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Promoting Secure Attachment in Children without Parental Care in Egypt

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Promoting Secure Attachment in Children without Parental Care in Egypt

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Abstract

In Egypt, if not living with extended family members, the majority of children without parental care are placed in care homes. Research shows that children without parental care, particularly those raised in care homes, generally receive low-quality care. This can lead to adverse effects on their mental health, physical health, developmental growth, sense of belonging, intimacy, social and behavioral competence, and academic performance. Studies also relate institutionalization to problems in attachment and caregiver-infant relationships. The Secure Base Model is a therapeutic caregiving framework that target children who were abused and neglected or experienced loss and separation. The model has five main dimensions that are important for the promotion of security and resilience: availability; sensitivity; acceptance; cooperation; and family membership. This research examines the quality of care and the issue of attachment in children without parental care in Egypt through the perspective of The Secure Base Model. The proposed research questions are: 1) Are caregivers in Egypt aware of their psychological role in caring for children at care homes? 2) To which extent do they apply – or not apply – dimensions of the secure base model? and 3) How are attachment theory and secure base model assumptions applied in the Egyptian context? In-depth interviews were conducted with a sample of 14 caregivers working in care homes and a matched sample of 12 biological mothers for purposes of cultural comparison. The majority of both the caregivers and biological mothers exhibited many of the themes that indicate strengths in their relationship with children. Likewise, the majority of both groups did not exhibit most of the themes that indicate weaknesses in the relationship. The section that showed the highest strengths for both groups was availability. In contrast, the sections on

describing the child, acceptance, and cooperation seemed to be weaker. When comparing the results of both groups, the mothers seemed to generally do better than the caregivers. In addition, caregivers showed contradicting feelings of happiness, responsibility, and denial towards the children's attachment to them, which was not seen in the sample of mothers. Finally, both groups showed difficulty identifying and naming their own and the children's emotions across all the sections of the interview. The possible reasons of these results within the Egyptian context are discussed, and recommendations are made for improving attachment outcomes for children without parental care at the societal, institutional, and individual levels.

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Promoting Secure Attachment in Children without Parental Care in Egypt

According to UNICEF (2017), there were 52 million children without parental care living in Africa in 2015. In Egypt, official figures indicate that children without parental care reached 24,000 in 2016 (CAPMAS & UNICEF, 2017). Research shows that children without parental care, particularly those in care homes, receive low-quality care. Worldwide and in the Middle East, this often leads to adverse effects on their mental health, physical health, developmental growth, sense of belonging, intimacy achievement, social and behavioral competence, and academic performance (Behilak et al., 2015; Eapen, 2009; Ethnasios, 2012; Fawzy & Fouad, 2010; Groak et al., 2005; Ibrahim et al., 2012; Koumi et al., 2012; MacKenzie et al., 2012; Sigal & Perry, 2003; Smyke et al., 2007). Studies also relate the negative consequences of institutionalization to problems in attachment and caregiver-infant relationships, in particular, attachment (Crockenberg et al., 2008; McLaughlin et al., 2012; Sigal & Perry, 2003). Research shows that secure attachment is significant for the mental health of children as well as their cognitive, emotional, and social development (Ahmad et al., 2005; Crockenberg et al., 2008; Hrdy, 2001; McLaughlin et al., 2012; Veríssimo et al., 2014). In addition, it is positively associated with emotional regulation and ego-resiliency in adulthood, and negatively associated with depression and anxiety symptoms (Beek & Schofield, 2016; McLaughlin et al., 2012; Zimmermann, 1999).

In Egypt, if not living with extended family members, the majority of children without parental care are placed in care homes (Gibbons, 2007; Hassanin, 2018). Like elsewhere in the world, most caregivers in Egyptian care homes are not well-trained on the psychological aspects of caregiving (Behilak et al., 2015; Kelly, 2016). This lack of training may result in low-quality care, and may also disrupt the formation of secure attachments, thus impairing the psychological health and security of institutionalized children. However, there

is little research on what caregivers in Egyptian care homes actually do when they care for children. Are their care practices likely to lead to the development of insecure attachments and harm children's psychological health? The purpose of this research is to examine the care provided by Egyptian caregivers in institutional care homes to see if current practices are likely to harm the formation of secure attachments in the children under their care.

Attachment Theory and its Implications

Definition and Overview

The emotional bond between an infant and one or more of his/her caregivers is the commonly known meaning of attachment (Keller & Otto, 2009). According to Bowlby (1969), attachment behavior is a type of social behavior that is instinctive and as equally important as mating and parental behaviors. In children, attachment behavior can be identified by their recognition of their mother accompanied by a tendency to seek and maintain proximity to her (Ainsworth, 1967; Ainsworth et al., 1978; Bowlby, 1969), and experiencing and expressing distress when separated from her (Ainsworth, 1967, 1989; Ainsworth et al., 1978; Bell & Ainsworth, 1972; Bowlby, 1980). Most children will be able to discriminate between their mothers and other people around the age of four months (Bowlby, 1969) and form attachments to her, or a principal caregiver, during their first year (Ainsworth, 1967, 1989).

Unlike Bowlby's work and other early research, later research pointed out that children not only form attachment towards their mothers but also simultaneously towards other figures that are familiar to them (Ainsworth et al., 1978; Ainsworth, 1989; Hrdy, 2001; Wong et al., 2009). In fact, when children are separated from their mothers but are simultaneously cared for by another person who sufficiently substitutes the mother's role,

they direct attachment behavior towards this figure (Ainsworth et al., 1978). In addition, evidence in later research showed that attachment security in children could be harmed if the co-parent is absent (Carlson et al. 1989), and that being securely attached to few adults, not just mothers, is a necessity for children's survival and development (Crockenberg et al., 2008; Hrdy, 2001; Thompson-Jinariu, 2011).

Research shows that secure attachment is associated with better mental health (Ahmad et al., 2005; Crockenberg et al., 2008; McLaughlin et al., 2012). It is significant for the cognitive and emotional development of children (Crockenberg et al., 2008; Hrdy, 2001) as well as the emotional regulation and ego-resiliency of adults (Zimmermann, 1999). It is positively associated with having a sense of worthiness and a healthy level of self-esteem (Crockenberg et al., 2008), and negatively associated with symptoms of anxiety and depression (Beek & Schofield, 2016; McLaughlin et al., 2012). Secure attachment is also significantly associated with social competence (Veríssimo et al., 2014).

Attachment Styles, Caregivers' Role, and the Internal Working Models

Attachment Styles. Attachment can be secure or insecure (Ainsworth et al., 1978; Main & Solomon, 1990; McLaughlin et al., 2012; Muhamedrahimov & Palmov, 2004; Padrón et al., 2014; van den Boom, 1994; Velderman et al., 2006). Up until now, four attachment styles have been identified, namely: secure, insecure-avoidant, insecure-anxious/resistant, and insecure-disorganized (Keller & Otto, 2009). The key model used to assess attachment quality between infants and mothers is Mary Ainsworth's Strange Situation. It is a laboratory method that observes the infants' reactions to being separated from their mothers, being left with a stranger, and then reuniting with the mother. It also observes the infant-mother relationship at home (Ainsworth et al., 1978; Keller & Otto, 2009).

Based upon the strange situation, three of the four attachment styles were classified: secure, avoidant, and anxious/resistant (Ainsworth et al., 1978). In the study, infants were classified into these three groups based on some differentiating variables, such as: crying, responding to the mother's presence and absence, bodily contact, compliance, and anger. More specifically, securely attached infants' behavioral patterns differed from those of insecurely attached ones in both the experiment room and their homes. In the experiment room, securely attached infants were more keen on maintaining contact with their mothers than insecurely attached children; they felt more distressed due to the absence of their mothers when the mothers left them with the stranger. Upon reunion, securely attached infants showed less tendency to avoid their mothers, less tendency to resist contact with them, and more signals of being happy. At home, securely attached infants cried less than insecurely attached ones; they were less frequently angry, greeted their mothers more positively, initiated more close bodily contact, and felt less distressed when their mothers left the room (Ainsworth et al., 1978). The above described styles of attachment are seen as showing organized patterns of attachment behavior (Padrón et al., 2014), unlike the fourth attachment style that was defined in later research, namely: insecure-disorganized attachment (Main & Solomon, 1990; Padrón et al., 2014). According to Padrón, Carlson, & Sroufe (2014), the qualities that characterize disorganized attachment are: confusion, contradiction, and dissociation. Infants who have disorganized attachment show behaviors such as: simultaneous contradicting actions, freezing with confused expressions, incomplete movements or ones without direction. In addition, different infants who are classified under disorganized/disoriented attachment display different presentations of disorganized behavior (Main & Solomon, 1990).

Caregivers' Behavior. Research has shown that mothers' sensitive responsiveness to their children's signals is one key factor in developing secure attachment (Ainsworth et al., 1978; Crockenberg et al., 2008; Muhamedrahimov & Palmov, 2004; van den Boom, 1994). This responsiveness leads the child to trust the mother figure, and when that trust happens, the caregiver becomes a secure base which the child uses to explore the surrounding environment (Crockenberg et al., 2008). Likewise, as the child develops into an adolescent, the mother's sensitivity and acceptance of the adolescent's self-perception helps in letting the mother-adolescent relationship serve as a secure base for the adolescent to explore his/her independence (Allen et al., 2003).

Mary Ainsworth (1978) used the Strange Situation to examine the relationship between infants' attachment behaviors and their mothers' behaviors. She found that mothers of the securely attached children had the highest scores on scales of sensitivity, acceptance, cooperation, and accessibility. They showed sensitive responsiveness to their babies' signals. These mothers viewed their babies as separate individuals and respected their autonomy, which enabled them to perceive things from the babies' point of view and let them independently progress doing their activities without interruption. They also had the lowest scores on the variables of aversion to physical contact, providing the baby with unpleasant experience in physical contact, lack of emotional expressiveness, and rigidity. In contrast, mothers of insecure-avoidant infants scored the highest on most of these variables. Both mothers of insecure-avoidant and insecure-resistant infants were insensitive to their babies signals and communication. The mothers of insecure-avoidant infants were more rejecting than those of the other groups; they ignored their babies' communication, and they were more occupied with other interests than with their maternal role. As for the mothers of insecure-resistant infants, they also ignored their babies and showed behaviors indicating

inaccessibility, but they were also strongly invested in their role as mothers. Their behavior was fragmented, and showed signs of disturbance. They were not rejecting, but they showed compulsive behavior and high interference in their babies' activities (Ainsworth et al., 1978). Similarly, maltreatment in terms of child abuse or neglect, or both, has been associated with insecure attachment, particularly disorganized attachment (Carlson et al. 1989; Padrón et al., 2014).

Internal Working Models. Perhaps the most interesting and eye-opening element of attachment styles is how they are related to the infant's development of an internal working model. Infants internalize the way attachment figures respond to their signals and behavior to create generalized working models of self, others, and the world (Bretherton, 1995; Crockenberg et al., 2008; Padrón et al., 2014; Sroufe, 1989). The caregiver-infant relationship starts the development of the self, which is argued to comprise one's internal set of meanings, expectations, feelings, and attitudes (Sroufe, 1989). Coherence in the caregiver-infant relationship, influences coherence in the organization of self, affects the nature of attachment toward the caregiver, then can later affect the nature of attachment toward other attachment figures as well (Bretherton, 1995; Sroufe, 1989). For instance, as Bowlby (discussed in Fivush, 2006), argued, sensitivity and responsiveness from the caregiver leads the infant to create internal working models that characterize himself/herself as deserving of care, characterize that caregiver and other people as worthy of trust, and characterize the world as a safe place. Conversely, lack of sensitivity and responsiveness from the caregiver leads the infant to think of himself/herself as undeserving of care, think of others as unworthy of trust, and think of the world as an unsafe place (Crockenberg et al., 2008). Likewise, when primary caregivers exhibit insensitive and interfering responses, infants create incoherent

working models of self, which explain the confusion and unresolved state of mind for those having disorganized/disoriented attachment (Padrón et al., 2014).

There is an assumption that parents transmit their own attachment patterns to their children through their behavioral and verbal communication (Bretherton, 1995). However, some research shows that the quality of attachment could differ among different relationships for the same individual. This was based on the observation that some infants had a secure attachment toward one of their primary caregivers, and an insecure attachment toward the other (Bretherton, 1995; Keller, 2013). Therefore, the quality of fathers' caregiving involvement is also an important factor for attachment (Wong et al., 2009). However, there is also an alternative conception that argues that children use the working models developed in different attachment relationships to construct a new, integrated meta-model of attachment. In that sense, the child either develops a working model of the average of the different attachment relationships, or develops a unique working model for each relationship that is built on the realization that one experiences different selves in different relationships (Bretherton, 1995).

The Issue of Culture in Attachment

Because attachment theory focuses on a biological behavioral system, its functional processes are universal among humans (Ainsworth, 1989). Nevertheless, these processes could differ among people according to their genes, experiences, and cultural influences (Ainsworth, 1989). Attachment theory researchers have found that the distribution of attachment classifications varies across cultures, which is shown through the differences in the proportion of those who are classified as having secure, resistant/anxious, or avoidant attachment (Grossmann et al., 1981; Grossmann et al., 1985; Keller, 2013; Li et al., 2014). For instance, a study conducted in North Germany found different results than Ainsworth's

studies of children in the US (Ainsworth et al., 1978; Grossmann et al., 1981; Grossmann et al., 1985). In North Germany, the majority of infants were classified under the category of avoidant attachment, followed by secure attachment, then anxious attachment. More specifically, 49% of the participating children showed avoidant attachment towards the mother and 54.3% showed avoidant attachment towards the father; while 32.7% showed secure attachment towards the mother and 41.3% showed secure attachment towards the father; only 12.2% showed resistant/anxious attachment towards the mother and 2.2% showed resistant/anxious attachment towards the father, and 4.4% of the children were classified under a different category from those previously identified by Ainsworth's (Grossmann et al., 1981). The majority of the infants in Ainsworth's U.S. study were classified under the secure attachment category, followed by avoidant attachment then anxious attachment (Ainsworth et al., 1978). Similarly, another cross-cultural study compared parental attachment among adolescents from China, Italy, and Costa-Rica. Chinese adolescents showed weaker attachment towards their mothers than Italian and Costa-Rican ones. They also showed stronger attachment towards their fathers than their mothers (Li et al., 2014). On the other hand, a culturally modified application of the Strange Situation that was conducted with 30 one-year-old children in West-African Nso from Cameroon showed interesting results. With the goal of assessing the infants' emotional reaction through measuring the change in their stress-level before and after the presence and bodily contact of a stranger, it was found that the group whose cortisol level declined after the stranger's presence and interaction, indicating no signs of psychological or behavioral stress, was the group who showed no emotions or expressions at all (Keller & Otto, 2009).

Attachment theory was developed in a culture different from the cultures where it sometimes gets applied, which can make the application culturally inappropriate (Grossmann

et al., 1981; Keller & Otto, 2009). Cultural norms and values influence the behaviors of attachment figures (Grossmann et al., 1981; Grossmann et al., 1985; Keller, 2003; Li et al., 2014), and sometimes these cultural norms are not in congruence with biological needs, which in turn affects the degree of attachment security (Grossmann et al., 1981). For example, in Northern Germany, cultural norms emphasize keeping personal, physical, and emotional distance (Grossmann et al., 1985; Keller, 2003). There, carrying the infant every time he/she cries is considered as an act of spoiling, and having no demands from the infant's side, while being submissive to the demands from the parents' side is the ideal situation. As a result, parents in the Northern Germany study carried their infants for shorter periods than their counterparts in the U.S. and showed less tenderness and affection while carrying them (Grossmann et al., 1985). Similarly, in China, mothers' caregiving attitude is usually intrusive, with little or no awareness of the value of respecting the child's/adolescent's autonomy. In Chinese culture, children's resistance to such parenting style is considered disrespectful, and the mothers tend to respond to it with even more intrusions and restrictions, all of which create detachment from the mothers (Li et al., 2014).

Among West-African Nso women, good maternal care requires responsiveness to the infants' needs, anticipatory breastfeeding, as well as close and warm physical contact (Keller, 2003). However, sometimes these behaviors, particularly anticipatory breastfeeding, are done with the intention of preventing the infant from crying in order to raise the culturally ideal calm child who does not express negative emotions. When a child cries, he gets called a "bad child", and his mother's response, rather than soothing him, is directed towards asking him not to cry again because this is not expected from a person raised in their culture. It is important for Nso mothers to raise children who are calm so that they are able to get accustomed to multiple caregivers to enable the mothers to focus on other daily work. As a

result, in their village, calmness and inexpressiveness are the emotions characterizing the most adaptive emotional regulation strategy (Keller & Otto, 2009), which explains the expressionless attitude of the least distressed infants in the Strange Situation.

Similar to Nso mothers, and unlike early attachment theories, it is most common across cultures that caregiving patterns include multiple caregivers rather than one. This, in turn, changes the universally accepted perspective on caregiving attachment bonds, attachment definition, and its consequences (Keller, 2013). Furthermore, even though good parenting in the U.S. and Europe, based on Ainsworth, Blehar, Waters, & Wall (1978), requires respect for the child's autonomy, and respect for his/her wishes regardless of those of parents, in other non-Western cultures, ideal parenting is concerned with raising obedient children, and children are punished and frowned upon if they do not take their parents' wishes into consideration (Chao, 1995; Keller & Otto, 2009). In fact, studies conducted in Arab countries, including Egypt, show that the culture could lead to a parenting style that affects a child's mental health differently than in Western cultures (Dwairy, Et Al., 2006; Dwairy & Menshar, 2006; Rudy, 2006). In the West, three parenting styles are identified: permissive, authoritarian, and authoritative. Permissive parenting is high on affirmation and permissiveness and avoids exercising any parental control or power. Authoritarian parenting is high on exercising control, creating order, and discouraging verbal give and take between the child and parent. While authoritative parenting, which is considered to lead to the best behavioral outcomes for the child, emphasizes a balance between respecting the child's autonomy, promoting verbal give and take, and creating discipline (Baumrind, 1966). Unlike the results in the West, in Egypt and Palestine, the authoritarian parenting style that is high on restricting the autonomy of children was not associated with negative mental health outcomes. According to the authors of the studies, the different results could be related to the

differences between the collective nature of the Arab world culture compared to the individualistic nature of the culture in the West (Dwairy & Menshar, 2006). In collectivist cultures, mothers applied the authoritarian style of parenting more, yet, it was not associated with low levels of love, emotions, and warmth. Therefore, it was suggested that the negative mental health effects of authoritarian parenting style in individualistic cultures was more associated with lack of warmth rather than presence of control/authoritarianism (Rudy, 2006). In addition, Dwairy, et al. (2006) found that the parenting styles across the Arab societies were different from those in the West. In the Arab societies, three categories that included mixed-parenting patterns were identified: controlling-oriented parenting, flexible parenting, and inconsistent parenting. Controlling-oriented parenting combined both authoritarian and authoritative styles, flexible parenting combined both authoritative and permissive, while inconsistent parenting combined opposite styles: authoritarian and permissive. A more recent study of Egyptian parents found that the participants used the mixed inconsistent parenting pattern, which involves the alternation of both authoritarian and permissive parenting (Hanna, 2016).

Therefore, it is important to question and study if culturally influenced caregiving beliefs, behaviors, and patterns are psychologically healthy for children and families in the short and long term. Simultaneously, as suggested by Keller & Otto (2009), it is important to note that it is necessary to account for context and culture before advocating for one best universal solution strategies developed by Western research and applied on Western populations.

The Position of Children without Parental Care, Globally

Quality of Care Provided to Children without Parental Care

As of 2015, the world included 140 million children without parental care (UNICEF, 2017). Research shows that children in care-homes generally receive low-quality care (Castillo et al., 2012; Eapen, 2009; Fawzy & Fouad, 2010; Groak et al., 2005; Makame & Grantham-McGregor, 2002; Muhamedrahimov & Palmov, 2004; Smyke et al., 2007; Van Ijzendoorn, et al., N.D.). In care homes, caregivers are not well-trained (Castillo et al., 2012; Freidus, 2010; Groak et al., 2005), and they receive low payments (Freidus, 2010; Groak et al., 2005) for a low status job (Groak et al., 2005). This, in turn, makes the turnover rate of caregivers at care homes incredibly high (Crockenberg et al., 2008; Groak et al., 2005; Muhamedrahimov & Palmov, 2004). Therefore, children lack a consistent primary caregiver (Castillo et al., 2012; Crockenberg et al., 2008; Groak et al., 2005; Muhamedrahimov & Palmov, 2004). In fact, sometimes children have more than 60 caregivers in the first two years of their lives (Crockenberg et al., 2008; Groak et al., 2005; Muhamedrahimov & Palmov, 2004). As a result, those children's primary emotional-social environment is mainly characterized by instability and inconsistency (Crockenberg et al., 2008; Groak et al., 2005; Muhamedrahimov & Palmov, 2004). In addition, at multiple ages, children are moved away from the ward they were familiar with to another ward, without the company of their caregivers (Muhamedrahimov & Palmov, 2004). While it sometimes is argued that they are getting transferred to other caregivers who are 'specialized' in their age group (Muhamedrahimov & Palmov, 2004), this adds to the inconsistency of their care.

Some caregivers at some of the institutions exhibited higher scores on anxiety and depression when compared with biological mothers (Muhamedrahimov & Palmov, 2004), which, in turn, affects the emotional and psychological state of the children they take care of,

as they tune to the state of their caregivers. It was unclear in the study why they exhibited higher scores; however, after an intervention that provided a staff training on being socially responsive in addition to doing structural changes in the care-homes, the depression and anxiety levels decreased (Muhamedrahimov & Palmov, 2004). At the same time, caregivers are often not attentive nor responsive to the children and their signals (Castillo et al., 2012; Crockenberg et al., 2008; Groak et al., 2005; Muhamedrahimov & Palmov, 2004). They are usually more occupied with achieving their routine duties and maintenance chores, without emotionally or socially interacting with the children (Castillo et al., 2012; Crockenberg et al., 2008; Eapen, 2009; Groak et al., 2005; Muhamedrahimov & Palmov, 2004). Furthermore, when some caregivers attend to children, they are more likely to attend to the ones who are more social, and ignore others who are less social (Groak et al., 2005).

Sometimes placement in care homes offers children better economic conditions than that of the average child who comes from the same background or extended family, in terms of accessing food, housing, clothing, and schooling (Freidus, 2010; Sanou et al., 2008; Thomason, 2008). Conversely, sometimes children without parental care not only fail to have their emotional needs met, but also are deprived of having their physiological and basic needs met (Castillo et al., 2012; Makame & Grantham-McGregor, 2002). That is shown through them reporting going to bed hungry, not attending school, lacking economic resources (Makame & Grantham-McGregor, 2002), or through care home administrators reporting shortages in economic funding that results in providing inadequate food, water, and medical supplies (Castillo et al., 2012). Often, there are no abiding standards for care homes to provide an adequate level of care.

Physical and Mental Health of Children without Parental Care, and its Relation to Attachment

As a result of the low-quality care they usually receive, children without parental care, particularly those who are raised in care homes, are more likely to have hindered developmental growth (Eapen, 2009; Fawzy & Fouad, 2010; Johnson, et al., 2010; Miller et al., 2005; Smyke et al., 2007), deteriorated physical health (Sigal & Perry, 2003), deteriorated mental health (Ahmad et al., 2005; Fawzy & Fouad, 2010; Sigal & Perry, 2003), disrupted sense of belonging (Freidus, 2010), impaired intimacy achievement (Sigal & Perry, 2003), weakened social and behavioral competence (Ahmad et al., 2005; Eapen, 2009; Fawzy & Fouad, 2010; Groak et al., 2005; Smyke et al., 2007), and weakened academic performance (Ahmad et al., 2005; Sigal & Perry, 2003). These are common challenges faced by children raised at care homes in the Middle East and worldwide (MacKenzie et al., 2012). Regardless of all these factors, when they reach a certain age, those children/early adults are asked to transition from care-homes to independence, even when they are emotionally and practically unready, unsupported, and unequipped to make that move. (Ibrahim & Howe, 2011; SOS Children's Villages International & CELCIS, 2017; Stein, 2012). In addition to these challenges, young people leaving care in a patriarchal and collectivist culture like those in the Middle East, face heavier burdens. When studying the challenges faced by young people leaving care in Jordan, Ibrahim & Howe (2011) found that many of their study's participants experienced additional struggles managing their post-care identity in a family-based, patriarchal culture.

Similar to the importance of secure attachment to one's mental health, some studies link the negative consequences of institutionalization to problems in attachment and the caregiver-infant relationship (Crockenberg et al., 2008; McLaughlin et al., 2012; Sigal &

Perry, 2003). That is due to the difference between the amount and quality of attention and care received in care homes, and that received in family-based care (Castillo et al., 2012). This was further verified through comparing the results of institutionalization to those of foster or family care. When institutionalized children were compared to non-institutionalized children, whether raised in families or foster care, the latter group showed more secure attachment (McLaughlin et al., 2012) along with better mental health (Ahmad et al., 2005; McLaughlin et al., 2012). At the same time, non-institutionalized children also showed better results on the following indicators: physical growth (Johnson, et al., 2010; Miller et al., 2005; Smyke et al., 2007), cognitive development (Smyke et al., 2007; Van Ijzendoorn et al., 2008), activity in practicing hobbies and sports (Ahmad et al., 2005), and social competence (Ahmad et al., 2005; Smyke et al., 2007). Therefore, studies recommend shifting the system of caregiving for children without parental care from a care home-based one to a family-based one, in order to promote secure attachment, and prevent the expected adverse mental health problems (Eapen, 2009; McLaughlin et al., 2012). When family-based care is not possible, other studies recommend that caregivers in care homes get trained on understanding the psychological, emotional, and social needs of children to become able to apply their knowledge in their work (Bettmann, Mortensen, & Akuoko, 2015; Castillo et al., 2012; Eapen, 2009). This solution may be especially applicable for countries who are not yet ready for transforming the entire system to a family-based care one.

Improving Attachment Security for Children with Previous Attachment Insecurity

Even though some researchers argue that attachment patterns continue with the individual over time (Ainsworth, 1989), other researchers have argued that the constructed working models are not stable across different relationships (Bretherton, 1995), and that mental health interventions could foster the individual's ability to serve as a secure base in

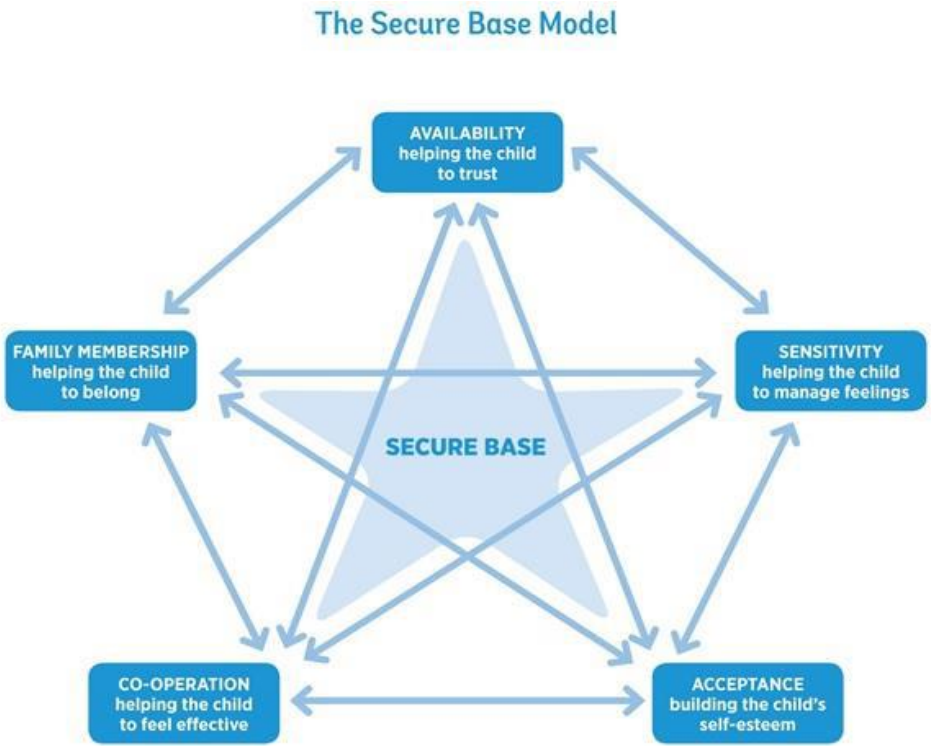
his/her relationships (Bretherton, 1995). Likewise, despite all the adverse consequences of insecure attachment in the situation of children without parental care, research shows that it is possible to improve attachment security for children who have experienced living in similar harmful circumstances through enhancing the quality of care they receive from their primary caregivers (Crockenberg et al., 2008; McLaughlin et al., 2012; Muhamedrahimov & Palmov, 2004; van den Boom, 1994; Velderman et al., 2006). In addition, research shows that interventions can be effective in enhancing the quality of caregivers' responsiveness, sensitivity, and social-emotional interaction with children, both through training the caregivers (Behilak et al., 2015; Crockenberg et al., 2008; Eapen, 2009; Groak et al., 2005; Muhamedrahimov & Palmov, 2004; van den Boom, 1994; Velderman et al., 2006) and through implementing structural changes to care homes that allow for relationship building, stability, and consistency between a child and a primary caregiver (Crockenberg et al., 2008; Eapen, 2009; Groak et al., 2005; Muhamedrahimov & Palmov, 2004). These interventions may be most important for children who are considered to be more difficult to care for. Some studies found that the relationship between improved maternal sensitivity and improved attachment security is particularly significant for highly-reactive and irritable infant groups (van den Boom, 1994; Velderman et al., 2006). Similarly, other studies found that the group whose general development improved the most post the training of their caregivers was that of children who had severe disabilities and were ignored the most before the intervention (Groak et al., 2005).

The Secure Base Model. Fortunately, there are therapeutic caregiving frameworks that target children who were abused and neglected or experienced loss and separation (Beek & Schofield, 2016; Thompson-Jinariu, 2011), such as the Secure Base model (Beek & Schofield, 2016). The Secure Base model is a framework based on attachment and resilience

theories, built on the findings of attachment research studies, and informed by expert practitioners in the field of alternative care. The model proposes that daily family interactions can be therapeutic for children and suggests caregiving methods that improve the security and resilience of children. The Secure Base model has five main dimensions that are important for the promotion of security and resilience, namely: *availability, sensitivity, acceptance, cooperation, and family membership* (Schofield & Beek, 2005; Beek & Schofield, 2016). Other research showed a model of four similar components necessary for improving attachment security, namely: *security, consistency, attunement, and acceptance* (Thompson-Jinariu, 2011). Both models call for similar qualities with different terminologies, where each of the qualities is built on the notion that it serves a developmental aspect in the child (as shown in the figure below).

Figure 1

The Secure Base Model



Source: The Secure Base Model (Beek & Schofield, 2016)

First, parents' (or other caregivers') availability and attentiveness to the child's physical and emotional needs helps the child to trust, and it creates security in the relationship. Second, accepting the child as he/she is, with all his/her limits and unique individuality, is key for building the child's self-esteem. Third, sensitivity and attunement to the child's emotions serve the goal of helping the child to understand and manage his/her emotions rather than reduce or eliminate them. Fourth, helping the child to feel effective while simultaneously creating and enforcing firm consistent boundaries helps the child to feel stable, secure and competent and to act cooperatively. Fifth, promoting family membership and treating fostered and birth children with equal care and attention helps the children to belong (Beek & Schofield, 2016; Thompson-Jinariu, 2011). Providing these five dimensions can create secure base relationships that can potentially improve the child's working models of self and others, hence make a previously insecure child feel that he/she is worthy of love and that others are worthy of trust (Beek & Schofield, 2016).

Situation of Children without Parental Care in Egypt

As of 2020, Egypt's population reached 102 million, of which 43 million are between the ages of 0 and 19 years old (World Bank, 2020). According to CAPMAS & UNICEF (2017), the number of children without parental care in Egypt was 23,779 in 2016; 9,597 of which resided in care homes and were between the age of 6 and 18 years old (information about those below 6 years was not found); 2,418 were in shelter nurseries, and 11,764 were living with foster families (starting two years and older). However, these figures are questionable due to the difficulty of gaining official figures from state agencies and the number of care-homes that are not officially registered. In fact, many children without parental care in Egypt are abandoned (Gibbons, 2007; Koumi et al., 2012; Megahead &

Cesario, 2008; Thomason, 2008). Sometimes, they are abandoned not because they do not have or know their parents, but because their parents placed them in care homes due to financial struggles (Ethnasios, 2012). Other times, they are abandoned as a result of being born outside of the wedlock (Koumi et al., 2012; Thomason, 2008). This is backed by the current Egyptian law as it does not require the biological parents of children born outside of the wedlock to provide them with care (Thomason, 2008). Other times, children get placed in care homes because they were found lost in the streets, at bazaars, or in front of religious premises or even hotels, not knowing whether their parents are alive and whether losing them was deliberate or not (Gibbons, 2005, 2007).

Religious Stances on Adoption

According to the U.S. Embassy in Egypt (2020), 90% of Egyptians are Muslims and 10% are Coptic Christians. In Islam, prophet Muhammad (PBUH) lost both of his parents when he was a child (The Quran 93:6). He then urged and promised great rewards for those who treat children without parents with kindness, and those who look after them through *Kafala*, in multiple *Hadiths*, which are Islamic teachings by Prophet Muhammad (PBUH). Prophet Muhammad (PBUH) said: "I and the person who looks after an orphan and provides for him, will be in Paradise like this," putting his index and middle fingers together (Sahih Muslim, 2983).

Kafala is a caregiving arrangement to provide for a child without parental care (Rotabi et al., 2017). It is the Islamic adoption alternative, as Islam prohibits adoption. *Kafala* resembles a permanent commitment to voluntarily protecting, educating, maintaining, and taking care of a child in the same way a parent would do to his/her child, without substituting his/her original identity or creating a parentage legal tie. In the Western model of closed adoption, a legal parentage relationship is constructed, with all its legal responsibilities and

privileges between a child and adults, that are different from his/her biological parents. It allows for the possibility that children may never be informed about their adoption status; hence, the child's identity may not be fully disclosed and he/she might lose all ties to his/her biological family. *Kafala* prohibits that. Likewise, some of the legal entitlements of adoption are not directly legally allowed through *Kafala* (Muslim Women's Shura Council, 2011). For example, in *Kafala,* the child is not legally or religiously bound to inherit his alternative parents' possessions; however, according to one of Prophet Muhammad's (PBUH) hadiths, people are religiously permitted to charitably specify up to third of their inheritance in their will for anyone who is not their biological child.

In addition to *Kafala*, many verses of the Holy Quran urge people to treat children without parents with kindness and take care of them and their rights (The Quran 2:83; 4:8). Other verses simultaneously condemn their oppression and harsh treatment (The Quran 93:9). Similarly, in Christianity, taking care of children without parents and defending them is strongly urged and taking advantage of them is condemned. For instance, the Holy Bible says: "Defend the weak and the fatherless; uphold the cause of the poor and the oppressed" (Psalm 82:3, New International Version) and "Do not take advantage of the widow or the fatherless" (Exodus 22:22, New International Version).

Alternative Families in Egypt

Even though religion in Egypt encourages taking care of children without parental care (Ahmad et al., 2005; Behilak et al., 2015; Fawzy & Fouad, 2010; Gibbons, 2007), alternative family-based care models have been an unlikely option for many Egyptians (Gibbons, 2005, 2007). This is mainly due to the social stigma associated with children without known parents (Gibbons, 2005), and due to avoiding an additional economic burden (Gibbons, 2005). Moreover, since Egypt follows the "Islamic Shari'a" law (Egypt

Constitution of 2014), like most other Muslim countries, it does not permit legal adoption (Muslim Women's Shura Council, 2011). In fact, in the General Provisions division of The Egyptian Child Law, article four states that "adoption is prohibited" and that the state is responsible for providing children without family care with alternative care (Child Law 1996, 2008). However, Christians in Egypt are not bound by the Shari'a law; thus, they can arrange to adopt children through the court (Megahead & Cesario, 2008). Nonetheless, the majority still do not adopt (Hassanin, 2018). Even though *Kafala* is encouraged in Islam, one of the reasons it could be an unlikely option for many Egyptians is that there is little public awareness on the difference between adoption and *Kafala*. Currently however, the Egyptian Ministry of Social Solidarity is moving towards enabling and encouraging the system of *Kafala*. On their website, the details and steps of applying for *Kafala* are available (وزارة التضامن الاجتماعي, n.d.)

Structure of care homes in Egypt

Many children without parental care live with one of their surviving biological parents, or with extended family members (UNICEF, 2017). If these options are not possible, they are placed in care homes (Gibbons, 2007; Hassanin, 2018). Most of these care homes are non-governmental and privately controlled (Ethnasios, 2012). They also differ in their scope, size, and management structure (Ethnasios, 2012; Gibbons, 2005, 2007). For instance, some are managed by families, and others are run by elected boards (Gibbons, 2005, 2007). Some are specialized in housing children with disabilities, others in housing children living in the streets, others in housing Muslim females, and others in housing Coptic boys, etc. (Ethnasios, 2012). Some are publicly supported, others are not (Ethnasios, 2012; Gibbons, 2007), hence their financial strengths differ (Ethnasios, 2012). Some house 12-30 children and others house over 300 (Gibbons, 2005, 2007). Similarly, the ratio of caregivers to children differs as

well (Gibbons, 2007). Despite these and other discrepancies, the two things that care homes usually have in common are their strict internal rules, as well as their highly guarded buildings (Gibbons, 2005, 2007), which make them isolated from the outside world and society at large.

Quality of Care and Environment at Care Homes in Egypt

Care homes in Egypt often aim to give their children the environment of a family (Gibbons, 2007; Thomason, 2008), particularly through their peers/siblings (Gibbons, 2007). For instance, even after leaving the institution or getting married, previously institutionalized individuals can choose to regularly visit the institution to stay in touch with their peers that they consider as their original family (Gibbons, 2007). Children are often also allowed time to play games and go for outings and trips (Gibbons, 2007; Thomason, 2008), which are unlikely experiences for children living with their underprivileged birth families (Thomason, 2008). Nevertheless, the overall mental health of institutionalized children is a topic of needed attention, given the quality of care and other difficult circumstances they have to experience growing up outside of family care. Today, international care standards call for the importance of investing in preventing family separation, supporting and equipping the families to keep their children in their care, and to have institutionalization only as a last resort when there is absolutely no opportunity for keeping the family together (OHCHR, 2021).

As in other countries, the position of the profession of caregiving in Egypt is problematic, as it is not adequately supported or publicly respected (Kelly, n.d.). Caregivers in Egyptian care homes are not well-trained on the psychological aspects of caregiving (Behilak et al., 2015; Kelly, 2016). In addition, children residing in institutions do not have a stable, consistent caregiver (Behilak et al., 2015; Ethnasios, 2012; Koumi et al., 2012). In one

study, only 64% of the children had a stable caregiver for six months or more (Koumi et al., 2012). One of the explanations for this is how the caregivers at the institutions perceive their work. According to Gibbons, (2007), the typical caregiver in Egypt is a young woman from rural areas who considers working as a surrogate mother just a transitional phase between school and marriage. Caregivers view this as an honorable job that helps them save money for their soon to happen marriage. Further, this attitude may be encouraged by the care homes themselves, as they sometimes support the bride-to-be caregivers in getting their wedding dresses and often hold a special farewell party for them before the wedding (Gibbons, 2007). Looking to enhance their lives, those young women find these transitional job benefits attractive (Gibbons, 2007).

In addition to the inconsistency and instability of caregivers, children may receive mixed signals of care and rejection inside the institutions (Behilak et al., 2015; Gibbons, 2007). For example, in one study, caregivers stated that they would not accept a marriage between their biological children and institutionalized children (Behilak et al., 2015). Moreover, as is the case in other countries, caregivers' quality of mothering is evaluated on how well-dressed and clean children are, without paying enough attention to their psychological needs (Gibbons, 2007). Conversely, sometimes staff working at care homes, rather than being caring toward the children, are envious of them for receiving material support without working for it (Gibbons, 2005). This leads them to sometimes steal the food, in-kind donations, or personal properties of the institutions' children (Gibbons, 2005, 2007).

Efforts to Promote an Adequate Standard of Care

Given all the structural and quality of care discrepancies among different institutions in Egypt, government officials monitor the institutions' activities to maintain an adequate standard of care (Ethnasios, 2012). In cooperation with the Ministry of Social Solidarity

(MoSS) and national and international civil society organizations, a non-governmental organization called "Wataneya Society" developed quality standards for the care-homes to help them improve the quality of care (Hassanin & Kotb, 2021; Wataneya Socity, n.d.). Those standards are recognized as the benchmark for the quality of service provision for all of the national-level care homes (Wataneya Society, n.d.). According to Wataneya Society's website, the Quality Standards for Alternative Care are concerned with six pillars: *child care, child protection, professional practices, management and administration, staffing, building and facilities* (Wataneya Society, n.d.). However, Wataneya Society's role in the application of those standards is only supportive. It creates programs to train and encourage care-homes to apply them, yet the authority of monitoring such application is the role of the ministry. Practice shows that care-homes in Egypt still need intensive and continuous support and technical guidance in order to become able to provide a healthy environment for the children and youths in their care (Hassanin & Kotb, 2021).

Psychological Health of Children without Parental Care in Egypt

As in other countries, the psychological health of children without parental care in Egypt is disrupted (Ethnasios, 2012; Fawzy & Fouad, 2010; Ibrahim et al., 2012; Kelly, 2016; Koumi et al., 2012; بكر, 2016). This includes greater risk of depression (Ethnasios, 2012; Fawzy & Fouad, 2010; Ibrahim et al., 2012; Koumi et al., 2012), which is 45 times more prevalent among females (Ibrahim et al., 2012). It also includes greater risk of anxiety (Fawzy & Fouad, 2010; Koumi et al., 2012), enuresis, attention deficit hyperactivity disorder, separation anxiety disorder, conduct disorder, sleep disorder (Koumi et al., 2012) feelings of isolation (Ethnasios, 2012; بكر, 2016), psychological insecurity (Ibrahim et al., 2012; بكر, 2016), fearfulness, and low levels of self-esteem and confidence (بكر, 2016). Children without

parental care in Egypt also find it difficult to form friendships and quality relationships (Ethnasios, 2012).

Stigma. Even though Egyptian culture encourages emotional, in-kind, or financial support to children without parental care (Ethnasios, 2012; Fawzy & Fouad, 2010; Gibbons, 2005, 2007; Thomason, 2008), they are still stigmatized (Behilak et al., 2015; Ethnasios, 2012; Gibbons, 2005, 2007; Thomason, 2008). Sometimes, they are stigmatized for being born outside of the wedlock (Behilak et al., 2015; Ethnasios, 2012; Thomason, 2008), or residing in care homes, and/or not having known family origins (Behilak et al., 2015; Ethnasios, 2012; Gibbons, 2007); other times they are stigmatized for carrying their parents' genes that would possibly make them demonstrate social misbehavior (Behilak et al., 2015; Gibbons, 2005, 2007).

Alongside the psychological consequences of feeling stigmatized, this stigma also stands in the way of children without parental care socially integrating and creating their own families (Ethnasios, 2012). Even though raising females who are good marriage material is a typical important value at the institutions (Gibbons, 2007), the wider culture usually delivers a different message. Previously institutionalized children may experience incidences of social and emotional rejection and relationship failures due to their association with a care home rather than a family (Ethnasios, 2012; Behilak et al., 2015).

Problems with Attachment. In addition to the psychological consequences of rejection, some children without parental care in Egypt, as in other countries, exhibit problems in attachment (Behilak et al., 2015; Ethnasios, 2012; Kelly, 2016). Institutionalized children have been found to display insecure attachment (Behilak et al., 2015) and indiscriminate friendliness (Behilak et al., 2015; Ethnasios, 2012). These problems are seen through them falling in love easily, fast, and imprudently as well as having unexplained,

intrusive emotions of love, thoughts of bonding, and unreciprocated behaviors of expressions towards strangers (Ethnasios, 2012). When this happens, institutions deal with the situation very strictly. In some institutions, the belief is that the only way to prevent females from getting into sexual relationships is through removing any sources of temptation (Gibbons, 2007). For that reason, internal rules are sometimes so strict that the institution will keep a female away from school and isolate her in her room for a month if administrators find that she is 'too interested' in boys at school (Gibbons, 2007).

Similarly, research shows that the same pattern of searching for affection of strangers is present with institutionalized children in Egypt before their adolescent years. For instance, it is common to notice the competition young children have for being hugged, touched, and lifted up when a stranger enters the room (Gibbons, 2007). As expected, one study showed a relationship between attachment issues and experiencing multiple inconsistent caregivers (Behilak et al., 2015). Similarly, one of the institutionalized individuals explained the reason behind their common intrusive search for love outside the institutions by feeling that caregivers only care for them because it is their job to do, not because it is real; moreover, knowing that the caregiver will sooner or later leave the institution leaves them with a desire not to give their emotions to an attachment figure that is not going to stay (Ethnasios, 2012).

Research Questions

There is a gap in research on whether the practices of caregivers in Egypt are likely to foster secure attachments in the children they work with. To address this gap, this research will examine the issue of attachment in children without parental care in Egypt through studying it from the angle of caregivers' quality of care. The proposed research questions are: 1) Are caregivers in Egypt aware of their psychological role in caring for children at care

homes? 2) To which extent do they apply – or not apply – dimensions of the secure base model? and 3) How are attachment theory, parenting and secure base model assumptions applied in the Egyptian context?

Methods

To answer these research questions, in-depth interviews were conducted with a sample of caregivers working in care homes and a matched sample of biological mothers. These two groups were compared to see if there were caregiving and attachment behaviors that were the result of cultural norms and therefore, done by both mothers and caregivers, rather than being unique to caregiving in an institutional setting.

Participants

Care Homes

Wataneya Society connected the researcher with the caregivers at three different high quality care homes in Egypt. The caregivers that were interviewed came from three care: two in Greater Cairo and one just outside of Cairo. All of these care homes apply the nationally recognized Quality Standards for Alternative Care in Egypt, and emphasize child protection policy. In addition, the three care homes participated in trainings with Wataneya Society to further improve the quality of care they provide. Because the care homes work with young children, the ratio of caregivers to children averages one caregiver to two children. The number of children cared for in the three care homes between zero to six years ranged from 14 to 43, with the number of caregivers ranging from 7 to 20.

Caregivers and Biological Mothers

The participants in the study were all females: 14 caregivers working in care homes, and 12 biological mothers who shared similar demographic characteristics with those of the caregivers. The caregivers' characteristics were as follows: first, taking the roles that

substitute that of biological mothers for infants from six months old to three years' old; second, working in care homes in Egypt; third, having a minimum of six months working experience in their current role, except one who had just two months of experience. The minimum of 6 months working experience was based on balancing two concerns: first, that they needed to have spent enough time with the children to be able to reflect on the situations asked; second, that given the typical high turnover rate of caregivers in the field, it would be challenging to find caregivers with longer experience. Each of the interviewed caregivers was taking care of two to four children, and simultaneously taking care of her colleagues' children when they were on leave. All of the caregivers worked on rotation, but some rotated by day and some rotated by week. Six of the interviewed caregivers were also biological mothers and were all working in the same care home. Three of the caregivers mentioned that they studied something relevant to social work and/or psychology, two of which worked at the same care home as part of their care home's policy is to hire specialized caregivers only. And one mentioned that she was previously raised in a care home herself. Eleven of the caregivers talked about a male child and only three talked about a female child. Only one of the children was one year old, four were around a year and a half, five were around two years old, and four were two and a half years old. It was interesting to note that two of the caregivers expressed their wish to take the child they talked about as *Kafala*, however, the care home does not allow them to.

Hoping to create a snowball matched sample of mothers through the caregivers' acquaintances, a question was added at the end of the interview on whether they knew of any biological mothers who might be interested in participating in the study. Only two of them provided contacts of their relatives, but the rest did not know any who consented to participate. The remaining ten mothers were reached through looking for the needed

characteristics in the researcher's personal network and a snowball sample of their acquaintances. The needed characteristics included living in rural areas or having strong ties to their family that currently lived in rural areas, having no or low-paid work and taking care of a six months to three years old biological child. The sample included four wives of doormen, three who worked in cleaning jobs, and the remaining did not mention having jobs. The majority of the mothers had more than one child but talked about the child that is between six months and three years old. Half of the participants talked about their sons, and half of them talked about their daughters. Only one of the children was nine months old, five were between one and two years old, and six were between two and three years old. The biological mothers' interviews were analyzed using the same methods of the caregivers' interviews analysis.

Materials

The tool used was a semi-structured in-depth interview evaluating caregivers' capacities to provide a secure base for the children they care for. The interview guide was developed by Gillian Schofield and Mary Beek from the University of East Anglia, Norwich in the UK (University of East Anglia, n.d.), which is based on the secure base model they developed for the promotion of secure attachment in children raised in foster family care (Schofield & Beek, 2005). The developers of the model and tool gave permission for use to anyone who does not change anything regarding the core elements of the model (University of East Anglia, n.d.). The Secure Base Interview (Appendix E) has seven sections as shown in the below (see Table 1):

Table 1

Secure Base Interview Sections and their Goals

Section	Goal
Section one: a brief description of the child	It aims at surprising the caregiver's unconscious mind to evaluate how he/she views the child
Section two: availability	It aims at evaluating the caregiver's availability, which helps the child to trust
Section three: sensitivity	It aims at evaluating the caregiver's sensitivity, which helps the child to manage feelings and behavior
Section four: acceptance	It aims at evaluating the caregiver's acceptance, which helps the child to build a healthy self-esteem
Section five: cooperation	It aims at evaluating how the caregiver's attitude and mindset are helping the child to feel effective and be cooperative
Section six: family membership	It aims at evaluating how the caregiver's attitude and mindset are helping the child to belong
Section seven: caregiving and support	It aims at looking into the caregiver's attitude towards the caregiving relationship and his/her support system

Further, to analyze how they viewed their role as caregivers, an additional question on how the participants view their role as caregivers was added in the beginning of the interview, namely: "how do you view your role as a caregiver?".

Procedures

To ensure that the methodology was appropriate in the Egyptian context, first, the tool was reviewed and discussed with two of Wataneya Society's members who were familiar with both the Egyptian context of alternative care and the psychological needs of the target group of children. Adjustments to make sure the interview questions fit into Egyptian culture were made as needed. The interview was then translated into Arabic because the native language of the study's participants is Arabic. Then it was back translated to English to help

ensure validity. The interview was pilot-tested on a participant that shared the demographic characteristics of the study's target participants, and minimal edits were required. The edited back-translated version was shared with the original owners of the interview for approval of using the interview guide with the changes. They had a few comments that were incorporated in the final used version of the interview. After that, the planned methodology was shared with the Institutional Review Board (IRB) at the American University in Cairo (AUC) to get ethical approval. After receiving the approval, phone interviews were conducted with the caregivers at care homes and recorded, after taking their consent (Appendix A). Finally, the same interviews were conducted and recorded with the matched sample of mothers, after taking their consent (Appendix B). To ensure confidentiality, the recordings of the interviews were saved on the password protected personal device of the researcher, which no one else could access. Simultaneously, codes were created to save the participants information without revealing their identities. During the interview, the caregivers were asked to choose one child to talk about through the whole interview. During the analysis, some of the indicators suggested by the authors of the Secure Base Interview and its analysis guidance were not applicable to the context of caregivers at care homes in Egypt. More specifically, in section three about sensitivity, the theme of the caregiver *"*finding it hard to think and talk about the child's past - finds it too painful or feels that the child needs a "fresh start"" was not applicable to the interviewed sample. Likewise, there were indicators in section six about family membership that were about talking and managing the child's thoughts and feelings about their birth or foster families. This is because the original interview guide was developed for a foster care group. Unlike the typical foster care arrangement in the west, those raised in care homes in Egypt do not usually have a known family history, which makes these themes irrelevant to the analysis.

Analysis

The Secure Base Interview provides a guide on how to analyze the interview. The main interview had seven sections. Each section of the guide/interview listed indicators of strengths in the caregiving relationship, along with indicators of difficulties.

After transcribing the interviews, strengths and difficulties indicators were assessed for each of the participants, with either: the presence of the indicator is clear or unclear. The answers of each indicator were then totaled to identify how many of the interviewed caregivers/mothers showed the indicator and how many did not. In order to facilitate comparison, percentages were then calculated on each indicator for both groups (caregivers and mothers). After that, the groups' overall scores of all the strengths' indicators in each of the sections were averaged in order to identify the sections that each group showed particular strength in.

To validate the analysis, a random sample of the answers of three caregivers and three mothers was shared with two community psychology colleagues who evaluated the presence or absence of two random indicators in each of the seven Secure Base interview sections. That amounted to a total of 168 answers, where our answers matched 142 times (84.5%) of the time.

Results

Secure Base Interview

The Secure Base Interview guide had seven sections, and there was an additional section that asked the interviewees about how they see their role as caregivers. The results of each section are presented below.

Section One: A Brief Description of the Child

In the first section, the interview authors Schofield & Beek (2013) point out some possible strengths and difficulties in the relationship as follows. Strengths would be present if the description included: "concise evidence, description that is specific to the child, description that is showing warmth and interest in the child, and description that is balanced in terms of strengths and difficulties of the child and the caregiver's feelings towards the child" (p. 48). On the other hand, difficulties in the relationship could be indicated through: "the caregiver giving vague and generalized information, the caregiver being cool/detached and lacks interest, the caregiver indicating hostility, the caregiver seeing the child as a burden, the caregiver being frightened by the child, or the caregiver giving description that is largely negative and critical" (p. 48).

Caregivers' Descriptions. The overall average score of this section for the caregivers was 66%, as the majority of them showed strengths in only two of the four indicators: warmth, and specific description. Thirteen out of the fourteen caregivers (93%) showed warmth, interest, and pleasure in the child. Twelve out of fourteen caregivers (85.71%) answered with a description that was specific to the child. Only seven (50%) answered with a description that included concise evidence. And only five (36%) had descriptions that were balanced in terms of strengths and difficulties; the remaining nine had descriptions that focused on the strengths only. On the other hand, seven (50%) of the caregivers gave a description that was vague, one (7.14%) seemed to be cool and detached, and another one (7.14%) had a description that was largely negative and critical. For instance, one of the caregivers who had only two months of experience said: "I don't know… What would come to my mind? I don't know how to describe him… He is 1.5 years old; how would I describe him?... I love them all. He and his siblings are the same for me. He is very calm*"*. In her

answer, even though she said she loved them all and tried giving a description that was specific to the child through saying that “he is very calm”, her other words such as “what would come to my mind? He is 1.5 years old” along with her nonverbal communication indicated that she was detached and lacked interest.

Mothers’ Descriptions. Similarly, the mothers also showed particular strengths in the same two indicators: warmth and specific description. Yet, their section’s overall average score of 75%, was higher than the caregivers, as more mothers showed the strengths’ indicators. The twelve (100%) of mothers had a description that was specific to the child. All but one (91.67%) clearly showed warmth, interest and pleasure in the child. Seven (58%) had a description that included concise evidence. And only six (50%) had a description that was balanced in terms of strengths and difficulties. Three (25%) of the biological mothers had descriptions that only showed the strengths. On the other hand, like the caregivers, six (50%) had a vague description, one (8.33%) seemed to be cool and detached, one (8.33%) had a largely negative and critical description, and one (8.33%) saw the child as a burden. However, the mother that was more critical revealed later in the interview that she just experienced a difficult situation that might have impacted her description right before our interview. She mentioned in this section that the girl is “very difficult and strong” in a critical way, even though she later praised her strength and said she raised her to be strong.

Section Two: Availability

In the interview guide, the themes identified by Schofield & Beek (2013) that would indicate strengths in the relationship are: “the caregiver having plenty of time available to focus on the child, the caregiver having emotional space and availability, the caregiver having capacity to reflect on the child's needs to build trust in them as caregivers, the caregiver’s ability to think about ways in which they might support the child to trust them,

and the caregiver being alert to the child's needs and signals" (p. 50). On the other hand, difficulties in the relationship could be indicated through: "the caregiver lacking time/energy, the caregiver's unmet needs coming to the forefront, the caregiver seeming overwhelmed by the child's demands, the caregiver feeling marginalized by the child, the caregiver distancing herself from the child, the caregiver not believing the child should need that much attention" (p. 50). In addition, in this section in particular, the authors recommend considering secure and insecure attachment patterns from the caregivers' answers, in order to analyze how the children behaved in situations of stress.

Caregivers' Availability. The averaged total score of the caregivers in this section was 100% as all of them displayed all the strength indicators. Fourteen (100%) of caregivers seemed to have plenty of time available to focus on the child, emotional space and availability, awareness to the child's signals and needs, thoughtfulness about ways in which they might support the child to trust them, and capacity to reflect on the child's needs to build trust in them as caregivers. For instance, one of them said:

> If one of his brothers takes his toy, he comes to me to complain and points at the brother who took his toy. Then you try to sooth him, he may get satisfied… or if not, he sits at a corner in the room while sad. I try to bring him what he wants…. He did that because he knows I am his mother…. All kids go to their moms when something happens…. He feels happy when he takes what he wants and that his mom will bring him his things…. I try to soothe and satisfy him and talk with him…. If he gets calmer, that's it, if not I try to bring him what he wants.

Here, the caregiver showed alertness to the child's signals and needs and thoughtfulness about different ways in which she might support him to trust her, which in turn led him to learn to go to her during situations that brought him stress. On the other hand, there was no clear

evidence that the caregivers showed any of the other difficulties' themes. However, when analyzing the attachment patterns of the children, only five (35.7%) of the caregivers mentioned behaviors that could indicate secure attachment patterns in the children; this was suggested by the children seeking the mother when stressed, knowing she would comfort him. Another five (35.7%) mentioned behaviors that could indicate ambivalent/anxious attachment patterns in the children; this was suggested through situations where the children insisted the caregivers take them everywhere or else, they cried hard. Two (14%) mentioned situations that could indicate a disorganized pattern, which was evident through the children refusing to eat or drink when the caregivers were back from their vacations. One (7%) mentioned a situation that indicated indiscriminate attachment and friendliness towards everyone the child knew or did not know. It was unclear under which attachment pattern the remaining one (7%) child would fall.

Mothers' Availability. The mothers' average score in this section was 86.67%, which is lower than that of the caregivers. All but one (91.67%) of the mothers clearly displayed having emotional space and availability as well as being alert to the child's signals and needs. All but one (91.67%) showed having plenty of time available to focus on the child, and could think about ways in which they may support the child to trust them. The indicator that had the lowest number of clear applications was the mothers' ability to reflect on the child's needs. Only nine (75%) of the mothers clearly displayed that indicator. For instance, when asked about a situation when the child was worried/upset, one of the mothers talked about a time when she was toilet-training her two years and four months old boy. She said:

> He doesn't like that I get mad at him, as an emotional child, he walks after me to make up for me… He tried to get me out of my anger through many ways. So, he used to

> cry so that I could calm him down... When that didn't work, he started trying to do what would make mom happy.... So, he started going to the toilet to get out of this situation.... He did that because he loves me. He doesn't want our relationship to be tense. He was upset that he wasn't loved like he used to be.... That the people are mad at him... I talked with him directly... I am upset because you did so and so, but I want you to do this to be clean and so that mom loves you.

Here, even though the mother tried communicating with the child and explaining that she wanted him to go to the toilet to be clean, she did that by making the child feel that their relationship is at a threat, and that he has the responsibility of clearing the tension. On the other hand, only two of the difficulties' themes were each clearly displayed by the mothers. One (8.33%) showed lack of time/energy, and two (16.7%) showed mothers' unmet needs coming to the forefront. None of the other difficulties' themes were clearly shown by the mothers.

When analyzing the attachment patterns of the children in family-care, eight (66%) of them showed secure attachment patterns, two of which were towards the father or the grandfather, and one of which showed disorganized attachment towards the father while simultaneously showed secure attachment patterns towards the mother. The security was evident through them seeking the attachment figure when worried or communicating with him/her when upset. The attachment patterns of the remaining four were unclear: one kept asking the mother if she would hit her; the second cried too hard whenever his father left the house without him, and the role of the mother was unclear; the third one stood next to her mother in silence when she (the mother) screamed at her until she would soothe her; and the fourth wanted the mother to do everything for him and was jealous of his father who he only saw once in nine months.

Section Three: Sensitivity

In the sensitivity section, the themes that could indicate strengths in the relationship are: “the caregiver’s ability to recognize and talk about the child's feelings and how they are expressed, the caregiver’s ability to recognize that the strong feelings are understandable in the circumstances, the caregiver’s ability to "stand in the shoes" of the child, think flexibly about what the child may be thinking and feeling and to reflect this back appropriately to the child, and the caregiver’s ability to think and talk about her own feelings and share them appropriately with the child and other people” (Schofield & Beek, 2013, pp. 51-52). On the other hand, the difficulties in the relationship could be indicated by: “the caregiver lacking interest or curiosity in the child's mind, the caregiver’s difficulty in thinking flexibly about a range of possible feelings/reasons for the child behaving in a certain way, the caregiver finding it hard to think and talk about the child's past - finds it too painful or feels that the child needs a "fresh start”, the caregiver feeling frequently negative or angry towards the child without a "pause for thought" about why the child is behaving in this way or how best to respond, and the caregiver appearing overwhelmed by their own strong feelings or finding it hard to think and talk about their own feelings” (Schofield & Beek, 2013, p. 52).

Caregivers’ Sensitivity. The average overall score of this section for the caregivers was 73%. All but one of the caregivers (93%) were able to recognize and talk about the child's feelings and how they were expressed. Then ten (71.43%) were able to recognize that the strong feelings were understandable in the circumstances. Only nine (64.26%) showed the ability to "stand in the shoes" of the child, think flexibly about what the child might be thinking and feeling, and to reflect this back appropriately to the child. Similarly, only nine (64.26%) showed the ability to think and talk about the caregiver's own feelings and share them appropriately with the child and other people. For example, one of the caregivers said:

> When I carry one of his siblings and don't carry him, he gets angry and cries and keeps hitting his head on the floor. Sometimes I punish him and tell him 'No, this is wrong'… I should carry your sibling just as I carry you… Kiss your brother…. So, he says 'baby?' I say yes, a baby, love each other, you are siblings. I do that so that he doesn't get raised on selfishness and self-love... When he is so angry, I carry him… But if he is just a little bit angry, I just tell him 'This is your brother… that's wrong, love him'. He would get angry then just surrender when he sees that I screamed and so on.

Here, the caregiver was able to think about what the child might be feeling yet did not seem to think the strong feelings were understandable nor did she reflect this back to the child in an appropriate way. In this section, there was a higher number of caregivers who expressed the difficulties themes as well. Three (21.4%) caregivers seemed to lack interest or curiosity in the child's mind, and another three (21.4%) seemed to be frequently negative or angry towards the child without a "pause for thought" about why the child was behaving in this way, or how best to respond. In addition, two (14.3%) caregivers showed difficulty in thinking flexibly about a range of possible feelings/reasons for the child's behavior, and another two (14.3%) appeared overwhelmed by their own strong feelings or found it hard to think and talk about their own feelings.

Mothers' Sensitivity. The mothers' overall average score in this section was 87.5%, which is higher than that of the caregivers. Here, the twelve (100%) of the mothers were able to recognize and talk about the child's feelings and expressions, and all but one (91.67%) were able to recognize that the strong feelings are understandable in the situation. Ten (83.3%) were able to think and talk about their own feelings and share them appropriately with the child or others, while only 9 (75%) were able to stand in the child's shoes to think

about how he/she may be thinking and feeling and to appropriately reflect that back to the child. For instance, one of the mothers said:

> He must have felt oppressed... Because sometimes the child has ego... So, he was thinking why doesn't she want to give it to me and make me comfortable?... But this is a selfish feeling that I don't want to raise in him, so I leave him ...I don't react. I started being worried that this would be his personality... I am worried that when he wants anything, this would be his attitude. Now that he screams, what would he do when he gets older? When he gets calm, we tell him that we shouldn't treat mom and dad like that. This isn't how we react in our home... What mom says is always right.... It will be in your favor.

Here, the mother was able to stand in the shoes of the child and think about what he/she might be thinking and feeling; she also tried to communicate the desired behavior with the child after he/she calmed down, yet she seemed to be expecting the child to act as an adult. She was worried that his/her behavior now would grow with him/her in the future; therefore, she thought that the behavior was selfish and that it needed to stop. Finally, only one mother showed lack of interest or curiosity in the child's mind, while none showed any of the remaining difficulties themes.

Section Four: Acceptance

In the acceptance section, the themes that could indicate strengths in the relationship are: "the caregiver showing joy, pride and pleasure in the child and providing vivid examples, the caregiver praising the child easily and readily, the caregiver helping the child to accept failures and setbacks in a kind and supportive way, and the caregiver supporting the child in pursuing (child-led) experiences, interests, and activities" (Schofield & Beek, 2013, p. 53). On the other hand, the themes that could indicate difficulties in the relationship are: "the

caregiver's tendency to focus on negative aspects of the child, with little evident pleasure or pride, the caregiver finding it hard to accept/enjoy the child's individuality and ways in which the child may be different to other family members, the caregiver seeing the child as a "burden", and the caregiver offering little active support to the child in pursuing (child-focused) experiences, interests and activities" (Schofield & Beek, 2013, p. 53).

Caregivers' Acceptance. The overall average score for the caregivers in this section was 77%. It was clear that 13 caregivers (92.86%) showed joy and pleasure in the child and could easily praise the child. Ten caregivers (71%) could actively support the child in pursuing child-led experiences. Yet, it was unclear for seven (50%) of the caregivers that they were able to help the children in accepting failures and setbacks in a kind and supportive way. For instance, one of the caregivers said:

> One time, the manager asked him a question while I was studying with him, and he didn't answer... Sometimes it is shyness or fear... This was the situation that things didn't go his way... So, the manager said that he won't take gifts like his brothers.... When he gets angry, he hits his legs on the floor to express his anger because he thinks that I would do for him what he wants if he does that... I told him no! Cry! You didn't answer like your brothers, so you won't get the gift like them…I told him, if you answer, I will give you the gift, or the bonbon.... Sometimes he is stubborn and doesn't act submissively in front of others.... So, I get upset.... I tell him you need to be submissive.

Here, the caregiver did not seem to support the child to accept the setback in a supportive way. Four caregivers (28.5%) offered the child little active support in pursuing child-led experience. Two (14.3%) found it hard to accept/enjoy the child's individuality and ways in which the child may be different from other family members. This was evident through them

comparing the child to his/her siblings or being unable to identify a situation where this particular child did not have things his way, as one said:

> If his daily routine isn't followed, he becomes upset... He's just a year and a half as I told you… This question (of a time when things did not go the child's way) is for older age children… He wants to wake up, eat, watch TV, sleep, watch TV, go eat, then watch TV… If I take him from lunch and take him to the room instead of the TV room, he gets upset… Because he knows this is his routine.

Here, the caregiver did not seem to enjoy the child's individuality and ways in which he/she could be different from other members; she only thought that all children only need to follow a certain daily routine, so she was unable to identify a situation when things went wrong for this child in specific. Finally, one caregiver (7.14%) seemed to see the child as a burden.

Mothers' Acceptance. The mothers' overall average acceptance score was equal to that of the caregivers: 77%. All 12 mothers (100%) showed joy, pride and pleasure in the child. Nine (75%) clearly showed that they actively supported the child in pursuing (child-led) experiences, interests, and activities. Eight (66.67%) clearly showed their ability to praise the child easily and readily. Another eight (66.67%) clearly showed that they could help the child to accept failures and setbacks in a kind and supportive way. In this section, it is worth noting that three (25%) of the mothers mentioned situations where the children felt good about themselves when the mother brought them something that they wanted, such as: clothes or a toy. Unlike the caregivers and the rest of the sections, two other mothers could not identify a situation where things went wrong for the child. On the other hand, in the difficulties themes, three (25%) showed offering little active support in helping the child to pursue child-led experiences and activities. As one of them said: "I don't think anything

happened like that... He still doesn't play the games that have winning and losing.... And if he can't do something, I just do it for him".

Section Five: Cooperation

The themes that indicate strengths in the cooperation section are: "the caregiver thinking about the child as an autonomous individual whose wishes, feelings, goals are valid and meaningful and who needs to feel effective, the caregiver's ability to look for ways of working together to achieve enjoyable cooperation with the child wherever possible, the caregiver promoting choice and effectiveness wherever possible, the caregiver's ability to set safe and clear boundaries and limits - and also negotiate them" (Schofield & Beek, 2013, p. 54). On the other hand, the themes that may indicate difficulties in cooperation are: "the caregiver emphasizing the need for control, the caregiver finding it difficult to accept/enjoy the child's need for autonomy and to allow choice/promote competence and effectiveness, and the caregiver finding it difficult to allow the child to try new things or take moderate risks" (Schofield & Beek, 2013, p. 54).

Caregivers' Cooperation. The overall average score of caregivers in this section was 75%. Twelve caregivers (85.7%) promoted choice and effectiveness whenever possible. Eleven (78.57%) of the caregivers thought about the child as an autonomous individual, and another 11 (78.57%) showed the ability to look for ways to achieve enjoyable cooperation with the child. Yet, only eight of the caregivers (57.1%) could set safe and clear boundaries and negotiate them. For instance, one caregiver said:

> We have a box that we put our toys in.... I asked him to get the toys, so he refused.... He hid the toy behind his back.... His brothers tried to forcefully take it from him, so he tensed his body. So, I got him another toy so that he would agree to get it for me.... And that he doesn't feel that I took something from him without making up for him.

> He must change.... This shouldn't be... All his brothers need to play together.... When he hid the toy behind his back, he felt that I would take it from him.... So, I prepared another toy asap.

Here, the caregiver thought of the child as an autonomous individual and tried to promote cooperation, yet it was not clear that her approach was working well since the child did not act cooperatively. She also tried to teach him to put the toy back when needed, yet it was not clear that she was well-able to set clear boundaries that let the child understand that it was time to just put the toy back. On the other hand, four caregivers (28.6%) emphasized the need for control, and three (21.43%) found it hard to enjoy the child's need for autonomy.

Mothers' Cooperation. The mothers' average overall score in this section was only 70%, even though they showed great strengths in two of the four indicators. This is because in this section, only three (25%) showed setting and negotiating safe and clear boundaries and limits. This low percentage decreased the average overall score to a score lower than that of caregivers. In contrast, the 12 mothers (100%) promoted choice and effectiveness whenever possible. The second highest theme in this section was shown by 11 mothers (91.67%), and it involved thinking of the child as an autonomous individual whose wishes, feelings, and goals are valid. Eight (66.67%) of the mothers could look for ways of working together to achieve enjoyable cooperation with the child. In this example, one of the mothers said:

> He gets engaged with any toy... He had a bike, he used to disassemble it then fix it again.... I used to scream at him, so he used to ignore me. But in his mind, he didn't want to annoy me... He has something from God that lets him act like that... He sees his dad fixing the car, etc. So, he wants to do with his toys just what his dad does with the cars... But when we prohibited him from doing something like that, he persisted... So, we would leave him. His dad tells me to leave him so that his brain develops. He

> feels so happy! And if he disassembled it and didn't put it back together, he would persist until he gets it... We observe him.... I used to scream at him and hit him, but his dad told me to leave him so that he learns to fix the things he has.... So, I started leaving him.

Here, the mother used to follow a disempowering attitude with her child, thinking that he was ruining the bike they got to him, and not acknowledging his need for autonomy and feeling effective. However, once her husband started letting her notice that this would help his brain to develop and she saw that the boy persisted until he fixed the bike again, she started acknowledging his effectiveness and leaving him to do it. In the difficulties themes, two (16.67%) of the mothers emphasized the need for control, another two (16.67%) found it difficult to accept the child's need for autonomy, and one (8.33%) showed difficulty in allowing the child to try new things or take moderate risks.

Section Six: Family Membership

In the family membership section, the indicator for strengths is: "the caregiver's ability to give verbal and non-verbal messages of the child's inclusion in the family, the caregiver's ability to talk openly and appropriately with the child about both the strengths and difficulties of their birth/foster family, the caregiver's ability to support the child sensitively in managing their thoughts/feelings about their foster or adoptive family and their birth family and in presenting their situation to the outside world, the caregiver supporting the child with contact appropriate to their needs and the care plan" (Schofield & Beek, 2013, p. 55). The first indicator was the only relevant one to the interviewees in this study because the context is different. The interview guidance assumes that the child is living with a foster family and has another known birth or foster family, which is not the case for most of the interviewees in Egypt. The middle two indicators were only counted for a few of the

interviewees who mentioned signs of attachment or detachment towards the owner/manager of the care home, or towards a *Kafala* person. On the other hand, the themes that might indicate difficulties in the relationship include: "the caregiver's tendency to treat the child differently/less considerately to other children in the family, the caregiver talking/thinking negatively about the birth/foster family and fails to understand the child's need to have some positive sense of their birth family connections (or connections), and the caregiver creating (unreasonable) barriers to connections/contact between the child and the birth/foster family" (Schofield & Beek, 2013, p. 55). The first indicator was the only one relevant to the context of the interviews in this study.

Caregivers' Family Membership. Thirteen caregivers (92.86%) were able to give verbal and non-verbal messages of the child's inclusion in the family. Out of four who mentioned belonging to the owner/manager of the care home or a *Kafala* person, only two showed the ability to talk openly and appropriately with the child about both the strengths and difficulties of their birth/foster family. Out of seven who mentioned belonging to the owner/manager or a *Kafala* person or another caregiver, four showed the ability to support the child sensitively in managing their thoughts/feelings about their foster or adoptive family and their birth family and in presenting their situation to the outside world. For instance, one of those who took care of a child that had a *Kafala* arrangement said: "He has *Kofala* that come to visit him… Honestly, I never met them because another caregiver takes him downstairs to meet them… So, I don't know how he deals with them". Here, the caregiver did not even know anything about the child's other family in order to talk openly or appropriately about them, hence support in managing his/her feelings towards them. Another one who took care of a child that showed belonging to the owner of the care-home said:

> He loves to go to the other branch of the care-home and asks me to go there because he meets his older siblings there... He feels so happy with his siblings, I get happy when he does that, I always tell him when you see mom (the owner), greet her and hug her. And it also comes from within him.... Whenever he sees her, he runs to her; he loves her so much.

This example showed the caregiver's ability to talk openly with the child about his/her care home's family and owner and that she promoted his/her feelings of belonging to them. On the other hand, none of the caregivers clearly showed the difficulty indicator. In this section, nine (64%) of the caregivers mentioned situations that described the child's belonging to his/her peers/siblings in the care-home. Two caregivers (14%) mentioned situations that described the child's belonging to his/her caregiver. And two caregivers (14%) mentioned a situation where the child showed belonging to his previous/other caregiver. One said:

> She goes to the surrogate mother that used to be responsible for her before I take her and says "mama"… She didn't forget the time they had together… She used to take care of her for a year and a month then I took her after that. Even when I make her mad or something, she looks at her… The other mom would say that "I'm no longer taking responsibility for you" jokingly… So, this mother tells her "no you were her first mother".

Here, the child felt belonging to her previous caregiver and the participant could describe and deal with it openly. However, together with mentioning situations that showed belonging to either the peers/siblings or the owners, four (28.5%) also mentioned situations that could describe indiscriminate attachment. One said:

> His nature is that he is very sociable… So, whenever anyone (visitor) passes, he runs to the new person as if he doesn't know you… He knows that the new one (visitors)

> would carry him, bring him toys, and wouldn't leave him… But mom doesn't carry him all day!... Because for me I am not his mom alone… His siblings also need me. But he also likes to play with his siblings, especially the ones who are living with him in the same room…. He wants his siblings in the room to eat with him more than others.

Here, even though the child showed signs of belonging to his same-room siblings, he also showed signs of indiscriminate attachment towards anyone who would visit their care-home.

Mothers' Family Membership. In the family membership section, eleven mothers (91.67%) could give verbal and non-verbal messages of the child's inclusion in the family, and the remaining indicators were irrelevant to the context of biological mothers in this study. Similarly, in the difficulties themes, none of the mothers showed a tendency to treat the child less considerately and the remaining two themes were irrelevant to the context. All of the mothers mentioned situations where the children showed belonging and attachment to different family members, including: the wife of their uncle, their grandparents and aunt, their fathers, their cousins, their siblings, and their family as a unit.

Section Seven: Caregiving and Support

In this section, the themes that could indicate strengths include: "the caregiver showing pleasure/satisfaction in their caregiving role for this child, the caregiver being able to identify difficulties, but not be overwhelmed by them, the caregiver being open to the idea that they may need additional advice and knowledge, the caregiver indicating that they have tried and tested strategies and people that they can rely on for practical and emotional support" (Schofield & Beek, 2013, p. 56). On the other hand, the themes indicating difficulties include: "the caregiver lacking pleasure and pride in caring for the child and being unwilling to consider outside help and advice to achieve change, the caregiver denying

difficulties or appearing overwhelmed by them, the caregiver being pessimistic/fatalistic about the child's capacity to change or their capacity to contribute to that change, the caregiver lacking support or denying the need for support" (Schofield & Beek, 2013, p. 56).

Caregivers' Caregiving and Support. This was the section that showed the weakest score among all sections for both groups. The overall average score of caregivers here was 53.6%. Even though all the caregivers showed pleasure and satisfaction in their role, only eight (57.14%) were able to identify difficulties without being overwhelmed by them, only four (28.57%) were open to the idea that they might need additional advice and knowledge, and another four (28.57%) indicated that they had tried and tested strategies and people that they can rely on for practical and emotional support. One of the four caregivers who were open to the idea that they might need additional advice and knowledge was one of the three with more formal education. She said: "I don't get mad when someone corrects me or gives me advice… I would like to know what is wrong to correct it… I will of course attend courses or awareness if there is a chance…". Similarly, two of the caregivers who indicated they had tried and tested strategies and people that they can rely on for practical and emotional support were of the more educated group. On the other hand, many of the ones who did not identify people or strategies to rely on for support indicated that what supports them most are intangible things, such as love, compassion, and divine support. One said: "The source of support is that I love her, that I consider her as my daughter". Interestingly, some caregivers indicated the need for other types of support. For instance, one caregiver said: "I want them here in the care home to allow us to take the kids outside… because when we take them for vaccination or anything, the kids would be very scared. Like the older kids go out for outings, I wish they do that to the infants as well". Similar to the strengths results,

ten (71.4%) of the caregivers lacked tangible support or denied the need for it, and five (35.71%) denied having difficulties, then none clearly indicated any of the other difficulties.

Mothers' Caregiving and Support. The average score of the mothers in this section showed the largest difference between them and the caregivers. The overall average score of the mothers in this section was 83.3%. All of the twelve mothers clearly showed pleasure and satisfaction in their role, all but one (91.67%) were able to identify difficulties without being overwhelmed by them, and the remaining one (8.33%) identified difficulties but seemed to be overwhelmed by them. Nine (75%) of the mothers indicated that they had tried and tested strategies and people that they relied on for practical and emotional support. Eight (66.67%) were open to the idea that they might need additional advice and knowledge. One of the mothers said

> Your questions are making me think how I am not noticing... observing what she is doing... I know what she is doing, but I am not seeing what she is doing... I feel that I want to know more about children! I feel that I don't know anything. Since a long time ago, and since I gave birth to two, I feel that I want to know more so that I take good care of them and their cognition gets developed well, and that they become something big! Sometimes I watch the TV to know what to do, but sometimes I am not able to do everything... Your questions are beautiful honestly. I didn't know what it would be about... Because this is the first time someone asks me that, I feel that I don't know anything about children... I want to know more!

On the other side, the difficulties' themes were mirroring the strengths ones. Hence, three (25%) lacked support or denied the need for it, one (8.33%) appeared denial or overwhelmed, and none of the mothers showed any of the other difficulties.

Additional Themes

There were a number of additional themes that emerged from the Secure Base interviews. These themes are presented below.

Caregivers' other Themes Related to Belonging and Attachment

One of the caregivers felt a huge responsibility towards the child's feelings of attachment to her. She said:

> When I come from a break/vacation, he comes to me happily and wants me to hold him… When he watches TV and I come, he recognizes me and acts as if he found something that was lost… I feel very happy, but I try not to make him dependent on that and very attached because I am just a surrogate mother… I may leave any time! God knows… I don't want his mental wellbeing to be ruined because of me… So, I try to let him play more and so on.

In contrast, some other caregivers seemed to have pleasure in the children's attachment to them, which was evident in the quotes: "I feel accomplished and that he loves me and can't replace me"; "This made me feel that I love him so much, and that he is attached to me as a result of feeling my tenderness". Interestingly, another one denied that the situation resembled attachment and belonging. She said:

> When she cried and I was busy, I took her to X (another caregiver) and once she saw her, she stopped crying as if nothing happened. She acted this way because she loves her and the mother also loves her and is good with her. I am glad that there is someone else that she loves, if I leave or anything like that, she is attached to someone else… But she is not attached, she just likes them. I don't know how that made me feel.

In other sections of the interview, one caregiver described indiscriminate attachment in the children at the care-home though saying: "Children in the care-home love anyone new that

they see (visitors)… They want to be carried…. But at home, they go to their mom because they are afraid of the visitor".

Caregivers' Other General Themes

When asked about how they view their role, the majority of caregivers mentioned that they see themselves doing the job of a mother and teaching the children what is right and what is wrong.

It was common among many of the caregivers that they had difficulty identifying or naming the emotions the children could have been feeling in different situations throughout the interview. It was also clear that many of them had difficulty identifying or naming their own emotions as caregivers. However, the caregivers would sometimes mention emotions spontaneously – such as saying "he was happy/sad", but then show difficulty naming them again when asked about how the child or how she herself was feeling.

Some of the caregivers mentioned a daily routine that included a lot of TV and screen time. A couple of caregivers mentioned that they encourage the children through comparing them (either positively or negatively) to their brothers. Moreover, some of the caregivers seemed to be trying to create rules, yet the methods used differed. For instance, one said: "If he is right, I will satisfy him... If he is wrong and does that, I tell him I will deprive you from having the bonbon... I will make him go to the room and not play with his siblings... Or I let him sit next to me and don't play with his siblings. That's when he is wrong". Another one said:

> He knows that if he screams hard, I will take him.... In the beginning, I used to do what he wanted. But when I discussed it with the supervisor, she said if he cries, leave him, and when he finishes, let him know that this is unacceptable and because you cried, you won't go out with us and won't play with your brothers.

Mothers' Other General Themes

Like the caregivers, it was common among the biological mothers to have difficulty in naming or identifying the emotions of the child in different situations along the interview. It was also common for them to have difficulty identifying their own emotions. Furthermore, two of the mothers said that the child "doesn't feel". In addition, a few mothers showed that they felt guilty/shameful for not giving their children enough time, or wanted to prove they were doing a good job parenting their child by bringing him/her everything they wanted. For a few mothers, this created some resistance while answering the situations about a time when the child was angry or things went wrong. One of the mothers seemed to also have a man sitting next to her to suggest answers during the interview. A few mothers also mentioned situations where children communicated their needs/feelings aggressively. One of them said: "If his dad has Pepsi and doesn't give him a glass, doesn't want to give him, he goes to get a slipper, or a rock, or anything to hit him, while saying 'why didn't you pour a glass for me, I am a human like you, pour one for me'"". Unlike the caregivers, a few mothers asked about the interviewer's opinion of their parenting during the interview and towards its end.

Discussion

The majority of both the caregivers and biological mothers exhibited many of the themes that indicate strengths in their relationship with children. Likewise, the majority of both groups did not exhibit most of the themes that indicate weaknesses in the relationship. The section that showed the highest strengths for both groups was availability. In contrast, describing the child, acceptance, and cooperation seemed to be weaker. When comparing the results of both groups, the mothers seemed to generally do better than the caregivers. More mothers than caregivers clearly exhibited the strengths across three of the seven sections of the Secure Base Interview: description of the child, sensitivity, as well as caregiving and

support. However, the caregivers' average overall score was higher in two sections: availability and cooperation. While both groups' overall scores were almost equal in two of the seven sections: acceptance and family membership, the family membership section was not similar in content. Caregivers showed contradicting feelings of happiness, responsibility, and denial towards the children belonging to them, which was not seen in the sample of mothers. In addition, belonging was mostly towards peers/siblings in the sample of caregivers, while belonging was shown towards different family members in the mothers' sample. Finally, both groups showed difficulty identifying and naming their own and the children's emotions across all the sections of the interview.

Caregiver's Awareness of their Psychological Role and Ability to Provide a Secure Base

The results show that many caregivers were aware of their psychological role, hence tried to provide for the children what a 'mother' would provide to her children, as many said. This was further shown through the average overall scores that were above 70% in six of the seven sections for the caregivers. The caregivers showed strengths in applying some of the Secure Base model indicators and dimensions and weaknesses in applying some others. However, the stronger performance of the mothers is in line with research on the drawbacks of being raised in care-homes, in particular in relationship to attachment (Eapen, 2009; McLaughlin et al., 2012). Even though the present study looked at care-homes that seemed to encompass love and warmth, the ability of mothers to provide a secure base for their children seemed to be stronger than that of the caregivers.

Description of the Child

While describing the child, both groups showed relatively weaker strengths, but overall, the mothers were generally stronger. Both the caregivers and the mothers showed particular strengths in showing warmth and pleasure in their caregiving role for the child and

having a description that was specific to the child. This could be a result of the high level of warmth and love exhibited in the parenting style of collectivist cultures (Rudy, 2006). On the other hand, both groups were weaker in including concise evidence in their descriptions of children, and having a balanced description in terms of strengths and difficulties. Their descriptions primarily focused on strengths, and therefore, the difficulty indicator related to being largely negative and critical was not shown. This could also be explained by the perceptions of Egyptian parents on their parenting roles that were shown in Hanna's (2016) study. When asked to rank seven parenting characteristics based on how important they perceived each, Egyptian parents clearly ranked bonding as the most important characteristic and negativity as the least (Hanna, 2016).

Another possible explanation for the focus on strengths could be one consequence of the weak application of complex thinking and critical thinking within the Egyptian educational system (Bali, 2013; Loveluck, 2012). According to Pacheco & Herrera (2021), complex thinking is the ability to think in multiple dimensions and recognize a reality that simultaneously integrates contradictions, such as both strengths and difficulties. It is higher order thinking that includes both critical and creative thinking. In Egypt, the prevalent educational system focuses more on memorization than on engaging critically with the subjects (Loveluck, 2012). In Bali's study (2013), only students who joined international high schools that employed Western-based curriculum indicated developing critical thinking skills through in-class discussions, assignments requiring critical research and writings as well as exposure to people coming from different backgrounds. On the other hand, students that studied Egyptian curriculum or a mix of Egyptian and international curricula indicated that their schools either did not have an effect on their critical thinking skills or impacted them

negatively. In the present study, it is likely that all or most participants came from the Egyptian school system, hence, their critical thinking skills could have been less developed.

Availability

While answering the questions about availability, both groups showed overall strength, but unlike the majority of the sections, the caregivers were stronger in meeting the indicators. This could be a result of the trainings the interviewed caregivers took through Wataneya Society. Specifically, two of the mothers showed less time or energy available to focus on the child, which could be due to their other work or household duties, while caregivers, as they stay at the care-home, only have the responsibility for looking after children. This could also be explained by the additional theme that emerged about the mothers' feelings of guilt and shame thinking they were not as available to their children as they wished they were. In Egypt, men and women in the society perceive taking care of the family as a woman's most important role. Studying gender roles within the Egyptian family structure, women were found to undertake the majority of the daily childcare tasks and be the central player in children's discipline (UN Women, 2017). This high level of expectations and responsibilities may lead to feelings of guilt when they are not met. While studying the consequences of the pressure of perfect motherhood, Henderson et al. (2015) found that mothers who feel guilty for not meeting parenting expectations have high levels of stress and anxiety and low levels of self-efficacy. They found that it is common for mothers to be negatively impacted by the existence of some unrealistic standards of motherhood perfection. Those feelings could have also stood in the way of some mothers communicating effectively with their children in the times they were upset or worried, therefore, created their relatively weaker ability to support their children to build trust in them. According to Smith (2020), feelings of shame could impede one's ability to communicate in a clear, calm, and assertive

way. Likewise, stress can increase feeling overwhelmed, angry, frustrated and hinder effective communication (The American Institute of Stress, 2019).

Schofield & Beek (2013) recommend that the availability dimension be used to identify attachment patterns. Despite the fact the mothers scored lower overall on this dimension, more of the children raised in families showed secure attachment than those raised in care-homes. Only five (35%) in the care-homes showed behaviors that could indicate secure attachment towards the caregiver, in comparison to eight (66%) of the children in family care. This means that even when the caregivers tried to do their jobs well, their children still had higher levels of insecure attachment than children raised in families, which could be a result of poor caregiving practices, inconsistency between caregivers along with the turnover among caregivers, or children's attachment patterns prior placement in the care-home.

Sensitivity

While answering the questions about sensitivity, the mothers had higher overall average scores and were stronger on the individual strengths' indicators. This supports the findings of Castillo et al. (2012) on the better quality of care and attention provided in family-based care in comparison to that of care-homes. Some of the indicators that could improve for the caregivers were their ability recognize the strong feelings were understandable in the situation, their ability to stand in the child's shoes and think about how he/she might be thinking and feeling, and their ability to think and talk about their own feelings and share them back to the child and other people. Similarly, the mothers showed less strength in their ability to stand in the child's shoes and think flexibly about what he/she could have been thinking and feeling. The weaknesses of these indicators were emphasized through the participants' difficulty in identifying and naming the children and their own emotions across

the entire interview. Educating them about identifying and dealing with emotions could help them not only score better on the sensitivity dimension but also across all the other dimensions of the Secure Base model.

Acceptance

In the acceptance section, both groups seemed to be relatively weaker. The only strengths both groups showed was the pleasure and joy in the child, while more caregivers showed strength in praising the child easily and readily. These two results could be explained by Rudy (2006)'s findings on the high level of warmth and love prevalent in the parenting behaviors of the collectivist cultures. On the other hand, the mothers scoring lower in praising the child easily and readily could be explained by the situations some of them mentioned while answering the question of a time their child felt good about him/herself. Rather than talking about a situation when children accomplished something or took the risk to try a new thing (Schofield & Beek, 2013), a few mothers mentioned a situation when the mother brought the children something that they wanted, such as: clothes or a toy. In those situations, the mothers were keener on showing the children they brought them what they wanted than praising them for achievement. On the other hand, two mothers could not identify a situation where things went wrong for the child, one of them said he has not reached the age of winning or losing, but the other did not identify a situation while the positive situation she mentioned related to her giving the child a shower and praising how clean she was after. A possible explanation for the above two results could be the mothers' relating the times where things went well/wrong for the child to meeting/not meeting the child's physiological and material needs. Gratton (1980) analyzed Maslow's Hierarchy of Needs with three different social classes and found that the needs that were most important to the middle-class group were esteem and self-actualization, while the needs that were most important for the lower-

class group were the physiological and belonging ones. Since the majority of the present study's participants had no or low-paid work, it could be possible that this was the reason mothers related material needs to times things went well/wrong for the children. The needs that they viewed to be most important when things went well/wrong for their children were physiological and materialistic rather than psychological.

Family Membership

As for the family membership dimension, there was only one indicator that was relevant to the context of all participants: "the caregiver's ability to give verbal and nonverbal messages of the child's inclusion in the family", and both groups showed strengths applying this indicator. However, other themes emerged about belonging, attachment, and the caregivers' attitude towards the attachment relationship. There were inconsistencies about how the caregivers viewed their attachment/bond with the children. Some felt responsible and cautious towards the attachment bond that they tried to distract children from getting too attached, fearing the day they would leave. Some were proud of the bond, not considering the consequences when they would leave. Others seemed to deny the child was forming attachments to the caregivers altogether. This shows the lack of clarity and inconsistency of the information that is provided to caregivers about dealing with their attachment relationships with the children, which goes in line with Behilak et al. (2015) and Kelly (2016) findings on how the majority of caregivers in Egypt do not receive adequate training on the psychological aspects of caregiving.

To standardize the way caregivers view their role with children, they need to receive adequate training on the concepts of relational and attachment needs of children in a contextually appropriate way (Bettmann et al., 2015). It is also important that they be aware of the impact of both caregiver stability/continuity and caregiving practices on the attachment

outcomes in children (Quiroga & Hamilton-Giachritsis, 2015). Meanwhile, it could be helpful to focus the attention of caregivers on contributing to building the child's sense of self and reducing his/her levels of anxiety without promoting themselves as primary attachment figures. Children at care-homes may need multiple sensitive caregivers to compensate for the absence of a continuous primary parent figure (G. Schofield, personal communication, October 19, 2020). These multiple caregivers can contribute to a child's secure base both at one point or over time. Children at a care-home might have preferred secure base figures at a particular time but also benefit from the sensitivity and availability of other caregivers in building their sense of self, internal working model and reducing their anxiety. While children can have multiple different secure base figures across their lifetimes and move between them, there will always be an impact of separation and loss and a challenge to build new relationships. In that sense, good practice is to foster continuity while moving away from, or between, caregivers. This could be done through maintaining contact with former caregivers or keeping them alive in the minds of children, through using photos or life story books or other methods (G. Schofield, personal communication, October 28, 2020).

According to the interviews, the majority of children inside the care-homes felt a sense of belonging with their peers/siblings. This goes in line with research that found that children not only form attachment towards their mothers, but also towards other familiar adult figures (Ainsworth et al., 1978; Ainsworth, 1989; Hrdy, 2001; Wong et al., 2009). Interestingly, recent research by Haddow et al. (2021) studying attachment in alternative care adolescents found that peer relationships could have a role in fulfilling their attachment needs, and that peer relationships could directly or indirectly mitigate some of their childhood disrupted attachment through their peer relationships. Given the positive impact of the

peers/siblings' relationship, The Child Welfare Information Gateway (2019) recommends that these relationships be fostered.

On the other hand, the children raised in biological families felt belonging towards multiple different family members. This is expected in the context of Egyptian families because it is common for mothers to rely on the support of grandparents and other family members to look after the children (Storm et al., 1991). It is also similar to the case of Nso families whose children were accustomed to multiple different caregivers (Keller & Otto, 2009). Signs of belonging to other family members could indicate a strength in those families, given the idea it is beneficial for children' development to have secure attachment towards multiple different caregivers (Crockenberg et al., 2008; Hrdy, 2001; Thompson-Jinariu, 2011).

Caregiving and Support

In the dimension of caregiving and support, the mothers showed considerably stronger results than the caregivers. This section showed the highest overall difference between both groups (30% difference). Even though all the participants showed joy and pleasure in their caregiving role, the majority of the mothers but only half of the caregivers were able to identify difficulties without being overwhelmed by them. In addition, there were more mothers than caregivers who were open to additional advice and knowledge. Further, there was a big difference between the number of mothers and caregivers who identified that they have tried strategies and people to rely on for practical or emotional support. The weakness in identifying support by the caregivers could be related to the inadequate support provided to the profession in Egypt (Kelly, 2016). In addition, the lack of interest in support or additional advice and knowledge could be explained by Gibbons' (2007) finding that the typical caregiver in Egypt views her caregiving role as a transitional phase between school and

marriage. Therefore, caregivers may not be interested in investing time and effort to learn more about a job they view as temporary. This view of the job as temporary is likely reinforced by the lack of support, both contributing to a sense that it is not worth it to put time and effort into learning how to do the job well.

Attachment Theory and Secure Base Model Assumptions in the Egyptian Context

Both groups showed interesting results that could be explained by cultural considerations. In different sections of the Secure Base Interview, it was interesting to note that participants showed high levels of warmth and joy in the child and their caregiving role, even if the rest of the results in the section were not as high. This could be a strength as a result of the participants' belonging to a collectivist culture with parenting styles that include high levels of warmth and love (Rudy, 2006). On the other hand, in the sections about acceptance and cooperation, both groups showed relatively weaker strengths in supporting the child to pursue child-led experiences and activities. This could be explained by the lack of awareness about the importance of this dimension in the development of the child. When studying expectations of childrearing in Egypt, Storm et al. (1991) found that parents lacked understanding about children's need for creative behavior and the methods to develop its potential during childhood. This is not surprising given that the idea of receiving formal training in parenting is still uncommon within the Egyptian context. In Hanna's (2016) study that included more than 200 participants from the upper and middle socioeconomic class in Egypt, 83% indicated never attending a training in parenting. In her study, parents learnt about parenting from online sources or through their networks of family and friends. This highlights that the lack of training is not a characteristic limited to the caregivers' population in Egypt.

In the same sections of cooperation and acceptance, both groups also showed relatively weaker strengths in helping the child to accept failures and setbacks in a kind and supportive way, and looking for ways to achieve enjoyable cooperation with the child. The caregivers in particular were weaker in thinking about the child as an autonomous individual, therefore more of them emphasized the need for control. This could be related to the challenges parents face in these areas. In Hanna's (2016) study, discipline was one of the areas that participants said they faced challenges in. This could also be aligned with the expected high prevalence of authoritarian parenting in collectivist societies (Rudy, 2006). Authoritarian parenting is a parenting style that is characterized by restricting the autonomy of the child (Dwairy & Menshar, 2006). In the Secure Base model assumptions, promoting the child's autonomy is key for building his/her effectiveness (Schofield & Beek, 2013). However, unlike the implications of authoritarian parenting in the West, studies conducted in the Arab world have shown that authoritarian parenting does not lead to the similar negative mental health consequences. In the West, control and warmth get treated as two opposites in the same variable, meaning that cannot happen together (Dwairy & Menshar, 2006). The results of the current study support the claim that control and warmth can be compatible in some collectivist cultures (Dwairy & Menshar, 2006). Therefore, it may not be as alarming to find those indicators in both groups within the Egyptian context, especially that they were accompanied by warmth. However, it would still be useful to explore ways that ensure caregivers promote the developmental aspects of acceptance and cooperation because they help in building the child's self-esteem and sense of effectiveness (Schofield & Beek, 2013).

Both groups showed weakness in setting safe and clear boundaries and negotiating them, yet the mothers were considerably weaker in this point. This could indicate a permissive parenting style, rather than an authoritarian style, and contradicts the claim that

authoritarian styles are more common in Arab cultures. Dwairy, et al. (2006) found that the parenting styles across the Arab societies were different from those in the West. In the West, authoritarianism and permissiveness are two poles on a linear continuum. In the Arab societies, three categories that included mixed-parenting styles were identified. One of those categories was labeled inconsistent parenting as it combined both authoritarian and permissive styles. This could mean that the participants of this study could as well fall under the inconsistent parenting style identified by Dwairy et. al. (2006) and Hanna's (2016) study of Egyptian parents.

Recommendations

This study showed that even though some children were raised by warm caregivers at care homes that are keen on providing quality care, they still showed higher patterns of insecure attachment than those raised in family-based care. Simultaneously, the biological mothers showed stronger ability to provide a secure base than the caregivers. Therefore, the following recommendations are suggested to improve outcomes for children living without parental care.

Recommendations on the Macroeconomic System level

- Developing a system that ensures taking the necessary steps to keep children with their families and leave placement at care-homes for only when there are no other options that are in the best interest of the child
- Building on the current efforts of promoting the *Kafala* system, while simultaneously building its monitoring and evaluation framework to ensure children get placed in suitable, caring families

- Increasing the efforts of child-protection stakeholders to raise awareness on the issue of attachment in children without parental care, the negative consequences of institutionalization, and the possible positive life-long impact that could happen for a child when raised in a caring family instead of a care-home
- Developing the system to foster consistency and continuity for the children through decreasing their number of placements and the movement among different caregivers and care homes during their childhood years
- Mandating a certain quality standard that ensures training caregivers on the attachment concepts and needs of children, and the importance of applying the five dimensions of the Secure Base model in their caregiving before taking on their caregiving role
- Developing the system, support, and career path of the caregiving profession in order to motivate caregivers to feel secure enough, motivated to learn to do their job better, hence provide a secure base for the children in their care

Recommendations on the Care Homes Level

- Providing a supportive environment for the caregivers in order for them to be able to take good care of the children. This could be done through acknowledging, rewarding, and investing in the knowledge and growth of the caregivers with the best performance, lowest turnover rates, and who treat children with warmth and joy
- Taking an active role in ending dealing with the profession of caregivers as a transitional phase through providing long-term contracts that both parties abide by. This will make it more reasonable for the care homes and caregivers to invest in the caregivers' growth and learning

- Providing all caregivers with the necessary basic training in order to be able to provide good quality care. Then seize opportunities to learn about and apply the concepts of child psychology, healthy upbringing, complex thinking, identifying and dealing with emotions, and all the knowledge and skills that would enable them to do their job in good quality
- Standardizing the definition/way of the child-caregiver relationship, so that caregivers understand how they are required to view their role, hence what to convey to the children since early childhood about their relationship. Here, it could be helpful to focus the attention of caregivers on contributing to building the child's sense of self and reducing his/her levels of anxiety without promoting themselves as primary attachment figures. This requires that caregivers be provided with adequate training on the concepts of relational and attachment needs of children in care-homes settings, and the impact of both caregiver stability/continuity and caregiving practices on the attachment outcomes in children
- Facilitating ways that ensure the continuity of the relationship between children and their former caregivers through either keeping contact with them or focusing on ways that keep the caregivers alive in the children's minds (such as using photos or life story books)
- Fostering peer/sibling attachment within the care homes, rather than attachment to the caregivers or the care homes. This is because many children showed signs of belonging to their peers/siblings and research showed that relationships with peers/siblings could play a role in fulfilling attachment needs. The Child Welfare Information Gateway (2019) recommends the following practices to foster peers/siblings' relationships. First, paying attention to who each child considers to be

his/her peer/sibling. Second, ensuring peers/siblings get assigned to the same caregiver. Third, providing trainings on the importance of fostering and maintaining the relationship of each child with his/her peers/siblings, even if any of them moved out of the care-home. Fourth, including both caregivers and children in the discussions of case-planning that are concerned with their peers/siblings. Fifth, discussing peers/siblings' issues with all the relevant individuals and incorporate plans to maintain their connections into the care-leaving plans. Sixth, developing a system that tracks the location and status of all peers/siblings.

Recommendations on Raising the Capacities of Caregivers

- Introducing the ideas of complex and critical thinking through the trainings' content and assignments provided to caregivers in order to enhance their capacities to pay attention to the multidimensional reality of the children in their care and the evidence behind any conclusions they make about them. This would help them to set their assumptions aside while observing the children. It would also help them intervene appropriately with the children when they see them within the overall context of their circumstances and behaviors
- Focusing on building the capacities of caregivers to provide a secure base through educating them on the children's needs to have caregivers who apply all of the dimensions of the Secure Base model in order to promote the children's secure attachment and resilience
- Paying special attention to the section of Sensitivity in the Secure Base model, given that most of the interviewees showed difficulty in identifying feelings for themselves and the children in their care. For that, it could be possible that improving their sensitivity could help improve their performance in the rest of the dimensions

- Taking into consideration the cultural context of applying the Secure Base concepts. Therefore, allow for the caregivers' expectations of some obedience as long as it is accompanied by warmth and is not abusive

Limitations

There were several limitations to this study. On the Secure Base model website, Schofield & Beek (n.d.) suggest that the model is not culturally specific, and while its caregiving dimensions can benefit all children of all ages, it suggests that different cultures or groups could need careful additional interventions from caregivers to achieve the required developmental aspects. For instance, children from groups experiencing discrimination might need additional emotional and physical availability to build a healthy sense of identity (University of East Anglia, n.d.). In Egypt, while conducting the study, some other limitations occurred. First, in the acceptance section, while the biological mothers were answering a situation when things went well/wrong for the children, some of them focused on situations that related to meeting the children's materialistic and physiological needs, rather than situations of taking risks or accomplishing things that raise the children's self-esteem. Analyzing Maslow's Hierarchy of Needs with three different social classes showed that the needs that were most important to the middle-class group were esteem and self-actualization, while the needs that were most important for the lower-class group were the physiological and belonging ones (Gratton, 1980). Therefore, it would be useful for future research to explore the validity of this dimension with the working/lower class, especially in a developing country with a weak social welfare system like Egypt.

Likewise, in the section of family membership, most of the indicators identified by Schofield & Beek (2013) were irrelevant to the context of children at care-homes in Egypt, as it is unlikely for most children to have known family origins. On the model's website,

Schofield & Beek (n.d.) highlighted that some themes showing higher involvement of extended family members in caretaking of children could emerge in different cultures, which was evident in the sample of biological mothers in this study. However, other themes emerged while analyzing this section with the caregivers' sample, such as: belonging to peers/siblings at the care-home, belonging to a current or previous caregiver, and indiscriminate attachment patterns. Therefore, it would be useful to consider adding those to the Secure Base Interview Guidance while analyzing similar studies in contexts like Egypt.

The interviews were conducted with a relatively small number of participants, which makes it difficult for the findings and conclusions to be generalized. However, given the common challenges faced in Egypt and the Middle East by children at care homes, these results could likely be applicable to similar contexts. In addition, the sample of the study's caregivers came from care homes who were keen on applying the national Quality Standards for Alternative Care in Egypt, which means that a more representative sample of caregivers coming from care homes across Egypt is likely to show poorer results. Moreover, the interview was conducted only once with each participant. Therefore, it could have been affected by the mood of the interviewee at the time. For instance, one of the mothers that had a description of the child that was highly negative and critical mentioned later in the interview that she was just dealing with a challenging situation with the child.

Recommendations for Future Research

For future research, it is recommended to research the consequences of different attachment patterns among children raised in alternative care in Egypt. It could also be useful to compare between a group of caregivers and a group of alternative/*Kafala* mothers. Since the *Kafala* system just started to be more recognized and popular within Egyptian society, a matched sample of *Kafala* mothers could give further insights about taking care of a child

that is not biologically related to them. In addition, it could be helpful to research the implications of the inconsistent parenting style within the Egyptian context. Moreover, since studies on Egypt and the Arab world do not relate restricting the child's autonomy to his/her mental health, it would be helpful to explore what else could promote the child's sense of effectiveness within the Egyptian/Arabic context. In addition, as some discrepancies occurred among the parenting behaviors of both groups, it could be helpful to study where each group gets guidance, the readiness of caregivers and parents to receive mandatory training before caring for children, and how development and parenting practitioners can develop advocacy strategies to raise awareness about contextually healthy parenting and attract participants to join those trainings.

Conclusion

The study suggests that the Secure Base model can be a helpful tool for assessing the capacities of caregivers, and identifying the need for intervention. However, some of its assumptions did not hold in the context of Egypt and/or care-homes, and those aspects of the model may need to be revised for use in these settings. The study also showed that the majority of caregivers and biological mothers were doing a good job of providing a secure base for children, although mothers were generally stronger. This was mainly due to the high levels of warmth and love that both groups exhibited, which confirms what research has found regarding parenting practices in collectivist cultures in general, including Egypt. Despite this strength, both groups also seemed at times to lack the structure that would make their caregiving and parenting practices consistent, and both groups had some deficiencies in understanding children's psychological needs. In addition, caregivers had contradictory views of how the children should feel about them in terms of attachment. Moving forward, it will be important to support caregivers (and parents) on the individual, institutional, and macro-

economic levels to embrace their caregiving and parenting strengths, while also finding ways to improve in the areas where challenges have been identified. This work to improve caregiving practices is essential if children without parental care in Egypt are to reap the benefits of a secure attachment, and gain the resiliency they need to overcome the challenges they face.

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Appendices

Appendix A: English Informed Consent to Caregivers

THE AMERICAN UNIVERSITY IN CAIRO
INSTITUTIONAL REVIEW BOARD

Documentation of Informed Consent for Participation in Research Study

Project Title: Caregiving Styles among Caregivers for Children without Parental Care in Egyptian Institutional Care

Principal Investigator: *Manar Ahmed Nada, manarnada@aucegypt.edu*

You are being asked to participate in a research study. The purpose of the research is to understand more about how caregivers in institutional care approach their daily work of caring for children, and the findings may be published and presented. The expected duration of your participation is about an hour to an hour and a half.

The procedures of the research will be as follows: you will be asked a series of questions. If you consent, your responses will be recorded to ensure accuracy.

There are no risks or discomforts associated with this research.

There may be indirect benefits to you from this research as the result may be used to enhance the quality of care for both caregivers in institutional care and children living in institutions.

The information you provide for purposes of this research is confidential so that you will not be identified in any description or publication of this research. Only the researchers will have access to the interview transcript or recording and your interview responses which will be kept in a password protected file on the researcher's computer.

For questions or concerns about the research, please contact the principal investigator Manar Ahmed at (*manarnada@aucegypt.edu*).

Participation in this study is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or the loss of benefits to which you are otherwise entitled.

Appendix B: English Informed Consent to Mothers

THE AMERICAN UNIVERSITY IN CAIRO
INSTITUTIONAL REVIEW BOARD

Documentation of Informed Consent for Participation in Research Study

Project Title: Caregiving Styles among Caregivers for Children without Parental Care in Egyptian Institutional Care

Principal Investigator: *Manar Ahmed Nada, manarnada@aucegypt.edu*

You are being asked to participate in a research study. The purpose of the research is to understand more about how mothers approach their daily work of caring for children, and the findings may be published and presented. The expected duration of your participation is about an hour to an hour and a half.

The procedures of the research will be as follows: you will be asked a series of questions. If you consent, your responses will be recorded to ensure accuracy.

There are no risks or discomforts associated with this research.

There may be indirect benefits to you from this research as the result may be used to enhance the quality of care for children in Egypt.

The information you provide for purposes of this research is confidential so that you will not be identified in any description or publication of this research. Only the researchers will have access to the interview transcript or recording and your interview responses which will be kept in a password protected file on the researcher's computer.

For questions or concerns about the research, please contact the principal investigator Manar Ahmed at (*manarnada@aucegypt.edu*).

Participation in this study is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or the loss of benefits to which you are otherwise entitled.

Appendix C: Arabic Informed Consent to Caregivers

الجامعة الأمريكية بالقاهرة

استمارة موافقة مسبقة للمشاركة في دراسة بحثية

عنوان البحث : (أساليب تقديم الرعاية بين مقدمي الرعاية للأطفال المحرومين من رعاية الوالدين في مؤسسات الرعاية المصرية)

الباحث الرئيسي: (منار أحمد عبد الكريم ندا، طالبة ماجستير علم النفس المجتمعي في الجامعة الأمريكية بالقاهرة)
البريد الالكتروني: manarnada@aucegypt.edu

انت مدعو للمشاركة فى دراسة بحثية عن (أساليب تقديم الرعاية بين مقدمي الرعاية للأطفال المحرومين من رعاية الوالدين في مؤسسات الرعاية المصرية). **هدف الدراسة** هو (فهم كيفية تعامل مقدمي الرعاية بمؤسسات الرعاية المصرية مع وظيفتهم الخاصة برعاية الأطفال، **مع احتمالية عرض ونشر النتائج**. المدة المتوقعة للمشاركة في هذا البحث هي من ساعة لساعة ونصف).

اجراءات الدراسة تشتمل على (أنني سأقوم بعرض بعض الأسئلة عليك. وعند موافقتك، سأقوم بتسجيل إجاباتك من أجل تحقيق الدقة)

لا توجد مخاطر متوقعة من المشاركة فى هذه الدراسة.

وربما تكون هناك فوائد غير مباشرة متوقعة من المشاركة في البحث حيث أنه يحتمل استخدام النتائج لتحسين جودة الرعاية لكل من مقدمي الرعاية بمؤسسات الرعاية والأطفال الذين يعيشون بها.

المعلومات التى ستدلي بها فى هذا البحث **سوف تكون سرية في أي من النتائج المنشورة لهذا البحث**. سيتمكن الباحثون فقط من الوصول إلى نص المقابلة أو تسجيلها وإجاباتك في المقابلة التي سيتم حفظها في ملف محمي بكلمة مرور على جهاز كمبيوتر الباحثة.

للإجابة على أي أسئلة أو تحفظات خاصة بالبحث، يمكنك التواصل مع الباحثة الرئيسية: منار أحمد على الرقم المستخدم في الاتصال.

ان المشاركة فى هذه الدراسة ماهى الا عمل تطوعى، حيث أن الامتناع عن المشاركة لا يتضمن أى عقوبات أو فقدان أى مزايا تحق لك. ويمكنك أيضا التوقف عن المشاركة فى أى وقت من دون عقوبة أو فقدان لهذه المزايا.

Appendix D: Arabic Informed Consent to Mothers

الجامعة الأمريكية بالقاهرة

استمارة موافقة مسبقة للمشاركة في دراسة بحثية

عنوان البحث : (أساليب تقديم الرعاية بين مقدمي الرعاية للأطفال المحرومين من رعاية الوالدين في مؤسسات الرعاية المصرية)

الباحث الرئيسي: (منار أحمد عبد الكريم ندا، طالبة ماجستير علم النفس المجتمعي في الجامعة الأمريكية بالقاهرة)
البريد الالكتروني: manarnada@aucegypt.edu

انت مدعو للمشاركة فى دراسة بحثية عن (أساليب تقديم الرعاية بين الأمهات المصرية). **هدف الدراسة** هو (فهم كيفية تعامل الأمهات مع دورهم الخاص برعاية أطفالهم، **مع احتمالية عرض ونشر النتائج**. المدة المتوقعة للمشاركة في هذا البحث هي من ساعة لساعة ونصف).

اجراءات الدراسة تشتمل على (أنني سأقوم بعرض بعض الأسئلة عليك. وعند موافقتك، سأقوم بتسجيل إجاباتك من أجل تحقيق الدقة)

لا توجد مخاطر متوقعة من المشاركة فى هذه الدراسة.

وربما تكون هناك فوائد غير مباشرة متوقعة من المشاركة في البحث حيث أنه يحتمل استخدام النتائج لتحسين جودة الرعاية لكل من الأمهات والأطفال بمصر.

المعلومات التى ستدلي بها فى هذا البحث **سوف تكون سرية في أي من النتائج المنشورة لهذا البحث**. سيتمكن الباحثون فقط من الوصول إلى نص المقابلة أو تسجيلها وإجاباتك في المقابلة التي سيتم حفظها في ملف محمي بكلمة مرور على جهاز كمبيوتر الباحثة.

للإجابة على أي أسئلة أو تحفظات خاصة بالبحث، يمكنك التواصل مع الباحثة الرئيسية: منار أحمد على رقم الرقم المستخدم في الاتصال.

ان المشاركة فى هذه الدراسة ماهى الا عمل تطوعى، حيث أن الامتناع عن المشاركة لا يتضمن أى عقوبات أو فقدان أى مزايا تحق لك. ويمكنك أيضا التوقف عن المشاركة فى أى وقت من دون عقوبة أو فقدان لهذه المزايا.

Appendix E: Secure Base Interview Guide

مقدمة عن الباحث وموضوع البحث وموافقة تليفونية للتسجيل

Introduction about the researcher, research objectives, and phone consent form for audiotaping.

أسئلة عن الخلفية

Background questions

-ممكن توصفلي\توصفيلي الوظيفة بتاعاتك؟

- Can you describe your occupation?

-إنت إزاي شايف\ة دورك في الوظيفة دي؟

- How do you see your role in this job?

خلال المقابلة، حضرتك هتفكر\ي في طفل محدد في الدار من الأطفال اللي بتقدم\ي لهم رعاية عشان نتكلم عنه.

During the interview, you will think about a specific child in one of the child care institutions to talk about him/her.

مقابلة نموذج الأساس الآمن

Secure base model interview

Introduction-مقدمة

الأسئلة الجاية هتكون عن 5 محاور لنمو وتطور (اسم الطفل)، وكمان عن تجربتك لرعايته. هيساعدنا النقاش في معرفة إيه الأمور الماشية بشكل كويس، وهيساعدنا نفكر في أي اقتراحات قد تكون مفيدة في المجال.

Following questions will be on five aspects of the growth and development of (child name) as well as your experience of caring for him/her. The discussion will help us understand what works well and will help us think about any additional recommendations for staff that might be useful in the field.

(1) **Section** – (1) القسم

وصف موجز\بسيط للطفل.

Child brief/Simple description

- ممكن تديني وصف موجز\بسيط عن أنت شايف (الطفل) إزاي؟ يعني إيه أول حاجات بتيجي في بالك لما تفكر فيه (أو اسمه ييجي قدامك)؟

- Can you give me a brief/simple description on how you see (child)? What is the first thing that comes to your mind when you think about him (or when you come across his name)?

القسم (2) الإتاحة - مساعدة الطفل على الثقة)للباحث: نريد اكتشاف رد فعل الطفل للشعور بالقلق، ورد فعل مقدم الرعاية له عندما حدث ذلك، إذا حاول الطفل اللجوء لمقدم الرعاية للراحة أم لا، وإذا كان الراعي متاح عاطفيًا وعمليًا)

Section (2) – availability- help the child to trust (for the researcher: we want to discover how the child reacted to distress and how this carer responded e.g. whether the child tried to seek comfort from this carer and how available emotionally and practically the carer was able to be).

مجموعة الأسئلة دي هتكون عن مدى قدرة (الطفل) على الثقة بالبالغين المقربين. هنفكر في اللي بيحصل لما يكون منزعج أو قلقان بخصوص أي حاجة.

This first group of questions will be about what happens when he is upset or worried about something.

- ممكن تفكر\ي في وقت معين كان (الطفل) فيه متضايق أو قلقان بسبب حاجة معينة؟

- Can you think about a time when (child) was upset or worried about something specific?

- عمل إيه (الطفل) قبل بالظبط ما ده يحصل، وأثناء ما كان بيحصل، وبعدها؟

- What did the child do exactly before this happened? And while it was happening? And afterwards?

- حضرتك تفتكر\ي ليه (الطفل) اتصرف بالطريقة دي بالذات؟

- Why do you think (the child) behaved this way specifically?

- تفتكري هو\هي كان بيفكر في إيه وحاسس إيه ساعتها؟

- What was he thinking about? And how did he feel then?

- وحضرتك عملت\ي إيه في الوقت ده؟

- What did you do then?

- وكان إيه نتيجة التصرف ده منك؟

- What was the result of your action?

- هل كان ده النهج أو الطريقة المعتادة بتاعتك لما (الطفل) يكون متضايق أو قلقان؟ ولا دي كانت طريقة تانية لمساعدته ساعتها؟

- Was this your normal approach or way when (the child) is upset or worried? Or was it another way to help him at this point?

  - وسلوك (الطفل) في الوقت ده خلاك\ي تحس\ي بإيه؟

- How did you feel about (the child) behavior?

(خلال المقابلة، من المهم تشجيع مقدم الرعاية على التركيز على حدث محدد. الإجابات المعممة مثل "هو على طول متعصب" ليست كافية لهذا النوع من التقييم.)

(During the interview, it is important to encourage the caregiver to focus on a specific occasion or event. General answers like “he is always nervous” are not enough for this type of evaluation.)

القسم (3) الحساسية والمواجدة - مساعدة الطفل على إدارة المشاعر والسلوك

Section 3- Sensitivity - helping the child manage his feelings and behaviour.

في مجموعة الأسئلة التانية، عايزين نشوف إزار (اسم الطفل) يسعبر عن مشاعره ويتعامل معاها. بيختلفوا الأطفال جدًا في طريقة تعاملهم مع المشاعر القوية زي الغضب والشعور بالذنب والحماس والحزن: في أطفال بيظهروا المشاعر دي بسهولة، وفي أطفال بيعبروا بشكل مبالغ، وفي أطفال بيكتموا ويكبتوا مشاعرهم. الأسئلة الجاية دي هتكون عن مدى قدرة (الطفل) على إدارة مشاعره/مشاعرها.

For the second set of questions we want to focus on how the child expresses and manages their feelings. Children differ greatly in how they deal with strong feelings like anger, guilt, excitement, and sadness. Some children express such feelings easily, other children express them in an exaggerated way, and some children silence and suppress their feelings. Following questions will be on (the child) ability to manage his/her feelings.

- تقدر\ي تفكر\ي في وقت محدد كان (الطفل) غضبان بسبب حاجة معينة؟

- Can you think about a time when (the child) was angry about something specific?

  - عمل إيه (الطفل) لما كانت عنده المشاعر دي؟ (قبلها على طول، وأثناء الموقف، وبعدها)

- What did (the child) do when he had those feelings? (right before it, during, and after it).

  - تفتكر\ي ليه (الطفل) اتصرف بالطريقة دي بالذات؟

- Why do you think (the child) behaved this way specifically?

  - تفتكري هو\هي كان بيفكر في إيه وحاسس إيه ساعتها؟

- What was he/she thinking about? What did he/she feel then?

- وحضرتك قلت\ي و\أو عملت\ي إيه في الوقت ده؟

o What did you say or do then?

- وكان إيه نتيجة التصرف ده منك؟

o What was the result of your action?

- هل كان ده النهج أو الطريقة المعتادة بتاعتك لما (الطفل) بيكون عنده مشاعر قوية عمومًا؟ ولا دي كانت طريقة مختلفة لمساعدته ساعتها؟

o Was this your normal approach or way when (the child) has strong feelings? Or was it another way to help him at this point?

- وسلوك (الطفل) في الوقت ده خلاك\ي تحس\ي بإيه؟

o How did you feel about (the child) behavior?

القسم (4) القبول - بناء الطفل لصورة صحية\حقيقية عن ذاته (أنه بيحس كويس عن نفسه لما بيحقق حاجة، وبيعرف برضه يتعامل ويتخطى الوضع لما الدنيا ماتمشيش كويس)

Section (4) acceptance- helping the child to build self-esteem (feeling good about him/herself when things go well but also coping with setbacks).

المجموعة الثالثة من الأسئلة الجاية عن كيفية شعور (اسم الطفل) تجاه نفسه/نفسها، وعن كيفية تعامله لو لم تسر الأمور على ما يرام.

The following questions – the third set- are about how (the child) feels about him/herself, and how they behave if things did not go well.

الجزء (1)

Part (1)

- تقدر\ي تفكر\ي في وقت معين أظهر فيه (الطفل) شعوره بالرضا عن نفسه/نفسها؟ (ملاحظة: ده ممكن يبقى وقت حس فيه بالإنجاز في حاجة بسيطة، أو بالفخر بنفسه، لو مافيش أمثلة، انتقل إلى الجزء 2).

o Can you think about a time when (the child) showed feelings of satisfaction about his/herself? (Note: This could be quite small achievement / sense of pleasure or pride. If there are no examples move to Part 2).

- عمل إيه الطفل في الوقت ده لما كان عنده المشاعر دي؟ (قبلها على طول، وأثناء الموقف، وبعده)

o What did (the child) do on the occasion when he had those feelings? (right before it, during, and after it).

- تفتكر\ي ليه (الطفل) اتصرف بالطريقة دي بالذات؟

o Why do you think (the child) behaved this way specifically?

- تفتكر\ي هو\هي كان بيفكر في إيه وحاسس إيه ساعتها؟

o What was he/she thinking about? What did he/she feel then?

- وحضرتك قلت\ي أو عملت\ي إيه في الوقت ده؟

o What did you say or do then?

- وكان إيه نتيجة التصرف ده منك؟

o What was the result of your action?

- هل كان ده النهج أو الطريقة المعتادة بتاعتك لما (الطفل) بيكون عنده شعور بالرضا عن نفسه؟ ولا وقتها لقيت\ي طرق تانية لمساعدته ساعتها؟

o Was this your normal approach or way when (the child) has feelings of satisfaction towards himself? Or was it another way to help him at this point?

- وسلوك (الطفل) في الوقت ده خلاك\ي تحس\ي بإيه؟

o How did you feel about (the child) behavior?

- الجزء (2) Part (2)

- تقدر\ي تفكر\ي في وقت معين لم تسر فيه الأمور (للطفل) بشكل جيد؟ (على سبيل المثال: يخسر لعبة، أو لا ينجح في حاجة معينة، أو ماكانش مبسوط ومعجب بشكله)

o Can you think about a time where things did not go well for (the child)? (Examples: he loses in a game, did not succeed in something specific, did not like his appearance)

- عمل إيه الطفل لما كان عنده المشاعر دي؟ (قبلها على طول، وأثناء الموقف، وبعده)

o What did the child do when he had those feelings? (right before it, during the situation, and after it).

- تفتكري ليه (الطفل) اتصرف بالطريقة دي بالذات؟

o Why do you think (the child) behaved this way specifically?

- تفتكري هو\هي كان بيفكر في إيه وحاسس إيه ساعتها؟

o What was he thinking about? And how did he feel then?

- وحضرتك قلتي و\أو عملتي إيه في الوقت ده؟

o What did you say or do then?

- كان إيه نتيجة التصرف ده منك؟

o What was the result of your action?

- هل كان ده النهج أو الطريقة المعتادة بتاعتك لما (الطفل) بيمر بمشاعر مشابهة؟ ولا لقيتي طرق تانية لمساعدته ساعتها؟

o Was this your normal approach or way when (the child) faces similar feelings? Or was it another way to help him at this point?

- وسلوك (الطفل) في الوقت ده خلاكي تحسي بإيه؟

o How did you feel about (the child) behavior this time?

القسم (5) التعاون - مساعدة الطفل على الشعور بأنه فعّال ومتعاون

Section (5) Cooperation - Help the child feel effective and cooperative

المجموعة دي من الأسئلة الجاية عن مدى شعور الطفل بأنه فعّال وكفء. من الأمثلة على حاجة زي دي هي:

Following questions - the fourth set out of five - are on the extent to which the child feels effective. Examples could include:

- أنه قادر يكمل مهمة معينة، زي إكمال البازل أو ليجو أو رسم حاجة.

- He is able to complete a certain mission, like completing a puzzle, a lego drawing something.

- أنه قادر يلاقي حل للقيام بالمهام، زي ترتيب الأوضة مع اخواته أو ترتيب اللعب والدولاب.

- He is able to find a solution to do a task, like arranging the room with his siblings or arranging the toys or the wardrobe.

-أنه عنده القدرة على الاختيار، زي اختيار الأكل بتاعه أو اختيار يلبس إيه.

- He is able to choose, like choosing his food or what to wear.

الجزء (1) Part (1)

- إزاي بيتعامل (الطفل) عادةً عند تنفيذ مهمة أو حل مشكلة أو مواجهة اختيار؟

o How does (the child) generally behave when he carries out a task or solve a problem or face a choice?

- تقدر\ي تدي مثال محدد عن ده؟

  - Can you give specific examples about this?

- تفتكر\ي ليه (الطفل) اتصرف بالطريقة دي بالذات؟

  - Why did the child act this way specifically?

- تفتكر\ي هو\هي كان بيفكر في إيه وحاسس إيه ساعتها؟

  - What was he/she thinking about? How did he feel then?

- وحضرتك قلت\ي و\أو عملت\ي إيه في الوقت ده؟

  - What did you say or do then?

- كان إيه نتيجة التصرف ده منك؟

  - What was the result of your action?

- هل كان ده النهج أو الطريقة المعتادة بتاعتك لما بتكون\ي عايز\ة (الطفل) يتعاون معاك\ي؟ ولا لقيت\ي طرق تانية لمساعدته ساعتها؟

  - Was this your normal approach or way when you want (the child) to co-operate with you? Or was it another way to help him at this point?

- وسلوك (الطفل) في الوقت ده خلاكي تحسي بإيه؟

  - How did you feel about (the child) behavior this time?

- Part two (2) الجزء

مجموعة الأسئلة الجاية عن كيفية تمكن (الطفل) من التعاون والعمل مع البالغين.

Following questions are on how the (Child) is able to cooperate and work with adults.

- تقدر\ي تفكر\ي في وقت معين طلبت\ي فيه من (الطفل) التعاون والتنازل\العمل معاك\ي؟ (على سبيل المثال، للاستعداد للخروج، أو لإنهاء اللعبة ووضع الألعاب في مكانها، إلخ)

  - Can you think about a time when you asked (the child) to cooperate and work with you? For example: getting ready to go out, or to finish the game and put the toys back in place, etc…)

- عمل إيه (الطفل) لما طلبت\ي منه يعمل كده؟ (قبلها على طول، وأثناء الموقف، وبعدها)

  - What did the child do when you asked him to do this? (right before it, during the situation, and after it)?

- تفتكر\ي ليه (الطفل) اتصرف بالطريقة دي بالذات؟

  - Why do you think the child behaved this way in specific?

- تفتكر\ي هو\هي كان بيفكر في إيه وحاسس إيه ساعتها؟

  - What was he/she thinking about it then? How did he feel?

- وحضرتك قلت\ي و\أو عملت\ي إيه في الوقت ده؟

  - What did you say or do then?

- كان إيه نتيجة التصرف ده منك؟

  - What was the result of your action?

- هل كان ده النهج أو الطريقة المعتادة بتاعتك لما بتكون\ي عايزة (الطفل) يتعاون معاك\ي؟ ولا لقيت\ي طرق تانية لمساعدته ساعتها؟

  - was this your normal approach or way when you want (the child) to cooperate with you? Or was it another way to help him at this point?

- وسلوك (الطفل) في الوقت ده خلاكي تحسي بإيه؟

  - How did you feel about (the child) behaviour this time?

Section (6) Membership- – Helping the child القسم (6) عضوية الأسرة - مساعدة الطفل على الانتماء **to belong**

أخيرًا، في المجموعة الخامسة من الأسئلة الجاية هنركز على شعور (الطفل) بالانتماء للعائلة\للدار ولأخواته في الدار.

Finally, for the fifth section, we are going to focus on (the child) feelings of belonging to the family/the institution and to his siblings in the institution?

- تقدر\ي تفكر\ي في وقت معين كنت\ي فيه على دراية بشعور (الطفل) بكونه جزء منتمي إلى العائلة\الدار أو أخواته؟ (على سبيل المثال، حاجات قالها أو عملها أظهرت أنه يشعر بأنه جزء من العائلة\الدار أو عائلة الأخوات أو مش جزء منهم)

  - Can you think about a time when you were aware of (the child) feeling that he is part of the family/the institution or his siblings? (example: something he said or did that showed that he feels he is part, or not part, of the family/the institutions or the siblings' family).

- إيه اللي عمله أو قاله (الطفل)؟

  - What did (the child) say or do?

- تفتكر\ي ليه (الطفل) اتكلم أو اتصرف بالطريقة دي بالذات؟

  - Why do you think the child spoke or behaved this way?

- تفتكر\ي هو\هي كان بيفكر في إيه وحاسس إيه ساعتها؟

  - What was he/she thinking about? How did he feel?

- وحضرتك قلت\ي و\أو عملت\ي إيه في الوقت ده؟

  - What did you say and/or do then?

- كان إيه نتيجة التصرف ده منك؟

  - What was the result of your action?

- هل كان ده النهج أو الطريقة المعتادة بتاعتك لما حاجة زي كده بتحصل؟ ولا لقيت\ي طرق تانية لمساعدته ساعتها؟

  - was this your normal approach or way when something similar happens? Or was it another way to help him at this point?

- وسلوك (الطفل) أو اللي هو قاله في الوقت ده خلاك\ي تحس\ي بإيه؟

  - How did you feel about what (the child) said?

دلوقتي هل الطفل عنده أسرة تانية منتمي ليها – مثلًا عائلة بيولوجية معروفة أو كفلاء غير اخواته في الدار؟

Now does the child have another family that he belongs to? For example, a known biological family or a different sponsor than his siblings in the institution?

لو الإجابة نعم، if yes,

- تقدر\ي تفكر\ي في وقت معين كنت\ي فيه على دراية بشعور (الطفل) بكونه جزء منتمي إلى العائلة دي؟ (على سبيل المثال، حاجات قالها أو عملها أظهرت أنه يشعر بأنه جزء من العائلة دي أو مش جزء منهم)

  - Can you think about a time when you were aware of (the child) feeling that he belongs to this family? (for example, something he said or did that showed that he feels part, or not part, of this family?

- إيه اللي عمله أو قاله (الطفل)؟

  - What did (the child) say or do?

- تفتكر\ي ليه (الطفل) اتكلم أو اتصرف بالطريقة دي بالذات؟

- Why did he talk or react in this specific way?

- تفتكري هو\هي كان بيفكر في إيه وحاسس إيه ساعتها؟

- What was he thinking or feeling then?

- وحضرتك قلت\ي و\أو عملت\ي إيه في الوقت ده؟

- What did you say or do then?

- كان إيه نتيجة التصرف ده منك؟

- What was the result of your action?

- هل كان ده النهج أو الطريقة المعتادة بتاعتك لما حاجة زي كده بتحصل؟ ولا لقيت\ي طرق تانية لمساعدته ساعتها؟

- was this your normal approach or way when something similar happens? Or was it another way to help him at this point?

- وسلوك (الطفل) أو اللي هو قاله في الوقت ده خلاك\ي تحس\ي بإيه؟

- How did you feel about what (the child) said?

Section 7 – offering care and support القسم (7) تقديم الرعاية والدعم

- إيه هي جوانب رعاية الطفل ده اللي بتديك\ي أكبر شعور بالفخر أو الإنجاز؟

- What are the aspects of care for this child that give you sense of pride and accomplishment?

- إيه هي أكتر حاجة كانت أو ما زالت صعبة؟

- What was most difficult, or still?

- إيه هي أكتر مصادر المساعدة والدعم بالنسبة لك كمقدم\ة رعاية للطفل ده؟ (مثال، مدير الدار، جلسات دعم، عائلتك، برامج تدريبية، مكافئات وحوافز من إدارة الدار، نجاح الشباب والأطفال)

- What are the sources of help and support for you as a caregiver for this child? (Example: the institution manager, support sessions, your family, training program, bonuses and incentives from the institution's management, children and youth success)

- تقدر\ي تفكر\ي في نوعية مساعدة معينة تحبها\تحبيها في أي حاجة من الحاجات اللي ناقشناها؟

- Can you think of the kind of help that you would like in any of the things we discussed?

إحنا كده أنهينا الأسئلة الأساسية في المقابلة، آخر سؤال هو:

By this, we are done with the main interview questions. Last question is:

- ممكن تفكر\ي معايا بإيجاز لو كانت علاقة تقديم الرعاية مع (الطفل) مشابهة لتجربتك في رعاية الأطفال الآخرين؟ ولا في طفل/تجربة مختلفة تقدر\ي تذكرها\تذكريها؟

- Briefly, can you think with me about what happens if the care relationship with (this child) is similar to your experience in caring for other children? Is there a different child/experience that you can remember?

- إلى مقدمي الرعاية بالدور، هل أنت أم لأطفال بيولوجيين؟

- To the caregivers in the institution, are you a mother to biological children?

- هل تعرفي حد من أقاربك ومعارفك أقدر أتواصل معاه عشان نعمل المقابلة دي؟

- Do you have anyone in your family or acquaintances that I can conduct this interview with?