Maternal perception of emotional difficulties of preschool children in rural Niger

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Abstract
Mental health care for infants and young children is often greatly limited in low-resource settings. The purpose of this study was to describe maternal perception of emotional difficulties of preschool children in a rural area of Niger (Maradi). In this context, both mental health awareness and services were scarce. This research was part of a larger cross-cultural validation study of a screening tool for psychological difficulties in children aged 3 to 6 years old. Data collection included group discussion and individual interviews. A total of 10 group interviews and 83 individual interviews were conducted. The results highlight mothers’ perceptions concerning their children’s psychological difficulties. Sleep difficulties were considered significant by the mothers and were used often as an entry point for further discussion of concerns. Peer and sibling relationships, separation anxiety, and reactions to difficult events were also described. Identification of mothers’ perceptions of children’s main difficulties through a mixed-method approach shows promise as a way to inform interventions to provide culturally appropriate care for children in need.

Keywords
community, humanitarian, identification, perception, psychological difficulties, qualitative research, young children

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Introduction

Addressing mental health needs in low-resource or humanitarian contexts, defined as regions affected by ongoing or chronic interspersed armed conflicts or natural disasters, is a public health imperative as children in need often remain without appropriate care (Jones, 2008; Patel, Flisher, Hetrick, & McGorry, 2007; Prince et al., 2007). Children’s mental health research in low-resource contexts is a relatively new field (Flaherty et al., 1988; Jordans, 2008; Lagunju, Bella-Awusah, Takon, & Omigbodun, 2012; Mollica et al., 2004; Jordans, Komproe, Tol & De Jong, 2009). The lack of research in low and middle income countries is a barrier to providing evidence-based appropriate care to young children, particularly preschool children, who remain among the most vulnerable (Baubet, Lachal, Ryngaert & Moro, 2006; Kohrt et al., 2011; Leckman & Leventhal, 2008; Patel, Flisher, Nikapota, & Malhotra, 2008). There is also a lack of cross-culturally validated tools for the identification of psychological difficulties (Gureje & Alem, 2000; Jacob, 2001; Kigozi, Ssebunnya, Kizza, & Ndyanabangi, 2008). The identification of such difficulties is important not only for providing care but also because such difficulties, if not detected and addressed, can lead to life-long social and psychiatric problems (Barenbaum, Ruchkin & Schwab-Stone, 2004; Parker & Asher, 2012, Stichick, 2001). There is little debate that early detection of children at risk of psychological difficulties both facilitates their care and improves outcomes (Mash & Dozois, 1996; Ringeisen, Oliver, & Menvielle, 2002).

To date, the development and implementation of mental health care for infants and young children in humanitarian contexts has also been limited (Jones, Rrustemi, Shahini & Uka, 2003; Jordans et al., 2008). The lack of validated tools to screen children that are easy and quick to administer by nonprofessionals contributes to evaluation and referral difficulties for children in need (Carter, Briggs-Gowan, & Davis, 2004; Egger & Angold, 2006). Due to the complexity of cross-cultural research, prior to psychometric validation of instruments, it is important to conduct qualitative research to understand how emotional difficulties are perceived and identified locally (Jorm, 2000; Bele, Bodhare, Valsangkar & Saraf, 2013). In this study we adopted a mixed-methods approach (Bolton & Weiss, 2001; Blignault et al., 2009) in the cross-cultural validation of a screening tool for young children, which showed promising results (Marquer et al., 2012).

The aim of this study was to describe children’s interaction with their environment, including physical and social domains; practices, beliefs, and expectations linked to child development; and parents’ perceptions, including their definition, experience and identification of psychological difficulties. Here, we focus on local maternal perceptions of emotional difficulties, with the aim of using this information to improve care provision.

Methods

This qualitative study was part of a larger project on the cross-cultural validation of the Psychological Screening Tool for Young Children (PSYCa 3–6) 3 to 6 years
of age. Quantitative results from the larger study have been published (Marquer et al., 2012). The PSYC 3–6 consists of 22 items covering several domains of psychological difficulties in young children, and includes evaluation of the child as well as his or her environment (social, family, cultural; Goodman, Ford, Simmons, Gatward, & Meltzer, 2012; Larsson & Granhag, 2005; Marans & Adelman, 1997).

**Design**

Maradi is a rural region located in the southeast of Niger, with the capital, the city of Maradi, at its center. Although poorly documented, the population is estimated to be 14 million. Prior to the study, a comprehensive information and awareness campaign was conducted to inform the population about the research aims and objectives. The study team, including a clinical psychologist (trained in cross-cultural psychiatry and qualitative research) and a translator (Hausa–French) organized introductory meetings with local village elders and chiefs to present the research before study implementation (Leanza et al., 2015). Participation of mothers and key informants (primarily midwives and elders) in both group and individual interviews was voluntary. Mothers were selected randomly using cluster-based sampling, a standard approach in settings without an adequate sampling frame. Interviews were conducted from November 2009 to July 2010. In total, 10 focus group discussions with key informants and 83 individual interviews were carried out.

Individual interviews explored difficulties at the family level. During the individual interviews, the child’s environment (family, social, cultural) was explored from birth to current age. Finally, several meetings were organized with psychiatrists, anthropologists, and health care staff of the hospitals in Niamey (the capital of Niger) and Maradi to allow professionals to share their experiences concerning children’s environment, psychopathology, and perceptions in this context. Our main interests were: first, the mother’s identification and description of the child and perception of a difficulty; second, the child and his daily activities; and finally, the clinician’s identification of the specific aspects of the child’s behavior and emotions as difficulties, taking into account the intensity of the difficulty, persistency, and comparison with the other siblings or peers of the same age. Data collection continued until saturation was reached.

**Focus group discussions**

Focus group discussions included mothers with children of any age under 18 years (eight to 10 participants per group) and individual interviews targeted mothers of children aged 3 to 6 years, mothers identified within the group discussions as key informants, and also mothers who were administered the tool and whose score identified their child as presenting difficulties within the larger research study. Group discussions were conducted first to gather general information
concerning beliefs and expectations toward children and perceptions of difficulties (Bhui, Mohamud, Warfa, Craig, & Stansfeld, 2003; Canino & Alegria, 2008; Draguns & Tanaka-Matsumi, 2003; Moro & Heidenreich, 2004; Osofsky, 1999).

**Individual interviews**

A semistructured interview was developed using information collected during group discussions. All interviews began with general sociodemographic questions concerning the child (for example, age, sex, number of siblings) and subsequently became more specific, with questions such as, “Since your child was born, have you had any specific worries concerning his behavior, health, or anything else?” This question was used to avoid defining a difficulty as psychological when it was associated with a medical condition, as in low-resource humanitarian contexts there are many common pediatric illnesses that remain untreated due to scarce or inexistent access to care. The interview also addressed the child’s environment (family and friends) and daily activities. If a behavior was pointed out as different compared to that of other children of the same age, the mother was asked to describe the behavior. We explored several domains of behaviors and emotion including sleep, separation anxiety, externalizing behavior, internalizing behavior, peer and sibling relationships, trauma or difficult events, feeding difficulties, and expressive language difficulties.

**Data analysis**

The Hausa–French translator participated in a 4-day training covering research methods and translation process. She was supervised individually during the duration of data collection (Marquer et al., 2012; Rousseau, Measham, & Moro, 2011). Questions were asked directly in Hausa and the main investigator added questions to clarify or explore new themes discussed by the participants (Bhui et al., 2003; Draguns & Tanaka-Matsumi, 2003; Verhoef & Casebeer, 2002). All focus groups and individual interviews were recorded and field notes taken by the first author.

Transcripts were analyzed using codes defined by study investigators prior to data collection. Additional codes for emerging themes were added. Both inductive and deductive codes were used and included beliefs, opinions, social pressures, and social norms. Thematic content analysis was performed manually and topics were expanded based on the data collected. The phrases most illustrative of opinions, perceptions, and behaviors most frequently expressed are reported, as well as examples of isolated and unique behavior (Denzin & Lincoln, 2005).

**Ethical considerations**

Ethics approval was obtained from the National Consultative Ethics Committee of Niger, the Ministry of Public Health of Niger, and the Committee for the Protection of Persons (CPP) Ile de France XI. At the village level, approval for
qualitative research with community members was obtained from local village elders and chiefs prior to implementation. All participants gave informed consent and, if indicated, received care free of charge from a trained mental health professional working with the Ministry of Health of Niger and Médecins Sans Frontières, either at home or in a health structure depending on the preference of the mother. No ethnic or identifying information was coded. All data were maintained in a secure place after completion of interviews. All children and mothers are identified with pseudonyms to ensure confidentiality.

Results

Weaning and community expectations

Although weaning precedes the preschool period of interest here, this period of life emerged frequently in interviews as a critical milestone related to empowerment. Weaning takes place between 15 and 24 months of age. In the past, the first child was entrusted to his grandmothers during weaning, from 3 to 4 months up to 1 year. At the time of this study, this practice seemed to be disappearing; mothers said: “I prefer to wean my child myself nowadays,” “I don’t want any more to be separate from my child for weaning,” and, “I’m using modern techniques such as using ‘plaster on the breast’ or ‘pepper’ to ‘disgust the child from the breast.’” During the first day of weaning, a special herbs concoction was given to the child “to give the child appetite.” To facilitate weaning, one woman stated that it is important “to prepare the child since birth.” During breast-feeding, the child is often in the arms of the mother, who is seated and not lying down as this “could avoid, prevent the weaning.” The child could get used to lying down, and he could associate lying down with breast-feeding.

Once weaned, the child is considered “empowered” and then joins his siblings at night in the same bed. The mother continues to monitor the child until he can fully take care of himself, for example, until “he is eating well in the family plate.” One mother described “I’m looking during the meal how he eats… until the time that I will be sure that he knows how to feed himself.” In the first year of life, there is a notion of the need to protect young children: “We protect the children,” “They are vulnerable as they don’t speak or walk.”

Community expectations

With regard to environmental (family, social) expectations for the child, “obedience, work, and help in the household” were perceived as positive values. Children should “obey” adults, “sleep well,” “eat well,” and be “in good health.” Withdrawal behavior was associated with “be[ing] sick” and “hav[ing] fever.” One mother declared that “if my child withdraws I know he is sick.” A child who was too demanding was perceived as a “child who doesn’t like to be refused something, he will cry a lot, he will stand somewhere until he has what he
wants.” One mother said, “It’s important that the child obey me... otherwise he will become a child that doesn’t listen... a child who will decide what he wants to do.”

Fighting back was also seen as important for children. For example, it was valued when a child defended himself and fought back against another child in the midst of play fighting. One mother said, “He is calm, really calm, it hurts me when another child kicks him and he doesn’t kick back.” The word “fighter” was often used in juxtaposition to “shy,” shuru shuru.

Summarizing a number of community expectations, one mother said that her child Laouali had a good character because “if I ask him to stop doing something, he will... if you send a child to buy something he will go... he is patient... he doesn’t fight.”

**Barriers to identifying psychological difficulties**

In order to understand local maternal perceptions of psychological difficulties in young children, we focused first on the identification of difficulties more generally. The mothers often associated difficulties with medical conditions, for example: “a child with fever,” “a child who is sick,” “a child who is going to a health center,” or “a child who has fever, malaria, pain in the stomach.” A child identified as having difficulties was often described by the mothers as a child who is “physically sick,” “cries a lot,” “screams,” and is “aggressive.” A medical condition was often the mothers’ first assumption when asked about difficulties pertaining to their children. A child who cried a lot, defined as “more than the other children,” was said to have “consequences” on the daily activities of the mother; he requested “more attention.” Mothers said that “often it’s a child that still has to sleep with them, even when he will be older.”

During group interviews, most of the interviewees perceived the young child as passive with respect to his environment, meaning that due to his young age he could not understand the same things as an adult. For example, it was said that “a child is too small [to present psychological difficulties], he can’t understand, he can’t talk, he can’t have problems, unless he has malaria, diarrhea or fever,” and that the child “is always with his mother,” who was perceived as a protection. Unless the difficulty was visible, such as “a child who is crying a lot and disturbs others” or a child who, “compared to his brother he is different, he is really aggressive,” difficulties were not immediately mentioned. The perception of a difficulty was more often associated with a medical condition.

Subsequent interviews also highlighted the need to ensure that medical issues and expected developmental steps were differentiated from psychological difficulties. As a result, we modified the progression during individual interviews to distinguish medical conditions from other conditions and also to ask mothers to describe anything different between a particular child and other children of the same age. We found over the course of several interviews that ensuring discussion of sleep disturbances, including nightmares and fears, facilitated access to any specific perception of difficulties.

As we gathered general information and differentiated medical and psychological difficulties, we explored the primary causes identified as leading to potential
psychological difficulties for the child. Three main categories were shared across different groups of mothers: “when the mother and the father are from the same family (for example two cousins),” “the child who doesn’t talk but understands,” and “the child who stammers.” The following provides a description of each of the domains of psychological difficulty investigated in greater detail.

**Maternal perception of psychological difficulties**

**Sleep difficulties.** Based on the group interviews, discussing nighttime appeared an interesting way to enter into the domain of psychological difficulties. Exploration of night behavior allowed access to information on sleep disturbances, which were often associated with cries, withdrawal, and separation difficulties. Generally, night was perceived as the “spirits domain” as “white and black” respectively pointed to “good and bad.” Nighttime was seen as a place of possible “attacks.”

Most of the time, if sleep was disturbed, the child was not asked to explain what he “dreamt,” “saw,” or “what was scaring him.” Mothers explained, “A child is not asked because he can’t know.” Fear was one of the main reasons described by the mothers to explain sleep disturbances such as “frequent waking up.”

Maternal perceptions of sleep difficulties are evident in several cases described in individual interviews. For example, describing Iro, a 4-year-old boy, his mother said: “He sleeps well but sometimes, when he got out of the household during the day and he saw something that scared him, in the night he cries a lot, saying what he saw… Even sometimes he refuses to go to bed.” She added that, “In fact he always reacts as if he is afraid of something… for example when someone claps his hands he will often startle.” This behavior seemed to have started “when my son started growing… after weaning him, in his second year, when he started differentiating things.” Iro’s mother started the interview describing this behavior as recent, but through the story of the child we realized that he had shown it for 2 years. Regarding the periodicity of waking up, startling, or crying, the mother said it occurred “every week, two to three times per week.” She also stated that, “When he wakes up, he can’t be consoled… he just cries a lot and doesn’t say anything, he usually cries one hour and a half or two until he is tired and goes back to sleep.”

The mother of Mamani, a 4-and-a-half year-old girl, identified difficulties that the child had presented from the time she was carried on her mother’s back. Mothers often described the behavior of their children by referring to specific periods of child development. In the case of Mamani, it could be inferred, then, that this behavior started a few years prior, because in the Maradi region, children are carried on the backs of their mothers until weaning (between 15 to 24 months). Her mother said,

Since I hold her on my back, she wakes up, crying and startling, and up to now she is doing it, we can’t sleep, she wakes up everybody in the household… When she starts nobody can sleep… each night… I used some traditional incense fumigation but it
doesn’t work . . . Yes Mamani is scared of something . . . I don’t know what happened on my back at that time.

The difficulties associated with this sleep disturbance by the mother were weight loss and fever. She consulted with a doctor who prescribed a treatment, but the mother continued to associate these physical symptoms with “the difficulty during the night.”

The mother of Samir, a boy of almost 4 years old, shared,

He falls asleep, then he wakes up during the night, crying, as if he was afraid of something, every two days . . . as if he was keeping something in his heart, it’s during the night that he is doing the dream . . . I can’t know what is happening to him . . . When he sleeps it’s as if he was talking, as if something was opening his eyes on him.

“It started when I weaned him,” said the mother, “he stayed with my mother for few weeks and when he came back, he started doing bad dreams.”

**Separation anxiety difficulties.** Separation difficulties were addressed by exploring how a child was perceived when he had difficulties being separated from his mother (or his caretaker). For example, mothers described the following separation-related difficulties: “He is always with me, he can’t let me go out without him.” “He always needs to know where I am,” “She often wakes up during the night to check I’m there and fell asleep again.”

The behavior of crying a lot when the mother left the household was considered “normal” until 2 or 3 years of age. From 3 to 4 years old, this behavior was perceived as a problem only if the mother had given birth to another child. For example, in this specific case, the mother needed to pay more attention to the newborn than to the elder brothers or sisters who were more independent. Iro’s mother shared, “He is crying a lot when I’m leaving but I will say that is often the case, if I’m in the household or not.” She added, “I will say that he has difficulties separating from me, he gets worried sometimes . . . but I’m not worried, he can be consoled by other members of the household . . . but each time I’m leaving, he will start crying for long.”

Another response to inquiry about separation from the mother noted: “I can’t know what she thinks, she is too young to understand, really I can’t know, even the child can’t know what is happening.”

**Behavior difficulties.** A child under 6 years of age who could not stand still was generally perceived as normal: “It’s normal, it’s a child, and all children are the same.” It was also said of this behavior: “It is childishness, maybe he will stop when he grows up.”

The mother of Mamadou, a boy of 4, said, “It’s a child who cannot stand still, even if you ask him, he can’t stop.” For example,

When he plays with something as a knife, when I want to take it from him, he runs away and smiles . . . This behavior he has it with me not with his father. When his sister
was born, he got upset, he said that he even doesn’t want to take her in his arms, and
that nobody should take her. He said one day, you should give her to someone.

Nassim, almost 6 years old, was described by his mother as having once been “calm
and obedient,” but had become “a child who can’t sit still, he can’t stopped.” She said,
“I don’t know why, each time we ask him to do something he doesn’t obey . . . He can
throw stones on people . . . We ask him to stop but he doesn’t want . . . he is like that
with everybody.” Regarding the cause of this change in behavior, she elaborated, “For
me this is God to decide . . . me I can’t know what happened before, that he changed,
I’m blind,” meaning, “I don’t know, if something happened to him I can’t know.”

She further explained:

This behavior started when he had fever, he was lying down and suddenly he woke up
startling, and since this moment he is like that. It was during one night he had a lot of
fever. Also now he refuses to do things, we send him somewhere and he answer “why
not sending one of my brother.”

Mothers also described some children as more restless than others. Such children
were perceived as “different” compared to their siblings or peers, or even as “mad.”
Identification of such children was often linked to a repeated behavior described by
the mother as “noisy,” and also to the observation that a given child “doesn’t
interact with other children.” Young children’s “fits of anger” were often asso-
ciated with “loud cries,” or a child’s refusal “to obey an adult.”

**Internalizing behavior difficulties.** Sadness was associated often with children not agree-
ing to do something: “Yes it can happen, he can be sad, even now, when he doesn’t
agree, he gets upset and withdrawn.” One mother said of her child, “He is sad,
sometimes he doesn’t want to do things we request him to do . . . He can stay 1 hour
doing nothing.” However, the main answer concerning sadness was, “How can a
young child be sad . . . they don’t know anything.” Sadness also was often ascribed
to children who presented a medical condition such as a fever that made them
generally apathetic or restless.

**Peer/sibling relationships.** Mothers described their perceptions of childhood inter-
actions with respect to peer and sibling relationships. Children “decide if yes or
no they want to play.” One mother said that her son “withdraws from his peers if
he wants . . . most of the time when he does that it’s because he is upset, something
happened that disturbed him.”

Among siblings, when there was a newborn, it was considered normal that the
youngest child showed signs of jealousy, although not for long:

It often doesn’t last for long . . . my son for example refused to sleep with his brothers
and sisters, and asked me to put the baby aside so that he could sleep with me, then he
got used to her, and everything went okay.
There was also a value in the community of sharing between siblings (food, toys, time): “All he found now, he is going to share it with her, even if she is not there, he will keep it for her.”

Witnessing and/or experiencing a difficult event. It was not considered possible for a child to experience psychological difficulties after having witnessed or experienced a difficult event (for example an accident or death). One mother (whose husband had died) explained of her son, “He is too young to have understood,” as if to deny that the child had perceived what had happened. Children were often interpreted as passive witnesses: “He was present when the person died, but he can’t recall or remember,” “During a few weeks she cried a lot, but she didn’t understand what happened to her sister.”

Exposure to a potential trauma was not immediately associated with possible difficulties, but the mothers sometimes made this link later in the interviews. One of the mothers interviewed explained,

My son has called him [his older brother who had died], asking for him, for several weeks during the night with often difficulties sleeping…repeated dreams where he was calling him, talking to him…I noticed that he has a loss of appetite…he was crying more…even more when he understood he will not come back…with time it has stopped, but it took a long time…He is too young to understand, I told him that his brother will come back…I told him that he is in school, 2 years after his death…He needs to be to patient…he will understand when he will grow up.

The mothers stated that generally, “We don’t talk with children about death,” asserting that, “The child needs to understand by himself that the person will not come back.” It was believed that the child would discover this by himself, around 8 or 10 years old. Children were never told that somebody died because they were “mentally not structured.” Regarding talking to children about a difficult event (such as death), one mother said, “You can’t do it…even if you do the child can’t understand.”

The consequences of witnessing a death were evident in one story recounted by a mother in this study. Sanoussi, 6 years old, and his young sister were playing in the household, when suddenly the sister felt bad. The mother took her to the health center, but she died on the way. The mother explained:

When Sanoussi saw us going out of the household, he cried…While coming back I told him that his sister had died…They were playing together when the problem arrived…he still talks about her, but it doesn’t bother me…today he avoids to play at the same play he was doing with his sister when it happened. They were playing a beating game, now he refuses to play it. If he sees children with a knife or object that can hurt someone he says that they shouldn’t play with it, otherwise it will happen the same thing as for his sister…For example when he plays with the others, he says to the others you can’t play to that because my sister left until now and didn’t come back yet.
During the interviews, mothers did not seem to associate any feelings of guilt with the events witnessed. While it might be expected that, as Sanoussi was playing with his sister when she became ill, he could feel responsible or that he had done something wrong to her, what was expressed could be interpreted as closer to worry:

He is more worried than his siblings since his sister died... He thinks his sister is not yet back because she played with a hurtful object. Sanoussi is always worried when he sees blood... For example last time his little sister was bleeding and he thought that she would die... Yes he does talk about her, often, and say my sister is dead.

Another illustrative case is that of Fatima (5 years old), who has two younger siblings that died. Her mother said, “Fatima cries a lot, and often asks where they are.” Fatima was present at the burial of one of her siblings, and she asked where he was going, “but nobody answered.” The father added that she saw that the body was buried, and that

Today when she talks about that, we tell her that she needs to be patient, until she forgets, until she will be old enough to understand... When she will be 15 years old, she will understand, 12 or 13 she is too young, it is childishness.

Since the death, Fatima

Refuses to eat, we have to oblige her... We think it’s linked to the death. She was really close to the last one, she was the one holding him on her back during the day and taking care of him.

**Feeding difficulties.** When eating difficulties appeared in the mothers’ descriptions, they were often associated with an identified physical condition such as a stomachache, headache, or fever. Other than when a medical condition was involved, children experiencing feeding difficulties were identified as “difficult.”

Usually, one mother said, a child eats until his “stomach is full.” The mother of a child with feeding difficulties described: “For example when I put the food in the common plate, he refuses and he cries. I have to give his part on his own plate for him to eat it.” Being selective about food was seen as a trait of a “difficult child” or “a child who needs to be forced to eat.” A child who eats well, on the other hand “eats all he finds, even if it’s bran, he will eat it, if he doesn’t it means he is sick, even a big child can’t be selective about his food, it’s not possible here.” “Eating well” for a child locally means “to eat everything.” The main answer we received about feeding was, “He eats well, all I prepare he eats, he doesn’t chose” and, “He doesn’t make choices,” meant that the child was not complicated; most of the time in this context families did not have a choice of food, and ate a monotonous diet.
Expressive language difficulties. The expressive language difficulties identified were often related to a delay in language acquisition or to pronunciation. Delay or absence of language did not seem to be identified as a difficulty until the age of 6. Stammering was also identified in multiple interviews and was often discussed by describing children as “talking less” or “with difficulties.” Mothers also described stammering in the following ways: “He speaks but he stammers,” “He can say few words but with a lot of time,” “He takes time to say something but we can understand what he wants to say.”

However, stammering was also identified as a difficulty only after 5 or 6 years old. Even in children 3 or 4 years old, language issues were not perceived as a difficulty but were rather associated with “the will of the child to speak or not.” Mothers did not seek help for stammering in younger children. They explained this by saying, for example, “Some children take time to talk,” “It’s God who decides,” and “He is going to talk.”

The mother of Salifou (almost 5 years old) described his difficulty with language in the following way:

He doesn’t speak; he doesn’t have a good language…He started talking during weaning time, but today he just says papa and mama…He stammers, he is like that…even his language is not yet mature…everyone has his own way to talk…he talks with us…he takes time but it’s not something that is bothering him.

The mother of Brahima (5 years old) described,

He doesn’t know how to speak, he can say papa and mama…he can talk but not like a mature child, I understand but not everyone can understand…If I send him to buy something, he can do it, he understands all…his language is delay…people said that it’s someone who doesn’t know how to speak.

The mother of Amidou (3 years old) described:

He doesn’t speak, if we oblige him to speak he cries, but he understands when we talk to him…when he wants, he talks and we understand him, but if we oblige him, he cries…but a child can wait until 5 years old to say the first word.

Discussion

Identification of psychological difficulties in young children in low-resource and humanitarian contexts is challenging due to the lack of mental health professionals and facilities and poor understanding and awareness of the mental health needs of children. In such contexts, qualitative research offers a way to understand local perceptions and identification of psychological difficulties, and also gather information on how to deliver appropriate care (Bolton & Tang, 2004). Research on
local concepts of illness also provides an opportunity to discuss such issues with the population seeking care and potentially improve patient help-seeking behavior.

Prior to this study, to our knowledge, there was no publication on children’s mental health in Maradi (Niger), although some work has addressed children in Nigeria (Omigbodun & Olatawura, 2008). Some research has been conducted in Maradi region focusing on a specific cult called “Bori” (Broustra-Monfouga, 1973; Lombard, 1967; Sullivan, 2005) and on feeding beliefs and practices in the Hausa population and their relationship to malnutrition (Cooper, 2009; Hampshire, Casiday, Kilpatrick, & Panter-Brick, 2009; Jaffré, 1996; Keith, 1991).

Limitations

There are several key limitations to this study. First, the results discussed here derive from only one setting with only one individual interview per caregiver. In mental health interventions and care, a trustful relationship between the client and the professional is essential to access personal information. In this context, the mothers may have overestimated their difficulties in the hopes that additional care could be obtained by answering a certain way. Conversely, some may have underestimated difficulties, fearing that the child would be perceived as different or not having understood that in cases of need, care would be provided. Talking about psychological difficulties involved revealing personal information and some caregivers may not have felt confident sharing information about their children.

We attempted to minimize these potential biases by ensuring that individual interviews were conducted within the home to encourage comfort and avoid the possibility of other adults listening or overhearing. Confidentiality was assured in all interviews and mothers were provided the possibility to stop the interview at any time and were free to not respond to any questions if they felt uncomfortable. Further, an awareness and information campaign as well as village-level in-depth presentations of the study were conducted in the region. This was designed to respond to any questions or concerns related to the study and ensure that mothers felt confident asking questions at any time if they wished. Finally, the use of an interpreter may have influenced the response to questions, as a third informant is present.

Conclusion

Despite these limitations, this study highlights the importance of understanding maternal or caregiver perceptions of children’s problematic behavior (Bossuroy, Wallon, Jobert, Mesnin, & Moro, 2013; Moro, Radjack, Taieb, Rezzoug, & Skandran, 2014). Understanding local concepts can improve implementation of medical and mental health care, in contexts where access to and provision of care is often scarce (Bolton & Weiss, 2001). The utility of this qualitative research approach reinforces the potential value of informative data collection in a short
time prior to the design and implementation of psychological interventions in humanitarian settings or before scale-up or first implementation in low-resource contexts (Bolton & Tang, 2004).

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Note

1. A study including Gusii mothers (Kenya) gathered similar data on mothers not talking to small children about death (Levine et al., 1994; Quinn, 2005).

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