

Behavioral and Emotional Problems among School Children in Tripoli, Libya: What Impact does it have on Community Public Health?

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Objective: to detect the prevalence of mental health problems, including behavioral and emotional difficulties among school children (6-15 years) in Tripoli, Libya as observed by their parents and teachers. **Methods:** The study took place in Tripoli, Libya. Data was collected over three months period between January and March 2022 from parents and teachers. The Arabic version of Strengths and Difficulties Questionnaire (SDQ, Goodman 2002) were used. The sample size was 300 children aged between 6 and 15 years who were attending compulsory education. Four schools were randomly selected and then children were randomly sampled from each class. Parents were asked to hand over the questionnaire to their child's teacher and collect them later. Data was analyzed to describe normative scores, bandings and cut-offs for normal, borderline and abnormal scores. Only public schools were included in the study. **Results:** When it came to the perception of teachers and parents, it was found that the response rate for parents and teachers were almost the same only 245 questionnaires were returned (134 male and 111 female) giving a response rate of 81.6%. out of these, 208, both the parents and teacher questionnaires were returned (84.8%), 26 filled in only the parents' questionnaires (10.6%), and 11 returned only the teacher's questionnaire (4.4%). TEACHERS rated their pupils consistently as showing difficulties in all areas with (23.0 %) of the children considered to be displaying abnormal behavior (Total Difficulties Score). The highest proportion of abnormal behavior was for peer relation (17.0%) and conduct problems (18.0%). PARENTS rated their children as having fewer problems than rated by teachers, but rates were still high with (15%) of the children receiving total difficulty scores in the abnormal band. The most problematic areas as assessed by parents were peer relations (29%) followed by emotion problems (22%). **Conclusion:** Parent SDQs revealed high rates of children with conduct, emotional and peer problems falling above the 90th centile established in the UK sample. Teachers SDQs revealed higher rates of children with conduct problems. Comparison with UK and Egypt data showed abnormal total difficulties score of 11.9% which is a bit higher than UK (10.1%) but lower than that of Egypt (20.6%). Much greater investment in child mental health care is needed. More efforts are needed to identify those children and decide what we can usefully do to help the many-not only the few.

Keywords: Tripoli, Libya, behavioral problems, school children, SDQ, mental health

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Introduction

Minimal researches have been directed toward children and adolescents' mental health including behavioral difficulties in Arab countries as data from these countries are poor and limited (Afifi 2005). Some data are available from few studies carried out in UAE (Eapen et al. 1998, Okasha 2004), Egypt (Hamid et al. 2009, Eapen and Ghubash 2004), Yemen (Alyahri and Goodman 2008) and Gaza strip (Thabet et al. 2000).

The SDQ has become one of the most widely used tools in child and adolescent mental health care across the globe. Although the SDQ was originally developed and validated within UK (Goodman 1997) and its reliability and validity have been simulated in many countries including Arab countries, important cross-cultural issues have been raised (Du et al. 2008, Alyahri and Goodman 2008). Having accurate and up-to-date information about the prevalence of behavioral difficulties in children is important in determining and influencing the health policy of any country. There is a wide spread wrong belief among parents, child health professionals, and politicians in Egypt that mental health disorders in children are not a major public health problem (Goodman et al. 2000a). Two advantages of SDQ are that it collects information from multiple informants and so reflects children's emotional and behavioral symptoms in different settings, and by using all the information from all respondents, enables an epidemiological rough estimate of the size of the problem as well as simple behavioral symptoms (Goodman et al. 2000b, Samad et al. 2005).

We have conducted a prevalence study in Tripoli, Libya using SDQ in order to detect the rates of behavioral difficulties among school children (6-15 years).

Method

Setting

The study was carried out in the city of Tripoli, the Capital of Libya. Tripoli is a cosmopolitan city and represents that of Libya as a whole. The populations of Tripoli are approximately two million. Schools were selected at random from different districts in the city. Only public schools were included in the study.

Sampling

Data were collected over three months period between January and March 2022 from parents and teachers. The Arabic version of Strengths and Difficulties Questionnaire (Goodman 2002a) were used .

SDQ is one of the most widely and internationally used measure of child mental health and has been translated into more than 80 languages. The tool can pick up the viewpoint of children and young people, their parents and teachers.

The sample size was 300 children aged between 6 and 15 years who were attending compulsory education. The Education Authority provided us with a list

of public schools. Schools were randomly selected and then children were randomly sampled from each class of selected school. Four schools were selected from different districts in Tripoli. All schools agreed to participate but some parents declined to fill-in the questionnaires. We randomly sampled 300 children from the 4 schools to cover the age group between six and fifteen years. Parents and teachers were informed of the study formally by letters delivered to them by a doctor through the school head-teacher. With the letter the parents were sent questionnaires and their return of the questionnaires was considered as consent to participate in the study. Teachers were also given a similar questionnaire to complete it. Ethical approval was not required under the local regulation from either the health or education authorities.

Data Collection and Tools

For each child a parent and the teacher were asked to complete the Arabic version of SDQ. This questionnaire includes 25 core items. The 25 items generate five scales: (1) emotional symptoms (2)conduct problems, (3)hyperactivity symptoms, (4) peer-relationship problems and (5)pro-social behavior. Each of these scales is scored from 0 to 10 and can be classed as “normal”, “borderline”, or” abnormal” depending on how the score compares with population standards based on original validation work in UK (Samad et al. 2005). All but the last scale (Pro-social behaviour) are summed to generate a total difficulties score ranging from 0–40.

Parents completed their questionnaires without any interference from the school teachers.

Analysis

The results from the five subscales of the SDQ and the total difficulties score were classified using the standardized cut-off values into “abnormal”, “normal” and “borderline”. Prevalence values were calculated. Data analysis was carried out using the Statistical Package for Social Scientists (SPSS version 12).

Results

When it came to the perception of teachers and parents, it was found that the response rate for parents and teachers were almost the same. Only 245 questionnaires were returned (134 male and 111 female) giving a response rate of 81.6%. out of these, 208, both the parents and teacher questionnaires were returned (84.8%), 26 filled in only the parents’ questionnaires (10.6%), and 11 returned only the teacher’s questionnaire (4.4%).

PARENTS rated their children as having fewer problems than rated by teachers, but rates were still high with (15%) of the children receiving total difficulty scores in the abnormal band. The most problematic areas as assessed by parents were peer relations (29%) followed by emotion problems (22%). **Table 1**

TEACHERS rated their pupils consistently as showing difficulties in all areas with (23.0%) of the children considered to be displaying abnormal behavior (Total Difficulties Score). The highest proportion of abnormal behavior was for peer relation (17.0%) and conduct problems (18.0%) .**Table 2**

Reasons for some of the parents not responding and not returning the questionnaire could be due wrong belief that if their children are found to be abnormal there is a good chance that they will be kicked off the school; Stigma attached to the diagnosis is another cause of some parents refusing to fill-in the questionnaire. Some of the school teachers refused to cooperate simply because they do not want to have problems with the parents as a result of their comments. A significant teachers-parents discrepancy (n=91) in reporting the different problems in the SDQ were noted .**Table 3**

Table 1 summarizes the results of abnormal SDQ from parents completed questionnaires (n208). The highest proportion of abnormal behavior were for Peer problem with (29.4%) followed by emotional symptoms (22%) of the children rated as in the abnormal category. 15% of children have total difficulties score in the abnormal band.

Table 1. Abnormal SDQ Scores from Parents Returned Questionnaires

Scales (n=208)	Male	Female	Total	Percentage
Pro-social	13	8	21	10%
Hyperactivity	14	6	20	10%
Emotional	20	26	46	22%
Conduct Problems	18	12	30	14%
Peer Problems	35	25	60	29.4%
Total Difficulties Score	20	11	31	15%

Table 2 summarizes the results of abnormal SDQ from teacher's completed questionnaires (n208). The highest proportion of abnormal behavior were for conduct problems (18%) followed by Peer problem with (17.3%) of the children rated as in the abnormal category. 22.3% of children have total difficulties score in the abnormal band

Table 2. Abnormal SDQ Scores from Teachers Returned Questionnaires

Scales (n=208)	Male	Female	Total	Percentage
Pro-social	20	12	32	15%
Hyperactivity	16	14	30	14%
Emotional	12	16	28	13%
Conduct Problems	25	12	37	18%
Peer Problems	20	15	35	17.3%
Total Difficulties Score	26	20	46	22.3%

Table 3 shows the teachers-parents discrepancy (n=91) in reporting the different problems in the SDQ scales. Looking at the table we can see that in some cases (28) the teacher's questionnaire scored abnormal and in (25 children) the score was borderline. Surprisingly for the same children the parent's questionnaire scored normal.

Table 3. *Teachers-Parents Agreement on SDQ*

Scales	Male	Female	Total
Teacher _ Ab Parents _ N (scale 1)	14	14	28
Teacher _ Ab Parents _ BL (scale 2)	6	5	11
Teacher _ BL Parents _ N (scale 3)	13	12	25
Teacher _ N Parents _ Ab (scale 4)	4	6	10
Teacher _ BL Parents _ Ab (scale 5)	6	2	8
Teachers _ N Parents _ BL (Total difficulties score)	1	8	9

Table 4 compares the prevalence of behavioral problems in school children in Egypt, the United Kingdom, and Libya as assessed by teachers and parent using the multi-informant SDQ. The reported prevalence of total difficulties scores by both teachers and parents is much less in Libya than in Egypt but much higher than in United Kingdom.

Table 4. *Comparison of the Prevalence of Behavioral Problems in School Children in Egypt, the United Kingdom, and Libya*

	Egypt	United Kingdom	Libya
<i>Abnormal total parent's difficulty score</i>	20.6%	10.1%	15%
<i>Abnormal total teacher's difficulty score</i>	34.7%	9.8%	22.3%

Discussion and Conclusion

Parent SDQs revealed high rates of children with conduct, emotional and peer problems falling above the 90th centile established in the UK sample. Teachers SDQs revealed higher rates of children with conduct problems. When data were compared to those from the UK and Egypt, the abnormal total difficulties score was 11.9%, which is slightly higher than the UK's (10.1%) but lower than Egypt's (20.6%).

Care for children's mental health requires a lot more financial spending. It will take more work to find those kids and determine what we can do to assist and support the many, not just the few.

Any development in the provision of child and adolescent mental health services should take into account the requirements for ongoing parent and teacher training sessions as well as programs that increase public awareness of mental health problems. Parents, teachers, and healthcare professionals should be aware of children's behavioral issues so that they can be treated as soon as possible and hence increasing the likelihood that the children will regain their normal mental health.

We believe that our sample is representative and a reflection of the whole Libyan children attending schools. However, we have demonstrated that the prevalence of the difficult symptoms, as assessed by teachers and parents, is substantially higher among Libyan children than UK but lesser than Egyptian children. A comparable study in Pakistan (Mullick and Goodman 2005) community group revealed similar patterns of findings. The abnormal rates were even greater on the SDQ (34.5%) and were not when the algorithm was applied (8.5%), despite the fact that their analysis only included parental reports. Mullick and Goodman (2001) in their study in Bangladesh, have also emphasized the significance of adopting the multi-informant algorithm and gathering data from two informants. Other studies among preschoolers generally revealed similar results of conduct problems. It is probable that the way we raise our children, excessive child protection, a lack of use of effective discipline techniques, and the relatively big sized family are all contributing factors to this pattern of a high prevalence of this abnormal behaviour. We have only included in this cross-sectional study children attending public schools; children who were attending private schools were excluded and this may have underestimated the true prevalence of behavioral problems in school children. Although the sample is relatively small, we believe that within the facilities at our disposal, the high rate of parental response, and the standardized questionnaire employed all contributed to the study's overall strength. Since it is outside the scope of this study, confirmation of diagnoses was not sought; even though we think the prevalence of the problem is probably true. Early detection procedures have the potential to have a significant impact on a child's education and health in a number of areas of child health, or at the very least lessen the severity of developmental difficulties; behavior difficulties are one of these. It would be quite fascinating to learn if any Arab nations including Libya have been able to find a solution to the issue of providing treatment for kids with behavioral and learning difficulties. This "hidden handicap" frustrates communities and otherwise normal families, often going unsuspected and unrecognized even by doctors and teachers. Health and education authorities must make greater efforts to identify these children and determine what can be done to help- the many—not just the few in order to decide what are the best practical measures to assist these children and their families and ensure that they receive the attention and care. As professionals, none of us can disagree that this is a serious issue, but what is the best course of action? In the best, and well-off, situations the children with behavioral difficulties can be helped; a few by medications, many by the care of parents, teachers and the community (Zeglam and Maouna 2011).

The only way for children with moderate to severe behavioral difficulties to reach their full potential are to attend special schools, which are expensive to

attend in any country in the world. Early detection and intervention are top goals for these kids in order to- if at all possible- avert any disabilities. The population of the world doubled between 1930 and 1975, growing by 2 billion people. Today the number is at 7 billion and growing. At least two-thirds of the population—including Arabs and Muslims—live in what are referred to as “underdeveloped or developing” countries. Behavior difficulties are now a significant issue that requires attention and answers due to the population growth and problems that have followed this increase in population.

There is a chance that these issues won't be given top priority in such nations. One may adopt an unenthusiastic and passive attitude and argue, “There are far worse problems in many Arab countries including Libya -- starvation, housing, sanitation, water supply, and war -- so why divert efforts?” Or “There are other issues that are frequently helped by straightforward steps, and we don't notice many behavioral issues around”.

There are certainly many other dreadful issues in Arab nations including Libya, but behavioral issues in children, especially autism spectrum , and attention deficit hyperactivity disorders, are such serious disabilities that every professional in the fields of health and education must at the very least advocate positively. Parental guidance is an additional responsibility that should be added to the primary health care workers' obligations, which are by no means small and simple (Zeglam and Darrat 2008, Zeglam and Maouna 2011, 2012).

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