Mothers gave examples of foul language used and how children smoke cigarettes in front of the school.

Sexual harassment or sexual exposure was also a shared concern in a few cases. Mothers mentioned cases of sexual harassment by other children at school, usually older students, in the school bathroom to which their child, or another child they knew, was exposed. They feared more significant ramifications of such incidents as the children grew up and felt that the school did not do enough to address these incidents. They tried

to teach their children to identify these risks and protect themselves; however, parents did not always have the tools to do so. In one case, this sexual exposure was the impetus for the mother to seek care, and she appreciated the help that she received in the mental health clinic:

> *"A boy exposed himself to [child] and touched him…you know. He learned this from school, and now [my child] is [sexually] harassing his sister. So, I came here…I liked the lecture about sexual harassment, and they taught them [to recognize] a good touch and a bad touch. [my child] said 'I did not know it was wrong'. They also taught him not to let a teacher harass him and that no one should enter the bathroom [stool] with him."* (mother of a 10-year-old boy, severe symptoms, hospital recruit, living in a planned neighborhood)

There were a few cases where mothers shared accounts of specific teachers who helped their child with their behavior. However, these accounts were few and far between. Mothers in these instances were sharing the examples of the engaged teacher who is actively helping their child, as the exception and not the rule

4.2.1.2 Social environment as a state of conflict

Participants drew a picture of constant conflict within and outside the household. As described above, mothers were in conflict with their spouses and often exposed to domestic violence, which they had to tolerate. They struggled with the husband's family, who wielded a large amount of influence on the mother's ability to parent and seek care. Participants shared accounts of fighting with their children who defied commands and acted out, frequently embarrassing the mother. They were required to be an arbiter of sibling rivalries among their children. They fought with neighbors. They struggled to make ends meet, and they struggled to be heard when it came to their children needs at

school or at a clinic. This constant struggle and fighting mode were palpably felt in their accounts. Mothers were exhausted, and this power struggle ended up being reflected in their self-provided accounts of the mistreatment of children.

These conflicts are recognized as contextual risk factors for disruptive behavioral disorders (2, 13, 17). Family risk, including exposure to intimate partner violence, along with sociodemographic risk such as chronic poverty, interacts with risks within the child to "produce and maintain maladaptive behavior patterns" (2).

4.2.2 Physical Environment

Overall, the mothers did not discuss environmental pollution as a factor related to child problematic behaviors or violence. For most parents, the idea of the environment itself was not clear. When the words for the environment (Bea'a) or pollution (talawoth) were used mothers usually referred to issues like personal hygiene, infections, food poisoning, dirt, insects, or even emotional stress on mothers. As one mother of a 9-year-old boy, recruited from the hospital clinic responded when asked about the impact of pollution on child behavior:

> *"Yes, of course, it impacts it…it is due to the blood transfusion he received in the incubator. He was ill twice, and he had blood pollution [meaning septicemia], and they changed his blood. This is the origin of all his problems."*

Environment (Bea'a) sometimes indicated the origin or the area where a person grows up. Pollution (talawoth) was often expanded to noise and 'moral pollution' such as the use of foul language or obscene activities that go against religion.

We tried to further probe on this topic by using a plethora of words and asking in different ways how pollutants may affect behavior. For example, whether there was

something in the air or water that could affect behavior? Or how they thought the factories surrounding their slum area could contribute to child health? The answers to these more direct questions were usually in the affirmative but with no elaboration on why when probed further. Many participants answered the interviewer that if they asked the question, then it has to do with child health. For those who answered negatively, they said it could affect health issues like cancer or chest diseases but not their child actions or violence.

> *"Of course [environment impacts children] …when you are raised in a clean environment is not like when you are raised in a dirty one with diseases…like when they are staying inside and [my son] wants to go to the beach. He wants to go to the beaches he sea on TV, which is blue and clean. I cannot provide this for him, and it affects him psychologically because I cannot provide a clean atmosphere" (*Mother of 8-year-old boy, moderate symptoms, hospital recruit, living in a slum area)

4.3 Parental Characteristics

4.3.1 Socio-Economic Standards

The limited financial ability of parents to provide for their children was a constant causative factor of problem behaviors according to mothers. Many participants discussed their inability to address their child's needs and aspirations. They felt that the children were aware of these limitations and that it led them to lash out in frustration. The limited finances affected the child's nutrition, schooling, housing, and the parents' ability to provide recreational activities in addition to other wants like toys, clothes, or electronics. Mothers worried that these deficiencies would have a long-term impact on the child no despite their best intentions and limited means.

> *"We are living in a [slum]; the conditions are much harder now. Before you could provide everything to your son, but now everything is in shortage, everything is lacking… I know that this is…the economic situation and the area we live in. They are the things that affect my son the most. You have to provide to your son everything he needs, within limits, so that he is not affected psychologically…like if I cannot help him study, I can hire a teacher to help him understand. If I cannot afford this, my son is lost."*
>
> (Mother of an11-year-old boy, severe symptoms, hospital recruit, lives in a slum area)

These limitations also impacted their ability to seek care or to stay in care, since even going to the clinic required money for transportation that they could not afford. Even if they could pay for treatment, it was hard to convince the father or other family members to prioritize this expense when they felt they could not see rapid and clear improvement.

> *"His dad does not approve of coming to [the clinic]. He feels [child] is not normal. My son will grow to be an idiot…not a normal, sane person whom you can rely on. He is trivial, impulsive, and won't be dependable compared to his cousins. So, his father is regretful. People complain about his behavior and say he is an idiot. I took him to the doctors, and his father started to interrupt the treatment because people still complain about [child's] behavior, so he feels there is no point of sending him to doctors."*
> *(*Mother of a 10-year-old boy, severe symptoms, hospital recruit, planned neighborhood)

4.3.2 Parental Education

Most mothers in our sample did not complete secondary school education, with almost half not completing preparatory education (the equivalent of 8th-grade education). Mothers were very aware of the limitations their lack of education posed to their ability to help their children. These perceived limitations were most prominent when it came to

helping children with their school assignments, rather than impacting the child's behavior. However, they felt that their own education affected their ability to find appropriate care or know how to deal with their child's problematic behaviors. As a mother of an 8-year-old girl, who resides in a slum area explains how education would have helped her children:

> *"When you understand, and you are educated, you can teach the child. Frankly, I am uneducated. I quit school in 8th grade, and I do not know how to deal with [children's problematic behavior]. I wish I can tell them good things, but I don't have things to teach them to begin with. I am the one in need of education. You know, there are people educated, like you, who know how to deal with kids. But I cannot deal with them in many situations."*

Chapter 5. Responses to children with problematic child behavior in an urban poverty setting

This chapter discusses adults' responses to the child's problematic behaviors based on maternal accounts. First, we discuss child-rearing norms according to mothers relaying both their experience raising children and their experience with their own parents as children. We also explore the disciplinary practices for parents in response to the problematic behaviors that mothers identified earlier, and the rationale for harsh discipline. Finally, we discuss responses within the school to children with problematic behavior and how they are perceived by mothers.

5.1 Parenting and Child-rearing norms

Our study explored both the child-rearing practices and behaviors as well the attitudes and values regarding parenting, which did not always match the parents' actual behaviors. Mothers were expected to be the primary caretaker in the household. They were responsible for all aspects of child-rearing inside and outside the home. Participants felt judged for any perceived shortcomings of their parenting and that their child actions reflected directly on their competence as mothers.

For our participants, there were numerous competing priorities included in their role as mothers. They generally prioritized meeting the basic needs of children around food, safety, school supplies, and healthcare as well as maintaining the household chores. They relayed a constant struggle to provide the basics within their, often dire, economic situation. Playing with children and spending 'quality time' with them often took a back seat.

There was no little place for recreational activities. Parents understood that their children needed the outlet for energy but were often helpless to provide such opportunities. They saw playing in the streets as unsafe and a source of bad influences by other children. At the same time, they had no access to sport 'clubs' or parks where children can play, and even when these options were available, they could not afford the cost.

However, a few mothers of boys in our sample focused on sports. Training places such as sports clubs and youth centers were not accessible for most of our sample. Mothers who wished to enroll their children in sports had to pay relatively large sums of money and spend time getting their children to their practices. Participants mainly mentioned soccer training for boys, although there was a variety of activities which they tried including karate, swimming and running. Participants found that sports had the advantage of "releasing the energy," so their children would be less likely to act out. In the long run, mothers saw soccer playing as a possible opportunity for the children to play professionally one day, citing famous players who came from very humble backgrounds. In addition, they saw practicing sports early as an 'inoculation' against bad behaviors in the future like smoking or doing drugs as their sons grew.

Another prominent role was helping children with their schooling. Education was a significant worry for many parents, and they were extremely critical of their children's school quality. Their children sought their help in dealing with homework and school assignments. However, since most of the sample had not completed secondary education, they were unable to help their children, which was a source of distress and embarrassment.

In many cases, mothers even professed their strong desire to get an education but cited obstacles such as judgment by people around them for attending school at an advanced age, or that the available adult education services were often subpar or corrupt.

> *"Of course, if I know how to read and write, I will sit with my daughter and explain this page says so and so. She sometimes comes saying, 'mom, I don't understand this math problem, I can't solve it' I tell her me neither…I tried to go to "illiteracy eradication" [free adult education program], and people laughed at us. There were people there who received their certification because they are related to the teachers, but for us, we failed. I was discouraged and did not want to go again." (*mother of an 8-year-old girl, moderate symptoms, slum area recruit)

While the mothers were responsible for almost everything regarding managing household needs and expenses, child-rearing, and schooling, the responsibility to provide the money mainly fell on the shoulders of the fathers. However, over half of our participants were working mothers who contributed entirely or substantially to the household finances. The added responsibility of maintaining a job outside of the home did not, however, alter the household-related expectations and demands of their husbands, children, and other family members. Several working mothers, whether married or a single parent, shared feelings of guilt regarding the impact of their work schedule on their children.

For mothers who carried the lion-share of parenting and provision for their house, having a man in the home was still seen as vital. They acknowledged that the men in their lives often failed to carry their responsibilities, but their mere presence as the 'man of the house' was necessary. This pattern was seen even among wives who experienced domestic violence, with mothers explaining that losing their husband would mean having

no opportunity of remarrying for reasons such as not trusting a stepfather to treat their children well, or not being seen by men as marriageable after being divorced with children. They also did not think other men in their family would step up to fulfill the father's role.

> *"I am psychologically affected… my uncle, who was responsible for us growing up would not let me get married because he wouldn't spend money preparing me [for marriage] …the same with my aunt, who is divorced and is still having to work [in old age]. The men in our family, you feel…if a husband leaves, she will have to be the man. Even if he dies, she will not remarry, and if she gets divorced, she will not remarry either. It is a once in a lifetime [marriage], and that is it. She spends her life working and raising children, and marriage is…forget it." (*Mother of an 11-year-old boy, mild symptoms, slum area recruit)

5.2 Discipline

5.2.1 Disciplinary practices

Key disciplinary practices discussed included verbal admonishment, physical punishment, and withdrawal of rewards. Most mothers discussed how verbal admonishment and directions were a better method of disciplining children over physical punishment. They relayed challenges they had in getting their children to listen to them, however, and were often frustrated by the child's lack of response to a 'talking to'.

Most participants saw the harsh physical discipline as a method of last resort and often used as a threat only. Many mothers described negotiating behaviors with their child, for example, offering small treats in exchange for better actions. Some, particularly those who were receiving medical care, used behavior-based disciplinary techniques, such as a point system with points received for good behaviors that lead to rewards and withdrawal of these points and the reward when bad behaviors occur.

Despite this near consensus that physical discipline is not preferable, most participants used harsh disciplinary practices in response to their child's problematic behaviors. This abundance of harsh discipline was not a surprising finding since several studies show a very high prevalence of harsh and physical disciplinary practices among Egyptian parents (27). However, the degree of tolerance and acceptability of these practices was very striking. Mothers readily shared details of severe beating of their children for what they acknowledged were not major offenses like answering back or hanging out in the street for too long. In some cases, the beating was so severe that it left physical marks and, in some cases, required medical attention.

Mothers also detailed the different types of harsh discipline they or their husbands employed, including tying the child, beating them with a hose or a stick, locking up in a room, and withholding food. Some mothers discussed repeated accounts of burning the child's back of the hand with a hot spoon as a form of deterrence from repeating the disruptive behavior. This practice is common in rural communities, from where many participants came before moving to urban slums. In most cases, this was meant as a reminder not to repeat the misbehavior, was reserved for older children and did not leave a permanent mark. In one severe case, the mother recalled burning the hand of her daughter when she was 18 months old, which left a permanent mark.

Participants relayed episodes where the child had enraged them severely to the point that they responded with beating them for a long time until another family member or neighbor interrupted them. Those episodes were colloquially called "'*al'a* " which many adults could recall receiving from a parent a few times in their life when they as a child did a major transgression. However, from several of the participants' accounts, it

seemed these episodes were frequent and in response to what they acknowledged was not a serious offense like not doing their homework or failing to respond to orders quickly.

5.2.2 Disciplinary rationale

Child discipline is a critical element of childrearing as a method to prevent future problematic behavior. It is a way for parents to impart knowledge to their children regarding expectations, rules, and principles that govern their behavior within and outside the household. This intentional nature of disciplinary action was not always present in the mothers' accounts. There was a clear awareness that in many instances the harsh physical punishment they gave their child, was not intended to prevent the misbehavior in the future, but rather as a venting mechanism. Mothers and fathers were under enormous social and economic pressures that rendered them liable to explode at any moment, and this included harsh punishment, which they acknowledged was not intended to improve the child's behavior. There was a sense of guilt following the harsh discipline, but mothers seemed unable to deal with the child in any other manner. They often expressed a desire to learn how to deal with the pressures of parenting and thought that no one understood how hard it was for them.

> *"She shouldn't be beaten, to begin with, but I am at my wit's end. What to do when every now and then someone pushes the door saying, 'Come, see what your daughter did' or 'come see how your daughter injured my daughter'. One day I got so mad, and when my [blood] pressure is high, I do not see what I am doing. I held her down and beat her with the hose of the gas cylinder. I kept beating her till she could not breathe. She slept for two days, not talking or eating or drinking…and after she woke up, nothing. Brought trouble from the streets again"* (mother of an 8-year-old girl, moderate symptoms, slum area recruit)

For another mother, the guilt over beating the child was a constant source of distress that was affecting her own mental health:

> *"I went to her teacher, who said she doesn't do her homework and tears her copy books. I told the teacher to beat her, and I blamed myself for saying that. I also blame myself when I beat her, and it hurts my mental health. I blame myself and swear 'oh lord I will not lay a hand on her,' and I ask Him for forgiveness and swear not to beat her again, but then I go back and do it."* (mother of a 6-year-old girl, moderate symptoms, hospital recruit, lives in a planned neighborhood)

Moreover, mothers often found that the effectiveness of harsh physical discipline decreased with time. They said their child "*naḥas*" or became like brass, indicating that physical punishment no longer served as a deterrent for bad behavior. This awareness did not make them more likely to stop the physical punishment since even if they believed it was no longer a deterrent of current bad behaviors, it was stopping the child from even worse actions.

> *"[I beat him] because he does not listen or has beaten another kid in the street. I tell him 'I will show you what beating is', I beat him, his brother also beats him. His father told me not to beat him because it makes the brain dull, and his body is brass (naḥas). Even if you beat him, he will do what he wants…his father wants me to let go but I cannot, I could eat him with my bare hand (a metaphor for severe beating)."* (Mother of an 8-year-old boy, moderate symptoms, slum area recruit)

5.2.3 Child reaction to discipline

Not all children took the harsh discipline silently or tolerated it. Mothers were aware that their children were growing, and that the harsh discipline was getting less effective with time. Simultaneously, children were growing bolder and confronting the parents about their disproportionate or violent reactions. In some cases, the child

reasoned with the parent to stop the harsh discipline or to at least not do it in front of others. In other cases, the child got to the point of answering back verbally or even physically, which parents found unacceptable and a major source of anxiety about the future of their relationship with the child.

> *"Sometimes if I say, 'Am I not talking to you?' and push him. He would push me back and say, 'don't talk to me this way. Don't lay a hand on me!'. I get really angry to the point where I hit him violently. I beat him, and he beats me back, but sometimes if I hurt him badly, he would cry. I know there are some things I did wrong while raising him. At the same time, the family environment in our house affected him negatively, since he was small, because of the way his father and I treat each other." (*mother of a 9-year-old boy, mild symptoms, hospital recruit, living in a slum area)

5.2.4 Normalization of harsh discipline

On embarking on this study, we expected to hear accounts of harsh disciplinary practices and even child abuse based on a large body of research in Egyptian context about the abundance of physical discipline across classes and settings (23, 26). However, as described above the maternal accounts we received were surprising in their normalization of harsh physical discipline of children. Mothers acknowledged that most of the time, this harsh treatment was mainly to vent their pent-up frustrations and anger and not intentionally meant to improve the child's behavior.

Verbal admonishment and 'negotiating' with children were seen as an ideal way of disciplining a child; however, it was not seen as effective. Despite the recognition of many participants that physical discipline was also ineffective, they were unable to stop it since it served as a venting mechanism for the parent's anger. They also feared that abruptly stopping this harsh discipline will lead to even worse behaviors by their

children. This concern was in addition to the anticipated outside criticism of mothers by family members about their disciplinary practices.

Research around the relation between harsh discipline and aggression in children shows variability by country or ethnicity (75). However, delineating the cultural differences from the relative poverty rates, discrimination, political dynamics and other explanations of family influences makes it a difficult task to understand the specificities of the relation between the harsh discipline and aggression or disruptive behavior in general (2). Although our study did not explore this correlation, many of the accounts shared showed counterproductive results when it came to the effect of harsh discipline on aggression in children or at least decreased effectiveness as children got accustomed to the violent treatment. Mothers shared remorse about many of the harsher practices they described, particularly when they led to permanent physical scars, let alone the emotional toll on the child.

5.3 Mothers as children: What changed about childcare?

During the follow-up interviews, we were interested in mothers contrasting their child-rearing patterns with the way they were raised by their own parents. This line of questions was intended to elaborate on culturally shifting expectations and practices.

Most participants said their parents did a better job raising them but that raising children used to be much easier. They felt that economic constraints were getting much harder, while children's desires and expectations were getting higher due to media influences.

For parents who grew up in rural areas, they found that the larger space to play and even work as a child in the fields made it easier for them to connect with their

mothers and 'release energy'. They could not practice this connection with their children while working in an urban setting, and in many cases, there was no outlet for the children to play or be physically active without falling into trouble. On the other hand, they thought their parents did not prioritize education and that the burden and stress of schooling for their children was something their parents did not have to contend with.

> *"In the old days, there was no internet, no satellite TV. Mothers were kind; they worked all day and night in the fields and at home. They did not have time for the children, so they took them with them in the fields. There was lots of space to let them go and play on their own. In the old days, parents did not send their kids to schools as often and did not bother much about their health. You would think this would make kids grow better, but it is worse now. The pressure makes you violent, and you shift this violence towards your child when it is not their fault. The child just reacts to what they see you, as a mother, doing."(*Mother of a 9-year-old boy, severe symptoms, slum area recruit)

Another difference in the way parents were raised pertained to discipline. They thought that their parents, though they often used harsh discipline, were intentional in their actions. Parents expected obedience and did not tolerate 'answering back' from children, and this deliberate discipline insured that children knew what not to do. In contrast, the increasing stress of parenting for participants made them respond impulsively to their children problematic behaviors in an inconsistent way, which they found to be increasingly ineffective in affecting the child's behavior. In contrast, they felt their parents' punishment was more deliberate and helped them remember not to repeat the same wrong behavior again.

Participants found themselves at another disadvantage when it comes to learning how to parent. They felt no one taught them how to raise their children and that the

advice they received from older women in their family was not helpful but rather judgmental of their failure to discipline the child.

For many participants, they felt no matter what they did; they were criticized. They were either too hard on the child or not hard enough. They either did not work and thus were not helping to improve their child's life or they were working too much and not paying attention to the children. If they taught their children, like they were raised, to avoid answering back to bullies and not to stoop to their level, they were raising weak children who cannot stand up for themselves, while if they taught the child to hit back or call them names, then they were raising a thug.

Finally, many mothers felt that there were negative aspects to their own parents' way of raising them that they did not want to repeat. Although they acknowledged their parents were just doing their best, they wanted to avoid following the same path when it came to issues like ignoring education, forced marriage and forcing their sons or daughters to work as a child.

> *"I try to raise [son's name] the same way I was raised and the manners I was taught because I believe I was raised well. But…I don't want to force him to do something he is not convinced to do, and then he has to bear the consequences and the responsibilities [of what he was forced to do]…my parents forced me to get married to my first husband…they forced me to work instead of finishing my education. All of this is wrong, of course, and I don't want to force him to do such things…I don't want to force him." (*Mother of an 11-year-old boy, severe symptoms, hospital recruit, planned neighborhood).

5.4 School response to child DBPs

The main response of school staff and teachers was complaining to the mothers about the child's action in class. Mothers shared their frustration with being summoned to

school often to hear about what their child has done with no help from the assigned school staff like the school social worker or psychological worker, which every school employ.

In some cases, the participants believed that their child was being bullied at school, and the disruptive behavior was in response to provocation by other children. Like a mother of an 11-year-old boy shared in response to a question regarding the school role in dealing with the child DBPs

> *"No, No, No, the school! Government schools have no role in these issues. Like, if I go to complain my child is being prosecuted by other children, they say 'they are kids playing with each other'. They have no role… the government schools have a social worker who is present, but when you talk to her to speak to your kid and improve his behavior, she does not do anything. Not with my son, not with anyone else. I have never seen them help anyone even though they should." (*severe symptoms, slum area recruit)

Some participants acknowledged that it is a hard job for school staff to control the children's behavior given the huge class sizes in public schools, where most of our sample sent their children. The class size justified to these mothers the teacher's use of harsh punishment in class, including beating the children. In some cases, they even requested that the teacher employ harsher punishment, hoping it would help discipline the child. For example, one mother of a barely 6-year-old boy with moderate symptoms explained why she does not mind the teacher's harsh punishment:

> *"His teacher loves him a lot. She loves me and loves him very much. But he is naughty and always tires her. I even can't stand his actions sometimes, so of course, he is annoying her with what he does. If me my mother can't stand him! One time he came and said the teacher pinched him. I asked where and took off his pants to see the blue and red mark where she pinched him. It left a serious mark. I know*

> *he is naughty (sha'i) and she loves him so frankly, I said he much had done something to drive her crazy that she pinched him this stupidly and I did not go to complain. I even bite him sometimes enough to kill (metaphor of painful biting)"*

However, other participants believed that the school's harsh punishment was harmful and found it to be counter-productive to improving the child's behavior and focusing on their education.

> *"He says 'Mister so and so hit me, or Ms. so and so beat me with a stick'. I think the beating created a psychological complex for him. He keeps saying, 'I don't want to go to learn. I am not going to school. I am not going!' I keep promising him treats to get him to go" (*mother of a 9-year-old child, mild symptoms, hospital recruit, slum area)

In a few cases, mothers saw these involved and caring schoolteachers were instrumental for their children wellbeing and found that certain teachers were able to improve their child's behavior and school outcomes dramatically. The teacher in these cases was a role model for the child, and they were willing to modify their behavior to keep the teacher's good opinion.

5.5 Maternal aspirations for their child's future: What does it mean to win in life?

A large part of child-rearing is motivated by a parent's vision for their child future. In our study, mothers commonly mentioned their aspirations for the child's future, along with the worries of their behavioral trajectory. These aspirations drive responses to DBPs if parents believe they could jeopardize their child's chance of success.

When asked what they considered to be 'successful parenting' or what they would consider as their child turning up to be a winner or '*faleḥ*', the answers revolved around being polite and respectable. In other words, they wanted their child to grow up with

good manners, like those they were raised on, and to be respected in their community. This respectability included having proper education, having ambition, a good job, and a living a religious life. There was a focus on specific career options which were seen as successful, like being a doctor, an engineer, or an officer. For girls, the expectations were similar but included neatness, cleanliness, and good marriage.

Finally, there was a theme of children growing to be 'better than me' among participants. Mothers understood that their harsh conditions limited their own potential and aspired for their children to grow up in better circumstances and more opportunities. This aspiration was often tied to better education, particularly among mothers who were not able to get an education themselves. Education seemed to be a proxy for other aspirations like a better socioeconomic standard, a better marriage potential, and overall better respectability in their community. This aspiration was common among mothers of boys and girls. However, there was an additional element of worry and trepidation among mothers of girls that their daughters might grow up with a similar 'lot in life' to them. As a Mother of a 6-year-old girl with moderate symptoms

> *"My understanding is limited…I wish for my daughter to be better. Sometimes I tell God, why did you give me a daughter? …I worry about her. I want her to be better than me…I did not finish my education…I don't know for sure, but I think it would have made a difference in her life if I was able to teach her better what is right and what is wrong. I want her to be the best."*

Another mother of an 8-year-old boy explained why she would be more occupied with a girl's potential to be better than she would about her son:

> *"I have to care more if I had a girl than with a boy…half of the girl's rights are lost in [this] society. So, I have to make her get the best certificate (complete education) so that when*

the goings are tough, she will fall back on her certificate and can manage her life. I wouldn't let her be like me."

5.6 Maternal Mental health and response to Child DBP

Although the focus of the study did not cover maternal mental health, specifically, it is an issue that came up in the study interviews repeatedly. Mothers were under enormous stressors from their surroundings, which took a toll on their mental health and affected both their perception of and response to their child's problematic behaviors. In some cases, mothers even acknowledged that their own mental health issues were directly affecting their children and could be causing them to act out. For all mothers in the study who complained of mental health symptoms (as self-identified or suspected by a data collector with medical training), referral to free mental health care was offered, and the cost for the transportation to the first appointment was covered by the study.

In order to demonstrate the impact of mental health, we chose one mother's case who has been diagnosed with mental health issues and provide a narrative of how her problems affected her response to her daughter's perceived DBP. Pseudonyms are used for the mother and daughter.

The case of Maryam

We first met Maryam at an educational support center in an unplanned slum area in the East of Alexandria. She seemed sad and withdrawn but willingly agreed to join the study. During the first interview, she would easily cry and was very forthcoming and self-critical in her answers.

When we asked about Aya, Maryam's 8-year-old daughter, it was clear that she was a very smart child. Aya had a strong personality and often confronted her mother

about her neglect, the discrimination in Maryam's treatment of Aya versus her younger sister and her mother's unnecessary harsh discipline.

The main complaint Maryam mentioned in regard to Aya's behavior was her constant shouting and screaming. With almost every question, she complained about the constant attention Aya wanted.

> *"She doesn't always listen. She can be calm and smart. Her teacher commends her and says she is great. But she annoys me with her screaming... she keeps screaming, and I can't take it and cry. I don't like the sound of screaming. I see normal kids, and they don't scream as much as she does."*

However, as the interview went on, Maryam was very frank about ignoring Aya to the point of neglecting to feed or clean her since she was an infant. She even claimed that she often could not hear her till her husband points out that Aya has been calling for her for a long time. She acknowledged that it is the reason Aya has to scream to get her attention. Maryam was aware that her treatment of Aya was not right and that it will affect her in the long run.

When explaining why she used such harsh disciplinary action towards Aya, especially compared to her younger sister, Maryam claimed that Aya's actions were not normal, and they led her to lose her temper.

> *"She does weird things. She cries and yells. She rolls on the floor. She doesn't walk right. She is not like other kids. It makes me angry, and I keep beating her till someone stops me…Sometimes she faints or sleeps afterward. I leave her be, and she wakes up the next afternoon."*

Maryam mentioned having had psychological issues since the time she gave birth to Aya. At first, she did not specify what these psychological issues were, but during the follow-up interview, she opened up about that time:

> *"My life has changed after Aya… I hated her. I would throw her on the floor. I did not want to nurse her…from the first day, I would say this is not my daughter…I was crying all the time…I would sit alone and keep crying. In the bathroom. There was no reason."*

These behaviors did not go unnoticed by her husband and his extended family, who live in the same house.

> *"My mother in law took her from me. She would feed her, and my sister in law would change her… We couldn't afford formula, and I would not nurse her so they would give her anise tea. She wouldn't grow for four months. My mother in law would yell at me that I am the mother, and I should nurse. My husband ended up buying formula when he could, and she started growing when we gave her cow milk."*

Maryam's husband and father tried to seek help. At first, her family thought she was under a spell of sorcery (*seḥr*) and brought her a religious healer who was thought to be able to deal with such problems.

> *"When my husband found me this blue and keep crying, he brought me a sheikh. He started reading the Quran to me, and I would shout at [the sheikh] saying you are a devil. He would read to me, and I would pass out. I would speak in a foreign tongue and would beat everyone around. The sheikh struck me, and I threw a glass bottle at him and injured him. I was not acting normal. He got angry said he would take his revenge on me and will cast jinn[1] [to harm] me."*

[1] Jinn is a term to describe unseen spirits in Arab culture. Belief in Jinn is abundant in other cultures as well. In this context, jinn is mentioned as a form of possession which can harm a person or alter their behavior

This did not stop her family from seeking the help of more religious healers. In a specific case, they sought the opinion of another 'sheikh' who is a healer specialized in Jinn issues, and he told her that a Jinn which possessed her during her pregnancy continues to affect her daughter. This proclamation has affected her relationship with the child and her desire to seek other forms of care.

> *"I went to many sheikhs…for this sorcery and possession issue. He said that she drank the sorcery with me since she was in your womb. He gave her a treatment. He asked first if she gets angry and screams. When I said yes, he gave me honey and herbs…it did not do anything."*

After these attempts with religious healers failed, Maryam's father decided it was enough and decided to take her to a psychiatrist.

> *"My father said that I need a doctor, a psychiatrist after he sought so many sheikhs. Someone told him she might have a psychological problem and that is when I went to the doctor."*

This experience with the psychiatrist did not prove effective, according to Maryam. She disliked the fact that it was a male doctor. She found him disrespectful and claimed he insulted her and likened her to an animal. The medicine he prescribed her, for depression, made her sleepy, and she could not do any housework. She felt it was not effective and ended up stopping it.

> *"I stayed with the psychiatrist for about 3 months. He insulted me. He would try to get me angry and see my response. He called me names. He wanted me to take off the 'Niqab' (face veil), and I don't like to. I would feel paralyzed and couldn't answer back. I did not want to go again; he would insult me… I don't let anyone insult me anymore."*

After she stopped going to the doctor, she claimed to have been mostly healed. However, this did not mean that her feelings about and treatment of Aya had changed.

> *"She would always scream and yell. I could not take it. I burnt her with a spoon when she was a year and a half. Don't ask me why. I heated the spoon on the fire and put it on her hand and her foot. I told her to stop calling me, mother. The burn on her hand became very large. I didn't expect that. I ruined her hand."*

She expressed deep remorse about this incident in particular. Her husband was furious at her for hurting the child. She does not know for sure, but she thinks he made sure she is not alone with Aya after that.

The response to this abuse did not stop with family. During a healthcare visit, Maryam thought that she might lose her child if she kept treating her this way.

> *"When I went to the vaccination appointment. The nurses saw her hand and asked what happened. When I said I burned her, they said I should be in jail for hurting a child this way. My mother in law explained that I was not well, and they told her not to allow me to do this to the child ever again."*

After the first interview, the study team referred Maryam immediately to a psychiatrist who provided care for free. She relayed her experience during the psychiatric visit in the follow-up interview. Although she found the visit helpful and wanted to continue in care, her husband's family believed it to be counterproductive.

> *"I went to the doctor you referred me too. I liked that she was a woman and she listened to me. I talked in a foreign tongue again. I stayed with her for over an hour talking. I felt better talking to her, but I kept crying. I tore my dress and my hair. She said I have to go back the following week with Aya and my husband. When I returned home, my mother in law tried to calm me down. She read the Quran to me. She and my husband said I couldn't go to the doctor again. They said, 'they would not treat you; you will just get sick again.'"*

Although this case is very specific in the severity of mental health issues of the mother, it is important to provide a striking example of the role of maternal mental health. The mother's psychiatric issues directly impacted child behavior and exaggerated the mother's response to the behavior. The interview draws a picture of a vicious cycle where the maternal mental health issues precipitated ill-treatment of the child, which in turn led the child to act out. The mother's response to the child's problematic behavior was very harsh and led to more problems for the child.

As a side note, there is mandatory reporting of child abuse cases for researchers or providers in Egypt. The research team repeatedly tried to provide psychiatric care for the mother and child, which has not been successful up to the time of writing of this dissertation.

Building on the results in this chapter, in the next chapter, we will discuss the patterns and forms of care-seeking for children DBPs as described by mothers.

Chapter 6. Maternal patterns of care-seeking and intervention expectations

Help-seeking is a complex decision-making process which is triggered by a challenging problem. Care-seeking or help-seeking for any health problem can be defined as a "problem-focused, planned behavior involving interpersonal interaction with a selected health-care professional" (76).

When it comes to children, they are dependent on their parents to identify the problem and deem it significant enough to warrant seeking care. Parents also decide the type of care they seek according to their perception of the nature of the problem as medical or otherwise.

In our study, we were interested in understanding all the different kinds of care mothers sought for their children's problem and the pathways they went through in their care-seeking journey. This pathway included the impetus to seek care, what were their expectations for it, their access to services, and the experience once they received the service.

We first explore care-seeking from formal medical services, followed by alternate routes of care-seeking parents took, such as visiting a sheikh (religious healer). Finally, we examine the maternal expectations and acceptability of a hypothetical intervention for DBPs focused on parenting training.

6.1 Health seeking behavior

For our study, nearly half of our sample was recruited from a clinical site (17 mothers out of 37). The rest of the sample did not seek any formal medical care for DBPs prior to recruitment. Thus, the following section presents key themes mainly from the

mothers actively seeking care at the Children's Psychiatric and Mental Health Clinic at Ma'moura Psychiatric Hospital. We also used some of the accounts from parents who did not seek care to explain the barriers behind and reasons for not wanting to pursue care.

6.1.1 Description of the child mental health clinic

DBPs were the most common reason for seeking mental health care for children in the Ma'moura Psychiatric Hospital, which was the clinical site for recruitment in this study. This reality is consistent with DBPs being the most common reason for seeking care both internationally, and in the Egyptian setting (1, 10).

The clinic is one of many outpatient clinics offered by the only public psychiatric hospital in Alexandria (Ma'moura) which operates twice a week from 8:30 AM to 1:30 PM. The clinic receives over 50 cases per day with only one or two psychiatrists and one or two psychologists on duty. On entering the outpatient clinic building, there is a large sign indicating the different clinics and their days and times of operation. There is a long hallway which leads to a metal staircase which takes you to the second floor where the children's clinic is located. On the top of the staircase, there is a large metal structure, similar to a fence, with a door to get to the clinic that separates the children's clinic from the addiction, autism spectrum disorder, and epilepsy clinics. Going into the entrance of the children's clinic there is a small waiting area with very few chairs which then leads to a dilapidated toilet which one has to walk through to get to the actual clinic offices. After the toilet, there is a hallway with three rooms where the psychiatrists and psychologists work.

Parents, mostly mothers, and their children are cramped into the hallway. The hallway is extremely loud, and there is an assistant who calls out the cases into the

doctors' or psychologists' offices. Parents are continuously trying to enter the doctors' offices complaining about the long wait. On entering the doctors' office, there are usually two patients along with their parents. The third room has a psychologist who carries out psychometric testing and conducts group therapy sessions. Due to the high caseload, the psychiatrists spend very limited time with each case, and they mainly speak to the parents before prescribing medicine or referring to the psychologist's office for assessment or therapy sessions. They are also frequently receiving cellphone calls regarding other cases as well as responding to interruptions from the waiting parents.

6.1.2 The impetus to seek formal medical care

While analyzing the interview data, there were two clear themes emerging regarding what motivated the mothers to consider seeking medical care. First, for most mothers in our study, the main impetus to seek care at the hospital revolved around perceived severe DBPs. There were three distinct subthemes that constituted a problem severe enough to warrant care: 1) a behavior resulting physical harm to the child or others, 2) a behavior with detrimental effects on the child's future or 3) a behavior which causes severe embarrassment to the mother. Examples of severe problems which drove mothers to seek care included arson, severe violence towards others, or perpetuating sexual harassment.

The second reason to seek mental health services was the failure of other routes of care-seeking like going to a sheikh, seeking help from the school, asking for help from other family members, or even in some cases seeking medical care from a general practitioner or a pediatrician.

Getting to a mental health care facility was often seen as the last resort and required recognition that the child's behavior is 'not normal' or they are not 'just an impolite child'. Mothers wanted to pursue mental health care-seeking answers on how to deal with their child and secondarily seeking medication that would help control the problematic behavior.

For a subset of mothers, the impetus to seek care included a co-morbid condition, particularly ADHD or specific learning impairments (SLI). They were diagnosed by a school health professional and referred to a child mental health clinic. For these mothers, the disruptive behaviors' impact on school performance was an extremely important reason for seeking care, even though they knew there were other issues related to a learning difficulty or attention that were affecting this performance. The purpose of seeking care also included confirmation of a medical diagnosis, which would result in the child's enrollment into integrated special education. Enrollment in special education included perks related to easier passage through grades and more attention to the child in school. However, for some mothers, they were very resistant to special education, even though they acknowledged their child's problems because for them it meant destroying the child's potential for success and labeling them as disabled. This resistance is due to the belief that the integrated special education meant the child would stay in this system throughout their school career and would impede their ability to get a higher education. There was also a stigma associated with being labeled as intellectually disabled or having a learning disability. Like a mother of an 8-year-old boy explains her reasoning for seeking care

"I first went to the [health insurance] clinic because my older son was not balanced in the class. He would always

forget, forgets, forgets. I took [both sons] to the clinic. [Younger son] doesn't like writing at all and the social worker at school sent me with both of them to go to 'integration' (integrated special education). I don't want to do this to them. They don't deserve this. I will destroy them with integration… When I went to the clinic, the doctor said to go to [a learning disability center]. I asked where that and she was like 'you ask, you look around', she did not want to answer me… I got out of their depressed and did not go back again."

6.1.3 Journey to the clinic

Most of the participants recruited from the clinic were there for their first or second visit. Mothers were interviewed after their appointment in a separate private area in the hospital. Mothers were keen on sharing the details of their care-seeking prior to the current clinic visit and all the trials and tribulations that the journey entailed.

For most mothers, the path to the hospital was circuitous and involved lots of confusion regarding where to seek care. They knew the child had a problem but did not know if it was medical in nature. If and when they recognized it was probably a medical problem, they did not know what kind of doctor was needed. Even when they knew they needed psychiatric care, it was not easy to identify where they can find affordable and accessible care. As a mother of a 10-year-old boy with moderately severe behavioral symptoms, a diagnosis of specific learning impairment (SLI) and ADHD shared her difficulty in accessing appropriate care:

"Listen, I did not understand at first. I mean frankly, I did not know that there is a treatment for these [behaviors]. We are not from around [the hospital area], and no matter what, we come from a low-class neighborhood (manti'a sha`bia). We are not educated or doctors so we can't ask around and so. I didn't know except when, thanks to Allah, God helped us, and we moved to [a better neighborhood]. I found a [child health] center where a nurse happened to be

speaking about education and kids who don't listen. I asked her, and she said 'yes, there is a center for [such children] go and examine him.'"

Given the extreme scarcity of child mental health professionals and facilities, it took mothers a few trials and errors to finally get to the child psychiatric clinic. There was no clear path for referrals, and most participants ended up at the clinic after it being coincidently mentioned by another health care provider, through word of mouth of other mothers or online, or through a recommendation from a social worker at the child's school. This is even though there is a formal referral mechanism from school clinics and public health providers for mental health problems.

As a Mother of a 7-year-old girl with severe DBPs narrates her journey to the hospital clinic:

"Oh, doctor if I told you my story. Since my daughter was two or three, I started noticing all these [problematic behaviors], and I didn't know how to deal with it or how to treat it. I went to the health insurance[2] [facility] since she was in kindergarten, and the doctor did not agree to refer me to a psychiatrist. She said, 'she is hyperactive and has attention deficit, and I will give her medicine to improve'. I did not find the problem to be just hyperactivity and attention deficit. I knew my daughter's psychology was not right. I got tired of the health insurance [facility] and stopped going. I went to other doctors who said she has anemia and that is why she is weak, and that it is affecting her brain. I kept going and coming for six months, and it was useless. I gave up and decided to seek private care."

She explained that she asked around and was advised by other mothers to go to a child psychiatrist's private clinic. She found the private care much more effective than

[2] Health insurance refers to the medical insurance for school children which provides public health care for low to no cost.

the care provided at the public health insurance clinic. In addition, she found the one on one behavioral modification sessions prescribed to her child were particularly helpful. However, as she explains, she could not continue in the private sector:

> *"You are not a stranger [so I will tell you], my husband [doesn't have steady work]. He is a garage attendant. He cannot afford to support our household and expensive treatment in the private sector. They wanted 150-200 pounds every week [9-12$]. We cannot afford this. I kept asking where to go. My eldest niece is smart; she looked on the internet and found another [cheaper] doctor. When I went to her clinic, she said, 'I can follow-up with you and prescribe treatment, but it is still going to be very expensive for you. I work at Ma'moura, so bring her there or go to [the Alexandria University Psychiatric Hospital], they have a children's clinic too'."*

A few mothers also expressed worry that the name of the hospital carried a stigma which they feared could affect their child in the long run if they are labeled as mentally ill or 'crazy'. They hid the fact that they sought care from other family members and instructed the child not to mention it at school. Even among mothers who did not express apprehension about stigma, there was a sense that others in their family or neighborhood would not understand why her child needed help and would judge her as seeking unnecessary expenses instead of focusing on disciplining her child better.

As one mother of a 10-year-old girl with severe symptoms explained why she refuses to seek medical care for her child's DBPs:

> *"I don't want to go down this path…she will be called sick, or labeled as someone who takes psychiatric medicine or goes to a psychiatrist or such things…rather I am trying to change myself a little since if I am different with her, she will change…for example [instead of beating her] I tell her, '[child name] if you listen to me and don't do things that upset me I will buy you what you want.'"*

6.1.4 Experience with care

The overall experience of mothers in care was mixed. Many found that the services did not provide many benefits to their children. They complained about the short time available to examine their child and that the physicians do not always explain how to deal with their child clearly. They found the doctors' directions regarding disciplining their children to be unrealistic and ineffective.

> *"I went to the health insurance [child mental health clinic] and did not like it…they did not take the mothers' visits seriously. As if I am coming because I have nothing else to do. As long as your child is sitting calmly in front of her and can write their name, they don't think he needs anything." (*Mother of an 8-year-old boy with moderate symptoms, hospital recruit, living in slum area)

6.1.5 Barriers to care

When knowledge about the services available for child mental health was not an issue, there were still several themes that arose in terms of barriers to care-seeking. First, the accessibility of service was a major problem. For most participants who lived in slum areas, the cost of transportation and distance to the clinic was a large hurdle. Some participants would need to take up to three different modes of transportation to get to care, and the cost was prohibitive, even when the actual service was free of charge. In addition, the time it took to get to care and back would consume most of their day which they could not spare given their many responsibilities with work, household chores and taking care of their other children.

When it came to the clinic itself, the perceived low quality of services in the public service or based on previous experience, was another deterrent to seeking care. Participants often cited examples of long wait lines, short appointment times, and lack of

adequate care as reasons for their low regard of public child health services. In addition, although there was no high fee associated with seeing a physician at government-run clinics, they usually had to shoulder the cost of the medication prescribed, or at least a portion of it, which was more than they could afford.

Additionally, in some cases, participants shared experiences with providers which were humiliating and discouraged further care-seeking. In these instances, the mothers felt that their complaints were not considered valid and that the provider treated them with disrespect for being poor or uneducated. In the case of a mother of a 10-year-old boy with severe behavioral symptoms, who is trying to persevere in treatment despite negative experiences with certain providers, explains:

> *"Yes, I am trying to continue with the follow-ups. I believe in God and in some of the people here… I just want them to get a better [specific provider]. I was dealing with someone here, and she told me not to come again and to go to the health insurance [facility]. She doesn't even talk to you or talks in a [disrespectful] manner…she keeps contradicting us…while [another provider] frankly is very good and talks to you and explains what needs to be done."*

When probed further about what she does not like about the public service, she compared her experience in public hospitals to the private sector:

> *"I don't like the behavioral modification [session at the public hospital]. It is useless… I tried it, and it did not help [child]. They sent me to the [another government facility] to get the medication [for free]. I only come here for the medication. To tell you the truth, the behavioral modification sessions are effective [in the private sector]. I took him to a [private provider]. You will get good care there, and the doctor tells you what is wrong in details. She did an intelligence test. She gave him sessions to improve his behavior and build his skills. It was good, but she wants lots of money. I could not continue with this doctor… It is a lot of money, and our [financial] condition is dire."*

Finally, another common barrier was not related to the service itself but rather the attitude of family members regarding seeking mental health services. Mothers usually worried about the refusal of their husbands or in-laws of their effort to find care. Many were coming to the clinic without informing other family members for fear that they will be prohibited from going. This negative attitude from the fathers and other family members had various reasons, including cost, time, and disbelieve in the necessity of care altogether. In some cases, the advice the mother got regarding how the father should deal with the child or her was another reason that husbands opposed returning to care.

6.2 Alternate help-seeking routes: The role of the 'sheikh'

All but four of our study participants mentioned seeking care for their child through a 'sheikh', meaning a religious healer or scholar. In both the clinic sample and the community-based sample, parents sought the opinion or intervention of a sheikh early on. The recommendations of these healers and the norms around their practice differed significantly. Some gave regular parenting advice accompanied by some religious motivation to follow said advice. Some were just the imam of the local mosque who was consulted regarding the child's problems. In one of the study areas, all of the eight mothers interviewed consulted the local imam whether their child was possessed with a 'Jinn' and his answer was that jinn does possess children. This answer was accepted by all but two of the mothers and hence dissuaded them from seeking other forms of 'jinn-expelling' interventions.

This trust in a religious figure was not limited to the imams or healers, with religious knowledge viewed as a possible authority to advice on matters of children and

including Quran teachers or even a woman wearing a niqab, who is seen as more religious for observing a stricter dress code.

In addition to the direct provision of care for DBPs, sheikhs had a great power to influence the opinions of mothers on how to deal with their children. The opinion of a sheikh, dissuading beating the child as 'haram', meaning an Islamically prohibited act, was enough for parents to reconsider their disciplinary practice. This persuasion to change was effective even when the same advice from a medical professional was not enough to change the parent's behavior. This influence was effective whether the religious opinion was given in person or through media outlets like television. A mother of a 10-year-old girl recruited from a slum area explains how such advice changed her views about disciplining children:

> *"Like I used to hit them till I knew that beating your child is 'haram'. If you slap a child on the face, you are breaking their spirit, so when I understood this, I quit [hitting them] right away. There are mothers who don't understand and would say 'oh, those kids don't respond to anything but beating and if you don't break them, they will not listen to you'. They don't understand that there are other things which could fare better than beating when it comes to children… I learned this from [a famous Sheik with a television show] and the Quran [female] teacher."*

For mothers who did not seek the care of a sheikh, they did not believe in the need for another person as an intermediary with God. At the same time, they were skeptical of some of the practices of religious healers to be able to trust them with helping their child.

> *"There is a sheikh whom they say can help, but I don't trust these things… [family members] say my son is possessed (malboos) since his uncles hit him hard, he was harmed. He is not malboos. I will not go to human, like me, to complain. I will complain to God, what would a human like me do?"*

6.3 Openness to intervention: What do mothers expect?

One of the ultimate goals of this study was to guide the design of a contextually driven intervention that addresses parents needs and takes into consideration local limitations and resources. Hence, we dedicated part of the follow-up interviews to exploring the attitude of mothers towards different proposed intervention, including mass media, community-based parenting interventions, clinical interventions, or a combination of them.

When asked what they would kind of intervention they thought would help their child, mothers did not have much to say. For many, particularly in the community-based sample who did not seek care before, it was difficult to imagine what an effective program for their child would look like. Their primary desire was to be 'told how to deal' with their child's behavioral problems.

When we probed further providing different scenarios of interventions, mothers showed the most eagerness towards a parenting intervention provided in their neighborhood. Accessibility was a primary concern, and the idea of having a program that can help them nearby was very attractive.

Participants did not provide specific components of such training which they found particularly helpful. For most, they thought anything would be helpful since they had very few if any, resources to help them with parenting at the time of the interview.

In terms of duration and frequency, most participants found that an hour or two once a week, preferably during the weekend (Friday or Saturday) would be ideal. Several mentioned a need for some parallel activity that would occupy their children during this time.

Finally, there was a substantial variation in preference of location or the expertise of the facilitator, but the majority expected an intervention to be inside the same neighborhood/slum area.

6.4 Implications of care-seeking patterns and experiences

The patterns of care-seeking in this study were highly related to the social construction of DBPs discussed above. Parents sought care for their children's problematic behavior not out of a sole medicalized view of DBPs but of a complex co-construction of these issues as both medical and constitutional 'badness' within their child. In addition, they attributed many of their children's problem to their surrounding conditions. This co-construction did not dissuade them from seeking medical care, since it seemed like a last resort to improve their child behavior, and since the other attributions are perceived as unmodifiable.

Another finding that adds to this narrative of multiple constructions is the fact that both mothers who sought care and those who did not seek the help of religious healers. In this instance, the culturally specific construction of DBPs attributes it to a parahuman force, possession by "Jinn", which controls and/or alters the child's behavior and personality (77).

It is abundantly clear from our findings, as well as previous data on psychiatric services in Egypt that the medical system at least in its affordable public form does not adequately respond to the parental and child needs in regard to DBPs. Services were often inaccessible, unaffordable, and perceived low quality. Facilities are understaffed and under-resourced to respond to the volume of cases.

The results of this study, as well as evidence regarding the effectiveness of intervention for DBPs in LMICs (78), suggest that a community-based parenting intervention that takes into consideration the contextual and cultural factors our study explored could be a more effective and cost-efficient alternative to specialized services for a large proportion of children with DBPs.

Chapter 7. Discussion and Conclusions

7.1 Discussion of findings

The data presented from in-depth interviews with mothers provides novel findings on how women in a poor urban context in Egypt define and negotiate the meaning of and influences on childhood DBPs. This chapter starts with a discussion of five main findings which have both theoretical and programmatic implications. Following these findings is a conclusion and a summary section detailing how this data contributes to an adaptation of the conceptual framework based on the research results. The chapter then ends with an overview of the strengths and limitations of this study and a brief description of the credibility and transferability of the findings.

The first key finding from this analysis draws on social constructionism as a theoretical foundation of this study. Our findings show how mothers rarely dichotomized their child's behavior as due to internal "badness" or a medical "sickness" only. This dichotomy of the social construction of DBPs, as initially discussed in the section on theory, has played a role in how "problematic children" are viewed and treated by the medical and judicial systems (59). For mothers in our study who sought medical care, it was the determination that the child's behavior was "not normal" that motivated them to seek care. However, their care-seeking did not symbolize an acceptance that the child's behaviors were purely a medical issue with available effective medical treatments available. Rather care-seeking symbolized how the women had nowhere else to turn. For both mothers who sought medical care and those who did not seek any, there was also a fear of a criminal nature within their child that would impact their long-term chances of success and could lead them down a path of crime. This fear of criminality is in addition

to the mothers' understanding of DBPs as an adaptive response by the child to extreme poverty and challenging physical and social environment. These findings highlight the false dichotomy of badness and sickness narratives, which in reality coexist with the meaning of DBPs always negotiated by parents and children. As a result, to address family concerns about a child, and to motivate treatment-seeking behaviors, interventions should address this complex meaning-making by families in their design and outcome measurement. For example, an intervention should address the concerns of parents regarding their surrounding neighborhood and environment and acknowledge the role these influences play on child DBPs, empowering parents with tools to counteract those challenges. An intervention should address the ideas regarding possession, to which many parents attribute their child's problems. Interventions should also discuss the concerns of the mothers regarding their children's problems, their motivations to seek-care, and their outcome expectations, issues that are fundamental to improving care and which are challenging to provide in an overstretched medical care system (79).

The second key finding, which builds on the first point, is that the biomedical model alone which defines DBPs as clinical disorders designated by a set of rigid criteria and timeline, does not apply to local understandings of children's problematic behaviors and their etiologies. Instead, a broader view of child behavioral problems as influenced by bioecocultural factors is a more accurate depiction for both research and practice purposes. Mother's in this study overwhelmingly discussed how the social and physical environments impacted their child's opportunities and their resulting DBPs. Mothers were less likely to discuss a biological paradigm for their child's DBP. None of the mothers, for example, offered environmental toxins or poor nutrition as factors causing

DBPs. There was also no discussion of a child being predisposed to DBPs through genetic inheritance. While the biological causes do exist, what our study participants emphasized, and what should impact how we view DBPs, is there is often an underlying ailment in the surrounding social environment that at least partially impacts children development and behavior. Our findings support this understanding of "child in-context" and highlights the limitations of modern western "universal" decontextualized descriptions of DBDs within a strict biomedical paradigm (7).

Ecological theorists argue that the biomedical understandings of etiology are continuously reshaped by social and structural factors which impact the more proximal influences on child development (7, 16). At the same time, ecological models of development and transcultural psychiatry emphasize the role of parental expectations and explanatory models for childhood problems in motivating care-seeking, and intervention effectiveness in addressing parental and child needs and expectation (31, 79, 80). This data supports these approaches by exploring the maternal accounts in the context of urban poverty where the cultural and ecological factors played a center-stage role in the maternal experiences of child DBPs rather than a purely bio-medical understanding of DBPs' causes, even among mothers who sought medical care.

The third overarching finding is the need for a gender lens when researching and addressing DBPs among children. This study found that the roles and expectations of girls vary significantly from that of boys. This difference impacts the definitions, causes, and meanings of DBPs that mothers discussed. Two examples from the findings that illustrate the importance of considering the gender lens are the different definitions of

DBPs based on the sex of the child, and the experiences of mothers as caregivers and intimate partner violence victims.

When we examine the differences in expectations of social behaviors by gender, we find that they are not unique to the Egyptian urban poverty context. Previous research around sibling care, children's nurturance, and social responsibility among five- to seven-year-old children in Euro-American samples found that socialization pressures place "girls and boys on different cultural pathways" (76). Girls were expected to be nurturing, direct other children, and be responsible for tasks. On the other hand, boys were often expected to show dominance, aggression, and disruptive behaviors (69, 76).

Among the mothers in this study, this difference in behavioral expectations carried over and was influenced by parental goals and aspirations for their children's future based on their gender. Mothers were more likely to express concerns about morality and cleanliness in their girls since they saw it as impacting marriageability. Research findings from a study in Nepal mirrored these results with parents and teachers worried that 'bad behaviors; in girls could lead to problems when she moved in with her husband's family (16). On the other hand, in our study, concerns about boys often focused on schooling and religiosity as mitigative factors against future delinquency and criminality. This concern of delinquency and criminality in boys has been the predominant focus of psychiatric and developmental psychological research for decades (2). This study highlights the need to move beyond this focus to recognize and treat DBPs in both males and females, working with the gender-based differences in symptom recognition and parental expectations.

The role of gender also became evident in the experiences of mothers as caregivers and often as victims of intimate partner violence (IPV). Mothers were the primary caregivers in our study population and carried the most significant burden of parenting. At the same time, as women in a context where IPV is prevalent and often tolerated, they were victims of violence which children witnessed. Their accounts clearly indicated that these exposures affected their children behavior and their ability to parent them. The exposure to violence also concerned them about the future of their daughters, whom they wanted to grow up in better conditions and not to end up with a similar lot in life.

We expected to hear accounts of spousal violence, given the well documented high rates of domestic violence in the Egyptian context. For example, the Egyptian Demographic Health Survey (EDHS) in 2014 showed that more than one-fourth of wives have been exposed to physical or sexual violence and that over 17% have been exposed to either during the past year (27). Despite the study team's awareness of these high rates of violence, the ease of disclosure of these exposures, and the details participants shared were remarkable in this study. This disclosure occurred even though we did not have a specific question about IPV and only asked directly about the relationship between them and their partner and how they thought it affected their children's behavior.

Childhood exposure to IPV is a well-known risk factor for externalizing problems in children, which include DBDs (2, 81). In a study of Spanish outpatient children, Miranda et al. found that exposure of mothers to IPV was both directly positively correlated with externalizing problems in children as well as indirectly through partial mediation by maternal mental health issues (81).

Even though it was not a focus of this work, maternal mental health issues, and their role in impacting how women defined and sought care for DBPs in this population were key findings. Mothers shared detailed accounts of a myriad of stressors inside and outside the home, which left them feeling isolated and frustrated. These stressors were often related to gender expectations of them, which placed the entire responsibility of taking care of the household and parenting on their shoulder. Their child-rearing role was also combined with the obligation to juggle work inside and outside the home for at least half of our sample. This added responsibility did not alleviate any of the burdens within their homes or change the expectations of their husbands and in-laws regarding their duties.

In addition to the stressors above, maternal accounts of mental health issues in our study were often associated with accounts of IPV and struggles related to poverty and the inability to improve their financial situation.

Maternal mental health, particularly maternal depression, is strongly associated with child psychopathology, including externalizing symptoms. In an adoption study, Tully et al. found that maternal depression was an environmental liability for childhood disruptive disorders (82). Their model also emphasized previous findings that family conflict and harsh parenting are characteristics of families with depressed parents, all of which are factors associated with conduct disorder in children (83).

The fifth and final key message was that the environmental influence on child behavior, as seen by the participants, was quite distinct from a more western understanding of environmental pollution and its effects on health. Across participants, there was a lack of attribution of environmental pollutants and neurotoxins to a child's

behavior, which is not surprising in the Egyptian context. Participants described the environment also as a person's origin. They tied it to purity, whether it came to the family environment or moral purity. They talked about the environment in music and film and how profanity and obscenity were creating a filthy environment in which children were growing. When asked about pollution, they talked about personal hygiene, accumulating garbage, and unclean food.

The literal word for the environment (*bea'a*) has been coopted by younger generations to mean tacky, vulgar, or of a lower class (84). Additionally, the social construction of environment among Egyptians has different connotations. This construction was described by Hopkins based on a study of environmental perceptions among Egyptians in the 1990s as follows:

> "The major metaphor [of environmental] is not nature but 'cleanliness.' Pollution is considered equivalent to dirt, and the metaphor of cleanliness is central to the understanding of environmental pollution in Egypt. Egyptians extend the image of dirt to the moral sphere and cite 'moral pollution,' ranging from boys teasing girls in the street to more serious criminality" (85).

Hopkins' research showed that the level of concern about the environmental exposures among Egyptians living in poverty is high, even if it does not correspond to a more western understanding of the environment. Egyptians are "preoccupied with garbage, sewage, and clean streets, followed by air, water, and noise pollution" (85, 86). This corresponds to a 'brown agenda' rather than a 'green agenda", something that is common in many developing countries. The "brown" agenda refers to problems of pollution and poverty, which cause environmental hazards in cities. While a "green" agenda prioritized issues like climate change, protection of wildlife and biodiversity, and reducing waste (86).

This difference in understanding of the environment is fundamental in the design of any environmental intervention targeting child mental health, or any other health outcome for that matter. It impacts the use of terminology to describe pollutants as well as the targets of interventions that would both address biological and ecological factors related to neurotoxicity and respond to the population needs for a clean environment which correspond to their definitions.

7.2 Summary of the findings and conceptual framework

The results of this dissertation identified the shared experiences of mothers living in urban poverty and parenting children with problematic behaviors. The three results chapters provide an overview of the different aspects impacting DBPs definitions and treatment through the lens of the mothers. The findings draw attention to the complex nature of the challenges facing children and mothers living in poverty and how different factors across the individual, household, and community levels interact and influence child DBP. Figure 2 illustrates a conceptual framework that unifies the central themes discussed by these mothers presented in chapter 4-6.

This framework builds on the conceptual framework that directed the study design and was presented in chapter 2 (figure 1). The initial model was an adaptation of Bronfenbrenner's ecological model for development across different levels of concentric influences within the micro-, meso-, exo- and macro-systems (32). In contrast, the adapted model shown below separates the causal influences, as identified by mothers in our study, from the maternal responses to DBPs and care-seeking related factors.

The adapted model places the child behavioral problems in the middle, classifying the influences into "distal" and 'intermediate' influences. These partially correspond to

the levels of the ecological model described before (organizational or exo- and structural or macro-systems correspond to the distal influences, and meso-environmental system corresponds to the intermediate influences). This placement helps distinguish the influences that occur within the child's immediate environment from the more peripheral factors that still influences child behavior. The bottom of the adapted model is occupied by the responses to child behavior and the care-seeking factors. This format allows us to examine the specific relationship between the different constructs and examine how they impact each other. It also helps in isolating possible modifiable influences and responses as targets for intervention.

The distal influences that are included are urban impoverishment and marginalization, the low quality of services politically allocated for slum area residents and marginalized populations, and gender norms and expectations operating at a structural level. The inclusion of these factors in the model highlights their direct and indirect influence on child DBPs. In this format, they reflect the structural violence aspect of DBPs among children living in poverty as discussed in chapter 2.

The first distal influence of urban poverty is the key underlying factor that contributes to the intermediate factors based on the mother's accounts. Urban poverty captures the marginalization and impoverishment of communities living in the slum area and poor neighborhoods. Poverty also encompasses the lack of information and opportunities for mothers and children, limiting the ability of mothers to seek care or access resources that may help address their child's behavioral problems. This impoverishment construct draws on the theoretical perspective of structural violence introduced earlier. The marginalization of communities in slum areas (ashwa'eyyat) or

low-class neighborhoods (manti'a sha`bia) blocks their potential for success and limits their opportunities for social mobility leaving mothers and children locked in a cycle of poverty.

The second distal influence is the quality of services available, including infrastructure, sanitation, health, and education. These deficiencies were shared by participants who detailed how their communities were deprived of essential services which impacted their child's behavior and affected their ability to seek care. The impact of these poor services and poverty discussed above on issues like poor housing, deficient nutrition, lack of access to clean water and sanitation results in an environmental injustice that impair children's mental and physical health and affects their long-term outcomes.

The third construct is gender dynamics. The findings illustrate how gender impacted the perception and response to child behavior, as well as how gender roles and expectations impact mothers and children in various aspects of life. Mothers shared numerous accounts of inter-partner violence, that often took place in front of their children. This gender dynamic within the household affected the child's behavior, and mothers worried would impact their long-term wellbeing and expectations in life. Mothers were aware that a large part of their 'bad lot in life' was due to their gender since it was behind their deprivation from educational opportunities, choice of partner, and other life choices.

The intermediate influences include a) the physical and social environment of children within the family and household, and school and neighborhood, b) the cultural factors like child-rearing norms and maternal expectations of their children and c) the parental characteristics including education, occupation, and socioeconomic status.

These influences, both distal and intermediate, impact children's behavioral outcomes and their identification as problematic by adults around them. They also impact the care-seeking behavior of mothers, often as barriers to care.

Parents' and adults' responses to children's problematic behaviors included discipline, supervision, neglect, and negotiation. These responses depend on the nature of the child's DBPs as well as the intermediate influences discussed before. The child-rearing norms, parental characteristics, and the surrounding environment all shape how mothers react to children's behavior. The responses are also affected by maternal mental health and stressors, mainly when it came to the use of harsh disciplinary practices as venting mechanisms for the mother's stress and frustration.

Child DBPs and their distal and intermediate influences also impacted the help-seeking patterns, including healthcare-seeking and seeking help from other groups like religious healers. Participants shared the barriers to reaching appropriate care and their experiences while in care. Cost and perceived effectiveness were major barriers to care. When asked about their attitude towards specific interventions targeting child behavior, the majority of mothers shared that they were most inclined to participate in parenting interventions which would be carried at the community level, preferably within their neighborhood.

Maternal mental health issues and stressors are an important factor that mothers described as influenced by both the intermediate influences and problematic child behaviors.

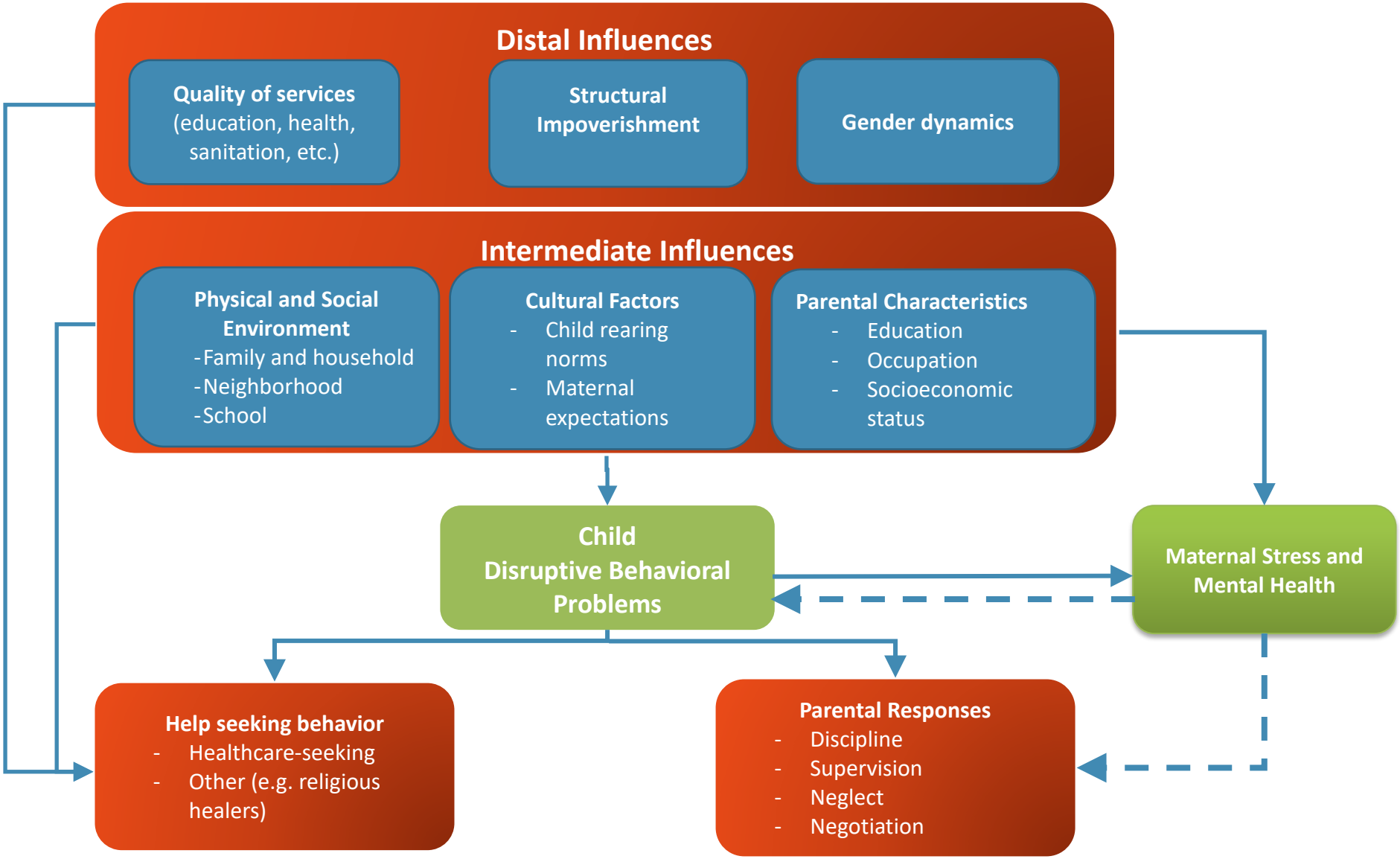

Figure 2. **Conceptual framework of perceived influences on, responses to and care-seeking behaviors for child problematic behaviors: Solid arrows represent data-driven relationships while dashed lines represent interpretive relationships by author**

7.3 Strengths and limitations

7.3.1 Strengths

This study is one of the few to explore the mental health needs of children with DBPs in Egypt. This study investigated a vital understudied aspect of child behavior by examining the context-specific factors affecting definitions of and response to DBDs. The research is unique in its exploration of the ecological and cultural factors surrounding DBPs simultaneously with an examination of the care-seeking patterns and expectations. The inclusion of two samples of mothers who sought medical care and those who did not, also allowed us to compare and contrast the barriers to care-seeking and differences in the construction of behavioral problems among the two groups. To our knowledge, this is the first study to explore this area qualitatively, in-depth and at this scope in the Middle East, and Egypt in particular.

By including mothers living in urban poverty and slum areas, a rapidly growing proportion of the world population (37), we were able to describe the peculiar needs and challenges faced by this population, which despite being partially specific to this context, are relevant to many other contexts across the planet. The narratives elicited provided a voice to a marginalized, underserved population.

Finally, given the limited resources for formal psychiatric care in most LMICs, the findings provide insight into local parental responses, unmet needs, and expectations of care, which are valuable to design acceptable and affordable contextually driven interventions.

7.3.2 Limitations

The study did not estimate specific environmental exposures that might be pertinent to childhood DBPs like blood lead levels, other heavy metal exposures, indoor pollution, and macro and micro-nutritional deficiencies.

This research also did not include interviewing schoolteachers or observations in schools. Such data would strengthen our understanding of another perspective of child DBPs given the length of time children spend in school and the critical role of the school environment, teachers and peers in impacting child behavior (2). However, due to local regulations at the time of data collection, it was difficult to obtain approvals for data collection in public schools within the study timeline.

In addition, the study focuses on a specific urban setting in Alexandria, Egypt, and specifically in the context of poverty, so findings might not be fully transferable to other settings in the region or other LMICs. In contrast, many of the exposures and realities of urban poverty in this setting are comparable to different low-income settings around the world, as discussed before.

The study depended on the engagement of mothers either in medical care or child educational services provided by an NGO, which meant that we were not able to include caregivers who were not as engaged in care and who might be unwilling or able to talk with us about these sensitive subjects. On the other hand, the goal of this study to inform intervention benefits from the inclusion of mothers who are engaged in care since they are more likely to seek and benefit from an intervention.

Finally, due to the settings used in the recruitment of mothers, all of our participants' children were enrolled in school, which might ignore children with the most

severe cases and who do not remain in school. However, since enrollment in elementary school education is above 90% in most of Egypt, including urban slum areas (40), we feel the findings are relevant to the majority of children in similar settings.

7.4 Credibility and Transferability

The credibility of findings within this study involved the debriefing of research staff on data collection tools, their field experience, and their insights on emerging themes and concepts. The author also shared initial interpretations of the data with the study team, the study PIs, and several Egyptian researchers familiar with this context. The observational data, field notes, and sociodemographic data collected aided in the triangulation of findings. We also compared themes across sites, and participant characteristics to understand the commonalities and differences of experiences and findings across our sample.

Theoretical triangulation was also helpful for the interpretation of findings through drawing on theories and conceptual frameworks of different disciplines such as sociology, developmental psychology, and anthropology. The initial results were also presented to the thesis advisory committee in addition to other experts in the field for feedback and assistance in developing conclusions.

Findings from this research about the environmental and cultural influences on child behavioral problems, the maternal expectations, and experiences of care and the realities of parenting in the context of urban poverty are transferable to other communities in Egypt as well as to other low-income settings in the developing world. In addition, it can be argued that the maternal and child experiences described in this study include experiences of structural violence such as exposure to violence, poor services,

and other injustices, that can translate to many poor urban settings in the industrialized world, particularly in the United States. The same can apply to findings around the role of gender dynamics and maternal mental health in relation to child psychopathology, which is relatively universal across settings.

Chapter 8. Recommendations for future research and implication on policy and practice

Our findings show the importance of exploring several additional research questions about risk factors and effective prevention and treatment strategies for child DBPs in Egypt and other LMICs settings. One such area would be to explore the insights of mental health practitioners, teachers, and other stakeholders which can provide a more holistic view of the influences on DBPs and the available gaps and opportunities for service provision.

Future research could also advance our understanding of ecocultural influences on child behavior by using longitudinal data to explore the relationship between environmental and cultural exposures and behavioral outcomes. A quantitative approach would help isolate key constructs that influence long-term outcomes and clarify the ways by which preventive and treatment strategies are effective.

In addition, incorporation of environmental exposure data using biological samples in mothers and children can help clarify how the proven associations of some environmental toxins, such as lead, with aggression in children, are modified or mediated by the social environment and cultural factors in contexts of urban poverty. Such studies and subsequent intervention to address environmental exposures should consider the specific contextual understanding of physical environment and pollution and the terminology used to describe it.

Our study also elucidates the role of poverty as a proxy for various potential pathways affecting child behavior such as competing demands of parents leading to decreased supervision, low quality of services, and exposure to environmental pollution

and violence. The study highlighted the difference between absolute and relative poverty. Mothers and children who lived on comparable income in the same slum area demonstrated differences in their access to services and support systems. Future longitudinal research could use measures like multidimensional poverty (40), which take into consideration other dimensions of poverty in addition to income such as access to clean water, sanitation, education, health services and vaccination, proper nutrition as well as information, to better reflect the mechanisms by which poverty affects behavioral outcomes in children.

Our findings highlighted the critical role of maternal mental health in influencing child behavioral outcomes. Maternal mental health could affect both the perception and response to child DBPs. Hence, we should address maternal mental health needs and outcomes within any intervention package for child DBPs.

The use of an ecocultural approach can also be useful to evaluate gender differences in frequency, presentation, and response to behavioral problems in children. Although there is a large body of epidemiological evidence on gender differences in the expression of behavioral problems, there is usually a focus on biological determinants of these differences (2). A focused exploration of the role of environment and culture in gender differences, beyond just the perception of problematic behaviors, informs design and evaluation of interventions that take into account this gender lens.

Implications for Policy and Practice

As this study demonstrated, qualitative research is a method that provided a deeper understanding of the mother's experiences of and responses to DBP. This understanding

identified gaps and opportunities to improve access and quality of service provision as well as informing contextually relevant psychosocial intervention design for addressing DBPs.

This study shows the importance of culture and environment when designing an intervention. Understanding what mothers consider as problematic behaviors and their expectations for their children is key to the conceptualization of appropriate modules for behavioral modification. Additionally, it is important to consider the time and resource constraints which mothers in this setting operate under and which limits their ability to seek care. Any effective intervention will need to be accessible and affordable to parents and address the problems which they see as priorities within their child behavioral issues.

In terms of service delivery within the medical system, there needs to be a concerted effort to strengthen referral mechanisms between primary care and schools on the one hand, and specialized mental health services on the other. Care should be given to improving the awareness of medical professionals of the available services and ways to direct parents and children to appropriate care when needed.

Chapter 2. **Appendices**

9.1 In-depth interview guide for mothers

Study Title: Ecocultural perspectives on problematic child behavior:
An exploratory qualitative study in urban Egypt

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Date (dd/mm/yyyy): |___|___|:|___|___|:|___|___|___|___|

Start time |___|___|:|___|___| Interview #: _____

End time |___|___|:|___|___| Audio file #: _____

Recruitment: Community Code __ Clinic Code ___

Interview code:

Name of Interviewer: _____

Name of transcriber: _____

Date of transcription: |___|___|:|___|___|:|___|___|___|___|

Guide for the interviewer:

- This interview guide is not meant to be used verbatim, and not all questions will be relevant to all respondents.
- Topics to be covered over 2 interviews
- The main questions are in bold. Probes are preceded by bullets.
- Questions are not meant to be asked in the same sequence. It is expected that participants may answer questions that appear later in the questionnaire as part of their response to earlier questions. In case that happens, feel free to probe around the topic as it comes about. However, make sure that the initial question was also answered (if relevant to your respondent).
- The probes included here are only suggestions. You can use other silent and verbal probes as necessary. If something is unclear, use clarifying questions and encourage participants to elaborate through mirroring or reflective probes.
- There are hints and comments not meant to be shared with the interviewee, but rather as guidance for you. Those comments will be in italic and/or between parentheses.
- Words between brackets like [location] or [service] should be replaced according to your interviewee's information.

Screening Question

Is the Potential participant:
Primary mother? □ Yes □ No
Relation to child: _____
Child age: _____

Does [CHILD'S NAME- DO NOT WRITE DOWN] seem to have more difficulty than most other [BOYS/GIRLS] her/his age with: following directions from adults, getting easily angered, talking back, OR breaking the rules?

➔ FOR CLINICAL RECRUITMENT:
DIAGNOSIS: _____

➔ FOR COMMUNITY RECRUITMENT ONLY:
SDQ CONDUCT SUBSCALE: _____

Statement/item	**Not true**	**Somewhat true**	**Certainly true**
• Often loses temper	□ 0	□ 1	□ 2
• Generally, well behaved, usually does what adults request	□ 2	□ 1	□ 0
• Often fights with other children or bullies them	□ 0	□ 1	□ 2
• Often lies or cheats	□ 0	□ 1	□ 2
• Steals from home, school or elsewhere	□ 0	□ 1	□ 2

TOTAL
Read informed consent IF SCORES 3 OR MORE

MOTHER INTERVIEW GUIDE

Hello, Thanks again for sitting with me for this interview. As explained, we are interested in asking about your child behavior and understanding your experience taking care of him/her. There is no right or wrong answer.

Section 1: Introduction

- Can you describe a typical day dealing with your [child name]?

Section 2: How are DBPs perceived?

- Do you notice any problems in the way your child behaves? If so, what are they?
- When did you start noticing it?
- What parts of what this child is doing causes problems? What parts do not cause problems?
- How are those behaviors different from other children his/her age?
- What makes these behaviors such a problem?
- How do you see those behaviors if your child was a girl/boy? [switch genders according to participant's child]
  How do those behaviors affect their future as successful boy/girl?
  What is a successful boy or successful girl?

Section 3: Ecocultural influences and explanatory models

- Why do you think your child is not behaving the way you expect him/her to behave?
- What do you think affects the problems you see with your child behavior?
- What is the role of other members of the family in the child misbehavior?

Probe:

- What is the role of the father? [or mother if the respondent is the father]
- What is the role of grandparents?
- What is the role of siblings?

- How does school affect your child behavior?
- What is the effect of the neighborhood/area you live in on your child behavior?
- How do you think your work, or your spouse work, affects your child?
- Does your child work? IF YES, what do he/she do?
  - How do you think it affects his/her behavior?

- Some people think things in the air, water, or soil [area/neighborhood] might affect your child behavior, and some people think it does not, what is your opinion?
- How do you think nutrition affects or doesn't affect your child behavior?

Section 4: Responses to DBP

- Have you thought of ways to improve the way your child behaves? If so, what are they?
- How effective where the ways you tried?
- If they worked-> why do you think they did?

- IF they did not work -> why do you think they did not?
- Would your response be different if your child was a girl/boy? [switch genders according to participant's child]
- Can you explain the methods you use to discipline your child?
- What affects the way you discipline your child for the same mistake? How is it affected by other people or other circumstances?
- How do you think your child would behave if you never beat them?
- Have you tried to withdraw reward instead of punishing your child when they misbehave?
  If YES, how did it work?
  IF NO, would you think it would help improve their behavior?
- During the past week, can you describe one time when your child misbehaved?
  - What might have caused them to misbehave?
  - Who else was involved?
  - What did you do in response?
  - How did it work?
- Have you sought care for your child behavior before? If so, what did you do or where did you go?

Probe

- Did you seek care from a health facility?
- Did you seek the care of a sheikh/pastor?
- Did you ask for the help of a community organization?
- Did you seek the help of schoolteacher/psychological worker/etc.?
- Did you use social media to ask for help?

- If you sought care, what was your experience there? How do you think it helped if at all, you take care of your child?
- Would you continue to seek the same care? Why or why not?
- How do you think the service you used could be improved?

Section 5: Other interventions and mitigation strategies

- What services do you think should be available for children who have problems with their behavior?

Probe

- Medical services
- Places for sports and playing
- Nutritional services
- Parenting training

- Where do you think those services should be delivered?
  (clinics, neighborhood, homes, community organizations, school, mosque or church, etc.)
- Would you want to watch a TV show or ad that talk about problems raising children? What would you want it to show you?
- If there is training on how to deal with your child, would you be interested in attending it? Why?

Probe

- What do you expect from such training?

- How times per months would you want the training to be? And How long each session would work for you?
- How many months would you want it to go on for?
- Where do you think such training should be carried out?
- Do you think it would be more helpful to have this training in a group?
  [IF YES] How large of a group? Why?
- Who do you think could deliver such intervention? (doctor, nurse, psychological or social worker, NGO volunteer, teacher) – male or female, old or young?
- What would prevent you from attending a parenting training?
  - Do you think your husband or family will have a problem with you attending this intervention? Why?
  - How would distance affect your ability to attend?

- If there is a parenting program considered for mothers 14 times once a week for 2 hours occurring at the hospital/center every Friday morning, where they discuss how to raise children with problems like [child name]?
- What do you think about such a program?
- Would you join?
- Would it be hard or easy?
- How would you feel talking in a group? Easier harder? Would you attend? Do you think you can share if people knew you?

B. Structured questions

(Adapted Egypt Household environment and possessions questionnaire)

a. How old are you?
   - 18-25
   - 25-35
   - 35- 45
   - above 45

1.2 How old were you when you first got married?
   - Less than 15
   - Less than 18
   - 18-25
   - More than 25

1.3 How old is your oldest child? _____

1.4 What is the highest schooling you received?
   - No education
   - Some primary
   - Completed primary
   - Some secondary
   - Completed secondary
   - Higher education

1.5 What is your marital status?
   - Never married
   - Married

- Divorced or separated
- Widowed

1.6 How many children do you have? ____

1.7 Is your dwelling owned or rented by your household?
- Owned
- Rented
- Other

1.8.1 What kind of toilet facility do members of your household usually use?
- Flush or pour-flush to sewer system
- Flush or pour-flush to something else
- Pit toilet/latrine toilet
- Bucket toilet
- No facility/field.
- OTHER _____

1.8.2 Do you share this facility with other households?
1.8.3 How many households use this toilet?
1.9.1 What is the main source of drinking water for members of your household?
- Piped water
- Public tap/standpipe
- Well
- Tanker truck / cart
- Surface water
- Bottled water.
- Other _____

1.9.2 Where is (SOURCE IN 1.9.1) located?
- In own dwelling
- In own yard/plot
- elsewhere

1.9.3. How long does it take to go there, get water, and come back?
MINUTES_____
1.9.4 Do you treat your water in any way to make it safer to drink?
- Yes
- No
- Don't know

1.10 Does your household have:
- Electricity?
- A color television?
- A smartphone, i.e., a phone on which the internet can be accessed?
- Another mobile phone?
- A telephone (landline)?
- A personal home computer (laptop, notebook. tablet, etc.)?
- Does your household own a satellite dish?

IF NO: In your home, are you connected to satellite from elsewhere?

1.11 How does your household mainly dispose of kitchen waste and trash?

- Collected
- Dumped
- Burned . . . . . .
- Fed to animals . . . . . .
- Other _____

1.12 How many rooms does your household use for sleeping? ROOMS . . . . . .

1.13 MAIN MATERIAL OF THE FLOOR.
RECORD OBSERVATION.

1.14 How often does anyone smoke inside your house?

- daily,
- weekly,
- monthly,
- less than monthly,
- or never?

_____

C. Record observational notes on the social and physical environment of the household (if relevant)

D. [Conclude interview, ask if they have further questions or comments. Thank participant for their time]

9.2 Map of study sites

Figure 3: Study recruitment sites: 1-3 represent Slum area sites and 4 represents the Children Psychiatric Clinic

9.3 Photographs of study sites

Study site 1: Houd 12 slum area

Study site 1: Houd 12 slum area

Study site 2: Al tabya Slum area

Home entrance in study site 3: Abis slum area

The neighborhood outside the home of a hospital recruited mother

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66. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and policy in mental health. 2015;42(5):533-44.
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73. Ille S. Private Tutoring in Egypt: Quality Education in a Deadlock between Low Income, Status and Motivation. Egyptian Center for Economic Studies Working Paper No. 2015;178.

74. Hartmann S. The informal market of education in Egypt: private tutoring and its implications: Johannes Gutenberg-Universität Mainz; 2008.
75. Rutter M, Tienda M. Ethnicity and Causal Mechanisms: Cambridge University Press; 2005.
76. Cornally N, McCarthy G. Help-seeking behaviour: A concept analysis. International Journal of Nursing Practice. 2011;17(3):280-8.
77. Lewis CP, Takala CR, Qaadir A, Cowan KE, Borreggine KL, Rackley SJ. Jinn and Psychosis: Providing Culturally Informed Care to Muslim Adolescents and Families. Journal of the American Academy of Child & Adolescent Psychiatry. 2017;56(6):455-7.
78. Burkey MD, Hosein M, Morton I, Purgato M, Adi A, Kurzrok M, et al. Psychosocial interventions for disruptive behaviour problems in children in low-and middle-income countries: a systematic review and meta-analysis. Journal of Child Psychology and Psychiatry. 2018;59(9):982-93.
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81. Miranda JK, de la Osa N, Granero R, Ezpeleta L. Maternal childhood abuse, intimate partner violence, and child psychopathology: The mediator role of mothers' mental health. Violence against women. 2013;19(1):50-68.
82. Tully EC, Iacono WG, McGue M. An adoption study of parental depression as an environmental liability for adolescent depression and childhood disruptive disorders. american Journal of Psychiatry. 2008;165(9):1148-54.
83. Fendrich M, Warner V, Weissman MM. Family risk factors, parental depression, and psychopathology in offspring. Developmental Psychology. 1990;26(1):40.
84. ElWakeel A. How One Word Reflects a Class Split in Egypt's Social Dynamics. Egyptian Streets. 2016.
85. Hopkins NS, Mehanna SR. Living with pollution in Egypt. Environmentalist. 2003;23(1):17-28.
86. Hopkins NS, Mehanna S, El-Haggar S. People and pollution: cultural constructions and social action in Egypt: American Univ in Cairo Press; 2001.

Curriculum Vitae

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Washington, DC 20011

OBJECTIVE

A physician and Public Health professional. Interest in child mental health research and programming in fragile settings. Strong quantitative and qualitative research experience in addition to leadership, writing and communication skills. Work experience various global settings, including clinical work, academia, and the UN.

EDUCATION

Ph.D. Johns Hopkins Bloomberg School of public health,
International Health Candidate– SBI Track 2019
GPA: 3.94

Certificate of Public Mental Health Research 2014
Johns Hopkins Bloomberg School of public health
GPA: 4.0

MPH Johns Hopkins Bloomberg School of public health
Epidemiology and Biostatistics Focus 2014
GPA: 3.83

MBBCh Alexandria Faculty of Medicine, Egypt 2009
General Medicine and Surgery
Excellent with Honors
GPA: 4.0

PROFESSIONAL EXPERIENCE

Research Assistant- Center for Humanitarian Health 2018- 2019
Johns Hopkins School of Public Health
Duties include developing qualitative research tools, supervising data collection, analyzing qualitative data and preparation of reports and manuscripts

Research Assistant - International Injury Research Unit 2015- Present
Johns Hopkins School of Public Health
Duties include: Analysis of quantitative data for Bogota, Colombia research site with a 10-site global road safety study (BIGRS), Systematic reviews of RTI interventions, report writing, manuscript preparation

Research Assistant- Department of Mental Health 2017- 2018
Johns Hopkins School of Public Health
Duties include screening and extraction of manuscripts for a Cochrane review of psychosocial interventions in humanitarian settings

Teaching Assistant 2016- 2019
Johns Hopkins School of Public Health
Courses include: Statistical Methods in Public Health, Health Survey Research Methods, Qualitative research theory and methods, Qualitative Data Analysis, and Urban health in LMICs

Humanitarian Coordinator 2014-2015
United Nations Population Fund- Egypt
Duties included: Planning and implementation of reproductive health and Sexual Gender-Based-Violence (SGBV) response for Syrian and African refugees, establishing safe spaces for women and girls addressing SGBV case management, and design of an adolescent "life-skills" program which addresses psychosocial support, sexual education and sport activities

Demonstrator of public health 2011 –2015
Community Medicine Department
Faculty of Medicine, Alexandria University

Assistant Lecturer of public health 2015- Present
Community Medicine Department
Faculty of Medicine, Alexandria University

House officer (Medical internship) 2010-2011
Alexandria Main University Hospital, Egypt

RESEARCH EXPERIENCE

Dissertation, Johns Hopkins Bloomberg School of public health 2018-2019
Advisor: Julie Denison, PhD
Title: "Ecocultural influences on disruptive child behavior - An exploratory qualitative study in the context of urban poverty in Egypt."
Advisory Committee: Julie Denison, Peter Winch, Sarah Murray, Mathew Burkey, and Caitlin Kennedy

Johns Hopkins School of Public Health
Centre for Humanitarian Health, Baltimore, MD 2018-2019
Graduate Research Assistant,
Supervisors: Paul Spiegel and Hannah Tappis
A case study of RMCNAH+N in Yemen during emergency

Duties include developing qualitative research tools, supervising data collection, analyzing qualitative data, and preparation of reports and manuscripts

Johns Hopkins School of Public Health
International Injury Research Unit, Baltimore, MD 2015- Present
Graduate Research Assistant
Duties include: Analysis of quantitative data for Bogota, Colombia research site with a 10-site global road safety study (BIGRS), Systematic reviews of RTI interventions, report writing, manuscript preparation
Supervisor: Andres Vecino-Ortiz, MD, PhD

Johns Hopkins School of Public Health
Department of Mental Health, Baltimore, MD 2017-2018
Graduate Research Assistant
Research assistant for a Cochrane review of psychosocial interventions in humanitarian settings
Supervisor: Emily Haroz, PhD

International collaborator for the TEMPO cohort study (INSERM- France) 2015
Study of childhood internalizing symptoms and adult socioeconomic status in a French cohort (18-year follow-up) (unpublished)

MPH Capstone Project
"Emergency Education as a psychosocial support intervention May 2014
for Syrian Refugee children in Lebanon. "—Advisor: Judith Bass, PhD

MPH Practicum Jan 2014
Adaptation of a psychosocial assessment tool for studying Syrian Refugee Children mental health in collaboration with Caritas Lebanon Migration Center and Johns Hopkins Centre for Refugee and Disaster Response
Supervisor: Shannon Doocy, PhD

Data collector 2012
for Verbal Autopsy of non-hospital deaths as part of the project for "Improving the quality of Cause of Deaths in Egypt" Funded by World Health Organization (WHO)-Geneva-

TEACHING EXPERIENCE

Teaching assistant
Johns Hopkins School of Public Health
- Urban Health in Low- and middle-Income Countries (online) 2019
- Qualitative research theory and methods 2019

- Qualitative Data Analysis 2017
- Health Survey Research Methods 2016
- Health Behavior Change at the Individual, Household 2016
- and Community Levels
- Statistical Methods in Public Health I 2015

Mixed Methods Research and innovative qualitative methods Mar 2019
Guest lecturer – Qualitative research theory and methods course
Johns Hopkins School of Public Health

Linguistic approaches to qualitative research Oct 2017
Guest moderator- Doctoral Seminar in Research Methods in Applied Medical Anthropology I
Johns Hopkins School of Public Health

Demonstrator of public health 2011-2015
Department of Community Medicine
Alexandria Faculty of Medicine, Alexandria Egypt
Duties included:
- Instruction of community medicine for medical students (2011-2013)
- Supervision of field visits for students (2011-2013)
- Preparation and instruction of nursing school public health curriculum (2011-2014)
- Research assistance on several faculty projects (2012)

Assistant lecturer of public health (on academic leave) 2015-Present
Department of Community Medicine
Alexandria Faculty of Medicine, Alexandria Egypt
Duties included:
- Training of public health master students on Biostatistics, Qualitative Research Methods, and Ethics of research (Summer 2016, Summer 2017, Summer 2018)

SELECT GRANTS AND AWARDS

Dr. Henry K. and Lola Beye Scholarship 2019
A fund supporting an outstanding student who has completed a medical degree and is pursuing a graduate degree in the Department of International Health at Johns Hopkins School of Public Health

Qualitative Dissertation Enhancement Awards Winter 2019
Center for Qualitative Studies in Health & Medicine (CQSHM)
Johns Hopkins University.
Provides support for a primarily qualitative dissertation research at a critical junction

World Bank's Margaret McNamara Educational Grant 2017/2018
A merit-based grant for an international female Ph.D. student at a US or Canadian institute

Misr Elkheir supplementary grant Winter 2017
A merit-based grant providing partial tuition support for graduate Egyptian Students at foreign institutes

International Peace Scholarship 2016/2017
P.E.O and
A need-based scholarship for an international female Ph.D. student at a US 2017/2018
Institute whose work reflects a mission to advance peace

Donald J Cohen Fellowship 2016
Research fellowship for promising young International Scholars in Child and Adolescent Mental Health
IACAPAP: Calgary, Canada

International Fellowship 2015/2016
American Association for University Women (AAUW)
A merit-based grant for an international female PhD student at a US or Canada institute

Johns Hopkins MPH Field Experience Fund Award 2014
An award funding travel fieldwork for exceptional capstone project

Johns Hopkins MPH Scholarship 2013/2014

Fulbright Foreign Student Program Grantee 2013/2014
Full scholarship and stipend for an MPH degree at Johns Hopkins University for foreign students

PUBLICATIONS

Journal Papers: Accepted for publication

Tappis, H., Elaraby, S., Elnakib, S., AlShawafi, N.A., BaSaleem, H., Ahmed, A.S., Othman, F., Shafique, F., Al-Kubati, E., Rafique, N., Spiegel, P., "Reproductive, Maternal, Newborn and Child Health service delivery during conflict in Yemen: a case study", To be published in Conflict and Health

PRESENTATIONS AND LECTURES

Mixed Methods Research and innovative qualitative methods Mar 2019
Guest lecturer – Qualitative research theory and methods course
Johns Hopkins School of Public Health

Child Mental Health and GBV among Syrian Refugees in Lebanon Apr 2014
Poster presentation for MPH travel awardees
Johns Hopkins School of Public Health

Risk-Taking Behaviors among Secondary School students in Alexandria Jun 2012
International Symposium on Child and Adolescent Psychiatry Research
Bocca Di Magra, Italy

PROFESSIONAL TRAINING

GBV programming in Humanitarian Settings May 2015
United Nations Population Fund, Arab state regional office
Khartoum, Sudan

Clinical Management of Rape (CMR) Course (Instructor) Mar 2015
Training of physicians in humanitarian-aid organization
At Alexandria Regional Center for Women's Health and Development

Psychological First Aid in humanitarian action Apr 2015
Save The Children -Cairo, Egypt

Reproductive health preparedness and disaster response reduction Mar 2015
United Nations Population Fund, Arab state regional office. Cairo, Egypt

Gender in Humanitarian Action Dec 2014
GenCap - Interagency Standing Committee
Amman, Jordan

Performance Improvement tools for Health Care (Instructor) Apr 2013
Planning and instruction of a workshop for hospital residents
Alexandria Main University Hospital

Medical clerkship
George Washington University hospitals in DC, USA Feb- Apr 2011

CERTIFICATION

CPHQ (Certified Professional of Healthcare Quality) 2012- 2016
by National Association for Healthcare Quality (NAHQ)- USA

General Practitioner of Medicine and Surgery 2011-Present
Egyptian Medical Syndicate

SELECT STUDENT ORGANIZATIONS AND COMMUNITY SERVICE

Academic chair of International Health Student Association 2015-2016
Johns Hopkins University

Communication Officer 2013-2014
Johns Hopkins Graduate Muslim Student Association

Secretary of JB Grant Global Health Society 2013-2014
Johns Hopkins School of Public Health

Refugee adolescent Mentor 2015
Girls Safe space in 6th October city, Egypt

Math tutoring for students 2014
Commodore Rodgers Elementary School, Baltimore

Short-term volunteer with SOURCE 2013-2014
(Student Outreach Resource organization)
Johns Hopkins University, Baltimore

LANGUAGES

Arabic: Native Language
English: Advanced Listener, Speaker, Reading, and Writing
French: Intermediate Listener and Reading, Novice Speaker and Writing

COMPUTER SKILLS

General Computer Competencies:
Advanced proficiency level in Microsoft Office Work Suite

Statistical Software Competencies:
STATA (advanced programing), R, SAS, and SPSS (Beginner)

Qualitative data analysis: Atlas.ti, NVivo

Spatial data presentation and analysis: ArcGIS, and R