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Specific coping behaviours related to depression in adolescents with a divorced parent

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ABSTRACT

Parents' divorce is one of the life events that elicit pressure in adolescents, to such an extent that parents' divorce is a predictor of depressive disorder in adolescents. Coping strategy plays an important role in the relationship between pressure and depression. This research aimed to examine coping strategies (problem-focused, emotion-focused, and dysfunctional coping) and specific coping behaviours which affect adolescents with divorced parents' depressive symptoms. Participants are 80 adolescents with divorced parents from several cities in Indonesia, aged between 13 to 19 years old (mean=16.6 years, SD=1.62 with 76% female and 24% male). Depressive symptoms were measured using the children's depression inventory, and specific coping behaviour was measured with Brief-COPE or coping orientation to problems experienced. In this research, it was found that 38% of the adolescents had depression. On the multiple linear regression, only problem-focused coping and dysfunctional coping significantly affected depression and not emotion-focused coping. Furthermore, among 14 specific coping behaviours, only instrumental support and behaviour disengagement affect depressive symptoms. These findings indicate that intervention focused on increasing the utilization of problem-focused coping and reducing dysfunctional coping might be beneficial to minimize depressive symptoms in adolescents with divorced parents.

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1. INTRODUCTION

Depressive disorder keeps increasing each year. In Indonesia, depressive disorder ranks first in 1990 and 2017, with a prevalence of 6.1% amongst the population of age 15-24 years old (N=157.695) [1]. Adolescence is a long transition period between childhood and adulthood, which causes many significant changes in developmental aspects. These changes can be a pressure for adolescents. The stress experienced by adolescents along with their development causes this period to be known as a critical period of dramatically increasing internalization problems, one of which is depression [2], [3].

One of the exposures to stress experienced by adolescents is parental divorce [4]. Tension, fighting, the conflict between parents, and drastic changes in family structure and routines are pressure children encounter due to parents' divorce [5], [6]. Children may lose one of their parents, have less interaction time with the single parent who is busy making a living, and reduced income, which causes lifestyle changes and limitations in previously owned facilities [7]. In Indonesia, the divorce rate has become higher over time, with yearly percentages from 2017 to 2019 being 19.34%, 20.25%, and 22.30%, respectively [8].

Several studies showed that parental divorce might be associated with depressive symptoms in adolescents and has become the strongest predictor of depressive disorder among adolescents [9]–[16]. Another research identified depressive symptoms that happened twice more among adolescents with divorced parents than those with complete family [7], with depressive disorder prevalence in adolescents with divorced parents changing from 5.7% to 8% in the years 2006, 2009, to 2016 [16]. Consequently, parents' divorce has a long-term effect, such as developing mental health problems in the future [17]. In the COVID-19 pandemic, a longitudinal study found pandemic has increased adolescent depressive symptoms, and parental conflicts add to the pressure. The pandemic and parental conflict were significant risk factors in predicting depressive symptoms in adolescents [18].

Although parents' divorce hurts adolescents' mental health, not all children are affected by their parents' divorce [19]. Some children can easily stand the pressure, but others keep showing difficulties in behaviour and psychological adjustment. One factor determining the variability is adolescents' ability and strategy to overcome life pressure [20]. Coping strategies moderate the relationship between parental conflict and internalizing symptoms in adolescents [21].

Coping strategy is vital to adolescents because it plays an essential role in adolescent mental health, especially when faced with stressful life events [22]. Adolescents have fewer skills, experience, and resources than adults in dealing with psychological stress. However, adolescents' ability to deal with psychological stress affects their ability to develop in the short and long term [23]. Coping strategies during adolescence will affect adult coping strategies [24]. The concern is that if an adolescents' coping strategy is ineffective, it will persist until adulthood and may develop serious psychological problems.

There are three main types of coping strategies [25]. Several studies have shown that problem-focused coping is related to good mental health [26], [27] and is negatively related to depressive symptoms [28]–[31]. Problem-focused coping consists of active efforts from an individual to produce solutions or to change conditions causing stress [32]. Conversely, dysfunctional coping inclines toward diverting the mind and behaviour away from the stressor, which may prolong depression episodes [30], [33], [34]. Unlike problem-focused coping and dysfunctional coping, studies have shown that emotion-focused coping is found to have different outcomes. It was found that emotion-focused coping has a significant negative correlation with depression [30]; on the other hand, it has a significant positive correlation with depression [35].

On each main type of coping strategy, specific coping behaviors include planning, using instrumental support, active coping, acceptance, religion, positive reframing, humour, emotional support, self-distraction, behavioural disengagement, denial, venting of emotions, self-blame and substance use. Active coping [30], [36] and instrumental support [30] have been associated with lower depression scores. Self-blame, self-distraction [30], [37], [38], behavioural disengagement coping behaviour [30], [39], [40], and denial [30] were related to increased depression.

Although several studies analyze coping strategies and depressive symptoms, studies that examine the effect of coping strategies on depressive symptoms of adolescents from divorced families are limited. A family with divorced parents is associated with low cohesiveness, a high rate of conflict in the family, and minimal parental support, which risk the adolescent developing poor coping strategies when going through the long-term distress resulting from divorce [19]. Family or parental problems can be considered triggers of stress adolescents face because they learn how parents handle problems through modeling [41]. However, adolescents may depend more on parental guidance in responding to stressors [42].

This study aims to: i) recognize the coping strategy serves as a predictor of depression in adolescents coming from a divorced family, where coping above strategies are problem-focused coping, emotion-focused coping, and dysfunctional coping; and ii) investigate the specific coping behaviour that significantly predicts depression, where specific coping behaviours are the fourteen subscales of coping behaviour based on [25] theory. The result of this study is expected to be utilized in constructing intervention that focuses on teaching coping strategies for adolescent psychological problems caused by parent divorce.

2. METHOD

2.1 Participants

Participants involved in this research were 80 adolescents with divorced parents and aged between 13–19 years old (average age is 16.6 years old, with a standard deviation of 1.62). They consisted of 24% male and 76% female participants from several cities in Indonesia. Participants' ages when parent divorce happened were early childhood (24%), school age (19%), early adolescence (29%), and middle adolescence (29%). In terms of parents' divorce timing, some divorces happened less than one year (4%), one to less than three years (13%), three to less than five years (14%), five to ten years (45%), and divorce happened more than ten years ago (25%). All participants have expressed their consent to be involved in this research through informed consent given.

2.2 Measurement

Depressive symptoms were measured using children depression inventory or CDI developed by Maria Kovacs. CDI was used in this research in the Indonesian translated version used previously by Husada [43]. In Indonesia, CDI can be used for individuals from 7-19 years old [44]. CDI consists of 27 questions where each item has three statements scored 0, 1, 2. Items on this scale are grouped in five subscales: negative mood, interpersonal problem, ineffectiveness, anhedonia, and negative self-esteem.

Coping strategies are measured using Brief-COPE or coping orientation to problems experienced consisting of 28 self-report items with 14 subscales [25], [45], which then grouped into three categories, namely problem-focused coping, i.e., planning, using instrumental support and active coping; emotion-focused coping, i.e., acceptance, religion, positive reframing, humour, and using emotional support; and lastly dysfunctional coping, i.e., self-distraction, behavioural disengagement, denial, venting of emotions, self-blame, substance use [27]. In this instrument, participants were asked how they utilize it when encountering problems. Each response was measured using a Likert scale ranging from 1 (never utilize the way) to 4 (always utilize the way).

2.3 Statistical analysis

This research used independent-samples t-test to see the difference in depressive symptoms and categories of coping strategy based on gender, bivariate correlation analysis to identify the relationship between coping strategies and depressive symptoms, and multiple linear regression analysis to identify coping behaviour that affects adolescents with divorced parents' depressive symptoms. Classic assumption tests and model fit evaluations were conducted before multiple linear regression analyses. There were three classic assumption tests, i.e., multicollinearity, heteroscedasticity, and normality test.

3. RESULTS AND DISCUSSION

3.1 Result

Overall, 38% of adolescents have depression, while the remaining 62% is excluded from the depression category. There was no difference in depressive symptoms among adolescents of different gender (F=.559, p=.141). Regarding coping strategies, only dysfunctional coping showed a significant difference between male and female adolescents (F=.481, p=.034), with the average score for females higher than males. In contrast, between problem-focused coping (F=5.932, p=.348) and emotion-focused coping (F=.086, p=.130), there was no significant difference between male and female adolescents.

3.1.1. The correlation between coping strategy and depressive symptoms

Bivariate correlation analysis showed in Table 1. Coping strategies that correlate with depressive symptoms are problem-focused coping (r=-.293, p<.01) and dysfunctional coping (r=.350, p<.01), whereas no correlation was found between emotion-focused coping and depressive symptoms. Specific coping behaviours that correlate positively with depressive symptoms are denial (r=.248, p<.05), behavioural disengagement (r=.399, p<.01), acceptance (r=.248, p<.05), self-blame (r=.306, p<.01), while behaviours that correlate negatively with depressive symptoms are using emotional support (r=-.233, p<.01) and using instrumental support (r=-.391, p<.01).

3.1.2. The role of coping strategy on depressive symptoms

Linear regression model results in this study are isolated from multicollinearity and heteroskedasticity. Multiple linear regression analysis shown in Tables 2 and 3 has passed the classic assumption test and model fit test, where the variance inflation factor (VIF) score is below 10, the tolerance score above .01, and the scatter plot showed dots with no specific pattern or form, and P-P Plot result showed dots' pattern almost as a straight line and residual score >.05.

The model fit test showed that F=9.847, p=.000, so the estimated linear regression model is the best fit to be used to explain the effect of coping strategies on depressive symptoms as seen in Table 2. Linear regression model results have a proportion of effect of as much as 27.2% towards depressive symptoms, whereas the remaining 72.8% was affected by other variables, not in the linear regression model.

Multiple linear regression analysis in Table 2 shows that problem-focused coping (β=-.473, p=.002) and dysfunctional coping (β=-.415, p=.000) affected adolescents' depressive symptoms, while emotion-focused solving did not significantly affect the depressive symptoms (β=.118, p=.445). The negative regression coefficient on problem-focused coping implies adolescents who adopt problem-focused coping have lower depressive symptoms. The more they use problem-focused coping, the lower the depressive symptoms experienced. The positive regression coefficient on dysfunctional coping implies that adolescents who utilized dysfunctional coping have higher depressive symptoms. In other words, regular practice of dysfunctional coping resulted in higher depressive symptoms experienced.

Table 1. Bivariate correlation analysis

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Depression	-	.082	-.199	.248*	.003	-.233*	-.391**	.399**	.031	-.156	-.053	-.019	.248*	-.045	.306**	-.293**	-.098	.350**
Self-distraction		-	.403**	-.006	.177	.169	.214	-.064	.275*	.472**	.476**	.226*	.338**	.079	.179	.466**	.453**	.416**
Active coping			-	.010	.133	.173	.268*	-.259*	.110	.511**	.510**	.130	.228*	.451**	-.107	.740**	.532**	.047
Denial				-	-.073	-.075	-.099	.347**	.280*	-.076	-.078	-.062	-.080	.233*	.244*	-.078	-.020	.589**
Substance use					-	.744**	.486**	.113	.242*	.193	.312**	.273*	.131	-.046	.026	.425**	.484**	.351**
Emotional support use						-	.672**	-.027	.362**	.313**	.388**	.254*	.008	.004	.014	.564**	.599**	.272*
Instrumental support							-	-.152	.264*	.410**	.355**	.141	-.029	.180	-.009	.750**	.517**	.145
Behavioral disengagement								-	.347**	-.296**	-.086	.141	-.017	-.114	.291**	-.213	-.106	.643**
Venting									-	.137	.274*	.186	.094	.101	.306**	.290**	.326**	.697**
Positive reframing										-	.547**	.231*	.125	.317**	.078	.635**	.726**	.108
Planning											-	.192	.289**	.455**	.277*	.800**	.671**	.306**
Humor												-	.128	-.069	.140	.202	.601**	.242*
Acceptance													-	-.045	.221*	.198	.370**	.187
Religion														-	.093	.459**	.436**	.110
Self-blame															-	.071	.187	.652**
PFC																-	.749**	.220*
EFC																	-	.334**
DC																		-

Note: Problem-focused coping (PFC), emotion-focused coping (EFC), dysfunctional coping (DC)
*p<.05, **p<.01, ***p<.001

Table 2. Multiple linear regression for coping strategies

Preedictors	Standardized coeeficient beta (β)	t	Sig.	R	R-square	F (Sig)
Problem-focused coping	-.473	-3.200	.002	.521	.272***	9.847
Emotion-focused coping	.118	.769	.445			(.000)
Dysfunctional coping	.415	3.993	.000			

*p<.05; **p<.01; ***p<.001

Table 3. Multiple linear regression specific coping behaviour

Preedictors	Standardized coeeficient beta (β)	t	Sig.	R	R-square	F (Sig)
Self-distraction	.156	1.272	.208	.657	.432***	3.536
Active coping	-.180	-1.358	.179			(.000)
Denial	.110	.973	.334			
Substance use	.259	1.740	.087			
Emotional support	-.113	-.621	.537			
Instrumental support	-.358	-2.632	.011			
Behavioral disengagement	.276	2.283	.026			
Venting	-.099	-.824	.413			
Positive reframing	.080	.601	.550			
Planning	-.063	-.411	.682			
Humour	-.081	-.784	.436			
Acceptance	.208	1.916	.060			
Religion	.111	.860	.393			
Self-blame	.140	1.217	.228			

*p<.05, **p<.01, ***p<.001

3.1.3. The role of specific coping behaviour on depressive symptoms

The model fit test showed F=3.536, p=.000, therefore, can be concluded that the estimated linear regression model can be used to explain the effect of coping strategies towards depressive symptoms as displayed in Table 3. The resulting regression linear model showed a 43.2% proportion on the effect of depressive symptoms, while the remaining 56.8% was affected by other variables apart from a linear regression model. Multiple linear regression results in Table 3 showed two specific coping behaviours that positively impact depressive symptoms which are instrumental support (β=-.358, p=.011) and behavioural disengagement (β=.276, p=.026). The negative regression coefficient on instrumental support explained that adolescents who use instrumental support coping behaviour presented fewer depressive symptoms than adolescents who did not use it. The more frequent utilization of the coping behaviour, the less depressive symptoms experienced. The positive regression coefficient on behavioural disengagement explained that adolescents who used behavioural disengagement had higher depressive symptoms than adolescents who did not use it. Thus, it may endorse that the more adolescents use this coping behaviour, the greater their depressive symptoms.

3.2 Discussion

This study aimed to examine categories of coping strategies and specific coping behaviour that become significant predictors of depression in adolescents with divorced parents. Study results showed that only problem-focused coping and dysfunctional coping may predict the development of depressive symptoms in adolescents who had their parents divorce, not the emotion-focused coping.

3.2.1. Problem-focused coping

Problem-focused coping focuses on problem-solving effort, therefore doing something to change the stressor. Adolescents with a background of divorced parents experience several stressful life events during the process and after the divorce [19]. By using problem-focused coping, adolescents actively seek ways to overcome life pressure, be more adaptive, and have better mental health [46]. Problem-focused coping is crucial in anticipating the development of depressive symptoms in adolescents because it can protect adolescents from the severity of depression. Adolescents who use problem-focused coping when dealing with stressful situations are less likely to experience depressive moods [29]. Adolescents who experienced higher discrimination and used problem-focused coping showed fewer depressive symptoms [47].

The only specific coping behaviour in the problem-focused coping dimension, which becomes a depressive predictor in the regression model, is using instrumental support. Using instrumental support is one of the specific coping behaviors adolescents apply to deal with the pressures caused by their parent's divorce [48]. Using instrumental support is a coping behaviour aimed at seeking help or advice from others to overcome problems [25]. The strategies to find instrumental support, including help-seeking, is an effective coping to handle various life events in contrast to solely relying on oneself, which is ineffective and has more risk [49]. Higher depressive symptoms relate to a lower possibility of seeking help from friends or family [50]. The higher intention of help-seeking from friends or family, the lower depression experienced. In depressive individuals, half of the respondents never seek help to overcome their problems [51].

In this study, using instrumental support coping became a predictor of the development of depressive symptoms experienced by adolescents with divorce families. Parent divorce forms various pressures on adolescents; one is the loss of parental support [19]. Nonetheless, adolescents are in the life stage where they need advice or information on self-direction regardless and to be more focused on overcoming their problems. By using instrumental support coping, adolescents receive the information they need to face their parent's divorce effect.

Other coping behaviour within problem-focused coping dimensions, such as planning and active coping, do not correlate with depression and are not a predictor of depression on a regression model. This contrasts with the previous study, which showed a negative correlation between planning and active coping with depressive symptoms. The possible cause of the absence of a relationship may be that planning and active coping significantly correlate with using instrumental support.

3.2.2. Dysfunctional coping

Dysfunctional coping is a significant predictor of depression in the regression model. This finding is consistent with previous studies [52], [53], where dysfunctional coping application has a higher risk for diagnosis of depression [54], [55]. Dysfunctional coping is a coping strategy that aims to divert attention and stress from its cause. This strategy is only effective initially but becomes ineffective if applied repetitively, continuously, and in the long term [25]. Dysfunctional coping includes behavioural disengagement, self-distraction, substance use, venting, and self-blame [25].

The only specific coping behaviour within the dysfunctional coping dimension which correlates positively with depression and becomes the predictor of depression in the regression model is behavioural disengagement. Along with a study by Burker *et al*. [39], a higher level of depression correlates with a higher application of behavioural disengagement when encountering a problem. Individuals who apply behavioural disengagement feel hopeless in facing the stressor. Therefore , the problem will still exist and induce even more significant negative consequences than individuals who focus on problem-solving efforts [56], [57]. Generally, those who use this coping technique have given up and considered their problem unsolvable [58]. This condition brings out feelings of helplessness which facilitate the onset of depressive symptoms and maintain the current symptoms. Coping involving the act of surrender when encountering a problem is a risk factor and depressive symptom in adolescents [40], [59].

Adolescents with divorced parents use behavioural disengagement coping strategies to overcome the pressure caused by their parent's divorce [60]. Abelsohn also stated that coping was used to escape from situations that make them uncomfortable, namely the negative parenting and other impacts caused by a parent's divorce. Adolescents consider problems between both parents to be out of their control. Hence, they favor disengaging from the problems.

3.2.3. Emotion-focused coping

Emotion-focused coping is not a predictor of depressive symptoms in adolescents with divorced parents. This finding contrasts a study conducted by Horwitz *et al*. [61], which found that emotion-focused coping was a significant predictor in adolescents' depressive development. The possible cause is due to differences in research participants' characteristics. There are several parent divorce impacts that influence adolescents' coping behaviour.

Emotion-focused coping consists of five specific coping behaviours namely positive reframing, humour, religion, acceptance, and using emotional support [25]. In this study, all five coping behaviours did not predict adolescent depression, and only two coping behaviours correlated with depression, in different directions. Applying emotional support correlates negatively with depression, and acceptance correlates positively with depression. The aversion to correlation may cause emotion-focused coping to not correlate with depression.

Positive reframing, humour, and religion are not a predictor of depression and are not correlated to depression; i) positive reframing involves more complex cognitive ability while not all adolescents could interpret negative issues with positive thinking. This is also influenced by adolescent brain structure which has just started to develop, especially in early adolescence where lobus frontal development is slower than the limbic system [62]. Hence, when they experience the pressure of a parent's divorce, their emotion is triggered easily and they have difficulties with more complex thinking, to find positive meaning from their experience of parent divorce. Adolescents start to think more complexly when they are in their late adolescence; ii) humor, adolescents who have parental divorce constantly face parental conflict and feuds, experience decreased social, emotional, and financial support from their parents, and receive pressure from extended family and their surroundings [19]. The adolescent lost his parent as the primary source to fulfill their needs. The impact of divorce is experienced as immense pressure unsolvable by humour. This may cause no correlation between humour as coping and depression; and iii) religion, in adolescence, religious coping is a limited option to the oppression, which correlates positively with age. The younger their age, the narrower the usage. This is one of the possible causes of no correlation between specific coping of religion and depression [63].

One finding different from previous research was that acceptance correlates positively with depression. In this study, the more adolescents accepted their parent's divorce, the higher depressive score they had. The adolescents might have tried to get the divorce because it will set them free from constant conflict and harshness, but on the other hand, they cannot bear the equal amount of pressure. Altogether, it created internal conflict inside, which later could elicit depressive symptoms. Acceptance not accompanied by active coping strategies would cause unresolved problems. Nevertheless, in the adolescence stage of life, they need support from adults to overcome relatively challenging problems.

4 CONCLUSION

This research showed that problem-focused coping and dysfunctional coping influence depression, not emotion-focused coping. Furthermore, out of fourteen specific coping behaviours, only instrumental support and behaviour disengagement influence depressive symptoms. Adolescents who used problem-focused coping more frequently had lower depressive symptoms because they were able to actively seek means to overcome life pressure caused by parent divorce which was to seek social support. On the other hand, adolescents who used dysfunctional coping more frequently had higher depressive symptoms because they tend to redirect their attention from pressure, thus problems that could not be solved. These findings implied practically that adolescents with divorced parents need to be trained to utilize problem-focused coping. This training is crucial as adolescents ought to sustain the long-term impact of their parents' divorce.

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