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Impact of Coping Strategies on Mental Health among University Students

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ABSTRACT

The purpose of the present study was to explore the impact of coping strategies on mental health among university students. The sample consisted of 150 students, age range was from 18-38 years old, taken from different colleges & universities of Multan. The COPE (Carver, Scheier, & Weintraub, 1989) is a 60-item measure designed to assess the usual responses of individuals to stress using a four-point Likert scale. The MHI-18 is a shortened version of the original 36-item scale which was developed for use in general populations by Veit and Ware (1983) to assess psychological distress and wellbeing in general populations. Result indicated that coping strategies significantly correlated with mental health. It was also investigated that coping strategies have significant impact on mental health. Positive interpretation and growth, acceptance, active coping strategies, planning and religious coping strategies have greater impact on mental health.

Keywords: Coping Strategies, Mental Health

Introduction

Coping Strategies

Early work of coping, based on psychoanalytic theories (Freud 1962; A. Freud 1936; Haan 1977; Vaillant 1977), coping was subordinated to defenses and seen as an unconscious practice (McCrae 1984). Defense mechanisms were of concern as psychopathology was seen as a method of managing threat (Lazarus 1993). Coping was distinct as 'realistic and flexible thoughts and acts that solve problems and thereby reduce stress' (Lazarus 1993), behavior being seen as less important than cognition.

A hierarchy of coping was constructed with mature ego processes at the top and regressive ego functioning at the bottom (Haan 1977; Vaillant 1977), with precision in terms of 'reality' being the underlying criterion. Current analytic thought is now framed in terms of cognitive-motivational processes, such as the development of competence and control (Lazarus 1993). Coping is seen as involving conscious responses to an external stressor, rather than unconscious responses to internal conflicts (Moos 1976). Thus investigators can recognize the stressor, and the individual can be asked directly to report it rather than needing a clinician to reveal and interpret the underlying conflict and defense processes (McCrae 1984).

Mental health

World Health Organization (WHO) defines mental health "is not just the absence of mental disorder". It is considered as the state of well-being in which people can cope with normal stresses of life. In other words, mental health includes all aspects of life from home to



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school, university and workplace. The WHO has defined the mental health as the ability to establish relationships with others, change the personal and social environments, and resolve the conflicts and personal desires logically, righteously, and properly (Salehi.et.all, 2007). Little attention is paid to the mental feature of health in many countries, particularly the developing countries, due to focusing on other health priorities such as epidemics of transferable diseases in the past and chronic diseases in the present era. Though, as indicated in the statistics on the prevalence of mental disorders in different countries, the mental health status is at a critical level (Riahi MS,et.all, 2008).

WHO experts believed that the amount of behavioral and mental issues is on a growing trend in the developing countries This increase is largely reliant on the population growth and social modifications such as urbanization, changes in people's lifestyle, emotional problems, and mild mental illnesses. Some of these problems are directly related to evolutionary factors of late adolescence. The speed of mental illness is reported to be 10-12% among the students studying in the developed countries. The mental illness is measured as one of the reasons for the students' expulsion, academic failure, and dropout regardless of its severity (Yosofi et al, 2012).

Literature Review

Soliman (2013) conducted a study on perception of stress and coping strategies by medical students at King Saud University, Saudi Arabia. Objective of the study was that medical students face a number of stressors, which affect their academic performance and quality of life. The aim of the study was to assess the presence of stress and the strategies for coping perceived by medical students. Results found that the prevalence of perceived stress among medical students was high. This might influence not only their academic performance but also all aspects of health and life. There is a wide range of strategies for coping with stress, and student councils could play an important role in helping students cope with stress.

Bagana (2014) was study adolescents' patterns of depressive symptoms, proactive coping and self-perceived success in academic domain. The purpose of this study is to examine the adolescents' depressive symptom patterns in relation with their level of proactive coping and self-perceived success in the academic domain. 100 adolescents, aged 17 – 19 years ($M = 17.97$, $SD = .43$), 41 male and 59 female students participated in the study. The results revealed that the relations between the variables and those patterns of depressive symptoms were differentiated by the communication between adolescents' gender, level of proactive coping and of self-perceived success in the academic domain. The results can be included in adolescents' trainings and in activities that prevent the adolescents' depression.

Objectives

To check the relation among coping strategies & mental health among students

To find out impact of coping strategies on mental health of students

Hypothesis

There will be a significant relationship among coping strategies & mental health.

There will be a significant impact of coping strategies on anxiety-mental health.

There will be a significant impact of coping strategies on depression-mental health.

There will be a significant impact of coping strategies on behavioral control-mental health.

There will be a significant impact of coping strategies on positive-affect-mental health.



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Method

Statistical Population, Sample and Sampling Method

The statistical population measured by G-Power analysis was 150 students from different colleges and universities of Multan. The education level of participants varied from graduation to PhD degree. Age range between 18 to 38 and all participants were students of different departments. Informed written consent was taken from the participants after explaining them the purpose of research. Convenient sampling technique was used to collect data from different colleges and universities of Multan.

Research Design

A quantitative research design was used for the purpose of study. Data was obtained through survey method using convenient sampling technique.

Instruments

Coping Operations Preference Enquiry

The COPE (Carver, Scheier, & Weintraub, 1989) is a 60-item measure designed to assess the usual responses of individuals to stress using a four-point Likert type scale from 0 ("I don't usually do this at all") to 4 ("I usually do this a lot"). Scores from individual items are summed without reversing them in order to form one of fifteen scales. Examples of those scales (with a representative item in parentheses) include: mental disengagement ("I turn to work or other substitute activities to get my mind off of things"), active coping ("I concentrate my efforts on doing something about it."), and use of emotional support ("I discuss my feelings with someone.") These scale scores were found to have internal consistency reliability coefficients in an acceptable range (all > .60; Carver, Scheier, & Weintraub, 1989) and two separate samples produced the same factor structure.

Mental Health Inventory

The MHI-18 is a shortened version of the original 36-item scale which was developed for use in general populations by Veita and Ware (1983) to assess psychological distress and wellbeing in general populations. It contains items assessing anxiety, depression, behavioral control, and positive affect. Psychological well-being is comprised of positive affect and emotional ties. Psychological distress consists of depression, anxiety, and loss of behavioral/ emotional control. Subjects are asked to indicate how often they have experienced various emotions during the prior four week period. Choices are given along a 6-point scale, ranging from 1 (all of the time) to 6 (none of the time). The subscale and total scores range from 0-100, with higher scores indicating better mental health.

Procedure

The available tools were identified and data from 150 participants was conducted. Participant were belongs to different colleges and universities of Multan. A convenient sampling technique was used and a written informed consent was taken from the participants. Standardized scales were administered with demographic form which includes age, gender, education and GPA/ division. All the ethical requirements were taken into account.

Results

After the one month of data collection phase, data was organized on SPSS (version 20) data sheet and statistical analysis was run. Descriptive statistics was utilized to measure mean, standard deviation and alpha reliability. Correlation was used to analyze the relation



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among coping strategies & mental health. Regression analysis was used to check the impact of coping strategies on mental health.

Table 1

Correlation Analysis of study variables (N=150)

	PG	P	AA	USIS	A	US ES	M D	EE	H	RA	BD	SC	D	SC A	R
PG	1	.502* *	.512* *	.325* *	.431* *	.549* *	.455* *	.347* *	-.136	.562* *	.008	-.178* *	-.048	.423* *	.261* *
P		1	.518* *	.266* *	.239* *	.529* *	.493* *	.349* *	-.292* *	.439* *	-.020	-.187* *	-.162* *	.277* *	.414* *
AA			1	.275* *	.286* *	.590* *	.538* *	.357* *	-.272* *	.589* *	.034	-.198* *	-.121	.300* *	.431* *
USIS				1	.187	.312* *	.245* *	.173* *	-.116	.272* *	-.005	-.053	-.009	.069	.170* *
A					1	.410* *	.401* *	.228* *	.050	.448* *	.152	-.207* *	.098	.318* *	.105
UOSES						1	.462	.395* *	-.107	.546* *	.181*	-.117	-.061	.452* *	.351* *
M D							1	.501	-.064	.410* *	.118	-.224* *	0.74	.446* *	.286* *
EE								1	.007	.311* *	.213* *	-.050	.009	.256* *	.250* *
H									1	-.210* *	.373** *	.204* *	.316* *	.146	-.090
RA										1	.003	-.171* *	-.149	.246* *	.300* *
BD											1	.012	.137	.246* *	.095



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SU											1	.081	-.077	-.160
D												1	.058	-.051
SCA													1	.149
R														1

*P<0.05, ** P<0.01, P>0.05

Note: PG= positive interpretation and growth, P= planning, AA=active approach, USIS=use of social instrumental support, A= acceptance, USES= use of social emotional support, MD= mental deactivation, EE= expressing the emotion, H=humor, RA= religious approach, BD= behavior deactivation, SC= substance consumption, D= denial, SCA= suppression of competing activities, R=restraint

Table 2

Standard Regression Model showing impact of coping strategies on Anxiety (N=150)

Model	B	Std. Error	Beta	T	Sig
(Constant)	4.438	2.773		1.600	.112
Positive interpretation and growth	.232	.162	.128	1.435	.154
Planning	.367	.149	.215	2.455	.015*
Active coping	.730	.167	.419	4.384	.000***
Use of social instrumental support	-.111	.096	-.079	-1.161	.248
Acceptance	.161	.164	.076	.985	.326
Use of social emotional support	.132	.173	.071	.763	.447
Mental deactivation	-.162	.189	-.077	-.858	.393
Expressing the emotions	.124	.161	.058	.767	.444
Humor	-.107	.147	-.056	-.726	.469
Religious approach	-.246	.167	-.131	-1.473	.143
Behavioral deactivation	.016	.135	.008	.119	.906
Substance consumption	.243	.133	.123	1.828	.070
Denial	-.151	.093	-.111	-1.627	.106
Suppression of competing activities	-.029	.159	-.014	-.182	.856
Restraint	.160	.096	.120	1.664	.099

R² : .483, Adjusted R² : .425, F(15, 134)= 8.336, *P< 0.05,*** P<0.001, P>0.05

Coping strategies has insignificant impact on anxiety except planning coping strategies and active coping strategies.



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Table 3

Standard Regression Model showing impact of coping strategies on Depression

Model	B	Std. Error	Beta	T	Sig
(Constant)	6.225	2.399		2.595	.011**
Positive interpretation and growth	.063	.140	.046	.449	.654
Planning	.191	.129	.150	1.475	.142
Active approach	.014	.144	.011	.098	.922
Use of social instrumental support	-.110	.083	-.105	-1.327	.187
Acceptance	.039	.142	.025	.275	.784
Use of social emotional support	.246	.150	.178	1.644	.102
Mental deactivation	.145	.163	.093	.889	.376
Expressing the emotion	.021	.139	.013	.151	.880
Humor	-.216	.127	-.152	-1.697	.092
Religious approach	.279	.144	.200	1.932	.05*
Behavior deactivation	.139	.117	.099	1.191	.236
Substance consumption	.030	.115	.020	.259	.796
Denial	-.037	.080	-.036	-.456	.649
Suppression of competing	-.105	.138	-.070	-.764	.446
Restraint	-.008	.083	-.009	-.102	.919

R²: .305, Adjusted R²: .227, F(15,134) = 3.917, *P < 0.05, ** P < 0.01, P > 0.05

Coping strategies has insignificant impact on depression except religious approach of coping strategies.



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Table 4

Standard Regression Model showing impact of coping strategies on Behavioral Control (N=150)

Model	B	Std. Error	Beta	T	Sig
(Constant)	12.637	2.587		4.886	.000***
Positive interpretation and growth	.018	.151	.012	.120	.905
Planning	.287	.139	.209	2.059	.041*
Active coping	.267	.155	.190	1.719	.088
Use of social instrumental support	-.084	.090	-.074	-.942	.348
Acceptance	-.031	.153	-.018	-.203	.839
Use of social emotional support	.093	.161	.062	.577	.565
Mental deactivation	.217	.176	.128	1.231	.221
Expressing the emotions	.020	.150	.012	.133	.894
Humor	.013	.137	.008	.094	.926
Religious approach	-.100	.156	-.067	-.645	.520
Behavioral deactivation	-.173	.126	-.113	-1.370	.173
Substance consumption	-.282	.124	-.177	-2.277	.024*
Denial	-.149	.087	-.135	-1.715	.089
Suppression of competing activities	.024	.148	.015	.165	.869
Restraint	.027	.090	.025	.305	.761

R² : .306, Adjusted R² : .229, F(15, 134)= 3.948, *P< 0.05,*** P<0.001, P>0.05

Coping strategies has insignificant impact on behavioral control except planning and substance consumption coping strategies.

Table 5

Standard Regression Model showing impact of coping strategies on Positive Affect (N=150)

Model	B	Std. Error	Beta	T	Sig
(Constant)	15.171	2.503		6.062	.000***
Positive interpretation and growth	.017	.146	.012	.117	.907
Planning	.226	.135	.175	1.680	.095
Active approach	.299	.150	.226	1.986	.049*
Use of social instrumental support	-.047	.087	-.044	-.548	.585
Acceptance	-.069	.148	-.043	-.467	.641
Use of social emotional support	.214	.156	.152	1.371	.173
Mental deactivation	-.115	.170	-.072	-.673	.502
Expressing the emotion	-.134	.145	-.083	-.921	.359



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Humor	-.182	.133	-.126	-1.373	.172
Religious approach	-.082	.151	-.058	-.545	.587
Behavior deactivation	.166	.122	.116	1.362	.175
Substance consumption	-.085	.120	-.057	-.712	.478
Denial	-.100	.084	-.097	-1.194	.234
Suppression of competing	-.137	.144	-.089	-.954	.342
Restraint	.138	.087	.136	1.591	.114

$R^2: .270$, Adjusted $R^2: .188$, $F(15,134) = 3.299$, * $P < 0.05$, *** $P < 0.001$, $P > 0.05$

Coping strategies has insignificant impact on positive effect except active coping strategies.

Discussion

The first hypothesis, that coping strategies & mental health significant positive correlated with each other. Results of correlational analysis supported our first hypothesis. It was found that positive interpretation and growth coping preference is significant correlated with mental health. Planning coping strategies, active approach of coping, use of social instrumental support coping strategies are also significant correlated with mental health. Acceptance coping has no significant relation with mental health. Use of social instrumental support shows significant correlation with mental health. Mental deactivation coping style also shows significant correlation with mental health. Expressing emotion coping strategies are also significant correlated with mental health. Humor coping strategies has no significant relation with mental health. Religious approach coping were highly significant correlated with mental health. Behavioral deactivation coping strategies show no correlation with mental health. Substance use coping strategies are negatively correlated with mental health. Denial coping strategies were also negatively correlated with mental health.

The second hypothesis of the study was that there will be a significant impact of coping strategies on anxiety of mental health. Results indicate that there was a significant impact of planning and active coping strategies on anxiety. In third hypothesis it was concluded that religious coping strategies have significant impact on depression. Likewise, Planning coping strategies have significant impact on behavior control of mental health. Maladaptive coping strategies as substance conception have also significant impact on behavior control. Active coping strategies have significant impact on positive affect.

Conclusion:

These findings suggest that positive attitude and growth, acceptance, religious coping and planning of coping strategies were significantly correlation with mental health. It was also concluded that adaptive coping strategies were greater impact on mental health.

Limitations:

The findings of this study are limited to a small sample.

In this study data was collect only from Multan city so that results cannot be generalized to the whole Pakistan community.

Present research examined in quantitative method, psychological factors should be study in qualitative method also.

Suggestion:

It is also suggested to draw a large sample for this purpose.

It was may be more effective to conduct a longitudinal research to study the long run use of coping



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strategies by students.

In addition, further study is needed to investigate psychological intervention that facilitates useful coping strategies among mental health survivors.

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