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Investigating the Association between Coping Styles and Social Identity in Adolescents of Marginal and Non-Marginal Areas

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Abstract

Objective: This study aimed to investigate the relationship between coping styles and social identity among adolescents residing in marginal and non-marginal areas.
Method: A cross-sectional study design with a descriptive-analytic approach was utilized. The study population consisted of adolescents aged 12 to 19 from Kermanshah city, with 222 participants evenly distributed between marginal and non-marginal areas. Adolescents were enrolled in the study using a multi-stage sampling method (stratified cluster, simple randomized method). Data were collected using the Standard Social Identity questionnaire and Lazarus and Folkman's Coping Styles questionnaire. The data were analyzed statistically in the SPSS software environment (version 25) using appropriate statistical tests.
Results: The results of the study showed that there is a significant relationship between the components of social identity and coping styles in adolescents ($P < 0.05$). Emotion-focused and problem-focused coping styles had the ability to explain social identity in the adolescents of Kermanshah city. Also, in comparing the coping styles and social identity between adolescents from marginalized and non-marginalized areas in the city of Kermanshah, there was no significant difference ($P < 0.05$).
Conclusion: This study underscores the importance of understanding how coping strategies influence social identity among adolescents across different socio-environmental contexts. The findings highlight the need for further research to explore the mechanisms underlying these relationships and consider the role of contextual factors in shaping adolescent development.

Key words: *Adolescents; Coping Skill; Cross-Sectional Studies; Social Identity; Teenagers*

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The phenomenon of urbanization has led to the increase of suburban areas; this trend is observed both near big cities and in smaller urban centers (1). It is estimated that between 25 and 50 percent of the world's urban population, totaling more than 900 million people, live in slums. It is expected that this number will increase to 2 billion people in the near future (2). In Iran, statistics up to 2018 show that 9.7% of the population is marginalized (3). In Kermanshah, a metropolis in Iran, the huge population with diverse social, ethnic, and economic backgrounds highlights the importance of marginalization (4). Despite the existence of more than 36 unplanned settlements lacking urban standards and with more than 35% of the urban population living in informal settlements, Kermanshah is struggling with a severe crisis of marginalization (5).

Marginalization has adverse effects on residents, both at the city level and at the neighborhood level (6). Research shows that marginalized groups, including people with low incomes, limited education, and ethnic minorities, face greater risks of mental health disorders. Issues related to housing and ethnic concentration exacerbate these challenges (7). In addition, marginalization is significantly related to juvenile delinquency and crime and creates an unfavorable socio-economic-cultural environment due to insufficient leisure facilities. Adolescents are especially at risk due to rapid developmental changes and identity formation (8, 9). The prevalence of delinquent behaviors such as substance abuse, vandalism, and truancy among suburban youth, especially in schools with higher proportions of low-income and minority students, underscores the importance of these issues (10, 11).

The stage of adolescence includes the central period of self-discovery in the field of social interactions (12). According to the report of the World Health Organization, adolescents include people aged 10 to 19 (13). This transitional phase from childhood to adulthood introduces new cultural and social perspectives as well as expectations along with new stressors (12). Significantly, independence and social impersonation appear as prominent stressors during this period (14).

Social identity expresses a person's self-perception, which is formed by a complex interaction of individual and social identities that affects their self-esteem (15). According to social identity theory, presented by Tajfel and Turner, an individual's self-concept derives from perceived membership in social groups (16). As adolescents go about the complex task of constructing their identity, social identity influences social influence and maps accepted norms and behaviors in pivotal contexts such as peer groups. Consequently, this dynamic can create various mental health barriers throughout their lives (15, 17).

In the context of identity acquisition and social identity in adolescence, coping plays a crucial role in helping adolescents manage stressors. This is because reactions to stressors vary due to individual differences in personality and experiences with stress among adolescents (12). Coping is a multifaceted and closely scrutinized construct that serves as a significant focal point for interventions aiming at improving adolescent mental health. It involves ongoing cognitive and behavioral efforts to manage specific external or internal demands (18).

The coping theory introduced by Lazarus and Folkman defines coping as cognitive and behavioral efforts to manage stressors. Coping styles, which can be problem-oriented or emotion-oriented, significantly affect psychological outcomes and social identity formation (19). Coping styles adopted by adolescents to face challenges and stressful factors can affect the formation of their social identity. For instance, employing a problem-oriented approach and addressing problems logically and adaptively can lead to psychological satisfaction, increased self-confidence, and a heightened sense of self-efficacy, thereby enhancing social identity (20, 21). Additionally, according to studies, negative relationships exist between problem-oriented coping styles and a propensity for risky behaviors, while positive relationships exist between emotion-oriented coping styles and a tendency towards risky behaviors. Relying on emotional coping mechanisms can lead to complications such as depression in the long run (22, 23).

Past research has highlighted the importance of coping mechanisms in facing challenges in adolescence. Studies show that coping styles are important in managing stressors with important consequences for mental health (24). A study by Tang *et al.* revealed that coping styles are potential predictors of depression among adolescents (25). However, until now, there has been no study investigating the relationship between coping styles and social identity in adolescents, especially in different areas such as marginalized areas.

The purpose of this study was to investigate the relationship between coping styles and the formation of social identity among teenagers living in marginal and non-marginal urban areas. While previous research has highlighted the importance of coping mechanisms in navigating adolescent challenges, limited attention has been paid to their specific impact on social identity development, particularly in marginalized communities. By examining how different coping strategies affect the formation of social identity, appropriate interventions can be adopted in this particular population Therefore, the primary goal of this study was to examine the relationship between coping styles and social identity among adolescents in Kermanshah, and the secondary aim was to compare the status of coping styles and social identity among adolescents living in marginalized and non-marginalized areas.

Materials and Methods

Study Design

This research employed a cross-sectional study design with a descriptive-analytic approach to fulfill the study objectives.

Study Population

The study population for this research comprised adolescents aged 12 to 19 residing in both marginal and non-marginal areas of Kermanshah city. Criteria for inclusion in the study included willingness and consent to participate, being between the ages of 12 and 19, absence of mental retardation or physical disabilities such as deafness or blindness, proficiency in reading and writing, no history of psychiatric disorders, not currently undergoing counseling or psychotherapy, and no history of drug use within the past year. Exclusion criteria for the study encompassed failure to complete more than 10% of the questionnaire items. Since answering some of these questions and understanding them was difficult for adolescents particularly in marginalized areas, they were made comprehensible to the participants as much as possible within a trust-based relationship by providing necessary explanations. Additionally, the absence of a psychiatric disorder history was based on the information recorded in the Ministry of Health's SIB system, as well as the reports of a history of psychiatric consultation or having a psychiatric file, provided by the parents and the participants. The sample size was determined using the formula for comparing a quantitative trait in two groups, with parameters including a confidence factor of 95% (1-α), a test power of 90% (1-β), and other parameters derived from a similar study (26). Considering that this study was an evaluation of the correlation between the variables and that in such studies it is preferable to choose a larger minimum sample size, the research team considered a minimum sample size of at least 125 individuals per group, totaling 250 individuals.

A multi-stage sampling approach, involving stratified-cluster, and simple random sampling techniques was employed. The eight districts of Kermanshah city were initially categorized into marginal and non-marginal groups. Health centers within each group were designated as clusters, resulting in 20 clusters. Seven clusters from marginal areas and 13 from non-marginal areas were randomly selected based on population distribution percentages (35% from marginalized areas and 65% from non-marginalized areas). Data on families with teenagers were obtained from health center files and the SIB system. Samples were then randomly selected from these databases, and individuals were contacted and invited to participate with informed written consent. Ten adolescents from each cluster in non-marginal areas and 17 adolescents from each cluster in marginal areas (18 from one) were randomly selected and invited to the study. Seventeen individuals, which were on the list of randomly selected samples, were not willing to participate. After excluding 11 participants with incomplete questionnaires based on the mentioned exclusion criteria, the final sample size was 222.

Ethical Considerations

Ethical approval for this study was obtained from the Research Committee of Kermanshah University of Medical Sciences under the code IR.KUMS.REC.1400.038. Participants were fully informed of the study's objectives and assured of confidentiality. Since a significant portion of the samples were under the age of 18, in addition to the consent of the participants, the parents of the adolescents filled out and signed the informed consent form for participation in the research. The data collection was carried out with the agreement and cooperation of the research samples and the parents.

Data Collection

Following approvals from both the ethics committee and the vice president of research and technology at Kermanshah University of Medical Sciences, along with obtaining necessary permits in 2022, the researcher commenced data collection at health centers in marginal and non-marginal areas of Kermanshah city, equipped with an introductory letter. Within each center, participants were randomly selected, contacted via phone, and provided with detailed explanations of the study's objectives and procedures, inviting their participation. Following initial consent, participants completed structured questionnaire-based interviews. Data collection spanned six months, from December 2021 to May 2022.

Measures

To evaluate social identity, a questionnaire was employed, designed to capture two dimensions: individual and collective identity. This self-assessment tool comprises 20 items, evenly split between the two dimensions. Participants rate their agreement on a five-point Likert scale, ranging from "completely agree = 5" to "completely disagree = 1", with intermediate options "agree = 4", "I have no opinion = 3", and "disagree = 2". Therefore, the questionnaire's possible scores range from 20 to 100, with some items reverse-scored. The questionnaire's reliability, evaluated using Cronbach's alpha, yielded a coefficient of 0.74 for the entire instrument and 0.51 to 0.58 for each item, which is a satisfactory level (27).

To assess coping styles, the Lazarus and Folkman coping strategies scale was utilized. This questionnaire is designed with 66 items and measures 8 coping scales. Scoring of the Lazarus Coping Strategies Questionnaire is done using two methods: raw and relative. Raw scores describe the coping effort for each of the eight types of coping and are the sum of the subject's responses to the components of the scale. Relative scores describe the proportion of effort made in each type of confrontation. In both scoring methods, respondents rate each item on a four-point Likert scale, indicating the frequency of each strategy as follows: zero indicates "I did not use it," one denotes "I used it very little," two represents "I used it to some extent", and three indicates "I used it to a large

extent". The problem-oriented part includes four characteristics: seeking social support, taking responsibility, thoughtful problem solving, and positive reappraisal, while the emotion-oriented part includes four characteristics: confrontation, distancing, avoidance, and self-control. The reliability coefficient of this tool in Iran, assessed using Cronbach's alpha method, was 0.80. The research results demonstrated that this questionnaire has acceptable validity and reliability (28).

Data Analyses

Data analysis was conducted using SPSS version 25 software. Descriptive statistics methods were employed to summarize and describe the variables. The normality of the distribution of indicator scores was assessed using the Kolmogorov-Smirnov test, confirming normal distribution. Subsequently, parametric proportional statistical tests were utilized to analyze the obtained data at a significance level of less than 0.05. Pearson's correlation test and multivariate regression analysis were employed to explore the correlation between social identity and coping styles among teenagers residing in both marginal and non-marginal areas. All regression assumptions, including linearity, independence, homoscedasticity, and normality of residuals, were thoroughly checked and confirmed to be satisfied.

It should be noted that since this study is the result of a thesis and there have been numerous variables under investigation in this research work, there is a possibility of multiple publications.

Results

A total of 222 adolescents participated in the study, evenly divided between marginal and non-marginal areas, with 111 adolescents from each group. The average age of participants in marginal areas was 15.4 years with a standard deviation of 1.7, whereas in non-marginal areas, it was 15.5 years with a standard deviation of 1.58. Moreover, 54% of participants from marginal areas had completed high school education, compared to 52% in non-marginal areas. Regarding paternal education, 53% of fathers in marginal areas had education below diploma level, whereas in non-marginal areas, 61% had bachelor's degrees or higher. Further details are presented in Table 1.

Table 1. General Characteristics of the Study Population

Variables		Marginal Areas N (%)	Non-Marginal Areas N (%)
Gender	Male	54 (49%)	51 (46%)
	Female	58 (51%)	60 (54%)
Education	Elementary	15 (13%)	4 (4%)
	Guidance	37 (33%)	49 (44%)
	High school	59 (54%)	58 (52%)
Insurance	NO	44 (40%)	5 (4%)
	Yes	67 (60%)	106 (96%)
Monthly income	< a million	34 (31%)	6 (5%)
	1 – 1.5 million	1 (1%)	0 (0%)
	> 1.5 million	76 (68%)	105 (95%)
Father's Education	Illiterate	18 (16%)	
	Below Diploma	59 (53%)	9 (8%)
	Diploma	25 (22%)	34 (31%)
	Bachelor's Degree	9 (8%)	68 (61%)
Mother's Education	Illiterate	23 (21%)	
	Below Diploma	62 (56%)	13 (12%)
	Diploma	20 (18%)	51 (46%)
	Bachelor's Degree	6 (5%)	47 (42%)
Age	Mean ± SD	15.4 ± 1.7	15.5 ± 1.58

The mean scores of coping styles in both areas ranged from 66 to 110, indicating moderate coping styles in these areas. Additionally, as shown in Table 2, in non-marginalized teenagers, the average use of problem-focused strategies is higher than emotion-focused strategies. Furthermore, the results of ANCOVA show that there is no significant difference between coping styles in marginal and non-marginal areas, with the value of Wilks' Lambda being ($f = 0.47$ and $sig = 0.87$) ($P > 0.05$). The independent t-test also indicates no difference between social identity in marginal and non-marginal areas ($t = -1.04$, $P > 0.05$).

Table 2. Mean Coping Styles and Social Identity among Adolescents Residing in Marginal and Non-Marginal Areas

Variables	Marginal Areas Mean ± SD	Non-Marginal Areas Mean ± SD	Statistical Test Results
Coping styles			0.47 (F)
Problem-Focused Strategy	40 ± 11.3	38.3 ± 11.2	
Emotion-Focused Strategy	37.05 ± 10.4	35.9 ± 11.4	
Direct Coping Style	8.03 ± 3.3	7.67 ± 2.8	
Distancing	8.03 ± 3.03	7.85 ± 3.5	
Self-Control	11.1 ± 3.4	10.5 ± 3.7	
Seeking Social Support	9.6 ± 3.8	9.08 ± 3.9	
Accepting Responsibility	7.3 ± 2.5	7.3 ± 2.3	
Escape-Avoidance	9.8 ± 4.06	9.85 ± 4.5	
Planned Problem Solving	10.7 ± 3.6	10.2 ± 3.7	
Positive Reappraisal	12.3 ± 3.8	11.6 ± 3.6	
Social identity	71.8 ± 11.07	73.5 ± 12.2	-1.04 (t)

Pearson's correlation test showed that there is no significant relationship between the total score of coping styles and social identity in marginal and non-marginal areas ($r = 0.06$, $P > 0.05$; $r = -0.06$, $P > 0.05$). However, there was a significant negative correlation between emotion-focused coping styles in both areas ($r = -0.20$, $P < 0.05$; $r = -0.41$, $P < 0.05$). Conversely, there was a positive correlation between problem-focused coping styles and social identity in both areas ($r = 0.29$, $P < 0.05$; $r = 0.31$, $P < 0.05$). In the subdomains of coping styles, there was a significant correlation only between Seeking Social Support, Escape-Avoidance, Planned Problem Solving, and social identity in both areas (Table 3).

According to the results of multivariable regression in Table 4, one standard deviation of simultaneous change in avoidant style, planned problem solving, and seeking social support causes -0.45, 0.44, and 0.28 standard deviations in social identity among teenagers in marginal areas, respectively. Similarly, in non-marginalized areas, one standard deviation of simultaneous change in avoidant style, planned problem solving, and seeking social support results in -0.64, 0.27, and 0.18 standard deviations in social identity among adolescents, respectively.

Table 3. Pearson's Correlation Coefficient of Coping Styles and Social Identity between Marginal and Non-Marginal Areas

Variables	Marginal Areas	Non-Marginal Areas
Coping styles (total)	0.06	-0.06
Emotional- focused coping styles	-0.20*	-0.41*
problem- focused coping styles	0.29*	0.31*
Direct Coping Style	-0.14	-0.08
Distancing	0.05	-0.22*
Self-Control	-0.06	-0.18
Seeking Social Support	0.27*	0.42*
Accepting Responsibility	0.13	-0.06
Escape-Avoidance	-0.39*	-0.66*
Planned Problem Solving	0.27*	0.36*
Positive Reappraisal	0.26*	0.18

*$p < 0.05$

Table 4. Regression Coefficients of the Predictor Variable (Coping Styles) on the Social Identity of Teenagers in Marginal and Non-Marginal Areas

Residential Area	Variables	β	β-adjusted	B	SE	P
Marginal	Escape-Avoidance	-0.39	-0.45	-1.2	0.23	0.001
	Planned Problem Solving	0.42	0.44	1.3	0.27	0.001
	Seeking Social Support	0.23	0.28	0.83	0.24	0.001
Non-Marginal	Escape-Avoidance	-0.66	-0.64	-1.7	0.16	0.001
	Planned Problem Solving	0.37	0.27	0.87	0.24	0.001
	Seeking Social Support	0.22	0.18	0.56	0.22	0.01

Discussion

The aim of this study was to evaluate the correlation between coping styles and social identity in adolescents residing in marginal and non-marginal areas. To the best of our knowledge, this study is the first to assess this relationship in different marginal and non-marginal areas. In this research, no significant relationship was found between the total score of coping style and social identity, regardless of the residential area of the participants (marginal or non-marginal). However, a significant correlation was found in two specific coping styles with social identity. Adolescents who used emotion-focused coping styles had a weaker social identity, while adolescents who used problem-focused coping styles had a stronger social identity. In addition, there was no significant difference between coping styles in marginal and non-marginal areas. These results are consistent with previous studies (29, 30).

Biernat *et al.* conducted a study in 2020 titled "Coping strategies in adolescents in situations of social conflict and the locus of control" and stated in their results that adolescents adopt different coping styles in situations and social challenges (31). Luyckx and colleagues also examined the relationship between identity processes and coping styles in students, showing that coping styles and identity processes act as two factors that mutually influence each other. Coping styles are considered a facilitating or disrupting factor in identity processes, and identity is also considered a potential internal source for resorting to a specific coping style (32). In a study conducted by Barreo *et al.* titled "Impact of adolescent identity construction on the establishment of dysfunctional behaviors and on the generation of coping strategies," the results indicated that identity development is a factor that affects individuals' coping and the creation of problematic and protective behaviors (29). Additionally, the results of a study conducted by Morrison *et al.* (2019) represented the relationship between coping strategies and cultural identity (in the form of African social framework) and their role in the mental health components among students (33). Akgül and colleagues (2021) also found in their study that various coping strategies are predictors of change in certain identity dimensions among immigrant adolescents who had to live in marginal areas (34). Since these results are consistent with the findings of the current research, it can be argued that the methods adolescents adopt to cope with the challenges and stressors they face can play a role in shaping their social identity.

Instead of actively solving problems, emotional coping mechanisms frequently involve the avoidance or repression of emotions, which might impede the development of socially appropriate behaviors and interpersonal skills (35). Adolescents who rely on emotional coping techniques may find it difficult to make friends and negotiate social situations, which can undermine their sense of social identity (36). Additionally, excessive reliance on emotional coping strategies may result in heightened levels of emotional distress and internalizing behaviors, such as withdrawal or social isolation, further exacerbating feelings of alienation or disconnection from social groups (37).

In addition, emotion-based coping styles can weaken a person's social identity through incompatible cognitive processes and negative self-perception (38). Adolescents who usually use emotional coping styles may perpetuate a cycle of negative affect and impaired social functioning by creating cognitive schemas with pessimism, self-doubt or rumination (39). This negative cognitive framework can distort the perceptions of self and others and hinder the development of a positive and coherent social identity.

On the other hand, problem-focused coping strategies are determined by active involvement with stressful factors and an active approach to problem solving, which can strengthen the sense of mastery and efficiency in adolescents (40). By actively addressing challenges and searching for solutions, teenagers may feel more in control of their environment and circumstances, and this also increases self-confidence and self-perception in social contexts (41). This increased sense of mastery can lead to a stronger sense of identity, because adolescents see themselves as capable and competent people who are able to overcome obstacles and achieve their goals (42).

In addition, problem-focused coping styles can increase social interactions and improve interpersonal

relationships by increasing problem-solving skills and correct cognitive processing (43). Adolescents who use a problem-focused coping style employ more effective communication, cooperation, and conflict resolution strategies when they are involved in social challenges (44). By effectively managing interpersonal conflicts and stressors, adolescents can promote positive social relationships and strengthen their sense of belonging in peer groups (45). In addition, the problem-focused coping style leads to active participation in social roles and responsibilities and strengthens the sense of commitment to social relationships and group membership (46).

The absence of a significant difference between coping styles in marginal and non-marginal areas may be related to several factors, including the pervasive influence of technology on adolescents' coping mechanisms. In today's digital age, adolescents with different socio-economic backgrounds have wide access to resources and broad technological platforms to deal with stressful factors and seek social support (47). Also, the widespread use of smart phones, social media, and online communication platforms has made it easier to access coping resources and support networks and has caused geographic and socio-economic gaps to disappear (48). As a result, adolescents from marginal and non-marginal areas may exhibit similar coping behaviors and strategies, due to the use of common technological resources to manage stressors and seek social connections.

Furthermore, in explaining the findings of this study, it can be said that adolescence itself is a period full of tension and crisis, where the type of coping behavior chosen by adolescents during this crisis period, whether anxiety-driven or problem-solving, cannot be solely influenced by their place of residence. Age can also play a very significant role. In the early stages of puberty, adolescents, due to immaturity and insufficient cognitive development and lack of experience, are less receptive to developmental changes and try to avoid and distance themselves from accompanying changes, preferring the environment to continue as it is. However, in higher stages of growth, considering cognitive theories and the impact of experience accumulation, they possess greater adaptability. Adolescents at this stage of life, due to the crises of adolescence, do not differ much in their coping strategies. And these findings may be related to the period of adolescence. Additionally, due to their young age and lack of experience, adolescents are not sufficiently equipped to cope with tensions and challenges, which means they often adopt dominant coping strategies (39).

Limitation

The factor of age group and inexperience in coping strategies in this age group and the insufficient sample size can also play a significant role in the obtained results.

Despite the good evidence obtained in this study, it has limitations that should be mentioned. First, the cross-sectional design of this study cannot accurately determine the cause-and-effect relationship between coping styles and social identity. For this reason, longitudinal studies are needed to determine changes in the relationship between coping strategies and their impact on social identity formation in adolescents over time. Furthermore, by relying on self-report measures to assess coping styles and social identity, the results may suffer from response bias and social desirability effects, which may affect the validity and reliability of the data collected. Furthermore, this study did not consider contextual factors such as family dynamics, peer relationships, or community characteristics that may interact with coping styles to influence social identity outcomes. In order to have a more accurate understanding of the relationships between contextual factors and coping styles and social identity in adolescents, future research should use more comprehensive designs that examine contextual and interpersonal factors.

Among the limitations of this study, one can refer to the large number of questionnaires and their items. Understanding some of the questionnaire items was difficult for adolescents, which was made as comprehensible as possible to the participants by writing explanations for each item and also explaining them in person. It is recommended that future studies, if possible, use questionnaires specifically designed for adolescents. Additionally, the COVID-19 conditions made access to the samples difficult. More precise investigations are needed with a higher number of samples and in more regions.

Conclusion

In conclusion, the results of this study showed that there are no significant differences in coping styles between adolescents from marginal and non-marginal areas. Also, the type of coping styles was found to be associated with social identity in adolescents. The findings revealed that teenagers who adopt a problem-focused coping strategy tend to have a stronger social identity, whereas those who use an emotion-focused coping strategy tend to have a weaker social identity. This underscores the need for considering the diverse coping methods of teenagers across different areas. As a result, policymakers and social planners should take these coping strategies into account when addressing adolescent issues.

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Conflict of Interest

None.

References

1. Xu J, Takahashi M. Urban marginalization and the declining capacity for disaster risks in contemporary China. Soc Sci. 2021;10(11):424.
2. Friesen J, Taubenböck H, Wurm M, Pelz PF. Size distributions of slums across the globe using different data and classification methods. Eur J Remote Sens. 2019;52(sup2):99-111.
3. Cronin S. Social histories of Iran: modernism and marginality in the Middle East: Cambridge University Press; 2021.
4. Tymoshenko V, Shakun V, Makarenko L, Galiy M. Marginal behaviour as a factor of the commission of an offence. Rev Amazon investig. 2020;9(28):130-8.
5. Karimi J, Ahmadi V, Hamed B. Urban Indigents (Historical and Demographic Review on suburbia in Kermanshah). Two Quarterly Journal of Contemporary Sociological Research. 2018;6(11):1-26.
6. Baah FO, Teitelman AM, Riegel B. Marginalization: Conceptualizing patient vulnerabilities in the framework of social determinants of health-An integrative review. Nurs Inq. 2019;26(1):e12268.
7. Persad RA. Spatio-temporal analysis of mental illness and the impact of marginalization-based factors: a case study of Ontario, Canada. Ann GIS. 2020;26(3):237-50.
8. Benner AD, Wang Y. Adolescent substance use: The role of demographic marginalization and socioemotional distress. Dev Psychol. 2015;51(8):1086-97.
9. Sapiro B, Ward A. Marginalized youth, mental health, and connection with others: A review of the literature. Child Adolesc Social Work J. 2020;37(4):343-57.
10. Aderibigbe OO, Stewart SL, Hirdes JP, Perlman C. Substance Use among Youth in Community and Residential Mental Health Care Facilities in Ontario, Canada. Int J Environ Res Public Health. 2022;19(3):1731.
11. Henriksen A-K, Bengtsson TT. Trivializing violence: Marginalized youth narrating everyday violence. Theor Criminol. 2018;22(1):99-115.
12. Markova S, Nikitskaya E. Coping strategies of adolescents with deviant behaviour. Int J Adolesc Youth. 2017;22(1):36-46.
13. Sawyer SM, Azzopardi PS, Wickremarathne D, Patton GC. The age of adolescence. Lancet Child Adolesc Health. 2018;2(3):223-8.
14. Folayan MO, Cáceres CF, Sam-Agudu NA, Odetoyinbo M, Stockman JK, Harrison A. Psychological Stressors and Coping Strategies Used by Adolescents Living with and Not Living with Hiv Infection in Nigeria. AIDS Behav. 2017;21(9):2736-45.
15. Pegg KJ, O'Donnell AW, Lala G, Barber BL. The Role of Online Social Identity in the Relationship Between Alcohol-Related Content on Social Networking Sites and Adolescent Alcohol Use. Cyberpsychol Behav Soc Netw. 2018;21(1):50-5.
16. Hogg MA. Social identity theory: Springer; 2016.
17. Koni E, Moradi S, Arahanga-Doyle H, Neha T, Hayhurst JG, Boyes M, et al. Promoting resilience in adolescents: A new social identity benefits those who need it most. PLoS One. 2019;14(1):e0210521.
18. Ahmad S, Ishtiaq SM, Mustafa M. The Role of Socio-Economic Status in Adoption of Coping Strategies Among Adolescents Against Domestic Violence. J Interpers Violence. 2017;32(18):2862-81.
19. Biggs A, Brough P, Drummond S. Lazarus and Folkman's psychological stress and coping theory. The handbook of stress and health: A guide to research and practice. 2017:349-64.
20. Cong CW, Ling WS, Aun TS. Problem-focused coping and depression among adolescents: Mediating effect of self-esteem. Curr Psychol. 2021;40(11):5587-94.
21. Yulhaidir L, Soetjipto BE, Eva N, Chusniyah T. The Effect of Problem-Focused Coping Training on the Resilience of Early Adolescent Students Across School Engagement. J ReAtt Ther Dev Divers. 2023;6(10s (2)):464-75.
22. Major B, Schmader T. Stigma, social identity threat, and health. The Oxford handbook of stigma, discrimination, and health. 2018:85-103.
23. Mirzaei S, Mehrolhassani MH, Yazdi-Feyzabadi V, Jahanara A, Haghdoost AA, Oroomiei N. Identifying the challenges of policy content related to high-risk sexual behaviors, stimulant drugs, and alcohol consumption in adolescents. BMC Health Serv Res. 2024;24(1):788.
24. Rodríguez-Naranjo C, Caño A. Daily stress and coping styles in adolescent hopelessness depression: Moderating effects of gender. Pers Individ Dif. 2016;97:109-14.
25. Tang W, Dai Q. Depressive symptoms among first-year Chinese undergraduates: The roles of socio-demographics, coping style, and social support. Psychiatry Res. 2018;270:89-96.
26. Eshaghi Moghaddam Kate Shamshir F, Abdollahi MH, Shahgholian M. Comparison of Early Maladjusted Schemas, Hidden Anxiety, and Cognitive Regulation of Emotion in Normal and Delinquency Juveniles. The Neuroscience Journal of Shefaye Khatam. 2015;3(4):31-40.
27. Saffarinia M, Agayousefi AR, Mostafaie A. The Relationship between Social Procrastination and Social Identity and Students' Academic Performance. Soc Cogn. 2015;3(2):123-34.
28. Rezakhani S. Conctruction and Standardization of Coping Strategies Questionnaire with Stress for College Students. Innovation in Management Education (Journal of Modern Thoughts in Education). 2011;6(22):83-101.

29. Pérez Barrero A, Louis García EO. Impact of adolescent identity construction on the establishment of dysfunctional behaviors and on the generation of coping strategies. 2021.
30. Ghadampour E, Mirderikvand F, Nosratabadi M, Torfayeh M, Pourabadei P. Socioemotional Adjustment and Identity Styles in Adolescents with Internet Addiction: The Mediating Role of Coping Strategies. Health Education and Health Promotion. 2020;8(2):87-94.
31. Moreno AG, Molero Jurado MD. Coping Strategies in Conflicts among Adolescents: a Systematic Review. REMIE-Multidisciplinary Journal of Educational Research. 2022;12(2).
32. Ang C-S, Liang C. Social Influence in Malaysia and Singapore: Interrelationships between Cultural Orientation, Social Group Identity, Coping Style, and Social Conformity. Psychol Thought. 2021;14(1).
33. Morrison KS, Hopkins R. Cultural identity, Africultural coping strategies, and depression as predictors of suicidal ideations and attempts among African American female college students. J Black Psychol. 2019;45(1):3-25.
34. Akgül G, Klimstra T, Çok F. The role of coping strategies in interpersonal identity development of war-affected immigrant adolescents. New Dir Child Adolesc Dev. 2021;2021(176):103-21.
35. Ben-Zur H. Emotion-focused coping. Encyclopedia of personality and individual differences. 2020:1343-5.
36. Sandra L, Koesma RE, Soetikno N, Dewi FIR. Emotion-Focused Coping as a Mediator in the Relationship between Loneliness and Self-injurious Behavior in Adolescents during the Covid-19 Pandemic. J posit Psychol wellbeing. 2022;6(1):2526-37.
37. Karimzade A, Besharat MA. An investigation of the relationship between personality dimensions and stress coping styles. Procedia Soc Behav Sci. 2011;30:797-802.
38. Steger J, Harris LL. Exploring the Relationship Between Athletic Identity on Certain Coping Mechanisms in Adolescent Athletes. Journal of Sports Medicine & Allied Health Sciences: Official Journal of the Ohio Athletic Trainers' Association. 2022;8(1):35.
39. Ke T, Barlas J. Thinking about feeling: Using trait emotional intelligence in understanding the associations between early maladaptive schemas and coping styles. Psychol Psychother. 2020;93(1):1-20.
40. Grund A, Carstens C-A. Self-control motivationally reconsidered: “Acting” self-controlled is different to “being good” at self-control. Motiv Emot. 2019;43(1):63-81.
41. Siu OL, Lo BCY, Ng TK, Wang H. Social support and student outcomes: The mediating roles of psychological capital, study engagement, and problem-focused coping. Curr Psychol. 2023;42(4):2670-9.
42. Crocetti E. Identity formation in adolescence: The dynamic of forming and consolidating identity commitments. Child Dev Perspect. 2017 Jun;11(2):145-50.
43. Yıldız F, Gündüz B. An investigation of the mediator role of emotional regulation in the relationship between cognitive flexibility and psychological symptoms in adolescents. J Educ Sci Psychol. 2020;10(2):133-46.
44. Balogh-Pécsi A, Tóth E, Kasik L. Social problem-solving, coping strategies and communication among 5th and 7th graders. Int J Adolesc Youth. 2024;29(1):2331592.
45. Kulsharipova Z. Interpersonal conflicts in adolescence. Bulletin of the Karaganda university Pedagogy series. 2020;98(2):54-62.
46. Wang H, Ng TK, Siu OL. How does psychological capital lead to better well-being for students? The roles of family support and problem-focused coping. Curr Psychol. 2022:1-12.
47. Peat G, Rodriguez A, Smith J. Social media use in adolescents and young adults with serious illnesses: an integrative review. BMJ Support Palliat Care. 2019;9(3):235-44.
48. Cauberghe V, Van Wesenbeeck I, De Jans S, Hudders L, Ponnet K. How adolescents use social media to cope with feelings of loneliness and anxiety during COVID-19 lockdown. Cyberpsychol Behav Soc Netw. 2021;24(4):250-7.