

## COPING STRATEGIES OF CHILDREN AND ADOLESCENTS EXPOSED TO WAR CONFLICT

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**Abstract** :The aim of this study was to investigate whether the association between trauma exposure and posttraumatic stress symptoms in Palestinian children and adolescents living in a region of war conflict, was mediated or moderated by certain coping strategies. Participants consisted of 424 children and adolescents aged between 8-16 years, who were randomly selected from 32 schools in Gaza and the West Bank. Measures included the Traumatic Event Checklist, the Impact of Event Scale, and the Adolescent Coping Orientation for Problems Experiences. Children experienced an average of 13.7 traumatic events. The most common traumatic events were, witnessing demolition of a friend's home (92.4%) and hearing killing of a close relative (84.4%). The frequency of IES scores above the established cut-off score (likely PTSD) was 21.2%. There was significant association between exposure to traumatic events and PTSD symptoms. Exposure to trauma was moderated by seeking social and spiritual support in predicting PTSD symptoms. These findings that traumatized children use coping strategies to overcome the stress and trauma could be of help to clinicians designing school or community programmes in enhancing children's problem-resolving strategies in areas of political conflict.

### Introduction

Different models and frameworks have been proposed and investigated on coping strategies adopted by young people in response to stressful events such as trauma. By using various coping strategies, individuals try to modify adverse aspects of their environment as well as to minimize internal threat induced by stress (Lazarus, 1993), in a dynamic and reciprocal relationship between emotions and coping (Folkman & Lazarus, 1988). Coping strategies have been broadly defined as problem-focused (acting on the environment or the individual) or emotion-focused (attempting to change the meaning of the event or how this is attended to (Shapiro & Levendosky, 1999). They are often also classified as either primary (the judgement of an encounter as stressful) or secondary appraisal (evaluation of the potential effectiveness and consequences of using coping strategies)

(Folkman, Lazarus, Dunkel-Schetter, De Longis & Gruen, 1986). Most research in young life arises from adolescents and young adults who suffered chronic illness, abuse-related trauma, or who have experienced other types of stressful events (Spirito, Stark, Gil & Tyc, 1995; Valentiner, Foa, Riggs & Gershuny, 1996). In recent years, there has also been increasing attention on the impact of war trauma and political conflict on young people and their families, and the underlying mechanisms involved.

Several studies have found that avoidant coping strategies are associated with maladaptive responses to traumatic experiences (Solomon, Mikulincer & Flum, 1988; Bal, Van Oost, De Bourdeaudhuij & Crombez, 2003b). This association is consistent with proposals that trauma resolution requires the network of trauma-related schemata to be activated and

modified. The process assumes that cognitive strategies that result in avoidance will inhibit this network activation and will contribute to the development of psychopathology such as posttraumatic stress disorders (PTSD). Avoidant coping has been found to predict child and adolescent symptomatology across time, which in turn increase withdrawal, thus creating a vicious circle (Seiffge-Krenke, 2000). There is evidence that such mechanisms operate across cultures (Kausar & Munir, 2004). In a previous study with Palestinian adolescents (Thabet, Tischler & Vostanis, 2004), we found that reliance on emotion-focused or avoidance coping strategies was associated with exposure to parental maltreatment and predicted emotional problems in young life. However, there is also some evidence to support the theory that avoidant / emotion-focused strategies can be effective in some situations that cannot be changed, therefore problem-focused strategies may be more effective. In such a study of Israeli children and adolescents during scud missile bombardment, Weisenberg, Schwarzwald, Waysman, Solomon & Klingmann (1993) established the frequent use of information-seeking, checking and wishful thinking.

Gender differences have been demonstrated in using different strategies to cope with daily stressors and in war situations, in that girls are more likely to use social and family support, while boys more commonly use confrontation and aggression, and try to solve problems by themselves (Hundt, Chatty, Thabet & Abuateya, 2004; Kausar & Munir, 2004). Difficulties in interpreting previous research findings include the dynamic nature of coping (i.e. this is not necessarily a stable characteristic), its moderation or mediation by other factors, and the nature and severity of the stressful event or trauma. For, example, Bal, Crombez, Van Oost and Debourdeaudhuij (2003a) found that high support from the family was associated with less adolescent avoidance coping and more support-seeking in response to some stressful events, although this model was not replicated in adolescents who had been sexually abused. Relationship with the main carer (attachment style) is another important factor that can mediate the relationship between trauma and coping strategies (Shapiro & Levendosky, 1999).

Previous studies with children and adolescents exposed to political violence and armed conflict have predominantly focused on the impact of trauma on their mental health (Vostanis, 2004). It is well established that exposure to political violence is positively correlated with mental health presentations (usually posttraumatic stress disorders and depression), often in a 'dose-effect' relationship (Thabet & Vostanis, 1999; Smith, Perrin, Yule, Hacam & Stuvland, 2002; Thabet, Abed & Vostanis, 2002; Qouta, Punamaki & El Sarraj, 2003; Shaw, 2003). The underlying mechanisms have been more difficult to explore, because of the number of potentially confounding variables such as loss of loved ones, disruption of social networks, lack of basic health needs, or displacement.

Some studies have taken into consideration some of these factors, as well as adolescents' coping strategies, in exploring this complex relationship. Following the war in former Yugoslavia, Durakovic-Belko, Kulenovic and Dapic (2003) investigated the risk factors for posttraumatic and depressive disorders in children and young people, and found different patterns for the two types of psychopathology. Variance in posttraumatic stress symptoms was mainly explained by traumatic war experiences (20%) and individual and socioeconomic factors (17%), and less (9%) by cognitive

appraisals and coping mechanisms. In contrast, depression was predicted by individual and socioeconomic factors (36%) and less by war experiences (8%), whilst cognitive appraisal and coping mechanisms did not contribute significantly. Family adaptation to the Lebanese war was predicted by family resources and social support, and was associated with increased use of cognitive coping strategies (Farhood, 1999). Also, perceived stress was a stronger predictor than the actual events experienced by families.

Descriptive or qualitative studies have established themes of coping strategies among refugees and displaced young people following war situations. Kline and Mone (2003) identified three coping strategies employed by young refugees in Sierra Leone, i.e. maintaining an intact sense of purpose, effective control of traumatic memories, and successful protection against destructive social isolation. Halcon et al. (2004) established coping strategies such as sleeping, reading, praying and talking to friends among Somali and Ethiopian refugee youths living in the US. Adolescents' search for meaning to the conflict and sensitivity to the political environment has been found to be related to insecurity about the prospect of future war in Bosnia Herzegovina, thus adversely affecting their adjustment (Jones, 2002). Similar findings were established by Punamaki, Qouta and El Sarraj (1997), in that Palestinian boys were more likely to engage in political activity in order to cope with trauma. It is important to note that not all coping responses are specific to the conflict, as these can be interlinked with universal adolescent developmental issues. For example, some concerns expressed by high school students in Jerusalem were specific to the conflict in the region, i.e. coping with aggression, war, and enlistment into the army, while other concerns were universal (self-image, peer relationships, and school) (Palti et al., 1995).

Overall, little is known as yet on the coping strategies that could mediate or moderate the impact of war trauma on adolescent emotional well-being and psychopathology. This was the rationale for this study. Its aim was to investigate whether the relationship between war trauma and posttraumatic stress reactions in a sample of Palestinian children and adolescents was mediated by certain coping strategies, notably avoidant / emotion-focused, as indicated by previous literature.

## Method

### Participants

Children and young people were selected, using a multistage procedure; these were randomly selected first by representative areas, then by school and classes. As a result, 208 children from 20 schools in the Gaza Strip, and 216 children from 12 schools in the West Bank were selected. Permission to contact the schools was granted by the Education Department. A parent (the mother in all cases) signed a consent form that was read to them, outlining the purpose of the study. The data was collected during a period of political conflict in the region (Al Aqsa Intifada).

The sample from the Gaza Strip was derived from north Gaza (26.4%), the middle area (31.3%), Khan Younis (32.2%), and Rafah (10.1%). Children living in the West Bank came from Bethlehem (35.2%), East Jerusalem (41.2%), and Hebron (23.6%). Of the 424 children, 216 (51%) were female, and 208 (49%) male, ranging in age from 8-16 years (mean age 12 years). The family size included 88 families (20.8%) with 4 or less children, 206 (48.6%) with 5-7 children, and 130 (30.6%)

with 8 or more children. The family income was defined as low (monthly average less than \$300) by 321 families (75.7%), medium (\$300-\$600) by 65 families (15.3%), and high (\$600 or above) by 38 families (9.0%).

### Measures

#### *Traumatic Event Checklist (Thabet & Vostanis, 1999)*

This checklist consists of 20 items covering different types of traumatic events that a child may have been exposed to in the particular circumstances of the regional conflict, which differ from those of traditional war conflicts (tear gas, beating, witnessing beating, night raids, humiliation, witnessing bombardment of homes by helicopters, heavy artillery and tanks, and witnessing mutilated bodies on television). This checklist can be completed by children of 6-16 years ('yes' or 'no'). In this study, the internal consistency of the scale, calculated using Chronbach's alpha, was  $\alpha=0.96$ . The split half reliability of the scale was 0.94.

#### *Impact of Event Scale (IES – Dyregrov, Kuterovac & Barath, 1996)*

The IES is a standardized instrument widely used to measure PTSD in children. This 15-item scale was developed to measure the two most characteristic aspects of post-traumatic psychopathology, namely the strength of unpleasant, intrusive thoughts, and the energy spent in trying to block them out of consciousness. The Intrusion sub-scale of the IES draws upon the signs and symptoms of intrusive (invading, disturbing) cognitions and affect. The Avoidance sub-scale includes avoidance behaviour, denial or the blocking of thoughts and images. Items are rated as 'never' (0), 'rarely' (1), 'sometimes' (3), or 'often' (5). The total and sub-scales scores were estimated, as well as a categorical variable based on Yule and Udwin's (1991) cut-off of 40 or above for the likely presence of PTSD. The IES has been used with Palestinian children (Thabet, Abed & Vostanis, 2001). In this study, the split half reliability of the scale was high ( $r = 0.76$ ). The internal consistency of the scale, calculated using Chronbach's alpha, was  $\alpha=0.76$ .

#### *The Adolescent Coping Orientation for Problems Experiences (A-COPE - Patterson & McCubbin, 1987)*

The A-COPE is a self-report instrument that describes and measures coping strategies during adolescence. It consists of 54 items measuring specific coping behaviours which adolescents may use to manage and adapt to stressful situations. Each item is rated on a 5-point scale (1 = never; to 5 = most of the time) to indicate how often they use each coping strategy when feeling tense or facing a problem. Patterson and McCubbin (1987) identified the following 12 sub-scales by using factor analysis: engaging in demanding activity, self-reliance and optimism, developing social support, seeking diversions, solving family problems, seeking spiritual support, investing in close friendships, use of humour, seeking professional support, relaxing, ventilating feelings, relaxing, and avoiding problems. This scale was translated to Arabic language and was previously used in a pilot study. The 12 sub-scales scores were included in the analysis. In this study, the split half reliability technique of the scale was high ( $r=0.87$ ). Its internal consistency, calculated using Chronbach's alpha, was also high ( $\alpha=0.92$ ).

### Statistical analysis

Descriptive statistics and frequencies were used to present the pattern of data for the whole sample. Subgroups (e.g. according to gender) were compared on IES or A-COPE continuous scores by Mann-Whitney non-parametric test, as the questionnaire scores were not normally distributed. The association between age and questionnaire scores was analysed by Spearman non-parametric rank correlation test. The relationship between total trauma scores as the independent variable and PTSD symptoms (total or sub-scales IES scores) as the dependent variable was investigated by univariate regression analyses. The analyses were then repeated using a multivariate model, with the 12 coping strategies as covariates in the second block of the regression model.

### Results

#### *Exposure to traumatic events*

Children had been exposed to a wide range of traumatic experiences during the period of conflict. Of the twenty possible exposures, the children experienced an average of 13.7 (SD =3.04, range 0-20). The most common traumatic events were (Table 1), witnessing of a friend's home demolition (N=391; 92.2%) and hearing of the killing of a close relative (N=358; 84.4%), while the least common (nevertheless substantive) events were, witnessing bombardment of their house by helicopters (N=134; 31.6%) and watching mutilated bodies on TV (N=35; 8.3%). Both direct and indirect experiences of beating, shooting and killing of close relatives or friends were commonly reported. Boys had been significantly more exposed to traumatic events (Mann-Whitney test,  $z=-6.03$ ,  $p<0.001$ ).

**Table 1: Children's exposure to types of traumatic experiences (N=424)**

Trauma event	No	%
Witnessing demolition of friend's home	391	92.2
Hearing of killing of a close relative	358	84.4
Witnessing beating of a close relative	356	84.0
Witnessing beating of a friend	352	83.0
Witnessing tanks and heavy artillery firing at own home	345	81.4
Witnessing shooting of a close relative	344	81.1
Night raids of own home	340	80.2
Witnessing killing of a close relative	339	80.0
Witnessing arrest of a friend	335	79.0
Beating and humiliation by the army	319	75.2
Hearing killing of a friend	300	70.8
Witnessing shooting of a friend	298	70.3
Day raids of home	297	70.0
Witnessing demolition of own home	297	70.0
Hearing killing of a friend	291	68.6
Witnessing arrest of close relative	283	66.7
Witnessing tanks and heavy artillery firing at other homes	225	53.1
Stopping at checkpoints for long hours	183	43.2
Witnessing bombardment of own home by helicopters	134	31.6
Watching mutilated bodies on TV	35	8.3

### Exposure to trauma and PTSD symptoms

The most common PTSD symptoms (IES items) that were rated as 'often occurring', were: upset by reminders of trauma (25.7%), tried to remove memories of trauma from my mind (23.6%), avoidance of reminders (22.9%). Ninety children (valid frequency 21.2% because of 24 missing data) scored above the cut-off score of 40 or above (Yule & Udwin, 1991), which indicates the likelihood of PTSD. Neither the total IES scores nor the IES sub-scales scores were significantly correlated with the child's age (Spearman correlation test  $r=0.02$ ,  $p=0.74$ ). IES scores did not distinguish between boys and girls (Mann-Whitney U test  $z=-0.94$ ,  $p=0.34$ ).

Children scoring within the likely clinical PTSD range had experienced significantly more traumatic events (Mann-Whitney U test:  $z=2.5$ ,  $p=0.009$ ). In a univariate linear regression, with total IES scores or each of its sub-scales scores entered as the dependent variable, and the total trauma events score as the independent variable, the level of exposure to trauma predicted all three types of PTSD symptoms:

Prediction of total IES scores:  $B=-0.72$  (95% CI=-1.03 to -0.42),  $R^2=0.052$ ,  $p<0.001$ .

Prediction of IES Intrusion sub-scales scores:  $B=-0.27$  (95% CI=-0.44 to -0.11),  $R^2=0.025$ ,  $p=0.001$ .

Prediction of IES Avoidance sub-scales scores:  $B=-0.42$  (95% CI=-0.60 to -0.24),  $R^2=0.050$ ,  $p<0.001$ .

### Coping strategies

Girls used the following coping strategies significantly more than boys (Mann-Whitney non-parametric test): ventilating feelings ( $z=-3.32$ ,  $p=0.001$ ); seeking diversion ( $z=-2.21$ ,  $p=0.027$ ); solving family problems ( $z=-2.29$ ,  $p=0.022$ ); seeking spiritual support ( $z=-2.91$ ,  $p=0.004$ ); investing in close friends ( $z=-3.77$ ,  $p<0.001$ ); seeking professional support ( $z=-2.07$ ,  $p=0.038$ ); being humorous ( $z=-2.63$ ,  $p=0.009$ ); and relaxing ( $z=-2.25$ ,  $p=0.025$ ). There was no significant association between children's age and any of the coping strategies scores (Spearman rank correlation).

### Exposure to trauma, coping strategies and PTSD symptoms

In order to investigate the relationships between exposure to traumatic experiences and coping strategies as predictors, and PTSD symptoms as outcome, a series of hierarchical multiple regression analyses were used. In Step 1, the total traumatic events scores were introduced in the equation. In Step 2, a block of the 12 A-COPE sub-scales scores was added. Total IES scores constituted the dependent variable. The emerging models are presented in Table 2. Total IES scores (PTSD symptoms) were significantly predicted by the level of trauma exposure, as well as by lack of use of social and spiritual support coping strategies.

**Table 2: Hierarchical multiple regression of predictors (exposure to trauma and coping strategies) of PTSD symptoms (total IES scores)**

Model	Variables in the model (predictors)	B	p level	R square	R square change
1	Traumatic events	-0.75	<0.001	0.06	0.06
2	Traumatic events Developing social support	-0.39 1.11	0.010 <0.001	0.24	0.18
3	Traumatic events Developing social support Seeking spiritual support	-0.36 1.24 0.59	0.015 <0.001 0.013	0.26	0.02

The same analytic process was repeated with either the IES Intrusion or Avoidance sub-scale score as the dependent variable. Intrusion PTSD symptoms were predicted by trauma exposure and coping by ventilating feelings, and by low use of social support coping strategies (Table 3). Avoidance PTSD symptoms were predicted by exposure to trauma, engagement in demanding activities as a coping strategy, and low use of social and spiritual support.

**Table 3: Predictors of Intrusion symptoms (IES scores) (final model only)**

Variables in the model (predictors)	B	p level	R square for model
Traumatic events	-0.30	0.001	0.18
Developing social support	0.77	<0.001	
Ventilating feelings	-0.37	0.001	

**Table 4: Predictors of Avoidance symptoms (IES scores) (final model only)**

Variables in the model (predictors)	B	p level	R square for model
Traumatic events	-0.14	0.096	0.28
Developing social support	0.53	<0.001	
Seeking spiritual support	0.40	0.003	
Developing self-reliance	0.20	0.008	
Engaging in demanding activities	-0.30	0.027	

### Discussion

Following previous consistent research findings on the impact of trauma on children's mental health, recently there has been interest in the mechanisms underlying this association, and the identification of factors that make children vulnerable or resilient to external adversities and stressors arising from abuse,



domestic or community violence. This study examined the relationship between exposure to war trauma, coping strategies and posttraumatic stress symptoms in a group of children and adolescents living in the Gaza Strip and the West Bank during a period of conflict in the region. Consistently with previous research, children and adolescents in this study reported a substantial number of traumatic events, which were associated with highly prevalent posttraumatic stress reactions (prevalence of likely PTSD reactions of 21.2%).

Children who experience political and military conflict are more likely to express their distress through emotional (predominantly depressive and posttraumatic stress) and behavioural presentations (Garbarino & Kostelny, 1996; Thabet & Vostanis, 1999; Dyregrov, Gjestad & Raundalen, 2002; Khamis, 2004). These may follow different pathways and be mediated by different risk factors in their development and outcome (Sack, Him & Dickason, 1999). Such reactions are likely to persist or recur (Durakovic-Belko et al., 2003). Identified predictors of outcome include both child-related and environmental factors. Children's attributions, subjective appraisal of the experience, future expectations, perceived threat, impact of trauma on parents, family and social supports have all been associated with their emotional responses (Hoffman & Bizman, 1996; Punamaki, 1996; Udwin, Boyle, Yule, Bolton & O'Ryan, 2000).

Two types of coping strategies were found to moderate the impact of trauma exposure, i.e. developing social supports and seeking spiritual support. Self-reliance was also inversely associated with PTSD avoidance symptoms. In contrast, the use of emotion-focused strategies (ventilating feelings) was associated with higher PTSD intrusion symptoms, and engaging in demanding activities with PTSD avoidance symptoms. These findings provide support on the mediating and moderating role of coping strategies, as conceptualised by previous theoretical models (e.g. Lazarus, 1993). For example, Farhood (1993) found that social support and family adaptation were associated with increased use of cognitive strategies by Lebanese children during the war. Interestingly, social support was also the most prevalent coping mechanism in among Israeli children, despite their sociocultural differences and different perceptions on the causes of the conflict in the region (Bleich, Gelkopf & Solomon, 2003), which thus indicate some common mechanisms across cultures. This coping strategy is possibly particularly prominent in closely knit societies.

Coping strategies are, of course, complex human responses that may be used differently by the same individual or in response to different events, or change with time, are thus difficult to measure (Lazarus, 1993). They have also been shown to operate differently across cultures (Slone, Adiri & Arian, 1998) and types of adverse events and stressors (Spirito, Stark, Gil & Tyc, 1995; Seiffge-Krenke, 2000). For example, avoidant coping has been found to be used by children and adolescents who had been sexually abused and developed maladaptive emotional symptoms, but not by young people exposed to other events (Bal et al., 2003a & 2003b). Even in cases of sexual abuse, avoidant strategies were mediated by attachment relationships difficulties (Shapiro & Levendosky, 1999). We have established a similar pattern among Palestinian children and adolescents, which provides further support for cross-cultural similarities in coping styles. In a previous study (Thabet et al., 2003), we found reliance on emotion-focused (or avoidant) strategies to be associated with physical maltreatment of young people, which was not replicated in this study in relation to war trauma.

In contrast, seeking spiritual support may be relevant to certain cultures, as this has not been established as a frequent coping strategy in previous western studies. It was, however, used by refugee Somali and Ethiopian children and young people (Halcon et al., 2004). This study has also supported previous findings that girls use more emotion-focused and social problem solving strategies than boys, although social and family resources may be more available to them (Spirito et al., 1995). It did not, however, find age differences within the study cohort, with some previous studies reporting that older adolescents used a greater variety of strategies, which were cognitive-focused (Willimas & McGillicuddy-De Lisi, 2000). This could be related to the choice of coping instrument in this study, as we may not have measured sufficiently young people's attributions, reappraisal of situations and planned problem solving.

This study has several limitations. A cross-sectional design would not have established changes in coping strategies (Lazarus, 1993). There may also be constraints in the validity of the instrument in measuring coping as a process, despite the extensive use of the A-COPE. Also, its application in different cultures. Other potential mediating or moderating variables, such as parental responses to trauma and young people's attributions (Smith, Perrin, Yule & Rabe-Hesketh, 2001), may have interacted with coping strategies identified in this study. These gaps in the literature could be addressed by future research, including longitudinal studies that measure coping strategies as a developmental process.

Although beyond the remit of this study, the findings have indirect implications for interventions and services working with traumatized children, young people and their families in areas of war conflict. Young people's coping strategies can thus be enhanced both through existing community services (such as non governmental organisations) addressing a broad range of children's needs (health, social and educational) (e.g. Kombarakaran, 2004) and with direct interventions for the small number of children with more severe needs who will require the limited amount of specialist resources (Jones, Brustemi, Shahini & Uka, 2003). Such interventions include behavioural therapy techniques such as exposure strategies, and cognitive techniques on reformulating pre-existing appraisals (Smith, Dyregrov & Yule, 2002; Bal et al., 2003). These could involve parents and teachers, wherever possible.

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