Association of Coping Strategies and Quality of Life with Lifetime Traumatic Events among University Students: A Cross-sectional Study

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ABSTRACT

Introduction: Research on psychological trauma has primarily focused on evaluating the psychological effects of specific incidents. Individuals who have experienced a traumatic event are at a higher risk of exposure to multiple traumatic events in the future. Coping models typically distinguish between three main categories: task-oriented, emotion-oriented, and avoidance-oriented coping. Physical, psychological, social, and environmental factors all affect Quality of Life (QoL), and trauma frequently leads to distress and reduced wellbeing.

Aim: To evaluate the association between coping strategies and QoL in relation to lifetime traumatic events among university students.

Materials and Methods: The present cross-sectional study was conducted at NITTE (Deemed to be University), NITTE Institute of Physiotherapy, Mangalore, Karnataka, India. The study was conducted at the university wellness centre between March 2024 and March 2025. The study enrolled college students aged 18 years and above. The Brief Trauma Questionnaire (BTQ) was used to differentiate between students who screened positive and negative for lifetime traumatic events. This was followed by assessing coping strategies using the Coping Inventory for Stressful Situations and QoL using the World Health Organisation (WHO) Quality of Life Brief version (WHOQoL-BREF). A total of 189 participants were screened, of whom 94 were included and 95 were excluded. Data were analysed using Statistical Packages for the Social Sciences (SPSS) v29.0.10, with descriptive statistics, t-tests, one-way Analysis of Variance (ANOVA), likelihood ratio tests, and the Karl Pearson's correlation coefficient. A p-value <0.05 was considered statistically significant.

Results: The mean age of thje study participants was 20.39±1.44 years {mean±Standard Deviation (SD)}. psychological, environmental, and overall QoL domains (mean and cumulative scores) were all strongly associated (p<0.004) with task-oriented coping. Additionally, emotion-oriented coping strategies were found to be negatively associated with both environmental and overall QoL domains, with the association reaching statistical significance (p<0.04). However, none of the QoL domains were associated with avoidance-oriented coping strategies.

Conclusion: The evidence from present study underscores the positive influence of task-oriented coping on QoL across several domains. In contrast, emotion-oriented and avoidance-oriented coping strategies are generally less beneficial and may contribute to poorer outcomes in specific areas, such as environmental quality and overall QoL.

INTRODUCTION

Research on traumatic events has largely focused on evaluating the psychological effects of specific experiences involving individuals who have encountered distressing situations, such as personal bereavement, childhood sexual abuse, or severe accidents [1]. Post-traumatic Stress Disorder (PTSD) is characterised by persistent emotional disturbances following a traumatic event or witnessing one. Individuals who experience post-traumatic nightmares report that half of their dreams are exact reproductions of traumatic incidents [2].

Individuals who have experienced a single psychologically distressing event are at a higher risk of exposure to multiple traumatic experiences in the future [3]. Exposure to a single traumatic event can trigger a stress response in the body, increasing vulnerability to subsequent trauma. This initial stress can disrupt physiological and psychological balance, potentially creating a cycle of heightened sensitivity to later traumatic events [4]. However, it is unclear whether this vulnerability is directly related to past trauma [3].

A cross-sectional survey in China reported that 34.3% of children and adults had been exposed to traumatic events [5]. Similarly, a cohort study of young individuals in England and Wales found that the prevalence of traumatic exposure by age 18 years was 31.3% [6]. There remains an epidemiological gap in India regarding the prevalence of lifetime traumatic events, as limited studies have been conducted and are largely confined to specific cities, restricting generalisability.

Children and adolescents frequently experience childhood trauma and adversity, with physical abuse being the most common form. Although little evidence exists on how college students cope with childhood trauma, research indicates that coping mechanisms evolve over time [7,8].

Coping refers to deliberate attempts to manage trauma. Maladaptive coping leads to ineffective outcomes, while adaptive coping promotes psychological recovery [9]. Based on the goal and purpose of coping efforts, models generally classify coping strategies into three categories: task-oriented, emotion-oriented, and avoidance-oriented [10].

The QoL represents subjective satisfaction and functioning in the physiological, behavioural, social, and environmental domains of life [11]. Operationally, overall life satisfaction is the sum of contentment across significant areas of life. Scholarly investigations have demonstrated a link between traumatic events and QoL [12]. The construct of QoL is complex and multidimensional, influenced by an individual's physical and emotional state, social integration, and external environmental factors [11].

Despite growing interest, studies exploring QoL and coping skills in relation to lifetime traumatic events remain limited. The WHOQoL-BREF is a widely used tool for assessing an individual's subjective experience of life and health [13]. A study among displaced Ethiopians found that coping mechanisms and perceived social support directly and indirectly moderated the impact of trauma and mental distress on QoL when measured using the WHOQoL-BREF. Adaptive coping mitigated negative effects and improved QoL, whereas maladaptive coping increased distress and reduced QoL [14]. Traumatic experiences can negatively affect QoL both directly and indirectly. Coping strategies play a central role in this relationship, with adaptive coping promoting resilience and improved QoL, while maladaptive coping is associated with poorer outcomes. Thus, coping serves as a key mediator between trauma and QoL [8].

Existing literature has examined the connection between QoL and coping mechanisms in various contexts, including student stress, traumatic experiences, and health-related professions, particularly during the pandemic. Studies have also explored how stressful situations and QoL influence students' academic performance. However, there is limited research specifically investigating coping strategies used in response to lifetime traumatic events and the association between different coping styles (avoidance-oriented, emotion-oriented, and problem-oriented) and overall QoL. Therefore, the present study was conducted to explore how coping strategies and QoL are associated with lifetime traumatic events among University students. It specifically aimed to screen students for traumatic experiences, assess their coping strategies and QoL, and examined how these factors were interrelated.

MATERIALS AND METHODS
The present cross-sectional study was conducted at NITTE (Deemed to be University), NITTE Institute of Physiotherapy, Mangalore, Karnataka, India, between March 2024 and March 2025. The research protocol was reviewed and approved (Ref: NIPT/IEC/Min/2023-2024, dated 19 January 2024). Written informed consent was obtained from all participants prior to enrolment.

Inclusion criteria: Students between 18 and 30 years of age; Both males and females were included, Students with positive trauma exposure, defined as the experience of at least one traumatic event during their lifetime [15], as screened by the BTQ, and capable of comprehending written English.

Exclusion criteria: Students who declined participation, trauma not included in the BTQ [15], and candidates who answered "NO" to all traumatic events were excluded from the study.

Sample size calculation: The anticipated prevalence was considered to be 34% [5], with an absolute precision of 10% and a confidence level of 95%.

$$n = \frac{(Z_{1-\alpha/2})^2 p(1-p)}{d^2}$$

Where, p = Anticipated prevalence (34%) α = Significance level (5%), d = Precision (10%)

$$n = \frac{(1.96)^2 * 0.34(1-0.34)}{(0.10)^2} = 86$$

Participants were recruited using convenience sampling, wherein individuals were selected based on their accessibility, availability during free lecture hours, and willingness to participate. This non probability sampling method was chosen because of its logistical feasibility and ease of access within an academic setting. Both undergraduate and postgraduate students were included in the study.

Study Procedure
Brief Trauma Questionnaire (BTQ): The BTQ is a succinct, self-report assessment tool designed to evaluate an individual's exposure to potentially distressing events. It identifies involvement in traumatic encounters and serves as a foundational step in recognising individuals who may be at risk. Rather than directly measuring psychological symptoms, the BTQ focuses on the occurrence and nature of traumatic exposure [15].

Coping Inventory for Stressful Situations (CISS): The questionnaire is not freely available for public use and is copyrighted. However, formal permission was obtained from the original author for its use in this study. The 48-item CISS assesses the common coping mechanisms employed in stressful circumstances. Respondents rated how often they engaged in various coping behaviours when under stress, on a scale ranging from "1 (not at all)" to "5 (very often)." The items were divided into three distinct coping domains: avoidance-oriented, emotion-oriented, and task-oriented coping. The avoidance-oriented scale consists of two subscales: distraction and social diversion. Scores for each domain were calculated by summing the relevant 16 items, with higher scores indicating greater reliance on that coping strategy. For adults and college students, internal consistency was assessed using Cronbach's alpha coefficients, which ranged from 0.76 to 0.92 [10,16,17].

World Health Organisation Quality of Life scale-Brief version-(WHOQoL-BREF): This is a 26-item survey instrument used to evaluate overall quality of life and physical wellbeing. It is structured around four key domains: physical health (7 items), psychological health (6 items), social relationships (3 items), and environmental conditions (8 items). Responses to each item are rated on a 5-point Likert scale (1-5), indicating varying levels of the construct being measured [11]. The reliability of the scale was 0.896 according to Cronbach's alpha coefficient, and it has been validated for use among medical college students [13,18].
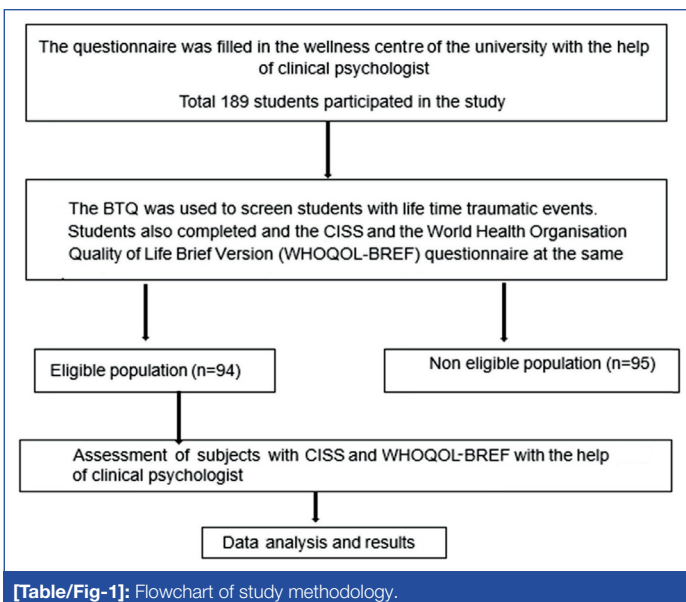
After receiving ethical clearance from the Institution and University ethics committees, students were recruited from a constituent college. The study was conducted in the college wellness centre in the presence of a clinical psychologist to ensure participant privacy. Before completing the questionnaire, participants' demographic details (age, gender, and number of traumatic events) were recorded. Respondents were asked to pick a random number through the lottery method and enter this number on the questionnaire instead of their name to maintain confidentiality. Participants took approximately 10 minutes to complete the questionnaire. Data collection was carried out through one-to-one interviews between the clinical psychologist and each subject. Online anonymous forms were avoided to ensure the accuracy, completeness, and clarity of responses. This approach allowed the researcher to clarify any doubts regarding questionnaire items in real time, reducing the risk of missing or misinterpreted data.

STATISTICAL ANALYSIS
Data were analysed using SPSS software (SPSS Inc., Chicago, IL), version 29.0.10. Descriptive statistics, including frequency distribution, percentage, measures of central tendency, and standard deviation, were used to summarise the data. An Independent samples t-test was applied to compare age, number of traumatic events, coping strategies, and QoL between males and females. One-way ANOVA was used to compare age, number of traumatic events, and coping strategies across QoL categories. The likelihood ratio test was used to assess the association between QoL and gender. The Karl Pearson's correlation coefficient (r) was used to examine relationships between various coping strategy domains, QoL, and age. A p-value <0.05 was considered statistically significant. Post-hoc analysis using the Tukey test was conducted for multiple comparisons.

RESULTS
A total of 94 participants completed the BTQ assessing DSM-5 Criterion A1 traumatic events, with no missing data [Table/Fig-1].

[Table/Fig-1]: Flowchart of study methodology.

The study included 94 participants, aged 18 to 25 years, with a mean age of was 20.39±1.44 (mean±SD). The number of lifetime traumatic events reported ranged from 1 to 7, with a mean of 1.96±1.32. Of the total participants, 25 (35.2%) were males and 46 (64.8%) were females, indicating a higher representation of females in the sample.

The most commonly reported traumatic event was physical punishment before the age of 18 years (36 cases). Other frequently reported events included serious accidents and the death of close relatives or loved ones (24 cases), sexual abuse (23 cases), and being attacked by a friend or stranger (22 cases). Witnessing someone else's serious injury (21 cases) and natural or technological disasters (17 cases) were also notable. Serious injuries (14 cases) and life-threatening illnesses (2 cases) were less commonly reported. War-related trauma was not reported by any participant [Table/Fig-2].

BTQ scale item	Event description	Yes n (%)	No n (%)	Perceived injury risk n (%)	Serious injury n (%)
1	Warzone trauma	0	94 (100)		
2	Grave accident	24 (25.5)	70 (74.5)	5 (5.3)	1 (1)
3	Biological or technological crisis	17 (18.1)	77 (81.9)	20 (21.2)	7 (7.4)
4	Life threatening illness	2 (2.1)	92 (97.9)		N/A
5	Physical punishment by parent, caretaker or teacher before age of 18 years	36 (38.3)	58 (61.7)	8 (8.5)	3 (3.1)
6	Attacked by friends or strangers	22 (23.4)	72 (76.6)	13 (13.8)	4 (4.2)
7	Sexual abuse	23 (24.5)	71 (75.5)	7 (7.4)	3 (3.1)
8	Seriously injured	14 (14.9)	80 (85.1)	N/A	7 (7.4)
9	Death of close relatives or loved ones	24 (25.5)	70 (74.5)	N/A	4 (4.2)
10	Witness of someone else's serious injury	21 (22.3)	73 (77.7)	N/A	N/A

[Table/Fig-2]: Types of distressing episodes and the number of reported incidents.

When comparing coping strategies based on gender, a statistically significant difference was observed in emotion-oriented coping, where females had notably higher mean scores than males (p=0.002). This suggests that females are more inclined to rely on emotional coping mechanisms than males [Table/Fig-3]. The QoL did not significantly differ between males and females, with a p-value of 0.269 [Table/Fig-4].

Coping strategies		Mean±SD	t	p-value
Task-oriented	Male	54.36±7.50	0.64	0.523
	Female	53.11±8.01		
Emotion	Male	46.56±8.33	-3.18	0.002*
	Female	53.26±8.56		
Avoidance	Male	50.44±8.24	-0.57	0.572
	Female	51.50±7.11		

[Table/Fig-3]: Comparison of coping strategies according to gender.
(SD: Standard deviation; t= Independent sample t-test; * Significant- p-value <0.05 considered statistically significant)

Variable		Gender		Likeli-hood ratio	p-value
		Male n (%)	Female n (%)		
Quality of Life (QoL)	Poor (21-40)	0	2 (4.3)	3.93	0.269
	Moderate (41-60)	11 (44)	22 (47.8)		
	Good (61-80)	13 (52)	22 (47.8)		
	Very good (81-100)	1 (4)	0		

[Table/Fig-4]: Association between Quality of Life (QoL) and gender.
(QoL: Quality of life; n: Number of participants; %: Percentage)

On post-hoc analysis, task-oriented coping was significantly higher among participants with very good QoL compared to those with moderate QoL. Similarly, emotion-oriented coping showed significant differences between poor and very good, moderate and very good, and good and very good QoL groups, indicating greater use of these strategies among individuals with higher QoL [Table/Fig-5].

Coping strategies		Mean difference	p-value
Task-oriented	Poor (21-40) vs. Moderate (41-60)	-2.91	0.928
	Poor (21-40) vs. Good (61-80)	-6.47	0.524
	Poor (21-40) vs. Very good (81-100)	-17.00	0.096
	Moderate (41-60) vs. Good (61-80)	-3.56	0.157
	Moderate (41-60) vs. Very good (81-100)	-14.10	0.045*
	Good (61-80) vs. Very good (81-100)	-10.53	0.264
Emotion	Poor (21-40) vs. Moderate (41-60)	13.02	0.096
	Poor (21-40) vs. Good (61-80)	12.29	0.126
	Poor (21-40) vs. Very good (81-100)	33.83	0.001*
	Moderate (41-60) vs. Good (61-80)	-0.73	0.982
	Moderate (41-60) vs. Very good (81-100)	20.81	0.014*
	Good (61-80) vs. Very good (81-100)	21.54	0.010*

[Table/Fig-5]: Multiple comparison of coping strategies: Task-oriented and emotions according to Quality Of Life (QoL).
ANOVA followed by post-hoc Tukey's multiple comparison test; p-value <0.05 considered statistically significant;* indicates significance
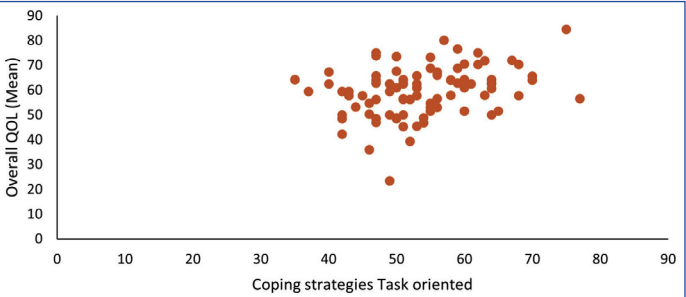
Task-oriented coping showed significant positive correlations with psychological, social, environmental, and overall QoL, indicating that it is associated with better QoL. Emotion-oriented coping had significant negative correlations with environmental and overall QoL, indicating poorer QoL with increased emotional coping. Avoidance coping did not show any significant correlations with QoL domains. These findings highlight that task-oriented coping is positively linked to better QoL, whereas emotion-oriented coping is negatively associated [Table/Fig-6,7].

DISCUSSION

University students were specifically selected as the study sample because this population is easily accessible, and young adults are considered a group at risk for experiencing various stressful or traumatic events. The present study assessed lifetime exposure to potentially traumatic events using the BTQ, which was designed

Quality of Life (QoL)		Mean±SD	Coping strategies		
			Task-oriented	Emotion	Avoidance
Physical	"r"	53.98±10.75	0.089	-0.103	0.081
	p-value		0.394	0.324	0.439
Psychological	"r"	58.93±11.90	0.274	-0.073	0.165
	p-value		0.008*	0.484	0.113
Social	"r"	61.02±16.83	0.272	-0.113	0.126
	p-value		0.008*	0.278	0.226
Environmental	"r"	64.35±13.58	0.202	-0.244	-0.023
	p-value		0.050*	0.018*	0.825
Overall QoL (Cumulative score)	"r"	238.78±39.12	0.292	-0.206	0.110
	p-value		0.004*	0.047*	0.293
Overall QoL (Mean)	"r"	59.57±9.82	0.294	-0.183	0.118
	p-value		0.004*	0.078	0.258

[Table/Fig-6]: Relation between coping strategies and QoL.
("r" = Pearson's correlation coefficient; * Significant; p-value <0.05 considered statistically significant)

[Table/Fig-7]: Correlation between the coping strategies: task-oriented and overall QoL (mean).

to capture Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV/DSM-5 Criterion A events. While authors determined whether students had experienced such exposures, they did not independently verify PTSD Criterion A1 fulfilment for each case. Therefore, authors reported traumatic exposure broadly, without implying a PTSD diagnosis.

A general negative association emerged between emotion-oriented coping and several QoL dimensions. None of the QoL domains in the present study showed a significant correlation with avoidance coping. However, better QoL outcomes were consistently linked with task-oriented coping.

The findings related to emotion-oriented coping are consistent with the work of Nolen-Hoeksema S, who reported that relying too heavily on emotional regulation without taking proactive measures may be detrimental to overall life satisfaction [19]. However, emotion-oriented coping is not always maladaptive; in some situations, it may be beneficial when individuals need to process their feelings before taking proactive steps to resolve issues [20].

Additionally, the findings are consistent with research indicating that avoidance coping may provide short-term relief but can exacerbate stress in the long term by preventing individuals from addressing the root cause of their distress [21].

Task-oriented coping and psychological QoL showed a positive correlation, suggesting that proactive trauma management may improve mental health. The present finding is consistent with earlier studies demonstrating that problem-solving techniques lessen emotional distress, anxiety, and depression through active problem solving and cognitive restructuring [22]. Additionally, the significant correlation between task-oriented coping and social QoL indicates that actively managing stress may help individuals preserve or enhance their social connections by seeking help and building peer networks [23]. The positive association between task-oriented coping and environmental QoL implies that those

who use this coping strategy may establish or maintain a more stable and supportive environment. Furthermore, the positive correlation with overall QoL supports the notion that individuals who use task-oriented strategies tend to have a more favourable life experience.

It was relatively common for a participant to report four or more distinct traumatic experiences, whereas it was uncommon for participants to report no traumatic events. This is consistent with findings by Breslau N et al., who reported that exposure to traumatic events is more likely to occur in men, and with Norris FH, who noted that this sex difference in exposure risk is event-specific [24,25]. Women were more likely to have experienced rape or abusive relationships, whereas men were more likely to have experienced war, life-threatening situations, fire, or accidents [1].

According to Thompson NJ et al., resilient individuals use adaptive coping mechanisms that reduce PTSD symptoms, whereas less resilient individuals resort to dysfunctional strategies that worsen PTSD outcomes [26].

Recent intervention research among University students demonstrates that structured trauma-coping programs can significantly reduce perceived stress, indicating that resilience-building and problem-focused coping training may be effective in promoting task-oriented coping strategies [27]. The present findings supported the need for trauma-informed approaches in higher education, such as faculty training, sensitive pedagogical strategies, and increased institutional awareness of trauma's impact [28]. University mental health services should integrate trauma screening, counselling, and resilience-building workshops to foster adaptive coping. Studies highlight that trauma-informed campus programs and peer support interventions significantly enhance students' wellbeing and academic functioning [29]. Stigma, gender norms, and traditional healing practices also shape coping behaviours. Interventions aligned with community rituals, religious values, and local leadership are more effective, while culturally insensitive approaches may pose risks to mental health [30].

Individual data collection was conducted with the assistance of a clinical psychologist, ensuring a smooth and confidential process. Participant confidentiality was strictly maintained throughout the study.

Limitation(s)

The present study focused on three types of coping strategies; however, other strategies, such as avoidance coping combined with acceptance or seeking social support, may also significantly impact QoL. The QoL measures used may not fully reflect all aspects of an individual's wellbeing. Additionally, there was limited control for potential confounders such as trauma severity, PTSD severity, time since trauma, and pre-existing mental health conditions. Longitudinal designs and a more diverse sample would be useful to determine whether specific coping mechanisms improve QoL, or whether high QoL encourages the use of certain coping styles.

CONCLUSION(S)

The findings indicate a positive effect of task-oriented coping on QoL across multiple domains. In contrast, emotion-oriented and avoidance-oriented coping strategies appear less beneficial and may contribute to poorer outcomes in areas such as environmental quality and overall QoL. These results emphasise the importance of fostering adaptive coping strategies that involve active problem-solving and engagement with life's challenges. Educating individuals about the benefits of task-oriented coping, while being mindful of the potential drawbacks of emotion-oriented and avoidance strategies, may improve wellbeing and life satisfaction.

REFERENCES

[1] Vrana S, Lauterbach D. Prevalence of traumatic events and post-traumatic psychological symptoms in a nonclinical sample of college students. Journal of Traumatic Stress. 1994;7(2):289-302.

[2] Riaz BK, Islam MZ, Ahmed HU, Akhtar K, Haque A, Amin KB, et al. Post-traumatic stress disorders and coping strategies of health professionals during COVID-19 pandemic in Bangladesh: Findings of a countrywide cross-sectional study. The Lancet Regional Health-Southeast Asia. 2023;11:100195.

[3] Benjet C, Bromet E, Karam EG, Kessler RC, McLaughlin KA, Ruscio AM, et al. The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. Psychological Medicine. 2016;46(2):327-43.

[4] Sledjeski EM, Speisman B, Dierker LC. Does number of lifetime traumas explain the relationship between PTSD and chronic medical conditions? Answers from the National Comorbidity Survey-Replication (NCS-R). Journal of Behavioral Medicine. 2008;31(4):341-49.

[5] Yuan T, Li X, Liu H, Guo LL, Li JL, Xu G, et al. Community trauma exposure and post-traumatic stress disorder in Chinese children and adolescents. Frontiers in Psychiatry. 2023;14:1151631.

[6] Lewis SJ, Arseneault L, Caspi A, Fisher HL, Matthews T, Moffitt TE, et al. The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. The Lancet Psychiatry. 2019;6(3):247-56.

[7] Naqvi WM, Gabr M, Arora SP, Mishra GV, Pashine AA, Syed ZQ. Bridging, mapping, and addressing research gaps in health sciences: The Naqvi-Gabr Research Gap Framework. Cureus. 2024;16(3):e12345.

[8] Perry Y, Cuellar MJ. Coping methods used by college undergraduate and graduate students while experiencing childhood adversities and traumas. Journal of Child & Adolescent Trauma. 2022;15(2):451-59.

[9] Kar N. Coping strategies used by adult survivors in the process of recovery from disaster trauma: A narrative review. Odisha Journal of Psychiatry. 2022;18(1):03-10.

[10] Crăciun B. Coping strategies, self-criticism and gender factor in relation to quality of life. Procedia-Social and Behavioral Sciences. 2013;78:466-70.

[11] Patrick DL, Erickson P. Assessing health-related quality of life for clinical decision-making. Quality of Life Assessment: Key Issues in the 1990s. 1993;11-63.

[12] Lamoureux-Lamarche C, Vasiliadis HM. Lifetime traumatic events, health- related quality of life, and satisfaction with life in older adults. Quality of Life Research. 2017;26(10):2683-92.

[13] Ilić I, Šipetić-Grujičić S, Grujičić J, Živanović Mačužić I, Kocić S, Ilić M. Psychometric properties of the world health organization's quality of life (WHOQOL-BREF) questionnaire in medical students. Medicina. 2019;55(12):772.

[14] Araya M, Chotai J, Komproe IH, de Jong JT. Effect of trauma on quality of life as mediated by mental distress and moderated by coping and social support among postconflict displaced Ethiopians. Quality of Life Research. 2007;16(6):915-27.

[15] Schnurr P, Vielhauer M, Weathers F, Findler M. The brief trauma questionnaire (BTQ)[measurement instrument] [Internet]. 1999.

[16] Choi Y, Moon E, Park JM, Lee BD, Lee YM, Jeong HJ, et al. Psychometric properties of the coping inventory for stressful situations in Korean adults. Psychiatry Investigation. 2017;14(4):427-33.

[17] Endler NS, Parker JD. Assessment of multidimensional coping: Task, emotion, and avoidance strategies. Psychological Assessment. 1994;6(1):50-09.

[18] Whoqol Group. Development of the World Health Organization WHOQOL-BREF quality of life assessment. Psychological Medicine. 1998;28(3):551-58.

[19] Nolen-Hoeksema S. The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. Journal of Abnormal Psychology. 2000;109(3):504-11.

[20] Folkman S, Moskowitz JT. Coping: Pitfalls and promise. Annu Rev Psychol. 2004;55(1):745-74.

[21] Ayers TS, Sandler IN, West SG, Roosa MW. A dispositional and situational assessment of children's coping: Testing alternative models of coping. Journal of Personality. 1996;64(4):923-58.

[22] Carver CS. You want to measure coping but your protocol'too long: Consider the brief cope. International Journal of Behavioral Medicine. 1997;4(1):92-100.

[23] Penley JA, Tomaka J, Wiebe JS. The association of coping to physical and psychological health outcomes: A meta-analytic review. J Behav Med. 2002;25(6):551-603.

[24] Breslau N, Davis GC, Andreski P, Peterson E. Traumatic events and posttraumatic stress disorder in an urban population of young adults. Arch Gen Psychiatry. 1991;48(3):216-22.

[25] Norris FH. Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. J Consult Clin Psychol. 1992;60(3):409-18.

[26] Thompson NJ, Fiorillo D, Rothbaum BO, Ressler KJ, Michopoulos V. Coping strategies as mediators in relation to resilience and posttraumatic stress disorder. J Affect Disord. 2018;225:153-59.

[27] Elsary AY, El-Sherbiny NA. The impact of stress-coping strategies on perceived stress during the COVID-19 pandemic among university students an interventional study. BMC Psychiatry. 2023;23(1):510.

[28] Gao H, Chen PF, Yao L. Trauma-informed practices in higher education: A comprehensive literature review (2015-2023). Int J High Educ. 2023;12(6):149-65.

[29] Henshaw LA. Building trauma-informed approaches in higher education. Behav Sci. 2022;12(10):368.

[30] Zeleke WA, Dagnew M, Wondie Y, Hailu T, Holmes C, Mekonen MM, et al. Assessment of cultural and contextual factors in trauma-informed interventions for internally displaced people in ethiopia: A community-based participatory action research. Trauma Care. 2025;5(1):04-15.

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AUTHOR DECLARATION:
• Financial or Other Competing Interests: None
• Was Ethics Committee Approval obtained for this study?   Yes
• Was informed consent obtained from the subjects involved in the study?   Yes
• For any images presented appropriate consent has been obtained from the subjects.   NA