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Coping skills and mental health status in adolescents when a parent has cancer: A multicenter and multi-perspective study

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ABSTRACT

Objective: Parental cancer increases the risk of psychosocial problems in adolescents. We investigated the frequency and efficacy of adolescents' coping strategies and relationships between those strategies and mental health status. Age and gender differences regarding coping and mental health were also investigated.
Methods: In total, 214 adolescents from 167 families participated in a cross-sectional, multicenter study. All participants were recruited from standard oncological care. Among the participants, 52% utilized a child-centered intervention program. Adolescents' coping skills were measured using KIDCOPE. Mental health status was rated by adolescents and parents by the SDQ for symptomatology and the KIDSCREEN for well-being.
Results: We found that 29% of the adolescents showed emotional and behavioral problems. We found gender differences in mental health status but not in coping. Adolescents used a broad spectrum of coping strategies. Active problem-solving, distraction, acceptance, wishful thinking and seeking social support were the most frequently used coping strategies. The utilization of certain coping skills was mediated by their perceived efficacy. Problem-focused or approach-oriented coping strategies generally are associated with better mental health, while avoidance-oriented coping are associated with worse mental health. Emotion-focused coping was associated with both lower and higher mental health.
Conclusion: The strategies used by adolescents to cope with parental cancer are associated with their mental health. Problem-solving and approach-oriented coping strategies should be facilitated by psychological interventions regardless of age and gender. Age and gender differences in adolescents' mental health should be further investigated because these differences are not explained by differences in coping strategies.
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Introduction

When a parent is diagnosed with cancer, the entire family faces disruption and distress [1]. The confrontation with the illness affects both parental [2] and family functioning [3]. Children and adolescents of cancer patients are particularly affected because of their dependence on parental care and support [4] and are at an increased risk of developing psychosocial problems [5]. As shown in other contexts in which people are faced with severe stress [6], most children and adolescents exhibit a good level of adjustment despite their parent's illness. However, some children and adolescents become highly distressed or develop psychosocial problems [7,8]. Despite this, adolescents may still experience a sense of well-being, even under extremely difficult circumstances [9–11]. As discussed in a previous systematic review [12], the presence of well-being in children and adolescents has not been studied with regard to parental cancer.

Furthermore, two studies found differences between *parent-reported and adolescent self-reported mental health* outcomes, with adolescents reporting more problems than their parents. This finding indicates that parents underestimate their children's problems [13,14].

A number of studies also reported differences in the children's ability to adjust to parental cancer with respect to the children's *age and gender*. Older children, especially adolescents, seemed more burdened than younger children [14–17], and daughters showed more problems than sons [18,19]. Other studies, however, have found no

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differences regarding age [13,20–23] or gender [13,17,24,25] in terms of coping skills.

Parental cancer affects adolescents in two different ways. An adolescent's concern for the sick parent could directly affect the adolescent's well-being, and lack of parental support could affect the adolescent's coping ability [26]. The ways in which adolescents cope with stressful situations impact both current and future psychopathology and well-being [27].

The most widely acknowledged *definition of coping* stems from Lazarus and Folkman [28] who defined *coping* as "constantly changing cognitive and behavioral efforts to manage specific external or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Folkman and Greer [6] provided a coping model that elaborated on the well-known cognitive-transactional model [29] to include two *mental health* outcomes: *psychopathology and well-being*. In consideration of Bandura's social cognitive theory [30], the model included perceived self-efficacy for coping, which seemed to be an important mediator of coping and stress responses [31,32] and reflected the effective use of coping behavior. The large variety of coping strategies is classified into different "*ways of coping*" [33], which reflect strategies with common functional patterns. In this model, coping was categorized into two types: *problem-focused coping*, used to resolve a stressful relationship between the self and the environment, and *emotion-focused coping*, used to palliate negative emotions caused by stress [27]. Two interview studies of children and adolescents confronted with parental cancer found that emotion-focused coping was used mostly by adolescents [34,35] and was associated with higher depression and anxiety rates than problem-focused coping [34]. Other studies found that problem-focused coping was often not associated with adaptive functioning [36], especially when emotional states were suppressed or not clearly reflected, and that emotion-focused coping could reduce adjustment problems [37]. The conceptualization of emotion- vs. problem-focused coping yields inconsistent results, and the distinction between emotion- and problem-focused strategies was discussed in depth in a previous study [33].

We extended the theoretical model of Folkman and Greer [6] by providing an alternative categorization of coping and by differentiating between *approach-oriented coping*, involving the management of a stressful event through a variety of resources (e.g., active problem-solving and social support seeking), and *avoidance-oriented coping*, used to indirectly minimize stress (e.g., distraction, wishful thinking, and social withdrawal) [38,39]. Previous studies found that approach-oriented coping was associated with better psychological functioning and well-being [39]. This hypothesis has not yet been examined in adolescents of parents with cancer [12].

As mentioned previously, adolescent mental health may vary according to age and gender [7,8,12], and there may be age and gender differences in terms of coping patterns. Previous studies investigated differences in coping due to age and gender [40]. Girls predominantly cope with stressors by seeking social support [41–43], thereby applying a more emotion-focused coping [41,44] strategy; they also tend to use coping strategies related to lower functioning [40,45]. In older children, the use of both distraction [41,46], which facilitates problem-focused coping [41,46], and emotion-focused strategies [44,45] increases.

As illness characteristics of parental cancer are not associated with adolescents' psychological functioning [7,8,12], coping could be an adequate predictor. Information regarding the specific use and efficacy of various coping strategies in this population could provide useful information for the development of intervention programs [47].

Objectives

This study examined adolescent coping and mental health (psychopathology and well-being) when a parent has cancer and focused on the different ways of coping. The objective was to identify the status of the adolescents' functioning and to examine whether there is a difference between self- and parent-reported functioning. Furthermore, we investigated age and gender differences regarding adolescent coping and the frequency and self-perceived efficacy of particular coping strategies. We also investigated whether the perceived efficacy mediated the use of coping strategies. Finally, we analyzed which coping strategies are associated with adolescents' functioning.

Hypotheses

H1. We expect mental health differences due to age and gender, with lower functioning in girls and older adolescents.

H2. We expect differences in the use of coping strategies, with girls and older adolescents using more coping strategies that are related to worse mental health.

H3. We expect that the usage of different coping strategies is mediated by their perceived efficacy.

H4. We expect that emotion-focused and avoidance-oriented coping are associated with worse functioning, while problem-focused and approach-oriented coping strategies are associated with better mental health.

Methods

Participants

This study is part of a nationwide, multicenter study in Germany. The goal of this project is to examine the indication criteria for preventive psychosocial interventions for children of cancer patients. Data were simultaneously collected between October 2009 and February 2011 at five university oncology centers in Germany. Parental cancer patients, their partners and underage children (0–18 years) were recruited in standard oncological care. 48% of the participating families utilized a family-based intervention that addressed the children's adjustment to parental cancer. The other 52% of the participating families were recruited in the context of standard oncological care in which this child-centered intervention was not offered. In all centers, we obtained ethical approval, and each participant provided informed consent after having received oral and written information about the study. Family members were instructed to complete the questionnaires independently and to not consult with other family members. The subsample used in the present cross-sectional study was extracted from this entire database. In this study, we included data from families with at least one adolescent (11–18 years old). Children between 0 and 10 years old were excluded. Both parents and adolescents had to be fluent in German. Finally, a sample of 214 adolescents and their 260 parents from 167 families was selected.

Missing values

Missing data are unavoidable in clinical research [48]. In our dataset, 30% of all participating subjects had at least one missing value. There were no missing values regarding illness or sociodemographic variables. Missing data are assumed to be dependent on other observed variables (e.g., sociodemographic and illness variables) and, therefore, are not completely missing at random (MCAR) [49]. Deleting cases or replacing missing values with mean values to address the missing data could produce crucial sample bias [49–52]. In this study, a multiple imputation model was employed to handle the missing values and to generate a unique sample for all sub-analyses [53]. This approach is widely accepted as a state-of-the-art method [50,52,54] of reducing

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