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Caregiver and community insights on coping strategies used by adolescents living in conflict-affected communities

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Abstract

The aim of this qualitative study was to provide a context specific understanding of adolescent (10–15 years of age) exposure and coping with trauma from the perspective of mothers/female caregivers and key informants in rural conflict-affected villages. Focus groups were conducted with mothers/female caregivers (4 groups with total participants n=26) and interviews were conducted with key informants (n=9) in four villages in the Walungu Territory, Eastern Democratic Republic of Congo. Focus group and interview guides were designed to elicit responses by participants on adolescent exposures to trauma and coping strategies. A grounded theory approach was used to identify emergent themes. Mothers/female caregivers and key informants reported use of both cognitive and behavioral coping strategies by adolescents. Cognitive coping strategies included avoidance and trying to forget. Behavioral strategies included self-imposed isolation, risk taking and social support seeking behaviors. Findings indicated community social support was a critical resource for adolescents, particularly for adolescents that did not have adequate support from their family. Supporting positive peer, family and community relationships can help prevent risk taking behaviors and teach positive coping strategies to break a cycle of violence reported in these communities. Recommendations for gender specific intervention programming are highlighted.

Keywords

Adolescent; Conflict; Trauma; Coping

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Author contributions

The study was designed by MC and NG. The data were analyzed and interpreted by MC and NG. Manuscript preparation was done by MC and NG. All authors contributed critically and significantly to drafting a final manuscript. All authors approved the final version.

Conflict of Interest Statement

The authors declare they have no other disclosures.

Background

Globally, an estimated 2 million children have lost their lives over the past decade to armed conflict, 6 million have been left severely injured or disabled, 12 million have been left destitute and 300,000 children have served as child soldiers (Attanayake et al., 2009). The stress and trauma of armed conflict can be particularly impactful to adolescent mental health. The period between childhood and adolescence is a developmental period characterized by, “complex and multiple changes across biological, psychological and interpersonal domains” (Oshri, Rogosch, & Cicchetti, 2013). This complex developmental period makes adolescents vulnerable to potentially traumatic events that can have immediate and long-term impact on social, affective and cognitive development. The psychological impact of armed conflict on adolescents can increase symptoms of post-traumatic stress disorder (PTSD), anxiety, depression (Thabet, Abed, & Vostanis, 2004), cause psychophysiological disturbances such as nightmares and trouble sleeping, fear, grief, behavioral problems (Bayer, Klasen, & Adam, 2007), and reduce educational attainment and performance, lack of hope and cause personality changes (Kuterovac-Jagodic, 2003).

However, recent research has also indicated that adolescents exposed to armed conflict do not necessarily develop psychopathology, and, in contrast, many adolescents demonstrate remarkable resilience. Research has increasingly focused on resilience, seeking to identify factors that allow some individuals to cope better than others when faced with adversity (Garnezy, 1971; Masten & Narayan, 2012; Rutter, 2007; Werner, 2012). Adolescents co-construct their social worlds through relationships with family, peers, and communities, and these relationships can be instrumental in promoting resilience (James, 2007; Martin & Dorothy, 2000; Panter-Brick, 2002; Prout, 2002). Parents/caretakers provide both material and emotional support to their children, and also model cognitive and behavioral strategies for coping with trauma and other forms of stress. Protective factors at the family level include provision of support, stability and parental monitoring (Barber, 1999; Derluyn & Broekaert, 2007; Durakovic-Belko, Kulenovic, & Dapic, 2003). Peer relationships and feeling supported by peers helps prevent isolation and can provide additional sources of emotional support. At the community level, attachment to community through school or churches, community acceptance, and access to social support have been associated with adolescent resilience (Betancourt et al., 2013; Betancourt, Brennan, Rubin-Smith, Fitzmaurice, & Gilman, 2010; Derluyn & Broekaert, 2007; Ehntholt & Yule, 2006).

Adolescent Coping Strategies

Lazarus and Folkman originated the term “coping” to describe responses to stress (Lazarus & Folkman, 1984). Lazarus and Folkman defined stress as a condition or feeling experienced when a person appraises an event as “exceeding his or her resources and as endangering well-being” (Lazarus & Folkman, 1984). More recent research has defined coping as, “the set of cognitive and behavioral strategies used by an individual to manage the demands of stressful situations” (Campbell-Sills, Cohan, & Stein, 2006). Coping is effective if stress is accurately appraised and specific behavioral and cognitive strategies are used to manage, reduce or tolerate stressful events (Folkman & Moskowitz, 2004). Coping strategies are important because employment of coping strategies can influence psychosocial,

emotional and behavioral functioning of adolescents (Skinner, Edge, Altman, & Sherwood, 2003).

The risk or benefit of coping strategies is context dependent and what is adaptive in one context may be maladaptive under different circumstances (Theron, Theron, & Malindi, 2013; Ungar, Ghazinour, & Richter, 2013). In humanitarian emergencies and conflict settings, problem focused coping may be less appropriate than emotion focused coping because emotion focused coping may be the only practical strategy available when fixing the problem or stressor is not a achievable in that context (Pincus & Friedman, 2004). The majority of qualitative research on coping strategies among conflict-affected adolescents have included older adolescents, however, the findings from this older age group offer insight into how cultural context can motivate use and acceptance of particular coping strategies among adolescents. Qualitative case-study research with Cambodian refugees ages 14–20, found that avoidant coping strategies were common among traumatized Cambodian refugees and use of these strategies may have been motivated by a cultural climate that sought to avoid thoughts, behaviors and activities that reminded them of “dishonorable events in Cambodian history” and collective shame felt by Cambodians (Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984). Qualitative narrative research with 14 Sudanese refugees ages 16–18, found that suppression and distraction were common coping strategies and use of these strategies may be motivated by a sense of communal self and as protection against “feelings that they feel powerless to handle” (Goodman, 2004). Research with Zimbabwean adolescents ages 17–19, found greater use of emotion focused strategies rather than problem solving strategies because cultural norms discouraged problem solving strategies that could involve confrontation or challenging of elders (Magaya, Asner-Self, & Schreiber, 2005). In addition, gender norms within a culture can shape use of coping strategies. A mixed method study among Palestinian refugee adolescents ages 8–17 living in Gaza found that gender norms influenced coping strategy use so that girls were less likely to use leisure or relaxation coping strategies, including going shopping or exercising, that would require them to be far from home, whereas boys were more likely to use these coping strategies (Hundt, Chatty, Thabet, & Abuateya, 2004).

The Democratic Republic of Congo (DRC), the setting of this study, has endured decades of destruction to health and social infrastructure (Mukwege, Mohamed-Ahmed, & Fitchett, 2010). A history of colonialism, theft of the DRC’s mineral wealth and strategic ‘pitting’ of ethnic groups against one another has resulted in prolonged conflict and persisting insecurity. The effects of conflict have been particularly profound in rural areas of the South Kivu Province in Eastern DRC. High levels of poverty, limited livelihood and employment opportunities, population displacement resulting from conflict and destruction of health and education institutions has weakened local capacity to respond to adolescent mental health needs. Previous research in eastern DRC found that among 477 girls and 569 boys ages 13–21, approximately 95% had experienced at least one traumatic event; and, on average adolescent were exposed to 4.7 traumatic events over their lifetime, with 52% meeting the criteria for PTSD (Mels, Derluyn, Broekaert, & Rosseel, 2009). Within this context, adolescents, families and communities are rebuilding their households and communities to improve the life and livelihoods of future generations.

Despite recognition that coping must be understood from a contextually grounded perspective, limited evidence is available to specify how adolescents cope within conflict and post-conflict settings and which strategies are most beneficial to adolescent mental health. Qualitative techniques such as focus groups and individual interviews define and provide greater depth of knowledge as to the cognitive and behavioral coping strategies utilized by conflict-affected adolescents. Previous research in this context utilized a grounded theory perspective to analyze Congolese adolescents in-depth interviews to gain the perspective of adolescents on trauma and coping (Cherewick et al., 2015). The current study sought to extend this theoretical approach to adolescent's parents/caregivers and key informants within the same contextual setting to elicit understanding of how adults in the community perceived adolescent exposure to trauma and coping strategies utilized in response to trauma.

Research Aim

The purpose of the study is to report mothers/female caregivers and key informant's perceptions of 10–15 year old adolescent exposures to traumatic events, utilization of coping strategies in response to traumatic events, and insight on opportunities for supporting beneficial and mitigating harmful coping strategies to promote resilience among adolescents in a rural, low-resource, post-conflict setting.

Methods

Study Setting

This study took place in rural villages in the Walungu territory in South Kivu, Eastern DRC. The Walungu territory is 50km south of Bukavu, the capital of South Kivu and has been afflicted by conflict since 1999. The study was conducted in partnership with Programme d'Appui aux Initiatives Economiques (PAIDEK), a non-profit, non-governmental Congolese microfinance organization and was nested within two microfinance projects, Rabbits for Resilience (RFR) and Pigs for Peace (PFP). RFR and PFP are pragmatic community trials to test the effectiveness of an adolescent-led rabbit animal husbandry microfinance program combined with an adult pig animal husbandry microfinance program, with the aim of improving health, economic stability and relationships between families and communities through loans and repayment of pigs and rabbits (Glass, Perrin, Kohli, & Remy, 2014). Male or female adolescents ages 10–15 years were eligible for participation with RFR. Participants who were ages 16 years and older were eligible for participation in PFP. The current analysis includes qualitative data collected in July 2014 with mothers/female caregivers and key informants within four villages participating in the RFR/PFP programs.

Sample

A purposive sampling strategy was used to identify parents/caregivers of adolescents and key informants enrolled in the parent study. Parents/caregivers and key informants were selected from four of the 10 study villages, Karherwa, Cagombe, Izege and Cize. These villages were selected because of the reported high exposure to conflict-related trauma. Within these villages, baseline data from the parent study was used for purposive sampling of adolescents based on age, gender and exposure to traumatic events. Traumatic exposures

were represented by a wide range of experiences including murder of family/friends, having ill health without care, lacking food and water, being seriously injured, being close to death, separation from family, experiences in combat and brainwashing. Adolescents were selected to represent a range of exposure to trauma: low exposure to trauma (0–1 events), medium exposure (2–3 events) and high exposure (4 or more events). Within each trauma exposure level, sampling involved achieving a balanced distribution of participants by age (10–12 and 13–15) and gender. Parents/caregivers of each of the 48 adolescents identified (12 in each village) were invited to participate in focus groups. Four focus groups (one group in each village) were conducted with mothers/female caregivers, as no fathers or male caregivers were successfully recruited. Individual in-depth interviews were planned with adults having roles and responsibilities (e.g. teacher, traditional or religious leader) in the villages that resulted in relationships with adolescents and that would be able to provide insight into trauma exposure and coping strategies. Ten key informants from the four villages were identified and invited to participate in in-depth interviews.

Study Procedures

Congolese team members actively participated in the design, development, piloting and revision of the key informant interview and focus group guides. The team reviewed and revised interview questions to ensure cultural relevance. The interview guides were translated into local languages, Swahili and Mashi, to be used for interviews and focus groups. The final guides consisted of broad open-ended questions related to the following topics, 1) identification of types of trauma-related experiences, 2) methods for coping utilized by adolescents, 3) perception of gender differences in coping, 4) sources of psychosocial support, and, 5) risks or benefits of coping strategies. Probes were developed with Congolese team members to capture greater depth in participant responses during the focus groups and individual interviews. The focus group guide was constructed of three sections. The first section was a free list exercise, a method which asks participants to list answers in response to a single primary question (Bernard, 2011). Participants in each focus group were asked the primary question, “What are all of the ways that youth think or behave in response to traumatic/stressful life events?” The second section asked participants to consider how the aforementioned cognitive and behavioral strategies improved or harmed different aspects of mental health and well being among adolescents. The third section of the focus group guide was constructed of open-ended questions aimed at probing on gender differences in coping behaviors. After final revisions to the interview and focus group guides, the Congolese research team participated in a two day team training in administration of consent (in alignment with IRB regulations), human subjects research ethics, qualitative interview skills and focus group methodology. The training provided discussion on how to support participants that became distressed or upset during an interview or group discussion.

Data Collection

Mothers/caregivers of eligible adolescents and key informants were provided with information pertaining to the purpose of the study, risks and benefits of participation in the study and were asked to provide verbal informed consent. Unique identification numbers were assigned to all participants, all interviews were conducted in private and no information

was shared outside the research team. After mothers/caregivers and key informants provided informed consent the interviewer selected a location for the interview or focus group that would allow for privacy and disclosure during the interview or focus group. Trained male and female Congolese interviewers fluent in French, Swahili and Mashi conducted focus groups and interviews. Initial questions allowed the interviewer/facilitator to develop a level of rapport with community members so that participants would feel comfortable answering the questions. The key informant interview lasted 30–60 minutes in length. Each focus group was conducted by a facilitator and a note-taker and lasted 45–60 minutes. Participants were provided with compensation for their time equal to 2USD, an amount considered appropriate after consultation with village leaders and research team members.

Ethics Statement

The Johns Hopkins School of Medicine Institutional Review Board (IRB) approved this study on June 23, 2014. A committee of respected Congolese educators at the Université Catholique at Bukavu reviewed and approved this study, as there is no formal institutional review board in South Kivu. The research team received approval to conduct the research with local partners PAIDEK and by village traditional and administrative leaders.

Analysis

To achieve the study purpose, a grounded theory approach, rooted in a participatory transformative paradigm was utilized (Charmaz, 2006; Mertens, 2009). The grounded theory methodological approach is based on the constructivist epistemology, that meaning is co-created in the discourse between people and grounded in a particular cultural context. After completion of interviews and focus groups, a Congolese translator completed translation of all transcripts from French or the local language (Swahili or Mashi) to English. The translations were crosschecked by researchers based in the US and in consultation with the Congolese research team. The free list data provided an overview of ways adolescents coped with stress and trauma from the mother/caregiver's perspective. The free list data were consolidated into a summary list and ranked in decreasing order of how many respondents reported a coping strategy. After completion of translation and review of focus group questions (sections 2 and 3), and key informant in-depth interviews, the analysis commenced with the grounded theory approach (Charmaz, 2006; Mertens, 2009). The steps taken to complete the grounded theory methodological approach included: *initial codes* developed through line-by-line coding of all key informant interviews and focus group transcripts to identify implicit meanings; *initial codes* to identify common responses and similarities and differences in responses; *focused codes that were* developed by using the most significant and/or frequent initial codes; *axial coding* to represent the content of focused codes and to relate common codes, categories and concepts to each other; and, applying a *final coding structure* to each transcript using Atlas.ti 6 software (Scientific Software Development GmbH, Berlin) (Charmaz, 2006). During the application of focused and axial coding, memos were written by the researchers to help identify emergent themes, and iterative inductive content analysis was used to identify connections between themes (Charmaz, 2006; Creswell & Zhang, 2009). Throughout the analysis and interpretation phases, team members ensured the quality of findings through, 1) grounding findings in the data and

engaging in debriefing and peer review during the analysis process, 2) documenting the process and ensuring transparency, 3) confirming fairness and balance in selecting representative quotes and exemplars to illustrate themes.

Results

A total of 26 mothers/female caregivers participated in one of four focus groups (one focus group per village). The majority of female caregivers were 25 years or older, married, had received no schooling and had an average of four children in the home (Glass et al., 2014). The number of people in each focus group ranged from five to eight; 5 from Karherwa, 7 from Cagombe, 8 from Izege, and 6 from Cize. Mothers/caregivers represent both male and female adolescents, ages 10–15, with a range of trauma exposure. Demographics of the adolescents represented by mother/caregivers are presented in Table 1. Fourteen caregivers represented adolescents who reported high trauma exposure (4 or more events in lifetime), 8 caregivers represented adolescents who had experienced medium trauma exposure (2–3 events in lifetime) and 4 caregivers represented adolescents who had low trauma exposure (0–1 event in lifetime). Nine key informants were interviewed including six teachers and three traditional village chiefs. Key informant interviews included four females (age range 26–40) and five males (ages 23–35).

As noted above, the focus group started with a free list exercise in which participants were asked, “What are all of the ways that youth think or behave in response to traumatic/stressful life events?” Results from the free list analysis are presented in Table 2. Twelve common coping strategies were mentioned and similar concepts were grouped together. For example, “the child isolates themselves” was grouped with “the child stays alone”. The free list responses served as a reference throughout the focus group to probe further how the aforementioned coping strategies were related to positive or negative mental health and well-being outcomes and gender differences in use and effectiveness of these coping strategies. Therefore, the iterative inductive content analysis sought to connect free list responses to descriptions of trauma experiences that respondents believed motivated use of particular coping strategies and nuanced descriptions of how these coping strategies were perceived as positive or negative. In identification of the emergent themes, the analysis also sought to illuminate any gender differences in coping strategy use or effectiveness. Analysis resulted in three salient themes, 1) Adolescent exposures to trauma promote maladaptive risk taking and contribute to a cycle of violence 2) Gender differences in behavioral and cognitive avoidance, and, 3) Positive effects of social support seeking in response to exposure to trauma. The themes were organized from least helpful/harmful coping strategies (increased risk-taking), mixed perceptions of the benefit or harm of cognitive and behavioral avoidance, and, finally the most helpful coping strategies (seeking peer, family and community social support).

Emergent theme: Exposure to trauma, adolescent risk-taking and the cycle of violence

Mothers/caregivers and key informants reported past and present trauma and violence experienced by adolescents within the home and in the community. The legacy of the conflict in the DRC has perpetuated insecurity. Militia groups have continued to destabilize

the Kivu regions and interviews revealed a wide range of adolescent exposures to conflict related violence. Participants explained that some traumatic experiences resulting from the conflict had been “inherited” by adolescents. For example, rape of women was a common practice of militia during the multiple periods of conflict in the region. Some of these rapes resulted in pregnancy, and survivors gave birth to their attacker’s children. A teacher recalled,

“For instance, during the war, some women were abducted into the forest by Interahamwe [armed group] elements. They were raped, and some of them got pregnant and eventually delivered. When these women were freed and came home, they brought their children along with them. A lucky woman could be welcome by her husband, but not the rape-born child.”

Some of these children are rejected from their families and forced to find alternative means of survival. A teacher described mental health effects of children born from militia rape.

“The child or adolescent must be affected and afraid, and think that those events will come back. That’s why, when you send the child to fetch water in the evening, he can refuse out of fear. Some Interahamwe’s violence-born children fight with their friends when these tell them that they are Interahamwe’s sons. And they ask their mothers who a Interahamwe is. I have three such children in my religion class. When I asked them what it was like to be born from unknown fathers, they started to weep and said they would kill their fathers if they could see them. After that, they didn’t participate in any class activity. These children finished the year without paying anything, because it is difficult to dismiss children in such a situation. Sometimes a child leaves the classroom very angry and determined to join the military for vengeance when he comes of age.”

A mother/caregiver echoed how trauma resulted in risk taking,

“He can react to such a traumatic event by taking alcohol and using drugs, becoming a thief, an armed robber, selling his property in order to get money for hemp, etc. In the end, he can go mad. By becoming an armed robber or a street kid, he can start killing people in the same way as his father was killed.”

Participants provided examples of how trauma can lead to a cycle of violence that not only impacts adolescents, but also destabilizes communities. A key informant explained,

“These events cause children or adults to be broody. Because of their immaturity, children can end up committing suicide or becoming mineral-diggers. Traumatizing a child is killing him with no gun or poison. It unsettles the child and leads to the stagnation of society.”

Both mothers/caregivers and community members shared concerns that direct experiences of trauma by adolescents and traumatic experiences of family and community members “inherited” by adolescents can lead to adolescent risk-taking and perpetuate violence and instability.

Furthermore, cultural belief systems could be potentially harmful to adolescent mental health. Belief that sorcerers exist in communities and community discourse speculating who

may be a sorcerer or victim of sorcery could destabilize relationships. Participants reported that a continuing threat of violence was from “poisoning” or other forms of harm from sorcerers. Sorcerers were described as being any age and are believed to have the power to “poison” others or cause ill health. Participants explained that community members often accused others of being sorcerers, and that these accusations had the potential to escalate community violence. A key informant described this impact, “They have little meetings, and fight. For instance, yesterday, an angry adolescent attacked a woman, accusing her of sorcery. They started to beat her up.” Another key informant echoed this statement and explained that adolescents themselves can use “sorcery” to survive.

“As they’ve already gone bad, some will stick to alcoholism, magic and sorcery as income-generating activities. If they don’t steal, they can’t survive. They don’t accept advice and help (salvation) from a wise person in the village. They don’t want to see anybody, and just keep doing what pleases them. Abandoning them will result in their total decline.”

Labeling an adolescent as a sorcerer has potential risks such as causing stigma and isolation by families and communities. Furthermore, the existence of belief systems around sorcery could perpetuate community instability and be an obstacle to the benefit of building community trust and support networks that help to stabilize families and communities.

Emergent Theme: Gender differences and the consequences of cognitive avoidance and behavioral isolation

A common response from participants was that adolescents cope by avoiding the memory of their trauma. There were a variety of ways in which respondents described this coping strategy ranging from cognitive avoidance such as “forgetting” the trauma to behavioral avoidance such as “isolating” from others. The perception of whether this coping strategy was beneficial or not varied. For example, many participants described adolescents “forgetting” the trauma as a positive adaptation and the ultimate goal of recovery from trauma. Many different activities were described as helping children to “forget it all” such as play, work and prayer. Some respondents described difference by gender in the ability to “forget it all”. For example, a teacher reported, “Girls are affected differently from boys. Boys forget faster than girls. When something bad happens in the life of a girl, she’ll keep alluding to it every time. A boy, however, forgets with time.”

Another distancing technique described was adolescent’s behavioral avoidance by isolation, either self-imposed or isolation resulting from rejection of peers or family. A key informant explained the different ways isolation could occur for a traumatized adolescent.

“When such a adolescent is made ill at ease by his peer, he can sometimes decide to follow his father in the mountains, because when his mates want to tease him, they show him the mountains from which his Interahamwe father came. The child can also commit suicide, or grievously wound, in anger, his mates, and that’s a serious problem. He can drop out of school, refuse to eat and put the whole family in trouble. He can disappear from the house and become a street kid. Such an adolescent isolates himself from his friends. He can become naughty, smoke hemp, take alcohol, turn into a thief, sleep outside, etc.”

While cognitive avoidance of the memory of trauma was perceived as a positive adaptation to trauma, behavioral avoidance and isolation from peer, family and community relationships were perceived as particularly harmful to adolescent mental health.

Being rejected from family may have gender specific consequences for adolescents. For girls, early marriage and sex work were identified as resulting from the need to fulfill basic needs and a lack of other viable livelihood and income generating opportunities. A teacher explained, “In Kaniola, for example, 8, 9 and 10-year-old girls go to mining zones for prostitution with diggers, when they are abandoned by the family. They behave like mature women.” Another caregiver warned of girls engaging in prostitution after having experienced traumatic events, “Girls start seducing boys and become proud. They dress up immorally and don’t listen to their parents. They wear trousers, imitate western ladies’ behavior, become prostitutes, and hang out with married men.” Participants reported that girls might engage in prostitution or early marriage as a coping strategy to gain resources, however other motivations for entering early marriage were suggested. For example, participants explained that marriage might provide emotional support. For example, one teacher explained, “When they’re sad, some girls become prostitutes for survival, and get pregnant. When they suffer, girls feel the need to get married quickly in order to end their suffering.”

Emergent Theme: Positive social support can benefit adolescents

A key coping strategy thematic in focus groups and interviews was the benefit of seeking social support. Support seeking was described at multiple levels in an adolescent’s social ecology. Peer relationships were described as particularly important to adolescent boys. For example a mother/caregiver explained, “Bad friends and neighbors can also have a negative influence on the behavior of a child. If it’s a good friendship, the child will be stable and behave in a responsible manner.” However, other participants cautioned that these relationships could motivate potentially harmful behavior. A mother/caregiver explained that peers can be, “bad company, my boy was not smoking before he started to hang out with smoking friends.” Many interviewees echoed the perception that boys were particularly vulnerable to participating in deviant behavior with peers.

Family was also described as a critical source of support for adolescents, particularly the role of the family in providing basic needs (food and school fees). Family was also perceived as an important source of counsel or advice. A caregiver explained the importance of how caregivers should support adolescents, “The child can change if his family helps him, encouraging him to get back on the right path”. Respondents also explained that family relationships have the potential to model positive social interactions and would benefit adolescents. For example, a caregiver explained,

“What can make a child stable is, first and foremost, happiness in his/her own family. Mutual respect between parents can also help children. They must learn respect from their own parents. Parents must satisfy children’s daily needs so that they can be stable.”

However, respondents also described that lack of family support was a threat to adolescent mental health that could be mitigated through greater community ties. Adolescents without

family or who have been rejected from family face additional stressors such as lack of shelter, resources to meet basic needs, and a lack of security. When family support systems are unavailable, participants suggested adolescents rely more heavily on community support systems to supply the resources typically provided by families. Furthermore, participants explained that community members could help support parents/caregivers, helping to guide parenting decisions and investments in adolescents. A teacher explained,

“If the family has given him advice, but he doesn’t listen, they can turn to the neighbors and his friends for help. In our community, once we’ve identified such a child, we first visit his family and ask them questions about the child.”

By providing support to caregivers, community members work with families as a unified team to guide adolescents towards positive coping strategies. A community leader recounted the importance of families working with the community to support adolescents,

“The community must get closer to the adolescent, because it can save the life of a slandered child on the brink of suicide. For instance, the adolescent who was rescued by his mother started to sing in the choir afterwards. The community must take care of the adolescent and provide them with vocational training. If an adolescent rejects the community, a friend must be sent to sensitize him. Once he gets back under control, he must receive advice from the community, little by little.”

Community support systems are integrated into adolescent lives in a variety of forms. In DRC, churches and schools are the most prominent community resources accessible to adolescents and work synergistically with family to provide support adolescents.

Discussion

This study sought to understand how mothers/caregivers and key informants perceived the effects of exposure to trauma on adolescents and coping strategies used in response to trauma. Findings highlight that adolescent exposure to trauma impacts not only the individual but also harms family and communities and can lead to a cycle of violence. In the free list interviews, mothers/caregivers listed mostly maladaptive strategies in response to trauma. These maladaptive strategies often involved risk-taking behavior such as drinking, stealing, and seeking revenge. Importantly, participants described cognitive avoidance or distancing oneself from memories of trauma as beneficial, however behavioral avoidance such as self-isolation or family/community rejection was perceived as particularly harmful. This distinction is important because it parallels findings from other collectivistic contexts that show that cognitive avoidance is often preferred by adolescents in these contexts, and, at the same time, behavioral isolation or lack of engagement in social relationships is harmful to adolescents (Kohli & Connolly, 2009; Magaya et al., 2005; Mels, Derluyn, Broekaert, & Garcia-Perez, 2013). Reasons provided for why cognitive avoidance and distancing may be preferred include that adolescents are respecting social norms that encourage accommodation and acceptance in collectivistic societies (Magaya et al., 2005), that this may be the only strategy available to adolescents (Mels et al., 2013), and suggestions that avoidance may be an adaptive strategy for conflict-affected adolescents in the short-term (Boxer, Sloan-Power, Mercado, & Schappell, 2012). Importantly, in this study, rather than

perceiving “seeking social support” as a coping strategy, caregivers and key informants described social support in the family and community as a solution to remedy maladaptive coping strategies. Respondents explained that while support within the family was important to adolescent mental health, community support systems could also be a resource for youth outside of the family, and could simultaneously support families to better parent their children.

Implications for Intervention Programming to Support Positive Coping Strategies

Findings from this study support intervention planning that utilizes a social ecological approach. Bronfenbrenner first described social ecological theory in the 1970s to explain human behavior from multiple levels including the individual level (i.e. child characteristics), microenvironment (i.e. relationships between peers and caregivers) and mesoenvironment (i.e. child and family relationships with community organizations, schools and faith based institutions) (Bronfenbrenner, 1979). Utilizing a social ecological approach, intervention programming should be developed to include peers, parents/caregivers and community members such as teachers, traditional and religious leaders. This approach is useful because it takes into account the complex array of interrelationships, bi-directional feedback loops and opportunities to target multiple influences adolescent developmental trajectories. For example, social support and feeling connected to neighbors and schools has been found to result in better mental health outcomes in children (Kliewer, Lepore, Oskin, & Johnson, 1998). Developmental science on adolescence indicates that during adolescence there is a strong increase in young people’s desire to understand their social world and adolescents are increasingly sensitive to social acceptance (Crone & Dahl, 2012). Peer relationships provide opportunities to express feelings, shared experiences, and provide opportunities engage in healthy activities such as civic engagement (Sherrod, Flanagan, & Youniss, 2002) that can contribute to social cohesion and benefit health and well-being (Ballard & Syme, 2016; Sherrod et al., 2002). Reaching out to youth who isolate themselves or are rejected from others is of particular importance because in this study, isolated youth were described as more likely to engage in risk taking activities such as stealing or prostitution. By engaging adolescents in community activities such as sports, church groups, choir, and play, adolescents may be less likely to be stigmatized or isolated and feel closer to peers, family and community members (Ballard & Syme, 2016).

Investment in community support systems can also help to protect against stigmatization of youth as sorcerers or witches, a belief that was often attributed to “troubled” youth in this study and could result in further rejection from the family and community and motivate risk-taking behaviors. Collaboration with local leaders to develop intervention approaches that minimize isolation of youth and emphasize the importance of adolescents as an asset to communities and their future could be effective in breaking a cycle of violence experienced in communities.

Future research and programming should also consider how gender could inform intervention programming. Prior research in humanitarian settings has indicated separation from families, limited economic opportunities and weakened community protection mechanisms can result in adolescent girls being at risk for early marriage, sexual exploitation and sexual violence

(Falb et al., 2016). Teaching girls skills that empower their ability to seek support outside of early marriage is critical not only to protect girls from coercion, but also because girls who delay marriage are more likely to complete more years of school and have better economic opportunities in the future (Jensen & Thornton, 2003). For example, providing more opportunities for girls to gain social support through peer and community relationships could help create meaningful roles in the community that lead to economic autonomy and empower girl's agency and deter girls from entering early marriage or engaging in prostitution (Chandra-Mouli, Camacho, & Michaud, 2013; Walker, 2012). Educating families on alternatives to early marriage for girls are an important component to intervention programming. For example, research from Jordan found that some families viewed child marriage as a form of "protection", a way for families to keep the 'honour' of their daughters, as well as a means to reduce the number of people in the household and associated economic burden (Spencer et al., 2015). Girl's sexuality is also often perceived as their sole commodity to be exchanged to gain resources through transactional sex (Hunter, 2002; Luke, 2003). Providing alternative paths to gain assets for girls could protect against early marriage and transactional sex. Community support of girl's engagement in livelihood activities can provide an alternative solution to meeting basic needs and shift cultural norms to help prevent early marriage or prostitution (Petersen, Bhana, & McKay, 2005). Furthermore, provision of opportunities to engage in positive activities outside of the home could have other benefits to mental health and well-being of girls. Having greater mobility and programs outside the home can also be leveraged as potential areas to disseminate health information and access to protection services (Falb et al., 2016).

In this study, boys were perceived as being particularly vulnerable to negative peer pressure in this context. Research shows that a history of peer rejection can make adolescents more vulnerable to peer influence and result in self organization into peer groups that support problem behavior and lead to more serious consequences such as increases in violence (Dishion, Ha, & Véronneau, 2012). Furthermore, research indicates that as youth engage in more deviant peer groups, a reciprocal disengagement from parental influence can occur as youth avoid supervision (Stoolmiller, 1994). In this study, mothers/caregivers described how boys were resistant to parental advice. Involving parents in intervention activities could help to facilitate stronger relationships and respect for parent's supervision during adolescence. Participants in this study also suggested that community members could help to guide parents and support positive interactions with boys and girls. Providing activities where boys have the opportunity for peer reinforcement within a structured environment could help deter youth from seeking other types of rewarding peer interactions that can include deviant talk, behavior and attitudes (Dishion et al., 2012). In this context, participation in sports, youth groups and faith-based groups would be culturally appropriate activities for boys and provide positive environments for boys to interact with peer groups.

Previous prevention studies have found that provision of safe spaces for adolescents to participate in activities promoted overall well-being and resilience in both boys and girls (UNICEF, 2011). These safe spaces can be designed to target gender specific vulnerabilities. For example, there are promising advances in intervention programming addressing risks to adolescent girls. The Creating Opportunities through Mentorship, Parental involvement and Safe Spaces (COMPASS) program is an intervention currently being evaluated in DRC and

seeks to offer gender specific interventions for girls through the implementation of structured activities that focused on topics such as self-confidence, building friendships, gender based violence and creating healthy relationships to improve girl's confidence in negotiating sex and understanding their self worth (Falb et al., 2016). Future research should continue to implement gender specific interventions aimed at promoting girl's agency, access to activities that support empowerment, and mobility outside the home and reduce vulnerability to coercion, sexual exploitation and early marriage.

Limitations.

Results from this study may not be generalizable to other post-conflict settings as the utility of coping strategies were defined within the cultural context of the Walungu Territory in rural Eastern DRC. However, we provided 'thick description' in order to support transferability in which readers can consider if other contexts are sufficiently similar to assess if findings may be applicable to another context (Glass, Ramazani, Tosha, Mpanano, & Cinyabuguma, 2012; Lincoln & Guba, 1990). For example, in more urban technologically advanced contexts, adolescents may engage more with social media to interact with peers and the potential for interventions that include social media could be important. Coping strategies may also differ in societies that are more individualistic and less collectivistic. In DRC, community relationships are an important part of an adolescents' social ecology and are a critical resource to be leveraged in intervention designs (Lincoln & Guba, 1990). This research is limited to reports from mothers/caregivers and key informants on young adolescents ages 10–15. Future research should investigate perspectives from caregivers and community members on developmental changes in coping strategy use throughout adolescence and compare and contrast those perceptions with reports from adolescents. Results from studies that examine coping strategies used in response to traumatic stress along adolescent developmental trajectories can be used to tailor programs to be developmentally appropriate and enhance the effectiveness of programs seeking to support positive coping in adolescence.

Conclusion

This qualitative research provides a culturally specific understanding of adolescent coping strategies from the perspective of mothers/caregivers and key informants within rural communities that have experienced prolonged conflict. Findings suggest that interventions which support positive coping strategies such as provision of safe spaces for adolescents to engage with peers may promote adolescent mental health resilience in response to trauma. Furthermore, structured and mentored activities facilitated by trusted and respected adults in the community can provide new ways for adolescents to receive support and prevent risky behaviors that can result in further trauma and violence in rural communities in the Eastern DRC. Of importance is the opportunity to include gender specific intervention programming that seeks to reduce risk-taking behaviors that are more common among girls (early marriage and prostitution) and boys (alcohol use and violence). Interventions should also aim to promote positive aspects of mental health and well being for both boys and girls including promotion of self-esteem, hope for the future, empowerment and empathy. Engagement of positive support structures between adolescents and peers, family and

community members in intervention planning can take advantage of the complex, bidirectional and mutually reinforcing relationships within an adolescent's social ecology to ultimately improve the mental health and well-being of adolescents and promote a positive future for communities in post-conflict settings.

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List of abbreviations

DRC	Democratic Republic of Congo
RFR	Rabbits for Resilience
PFP	Pigs for Peace
PAIDEK	Programme d'Appui aux Initiatives Economiques

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Table 1.

Sample Demographics of Adolescents Represented by Caregivers

	Girls		Boys		Total
	Ages 10–12	Ages 13–15	Ages 10–12	Ages 13–15	
Trauma Exposure	N	N	N	N	N
Low (0–1 events)	0	2	2	0	4
Medium (2–3 events)	1	2	2	3	8
High (4+ events)	3	6	2	3	14
Total	4	10	6	6	26

Table 2.

Free list responses from mothers/caregivers in focus groups (N=26).

What are coping strategies of children who are exposed to traumatic/stressful life events?	
The child does not talk/remains silent	
The child cries/cries for no reason	
The child refuses to work	
The child steals from others	
The child isolates themselves from others/stays alone	
The child is very wicked/naughty/becomes rebellious	
The child is fearful	
The child drinks alcohol/smoke	
The child doesn't play with others	
The child becomes a street kid/starts begging	
The child gets involved with sorcery/witchcraft	
The child seeks to get married	

Note. Coping Strategies are listed in decreasing order of frequency mentioned