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EVALUATION OF THE COPING SKILLS OF ADOLESCENTS WITH ALCOHOL AND SUBSTANCE ADDICTION

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M.Sc. THESIS

HAWAH BEAUTY JACKSON

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M.Sc. THESIS

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June, 2023

Approval

We certify that we have read the thesis submitted by Hawah B. Jackson titled **"Evaluation of the Coping Skills of Adolescents with Alcohol and Substance Addiction"** and that in our combined opinion it is fully adequate, in scope and in quality, as a thesis for the degree of Master of Nursing.

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Declaration

I hereby declare that all information, documents, analysis, and results in this thesis have been collected and presented according to the academic rules and ethical guidelines of the Institute of Graduate Studies, Near East University. I also declare that as required by these rules and conduct, I have fully cited and referenced information and data that are not original to this study.

Hawah B. Jackson

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Thanks be to God, the Father of our Lord Jesus Christ, who has blessed me with everything that I need for life and godliness, including the ability to study and the motivation to do so, in order to pursue a vocation that I am passionate about.

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Hawah Beauty Jackson

Abstract

Evaluation of the Coping Skills of Adolescents with Alcohol and Substance Addiction

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The purpose of this study was to evaluate the coping skills of adolescents with alcohol and substance addiction. The descriptive design was used for this study. The study group population included 70 adolescents with alcohol and substance addiction undergoing therapy at the E.S. Grant Rehabilitation Center, in the city of Monrovia, Montserrado County, Liberia. For the control group, 70 adolescents were taken from the J.W. Harris High School in the city of Monrovia, Montserrado County, Liberia. The ages of adolescents ranged from 12-20. The data were collected through a personal identification form and The Coping Scale for Children and Youth in December 2022. Most of the adolescents in the study group were male (75.7%), while most of the adolescents in the control group were female (51.4%). Regarding Assistance seeking, adolescents with alcohol and substance addiction had a median score of 11. As for Cognitive-Behavioral Problem Solving, they had a median score of 24. In Cognitive Avoidance, they had a median score of 26. Regarding Behavioral Avoidance, they had 14. Adolescents with alcohol and substance addiction tend to use less negative coping strategies such as behavioral avoidance compared to the control group. Urban adolescents in the study group had more Assistance Seeking and Cognitive Behavioral problem solving than those from rural settings. There should be trainings on positive coping strategies for adolescents.

Keywords: coping skills, alcohol, substance addiction, adolescent, Liberia

Özet

Alkol ve Madde Bağımlılığı Olan Ergenlerin Başa Çıkma Becerilerinin Değerlendirilmesi

Jackson, Hawah Beauty

Yüksek Lisans, Hemşirelik

Haziran 2023, 67 Sayfa

Bu çalışmanın amacı, alkol ve madde bağımlılığı olan ergenlerin baş etme becerilerini değerlendirmektir. Bu çalışma için betimsel desen kullanılmıştır. Çalışma grubu Liberya, Montserrado County, Monrovia şehrinde bulunan E.S. Grant Rehabilitasyon Merkezi'nde tedavi gören alkol ve madde bağımlısı 70 ergenden oluşmaktadır. Kontrol grubu için Liberya, Montserrado County, Monrovia şehrindeki J.W. Harris Lisesi'nden 70 ergen alınmıştır. Ergenlerin yaşları 12-20 arasında değişmektedir. Veriler birey tanıtım formu ve Çocuklar ve Gençler için Başa Çıkma Ölçeği aracılığıyla Aralık 2022'de toplanmıştır. Çalışma grubundaki ergenlerin çoğu erkek (%75,7), kontrol grubundaki ergenlerin çoğu ise kızdır (%51,4). Yardım arama konusunda, alkol ve madde bağımlılığı olan ergenlerin medyan puanı 11'dir. Bilişsel-Davranışsal Problem Çözme konusunda ise medyan puanı 24'tür. Bilişsel Kaçınma alanında medyan puanı 26'dır. Davranışsal Kaçınma konusunda ise 14 puan almışlardır. Alkol ve madde bağımlılığı olan ergenler, kontrol grubuna kıyasla davranışsal kaçınma gibi olumsuz başa çıkma stratejilerini daha az kullanma eğilimindedir. Çalışma grubundaki şehirli ergenler, kırsal kesimden gelenlere göre daha fazla Yardım Arama ve Bilişsel Davranışçı problem çözme becerisine sahiptir. Ergenlere olumlu başa çıkma stratejileri konusunda eğitim verilmelidir.

Anahtar Kelimeler: başa çıkma becerileri, alkol, madde bağımlılığı, ergen, Liberya

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List of Abbreviations

WHO:	World Health Organization
SUDs:	Substance Use Disorders
PTSD:	Post-traumatic stress disorder
DBT:	Dialectical Behavior Therapy

CHAPTER I

Background

In many parts of the globe, drinking alcohol is common and used as a source of fun and relaxation. Underage drinking is a major policy issue and public health problem in many nations throughout the globe and a significant cause of unintentional mortality among young people. In addition, heavy drinking is linked to a variety of health and legal problems, including accidents, unexpected pregnancies, STDs, vandalism, and incarceration (Hingson et al, 2019).

The World Health Organization found that youth alcohol use was on the rise in 2014 (aged 13-15). Also included in the study was information on the proportion of adolescents (aged 13-15) who had used at least one alcoholic drink during the previous 30 days, as well as an analysis of the rising trend of drinking among adults aged 18 to 25 (WHO, 2018). The Seychelles had the greatest prevalence of student alcohol use in Africa (62.1% of males and 61.2% of girls), followed by Zambia (38.7% of boys and 45.9% of girls). Women in Sub-Saharan Africa are disproportionately affected by the spread of HIV and the associated poverty, both of which have been linked to increased alcohol use. Female alcohol use in Zambia is mostly attributed to economic factors and comparisons with other African nations. As a result of their economic precarity, young women are more likely to engage in prostitution and to use alcohol as part of their business (Singh et al., 2011). St. Lucia (59.2% of boys and 52.2% of girls), Uruguay (62.0% of boys and 57.7% of girls), Argentina (55.4% of boys and 49.0% of girls), and Uruguay again topped the list for the Americas (WHO, 2019).

Regarding repercussions, in all regions of the world, Europe has the highest risk for male mortality between the ages of 15 and 29, while the danger is highest among those aged 35 to 44. In this age bracket, the leading killers were accidents, violence, war, and heart disease (WHO, 2019). In 2012, alcohol was a contributing factor in the deaths of around 3.3 million people over the world. The survey found that cardiovascular illness was the leading cause of mortality, followed by accidents, gastrointestinal disorders (especially liver cirrhosis), and malignancies. Consistent with trends of alcohol use, the number of fatalities directly attributed to alcohol use is highest in the European Region and lowest in the African and Eastern Mediterranean Areas (WHO, 2019).

According to the World Health Organization, developing countries have the highest rates of alcohol use worldwide (WHO, 2019). Specifically, this is true in the South-East Asian and Western Pacific areas. Alcohol abuse among young people, namely those between the ages of 13 and 15, is a worldwide problem with far-reaching effects on both society and the person, as discussed above. According to WHO data, there is a strong correlation between alcohol intake and economic and social disadvantages (WHO, 2019).

As a result, alcoholic beverages are consumed extensively worldwide. In 2005, the average person over the age of 15 consumed roughly 6 liters of pure alcohol, as reported by the World Health Organization (WHO, 2019). The survey found that drinking rates were on the rise among both underage and young adult adolescents (those aged 18–25). Researchers found that high school students' drinking rates only rose from there (Chartier et al., 2018).

Substance abuse is the repeated, non-medical use of any chemical substance to produce altered states of consciousness that are harmful to one's own physical or mental health or the health of others. Substance abuse includes both the inappropriate use of legally available drugs (prescription medicine) and the unlawful use of drugs like cocaine and cannabis, all of which have negative effects on the health and safety of teenagers and on society.

Substance misuse is a problem among adolescents, and this includes both illicit and legal drugs. Over the counter and prescription medications such as pain relievers, tranquilizers including benzodiazepines, cough mixtures including codeine, and slimming pills are examples of legal drugs (Rice et al., 2018).

Researchers from across the globe have examined teenage drug abuse. Approximately 13 million 12-17-year-olds experiment with alcohol, cigarettes, and other drugs every year (Lennox & Cecchini, 2008). Additionally, a study by the Canadian Centre on Substance Abuse (2002) found that the median age of first-time drug users was 12. Of the students in grades 7-12, around 64.7% have tried alcohol, 29.0% have tried cannabis, 43.0% have tried cocaine powder, and 4.0% have tried other drugs including heroin, ketamine, or crystal methamphetamine (Canadian Centre for Substance Abuse, 2023).

The United Nations Office on Drugs and Criminality (2019) states that unemployment, poverty, and general crime all contribute to drug usage. Many households and neighborhoods are being wiped out by these societal evils. Currently,

South Africa is being inundated with substances from all over the globe. Drug dealers coerce young people into trying drugs; once hooked, the users might get their peers to try drugs as well (United Nations Office on Drugs and Crime, 2019). Unfortunately, many young people nowadays see drug use as a natural and even desirable aspect of coming of age. Substance dependency has major negative implications, yet few people recognize them (Madu & Matla, 2018).

Adolescent substance addiction has significant economic consequences for every nation. Evidence of this may be seen in the substantial funding given to clinics throughout South Africa that focus on prevention and treatment (United Nations Office on Drugs and Crime, 2019). Since poverty is a contributing factor to drug misuse, this has far-reaching effects on the whole nation and might be employed elsewhere, such as in poverty reduction programs.

In order to prevent young people from being entangled with drugs, several organizations regulate drug distribution. The Liberia Drug Enforcement Agency, the Liberian National Police, etc., are only a few examples. It is believed that two out of every ten young people in the country of Liberia use illicit drugs. These young individuals who live in ghettos, on street corners, and in cemeteries often turn to criminal activity, including armed robberies, in order to satisfy the need for and the need to utilize narcotic narcotics (UNFPA Liberia, 2022).

Addiction to substances is a serious challenge for individuals living in post-conflict areas, and it has a detrimental effect on both their physical and mental well-being (Kohrt et al., 2018). After a civil war that lasted for fourteen years in Liberia, it is believed that drug abuse is a major component that contributes to the rise in interpersonal violence, sexual risk-taking, and other issues that plague Liberian culture. This belief stems from the fact that drug abuse is prevalent in Liberia today. On the other hand, in Liberia, not all aspects of the issue, including its existence, fundamental origins, and impacts, are well understood. Because of information gaps related to substance use, it is difficult to conduct in-depth studies to estimate the amount of drug use, and it is also difficult to provide support to the community of individuals who use drugs (Kohrt et al., 2018).

The approach to overcoming difficult circumstances or demands is known as the “coping style,” and it has the potential to significantly impact how you feel (Berry et al., 2022). According to the results of Mason et al., (2018) research, there are three basic ways to deal with stressful situations. These include task orientation,

emotion orientation, and avoidance orientation (Mason et al., 2018). Your coping style may remain largely the same despite the variety of events and experiences you encounter, but the specific coping techniques you use within this wider framework may alter and develop over time (Berry et al., 2022). The researchers argue that a higher assessment and validity made be achieved by concentrating on coping techniques within particular settings rather than on how a person generally copes with stress. This is because the researchers feel that concentrating on coping techniques within certain circumstances will generate more accurate findings (Berry et al., 2022).

To develop effective public health strategies to deal with the problem of substance abuse among Liberian youth, it is important to know more about substance abuse's major themes and how they affect both individuals and the environment (Blom et al., 2021). This is important to know to come up with effective public health plans to deal with the problem of drug abuse among Liberian youth (Mwanri, L., & Mude, W. 2021). This knowledge will be essential for developing effective public health measures to address the issue of drug addiction among Liberian kids.

Liberia, a country in West Africa, ended a violent 14-year civil war in 2003 after devastating damage was done to the country's infrastructure in the areas of economy, health, infrastructure, and education (Kudesia, 2019). The rehabilitation of Liberia is still hampered by the prevalence of chronic diseases including HIV/AIDS, mental illness, and substance use problems (Hook et al., 2020). From an economic perspective, Liberia is still regarded as having one of the world's poorest and unhappiest populations (Multidimensional Poverty Index, 2022). Unfortunately, even though there has been some progress in the schooling rates of young people in sub-Saharan Africa, there has been a worrying increase in the prevalence of high-risk behaviors, such as the use of alcohol and other drugs, among young people in the area (Cordeiro et al., 2019).

Statement of the Problem

Many young people's drug usage involves the use of many substances at once, making substance misuse among teenagers a huge public health issue (Schulenberg & Maggs, 2002). Many youths develop a substance use problem as a direct result of their drug use, and these repercussions last a lifetime. It seems that many persons, beginning in adolescence and continuing into adulthood, acquire the required

behavioral and physiological signs of addiction, demonstrating that they are reliant (Schulenberg & Maggs, 2002).

Many factors contribute to young people's experimentation with and ultimately abuse of drugs. Devastating impacts on persons and society are caused by the accumulation of risks (Siegel, 2021).

Purpose of the Study

The objectives of the study are as follow:

1. To evaluate the coping skills of adolescents with alcohol and substance addiction.
2. To establish whether there is a difference between the coping skills of adolescents with alcohol and substance addiction and the coping skills of adolescents without alcohol and substance addiction.
3. To examine the factors that affect the coping skills of adolescents with alcohol and substance addiction.
4. To examine the factors that affect the coping skills of adolescent without alcohol and substance addiction.

Research Questions/Hypotheses

1. What are the coping skills of adolescents with alcohol and substance addiction?
2. Is there a difference between the coping skills of adolescents with alcohol and substance addiction and the coping skills of adolescents without alcohol and substance addiction?
3. What factors affect the coping skills of adolescents with alcohol and substance addiction?
4. What factors affect the coping skills of adolescent without alcohol and substance addiction?

Significance of the Study

In order to create efficient public health policies to combat the issue of drug misuse among young people in Liberia, it is crucial to have a deeper understanding of the fundamental themes surrounding substance abuse and its effects on both the individual and the larger community. This knowledge is critical for developing public health strategies to combat the issue of drug misuse among young people in Liberia. The results of this research will be crucial for shaping public health policies

that effectively address the problem of drug addiction among Liberian youth. Without a doubt, the results of this research will be useful to Liberian politicians and health authorities. Admittedly, the study's results will be of great assistance to other researchers who are interested in the effects of alcohol and drug misuse on adolescents.

This study will contribute to a more thorough comprehension of the serious issue of drug usage and may pave the way for the creation of intervention strategies that are both appropriate and successful in Liberia.

This research will aid policymakers in drafting laws that promote adolescents' coping abilities; it will also aid doctors, social workers, and nurses in developing preventative and curative tools for young people experiencing emotional distress; and it will aid governments in formulating more all-encompassing rules and regulations.

Limitations

This research has a few limitations. For starters, the sample was only drawn from the E.S. Grant Rehabilitation Center in Monrovia and the J.W. Harris School in Monrovia; therefore, its results may not be applicable to a broader level or to suit other country's case or context. Since this study relied on a self-administered questionnaire, there's a chance that some participants didn't fully grasp the nature of the questions being asked and therefore picked an answer at random without giving it much thought.

Definition of Terms

Addiction: is the act of refusing to abstain from a drug or habit despite its negative effects on one's mental and physical health.

Adolescence: is the time of life when a person is changing and maturing between childhood and maturity.

Coping Style: the approach to overcoming difficult circumstances or demands is known as the "coping style," and it has the potential to significantly impact how you feel.

Substance Abuse is the misuse or excessive use of any drug, including alcohol, prescription medication, and illicit drugs.

CHAPTER II

Literature Review

The use of illicit substances by teenagers has reached epidemic proportions, and early onset poly-substance use is becoming increasingly prevalent among people in this age range. Monitoring the Future's annual study from 2019 found that 48.3% of 12th students having used an illicit substance at some time in their life, and 24.4% of those 12th graders have tried drugs during the prior 30 days (Schulenberg & Maggs, 2002). Many adolescents who start using drugs at a young age are at risk of developing a substance use disorder in their later years. Many people appear to develop the necessary behavioral and physiological indicators of addiction during the course of adolescence and adulthood, which is a trajectory that suggests they will eventually satisfy the criteria for dependence. Some cases of substance use disorders (SUDs) in adolescents are self-limited and only last a short time, while other cases are chronic and can lead to a person spending their entire life trying to maintain sobriety. Adolescent substance use disorders (SUDs) range from mild to severe, with some cases being self-limited and lasting just a short time (Cohen et al., 2020). There are scores of elements that add to an increase in the probability of a teenager using drugs for the first time and subsequently developing an addiction. Because of the buildup of risk factors, both individuals and families, as well as communities, are subjected to significant amounts of suffering (Cohen et al., 2020).

Adolescent Substance Use

When teenagers start using drugs before the age of 18, they place themselves at a greatly greater risk of developing a substance use disorder before the age of 20. This has serious repercussions that may end in difficulties with drug usage and sobriety that last a person's whole life. In 2015, the National Survey on Drug Use and Health found that 1.2 million teenagers between the ages of 12 and 17 who matched the criteria for a substance use disorder (SUD) (SAMHSA, 2021). Adolescents have unique challenges when it comes to receiving treatment services, frequently exceeding those faced by adults. Adolescents need individualized treatment plans that take into consideration their age, level of development, level of family reliance, and cognitive capacities. All these facets of a person's life are very different between adults and teenagers, making direct comparisons between the two groups problematic. Without proper intervention, the prevalence of drug abuse disorders among adults rises steadily: from 1.2 million people aged 12–17, the number of

people who fulfill the criteria for a substance use disorder rises to 5.3 million people aged 18–25 (SAMHSA, 2021).

Co-occurring Disorders

Adolescents' mental health, especially in the areas of emotion control and drug use, suffers when depression is present, making it the second most prevalent co-occurring disease. Roughly 75% of young adults struggle with both drug abuse and mental health issues simultaneously. The second most prevalent comorbidity is depression (Hersh et al., 2018). A study that tracked children from the ages of 9 to 13 over the course of many years revealed that those who showed early indications of internalizing illnesses, notably anxiety and depression, were at an elevated risk for the onset and continuing misuse of alcohol (Costello et al., 2019). Adolescent depression has been linked to a host of negative outcomes in later life, including difficulties in social and academic functioning, an increased risk of smoking and substance misuse, an increased risk of obesity, an increased risk of suicidal behavior, and an increased risk of anxious and bipolar disorders (Thapar et al., 2022).

Getting clean and staying sober may be very challenging for adolescents whose primary problem is drug misuse, and these adolescents confront a variety of obstacles along the way. Individuals with comorbid illnesses, such as depression, have a higher chance of negative consequences including suicide attempts, smoking, and other mental health problems, as well as a higher death rate. As a result, the risk factors increase for these individuals (Aharonovich et al, 2022). The co-occurring illnesses may present themselves in a variety of ways: teenagers may struggle with a mental health problem that either causes or helps to moderate their drug use; alternatively, adolescents may acquire mental health disorders as a direct result of their substance use (Hersh et al., 2018).

The National Survey on Drug Use and Health in 2015 found that there are 350,000 teenagers who have diagnoses of both drug misuse and mental health conditions simultaneously (SAMSHA, 2021). Adolescents at risk of developing drug use disorders, depressive symptoms, and ineffective coping with emotional distress are prone to experiencing a number of co-morbidities, as has been proven throughout time.

Depression is the second most prevalent co-occurring illness with drug use among adolescents, and it is estimated that between 20 and 30 percent of the population suffers from this condition (Hersh et al., 2019). There is still a lack of a

complete knowledge of whether co-occurring condition, either depression or drug abuse, arises first, and whether this has an influence on the therapy that teenagers get (Hersh et al., 2019). Adolescents who suffer from both mental health and drug use problems have unique treatment needs, and thus need specialized care plans and coordination of care. Evidence-based integrated treatments, such as cognitive behavioral therapy and motivational interventions, have been proven to potentially address drug use disorder and mental health condition simultaneously (Hawkins et al., 2019).

Recent studies have demonstrated that many young adults develop effective responses to depression. But other teens start using drugs because they engage in risky behavior to cope with their own emotions of emotional dysregulation (Auerbach et al., 2019). Many young people who experience depression state that they have participated in these potentially harmful actions in order to get brief respite from their feelings of emotional pain. High-risk conduct may become normalized and the go-to approach for young people to deal with their incapacity to withstand subsequent suffering, which is problematic since it reinforces the risky behavior rather than teaching them other, healthier coping mechanisms (Auerbach et al., 2019).

Factors to Adolescent Substance Use

Several routes, including those leading from depressive symptoms and emotion dysregulation to stressful life events and self-control, may be traced back to the presence of links between individual and environmental risk and protective variables for kids who are at risk. The presence of familial risk factors, such as a parental history of drug abuse, consistent family life, ineffective emotion management, and maladaptive coping abilities, all have a negative influence on the likelihood that teenage children will begin using substances (Gruber & Taylor, 2018).

It is more probable that a child will develop psychological and behavioral issues if they are raised in a home with a parent who uses drugs or alcohol (Gruber & Taylor, 2018). Research that followed participants over time found a correlation between young people who had parents who abused alcohol and the progression of problem drinking among teenagers, as well as the continuation of such behavior into adulthood. There is a strong and consistent body of research that relates a parent or

guardian's drug usage to their child's involvement in and reliance on substance use (Iacono et al., 2020).

Child risk factors identified by Clark and colleagues (2019), who followed adolescents aged 11 to 19, were parental SUD, early adolescent cigarette or alcohol use, and adolescent difficulties in controlling their emotions. According to the findings of this research, teenagers who had two parents who abused substances were at a dramatically increased risk of becoming involved with these substances themselves. It was claimed by adolescents that they often began using drugs as a form of rebellion or to alleviate stress at home; however, those adolescents whose families had supportive connections indicated that these relationship traits served as a barrier for drug use (Gruber & Taylor, 2018).

Substance addiction is associated with considerable difficulties in emotion regulation, such as low distress tolerance (the amount of bodily pain one can endure) and poor coping skills (the capacity to avoid or change unpleasant emotions) (Siegel, 2021). To a large extent, adolescents' drug usage is correlated with their ability to manage their emotions. Substance use was shown to have direct correlations with internalizing and externalizing symptoms, including depressive symptoms, and emotional dysregulation. Patterns of increasing difficulty in emotion regulation and subsequent coping altered the routes to drug use. Substance use often begins early in life for those who repress their emotions or rely on others for emotional support. Adolescents' displays of increasing problems with emotion regulation and depressive symptomology are moderated by their parents' levels of emotional dysregulation (Gratz et al., 2019). Teens at risk for problems with emotion regulation and substance abuse often experience negative effects from family relationships (i.e. family attachment patterns, conflict, and substance use) (Siegel, 2021).

Young people at risk who are just beginning the process of sobriety have a number of challenges. The accumulation of risk factors, such as depressive symptomology and emotion dysregulation as a result of drug use, affects an adolescent's capacity to stay sober (Sinha, 2018).

Treatment for Substance Abuse and Emotional Regulation

The capacity to control one's emotions is fundamental to one's mental health, and persistent issues in this area have been related to disease. It has been established via research that early intervention and preventive strategies for drug using kids should prioritize the treatment of underlying mental illnesses, such as depression

(Siegel, 2021). Increases in general happiness have been shown to have a beneficial effect on young people who use drugs in a number of studies. In particular, cognitive frameworks, like cognitive behavioral therapy, have been shown to be useful in addressing and enhancing emotion control through mindfulness (Kaplan et al., 2021). While the data on treatment results for co-occurring disorders is still ambiguous, DBT has been shown to reduce depressive symptoms (Ritschel, Cheavens & Nelson, 2021). When applied to kids with multiple problems, dialectical behavior therapy (DBT) emphasizes the two-way impact of one's surroundings on his or her mental health. DBT targets those who are unable to apply coping strategies in a healthy manner due to personal and environmental risk factors such as difficulties with emotional and self-regulation and a low tolerance for suffering. Negative behavioral patterns might develop as a result of using maladaptive coping strategies (Linehan, 2014; Farris et al., 2016).

DBT has been shown to be effective for substance abuse disorder and co-occurring disorders (Dimeff, 2022; Reynolds et al., 2009). Substance abuse is often used as a strategy to cope with or alleviate negative emotions, and one goal of therapy is to help patients learn to better regulate their emotions and therefore gain more behavioral control. Depression and emotional dysregulation are two symptoms of internalizing disorders that may be exacerbated by drug use, making it crucial to understand how this may affect treatment strategies (Asarnow et al., 2021).

Coping

Significant theoretical and empirical research has accumulated over the last two decades on the link between exposure to stressful life events and subsequent declines in physical and mental health (Coghlan et al., 2019). Individuals' coping abilities and patterns of behavior are only two of the numerous factors thought to moderate the connection between stress and the results of any attempts at adaptation. Historically, research on coping has focused on either (a) the impact of coping processes on adjustment, or (b) the creation of a typology of coping strategies. (Kothari et al., 2022).

Different methods have been used to categorize coping behavior, but the dichotomy between approach (or confrontational) and avoidance (or evasive) tactics remains consistent across the board. The first group engages in actions that aim to alter the stressful circumstance or lessen the suffering they experience, whereas the

latter group engages in actions that either sidestep or indirectly address the underlying cause of the stress. Other classifications have made a distinction between active and passive techniques as well as between behavioral and cognitive ones. One such theory of coping divides coping methods into primary and secondary categories (Kothari et al., 2022). Within this framework, "primary coping" refers to actions taken to alter the underlying conditions or events that are causing the stress, while "secondary coping" refers to actions taken to ensure the greatest possible degree of "goodness of fit" between oneself and the circumstances.

The vast majority of studies on stress and resiliency to far have included adults. Children's coping attempts and adaptive outcomes have only recently started to be used theoretical models and intervention tactics generated from this research. However, this is not because children's lives are devoid of stress; on the contrary, it is evident that children face a wide variety of major and minor stressors such as the loss of a parent, parental separation or divorce, illness in the family or oneself, parental unemployment, difficulties with peers or in school, family violence, and so on (Haggerty et al., 2021). When children's coping strategies fall short, they, too, exhibit a broad variety of negative behavioral, emotional, and physical responses (Compas et al., 1988).

Compas et al. (1993) noted in a review of the literature on children's coping that recent attempts to investigate children's coping behavior have relied heavily on interview procedures. This method offers the benefit of yielding a wide variety of data and the advantage of procedural flexibility and maximal response variability, but it also has numerous downsides. The most significant of them include the potential for interviewer bias, the absence of uniformity among individuals, and the inter-investigator heterogeneity in the process of classifying the narrative data into valid and theoretically equivalent coping categories. Collection of data from large samples of children's coping experiences is complicated by the need to conduct individual interviews. Observational methods have also been used in studies to collect information on how youngsters are able to deal with adversity (Curry et al., 2020).

Multiple research projects, all using various coping theories, have shown a correlation between teenagers' emotional focus and higher rates of drug use, and adolescents' problem focus with lower rates of substance use (Aldridge-Gerry et al., 2019). Positive coping behaviors, such as religious involvement, planning ahead, and

social support, were associated with lower alcohol use among adolescents, whereas negative coping behaviors, such as denial, disengagement, and drinking to deal, were associated with higher consumption.

Wills, Sandy, Yaeger, Cleary, and Shinar (2011) performed study on gender differences in adolescent coping and substance use and found that girls exhibit a stronger positive association between life stress and drug use than males. Wills et al. (1995) observed no differences in the effects of coping on drug use based on gender.

Co-rumination, which consists of "excessively discussing difficulties," is an emotion-focused coping strategy that may be more common among adolescent females than boys. Adolescent females who engage in co-rumination are less likely to have internalizing symptoms like sadness and anxiety, but they are more likely to experience issues in their friendships, according to research by Hong et al. (2019). Although teenage females may be at a higher risk for internalizing symptoms when engaging in co-rumination, Hong et al. (2019) argued that the positive friendship advantages of co-rumination may be more reinforcing for this population.

Cognitive Avoidance

Cognitive avoidance is an effort to avoid unfavorable occurrences that may be presented intellectually (denial, thought replacement, and thought suppression), as well as behaviorally (avoiding responsibilities and drug usage). Cognitive avoidance is a kind of avoidance behavior (Farris et al., 2016). The term "avoidance" refers to the process of avoiding an activity, a person, or an item, which temporarily alleviates one's suffering but leads to a greater level of ongoing uneasiness in the long run. Avoidance is not an effective strategy since it inhibits people from displaying appropriate reactions to emotional stimuli and leads to the replacement of techniques for emotion management. Therefore, avoidance is not a strategy (Hong, 2019).

Cognitive avoidance has been shown to play a role in anxiety disorders, depression disorder, hyperactivity disorder, anti-social behaviors, and the tendency toward alcohol and substance use in some studies (Hong et al., 2019).

The authors of the research that was conducted by Pomerleau and Pomerleau (2019) demonstrate that there is a positive correlation between the cognitive avoidance score and cigarette smoking. Hong et al. (2019) conducted an experiment with 17 male smokers and discovered a correlation between cognitive avoidance and cigarette use. According to the findings of Shadel et al., (2019), there is a positive correlation between nicotine dependence and cognitive avoidance. Accordingly,

Farris et al. (2016) demonstrated how the practice of cognitive avoidance might reduce the risk of relapse and satisfy cravings in nicotine-dependent individuals.

Some societies are more prone to experience stress than others, and this disparity can be attributed to several factors, including racial or ethnic background, socioeconomic standing, and the social conditions that prevail in that society. These factors can result in mental disorders or cognitive dysfunctional patterns (Zarani et al., 2019). One might make the argument that certain forms of coping methods can either decrease or raise an individual's likelihood of engaging in drug use (Capella & Adan, 2017).

In its widest definition, coping refers to the emotional, cognitive, or behavioral efforts undertaken to manage, control, or eliminate a potentially harmful or destructive situation or to decrease the impact that it has on a person. Disengagement coping, which aims to avoid confrontation with a danger or avoiding stress-related feelings (Skinner & Wellborn, 2021), is often inefficient at lowering long-term suffering. While it may help a person with their well-being in the short-term. While it could improve someone's wellbeing in the near term, it often has little impact in easing long-term discomfort. One of the various disengagements coping techniques that focuses on diverting attention from an unpleasant situation is cognitive avoidance. This makes it possible to analyze the threat's presence and its effects later, if at all, leaving cognitive avoidance as one of the several disengagement coping mechanisms. Higher levels of avoidance coping are often indicative of poor outcomes, such as an increase in anxiety and depression, a reduction in positive affect, and deteriorating psychological adjustment and physical health as a result of increased exposure to the harmful health effects of stress (Penley et al. 2018). Even while it is well acknowledged that cognitive avoidance is a bad habit, some study suggests that using a distancing tactic may provide individuals the time they need to develop the right stress-management techniques and tools. When a stressor is really severe and speedy processing would be challenging, event when the stressor is uncontrollable, such as when a loved one passes away, it may also be adaptive (Folkman & Moskowitz, 2018).

Behavioral Avoidance

People engage in a variety of avoidance actions in order to either guarantee that they will not be engaged in a certain circumstance or that they will be able to exit a situation that they have already entered. These actions are also used to refer to

those who consciously avoid experiencing uncomfortable emotions. It's possible that underlying mental health problems are the cause of avoidant actions (Gazelle & Ladd, 2002).

In the field of psychology, avoidance coping is both a strategy for dealing with stressful situations and a kind of experience avoidance. It is defined by a person's attempts, conscious or unconscious, to avoid dealing with a stressor in order to shield oneself from the problems that the stressor provides. This is the defining characteristic of avoidance behavior. The avoidance coping strategy may lead to many types of escapism, such as drug misuse, social isolation, and other such behaviors. Even if someone may exhibit avoidant behaviors, this does not mean that they necessarily have avoidant personality disorder simply because they do not engage in high enough levels of these behaviors to match the criteria for this disease. The avoidance coping strategy is not just a sign of post-traumatic stress disorder (PTSD), but it is also connected to the symptoms of anxiety and depression (Gazelle & Ladd, 2002).

Unintentionally, young people participate in hazardous behaviors, and preventive activities have the potential to mitigate or eliminate the negative effects of these behaviors. Although the hazardous actions that teenagers engage in are considered to be impulsive or unplanned, the preventive practices they engage in are purposeful. Peer resistance skills, a negative attitude toward drugs, perceived self-efficacy, and high levels of self-control were shown to be four predictors of an intention not to misuse drugs. In addition, the educational standing of pupils, their interest in school, their absenteeism, and the amount of time spent with friends were all predictors of whether or not they intended to consume drugs. Intentionality is key to healthy habits. As a consequence of this, an increase in behavior intentions to abstain from drug abuse would serve as a protective factor in the fight against drug abuse among teenagers, in addition to the fight against high-risk behaviors. People tend to steer clear of potentially harmful situations whenever they can (Gazelle & Ladd, 2002).

Assistance Seeking

Social support has been shown to be a protective factor for health status in adult studies, with greater levels of support correlated with reduced levels of mental and physical symptomatology. The protective impact has been linked to social support's correlation with reduced drug use (Landis et al., 2007; Umberson et al.,

2021). Consistent research has shown that the emotional and instrumental support of parents and other adults is a protective factor (Wills et al., 1995).

Gender and Coping

Adolescents of different sexes have different worries and different coping mechanisms, which must be considered when studying how these factors evolve over time. More girls than boys report having issues, and girls tend to exaggerate the severity of their problems (Huba et al., 2021). Concern management is one area where there is continuous gender disparity. As a rule, girls are more sociable and reliant on their friends than guys. Females, according to Ptacek et al., (1994), rely more on social support, while men rely more on ventilation; males, according to Patterson and McCubbin (2021), rely more on humor, while females prioritize connections with close relatives, friends, and coworkers. Using Patterson and McCubbin's (2019) A-Cope as a gauge of coping, Copeland and Hess (2019) discovered that women used proactive orientation and catharsis while men resorted to avoidance and physical distractions. One research of teenage males revealed that high-achieving guys relied more heavily on social support than their less successful peers (Smith, Frydenberg & Poole, 2019).

CHAPTER III

Methodology

Research Design

Because of its ability to investigate and characterize the connection between variables without altering those variables, a descriptive design is a method that is most appropriate for this research. In descriptive research, some of the purposes include analysis, the identification and extraction of patterns, and comparisons for the purpose of explanation.

Participants / Population & Sample

All teenagers between the ages of 12 and 20 who were struggling with an addiction to alcohol or drugs and were undergoing treatment at the E. S. Grant Rehabilitation Center in the city of Monrovia, which is in Montserrado County, Liberia, were included in this study's population. The study group population included 70 adolescents with alcohol and substance addiction undergoing therapy at the E.S. Grant Rehabilitation Center. For the control group, 70 adolescents were taken from the J.W. Harris High School in the city of Monrovia, Montserrado County, Liberia. Ages of adolescents ranged from 12 – 20.

The E. S. Grant Rehabilitation Center is unique psychiatric hospital in Liberia. Cap Anamur, a German non-governmental organization, was in charge of running the hospital, which was a private facility. In 2008, the facility joined the public health system and is now under JFK facility management. It has a capacity for one hundred inpatients, and it offers outpatient consultations throughout the week as well as groups for those who are addicted to substances. Patients with disorders such as drug misuse, bipolar disorder, schizophrenia, anxiety, and epilepsy are admitted to the facility. The hospital is equipped with its very own laboratory, where patients may be tested for diseases including HIV, syphilis, and malaria.

The J.W. Harris School is widely regarded as one of the country's premier educational institutions of its kind. It can be found in Clara Town, which is located on Bushrod Island in Monrovia, which is the nation's capital city. The JW Harris School welcomes students of all sexes, boys, and girls. The school adheres to the philosophy that pupils should be equipped with information so that they may take the initiative in all aspects of life.

Inclusion Criteria for the study group:

- Adolescents receiving treatment for alcohol and substance abuse at the ES Grant Rehabilitation Center in Monrovia, Liberia.
- Being able to write and read English.

Inclusion Criteria for the control group:

- Adolescents attending the JW Harris High School in Monrovia, Liberia in 2022-2023 academic year.
- Being able to write and read English.

Exclusion Criteria for the study group:

- Having psychiatric comorbidity

Exclusion Criteria for the control group:

- Adolescents with alcohol and substance abuse

Data Collection Tools/Materials

The survey tool was administered using Google Survey Services. The questionnaire was shared with the participants through the rehabilitation center staff and schoolteachers.

The data were collected through a personal identification form and The Coping Scale for Children and Youth (Appendix A). The personal identification form consisted of 5 questions for the control group and 24 questions for the study group prepared based on the literature (Skinner, H. A. 1982).

The Coping Scale for Children and Youth is a self-report application gives an effective process of huge–scale data collection on Children's and Youth's coping. It was developed by Brodzinsky et al., 1992. Coping scale consists of list of statements that participants use to elevate coping strategies and the capability to self- regulates in reply to different occurrence stressors. The scale comprises of four meaningful factors and these four factors comprised of 29 items. Assistance Seeking, it consists of 4 items, interpersonal problem being solved, which as to do with getting an advice from someone and sharing feelings with someone. Cognitive-Behavioral Problem Solving, it has 8 items, and these items include both cognitive\affective and direct behavioral components. Examples include making a plan to solve the problem and then following the plan and thinking about the problem in a new way so as to minimize distress. Cognitive Avoidance has 11 items that involve the emotion management, selective attention, cognitive redefinition, and minimization of the problem. Examples include putting the problem out of one's mind, and trying to

pretend that the problem did not happen. And lastly, Behavioral Avoidance includes 6 items that has to do with taking oneself out of the surrounding area of the stressor or reducing tension by indirect means such as displacement of anger on to another person. Examples include staying away from people who remind you of the problem, or being mean to someone even though they did not deserve it. Cronbach's alpha is .72 for the Assistance Seeking subscale, .81 for the Cognitive-Behavioral Problem-Solving subscale, .80 for the Cognitive Avoidance subscale, and .70 for the Behavioral Avoidance subscale (Brodzinsky et al., 1992). In this study, Cronbach's alpha value is .772 for Assistance seeking, .921 for Cognitive-behavioral Problem solving, .935 for Cognitive Avoidance, and .771 for Behavioral avoidance.

Data Collection Procedures

The data were collected in December 2022. The questionnaire was shared with the study participants with consent from their parents and the administrators from both the school and the rehab center. The purpose of the research was explained to the study participants, parents, and administrators. It was made clear to the participants that their participation in the research is entirely voluntary, and that they are able to withdraw their consent at any point during the duration of the study.

Data Analysis/Evaluation

Descriptive statistics such as frequency distributions, mean, and standard deviations were computed. Other statistical methods to be applied to the gathered data included the Mann Whitney U test and Kruskal Wallis Analysis of Variance. Statistics Packages for social students (SPSS) version 22 was used to analyze the data and for result presentations.

Ethical Considerations

The researcher was given a letter of clearance to perform this academic study by the ethics committee of the Near East University (NEU/2022/108-1632) (Appendix B). Permission letters were obtained from the institutions where the research was conducted (Appendix C and D). The researcher communicated to the participants the information they need to understand the goal of the study. All information gathered for the purpose of this research was held in strict confidence.

CHAPTER IV

Findings

This study is about understanding the Coping Skills of adolescents with alcohol and substance addiction and the Coping Skills of adolescents without alcohol and substance addiction in Monrovia, Liberia among students aged 12-20. The actual number of participants in this study is 70 adolescents at the rehab center which are the study group and 70 adolescents taken from J. W. Harris School in Clara Town, which is the control group. Several demographic parameters were considered because of their significance in understanding the replies. Among them were the adolescent's gender, age range, county of origin, place of longest stay, and adolescent living conditions.

Demographic Data

Table 1 below the information about the adolescent's gender, age range, place of longest stay, and adolescents' living conditions for both the study and control group.

Table 1.

Respondent's Demographic Data (n=140)

	STUDY GROUP		**CONTROL GROUP**	
Variable	**n**	**%**	**n**	**%**
Gender				
Female	17	24.3	36	51.4
Male	53	75.7	34	48.6
Age Group				
12 - 14	5	7.1	7	10.0
15 - 17	36	51.4	26	37.1
18 - 20	29	41.4	37	52.9
Longest Residence				
Rural	17	24.3	24	34.3
Urban	53	75.7	46	65.7
Adolescent living condition				
Alone	3	4.3	4	5.7
With friends	5	7.1	8	11.4
Both parent	15	21.4	27	38.6
Father	7	10.0	7	10.0
Guardians	25	35.7	10	14.3
Mother	15	21.4	14	20.0
Total	**70**	**100.0**	**70**	**100.0**

Study group

Table 1 presents the demographic data of both the study and control group. The study group had 17 (24.3%) females with 53 (75.7%) males. 12 -14 years old were 5 (7.1%), 15 – 17 were 36 (51.4%) making up the largest age group, 18 – 20 were 29 (41.4%). The longest stay area of the adolescents was from the rural with 53 (75.7%) while 17 (24.3%) were from the rural. 3 (4.3%) of the adolescent live alone, 5 (7.1%) live with friends, 15 (21.4%) live with both parents, 7 (10%) live with father alone, 25 (35.7%) live with guardians, and 15 (21.4%) live with mother.

Control Group

The control had 36 (51.4%) females with 34 (48.6%) males. 12 -14 years old were 7 (10%), 15 – 17 were 26 (37.1%) and 18 – 20 were 37 (52.9%). The longest stay area of the adolescents was from the urban with 46 (65.7%) while 24 (34.3%) were from the rural. 4 (5.7%) of the adolescent live alone, 8 (11.4%) live with friends, 27 (38.6%) live with both parents, 7 (10%) live with father alone, 10 (14.3%) live with guardians, and 14 (21.4%) live with mother.

Substance use characteristics of Study Group

The study tends to understand the responses of the study group, which are adolescents who are at the Rehab center, to know their drug habits before they were taken to the rehab center.

As seen from Table 2 below, all of the adolescents at the rehab center has taken drugs other than for medical purposes 70 (100%), almost all of them have abused prescriptive drug 58 (82.1%), they have abuse more than one drug at a time 59 (84.3%), they do not go through the week without using drug 52 (74.3%), they are not able to stop using drugs when they want to 48 (68.6%), they feel bad and guilty about drug 60 (85.7%), their parents or guardian abuse drug before 43 (61.4%), they have been if problem at school because of drug 49 (70%), they have gotten into a fight because of drug 46 (65.7%), they have engage into illegal activities in order to obtain drug 35 (50%), they experience withdrawal symptoms when they stop using drugs 63 (90%), and they have gone to people for help because drug 70 (100%).

Table 2.

Drugs screening responses of the study group (n=70)

Questions	Categories	n	%
Have you use drugs other than those required for medical reasons?	Yes	70	100.0
	No	0	0
Have you abused prescription drug before?	No	12	17.1
	Yes	58	82.9
Do you abuse more than one drug at a time?	No	11	15.7
	Yes	59	84.3
Can you get through the week without using drugs?	No	18	25.7
	Yes	52	74.3
Are you always able to stop using drugs when you want to?	No	22	31.4
	Yes	48	68.6
Do you ever feel bad or guilty about your drug use?	No	10	14.3
	Yes	60	85.7
Do your parents or guardians know you are involved with drug?	No	27	38.6
	Yes	43	61.4
Do your parents or guardians ever complain about your involvement with drug?	No	21	30.0
	Yes	49	70.0
Has drug created problems between you and your parents/ guardians?	No	10	14.3
	Yes	60	85.7
Have you lost friends because of your use of drugs?	No	27	38.6
	Yes	43	61.4
Have you been in trouble at school because of your use of drugs?	No	21	30.0
	Yes	49	70.0
Have you gotten into fights when under the influence of drugs?	No	24	34.3
	Yes	46	65.7
Have you engaged in illegal activities in order to obtain drugs?	No	35	50.0
	Yes	35	50.0
Have you been arrested for possession of illegal drugs?	No	48	68.6
	Yes	22	31.4
Have you had “blackouts” or “flashback” as a result of drugs use?	No	3	4.3
	Yes	67	95.7
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	7	10.0
	Yes	63	90.0
Have you had medical problems as a result of your drugs use (e.g. Memory loss, Hepatitis, convulsions, bleeding, etc.)?	No	8	11.4
	Yes	62	88.6
Have you gone to anyone for help for a drug problem?	Yes	70	100.0
	No	0	000
Have been involved in a treatment program specifically related to drug use?	Yes	70	100.0
	No	0	000.0

Findings for Research Question I

What are the coping skills of adolescents with alcohol and substance addiction?

Table 3.

The Descriptive Statistics of the coping scores of adolescents in both the study and control groups (n=70)

Scale	Study Group				Control Group			
	Mean	SD	Median	Min-Max	Mean	SD	Median	Min-Max
Assistance Seeking	10.61	1.32	11	7-13	10.24	2.39	10	5-16
Cognitive-Behavioral Problem Solving	22.24	5.97	24	8-32	22.35	4.77	23	9-32
Cognitive Avoidance	28.05	7.22	26	13-44	26.3	6.69	25	11-41
Behavioral Avoidance	13.95	2.21	14	6-22	15.65	3.41	16	7-24

Table 3 above represents the coping scores of adolescents regarding Assistance Seeking, Cognitive-Behavioral Problem Solving, Cognitive Avoidance, and Behavioral Avoidance of both the study and control groups.

Regarding Assistance seeking, the study group has a median score of 11. In contrast, the control group has a median score of 10. As for Cognitive-Behavioral Problem Solving, the study group has a median score of 24 and the control group has 23. In Cognitive Avoidance, the study group has a median score of 26, while the control group has a score of 25. Lastly, regarding Behavioral Avoidance, the control group has a median score of 16. In contrast, the study group has 14, showing that the control group has a high Behavioral Avoidance attitude as compared to the study group.

Findings for Research Question 2

Is there a difference between the coping skills of adolescents with alcohol and substance addiction and those of adolescents without alcohol and substance addiction?

Table 4.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills according to the group of adolescents.

Scale	Group	n	Median (Min-Max)	Mean Rank	Sum of Ranks	U	p
Assistance Seeking	Control	70	10(5 – 16)	66.92	4684.50	2199.5	.287
	Study	70	11(7 – 13)	74.08	5185.50		
Cognitive Behavioral problem solving	Control	70	23(9 – 32)	69.95	4896.50	2411.5	.872
	Study	70	24(8 – 32)	71.05	4973.50		
Cognitive avoidance	Control	70	25(11- 41)	67.06	4694.50	2209.5	.315
	Study	70	26(13 – 44)	73.94	5175.50		
Behavioral avoidance	Control	70	16(7– 24)	82.44	5771.00	1614	.000**
	Study	70	14(6 – 22)	58.56	4099.00		

P≤0.05* p≤0.01**

As seen from table 4 above, there is no statistically significant difference related to Assistance seeking, cognitive behavioral problem-solving, and cognitive avoidance of adolescents between the study and control group. There is, however, a significant difference related to behavioral avoidance of adolescents between the study and control group ($p < 0.001$). The Control group (16) has a higher medium score as compared to the study group (14).

Findings for Research Question 3

What factors affect the coping skills of adolescents with alcohol and substance addiction?

As seen from Table 5 below, there is no statistically significant difference in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the study group according to the gender of the adolescents.

Table 5.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the study group according to the gender of the adolescents

Scale	Gender	n	Median (Min-Max)	Mean Rank	Sum of Ranks	U	p
Assistance Seeking	Male	53	11(7– 13)	35.18	1864.50	433.5	.807
	Female	17	11(8– 13)	36.50	620.50		
Cognitive Behavioral problem solving	Male	53	24(8– 32)	33.93	1798.50	367.5	.250
	Female	17	24(16–32)	40.38	36.50		
Cognitive avoidance	Male	53	26(17–44)	35.23	1867.00	436	.842
	Female	17	25(13–44)	36.35	618.00		
Behavioral avoidance	Male	53	14(6– 22)	37.29	1976.50	355.5	.184
	Female	17	13(12–18)	29.91	508.50		

P≤0.05* p≤0.01**

Table 6.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the study group according to the adolescent's longer stay area

Variable	Area	n	Median (Min-Max)	Mean Rank	Sum of Ranks	U	p
Assistance Seeking	Rural	17	10(7– 12)	21.50	365.50	212.5	.001**
	Urban	53	11(7– 13)	39.99	2119.50		
Cognitive Behavioral problem solving	Rural	17	16(8– 31)	23.21	394.50	241.5	.004**
	Urban	53	24(8– 32)	39.44	2090.50		
Cognitive avoidance	Rural	17	27(22–44)	40.15	682.50	371.5	.278
	Urban	53	25(13–44)	34.01	1802.50		
Behavioral avoidance	Rural	17	14(6– 18)	34.79	591.50	438.5	.867
	Urban	53	14(12–22)	35.73	1893.50		

P≤0.05* p≤0.01**

Table 6 above show that there is a statistically significant difference in Assistance seeking ($p < 0.001$) and Cognitive Behavioral problem solving ($p < 0.05$) in terms of the adolescent's longest stay area ($p < 0.05$). The result shows that those who stay the longest in the urban area have a higher medium score as compared to

those who stay the longest in the rural area. There is no statistically significant difference in cognitive avoidance and Behavioral avoidance in terms of where the adolescents spend a longer time.

Table 7.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the study group according to the adolescent adolescent's age group

Variable	**Age group**	**n**	**Median (Min-Max)**	**Mean Rank**	**X^2**	**p**
Assistance seeking	12 - 14	5	11(10– 13)	42.90	3.300	.192
	15 - 17	36	11(7– 13)	38.35		
	18 - 20	29	11(7– 13)	30.69		
Cognitive Behavioral Problem Solving	12 - 14	5	16(16– 26)	25.60	1.344	.511
	15 - 17	36	24(8– 32)	36.69		
	18 - 20	29	24(8– 31)	35.72		
Cognitive Avoidance	12 - 14	5	31(21– 44)	39.90	.524	.769
	15 - 17	36	25.5(13– 44)	33.99		
	18 - 20	29	26(18– 44)	36.62		
Behavioral Avoidance	12 - 14	5	15(14– 16)	50.90	5.981	.050
	15 - 17	36	13(6– 19)	30.63		
	18 - 20	29	14(12– 22)	38.90		

$P \leq 0.05^*$ $p \leq 0.01^{**}$

Table 7 above shows that there is no significant difference in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the study group according to the adolescent age group.

Table 8 below shows that there is no significant difference in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the study group according to the adolescents' living conditions.

Table 8.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the study group according to the adolescent's living condition

Variable	Living Condition	n	Median (Min-Max)	Mean Rank	X^2	p
Assistance seeking	Both Parents	15	11(7– 12)	38.74	9.998	.075
	Mother	15	11(7– 13)	41.70		
	Father	7	10(10– 12)	31.79		
	Guardian	25	11(9– 13)	37.08		
	Alone	3	10(8– 10)	14.17		
	With Friends	5	9(7– 13)	18.10		
Cognitive Behavioral problem solving	Both Parents	15	24(8– 32)	40.23	2.304	.806
	Mother	15	24(16– 32)	37.13		
	Father	7	20(8– 27)	29.00		
	Guardian	25	24(9– 31)	32.68		
	Alone	3	24(16– 29)	36.83		
	With Friends	5	24(19– 30)	38.80		
Cognitive avoidance	Both Parents	15	25(17– 44)	32.97	2.781	.734
	Mother	15	26(13– 44)	40.37		
	Father	7	27(22– 38)	35.29		
	Guardian	25	24(16– 44)	32.12		
	Alone	3	33(24– 34)	46.00		
	With Friends	5	26(23– 40)	39.40		
Behavioral avoidance	Both Parents	15	14(12– 18)	32.77	3.972	.553
	Mother	15	14(12– 18)	34.63		
	Father	7	16(12– 22)	49.36		
	Guardian	25	14(6– 18)	33.82		
	Alone	3	13(12– 17)	32.50		
	With Friends	5	14(13– 14)	37.10		

P≤0.05* p≤0.01**

Findings for Research Question 4

What factors affect the coping skills of adolescents without alcohol and substance addiction?

Table 9.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the Control group according to the gender of the adolescents

Variable	Gender	n	Median (Min-Max)	Mean Rank	Sum of Ranks	U	p
Assistance Seeking	Male	34	10(5– 15)	32.37	1100.50	505.5	.207
	Female	36	11(6– 16)	38.46	1384.50		
Cognitive Behavioral problem solving	Male	34	23(11– 32)	35.76	1216.00	603	.915
	Female	36	23(9– 30)	35.25	1269.00		
Cognitive avoidance	Male	34	29(11– 41)	30.72	1040.50	449.5	.056
	Female	36		40.01	1440.50		
Behavioral avoidance	Male	34	15(7– 21)	30.01	1020.50	425.5	.028*
	Female	36	17(7– 24)	40.64	1464.50		

P≤0.05* p≤0.01**

As seen from table 9 above, there is no statistically significant difference in Assistance seeking, cognitive behavioral problem-solving, and cognitive avoidance for the control group according to the gender of the adolescents. There is a statistically significant difference in the behavioral avoidance skills of the control group according to the gender of the adolescents. Females have more medium (17) score as compared to female.

Table 10 below shows that there is no statistically significant difference in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the control group according to the adolescent's longer stay area.

Table 10.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the control group according to the adolescent's longer stay area

Variable	Area	n	Median (Min-Max)	Mean Rank	Sum of Ranks	U	p
Assistance Seeking	Rural	24	11(5– 15)	35.17	844.00	544	.920
	Urban	46	10(6– 16)	35.67	1641.00		
Cognitive Behavioral problem solving	Rural	24	22.5(10– 32)	32.40	777.50	477.5	.355
	Urban	46	23(9– 32)	37.12	1707.50		
Cognitive avoidance	Rural	24	25(11– 35)	34.23	821.50	521.5	.705
	Urban	46	25.5(12– 41)	36.16	1663.50		
Behavioral avoidance	Rural	24	15(12– 23)	32.71	785.00	485	.405
	Urban	46	16(7– 24)	36.96	1700.00		

P≤0.05* p≤0.01**

Table 11.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the control group according to the adolescent's age group

Variable	Age group	n	Median (Min-Max)	Mean Rank	X^2	p
Assistance seeking	12 – 14	7	11(7– 13)	34.86	9.018	.011*
	15 - 17	26	11(6– 16)	44.67		
	18 - 20	37	9(5– 13)	29.18		
Cognitive Behavioral problem solving	12 - 14	7	23(15– 23)	28.79	1.546	.462
	15 - 17	26	22(11– 30)	33.71		
	18 - 20	37	24(9– 32)	38.03		
Cognitive avoidance	12 - 14	7	27(13– 33)	31.07	1.165	.558
	15 - 17	26	25(11– 40)	38.71		
	18 - 20	37	25(12– 41)	34.08		
Behavioral avoidance	12 - 14	7	14(9– 20)	33.36	.170	.918
	15 - 17	26	16(10– 22)	36.62		
	18 - 20	37	15(7– 24)	35.12		

P≤0.05* p≤0.01**

Table 11 above shows that there is no significant difference in cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the control group according to the adolescent age group. There is a statistically significant difference in Assistance seeking for the control group according to the adolescent age group (p = 0.011). The post hoc test reveals that the difference is only between 15 - 17 and 18 – 20. 12-14 and 15 – 17 (11) has higher medium score.

Table 12.

Differences in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the control group according to the adolescent's living condition

Variable	Living Condition	n	Median (Min-Max)	Mean Rank	X^2	p
Assistance seeking	Both Parents	27	11(7– 13)	39.31	9.403	.094
	Mother	14	11.5(8– 16)	42.68		
	Father	7	10(5– 13)	32.43		
	Guardian	10	10.5(5– 14)	33.80		
	Alone	4	9(6– 15)	29.38		
	With Friends	8	8 (6– 11)	17.94		
Cognitive Behavioral problem solving	Both Parents	27	23(10–29)	33.50	8.528	.129
	Mother	14	22.5(13– 27)	34.71		
	Father	7	24(16– 27)	36.43		
	Guardian	10	23.5(11– 32)	37.65		
	Alone	4	29.5(24– 32)	61.75		
	With Friends	8	20.5(9– 27)	27.00		
Cognitive avoidance	Both Parents	27	24(12–35)	29.74	5.561	.351
	Mother	14	29(13– 39)	39.50		
	Father	7	25(13– 36)	33.36		
	Guardian	10	26.5(11– 40)	36.60		
	Alone	4	33(23– 35)	50.38		
	With Friends	8	27(22– 41)	41.00		
Behavioral avoidance	Both Parents	27	14(7– 22)	31.07	5.926	.313
	Mother	14	17.5(12– 23)	43.11		
	Father	7	17(12– 20)	44.00		
	Guardian	10	14.5(7– 21)	28.55		
	Alone	4	15.5(13– 18)	34.38		
	With Friends	8	17(12– 24)	38.94		

P≤0.05* p≤0.01**

Table 12 above shows that there is no significant difference in Assistance seeking, cognitive behavioral problem-solving, cognitive avoidance, and behavioral avoidance skills for the control group according to the adolescents' living conditions.

CHAPTER V

Discussion

In this chapter, based on the findings that this study has gathered, a discussion will be made in comparison or contrast to similar studies that have been conducted.

This research sought to find out the coping skills of adolescents with alcohol and substance addiction in Liberia, a country in West Africa. The first research question of this study asks about the coping skills of adolescents with alcohol and substance addiction. Regarding Assistance seeking, adolescents with alcohol and substance addiction had a median score of 11. This score was comparable to that found in another adolescent sample (mean= 8.83 ±2.43) (Ruchkin et al. 1999). As for Cognitive-Behavioral Problem Solving, they had a median score of 24. This score was comparable to the mean found in another adolescent sample (mean= 19.14±4.60) (Ruchkin et al. 1999). In Cognitive Avoidance, they had a median score of 26. This score was comparable to the mean found in another adolescent sample (mean= 24.79 ±5.20) (Ruchkin et al. 1999). Finally, Regarding Behavioral Avoidance, they had 14. This score was comparable to the mean found in another adolescent sample (mean= 12.93 ±3.26) (Ruchkin et al. 1999). The results of Ruchkin et al.'s study with delinquent adolescents were not similar to the results of this study. It may be considered that adolescents with alcohol and substance addiction have more tendency to use both positive coping strategies such as assistance seeking and negative coping strategies (cognitive-behavioral avoidance).

Commenting on assistance-seeking Belete et al (2019) found out in their study that just one hundred sixty-eight (30.7%) out of a total of five hundred forty-eight individuals with problematic drug use sought care for their substance-related behavioral disorder. Most of them looked for assistance from unofficial sources. One hundred and eighty-four (15.3%) of these individuals sought assistance from their loved ones; one hundred and ten (20.1%) of these individuals sought assistance from their friends; one hundred and three (18.8%) of these individuals sought assistance from their families; and one hundred (18.2%) of these individuals sought assistance from religious organizations. Ninety (16.4%) of the people who sought official assistance did so in order to get assistance from mental health specialists, while 89 (16.2%) sought assistance from general medical practitioners.

Related to cognitive avoidance, a study done by Hong et al., (2019) made this comment, “avoidance is not a strategy”. Cognitive avoidance has been shown to play a role in anxiety disorders, depression disorder, hyperactivity disorder, anti-social behaviors, and the tendency toward alcohol and substance use in some studies (Hong et al., 2019). The authors of the research that was conducted by Pomerleau et al, (2019) demonstrate that there is a positive correlation between the cognitive avoidance score and cigarette smoking. Hong et al. (2019) conducted an experiment with 17 male smokers and discovered a correlation between cognitive avoidance and cigarette use. According to the findings of Shadel et al., (2019), there is a positive correlation between nicotine dependence and cognitive avoidance. Accordingly, Farris et al. (2016) demonstrated how the practice of cognitive avoidance might reduce the risk of relapse and satisfy cravings in nicotine-dependent individuals.

The second research question of this study asks there is a difference between the coping skills of adolescents with alcohol and substance addiction and the coping skills of adolescents without alcohol and substance addiction. The study found that adolescents with alcohol and substance addiction has higher but not statistically significant scores in Assistance seeking, Cognitive behavioral problem solving, and Cognitive avoidance scores as compared to adolescents who are not on drugs which were the control group. Behavioral avoidance score of study group was statistically significantly lower than control group. Adolescents with alcohol and substance addiction scored lower on behavioral avoidance coping strategies, whereas the level of assistance seeking, cognitive-behavioral problem-solving, and cognitive avoidance strategies were almost the same in the two groups. It may be considered that adolescent with alcohol and substance addiction tend to use less negative coping strategies such as behavioral avoidance compared to the control group to solve their problems. Adolescents with alcohol and substance addiction are less likely to distance from the source of stress or to use indirect forms of reducing tension such as displacement of anger on to another person. Hamdan-Mansour et al. (2007) found that adolescents who used avoidance coping strategies had higher probability to use alcohol.

The study’s other research question was about factors that affect the coping skills of adolescents with alcohol and substance addiction. The study found that there was no difference in the coping score base on gender, age range, and whom the adolescent lives with. Since there was no difference, it can be concluded that both

males and females, in age range and the living condition of the adolescent have the same Assistance Seeking attitude, and they also have the same Cognitive Behavioral problem-solving skills, when it comes to Cognitive avoidance, they score the same and finally, as regards behavioral avoidance, they have the same attitude.

The results of previous research have shown that there is no difference between the sexes in terms of coping (Compas et al., 1988; Armistead et al., 1990; Gore et al., 1992). These studies support the finding of this research in that they all agree that coping with situations, drugs, alcohol, stress, etc., has nothing to do with gender.

This study found that there was a difference in Assistance Seeking and Cognitive Behavioral problem solving of adolescents from rural and urban areas in the study group. Urban adolescents had more Assistance Seeking and Cognitive Behavioral problem solving than those from rural settings. This study result can be tied with Kenkel (1986), Atkins & Krantz (1993), and the American Psychological Association Rural Task Force (2000). They reported "While there has been considerable conjecture, the influence of neighborhood factors on stress and coping strategies in adolescents is a topic that has received very little research. It is now recognized that rural families face unique stressors that have as much of an impact on adolescent functioning as urban stressors of crowding, noise, violence, and anomie. Romantic depictions of rural life as a simpler and less pressured environment are no longer accurate, and it is now recognized that rural families face these unique stressors" (Kenkel, 1986; Atkins & Krantz, 1993; American Psychological Association Rural Task Force, 2000). This kind of stress may be caused by a number of factors, such as being geographically isolated, experiencing loneliness, having difficulty accessing health care, and being economically unstable due to a significant dependence on primary industries (e.g., agriculture, mining, fishing). Adolescents from urban areas have easy access to people to talk with, they have access to healthcare facilities, these can be things that give them better coping skills as compared to adolescents from rural areas where those things are not readily available.

The study's last research question was about factors that affect the coping skills of adolescents without alcohol and substance addiction. This study found that there was a difference in behavioral avoidance of adolescents without alcohol and substance addiction as gender. Female adolescents had higher behavioral avoidance

scores. It was concluded that female adolescents without alcohol and substance addiction tend to use more negative coping strategies such as behavioral avoidance compared to male adolescents. Regarding gender and coping mechanisms, there are also some studies reveals that adolescents with respect to gender have different coping mechanisms. Adolescents of different sexes can have different worries and coping mechanisms. More girls than boys report having issues, and girls tend to exaggerate the severity of their problems (Huba et al., 2021). Concern management is one area where there is continuous gender disparity. As a rule, girls are more sociable and reliant on their friends than guys. According to Ptacek et al., (1994), females rely more on social support, while men rely more on ventilation; males, according to Patterson and McCubbin (2021), rely more on humor, while females prioritize connections with close relatives, friends, and coworkers. Copeland and Hess (2019) discovered that women used proactive orientation and catharsis while men resorted to avoidance and physical distractions. Brodzinsky et al., (1992) found that girls reported more frequent use of assistance seeking than boys.

This study found that there was a difference in Assistance Seeking of adolescents without alcohol and substance addiction as age groups. Adolescents in the 15-17 age group had higher Assistance Seeking scores than adolescents in the 18-20 age group. Adolescents in the 15-17 age group had more tendency to use positive coping strategies such as assistance seeking. This means adolescents in this age group use more getting an advice from someone and sharing feelings with someone. Stern and Zevon (1990) found that adolescents in ages 13–17 used more emotion-focused coping than adolescents in ages 18–20. Eschenbeck et al. (2007) found that children in the last grades of primary school prefer assistance seeking and cognitive strategies rather than avoidance strategies. Fields and Prinz (1997) reported that as the years progress, the variety of coping strategies becomes smaller, with the cognitive strategies the only type to increase in usage.

CHAPTER VI

Conclusion and Recommendations

In this chapter, based on the findings that this study has gathered, a conclusion will be made, and recommendations will be given for this study and for future studies.

Conclusion

- Regarding Assistance seeking, adolescents with alcohol and substance addiction had a median score of 11. As for Cognitive-Behavioral Problem Solving, they had a median score of 24. In Cognitive Avoidance, they had a median score of 26. Regarding Behavioral Avoidance, they had 14.
- Adolescents with alcohol and substance addiction tend to use less negative coping strategies such as behavioral avoidance compared to the control group to solve their problems.
- There was a difference in Assistance Seeking and Cognitive Behavioral problem solving of adolescents from rural and urban areas in the study group. Urban adolescents had more Assistance Seeking and Cognitive Behavioral problem solving than those from rural settings.
- There was a difference in behavioral avoidance of adolescents without alcohol and substance addiction as gender. Female adolescents had higher behavioral avoidance scores.
- There was a difference in Assistance Seeking of adolescents without alcohol and substance addiction as age groups. Adolescents in the 15-17 age group had higher Assistance Seeking scores than adolescents in the 18-20 age group.

Recommendations

The study is providing the following recommendations:

- Trainings on positive coping strategies should be organized for adolescents.
- When providing training on positive coping strategies, it should be taken into consideration whether the adolescent comes from rural or urban areas.
- Gender and age group differences should be taken into account when addressing adolescents' coping skills.

- That government come up with effective public health strategies to deal with the problem of substance and alcohol abuse among Liberian school-aged youth. Those strategies should include regularly checking students to see whether they are beginning to abuse Alcohol or substances and having counseling classes in all schools for early detection of behavioral problems. There should also be a course taught or emphasis placed on the effect of alcohol and substance abuse in all schools in Liberia.

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Appendices

Appendix A

PERSONAL IDENTIFICATION FROM (Study Group)

Dear Participant,

I am a master's student at Near East University, collage of Health Sciences, and Department of Nursing. The objective of this study is geared towards understanding the Coping Skills of adolescents with alcohol and substance addiction and the Coping Skills of adolescents without alcohol and substance addiction in Monrovia, Liberia among students aged 12-20.

Please note that your participation is totally voluntary, and if you choose to take part in this study, you will be answering questions via this questionnaire. The questionnaire consists of questions relating to some background about you, your experience with alcohol and substance addiction and some short assessment form. All information received will remain confidential, and no one will have access to them outside of the parties involved. Your answers will remain unidentified, and your name or client's number is not required from you. By submitting your answers, you are consenting for your data to be used in my project, but you will not be individually identified, and your response will be used for statistical purpose only. Thank you for your time and participation.

Respectfully yours.

Hawah B. Jackson

Master's Student in Mental Health and Psychiatric Counseling

Assist. Prof. Ayşegül SAVAŞAN

NEU Nursing Faculty

SECTION A

SOCIODEMORGAPHIC IMFROMATION QUESTIONAIRE

1. Gender

( ) Male ( ) Female

2. Age: ……..

( ) 12 and 14

( ) 15- 17

( ) 18-20

3. County of origin: ----------
4. Place of Longest Residence
   ( ) Urban (city capitals or Centre)
   ( ) Rural (district\town\village)
5. Specify the accommodation facility you live in
   ( ) I live with my both parents
   ( ) I live with my mother alone
   ( ) I live with my father alone
   ( ) I live with my guardians
   ( ) I live in an apartment or house alone
   ( ) I live in an apartment or house with friends

Research Questionnaire Form

SECTION B

6. Have you use drugs other than those required for medical reasons?
   ( ) yes ( ) No
7. Have you abused prescription drug before?
   ( ) Yes ( ) No
8. Do you abuse more than one drug at a time?
   ( ) Yes ( ) No
9. Can you get through the week without using drug?
   ( ) Yes ( ) No

10. Are you always able to stop using drugs when you want to?

( ) Yes ( ) No

11. Do you ever feel bad or guilty about your drug use?

( ) Yes ( ) No

12. Do your parents or guardians know you are involved with drug?

( ) Yes ( ) No

13. Do your parents or guardians ever complain about your involvement with drug?

( ) Yes ( ) No

14. Has drug created problems between you and your parents/ guardians?

( ) Yes ( ) No

15. Have you lost friends because of your use of drugs?

( ) Yes ( ) No

16. Have you been in trouble at school because of your use of drugs?

( ) Yes ( ) No

17. Have you gotten into fights when under the influence of drugs?

( ) Yes ( ) No

18. Have you engaged in illegal activities in order to obtain drugs?

( ) Yes ( ) No

19. Have you been arrested for possession of illegal drugs?

( ) Yes ( ) No

20. Have you had ‘’blackouts’’ or ‘’ flashback’’ as a result of drugs use?

( ) Yes ( ) No

21. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

( ) Yes ( ) No

22. Have you had medical problems as a result of your drugs use (e.g. Memory loss, Hepatitis, convulsions, bleeding, etc.)?

( ) Yes ( ) No

23. Have you gone to anyone for help for a drug problem?

( ) Yes ( ) No

24. Have been involved in a treatment program specifically related to drugs use?

( ) Yes ( ) No

SELECTION C

THE COPING SCALE FOR CHILDREN AND YOUTH

Instruction: please tick the option that most appropriately represents your experience. There is no wrong or right answer. How often have you experienced the following activities over the last 2 weeks?

	Factors and items	Never	Sometimes	Often	Always
Assistance Seeking					
1	I asked someone in my family for help with the problem.				
2	I got advice from someone about what I should do.				
3	I shared my feelings about the problem with another person.				
4	I kept my feelings to myself.				
Cognitive-Behavioral Problem Solving					
1	I thought about the problem and tried to figure out what I could do about it.				
2	I took a chance and tried a new way to solve the problem.				
3	I made a plan to solve the problem and then I followed the plan.				
4	I went over in my head some of the things I could do about the problem.				
5	I thought about the problem a new way so that it didn't upset me as much.				
6	I learned a new way of dealing with the problem.				
7	I tried to figure out how I felt about the problem.				
8	I figured out what had to be done and then I did it.				
Cognitive Avoidance					
1	I tried not thinking about the problem.				
2	I went on with things as if nothing was wrong.				
3	I pretended the problem wasn't very important to me.				

4	I knew I had lots of feelings about the problem, but I just didn't pay any attention to them.				
5	I tried to get away from the problem for a while by doing other things.				
6	I pretended the problem had nothing to do with me.				
7	I tried to pretend that the problem didn't happen.				
8	I hoped that things would somehow work out so I didn't do anything.				
9	I tried to pretend that my problem wasn't real.				
10	I realized there was nothing I could do. I just waited for it to be over.				
11	I put the problem out of my mind.				
Behavioral Avoidance					
1	I stayed away from things that reminded me about the problem.				
2	I tried not to feel anything inside me. I wanted to feel numb.				
3	I went to sleep so I wouldn't have to think about it.				
4	When I was upset about the problem, I was mean to someone even though they didn't deserve it.				
5	I tried not to be with anyone who reminded me of the problem.				
6	I decided to stay away from people and be by myself.				

PERSONAL IDENTIFICATION FROM (Control Group)

Dear Participant,

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Please note that your participation is totally voluntary, and if you choose to take part in this study, you will be answering questions via this questionnaire. The questionnaire consists of questions relating to some background about you, your experience with alcohol and substance addiction and some short assessment form. All information received will remain confidential, and no one will have access to them outside of the parties involved. Your answers will remain unidentified, and your name or student's number is not required from you. By submitting your answers, you are consenting for your data to be used in my project, but you will not be individually identified, and your response will be used for statistical purpose only. Thank you for your time and participation.

Respectfully yours.

Hawah B. Jackson

Master's Student in Mental Health and Psychiatric Counseling

Assist. Prof. Ayşegül SAVAŞAN

NEU Nursing Faculty

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SECTION B

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4	I kept my feelings to myself.				
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1	I thought about the problem and tried to figure out what I could do about it.				
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3	I went to sleep so I wouldn't have to think about it.				
4	When I was upset about the problem, I was mean to someone even though they didn't deserve it.				
5	I tried not to be with anyone who reminded me of the problem.				
6	I decided to stay away from people and be by myself.				

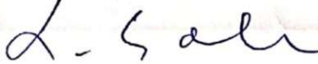
Appendix B

NEAR EAST UNIVERSITY
SCIENTIFIC RESEARCH ETHICS COMMITTEE

RESEARCH PROJECT EVALUATION REPORT

Meeting date :30.11.2022
Meeting Number :2022/108
Project number :1632

The project entitled **"Evaluation of Coping Skills of Adolescents with Alcohol and Substance Addiction"** (Project no: NEU/2022/108-1632) has been reviewed and approved by the Near East University Scientific Research Ethical Committee.



Prof. Dr. Şanda Çalı
Near East University
Head of Scientific Research Ethics Committee

Committee Member	*Decision* *Approved (✓) / Rejected (X)*	*Meeting Attendance* *Attended (✓) / Not attended(X)*
Prof. Dr. Tamer Yılmaz	✓	✓
Prof. Dr. Şahan Saygı	✓	✓
Prof. Dr. Mehmet Özmenoğlu	✓	✓
Prof. Dr. İlker Etikan	✓	✓
Doç. Dr. Mehtap Tınazlı	X	X
Doç. Dr. Nilüfer Galip Çelik	✓	✓
Yrd. Doç. Dr. Dilek Sarpkaya Güder	✓	✓

Appendix C

JOHN F. KENNEDY MEMORIAL MEDICAL

20th Street Sinkor
Monrovia, Liberia

Michael Kenyor
Legal Department
J. F. K Medical Center
Email:Michaelkenyor@gmail.com
Tel:+231888717277

Hawah B. Jackson
Master Student
Near East University
Northern Cyprus Republic of Turkey

November 24, 2022

Dear Miss. Hawah B. Jackson:

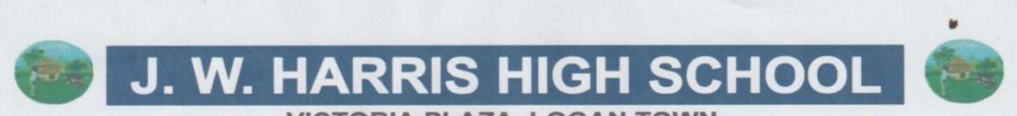
The Legal Office of J.F.K writes to officially inform you that, you have been accepted into the E.S. Grant Rehabilitation Center to conduct your Master Thesis. The institution accepts to be your Thesis Supervisor during the process of collection of data.

We do hope that you abide by all rules and regulation regarding the center.

Best regards,

Michael Kenyor
Legal Department
J. F. K Medical Center

Appendix D



J. W. HARRIS HIGH SCHOOL

VICTORIA PLAZA, LOGAN TOWN
BONG MINES BRIDGE, MON. LIBERIA

MASTER THESIS APPROVAL RESEARCH LETTER

From : Office of the Principal

To : Miss. Hawah B. Jackson
Student, International Master Thesis at Near East University
Northern Cyprus (TRNC)

Date : November 25, 2022

Congratulation, your request to conduct a research paper at our institution has been approved. We are pleased to inform you that we are willing to work with you throughout the research period. It's a pleasure selecting our institution among many institutions. Thanks once again, and we do hope to see you soon.

Respectfully yours,

Mr. Paul Johnson
PRINCIPAL
J. W. Harris High School

Similarity Report

Thesis

ORIGINALITY REPORT

14%	13%	7%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

#	Source	Type	%
1	docplayer.net	Internet Source	2%
2	coek.info	Internet Source	2%
3	www.tandfonline.com	Internet Source	1%
4	opencommons.uconn.edu	Internet Source	1%
5	elischolar.library.yale.edu	Internet Source	1%
6	www.researchgate.net	Internet Source	1%
7	personal.unizar.es	Internet Source	1%
8	www.lib.ncsu.edu	Internet Source	1%
9	erepository.mkuit.ac.rw	Internet Source	1%