COVER SHEET

ADOLESCENT COPING: DIFFERENCES IN THE STYLES AND STRATEGIES USED BY LEARNING DISABLED COMPARED TO NON LEARNING DISABLED ADOLESCENTS

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This study compared the coping strategies and styles of 30 learning disabled adolescents with 30 non learning disabled adolescents matched in age, gender and ethnicity from a large urban high school in Queensland. Results showed that the learning disabled adolescents use some different coping styles and strategies to their non learning disabled peers. The learning disabled group showed less tendency to relax, or work to achieve goals. They tended not to focus on the positive and not to attempt to solve problems. Rather they exhibited a higher tendency to use wishful thinking and believed that they could not cope. Cognitive and social skills deficits are proposed as the likely contributors to the differences. The implications of these findings are discussed.

The adolescent years are a time when significant demands are being placed on young people. Demands can include academic, personal, and social dilemmas (Shulman, Carlton-Ford, Levian, & Hed, 1995). It is furthermore, a time of major physical changes which can also influence psychological variables such as self confidence, shyness and anxiety (Frydenberg & Lewis, 1991b). These demands can generate high levels of stress for some individuals.

However, as Lazarus (1980) and Lazarus and Launier (1978) point out, stress is a normal component of living and most adolescents are able to manage it effectively. There are times however, when adolescents need to use coping strategies to manage their stress. The ability to achieve this successfully will depend on the repertoire of coping strategies known to the adolescent (Frydenberg & Lewis, 1993).

Lazarus et al., (1978) define coping as people's efforts, both physically and cognitively, to manage environmental and internal demands and. conflicts. Coping strategies require the ability to appraise situations, to search for information, to think both in the abstract and the concrete sense and to access resources and support when required.

Gender differences have been identified in the coping strategies used by adolescents, (Copeland & Hess, 1995; Frydenberg & Lewis, 1991b; Frydenberg & Lewis, 1996; Patterson & McCubbin, 1987; Seiffge-Krenke & Shulman, 1990; Spirito, Stark & Williams, 1988). Age and ethnicity have also been shown to mediate coping behaviour in this age group, (Compas, Malcarne & Fondacaro, 1988; Frydenberg et al. 1993; Seiffge-Krenke et al., 1990).

Furthermore, academic achievement has also been shown to effect coping behaviour in adolescents. Differences have been found between average achieving and capable adolescents (Frydenberg, 1993). When measured on the Adolescent Coping Scale (Frydenberg et al., 1993), capable adolescents were found to use strategies such as working hard to achieve and focusing on solving problems, whereas average achieving adolescents invested in close friends, thought things would get better, believed that they could not cope and utilised tension reduction strategies such as crying, screaming, or taking drugs (Frydenberg, 1993). Frydenberg, Lewis and Poole (1996) investigated the coping strategies used by overachieving adolescents. They found this group used problem focused coping strategies such as working and striving to achieve, trying to solve the problem and utilising social support.

Research on learning disabled adolescents and coping behaviour shows contradictory results. It would seem plausible that learning disabled adolescents have additional stresses placed on them because of the nature of their disability. They may not only have the stress of low achievement in school, but could also lack the skills required to cope because of their disabilities. Learning disabled adolescents have been shown to have cognitive and social deficits, problems in memory, perception, planning ability, motor skills and social adjustment (Shulman et al., 1995). As these attributes are necessary for functional coping and problem solving as well as learning, this group might not be equipped to manage as well as their

average or capable peers. Thus, they could be doubly disadvantaged due to the fact that they are achieving at a low level or failing at school, and may not have the skills or abilities to cope with the consequent stress.

This view has been supported by Shulman et al., (1995), who showed that learning disabled adolescents demonstrate lower levels of internal coping behaviour than their normal achieving peers. That is, learning disabled adolescents showed lower ability to appraise a source of stress and decide upon the action to be taken than their normal achieving peers. They also showed less tendency to decide independently how to manage a problem than their normal achieving peers (Shulman et al., 1995). Learning disabled adolescents have also been shown to rely more on withdrawal as a coping strategy than their normal achieving peers (Bryan & Bryan, 1981) and mobilised fewer peers for social support (Morrison, Laughlin, Smith, Ollansky & Moore, 1992).

However, Geisthardt and Munsch (1996), in a recent study reported that there were no differences in coping strategies between learning disabled adolescents and their normal achieving peers. Using the Coping Response Inventory (Ebata & Moos, 1991) they found that students coping with an interpersonal event did not differ in their reported use on any of the six individual coping strategies examined. However, in accounting for these results, the authors acknowledge that the groups were not matched in age. As Frydenberg et al., (1993) and others have shown that age effects the use of coping skills and problem solving abilities, this result could be attributed to the age differences between the two groups as the learning disabled adolescents were significantly older than their normal achieving peers. The present study therefore proposes to investigate if the coping strategies used by learning disabled adolescents are in fact different from their normal achieving peers when age, gender and ethnicity are matched.

Method

Subjects

The subjects were 60 secondary students aged from 13 years to 15 years 6 months with an average age of 13.5 years (SD = 0.63). Thirty of the students were learning disabled (LD) and were matched to thirty average to high achieving non learning disabled (NLD) students on ethnicity, gender and age. Ethnicity was determined on the basis of the language spoken at home. Each group had 28 Anglo-Australians (94%) and 2 European-Australians (6%). Gender was matched with 24 males (80%) and 6 females (20%) in each group. This approximates the ratio of 4:1 of males to females found in the learning disabled population (Durrant, 1994). There were no significant differences between the age of the groups with a mean age of 13.6 years (SD = 0.63) for the learning disabled group and 13.5 years (SD = 0.63) for the average to high achieving group $\underline{F}$ (1,58) = 0.04, n.s.

The learning disabled group was selected from students assessed by an ascertainment process conducted by the State Education Department. This involved the collection of psychological and educational achievement data leading to a case conference with the learning support teacher, the classroom teacher, the guidance officer, parents and a regional moderator. Students were placed according to their level of educational need on a six point scale, with six indicating the most severe level of learning disability. The average ascertainment level of the 30 learning disabled subjects was four. As a further check of the learning disabled students, their grades for the previous semester were examined. Only students with grades less than average in all of the core subjects of English, Mathematics and Science were included in the research.

The average to high achieving students (non learning disabled) were selected by their achievements of an average level or better in the same core subjects of English, Mathematics and Science. These students had not been through a learning disability ascertainment process.

All students were drawn from junior classes in a large urban high school in Queensland.

Materials

The Adolescent Coping Scale (Frydenberg et al., 1993) is a self report questionnaire containing 79 items where respondents indicate the frequency of adopting a described coping behaviour on a five point likert

scale (1 = "Doesn't apply or don't do it", 2 = "Used very little", 3 = "Used sometimes", 4 = "Used often", and 5 = "Used a great deal"). Previous factor analysis identified 18 scales which represent 18 common coping strategies used by adolescents (Frydenberg et al., 1993).

The 18 scales which reflect adolescent Coping are:

Scale 1: Social Support which is represented by items which indicate an inclination to share the problem with others and enlist support in its management.

Scale 2: Focus on Solving the Problem are items which focus on tackling the problem systematically and which takes into account different points of view or options.

Scale 3: Work Hard and Achieve are items describing commitment, ambition and industry.

Scale 4: Worry is characterised by items that indicate concern about the future in general or more specifically concern with happiness in the future.

Scale 5: Invest in Close Friends are items about engaging in a particular intimate relationship.

Scale 6: Seek to Belong items indicate a caring and concern for one's relationship with others in general and more specifically concern with what others think.

Scale 7: Wishful Thinking is characterised by items which are based on hope and anticipation of a positive outcome.

Scale 8: Not Coping consists of items which reflect the individual's inability to deal with the problem and the development of psychosomatic symptoms.

Scale 9: Tension Reduction is characterised by items which reflect an attempt to make oneself feel better by releasing tension.

Scale 10: Social Action items are about letting others know what is of concern and enlisting support by writing petitions or organising an activity such as a meeting or a rally.

Scale 11: Ignore the Problem is characterised by items which reflect a conscious blocking out of the problem.

Scale 12: Self-Blame is characterised by items which indicate that an individual sees him/herself as responsible for the concern or worry.

Scale 13: Keep to Self is characterised by items which reflect the individual's withdrawal from others and wish to keep others from knowing about concerns.

Scale 14: Seek Spiritual Support is comprised of items which reflect prayer and belief in the assistance of a spiritual leader or God.

Scale 15: Focus on the Positive is represented by items which indicate a positive and cheerful outlook on the current situation. This includes seeing the bright side of circumstances and seeing oneself as fortunate.

Scale 16: Seek Professional Help are items which denote the use of a professional adviser, such as a teacher or counsellor.

Scale 17: Seek Relaxing Diversions is about general relaxation. It is characterised by items which describe leisure activities such as reading and painting.

Scale 18: Physical Recreation is characterised by items which relate to playing sport and keeping fit.

Internal consistency of the 18 scales has been reported to have alphas ranging from .45 to .85. Test retest reliability over a two week period has been shown to be moderate (Frydenberg et al., 1993). In a measure of the interrelationships of the 18 individual scales, oblique factor analysis identified three styles of coping (Frydenberg et al., 1993).

The styles are defined as: 1. Solving the Problem, which represents a style of coping characterised by working at solving the problem while remaining optimistic, fit, relaxed and socially connected and includes the scales of Social Support, Focus on Solving the Problem, Physical Recreation, Seek Relaxing Diversions, Invest in Close Friends, Seek to Belong, Work Hard and Achieve and Focus on the Positive.

Style 2. Non-Productive coping which reflects a combination of what may be termed non-productive coping and avoidance strategies and includes the scales of Worry, Seek to Belong, Wishful Thinking, Not Coping, Ignore the Problem, Tension Reduction, Keep to Self and Self-Blame.

Style 3. Reference to Others where an attempt is made to access peers, professionals, deities, in a bid to deal with the concern and includes the scales of Social Support, Social Action, Seek Spiritual Support and Seek Professional Help

Procedure

Approval was obtained from the State Department of Education, the State High School, the students identified as suitable for the research and their parents. The Adolescent Coping Scale was administered to the learning disabled group and the average to high achieving group separately. This was done to minimise peer influence between the groups during the administration of the scale. Students were guaranteed confidentiality and feedback on the analysis of their responses. Reading support was provided to both groups where necessary to assist in the reading but not the interpretation of the questions.

The students were instructed to enter personal details which included name, age in years and months, sex, year level and the date of testing on the Adolescent Coping Scale form. They were instructed to think about problems they currently encounter or have encountered and respond to the 79 items.

Results

A multivariate analysis of variance (MANOVA) was conducted to compare scores between the learning disabled and the non learning disabled groups on the Adolescent Coping Scale. There was a significant difference in coping strategies used by the learning disabled and the non learning disabled groups, Pillais $F(1,58) = 2.05$, $p = <.05$. On examining the univariate F tests for the 18 coping strategies, significant differences were found between the two groups on 6 of the scales. The scales were, Solving the Problem, $F(1,58) = 8.54$, $p = <.01$, Wishful Thinking, $F(1,58) = 4.71$, $p = <.05$, Work, $F(1,58) = 14.15$, $p = <.001$, Not Coping, $F(1,58) = 6.79$, $p = <.05$, Focusing on the Positive, $F(1,58) = 4.356$, $p = <.05$, and Relaxing, $F(1,58) = 7.95$, $p = <.01$ (See Table 1).

Table 1. Mean scale scores on the Adolescent Coping Scale of learning disabled and non learning disabled adolescents.

Coping Scale	Learning Disabled (n = 30)		Non Learning Disabled (n = 30)		
Social Support	51.3	(16.2)	58.3	(14.7)	
Solving the Problem	56.3	(17.1)	68.1	(14.1)	**
Work Hard and Achieve	67.3	(13.2)	79.5	(11.7)	***
Worry	55.6	(16.9)	53.9	(15.8)	
Invest in Close Friends	60.7	(23.6)	58.7	(18.4)	
Seek to Belong	57.0	(15.9)	60.2	(13.5)	
Wishful Thinking	63.3	(15.9)	54.6	(14.9)	*
Not Coping	44.8	(13.7)	37.0	(8.8)	*
Tension Reduction	40.7	(13.2)	37.6	(11.9)	
Social Action	38.1	(14.4)	32.8	(12.0)	
Ignore the Problem	51.3	(12.9)	45.7	(13.3)	
Self Blame	47.3	(12.9)	46.8	(18.4)	
Keep to Self	55.7	(15.6)	55.7	(15.1)	
Seek Spiritual Support	40.3	(19.9)	37.5	(15.7)	
Focus on Positive	60.1	(17.6)	69.1	(15.8)	*
Seek Professional Help	38.0	(13.9)	35.8	(14.1)	
Seek Relaxing Diversions	75.4	(18.4)	87.5	(14.8)	**
Physical Recreation	74.9	(18.4)	71.6	(16.5)	

* $p < .05$

** $p < .01$

*** $p < .001$

A further MANOVA also revealed differences between the learning disabled group and the non learning disabled group on the style of coping, Pillais $F(1,58) = 3.91$, $p = <.05$. The univariate F tests showed significant differences on the style of Working at Solving the Problem, Pillais $F(1,58) = 9.56$, $p = <.01$. The learning disabled group (Mean 18.0, SD 4.4) used this style less than the non learning disabled group (Mean 20.9, SD 2.6). The other two styles of Referring to Others (LD Mean 9.1, SD 2.8 and NLD Mean 9.4, SD 1.9) and Non Productive Coping (LD Mean 25.8, SD 4.4 and NLD Mean 26.2, SD 4.3), revealed no significant differences.

Discussion

The results showed that adolescents with learning disabilities use coping strategies that are somewhat different from adolescents without learning disabilities. The learning disabled adolescents also showed a difference in coping style from their average achieving peers.

Six of the 18 scales of the Adolescent Coping Scale showed differences between the learning disabled and non learning disabled adolescents. Learning disabled adolescents used strategies such as wishful thinking and believing that they were not coping more than the average achieving adolescents, whereas productive strategies such as focusing on the positive, relaxing and working to solve the problem were used less. The remaining scales showed no differences between learning disabled and non learning disabled adolescents. However, the scale that describes the coping strategy of seeking social support showed a trend towards a significant difference, with the learning disabled adolescents preferring not to use this strategy as much as their average achieving peers.

Overall, learning disabled adolescents used a coping style that focused on the problem much less than their average achieving peers. The remaining styles which reflect reference to others and non productive coping showed no significant differences between the two groups.

The differences found in adolescent coping styles and strategies in this study may be explained by considering the characteristics of the individuals that make up the groups themselves.

The learning disabled population have been found to have deficits in cognitive and social skills (Shulman et al., 1995) which appear to be important factors in functional coping. The cognitive factors include the ability to appraise a situation and to decide on appropriate action when needed. Learning disabled adolescents have been shown to have an overall lower tendency to approach, appraise and decide independently how to overcome a problem (Shulman et al., 1995). As learning disabled adolescents have been found to have delays in problem solving (Andersson, Richards, & Hallahan, 1980; Barton, 1988) it would seem reasonable to assume that this could effect their ability to use functional coping measures. That is, the ability to decide and access appropriate strategies that will ensure a positive and effective outcome.

Learning disabled adolescents have also been shown to lack the social skills needed to establish and maintain relationships (Carlson, 1987; Feigin & Meisgeier, 1987; Hoyle & Serafica, 1987). As effective coping requires the ability to access support, establish relationships and communicate needs when required, the learning disabled adolescents are further disadvantaged due to their deficits in these important aspects of coping. It would seem therefore that this group would not use social strategies to cope, as much as average achieving adolescents. This, however, was not entirely borne out in this study. There was no difference in the style of coping in referring to others but there was a trend showing that learning disabled adolescents did not use social support as much as their non learning disabled peers.

Implications of these findings are that educators of early adolescents need to know that differences exist in the ways that learning disabled adolescents cope compared to non learning disabled adolescents. As the strategies adopted by learning disabled adolescents are primarily non functional, educators need to consider this when planning educational programs and intervention strategies.

General awareness raising both for parents and educators in schools, together with teacher training programs which focus on productive strategies of coping, as well as social skills training for learning disabled students need to be implemented. Specific programs in schools could include peer support, in the form of a buddy system for identified learning disabled students when they enrol in secondary school. Programs could also include self efficacy, life skills, confidence building, problem solving, communication, forming friendships and programs that assist the learning disabled student to identify and plan for short

and long term realistic and achievable goals.

Educators also need to consider the appropriateness of the current curriculum and assessment practices for this population in secondary schools. The current focus on academic achievement and expected outcomes is the same for both learning disabled and non learning disabled students. These expectations appear to be inappropriate for many of the learning disabled students and could have an impact on their confidence, willingness and motivation to attempt new work. Perhaps a focus on life skill issues and an assessment of a less academic nature could change the emphasis for these students to more achievable, realistic goals.

Further studies into appropriate curriculum and factors that have an influence on the learning disabled adolescents' confidence and willingness to work could be valuable for learning disability research. As this study found that learning disabled adolescents showed less willingness to work to achieve, research into mediating factors could assist our understanding of this disability.

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