Caregivers' Coping Strategies for Adolescents' Behavioural Problems in Oke-Ose Community, Kwara-State, Nigeria

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ABSTRACT

Behavioural problems in adolescents are a leading cause of health-related burden, accounting for 15–30% of the disability-adjusted life-years (DALYs) lost during the first three decades of life. However, there is limited data on how caregivers would cope if their adolescent develop these problems. This study was thus conducted to determine caregivers' response as well as coping strategies preference in case of adolescent(s) with behavioural problem. A community-based cross-sectional survey was conducted using a cluster sampling technique. Coping strategies preference was assessed using the Brief Cope Inventory. A 2-way dimensional compacted categorization was used to categorize the 28-item coping strategies of Brief Cope Inventory to emotional-based strategies (EBS) and problem-based strategies (PBS). Data were analyzed using descriptive statistics, Chi-square and multivariate linear regression model at $p<0.05$. 52% of the caregivers were aged 30 – 40 years while the mean age of adolescents was 14.8±2.3 years. The preferred response reported include corporal punishment (44%). The most preferred coping strategies caregivers would employ were active coping (69%) and planning (67%). Linear regression revealed caregiver's gender, level of education and adolescent's age were statistically associated with choice of coping strategy.

This study revealed that caregivers will likely employ healthy coping strategies should they encounter behavioural problem in their adolescent. Public health interventions targeting caregivers' attitude regarding the cause and effective coping behaviours for adolescent mental health problems need to be designed and evaluated for their effectiveness in low-income settings.

Keywords: Adolescent, behavioural problems, caregivers, coping strategies

INTRODUCTION

World Health Organization defines adolescents as individuals in the 10 to 19 years age group (WHO, 2015). Adolescence is a period with specific health and developmental needs and rights (Rulan *et al.*, 2005) marked by immense turmoil in emotional and behavioural spheres. Compared with young children, adolescents may have stronger cognitive capabilities and emotional expression as they are undergoing a phase of rapid unbalanced mental growth, making them more sensitive to adverse stimuli (Yurgelun-Todd, 2007). Behavioural problems are behaviours that depart from the social and legal norms of the society and cause social-control responses from external sources (Merson, 1957). Adolescents may display behaviours that could be considered socially unacceptable and these range from conduct problems, peer problems, risky sexual behaviours, emotional problems and attention deficit hyperactivity disorder.

Studies have shown that different factors are associated with increased risk of behavioural problems in adolescents. Adolescent boys have been shown to have slightly higher problem scores than girls and that behavioural problems tend to decline with increasing age in the adolescent period (Ravens-Sieberer *et al.*

2008; Amone *et al.* 2009; Amstadter *et al*, 2011). Some researchers also found an association between low Socio-Economic Status (SES) and high levels of mental health problems in adolescence (Braet, 2011; Wang *et al.*, 2014). Adolescents of single parent and step-parent have been reported to have more behavioural problems than those in intact families (Zukauskiene *et al.* 2003). Other factors predictive of psychopathology in adolescents include parenting behaviours and parent–child conflicts, temperament, health and experiences of early childhood care (Hemphill and Littlefield, 2006; Sun and Shek, 2010). Behavioural problems in adolescents can have serious consequences for the adolescents, their family, friends, schools, and the society at large (Chinawa, *et al.*, 2014).

Coping is considered one of the core concepts in the context of quality of life (Kartalova, *et al.*, 2008). 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. Carver (1989) proposed about fourteen (14) types of coping. Active coping is the process of taking active steps to try to remove the stressor or to ameliorate its effects. It includes initiating direct action, increasing one's efforts, and trying to execute a coping attempt in 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 (seeking advice, assistance, or information) or for emotional reasons (getting moral support, sympathy, or understanding). Other types of coping identified by Carver include; Venting of emotions (the tendency to focus on whatever distress or upset one is experiencing and to ventilate those feelings), behavioral disengagement (reducing one's effort to deal with the stressor, even giving up the attempt to attain goals with which the stressor is interfering), positive reframing, denial, acceptance, humour, self-blame, self-distraction, substance use and turning to religion as a coping response.

Meanwhile, coping models identify problem-based & emotion-based coping strategies as the categories of coping, based on the intention and function of coping efforts (Lazarus, *et al.*, 1984). The problem based coping involve strategies aim at solving the problem or changing the source of stress. For instance, planning or gathering information about the problem. The emotional based coping aims to reduce or manage the feelings of distress. For instance, denial of the problem, seeking emotional support etc. (Lazarus, *et al.*, 1984). 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 (Tuncay, *et al.*, 2008).

Caregiving an adolescent has the capability to create secondary stress, because apart from constant supervision, the caregiver can experience guilt, blame and anger associated with raising the adolescent (Middleton, 2008). Caregiving role for some people is a fulfilling enterprise which offers many rewards, but for others, especially those with one or more adolescents with behavioural problem(s), high demands and additional responsibilities are placed on them (Bonsu, 2014). These overwhelming challenges may require that caregivers equip themselves with coping strategies in order to effectively deal with multifaceted responses emanating from the environment or family (Bonsu, 2014).

Despite evidences of prevalence of adolescent problems, there have been limited researches on the type of coping strategies caregivers would employ in dealing with their adolescents' behavioural problems. This study, therefore, aims to contribute to global and local literature on adolescent mental health from caregivers' point of view as it will explore the different responses of caregivers and coping strategies awareness and preference. The novelty of this study is that it provides data on coping strategies that may be utilized by caregivers if faced with varying stressors that may be associated with raising an adolescent with mental health problems.

Objectives

1. To determine caregivers' response to maladaptive behaviour in adolescent.

2. To identify the different coping strategies that would be employed if a caregiver encounters adolescent behavioural problem(s)

3. To identify factors associated with caregivers' choice of coping strategies.

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MATERIALS AND METHODS

Study Area

The study was conducted in Oke-Ose community, Kwara-State. Oke-Ose is a semi-urban community located in 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 University of Ilorin Teaching Hospital. In the absence of a formal census, a recent local census has the population to be estimated as 3500 with young people (11-20 years) constituting about 19% of the total population. A large percentage of the community only have secondary education, thus majority of the adolescents are enrolled in either a primary or secondary school with very few furthering to higher levels of education.

Study design

A Cross sectional study was carried out.

Study population

This study was carried out among consenting caregivers (residing in the community) of at least one child between the ages of 10 and 19 years,. The minimum sample size for this study was estimated using the Kish formula assuming 95% level of confidence, a proportion of 20% from previous study (Sayal 2006), 5% precision, 5% for anticipated non-response rate of the respondents and a design effect of 1.5 to give 389.

Sampling technique

This study employed a cluster sampling technique. Oke-Ose community is divided into six districts according to the local government; Akinde, Budo Oba, Gori-ola, Idi gba, Dangiwa and Olukolu. Four of the six districts were selected by balloting and they were Gori-ola, Olukolu, Idi gba and Akinde. All houses in the four districts selected were visited (Interviews were conducted in households where adolescent were identified). One household was selected in houses where there were more than one households with adolescents using a ballot technique.

Data Collection

Data were collected with the aid of a semi-structured interviewer-administered questionnaire consisting of self-derived questions and adapted standardized questionnaire which have been validated in this environment; Brief Cope Inventory (Carver, 1997). Four research assistants were recruited and trained on interviewing skills and maintenance of ethical standards. Questionnaires were pre-tested to assess for clarity and sensitivity. The Administration was done after obtaining ethical approval from the Kwara-State Ethical Review Committee.

Data Analysis

Data were analyzed using Statistical Package for Social Sciences (SPSS) version 21 and summarized with proportions, frequency tables and a chart. ANOVA and t-test were used to determine association between the outcome and explanatory variables. Binary linear regression analysis was used to determine the predictors of caregivers' choice of coping strategy. Variables that were significant at 0.1 on bivariate analysis were included in the binary linear model. Level of statistical significance was set at 5%.

Variables

Independent variables; Socio-demographic characteristics: caregivers' gender, age, level of income and educational status.

Dependent variable; choice of coping strategy.

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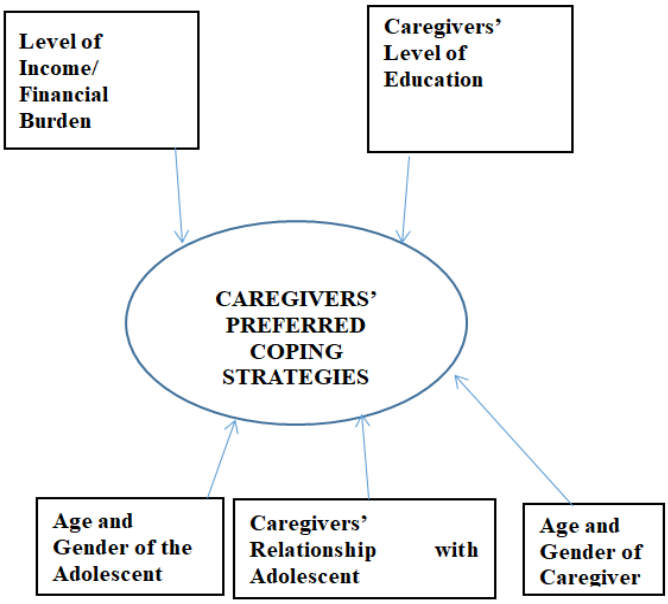
The Brief Cope Inventory contain 28 items in 14 subscales describing different coping strategies (two items per scale). The respondents indicated their preferred frequency of a particular coping behaviour with a scale of 1 ('I wont do this at all') to 4 ('I will do this a lot'). The scores obtainable in a subscale are 2-8. A mean score was obtained for each subscale to determine whether a caregiver adopt a particular coping strategy or not. A 2-way dimensional compacted categorization was used to categorize the 28-item coping strategies to emotional-based strategies (EBS) and problem-based strategies (PBS). The sum of responses to items 2,7,10, 14, 23 and 25 represent the problem based coping scores while the sum of others represent emotional based coping (using the Zeidner and Endler classification).

Conceptual Framework



RESULTS

Socio-demographic Characteristics of Caregivers

Overall, a total of 410 caregivers of adolescents in Oke-Ose community of Kwara state took part in this study. The socio-demographic profile of the caregivers 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 Islamic faith. Most, 170 (41.5%) of the respondents had secondary education as their highest level of education and 58% earned between ₦20, 000 and ₦60, 000 on a monthly basis. The mean age of the adolescents was 14.8±2.3 years and 262 (68.8%) had the caregiver as their biological parent.

Table 1: Socio-demographic characteristics of respondents

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

Caregivers' response to maladaptive behaviour

In response to any behavioral problems that could be exhibited by the adolescent, the most common response as shown in

below is to give corporal punishment as indicated by 181 (44%) caregivers. This is followed by 'have a discussion with the adolescent' (168;41%), 'set controls and monitor activities' (99;24%), 'set curfews' (77;19%), 'restrict access to money' (48;11.7%) and the least preferred action was to seek medical/spiritual help for the adolescent (5.8%).

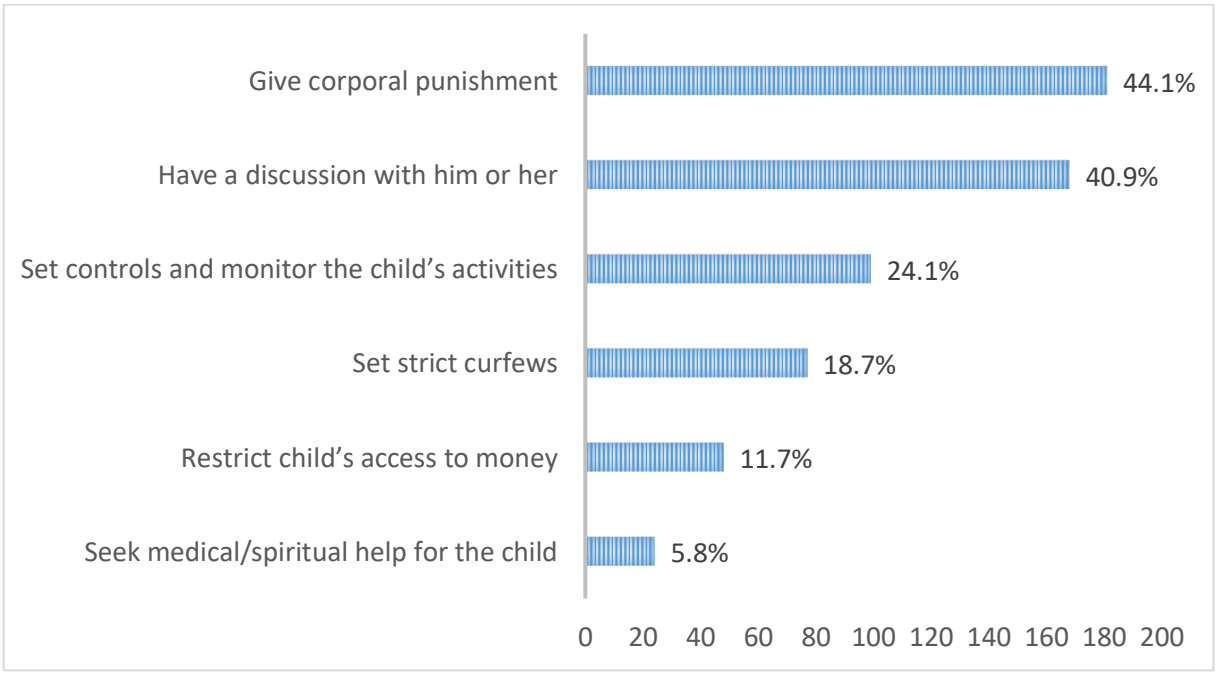


Figure 1: Caregivers' response to maladaptive behaviour

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Caregivers' choice of coping strategy

From Table 2 below, it can be seen that the most preferred coping strategies caregivers would employ if their adolescent exhibit behavioural problem include; planning strategy (66.6%), active coping strategy (68.5%), 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 caregivers. The least preferred coping strategy was substance use (3.9%).

Table 2: Caregivers' Choice of Coping Strategy

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

Association between Caregivers' Socio-demographic characteristics and Choice of Coping Strategy

Table 3 shows the mean difference in utilization of both Problem-Based and Emotional-based coping strategies. For emotional-based coping strategy, female caregivers and non-biological parents have a higher EBS score than their respective counterparts ($p>0.05$), caregivers with increased age, higher level of education, higher income have higher EBS scores. Although none was statistically significant.

For problem-based coping strategy, female caregivers have higher PBS score than the males but non-biological caregivers have a lower score compare to the biological caregivers. Caregivers less than 30 years, with no formal education and those who earn less that ₦20, 000 have lower PBS score than their counterparts.

Table 3: Association between Caregivers' Socio-demographic characteristics and Choice of Coping Strategy

Variables	PBS Mean (SD)	F-ratio	P-value	EBS Mean (SD)	F-ratio	P-value
Caregivers' 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		
Caregivers' 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		

*= t-test

Predictors of Caregivers' Choice of Coping Strategy

This model included caregiver's gender, age group, level of education, income level and relationship with adolescents. The PBS score for female caregivers is twice that of male (*β=0.205, p<0.005*). An increase in the caregiver's age, higher level of education, higher income, will significantly increase 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 caregivers will decrease by 11.6% *(β = 0.756, p<0.019).* (Table 4)

Table 4: Predictors of Caregivers' Choice of Coping Strategy

Variables	**B coefficient (unadjusted)**	**B coefficient (adjusted)**	**95% CI**
Caregivers' Gender			
Male	1.00	1.00	1.00
Female	1.388	1.567	0.74 - 2.393
Caregivers' 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 caregivers' response, choice of coping strategy and factors associated with it. The study revealed that giving corporal punishment is the most preferred action (41.1%) caregivers would employ if their adolescent exhibit behavioural problem(s) followed by having discussion (40.9%) with the adolescent. This is a little different from Daiz (2009) and Al-azzam & Daack-Harsh (2015) studies who reported caregivers would engage more in practices like 'increase involvement in academic task completion' 'having a discussion with him/her' then 'giving punishment'. The difference in response could be because, Nigerian caregivers hold a lot of power over their wards. Traditionally, they believe that boys and girls should be raised in typically masculine and feminine ways respectively. Therefore, in an attempt to produce a 'proper person' they consider

corporal punishment the most appropriate means of instilling values in them (Twun-Danso, 2010). Meanwhile, it's interesting to know that a good number (40.9%) of caregivers are beginning to see 'having discussion with the adolescent' as a way of handling adolescent matters. This could be as result of increase awareness on child abuse and increased enlightenment of parents and caregivers.

Set controls & monitor the adolescent's activities was showed in this study to be preferred by 24.1% of caregivers. Caregivers may be motivated to control and monitor their adolescents' activities because of the immediate and future consequences. The consequences are mostly related to social reputation as a result of their adolescent' behaviour in public (Wamoyi *et al.,* 2011). The least preferred action found in this study is to 'seek medical/spiritual help for the adolescent. This is contrary to the study by Chowdhury (2015) who reported that the most preferred action is seeking help from a close non-professional source. An explanation for this could be that, many caregivers may consider their adolescent's behavior as being part of "Normal Adolescence Syndrome", however, these may actually be signs of psychopathologies.

Also, this study revealed that most caregivers would mostly adopt coping strategies like; planning strategy, active coping strategy, instrumental support, positive reframing strategy and religious approach in order to keep up when their adolescent exhibit behavioral problem. These is keeping up with few other studies (Lin *et al.,* 2007; Hasting *et al.,* 2005) in Asia. The adoption of the religious coping is expected as the study area and population is of majorly Islamic faith and many being religious, thus having a child with psychopathology is seen as will of God which as to be accepted. This is in concordant with a study conducted in Tanzania by Mbwilo et al, (2010).

This study revealed caregiver's gender differences in the adoption of problem based coping strategies. Female caregivers are shown to want to adopt the coping method more than their male counterparts. This gender difference is similar to other studies (Drapper, 2009; Thakuri, 2014). This could be because women tend to involve themselves more in the emotional roles of caring for the well-being of family members, whereas fathers assume the provider role. Caregivers' income level also shows significant difference in the adoption of problem based coping strategy. It's assumed that caregivers who have higher income may also have more resources available to them which help them make the situation less stressful and they may look at their situation as an opportunity for growth (Pritzlaffa, 2001). Also, caregivers' with higher levels of education were shown to have higher score of both problem based and emotional based strategies. This is similar with other studies (Drapper, 2009; Thakuri, 2014). It is expected that, potential sources of benefits of education might include a greater sense of self-efficacy in coping with problems, which might help caregivers to be more persistent in finding ways to cope with stressors that could come with perceived major and minor problem behaviours in their adolescents. In addition, caregivers with more education are assumed to typically have more income and are likely to know about resources that they can use for help with specific problems (Brody *et al.,* 2002). Caregiver's age is shown to be associated with the choice of caregivers to adopt problem-based strategy. This is similar to the study of Thukuri (2014).

LIMITATIONS OF THE STUDY

By using vignette design, in which caregivers read descriptions of adolescents behaviours, rated these descriptions based on their adolescents and parenting and then choose a method of coping, the ecological validity of the results was enhanced. However, as with any analogue study, caregivers' actual behaviours in the real world were still unknown. Yet many researchers use vignettes to investigate perception or response to mental health problems because they are comprised of concrete stimuli which are held constant across participants (Finch, 1987).

The study was conducted only in Oke-Ose community of Kwara –state hence; this limits the generalizability of the findings to the entire population of caregivers in Nigeria.

CONCLUSION AND RECOMMENDATION

From the findings in this study, it can be concluded that caregivers' response to problem behaviours include majorly giving punishment and having discussion. This showed that caregivers are becoming aware of better ways of handling adolescents. However, the least response caregivers prefer is seeking help either medically or

spiritually. The implication of this is that, most cases of psychopathology in adolescents may go undetected and thus untreated. Active coping, planning, seeking social support, religious coping are the major preferred strategies caregivers would employ if/when their adolescent exhibit behavioural problem. Caregivers' gender, level of education, income and relationship with adolescent are all statistically associated with choice of utilization of coping strategy. Public health intervention programs targeting parents and other caregivers' attitude regarding the cause, treatment and effective coping behaviours for adolescent mental health problems need to be designed and evaluated for their effectiveness in low-income settings.

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