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Coping Strategies of the Adolescents Living in Childcare Homes

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Abstract: *About half of the mental health problems emerge during the adolescent period. The children in childcare homes are more vulnerable to threats posed by external factors having issues such as of homelessness, parental abuse, violence and death of the parents. Hence it is expected that these conditions can affect their emotional wellbeing. At the same time children and adolescents are highly resilient as well. Many of the mental health problems can be effectively prevented through the proper facilitation of healthy coping skills. This study aimed to assess and identify the coping strategies adopted by the adolescents living in childcare homes of Kathmandu Valley and to ascertain if there is any significant difference between boys and girls in coping strategies. The study followed the quantitative and cross-sectional design using 102 adolescents from six childcare homes of Kathmandu and Lalitpur districts. Brief Cope was used to measure the coping strategies of the participants. The adolescents were found to be using both problems focused coping strategies and emotion focused coping strategies more or less at the same time. Females were found to be using more problem focused coping significantly than male ($p<0.05$), while there was no gender difference in emotion focused coping ($p>0.05$).*

Keywords: Problem focused coping; emotion focused coping; adolescence; childcare homes; Nepal

Introduction

Many mental health problems such as depression, conduct disorder, anxiety, substance abuse and such others emerge in late childhood and early adolescence due to the transition that they have to go (World Health Organization (WHO), 2014) . At the same time children are also highly resilient and find ways to cope and move forward in the face of hardship and suffering (United Nation High Commissioner for Refugees, 2012). WHO (2017) recommends enhancing social skills, problem-solving skills and self-confidence can help prevent mental health problems. Therefore, adolescents overall mental wellbeing can be enhanced through the facilitation of effective coping strategies in them.

There are different models of coping. The famous model of coping is a transactional model of stress by Folkman and Lazarus (1980) which views coping as the person's cognitive and behavioural efforts to manage (reduce, minimize, master or tolerate) the internal and external demands of the person –environment transaction that is appraised as stressful. This model takes into the account of person-environment interaction while responding to the stress. Therefore it accounts for the influence of the mix of both environmental and personal factors in shaping of coping (Compas, 1987). This is moreover important in the case of adolescent's coping mechanism as a child is much dependent to the environment and surrounding while growing up. Several past literatures provided the evidence of the utility and usefulness of transactional model of coping (Roncaglia, 2014; Hampel & Petermann, 2006; Mullis & Chapman, 2000).

The advantage of using transactional model of stress is that coping serves two important functions: problem focused coping and emotion focused coping. Problem focused coping is concerned with the reduction of the demands of environmental constraint and expanding one's resources to tackle with it. Some instances of problem focused coping include quitting a stressful job, negotiating an extension for paying some bills, devising a new schedule for studying, choosing a different career to pursue, seeking medical or psychological treatment and learning new skills (Sarafino, 2006). Emotion focused coping is concerned with regulating or controlling the emotional response to the stressful situations or events. People can regulate their emotional responses through behavioural and cognitive approaches. Consuming alcohol or taking drugs, seeking emotional and social support, engaging in activities or sports deviating one's attention away from the problem etc constitute behavioural approach whereas cognitive approach involves denial of the situation, changing the meaning of the events, thinking wishfully or fantasy dreaming etc. Problem focused coping and emotion focused coping are not entirely dichotomous concepts.

People use both forms of coping in almost every type of situations (Folkman, Ric Lazarus and Gruen, 1986). According to Lazarus (1999) people have tendency to err by contrasting two forms of coping as distinctive form of coping and even determining which is useful. He goes on to say that both forms of coping are essential parts of the total coping effort, and each complement and facilitates the other. He warns that coping functions and strategies should never be thought in black and white terms but take it as the shades of gray which is complex of interconnected thoughts and actions aimed at improving the troubled relationship with the environment.

Nepal defines adolescents as adolescents within the age range of 12- 19 years of age. (CBS, 2014). For the present study, age range of 12- 19 years is taken as a criterion to determine adolescent. The children who are in transitional phase of development have two levels of adjustment problems. In one level they have to face the storm and stress brought out by the developmental phase (Hashmi, 2013; Erikson, 1964 ;United Nation Development Program, 2014). The rapid psychological and physical changes may lead them to confusion about their roles and identity (Erikson, 1964). This developmental stage demands lot of psychosocial adjustment from adolescents and can be stressful at times. In another level they have to cope

with their risks brought up by external factors such as social, cultural, political and environmental factors (United Nation Development Program, 2014). These external factors can result into poverty, discrimination, social exclusion and dangerous living environments. Adolescents living in protection homes are vulnerable from these two levels of problems as evidenced by the fact that the children and adolescents who have been living in child care homes have been found to be vulnerable of low emotional wellbeing and high chance of developing psychiatric disorder than the children and adolescents living with their own families (Buchaman & Brinke, 1997; McCann, James, Wilson, & Dunn, 1996; Bhatt, Apidechkul, Srichan, & Bhatt, 2020).

Moreover, they are more vulnerable from the threats exposed by external factors having issues such as of homelessness, parental abuse, violence, death of the parents etc and hence it is expected that these conditions can affect their emotional wellbeing. At the same time, it is also known that adolescents are resilient to deal with the adverse life events. (United Nation High Commissioner for Refugees, 2012). Adaptive coping strategies (problem focused coping and some of the emotion focused coping strategies such as acceptance, humour, religion and positive reframing) can contribute to Adolescents' resiliency (Wu et.al., 2020; Chen, Yang, & Chiang, 2018) . Assessment of coping of the adolescents living in child care homes can inform us the variability of coping strategies employed by them which can be used to enhance and facilitate one's resiliency and wellbeing

In this context, this study aims to assess and identify the coping strategies adopted by the adolescents living in childcare homes of Kathmandu Valley and see if there is any significant difference between boys and girls in coping strategies

Literature Review

It is to be noted that although coping is usually distinguished as problem focused coping and emotion focused coping, they coexist and are not opposite to each other (Carver and Scheier, 1994). Problem focused coping is usually associated with adaptive coping strategies – the coping which is supposed to reduce the stress whereas emotion focused coping can involve maladaptive coping strategies such as denial, avoidance, self blame and substance use (Agbaria and Mokh, 2021). The Past research found that young people generally used more adaptive coping strategies than less adaptive coping strategies (Carver, Scheier and Weintraub, 1989; Skinner and Zimmer – Gembeck, 2007; Rohail, 2015; Bashirgonbadi, Shahriari and Hosseinian ,2016). Although it was found that adaptive coping strategies had been favoured generally over a long period of time, young people used flexible and wide variety of coping strategies. Support seeking, problem solving, distraction, discussing the problem with parents or adults and thinking about the problem were the most frequently used coping strategies by the adolescents and youth (Rohail, 2015; Bashirgonbadi, Shahriari and Hosseinian ,2016). The available literatures in Nepal have suggested that Nepali adolescents and youth used various coping strategies – notably more positive and healthy coping strategies such as positive reframing, planning and acceptance, listening to music, seeking

emotional support, solving problem, understanding problem and playing games (Bhattarai, Maskey and Lopchan, 2016; Mahat, 1996; Raj, 2015; Sreeramareddy et al., 2007).

The exhaustive literature search indicates there is a lack of literature on coping of the children living in childcare home in Nepal. However the researches done in other countries found out that adolescents who were orphaned and living in the institution were found to have significantly more inefficient coping strategies which included wishful thoughts, self-blame, lack of confrontation and concern, reduced activity and ignoring the problem than adolescents in normal population (Bashirgonbadi, Shahriari & Hosseinian, 2016; Power, 2004). It was pointed out that the low social support system and networking of the orphaned adolescents living in the child care homes to be the main reasons for the adoption of more inefficient coping strategies.

Carver et al.(1989) reported significant gender difference in various coping strategies. They found out that females tended to use more emotion focused coping which included focusing on and venting out emotion, seeking social support both for instrumental (problem focused coping) and emotional reasons. In males, they found out using alcohol and drug significantly more than in females. This conclusion is supported by the finding of Matud (2004) although the subjects under study were adults. Similarly, Hampel and Petermann (2006) in their study of German adolescents' perceived stress, coping and adjustments , they also found out significant gender differences in coping strategies. They found out significant gender difference in emotion focused coping: distraction, in problem focused coping- social support and in maladaptive coping strategies – passive avoidance, rumination and resignation. These coping strategies were employed significantly more by girls than boys. All these findings confirm to gender stereotype.

The gender difference in coping strategies can be understood by two theories: socialization hypothesis (Ptacek, Smith and Zanas, 1992) and role-constraint hypothesis (Rosario, Shinn, Mørch and Huckabee, 1988). Both theories state that due to difference in socialization (learning and internalizing societal values and) and the roles associated for each gender contribute to differences in coping. For e.g., women are socialized to express their emotions and their role as a mother, sister, daughter is emotionally driven because of which in the face of any stressor they exhibit emotion focused coping. However some literatures found the alternative evidences.

Piko (2001) reported that although adolescent girls significantly use more passive coping and emotion oriented ways of coping more often, they also use problem focused coping as well which goes contrary to the gender role stereotypes. Rohail (2015) in fact reported surprising finding on gender difference among Pakistani adolescents. It was found out that girls used more active coping in which significant difference was found compared to boys. For a more religiously conservative society, this is totally contradictory to the established notion that girls use more emotion focused coping. Mullis and Chapman (2000) found no gender differences in coping. Borrowing the perspective of both socialization hypothesis and role-constraint hypothesis, similar gender outcomes in coping style can be attributed to rise of

feminism, equal women right and changing gender role which is becoming less distinct day by day in the recent days.

Method

Research Design

The research follows the quantitative research method and adopts cross sectional study design .The data for the emotional wellbeing and coping strategies were collected at a single point in time taking gender as a key variance of the sample. A cross-sectional design helps in understanding promotes understanding of the prevalence and nature of a problem at a given time and allows for comparing differences between groups.

Universe of the study

According to the report published by Central Child Welfare Board (CCWB) in 2016, there are 16,886 children living in 572 protection homes in the country (Central Child Welfare Board, 2016). In Kathmandu valley (Kathmandu. Lalitpur and Bhaktapur districts together), there are 10,102 children living in the 351 protection homes (Central Child Welfare Board, 2016). Among this population, more than hundred adolescents from six childcare homes of Kathmandu valley are taken for the study. The sample population includes fifty male and fifty two female adolescents.

Sample Design

Table 1 Sample design of the participants of the research

Organization	**Male**	**Female**	**Total**
Nepal Children's Organization (Bal Mandir)	6	6	12
Hope Rising Children Home	5	0	5
Nepal Youth Foundation (Olgapuri)	11	17	28
Tiom Laura Home	19	21	40
Father's Home	4	0	4
Nepal Deprived Women and Children Upliftment Center	5	8	13
TOTAL	50	52	102

Sampling

The purposive sampling technique was used for the study. Sampling was done in co-ordination with CCWB to select the childcare homes for sampling. Four homes in

Kathmandu district and two in Lalitpur were selected. The data from total of hundred and thirteen samples of adolescents aged 12 to 19 years were collected but only the data from hundred and two samples were selected for the analysis. The size of sample was almost proportionately distributed across gender (n = 50 male , $n_=$ 52 female).

Inclusion Criteria

The inclusion criteria for sample selection for the purpose of the study were:

- The children aged 12 to 19 years of age staying in the registered childcare homes within Kathmandu Valley.
- The children fulfilling the definition guidelines of the children who need special care and protection as per Standards of Operations and Management of Residential Childcare Homes, 2012.

Exclusion Criteria

The exclusion criterion was:

- Invalid data – incomplete questionnaire and the questionnaire with mistakes such as choosing two options where the participants have to choose

Conceptual Framework

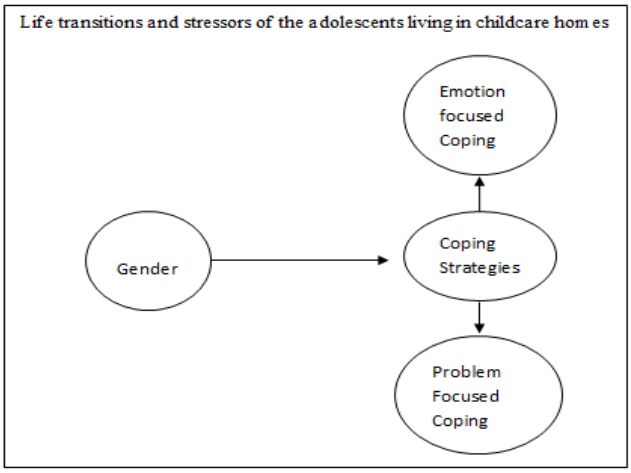

Figure 1 *Conceptual framework of the research*

Figure 1 represents the general conceptual framework of the relationship between gender and two different coping strategies – Emotion focused coping and problem focused coping. Here, gender is an independent variable which affects the scores in dependent variable coping which is divided into emotion focused coping and problem focused coping. The interaction

between the variables is studied in the broader context of the stress brought by the transition and other environmental factors of the adolescents living in the childcare homes of Kathmandu valley.

Data Collection Tools

Brief- Cope

The Brief COPE is the abbreviated version of the COPE Inventory and assesses dispositional as well as situational coping efforts (Charles and Carver, 1997). It is based upon the model developed by Folkman and Lazarus (1980) and the behavioural self-regulation model developed by Carver and Scheier (1981).The 28-item Brief COPE (consisting of 14 subscales) has acceptable psychometric properties. The Brief- COPE consists of fourteen two-item scales, namely, acceptance, active coping, positive reframing, planning, use of instrumental support, use of emotional support, behavioral disengagement, self-distraction, self-blame, humor, denial, religion, venting and substance use. The fourteen subscales of coping are further distilled into two broad functions of coping: Problem Focused Coping and Emotion Focused Coping Strategies. Active coping, planning, instrumental support make up problem focused coping and the rest is clubbed into emotion focused coping (Carver et al., 1989; Folkman et al., 1986 ; Sarafino, 2006) . Each of the item has four options that measure frequency of the items: 1) I haven't been doing this at all 2) I've been doing this a little bit 3) I've been doing this a medium amount 4) I've been doing this a lot. Scoring is done by assigning the points 1 to 4 to each of the options.

The option which indicates the highest frequency (I've been doing this a lot) is given the highest point (4 point) and other options are scored simlilarly. Brief Cope has been already validated and used in Nepal by the researchers such as Sreeramareddy et al., (2007) and Chase, Welton-Mitchell, & Bhattarai (2013) and is widely used tool in adolescents (McLoughlin, 2019; Muniandy, Richdale, Arnold, Trollor & Lawson, 2021).

Data Collection Method

In co-ordination with CCWB, six childcare homes in Kathmandu and Lalitpur district were approached. The homes were informed about the research and as the children were in their protection and below 18 years of age, consent from the respective authority of the home were sought prior to the data collection. Before administering the items, the verbal informed assent was sought from the participants. After that the self report measures were sought from the children in a group setting after proper instructions of the questionnaires. Each of the statement was interpreted and explained to the children by the researcher. To maintain consistency in the data, the researcher gave the same explanations, examples to all the participants. Strict confidentiality was maintained as each of the data was coded afterwards and no personal information has been divulged.

Ethical consideration

This research has been conducted in close co-ordination with Central Department of Psychology, Tribhuwan University and Central Child Welfare Board. A written consent was sought from each of the protection homes and every participant had the right to refuse to participate, walk out in the middle of the scales administration. Along with this verbal informed assent was sought from the participants. The children had the option not to mention their names to maintain their anonymity and confidentiality. Special care was taken in selecting the scales as it would have been emotionally damaging for the participants if the items in the scales reminded directly of their family and loss. Therefore the adolescents were not psychologically or emotionally harmed. The researcher followed the in-house rules while collecting the data such as not taking photographs of the children and not giving them gifts.

Result and Interpretation

The data was analyzed through Statistical Package for Social Sciences (SPSS), version 21. Microsoft excel was also used to computing and storing the data. Descriptive analyses were done through the function of means, standard deviations, Standard Errors etc. Inferential statistics were done through the function of independent samples *t* test and Pearson's *r*.

Socio-demographic characteristics of the participants

Table 2 Socio-demographic information of the informants

Orgnization	**Address**	**Male**	**Female**	**Total**
Nepal Children's Organization (Bal Mandir)	Siphal, Kathmandu	6	6	12
Hope Rising Children Home	Tikathaili, Lalitpur	5	0	5
Nepal Youth Foundation (Olgapuri)	Tikabhairab, Lalitpur	11	17	28
Tiom Laura Home	Tinchuli, Aarubari	19	21	40
Father's Home	Budhanilkantha, Kathmandu	4	0	4
Nepal Deprived Women and Children Upliftment Center	Bhangal, Kathmandu	5	8	13
TOTAL		50	52	102

Table 2 represents the socio-demographic profile of the participants of the study. As per the table 4.1 the sample population were taken from the six childcare homes : four from Kathmandu district and two from Lalitpur district. Majority of the sample population were from Kathmandu district. Fifty male and fifty two female sample population were included in the study.

Table 3 Gender - Age Cross tabulation

		Age							Total
		12	13	14	15	16	17	18	
Sex	Boys	8	9	12	13	6	2	0	50
	Girls	12	11	8	8	5	6	2	52
Total		20	20	20	21	11	8	2	102

The table 3 has shown the age-sex composition of the final selected participants in which 31 female and 29 male belonged to age group 12 to 14 years old and 21 male and 21 female belonged to age group 15 to 18 years old. The children's educational level varied from grade four to grade eleven in which some were from government schools and the other were from private schools.

Table 4 Mean age of male and female participants

Sex	N	Mean	Std. Deviation
Male	50	14.12	1.394
Female	52	14.15	1.862
Total	102	14.14	1.641

Table 4. shows the mean age of male and female participants. As per the table the mean age of fifty male participant is 14.12 with SD = 1.4. Similarly, the mean age of fifty two female participants is 14.15 with SD= 1.9. Altogether, the mean age of all the participants is 14.14 with SD = 1.64.

Table 5 Education level of the participants

Education	**Frequency**	**Percent**
Primary	15	14.7
Lower Secondary	51	50.0
Secondary	28	27.5
Higher Secondary	8	7.8
Total	102	100.0

Table 5 shows the education level of the participants. As per the table 15 participants were doing primary education (1 to 5 grade) making 14.7 % of the total participants. 51 participants were studying in lower secondary level (6 to 8 grade) making 50% of the total participants. Similarly, 28 participants were studying in secondary level (9 to 10 grade) making 27.5% of the total participants. Likewise, 8 participants were doing higher secondary level education (11-12 grade) making 7.8% of the total participants.

Descriptive analysis of Coping

Table 6 Means scores and SD of the participants on Coping

	N	Minimum	Maximum	Mean	Std. Deviation
Planning	102	2	8	6.54	1.33
Positive Reframing	102	3	8	6.36	1.33
Instrumental Support	102	3	8	6.36	1.36
Active Coping	102	3	8	6.32	1.40
Emotional Support	102	2	8	6.28	1.32
Acceptance	102	2	8	6.13	1.57
Self Distraction	102	2	8	5.62	1.54
Denial	102	2	8	5.62	1.54
Religion	102	2	8	5.34	2.13
Venting	102	2	8	5.29	1.61
Self blame	102	2	8	4.81	1.47
Humour	102	2	8	4.65	1.66
Behavioural Disengagement	102	2	8	3.89	1.50
Substance Use	102	2	8	2.35	1.04

Table 6 shows the mean scores of each of the fourteen subscales of coping. Since two items were clubbed to give one subscale, the values of the two items were added for each subscale. The mean score of each subscale was calculated with the raw data rather than with the adjusted data since it didn't make any difference to the frequency of the data. As per the mean score it is evidently clear that the participants used coping strategies such as planning, positive reframing, instrumental support, active coping, emotional support and acceptance more frequently. Self distraction, denial, religion and venting were moderately used. Self blame, humour and behavioural disengagement were used very little of the time. Similarly substance use got the lowest score suggesting this coping technique was not used by most of the participants.

Gender differences in Emotion Focused Coping and Problem Focused Coping

Table 7 Independent samples t- test

			T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
PF	Equal assumed	variances	-2.977	100	.004	-1.580	.531
EC	Equal assumed	variances	-1.540	100	.127	-2.144	1.392

Note: PF= Problem Focused Coping EC= Emotion Focused Coping

Independent samples *t*- test was performed using an alpha level .05. The analysis for problem focused coping showed gender difference between the boys (M= 18.42, SD= 3.06) and female (M= 20, SD= 2.25) as shown by t (100) = -2.977, p=0.004 The result indicates that girls used Problem Focused Coping significantly more than boys. Similarly, in emotion focused coping, the analysis of the data showed no gender difference as shown by t (100) = -1540, p=0.127.

Discussion and Conclusion

In the coping measure, the adolescents were found to be using more problems focused copings such as planning, using instrumental support and active coping. This result is consistent with the findings of other studies (Skinner and Zimmer-Gembeck, 2007; Rohail, 2015; Chase et.al., 2013; Sreeramareddy et.al., 2007). Although the adolescents used problem solving strategies frequently they also used invariably emotion focused strategies such as positive reframing, seeking emotional support and distraction. Maladaptive coping strategies such as behavioural disengagement, self-blame were very less used whereas denial was relatively more used. Substance abuse didn't find its place in the coping strategies of the adolescents. This result points out several implications. The first is the coping repertoire of an individual is flexible and adaptive to include all sorts of coping strategies (Carverl et.al., 1989; Skinner and Zimmer-Gembeck, 2007). Hence a coping repertoire of an individual comprises both problem focused and emotion focused coping functions depending upon the nature of the problem (Folkman and Lazarus, 1980).

Compas et.al.(1988)concluded that emotion focused coping was not as developed as problem focused in children and adolescents. Although many literatures suggest problem focused coping is more used by the adolescents, it can't be inferred outright to the claim made by Compas et.al., (1988) as there are literatures which had shown the female adolescents employing more emotion focused coping than problem focused coping (Carver et.al.,1989; Matud,2004; Hampel and Peterman, 2006). The reason for this gender difference was given to the socialization hypothesis (Ptacek et.al., 1992) and role –constraint hypothesis (Rosario et.al., 1988) which attributed gender difference due to internalization and learning of societal values, beliefs and the designated gender roles in the society.

In contrary to gender stereotyped belief, the present study surprisingly found that females (M= 20, SD = 2.2) significantly used problem focused coping more than males (M= 18.42, SD = 3.06). Similarly, there was no significant difference between the boys (M=55.26, SD= 7.6) and the girls (M=57.4, SD=6.3) in emotion focused coping. The findings are contrary to the theory of the socialization hypothesis (Ptacek et.al., 1992) and role –constraint hypothesis (Rosario et.al., 1988). The similar result has been repeated in Pakistan by Rohail (2015) who found that Pakistani adolescent girls used more active coping than boys. It is the testimony to the fact that gender stereotyped concept for role and socialization has been changing. The result indicated that the girls in child care homes were more proactive in finding the solution of the problems than the boys.

In conclusion, the present study has filled the glaring knowledge gap and given interesting insight into the coping of the adolescents living in child care homes. If the adolescents could be helped and facilitated in incorporating adaptive coping strategies such as planning, positive reframing, active coping, acceptance, seeking instrumental and emotional support could enhance the wellbeing of the adolescents, it would be the best way since it utilises the internal resources of an individual and can act as effective tools at very trying times. The research finding suggests a cautious approach in outright discrimination between problem focused coping and emotion focused coping as good and bad as both coping mechanisms are more or less employed by the adolescents at the same time. The adolescents in the childcare homes should be taught about the functions of coping appropriate to the situations.

Since the study is descriptive in nature the answer to the question 'why' is not explored in this study. The research could have been more comprehensive if it had incorporated qualitative aspect in its methodology as well. The other weakness of the study is its sample size which is not enough for generalization. While the participants were administering the self-report questionnaires, some of the participants had the tendency to choose extreme options which resulted in 'ceiling effect' in some of the participants.

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