PARENTAL RESPONSE AND COPING STRATEGIES FOR ADOLESCENTS' BEHAVIOURAL PROBLEMS: A COMMUNITY-BASED CROSS-SECTIONAL STUDY

M.O. Zubayr, A.M. Obimakinde, O.A. Popoola

Department of Community Medicine, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria

Correspondence:
Dr. Abimbola M. Obimakinde
Family Medicine Unit.
Dept. of Community Medicine,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Nigeria
Email: tolutammy@yahoo.com

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ABSTRACT

***Background*: Adolescent behavioural problems can be burdensome for parental figures. The lack of good parental responses and coping strategies may worsen adolescent mental health issues. Research in this domain can be informative for effective management of adolescents' behavioural problems in resource-limited settings like Nigeria.**

***Aim*: We assessed parental responses and coping strategies for adolescents with behavioural problems.**

***Methods*: A cross-sectional community-based survey with cluster sampling was conducted. Coping strategies were assessed using the Brief Cope Inventory (BCI), dichotomized into Emotional-Based Strategies (EBS) and Problem-Based Strategies (PBS) coping. The Strength and Difficulty Questionnaire (SDQ) assessed adolescent behavioural problems. Data were analyzed using descriptive and inferential statistics.**

***Results*: Four hundred and ten (410) parental figures of adolescents aged 14.8±2.3 years were recruited. Parental response to adolescent problem behaviours included corporal punishment in 44% and few (5.8%) sought medical or spiritual help for the adolescent. The most deployed parental coping strategy was "active" coping (69%) while "instrumental support" was the least adopted coping strategy. The age, gender, educational level and income of parental figures, were associated with the choice of utilizing PBS coping.**

***Conclusions*: Parental figures employed more corporal punishment and utilized active coping, and planning as coping strategies when dealing with adolescents' problem behaviours. Interventions to discourage corporal punishment and promote more effective parental coping are needed.**

Keywords: Adolescent, Coping strategies, Behavioural problems, Mental health, Parental figure

INTRODUCTION

Adolescence is a period with specific developmental needs and rights marked by immense turmoil in emotional and behavioural spheres for the growing individual.[1] Adolescents may display fluctuating cognitive capabilities and emotional expression as they are undergoing a phase of rapid physical growth, and unbalanced mental growth, making them more sensitive to adverse stimuli.[2] Behavioural problems are behaviours that depart from the social, moral and legal norms of society and cause social-control responses from external sources.[3] Adolescents may display socially unacceptable behaviours like conduct problems, peer problems, emotional problems and attention deficit hyperactivity disorder.[1,3]

Different factors are associated with an increased risk of behavioural problems in adolescents.[4,5,6] Adolescent boys tend to have slightly higher problem scores than girls and the behavioural problems tend to decline with increasing age in the adolescent period.[4,5,6] There is an association between low Socio-Economic Status (SES) and high levels of mental health problems in adolescence.[7,8] Adolescents of single-parent and step-parent have been reported to have more behavioural problems than those in intact families.[9] Other factors predictive of psychopathology in adolescents include parenting strategies and parent-child conflicts, the adolescents' temperament, health and educational attainment, and social status or resources available to the parental figure.[10,11] Behavioural problems in adolescents can have serious consequences for the adolescents, their families, friends, schools, and society at large, but mostly challenging for parental figures who are the primary custodians.[12]

Coping is considered one of the core concepts in the context of quality of life.[13] Zeidner and Endler (1996) defined coping as a cognitive or behavioural effort,

made by an individual to offset the impact of harm or stress when an automatic response is not readily available.[14] There is some similarity between parental response and parental coping strategies because both are parental behavioural efforts. However, parental responses are the immediate or intermediate actions deployed to tackle perceived adolescents' behavioural problems.[15] Parental response is usually a disciplinary response from the parental figure which can be verbal (scolding), non-verbal, aggressive(beating) or non-aggressive.[15] Contrarily, parental coping strategies are a set of learnt behavioural adaptions that parental figures utilize to handle their offspring's behavioural problems which are techniques developed and adapted over time.[13,14,16]

Carver proposed fourteen (14) types of coping including active coping, planning, social support, venting, behavioural disengagement, positive reframing, denial, acceptance, humour, self-blame, self-distraction, substance use and turning to religion as a coping response.[16] Active coping is taking active steps to remove the stressor or ameliorate its effects by initiating direct action, increasing one's efforts, and trying to execute a coping attempt in a stepwise fashion. Planning involves coming up with action strategies, thinking about what steps to take and how best to handle a problem. Social support involves people seeking support for either instrumental reasons e.g. seeking advice, assistance, or information or for emotional reasons e.g. getting moral support, sympathy, or understanding from significant others. Venting of emotions is the tendency to focus on whatever distress or upset one is experiencing and expressing those feelings and behavioural disengagement is reducing one's effort to deal with the stressor or even giving up. Positive reframing, denial, acceptance, humour, self-blame, self-distraction, substance use and turning to religion as a coping response are self-explanatory coping methods.

There are two broad categories of coping models namely Problem-Based Strategies (PBS) & Emotion-Based Strategies (EBS) based on the intention and function of coping efforts.[16] The PBS involves strategies which aim at solving the problem or changing the source of stress e.g. "planning" or gathering information about the problem. The EBS aims to reduce or manage feelings of distress e.g. "denial of the problem" or "seeking emotional support".[16] However, there is no consensus as to which coping strategies are most effective, and how well a coping strategy serves the purpose of solving problems or relieving emotional distress.[17,18] Although PBS is adjudged to be effective for parental figures dealing with behavioural problems in young persons.[17,18,19]

Parenting an adolescent can create secondary stress for the caregiver, because of the need for constant supervision, any parental figure can experience guilt, blame and anger associated with raising the adolescent.[20,21] The parenting role should be a fulfilling enterprise which can offer many rewards but when dealing with one or more adolescents with behavioural problems, high demands and additional responsibilities are placed on the parental figure.[21] These overwhelming challenges may require that such parental figure caregivers equip themselves with coping strategies to effectively deal with multifaceted responses emanating from the environment or family.[20,21]

Despite evidence of the prevalence of adolescent behavioural problems with emotional and conduct problems being the most common.[1,3,4] There is limited research on the parental response and coping strategies parental figures would employ in dealing with their adolescents' behavioural problems, in Nigeria. Contrarily in developed countries research on parental response and coping strategies for adolescents' problem behaviours abound, which has contributed to better management of troubled adolescents.[5–7] Therefore we conducted this study to contribute to the literature on parenting response and coping strategies for adolescent behavioural problems from the parental figures' point of view.

METHODS

***Study area*:** The study was conducted in the Oke-Ose community, Kwara State, North Central Nigeria. Oke-Ose is a semi-urban community located in the Ilorin East Local Government Area (LGA) of Kwara State. It is bounded in the south by a settlement called Dangiwa and to the east by the University of Ilorin, Teaching Hospital, Kwara State, Nigeria.

***Study design*:** A cross-sectional study was conducted.

***Study population*:** A local updated census at the time of the study in 2019 estimated that 3500 young people (aged 11-20 years) constituted about 19% of the total population in the Oke-Ose community.[22] The average family size of the community is relatively large with each household estimated to contain about five to ten people, and more than half of the number are young people. A large percentage of the parental figures in the community had secondary education as the highest educational attainment, thus the majority of the adolescents are enrolled in either a primary or secondary school with very few furthering to higher levels of education. The major occupations of the parental figures included: trading, farming and cloth weaving. This study was carried out among consenting

parental figures residing in the community who had at least one child between the ages of 10 and 19 years. In each selected household, one parental figure was interviewed.

Sampling technique: This study employed a cluster sampling technique. Oke-Ose community is divided into six districts namely; Akinde, Budo-Oba, Gori-ola, Idi-gba, Dangiwa and Olukolu. Four of the six districts were selected by simple random balloting from the list of six districts, keeping in mind the sampling frame and calculated sample size. The four selected districts were Gori-ola, Olukolu, Idi-gba and Akinde. All houses in the four districts selected were visited and interviews were conducted in households where adolescents were identified. In houses where there were many households, only one household with an adolescent was selected using a simple ballot technique. A household was defined as the number of related family members sharing a housing unit or part of a housing unit, sharing food and other essential resources for living.[22]

Data collection and analysis: Data were collected using both semi-structured and structured interviewer-administered questionnaires. The questionnaires used in this study are widely published validated standardized tools which had been culturally adapted.[10,13,16,20,23,24] The semi-structured questionnaire was pretested and used to obtain information on parental figures' socio-demographic characteristics and parental responses to adolescent's problem behaviour.[10,13]

The parental coping strategies, were assessed using the Brief Cope Inventory.[16,20] The Brief Cope Inventory,[16,20] and the Strengths and Difficulties Questionnaire (SDQ),[23,24] which was used to assess the adolescents' behavioural problems are both structured validated questionnaires. The Brief Cope Inventory contain 28 items with 14 subscales describing different coping strategies (with two items per subscale). The respondents indicated their preferred frequency of a particular coping behaviour with a scale of 1 ('I won't do this at all') to 4 ('I will do this a lot'). The scores obtainable in a subscale are a minimum of 2 and a maximum of 8 for each 28 items and a score of $\geq$4 is interpreted as "adopted" coping strategy. A mean score was obtained for each subscale to determine whether a caregiver adopted a particular coping strategy or not. The sum of responses to items 2,7,10, 14, 23 and 25 (of the Brief cope inventory) represents Problem-Based coping Strategies (PBS) while the sum of the other 22-items of the 28-items represents Emotional-Based coping Strategies (EBS). PBS coping aims to change or eliminate a problem by tackling the problem directly e.g. planning, problem-solving, or elimination of the problems. The EBS is when there is purely an emotional response to the stressor e.g. withdrawal, letting out anger and frustration, emotional support seeking, distractions, rumination, and resignation acceptance.

The parent-report version of the Strengths and Difficulties Questionnaire (SDQ)[23,24] was used to explore the parental perception of their adolescent's behaviours. The questionnaire consists of 25 items which are grouped into five subscales, each of which contains five items and the five subscales assessed for conduct, hyperactivity, emotional and peer problems as well as prosocial behaviors. The first four subscales constituted problem behaviours and were used in this study.

The questionnaire administration was done after obtaining ethical approval and informed consent. Data were analyzed using Statistical Package for Social Sciences (SPSS) version 21 (SPSS Inc., Chicago, IL) and summarized with proportions, frequency tables and a chart.

The outcome variables were the parental response and parental coping strategies while the explanatory variables were the adolescents' behavioural problems and parental sociodemography. The scores of four subscales of the SDQ was used to categorize the adolescents' behavioural problems and presented as percentages. The parental response to adolescents' problem behaviours was categorized and presented as proportions. The scores of the 14-subscales of the Brief coping strategies and the 2-way compacted categorization (EBS &PBS) were used for analysis and data interpretation. The relationship between categorical sociodemographic variables and the scores of the Brief cope inventory was analyzed using a t-test or ANOVA. Binary linear regression analysis was used to determine the predictors of parental choice of coping strategy.

RESULTS

A total of 410 parental figures of adolescents participated in this study. The socio-demographic profile is presented in Table 1. Over half of the respondents, 213 (52%) were aged between 30- 40 years, 266 (64.6%) were female, 343 (83.7%) were married and 312 (76.1%) were of the Islamic faith. Most, 170 (41.5%) of the respondents had secondary education as their highest level of education and 58% earned between ₦20,000 ($13) and ₦60,000 ($39) monthly. Of the parental figures, 262 (68.8%) were biological parents and the mean age of their adolescents was 14.8±2.3 years.

Table 1: Socio-demographic characteristics of parental figure

Variable	Frequency	Percentage
Gender		
Male	144	35.1
Female	266	64.9
Age Group		
< 30 years	62	15.2
30 – 40 years	213	52.0
41 – 50 years	92	22.4
> 50 years	43	10.4
Religion		
Islam	312	76.1
Christianity	97	23.7
Others	1	0.2
Marital Status		
Single	38	9.3
Married	343	83.7
Others	29	7
Family Type		
Monogamy	314	76.6
Polygamy	96	23.4
Educational Level		
Non-formal	50	12.2
Primary	96	23.4
Secondary	170	41.5
Tertiary	94	22.9
Monthly Income		
< 20,000	84	20.5
20,000 – 60,000	239	58.3
61,000 – 100,000	69	16.8
101,000 – 150,00	18	4.4
Relationship with adolescent		
Biological parent	262	68.8
Uncle/Aunt	79	19.3
Guardian	26	6.3
Grandparent	12	2.9
Step-parent	11	2.7

Parental figures' response to adolescents' behavioural problems

Perceived behavioural problems in adolescents assessed by the parental figure revealed that 24% of adolescents have emotional problems, 31% have conduct problems, 13% have hyperactivity problems and 83% have peer problems. Each of the parental figures perceived more than one behavioral problem in their adolescents hence the overlapping percentages.

The parental figure response to any of the above behavioural problems by the adolescent included (Figure 1) corporal punishment as indicated by 44% of the parental figures. This is followed by 'have a discussion with the adolescent' (41%), 'set controls and monitoring of the adolescent activities' (99;24%), 'setting curfews for the adolescent' (19%), 'restriction of the adolescent's access to money' (11.7%) and the least preferred parental response was to "seek medical/ spiritual help for the adolescent" (5.8%).

Parental figure's choice of coping strategy

Table 2 depicts that the most preferred coping strategy a parental figure would employ if their adolescent exhibits behavioural problems is the active coping strategy (68.5%). Others in declining order included; planning strategy (66.6%), instrumental support (56.6%), positive reframing strategy (53%) and religious approach (49%) which are the top 5 of the 14 variety of coping strategies evaluated for among the parental figure. The least preferred coping strategy was substance use (3.9%).

Association between parental figure socio-demographic characteristics and choice of coping Strategy

Using a 2-way dimensional compacted categorization of the 28-item Brief coping strategies, with resultant

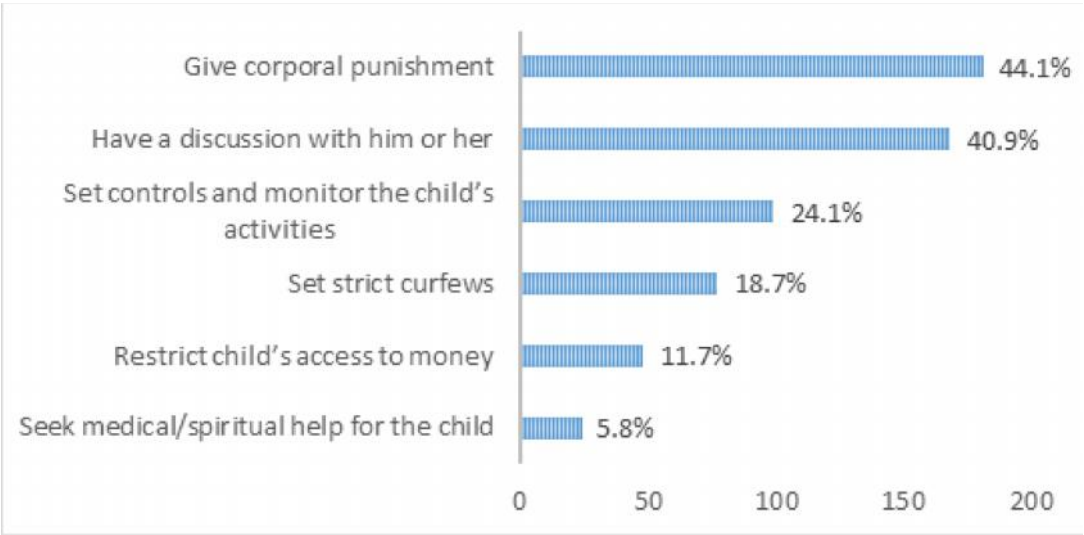

Figure 1: Parental figure response to adolescents' behavioural problems

Table 2: Parental figure preferred coping strategy (14-subscales of the Brief-COPE inventory)

	Variable	Adopted N (%)	Not Adopted N (%)
1	Active coping	281 (68.5)	29 (31.5)
2	Planning	273 (66.6)	137 (33.4)
3	Instrumental support	232 (56.6)	178 (43.4)
4	Positive reframing	219 (53.4)	191 (46.6)
5	Religion	201 (49.0)	209 (51.0)
6	Emotional support	196 (47.8)	214 (52.9)
7	Acceptance	139 (33.9)	271 (66.1)
8	Venting	150(36.6)	260(63.4)
9	Self-distraction	84 (20.5)	326 (79.5)
10	Behavioural disengagement	67 (16.3)	343 (83.7)
11	Denial	53 (12.9)	357 (87.1)
12	Self-blame	38 (9.3)	372 (90.7)
13	Humour	27 (6.6)	383 (93.4)
14	Substance use	16 (3.9)	394 (96.1)

emotional-based strategy (EBS) and problem-based strategy (PBS), Table 3 shows the mean difference in utilization of both Problem-Based and Emotional-based coping strategies. For the emotional-based coping strategy (EBS) female parental figures and non-biological parents have a higher EBS score than their respective counterparts ($p>0.05$), and parental figures with advanced age, higher level of education, and higher income have higher EBS scores. Although none was statistically significant. For problem-based coping strategy (PBS), female parental figures have higher PBS scores than the males but non-biological parental figures have a lower score compared to the biological parental figures. Parental figures younger than 30 years of age, those with no formal education, and those who earn less have lower PBS scores than their counterparts

Predictors of Parental figure choice of coping strategy

This model included the parental figure's gender, age group, level of education, income level, and relationship with adolescents. The PBS score for female caregivers is twice that of male ($\beta=0.205$, $p<0.005$). An increase in the parental figures' age, higher level of education, and higher income, significantly increased

Table 3: Association between parental figure socio-demographic characteristics and choice of coping strategy

Variables	PBS Mean (SD)	F-ratio	P-value	EBS Mean (SD)	F-ratio	P-value
Parental-figure gender						
Male	17.9±4.6	-4.1*	<0.001	47.4±5.8	-1.4*	0.17
Female	19.7±3.9			48.3±6.5		
Parental-figure age						
<30 years	16.9±4.9	6.39	<0.001	47.5±6.8	1.007	0.404
30 – 40 years	19.7±3.9			47.7±6.0		
41 – 50 years	19.4±4.1			48.4±6.3		
>50 years	18.4±3.7			49.9±7.3		
Educational status						
No formal education	16.5±4.5	7.29	<0.001	48.1±7.5	0.031	0.992
Primary	19.4±4.2			48.1±6.2		
Secondary	19.5±4.1			47.9±5.8		
Tertiary	19.1±4.1			48.0±6.7		
Level of income						
<20,000	16.9±4.8	11.83	<0.001	47.4±7.4	1.36	0.254
20,000-60,000	19.8±3.8			48.5±5.9		
61,000-100,000	19.6±4.1			47.4±5.4		
101,000-150,000	17.3±4.9			46.2±7.7		
Rel. with Adolescent						
Biological parent	19.5±4.2	3.4*	0.001	47.9±6.0	-0.75*	0.45
Non-biological parent	18.0±4.3			48±6.0		

the PBS score by 5% (β = 0.05, p=0.345), 12.4% (β=0.124 p=0.025) and 5.8% (β=0.058 p=0.309) respectively. However, the PBS score of non-biological parental figures decreases by 11.6% (β = 0.756, p<0.019). (Table 4)

Table 4: Predictors of parental figures' choice of coping strategy(PBS vs EBS)

Variables	B coefficient (unadjusted)	B coefficient (adjusted)	95% CI
Parental figure Gender			
Male	1.00	1.00	1.00
Female	1.388	1.567	0.74 - 2.393
Parental-figure Age			
<30 years	1.00	1.00	1.00
30 – 40 years	0.163	1.939	0.709 - 3.168
41 – 50 years	0.474	1.803	0.419 - 3.187
>50 years	-1.180	1.452	-0.316 - 3.220
Educational status			
No formal education	1.00	1.00	1.00
Primary	0.471	2.177	0.763 - 3.591
Secondary	0.839	2.026	0.674 - 3.378
Tertiary	0.134	2.552	1.014 - 4.089
Level of income			
<20,000	1.00	1.00	1.00
20,000-60,000	1.752	1.753	0.663 - 2.843
61,000-100,000	0.682	1.319	-0.161 - 2.80
101,000-150,000	-1.860	-0.705	-2.970 - 1.560
Relationship with Adolescent			
Biological parent	1.00	1.00	1.00
Non-biological parent	-2.767	-3.088	-5.489 – (-)0.688

DISCUSSION

The study investigated parental figures' response and coping strategy for behavioural problems in adolescents. We found that giving corporal punishment is the most preferred action caregivers would deploy if their adolescent exhibits behavioural problem(s) followed by discussing with the adolescent. This is slightly similar to the findings from studies conducted by Daiz[25] and Al-Azzam & Daack-Harsh[26] where it was reported that parental figures of adolescents with behavioural problems would engage more in practices like 'discussing with the adolescent' than 'giving punishment'. The difference in response could be because Nigerian parental figures tend to hold a lot of power over their wards. Traditionally in Nigeria, it is believed that in an attempt to produce a 'proper person' they consider corporal punishment the most appropriate means of instilling values in children and adolescents.[25,27] Meanwhile, it's interesting to know that a good number (40.9%) of parental figures in our study are beginning to see 'discussing with the adolescent' as a way of handling adolescent behavioural problems. This could be a result of increased awareness of child abuse and increased enlightenment of parents and caregivers in Nigeria.

Setting controls & monitoring the adolescent's activities was shown in this study to be preferred by 24.1% of parental figures. These parental figures may be motivated to control and monitor their adolescents' activities because of the immediate and future consequences. The consequences are mostly related to their social reputation as a result of their adolescent behaviour in public.[26] The least preferred parental response to adolescents' misbehaviours found in this study is to 'seek medical or spiritual help for the adolescent'. An explanation for this could be that many caregivers may consider their adolescent's behavioural problems as signs of psychopathology or spiritual problems. This contradicts the study by Chowdhury[29] who reported that the most preferred action for parental figures who experience adolescent behavioural problems was to seek help from a close non-professional source. The situation in our study is understandable considering Nigeria is a religious country and many of the citizens ascribe spiritual undertones to many challenges while the more educated citizens seek medical advice with or without spiritual intervention.

We found that the parental figures in our study mostly adopted coping strategies like 'planning strategy', 'active

coping', 'instrumental support', 'positive reframing', and 'religious' approaches to keep up when their adolescent exhibited behavioural problems. This finding is in concordance with few other studies.[28,30-32] The adoption of religious coping is expected as the study area and population are majorly of Islamic faith and many are ardent observers of the doctrine. Thus, having a child with problem behaviours may be viewed as God's will, which is to be accepted and coped with using religious beliefs. In the context of elaborating on understanding the difference between parental response and parental coping strategies, we found that religious perspective is one of the least parental responses. In contrast, the religious approach was a frequently reported coping strategy. This is because parental response is usually an immediate reaction therefore religious perspective isn't a frequent option but religious approach was frequently reported as a long-time parental coping approach to dealing with adolescents' behavioral problems.

This study revealed parental figures' gender-based differences in the adoption of problem-based coping strategies (PBS) and emotional-based coping strategies (EBS). Female parental figures had higher mean scores for both coping methods compared to their male counterparts. This gender difference is similar to what was reported in two other studies.[31-33] This gender difference may be because women, particularly mothers tend to involve themselves more in the emotional roles of caring for their children and are more driven to attempt to solve problems they encounter in their offspring or dependants whereas fathers or male parental figures usually assume the provider role.

There was a significant difference in the adoption of problem-based coping strategies based on the parental figure's income level. Plausibly a parental figure with a higher income and a higher socioeconomic status may have more resources available which help them make the situation of caring for an adolescent with behavioural problems less stressful.[33] Also, parental figures with higher levels of education were shown to have higher scores for both problem-based and emotional-based strategies in our study. This is similar to what was reported in other studies.[31,32] It is expected that a higher level of education comes with an advanced level of reasoning which might include a greater sense of self-efficacy in coping with problems. Therefore, parental figures with higher educational attainment will be more persistent in finding ways to cope with stressors that could come with perceived problem behaviours in their adolescents.[31,32]

In addition, better-educated parental figures are assumed to typically have more income and are aware of resources that they can use for help with dealing with problematic adolescents or dependants.[31-33] Parental figures below thirty years of age significantly had the lowest score for PBS which might reflect their lower level of cognitive awareness of problems and lower problem-solving skills which may limit their ability to utilize PBS when dealing with adolescents with problem behaviour. The parental figures above 50 years had the highest mean score for EBS which may depict their advanced ability to introspect and increase emotional awareness of self and their younger ones as similarly reported by Thukuri and others.[34,35] Non-biologic parental figures in our study had lower PBS scores compared to biologic parental figures, presumably because they have no or less blood-tie and feel less bothered to solve the issues which underscored the adolescent's problem behaviours. Interestingly the non-biologic parental figure also has more EBS coping which could mean they are prone to react emotionally to adolescents' problem behaviour and therefore deploy this coping mechanism rather than pursuing the root cause and finding a solution to the adolescents' behavioural problems.

CONCLUSION

It can be concluded from this study that in Nigeria parental figures' response to problem behaviours includes "giving punishment" and "having discussions with the adolescent". The fact that some parental figures choose to discuss with their adolescents as a response to problem behaviour shows that caregivers are becoming aware of better ways of handling their adolescents. The least preferred response by a parental figure was "seeking help for the adolescent either medically or spiritually". This could be because these few parental figures consider the problem behaviours as grievous psychopathologies or spiritual problems. The implication of parental figures who ascribed spiritual causes to adolescents' problem behaviours is that they may not seek appropriate help while the ones who think the behaviours are extreme psychopathology may end up over-treating or unnecessarily medicating the adolescent.

Finally, active coping, planning, seeking social support, and religious coping are the major preferred strategies parental figures would employ when their adolescent exhibits behavioural problems. Parental figures' gender, level of education, income, and relationship with adolescents are all statistically associated with the choice of utilization of PBS coping strategy. Public health intervention programs targeting parents' and other caregivers' attitudes regarding the cause, effective response, and coping strategies for adolescent behavioural problems are necessary for low-income settings like Nigeria.

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