Journal of Media Horizons
ISSN: 2710-4060 2710-4052 Volume 6, Issue 3, 2025

COPING STYLES IN KARACHI YOUTH: A SOCIOCULTURAL PERSPECTIVE

Sumayya Salim Khatri[*1], Aliya Nisar[2], Mohadesa Mohammad[3]

[*1,2]*Department of Psychology, DHACSS College for Women*

[*1]sumayyaadeem@gmail.com

DOI: https://doi.org/10.5281/zenodo.15860830

Keywords
coping strategies, gender differences, ethnicity, adolescents, Karachi

Article History
Received: 04 April, 2025
Accepted: 25 June, 2025
Published: 11 July, 2025

Corresponding Author: *
Sumayya Salim Khatri

Abstract

The present study investigates the coping strategies employed by adolescents in the metropolitan city of Karachi, with a focus on gender, ethnicity, and family structure. The primary aim was to determine whether specific coping styles are more prevalent among youth, and whether significant gender differences exist in the use of these strategies. The findings revealed statistically significant gender differences in several coping styles, including self-distraction ($p = .002$), active coping ($p = .028$), substance use ($p < .001$), planning ($p = .004$), and religious coping ($p = .002$). Ethnic differences were also observed in the use of substance coping ($p = .018$) and planning strategies ($p = .011$). While no significant gender differences were found among Urdu-speaking adolescents, the Punjabi subgroup demonstrated marked differences in self-distraction, religion, and active coping. These results highlight the influence of sociocultural factors on stress management among Karachi's youth.

INTRODUCTION

The developmental phase connecting childhood to adulthood is known as adolescence and consists of a complex interaction between biological, psychological, and social forces, all contributing to unique transformations in individual development. As these forces influence each other, they lead to a diversity of developmental paths and coping behavior (Hauser et al., 1991).

Coping has been defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). Coping has two major functions: regulating the emotional responses to the stressor called emotion-focused coping and having direct action to change or control the sources of stress referred to as problem-focused coping (Folkman & Lazarus, 1985). Problem-focused coping is an attempt to take direct action in order to find a solution to change the stressful situation into a better situation. Emotion-focused coping is an attempt to change the interpretation of the stressful situation reappraising the threatening event into a non-threatening one (Lazarus, 1993). Some studies (e.g., Folkman & Lazarus, 1985) indicated that problem-focused and emotion-focused coping strategies were both used in the same stressful encounter. Folkman and Lazarus (1985) confirmed that both types of coping, problem- and emotion-focused, were used in three stressful situations, namely, before the exam, after the exam, and when the grades were announced. The findings demonstrated that people coped with a single situation in complex ways. It has been reported that subjects have appraised the examination as both threat and challenge at any given phase of the exam. This finding showed that both types of appraisal could occur at the same time. In addition, both types of coping were used simultaneously.

Adolescents' cognitive perception of stressors determines which method of coping they use. Folkman and Lazarus (1980) argue that the stress process consists of three components, namely perception of a possible threat, planning what to do about the threat, and the process of acting out the plan, which refers to coping. There is a general consensus that coping includes the handling of stressors with the use of certain strategies and resources (Govender & Killian, 2001). Although resources, such as interpersonal relationships or psychological services are generously available, they can only be useful tools against stressors when they are actively pursued. Coping strategies, on the other hand, are determined by the cognitive evaluation of the stressor, including the rationality and flexibility of the individual's judgement, as well as the expectation of a certain result (Moos & Schaefer, 1993). Coping is considered as an important mediator between negative life events and psychological well-being, consequently coping may be an important determinant of successful adaptation among adolescents (Folkman & Lazarus, 1984; Herman-Stahl, Stemmler & Petersen, 1995).

Coping strategies are mainly divided in two groups or styles of coping, namely problem-focused and emotion-focused strategies. After cognitively assessing the stressful situation or problem, the individual decides which coping style or strategies to use. Problem-focused strategies are used to solve problems or to attack the source of the stress, while emotion-focused strategies help relieve emotional distress, which is caused by, or associated with, the stressful situation (Folkman & Lazarus, 1980). Emotion-focused strategies can be subdivided into cognitive emotion-focused and behavioural emotion-focused strategies.

Cognitive emotion-focused coping involves changing the way the individual thinks about the problem at hand, e.g. committing to positive thoughts or employing selective attention, whilst behavioural emotion-focused strategies entail doing something to feel better, but not solving the problem, e.g. venting anger or exercising (Folkman & Lazarus, 1984). A study by Lewis and Frydenberg (2002), revealed that adolescents using problem-solving strategies, tend to cope better, compared to those who used emotional-focused coping techniques. Similarly, Herman-Stahl et al. (1995) proclaim that adolescents who generally use a problem-focused style of coping reported fewer depressive symptoms compared to those who continually avoided or denied problems. Although several other studies on adolescents have also indicated that the use of problem-focused strategies promotes positive mental health, and that emotion-focused strategies are associated with poor psychological adjustment, emotion-focused strategies have been found to be more effective when challenged with an unsolvable problem, such as the death of a significant other (Compas, Malcarne & Fondacaro, 1988).

Coping strategies are defined as "…behavioural or cognitive attempts to manage those demands that are appraised as taxing or exceeding the resources of the person" (Kraaij et al., 2003, p. 186). Because stressors vary in degree and context, it is extremely difficult to categorize coping strategies in adaptive and maladaptive groups, for a certain strategy may be maladaptive in one situation, but perfectly adaptive in the next (DeLongis & Holtzman, 2005). In certain situations, certain coping strategies serve as protective components by regulating the negative effects brought on by stressful events, and creating alternatives to solve the problem, while others may worsen the effects of stress and become risk factors themselves (Seiffge-Krenke, 2000).

In a study on the relationship between adolescent self-esteem and coping, Chapman and Mullis (1999) discovered that seeking diversions, developing social support, developing self-reliance and engaging in demanding activities, were the coping strategies adolescents used most, while seeking professional support, using humour, investing in close friends, and seeking spiritual support, were identified as the strategies they least used. Kraaij et al. (2003) state that adolescents using positive refocusing and positive reappraisal when faced with a stressor, had significantly fewer depressive symptoms than those using self-blame, rumination, and catastrophising as coping strategies. Adolescents seem to turn to non-productive coping strategies when their attempts at problem-solving coping are unsuccessful, and those who employ more productive strategies also tend to use more non-productive strategies (Lewis & Frydenberg, 2002).

Adolescence alone marks a period of significant change in the developmental process. These changes occur in the physiological, emotional, and cognitive domains and can elicit feelings of excitement, fear, and stress. Many adolescents also face additional stressful and trying life events, such as parental divorce or the death of a family member (Hauser & Bowlds, 1990; Rice, Herman, & Petersen, 1993). Adolescents, especially those from underrepresented groups, often have very little or no control over the several stressful life events they encounter and, therefore, may feel overwhelmed and experience heightened distress (Figueira-McDonough, 1998). Maladaptive outcomes for these adolescents may result if they cannot cope adaptively with these overwhelming stressors. For example, at the end of a yearlong study with Mexican American adolescents, those who experienced greater emotional distress reported more alcohol use and involvement in peer violence (Tschann, Flores, Pasch, & Marin, 2005).

The order of birth plays a vital role in shaping ones personality it is well known. These personalities develop as coping strategies that one uses as child to make one feel okay in his or her particular position in the family. For example, a second-born is surely going to act differently that the first-born, even if they both have the same hair, the family gap between their two front teeth, and big feet.

As the family grows, each child develops his or her own coping strategies depending on their position in the family. These positions may be that of an only child, or first, second, third or last born. The coping strategies used may be serving many purposes e.g., to please, to be perfect, to be strong, to try to hurry, depending on their position in the family.

Since birth order is made up of coping skills, the nature of home life plays a vital role in the type of strategy chosen. The more harmonious the home, the less coping is necessary. In families where children must cope with abuse, neglect, substance abuse, chaos, over-protection, unreasonable control, frequent punishment, and unreasonable demands, they develop very strong birth order characteristics. The authors could not locate any systematic study to note the effect of birth order on the type of coping strategy employed.

Coping style is affected by the individual's appraisal of the situation he/she is faced with as well as by the resources available. The use of these resources may be approved of or prohibited by cultural values and norms (Lazarus & Folkman, 1984). Several cross-cultural studies indicated that how people cope with stressful events differ considerably across cultures. For example Marcella, Escurado, and Gordon (1972, as cited in Essau & Trommsdorff, 1996) found that coping strategies such as, projection, acceptance, religion, and perseverance were used in collectivistic cultures like, the Philippines, Korea and Taiwan. In Essau and Trommsdorff's (1996) study, it was found that Malaysian students as compared to North Americans and Germans used substantially more emotion-focused coping in dealing with their school-related problems. North Americans and Germans who used emotion-focused coping experienced fewer physical symptoms, whereas Malaysians experienced more symptoms. In contrast, Gerdes and Ping(1994) found that American students reported using less problem-focused coping strategies than Chinese students. Vandervoort (2001) investigated the cultural differences in ways of coping with sadness. According to the study results Asians and Caucasians were less likely to use confrontive (i.e., hostility, aggressive efforts to alter the situation, and risk-taking) and positive reappraisal coping strategies in dealing with sadness than multiethnic individuals. In addition, Asians used less distancing coping strategies (i.e., denial, escaping). In a study, Olah (1995) examined the influence of culture on coping behaviors of Indian, Italian, Hungarian, Swedish, and Yemenite 17-18-year-old adolescents. Results showed that adolescents in European countries reported significantly more frequently assimilative coping strategies (i.e., problem-focused, constructive, confrontative, information-seeking, seeking social support for instrumental reason) than boys and girls in India and Yemen, the latter generally preferring emotion-focused solutions. Similarly, Sinha, Willson, and Watson (2000) found greater use of emotion-focused coping (e.g., confrontive, distancing, seeking social support, positive reappraisal) in Indian students than in Canadians. The maximum difference between the Indian and Canadian samples was in positive reappraisal strategy. Use of problem-focused coping did not differ between the two cultures.

There seems to be a tendency among people in collectivistic cultures to use emotion focused coping,

whereas those in individualistic cultures are more likely to prefer problem-focused coping (Olah, 1995; Sinha, Willson, & Watson, 2000). Jerusalemand Schwarzer (1989) compared coping resources and coping between Turks living in Germany and Germans. Results revealed that while Germans received higher scores in instrumental coping, Turks received higher scores in emotional coping. In addition Germans had better coping resources (higher self-efficacy and self-esteem) in their own culture and they used more problem-focused coping.

Thus in the present study, the effect of ethnicity shall be studied on various ethnic groups residing in Karachi.

Since this is a preliminary report in Pakistan, no existing data provides evidence as to which strategy will be utilized by different ethnic groups. Thus non-directional hypotheses are developed in this regard.

H_1: There are gender differences in adolescents in coping strategies they use.

H_2: Birth order will influence the type of coping strategy used.

H_3: Ethnicity will have an influence on the type of coping strategy used.

H_4: Family structure will influence the type of coping strategy used.

METHODOLOGY

Participants

This study was intended to include 100 subjects (50 males and 50 females) from different fields of university education but some data was lost due to incomplete forms. The final data included 87 adolescents (44 females, 43 males). The age ranged from 15 to 22 (mean=18.84). The maximum percentage of them were middle born (41.4%). Urdu speaking adolescents were 34.5% followed by Punjabis who were 24.1% of the data.

Measure

Brief Cope

The Brief COPE (See Appendix) is a brief form of an inventory (COPE) originally developed by Carver, Scheier, and Weintraub (1989) to assess the different ways in which people respond to stress. Carver (1997) then conducted another study to revise the COPE to develop a briefer form.

The brief COPE Scale is a 28-item self report measure of problem-focused versus emotion-focused coping skills. The scale consists of 14 domains/sub-scales (self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion, self-blame) of two items each. Examples of questions include "I've been getting emotional support from others," "I've been giving up trying to deal with it," and "I've been taking action to try to make the situation better."

All questions are scored on a 4-point Likert scale ranging from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot). Participants are asked to respond to each item on a four-point Likert scale, indicating what they generally do and feel when they experience stressful events (1 = I have not been doing this at all – 4 = I have been doing this a lot). The higher the score on each coping strategy, the greater the use of the specific coping strategy.

In this study, Cronbach's Alpha of the brief COPE Scale was found to be .82. With regard to the internal consistency of the fourteen sub-scales for assessing coping strategies, the following Cronbach's alphas were found: acceptance .82, religion .77, planning .75, positive reframing .87, using instrumental support .76, active coping .83, using emotional support .71, humor .89, self-distraction .73, venting .84, self-blame .92, behavioural disengagement .81, denial .96, and substance use .92. The scales are only two items each, their reliabilities all meet or exceeded the value of .50 regarded as minimally acceptance (Carver et al., 1993; Nunnally, 1978).

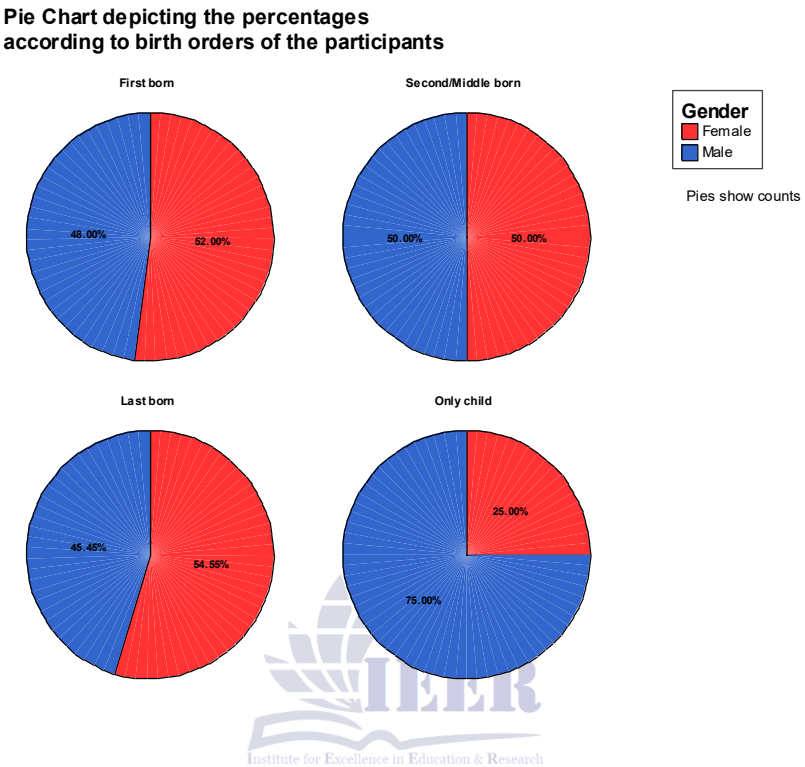
The researchers developed a sociodemographic questionnaire including gender , age, ethnicity, and family structure (joint or nuclear)

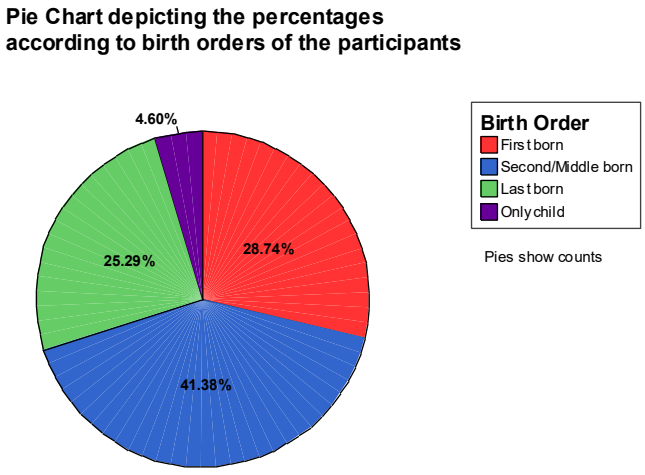
Procedure

The participants were college students randomly selected from D.A College for Women, Bahria University, Greenwich University and IBA institute. The subjects consent was taken and then given the form with the demographic details and the coping strategy scale was given to them to fill. The participants were instructed to rate themselves on the scale as in which strategy applied to them and not what they consider to be the right strategy. Means

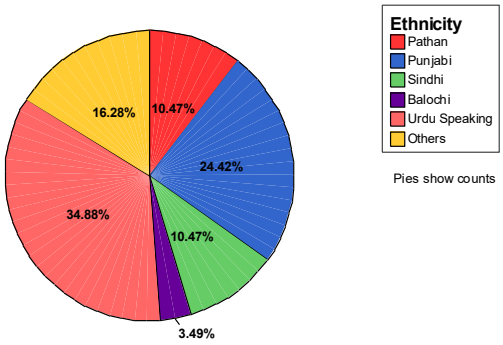
were calculated of this raw data for convenience. Independent sample t tests and one way ANOVA was applied to check the significance level of our data.

RESULTS

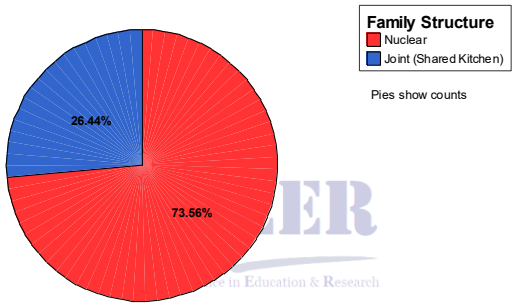




Pie Chart depicting the percentages according to ethnicity of the participants



Pie Chart depicting the percentages according to family structure of the participants



Pie Chart depicting the percentages according to family structure of the participants

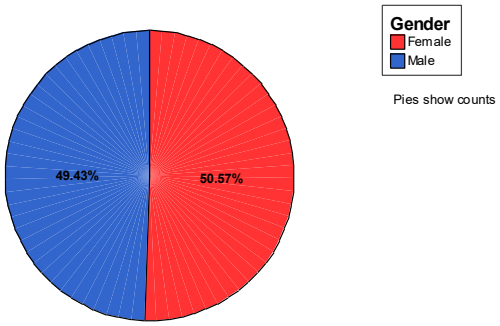


Table 1: Comparison of Means

Gender	Self-distraction	Active Coping	Denial	Substance Use	Use of Emotional Support	Use of Instrumental Support	Behavioural Disengagement	Venting	Positive Reframing	Planning	Humour	Acceptance	Religion	Self-blame
Female	3.70	4.30	2.11	.25	3.23	3.55	2.23	2.66	4.14	3.73	1.66	3.82	4.39	2.86
Male	2.51	3.35	1.93	1.65	3.14	3.14	2.14	2.79	3.16	3.21	2.84	3.30	3.28	2.72
Total	3.11	3.83	2.02	.94	3.18	3.34	2.18	2.72	3.66	3.47	2.24	3.56	3.84	2.79

Table:2 Independent Samples t-Test for Gender Differences in Coping Strategies

Coping Strategy	t	p	Mean Difference	95% CI for Difference
Self-Distraction	3.19	.002	1.19	[0.45, 1.94]
Active Coping	2.79	.007	0.95	[0.27, 1.62]
Substance Use	-5.09	< .001	-1.40	[-1.95, -0.85]
Denial	0.51	.614	0.18	[-0.54, 0.91]
Instrumental Support	1.08	.284	0.41	[-0.34, 1.16]
Behavioral Disengage	0.27	.791	0.09	[-0.57, 0.74]
Emotional Support	0.26	.799	0.09	[-0.60, 0.77]
Positive Reframing	1.56	.123	0.52	[-0.14, 1.18]
Humour	-3.06	.003	-1.18	[-1.94, -0.41]
Planning	2.94	.004	0.97	[0.32, 1.63]
Venting	-0.41	.680	-0.13	[-0.76, 0.50]
Acceptance	1.40	.164	0.52	[-0.22, 1.25]
Religion	3.12	.002	1.11	[0.40, 1.81]
Self-Blame	0.40	.693	0.14	[-0.57, 0.86]

Note. A positive mean difference indicates higher scores for females. CI = Confidence Interval. In coping strategies, males and females are significantly different in case of self-distraction, active coping, substance abuse, planning, and religion.

Table:3: One-Way ANOVA Results for Differences in Coping Strategies Across Ethnic Groups

Coping Strategy	F	p
Self-distraction	1.44	.220
Active coping	1.58	.176
Denial	1.08	.376
Substance use	2.92	.018*
Emotional support	1.06	.391
Instrumental support	0.76	.580
Behavioral disengagement	0.85	.522
Venting	0.31	.907
Planning	3.18	.011*
Positive reframing	1.79	.124
Humour	0.57	.724
Acceptance	1.61	.167
Religion	0.53	.755

Coping Strategy	F	p
Self-blame	0.16	.976

Note: p values < .05 are marked with an asterisk (*).
Only **substance use** and **planning** show statistically significant differences across ethnic groups.

Table 4: Independent Samples t-Test Comparing Age Groups on Coping Strategies

Coping Strategy	t	p	Mean Difference	95% CI for Mean Difference
Self-Distraction	2.25	.027	0.90	[0.10, 1.69]
Active Coping	1.08	.282	0.39	[-0.33, 1.12]
Substance Use	-1.46	.149	-0.47	[-1.11, 0.17]
Denial	0.41	.682	0.16	[-0.59, 0.90]
Instrumental Support	1.98	.051	0.76	[-0.00, 1.53]
Behavioral Diseng.	-0.90	.370	-0.31	[-0.99, 0.37]
Emotional Support	0.93	.353	0.33	[-0.38, 1.04]
Acceptance	2.59	.011	0.86	[0.20, 1.52]
Humor	-1.05	.297	-0.44	[-1.27, 0.39]
Planning	2.83	.006	0.98	[0.29, 1.66]
Venting	1.07	.290	0.35	[-0.30, 0.99]
Positive Reframing	0.15	.880	0.06	[-0.71, 0.82]
Religion	2.67	.009	0.99	[0.25, 1.74]
Self-Blame	-0.55	.586	-0.20	[-0.94, 0.54]

Middle and late adolescents show a significant difference in terms of Self distraction, religion, planning, instrumental support and acceptance.

TABLE 5: ANOVA showing comparison between family structure and coping strategies.

Coping Strategy	F	p
Self-distraction	0.38	.541
Active coping	0.34	.561
Denial	1.17	.283
Substance use	1.50	.224
Emotional support	0.63	.429
Instrumental support	0.29	.590
Behavioral disengagement	3.61	.061
Venting	0.05	.826
Planning	1.49	.226
Positive reframing	0.03	.858
Humour	0.04	.853
Acceptance	4.01	.048*
Religion	2.54	.114
Self-blame	2.73	.102

Note: p < .05 marked with an asterisk (*).
A statistically significant difference in **acceptance** was found between nuclear and joint families.

Table6: One-Way ANOVA Results for Differences in Coping Strategies by Family Type

Coping Strategy	F	p
Self-distraction	0.96	.416
Active coping	0.30	.822
Denial	0.01	.998
Substance use	2.47	.068
Emotional support	0.49	.693
Instrumental support	0.47	.705
Behavioral disengagement	1.22	.309
Venting	0.90	.447
Planning	0.85	.468
Positive reframing	0.18	.910
Humour	0.40	.754
Acceptance	0.85	.472
Religion	0.84	.476
Self-blame	1.72	.170

Note: No statistically significant differences were found across coping strategies by family type (p > .05 for all).

Table 7: Gender by Ethnicity Cross-Tabulation (Frequencies)

Gender	Pathan	Punjabi	Sindhi	Balochi	Urdu	Others	Total
Female	3	8	5	0	16	12	44
Male	6	13	4	3	14	2	42
Total	**9**	**21**	**9**	**3**	**30**	**14**	**86**

TABLE 8: One-way ANOVA showing birth order difference of coping strategies in Punjabis

Coping Strategy	df (Between, Within)	F	p
Self-distraction	3, 17	0.18	.907
Active coping	3, 17	0.05	.984
Denial	3, 17	0.98	.426
Substance use	3, 17	0.72	.552
Emotional support	3, 17	0.93	.448
Instrumental support	3, 17	2.48	.096
Behavioral disengagement	3, 17	1.19	.342
Venting	3, 17	2.37	.107
Planning	3, 17	1.68	.209
Acceptance	3, 17	0.85	.485
Humour	3, 17	2.01	.150

Coping Strategy	df (Between, Within)	F	p
Religion	3, 17	0.39	.762
Self-blame	3, 17	1.27	.315

Birth order shows no significant difference in terms of coping strategies in Punjabi when compared to other ethnicities.

Table9: One-way ANOVA Showing Gender Differences in Coping Strategies Among Punjabis

Coping Strategy	F	p
Self-Distraction	5.51	.030*
Active Coping	4.81	.041*
Denial	0.67	.422
Substance Use	4.08	.058
Emotional Support	0.21	.656
Instrumental Support	0.14	.709
Behavioral Disengagement	0.76	.393
Venting	0.06	.815
Planning	4.09	.058
Positive Reframing	0.66	.427
Humour	1.96	.177
Acceptance	1.44	.245
Religion	6.44	.020*
Self-Blame	1.70	.209

Note. *p < .05 indicates statistical significance.

Table10: One-way ANOVA Showing Age Group Differences in Coping Strategies Among Punjabis

Coping Strategy	F	p
Self-Distraction	1.61	.220
Active Coping	2.07	.166
Denial	7.00	.016*
Substance Use	3.58	.074
Emotional Support	0.88	.359
Instrumental Support	0.20	.664
Behavioral Disengagement	11.44	.003**
Venting	0.83	.374
Planning	3.62	.072
Acceptance	8.36	.009**
Humour	1.01	.328
Positive Reframing	0.51	.486
Religion	4.03	.059
Self-Blame	0.47	.500

Note. p < .05 is significant (*); p < .01 is highly significant (**).

Table 11: One-way ANOVA Showing Family Structure Differences in Coping Strategies Among Punjabis

Coping Strategy	F	p
Self-Distraction	1.09	.311
Active Coping	0.02	.900
Denial	9.59	.006**
Substance Use	4.85	.040*
Emotional Support	0.02	.886
Instrumental Support	0.93	.347
Behavioral Disengagement	2.79	.111
Venting	2.47	.133
Planning	1.87	.188
Positive Reframing	0.08	.780
Humour	1.16	.296
Acceptance	8.36	.009**
Religion	1.77	.199
Self-Blame	3.35	.083

Note. $p < .05$ is significant (*); $p < .01$ is highly significant (**).

Table 12

One-way ANOVA Showing Gender Differences in Coping Strategies Among Urdu-Speaking Adolescents

Coping Strategy	F	p
Self-Distraction	3.41	.075
Active Coping	1.93	.176
Denial	0.38	.541
Substance Use	5.93	.022*
Emotional Support	0.47	.498
Instrumental Support	0.01	.916
Behavioral Disengagement	2.68	.113
Venting	0.00	.950
Planning	2.48	.127
Positive Reframing	0.00	1.000
Humour	3.52	.071
Acceptance	1.11	.302
Religion	3.38	.077
Self-Blame	0.64	.429

Note. $p < .05$ is significant (*); $p < .01$ is highly significant (**).

Table 13
One-way ANOVA Showing Age Group Differences in Coping Strategies Among Urdu-Speaking Adolescents

Coping Strategy	F	p
Self-Distraction	0.01	.938
Active Coping	0.00	.986
Denial	0.94	.341
Substance Use	0.30	.589
Emotional Support	1.05	.313
Instrumental Support	6.24	.019*
Behavioral Disengagement	2.87	.101
Venting	0.45	.506
Planning	0.38	.541
Positive Reframing	0.48	.495
Humour	0.03	.873
Acceptance	3.39	.076
Religion	1.36	.253
Self-Blame	0.53	.472

Note. $p < .05$ is significant (*); $p < .01$ is highly significant (**).

Table 14: One-way ANOVA Showing Birth Order Differences in Coping Among Urdu-Speaking Adolescents

Coping Strategy	F	p
Self-Distraction	1.38	.271
Active Coping	**3.91**	**.020**
Denial	0.34	.797
Substance Use	**10.02**	**.000**
Emotional Support	1.59	.216
Instrumental Support	1.05	.388
Behavioral Disengagement	1.20	.328
Venting	0.55	.656
Planning	0.24	.867
Positive Reframing	0.52	.672
Humour	2.87	.056
Acceptance	**3.85**	**.021**
Religion	1.66	.201
Self-Blame	0.71	.555

Note. $p < .05$ is significant (*); $p < .01$ is highly significant (**).
Interpretation: Birth order significantly affected active coping, substance use, and acceptance strategies in Urdu-speaking adolescents.

Table 15: One-way ANOVA Showing Family Structure Differences in Coping Among Urdu-Speaking Adolescents

Coping Strategy	F	p
Self-Distraction	0.01	.929
Active Coping	0.01	.919
Denial	0.05	.825
Substance Use	0.09	.773
Emotional Support	0.04	.848
Instrumental Support	0.23	.637
Behavioral Disengagement	0.81	.375
Venting	0.85	.364
Planning	0.00	.959
Positive Reframing	0.22	.643
Humour	0.11	.741
Acceptance	0.01	.922
Religion	0.44	.511
Self-Blame	3.60	.068

Interpretation: No significant coping differences were found between adolescents from nuclear and joint family structures

DISCUSSION

Adolescence is period of physical and psychological development from the onset of puberty to maturity. The adolescent is no longer a child, but they haven't reached adulthood yet. Adolescence includes people between the ages of 13 and 21. Puberty is the physical maturing that makes an individual capable of sexual reproduction. Adolescence is not cultural universal. In some societies, young children go straight from childhood to the adult life once they have done the necessary puberty rites. Puberty rites are formal ceremonies that mark the entrance of young people into the adult life. People at the age of 13 to 14 that completed these puberty rites can become accepted into the adult society.

Most researchers agree that adolescence is a period of storm and stress or heightened emotionality. They disagree however, in regard to the causes of heightened emotionality. The older view point was glandular changes accounting for it. Most recent researches have shown, however that the period of greatest emotional tension does not coincide with the time when glandular changes are most pronounced. The investigations reveal that social factors seem to be of far greater importance.

This research focused on how adolescents across various ethnicities of Pakistan handle stress i.e. what coping strategies they use to handle stresses in their lives. Also, we were interested in seeing gender differences in coping.

There seems to be no one particular coping strategy that adolescents tend to use to deal with stress, since the coping scale used was measuring 14 different coping strategies based on responses on 2 items each. As mentioned earlier, the brief COPE Scale is a 28-item self report measure of problem-focused versus emotion-focused coping skills. The scale consists of 14 domains/sub-scales (self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, self-blame) of two items each.

Analysis of results shows (ref table 2) that in coping strategies, males and females are significantly different in case of self distraction($t=3.194$, $df=85$, $.002<p.05$), active coping($t=2.789$, $df=85$, $.028<p.05$), substance abuse($t=-5.091$, $df=85$, $.000<.05$), planning($t=2.938$, $df=85$, $.004<.05$) and religion($t=3.118$, $df=85$, $.002<.05$). As observed in the present research females used more of self-distraction,

active coping, planning and religion whereas males resort more to substance use or show a tendency to use that kind of strategy in dealing with stressful situations. It is an established fact that men and women differ in many ways, with different emotions and perceptions, with different personality characteristics (Burr, 1998). There has been much debate regarding the different gender related issues as more and more researches are being conducted. Although much of the research on gender is surrounded by controversy, researchers still ponder over different issues concerning gender differences. Many issues have been taken to account such as stress levels, adaptation and social relationships which are some of the areas in which there are significant gender differences (Larsen & Buss, 2002). The different coping styles adapted by the different sexes itself shows that there are evident differences between how both sexes cope with stress and chaotic life experiences. Researches show that men adapt more action direct approaches than women in stressful work situations (Porter & Stone, 1995).

Analyses of the data show difference in terms of ethnicity too. The coping strategy adopted by our youth is of substance use (F=2.918,.018<p.05) and planning (F=3.179,.011<p.05) (Ref table 3b). Comparisons of mean show that Pathans use more of substance use (M=1.22), athough the mean score for Balochis is the highest (M=3.67) but since N=3 it is very small to generalize onto the entire population. So far as planning strategy is concerned, Sindhis scored the highest (M=4.0) followed by Others (M=3.9). The lowest score for planning is for Balochis (M=1.33) {ref table 3a}.

Generally, it can be seen that substance abuse is one category that our adolescents do not generally resort to. It may involve some element of social desirability. Since this was a self-report measure, there may have been some faking on the part of adolescents so as to present a more favorable picture of oneself.

Further analysis of results also reveal that mid and late adolescents show a significant difference in terms of Self distraction(t=2.248,df=84,.027< p.05), religion(t=2.666,df=84,.009 <p.05), planning,(t=2.829,df=84,.006 p<.05), and acceptance(t=2.591,df=84,.001 p<.05)(ref table 4).This goes to show that as adolescents move closer to maturity, they do learn to accept their stresses and become more realistic in approaching them and show more positive ways of handling emotions, and plan better to deal with unavoidable stresses.

The present research also aimed to study any differences in terms of coping strategies in adolescents in joint families and nuclear families. The data included 73.6%nuclear family members and 26.4% joint family members. The only dimension along which they seem to show a significant difference is acceptance, as can be seen in table no 5 (F=4.011,.048 p<.05). Interestingly, the trend in the data showed a much greater number of adolescents belonging to nuclear family system rather than joint family system, reflecting a social change in our culture (nuclear family 73.56%, joint family 26.44%).

Birth order and coping strategies do not differ as opposed to the popular notion that first borns differ from last borns across a number of personality traits as well as their coping strategies. There is a significant difference in substance abuse (F=10.015,.000p<.01), acceptance (F=3.850,.021p<.05) and active coping (F=3.905,.020p<.05) amongst Urdu speaking compared to other ethnicities in context to birth order (ref table 14).

Ethnicity too does not happen to be related to any particular coping strategy except for a few interesting differences between Punjabi and Urdu speaking adolescents. A comparison is made between the two since it includes the highest percentage of these ethnicities in data, i.e24.1% Punjabis and 34.5% Urdu speaking adolescents. There is a more pronounced gender difference in Punjabis in Self distraction (F=5.507,.03p<.05), religion (F=6.441,.02p<.05) and active coping (F=4.813,.041p<.5){ref table 9} compared to other ethnicities. Urdu speaking adolescents however show no gender difference (ref table 12) across any coping strategies measured. At the same time age group difference can be seen in terms of denial, behavioral disengagement and acceptance coping strategies in Punjabis compared to other ethnicities. Earlier researches on Hispanic adolescents also showed a significant difference among ethnic groups in the kind of coping strategy used by them (Copeland & Hess, 1998). We are yet to have enough research evidence to see differences in various ethnic groups in Pakistan. Since in the present study, brief cope scale was used, it has provided us a very sketchy picture regarding the

coping strategies used by Pakistani adolescents. It is suggested that a more detailed coping scale be used and with a larger data to further discover any differences existing amongst various ethnicities and gender. Also some other scales be used that will reveal relationship of coping styles with other variables such as emotional stability and self esteem, so as to obtain a clearer perception of how our adolescents grow out of various dilemmas faced by them as an inevitable part of their everyday lives.

REFERENCES

Carver CS, Pozo C, Harris SD, Noriega V, Scheier MF, Robinson DS, Ketcham AS, Moffat FL, Clark KC. (1993). How Coping Mediates the Effect of Optimism on Distress – a Study of Women with Early-Stage Breast-Cancer**.** Journal of Personality and Social Psychology, 65:375-390.

Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. International Journal of Behavioral Medicine, 4, 92-100.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. Journal of Personality and Social Psychology, 56, 267-283.

Chapman, P.L., & Mullis, R.L. (1999). Adolescent coping strategies and selfesteem. Child Study Journal, 29(1), 69-79.

Compas, B.E., Malcarne, V.L., & Fondacaro, R.M. (1988). Coping with stressful events in children and young adolescents. Journal of Consulting Clinical Psychology, 56, 405-411.

DeLongis, A., & Holtzman, S. (2005). Coping in context: The role of stress, social support, and personality in coping. Journal of Personality, 73(6), 1633-1656.

Essau, C. A. & Trommsdorff, G. (1996). Coping with university-related problems: A cross-cultural comparison. Journal of Cross-cultural Psychology, 27, 315-328.

Figueira-McDonough, J. (1998). Voices of young people in poor inner-city neighborhoods. Youth & Society, 30, 123-163.

Folkman, S. and Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. Journal of Personality and Social Psychology 48, 150–170.

Folkman, S., & Lazarus, R.S. (1980). An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 21, 219-239.

Folkman, S., & Lazarus, R.S. (1984). Stress, appraisal and coping. New York: Springer.

Frydenberg, J. (2002). Quality Standards in eLearning: A Matrix of Analysis. International Review of Research in Open and Distance Learning, 3 (2).

Gerdes, E. P. & Ping, G. (1994). Coping differences between college women and men in China and The United States. Genetic, Social, and General Psychology Monographs, 120, 169-196. Retrieved April 21, 2000, from EBSCOhos database.

Govender, K., & Killian, B.J. (2001). The psychological effects of chronic violence on children living in South African townships. South African Journal of Psychology, 31(2), 1-12.

Hauser, S. T., & Bowlds, M. K. (1990). Stress, coping, and adaptation. In S. Feldman & G. R. Elliott (Eds.), At the threshold: The developing adolescent (pp. 388-413). Cambridge, MA: Harvard University Press.

Hauser, S.T., Jacobson, A.M., Borman, E.H., Noam, G.G., Bowlds, M.K., Knoebber, K., & Powers, S.I. (1991). Understanding coping within adolescence: ego development and coping strategies (p. 177-195). In E.M. Cummings, A.L. Greene & K.H. Karraker (Eds.), Life-Span Developmental Psychology: perspectives on stress and coping. New Jersey: Lawrence Erlbaum.

Herman-Stahl, M.A., Stemmler, M., & Petersen, A.C. (1995). Approach and avoidant coping: implications for adolescent mental health. Journal of Youth and Adolescence, 24(6), 649-665.

Jerusalem, M. & Schwarzer, R. (1989). Anxiety and self-concept as antecedents of stress and coping: A longitudinal study with German and Turkish adolescents. Personality and Individual Differences, 10, 785-792.

Kraaij, V., Garnefski, N., De Wilde, E.J., Dijkstra, A., Gebhardt, W., Meas, S., & Ter Doest, L. (2003). Negative life events and depressive symptoms in late adolescence: bonding and cognitive coping as vulnerability factors? Journal of Youth and Adolescence, 32(3), 185-193.

Lazarus, R. S. and Folkman, S. (1984). Stress, Appraisal, and Coping. New York: Springer.

Lazarus, R.S. (1993). From psychological stress the emotions: A history of a changing outlook. Anuual Review of Psychology, 44, 1—21.

Lazarus, Richard S. (1993). From psychological stress to the emotions: A history of changing outlooks. In Porter, L. W. and M. R. Rosenzweig (eds.), Annual Review of Psychology, Vol. 41. Palo Alto, CA: Annual Reviews, 1–21.

Lewis, R., & Frydenberg, E. (2002). Concomitants of failure to cope: What we should teach adolescents about coping. British Journal of Educational Psychology, 72, 419-431.

Moos, R., & Schaefer, J.A. (1993). Coping Resources and Processes: Current Concepts and measures. In L. Goldberg & S. Breznitz (Eds.), Handbook of Stress: Theoretical and Clinical aspects (2nd ed.) (p. 234-258). New York: Free Press.

Nunnally JC: Psychometric Theory. New York: McGraw-Hill Press; 1978.

Olah, A. (1995). Coping strategies among adolescents: A cross-cultural study. Journal of Adolescence, 18, 491-512.

Rice, K. G., Herman, M. A., & Petersen, A. C. (1993). Coping with challenge in adolescence: A conceptual model and psycho-educational intervention. Journal of Adolescence, 16, 235-251.

Seiffge-Krenke, I. (2000). Causal links between stressful events, coping style, and adolescent symptomatology. Journal of Adolescence, 23, 675-691.

Sinha, B. K., Wilson, L. R., & Watson, D. C. (2000). Stress and coping among students in India and Canada. Canadian Journal of Behavioral Science, 32, 218-225. Retrieved September 19, 2002, from the EBSCOhost database.

Tschann, J. M., Flores, E., Pasch, L. A., & Marin, B. V. (2005). Emotional distress, alcohol use, and peer violence among Mexican-American and European-American adolescents. Journal of Adolescent Health, 37, 11-18.

Vandervoort, D. J. (2001). Cross-cultural differences in coping with sadness. Current Psychology, 20, 147-153. Retrieved August 12, 2003, from the EBSCOhost database