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ORIGINAL ARTICLE

ASSOCIATION BETWEEN ANXIETY LEVELS AND COPING STRATEGIES AMONG UNDERGRADUATE DENTAL STUDENTS IN KARACHI: AN ANALYTICAL CROSS-SECTIONAL STUDY

[1]MARIUM IQBAL, [2]SADIA TABASSUM, [3]ESHA NOOR, [4]FATIMA ARSHAD, [5]OSHA SUDHAMCHAND, [6]PAYAL AMAR LAL

ABSTRACT

Objective: *To examine the association between coping style (predominantly maladaptive vs adaptive) and anxiety levels among undergraduate dental students in Karachi, Pakistan.*

Methodology: *An analytical cross-sectional survey was conducted at Jinnah Medical and Dental College (JMDC), Karachi. Anxiety was assessed using Generalized Anxiety Disorder-7 (GAD-7; 0-21) and coping using a 19-item adaptation of the Brief-COPE (1-4). Domain means were computed, and "predominantly maladaptive" coping was defined as maladaptive mean > adaptive mean. Logistic regression modeled maladaptive coping on GAD-7 score; ordinal logistic regression modeled GAD-7 category on coping style using robust standard errors. Complete-case analyses included n=168 (total n=175).*

Results: *Mean age was 21.31 ± 1.82 years; 37.7% reported predominantly maladaptive coping. The largest ethnic groups were Urdu-speaking (36.1%) and Sindhi (21.9%). Each 1-point increase in GAD-7 score was associated with higher odds of maladaptive coping (OR 1.09, 95% CI 1.02-1.15; p=0.0067), equivalent to OR 1.54 per 5-point increase. Predominantly maladaptive coping was associated with higher odds of a higher anxiety category (OR 2.18, 95% CI 1.25-3.80; p=0.006).*

Conclusion: *Predominantly maladaptive coping was associated with higher anxiety among undergraduate dental students.*

Keywords: *Anxiety; Coping mechanisms; Students, dental*

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INTRODUCTION

Stress arises when individuals appraise environmental demands as exceeding the coping resources available to them. In the transactional model, stress happens when a person feels the demands of a situation are greater than the coping resources they have[1]. Anxiety is a common manifestation of this burden in student populations.

Among nonfatal disease burden worldwide, anxiety disorders are a leading cause and rose markedly during and after the COVID-19 era, with tens of millions of additional cases estimated in 2020 alone. Students were heavily affected during this period, underscoring the need for stronger campus support and prevention strategies[2-4]. Dental students report substantial anxiety and psychological distress because of academic pressure, preclinical and clinical requirements, examinations, and patient-care responsibilities. Dentistry has been identified as a demanding course of study, and multi-country and systematic-review evidence shows that stress is common during training[5-8].

Regionally, work from Pakistan and neighboring settings shows a substantial burden of anxiety among dental undergraduates and highlights the range of coping strategies students use to manage academic and

[1] **Correspondence:** Sadia Tabassum, BDS, FCPS, Paediatric Dentistry, Jinnah Medical Dental College, 22-23 Shaheed-e-Millat Road, Karachi 74000, Pakistan, Email:sadyatabassum@gmail.com, Cell: 03335387294

[2] Marium Iqbal, FCPS, Professor, Operative Dentistry, Jinnah Medical Dental College, Karachi, Email: mariumdeens2024@gmail.com, Cell: 03003623450

[3] Esha Noor, 3rd Year BDS student, Jinnah Medical Dental College, Karachi, Email:eshanoor422@gmail.com, Cell: 03131134883

[4] Fatima Arshad, 3rd Year BDS student, Jinnah Medical Dental College, Karachi, Email:fatimaarshad3355@gmail.com, Cell: 03362280307

[5] Osha Sudhamchand, 3rd Year BDS student, Jinnah Medical Dental College, Karachi, Email:oshasudhamchand@gmail.com, Cell: 03400930036

[6] Payal Amar Lal, 3rd Year BDS student, Jinnah Medical Dental College, Karachi, Email:payallarai@icloud.com, Cell: 03213005502

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clinical pressures. However, most studies describe prevalence or list coping behaviours rather than quantifying how coping style relates to anxiety severity, leaving a practical evidence gap for program design[9,10]. Generalized Anxiety Disorder-7 (GAD-7) is a brief screening instrument with contemporary evidence for reliability and validity in student and general populations[11-15].

Coping mechanisms are the cognitive and behavioural strategies people use to manage stress. Contemporary literature broadly groups these into adaptive or approach strategies, such as planning, positive reframing, and support-seeking, and maladaptive or avoidant strategies, such as distraction, venting, and self-blame[16]. Maladaptive coping may worsen stress and anxiety over time, increasing the risk of burnout and dropout. Because Brief-COPE does not provide a validated clinical cut-point for classifying students as adaptive or maladaptive copers, summaries of overall coping style should be interpreted cautiously[17]. While studies do exist on anxiety among undergraduate dental students, less is known about how overall coping style relates to anxiety severity in our regional context. Understanding this relationship may help dental schools design feasible supports for student well-being.

Building on this regional evidence gap, we conducted an analytical cross-sectional survey of undergraduate BDS students at JMDC, Karachi, to examine whether coping style (adaptive versus maladaptive) is associated with anxiety level as measured by the GAD-7. We also explored whether basic sociodemographic characteristics were associated with coping style.

METHODOLOGY

Study setting and participants:

This analytical cross-sectional study was conducted at Jinnah Medical and Dental College (JMDC), Karachi, Pakistan. Eligible participants were currently enrolled undergraduate BDS students. Students with a self-reported prior diagnosis of a psychiatric disorder and those taking prescribed medications for anxiety or related conditions were excluded. The form opened with two screening questions asking whether the student had a prior psychiatric diagnosis and whether the student was currently taking prescribed medication for anxiety or another psychiatric condition. Students answering Yes to either item were not eligible to proceed.

Sample size and sampling technique:

We attempted a census of all eligible undergraduate BDS students enrolled at JMDC by inviting the full cohort to participate. Out of 190 enrolled students, 175 completed the questionnaire (response rate approximately 92%). We used complete-case analysis for regression models (analytic n=168).

Data collection instrument

For anxiety assessment, we used the English version of the Generalized Anxiety Disorder-7 (GAD-7; total range 0-21), a brief questionnaire widely used for anxiety screening[18]. Standard categories were used for descriptive analyses: minimal 0-4, mild 5-9, moderate 10-14, severe 15-21. Contemporary psychometric studies support its reliability and validity, and systematic review evidence supports its screening performance against gold-standard diagnostic interviews[11-15]. An Urdu version validated in Pakistan is available for local use, although the present survey was administered in English[19].

For coping strategies, we used selected Brief-COPE items (Appendix), each rated on a 4-point scale from 1 ("I haven't been doing this at all") to 4 ("I've been doing this a lot"). Items were grouped a priori into adaptive/approach domains (active coping, planning, positive reframing, acceptance, emotional support, instrumental support, religion, humor) and maladaptive/avoidant domains (distraction, venting, self-blame). For each domain, we computed the mean of its item(s). We then computed an overall adaptive coping mean (mean of the adaptive domain scores) and an overall maladaptive coping mean (mean of the maladaptive domain scores). Predominant coping style was classified as maladaptive if the maladaptive mean exceeded the adaptive mean; otherwise it was classified as adaptive[17]. Age (years) and self-identified ethnicity were collected; ethnicity was also examined in a collapsed 5-group form (Urdu, Sindhi, Punjabi, Pathan, Other). Because Brief-COPE does not provide a validated clinical cut-point for categorizing students as adaptive or maladaptive copers, this binary classification was used as a pragmatic summary measure for interpretability rather than as a validated diagnostic threshold. The domain grouping was specified a priori using Brief-COPE conceptual domains and is acknowledged as a measurement limitation in the Discussion.

Data collection procedure

Following ERC approval, the draft questionnaire was piloted in a small group of eligible students to assess clarity, wording, and item order. Pilot responses were excluded from the final dataset. Based on participant feedback, minor wording and sequencing refinements were made to improve clarity and face validity before full rollout. The final questionnaire and consent form were then distributed to the main survey cohort via an emailed Google Forms link. The form included an introductory section describing the study purpose and consent, followed by sections on sociodemographic characteristics, anxiety assessment, and coping strategies. To minimize information bias and social desirability effects, we used standardized instruments with stan-

dard scoring and collected responses confidentially through an online self-administered format. The high response rate after approaching the full cohort reduced the likelihood of substantial non-response bias.

Ethical considerations

We submitted the study protocol to the JMDC IRB for ethical approval (ERC no. 00093/24). Electronic informed consent was obtained from all participants before they accessed the online questionnaire.

Statistical Analysis

Data were analyzed in STATA SE 15.1. Descriptive statistics summarized participant characteristics and anxiety and coping distributions. Logistic regression was used to estimate the association between GAD-7 score and maladaptive coping, and ordinal logistic regression was used to estimate the association between coping style and GAD-7 category. Age and ethnicity were assessed as potential covariates in exploratory multivariable models; because their inclusion did not materially alter the primary association, the more parsimonious univariable models are presented. Sex/gender and year of study were not collected and therefore could not be evaluated. A two-sided alpha of 0.05 was considered statistically significant. Robust standard errors were used throughout. Internal consistency of the GAD-7 was evaluated using Cronbach's alpha.

RESULTS

Table 1 summarizes the student characteristics, coping style and GAD-7 categories.

None of the students screened reported a prior psychiatric diagnosis or current prescribed psychiatric medication use. Age and ethnicity had some missing data (Table 1). Mean age was 21.31 ± 1.82 years (n=163). Among the 168 participants with complete GAD-7 data, the largest anxiety category was mild (36.9%), followed by minimal (27.3%), moderate (22.6%), and severe (13.1%). Overall, 109 of 175 students (62.2%) were classified as predominantly adaptive copers and 66 (37.7%) as predominantly maladaptive copers; the largest ethnic groups were Urdu-speaking (36.1%) and Sindhi (21.9%). Table 2 and the regression analyses are based on complete cases (n=168), which is why the adaptive-coping total decreases from 109 in Table 1 to 102 in Table 2. In unadjusted analyses, coping style differed across anxiety categories (Pearson chi-square = 9.31, p=0.025; Table 2). In the primary logistic regression model (outcome: maladaptive coping), each 1-point increase in GAD-7 score was associated with higher odds of maladaptive coping (OR 1.09, 95% CI 1.02-1.15; p=0.0067), equivalent to OR 1.54 per 5-point increase (Table 3). Model calibration was acceptable (Hosmer-Lemeshow p=0.121), although discrimination was modest (AUC=0.63). In the secondary ordinal logistic regression model (outcome: GAD-7 category), maladaptive coping was associated with higher odds of being in a higher anxiety category (OR 2.18, 95% CI 1.25-3.80; p=0.006; Table 4). Cronbach's alpha for the GAD-7 was 0.836. Exploratory models additionally including age and ethnicity showed that neither variable was statistically significant and that the main association estimates changed minimally; therefore, the more parsimonious univariable models are presented.

TABLE 1: CHARACTERISTICS OF THE UNDERGRADUATE DENTAL STUDENTS (N=175)

Characteristic	n	Mean/ Percentage
Age (years)	163	21.31 ± 1.82
Ethnicity*		
Urdu	61	36.1%
Sindhi	37	21.9%
Punjabi	32	18.9%
Pathan	15	8.9%
Others	24	13.7%
Coping style		
Adaptive	109	62.2%
Maladaptive	66	37.7%
GAD-7 total	168	8.14 ± 5.30
GAD-7 category**		
Minimal 0–4	46	27.3%
Mild 5–9	62	36.9%
Moderate 10–14	38	22.6%
Severe 15–21	22	13.1%

* Ethnicity n=169 non-missing; "Other" included Baloch, Gilgiti, Gujarati, Hazarewal, Memoni, and Saraiki.

** Complete cases n=168.

TABLE 2: ANXIETY CATEGORY (GAD-7) BY COPING STYLE (UNADJUSTED)

GAD-7 category	Adaptive n (row %)	Maladaptive n (row %)	Row total (n)
Minimal	36 (78.2%)	10 (21.7%)	46
Mild	**36 (58.0%)**	**26 (41.9%)**	**62**
Moderate	18 (47.3%)	20 (52.6%)	38
Severe	12 (54.5%)	10 (45.4%)	22
Total	102	66	168

Pearson $\chi 2 = 9.31$, $p = 0.025$; N = 168. Row percentages shown. All expected cell counts ≥ 8.6, assumptions met.

TABLE 3: LOGISTIC REGRESSION OF MALADAPTIVE COPING ON GAD-7 TOTAL IN UNDERGRADUATE DENTAL STUDENTS (N=168)

Predictor	OR (95% CI)	P-value
GAD-7 total (per 1-point)	1.09 (1.02–1.15)	0.0067
GAD-7 total (per 5-point increase)	**1.54 (1.10-2.01)**	**0.0067**

TABLE 4: ORDINAL LOGISTIC REGRESSION OF GAD-7 CATEGORY ON COPING STYLE IN UNDERGRADUATE DENTAL STUDENTS (N=168)

Exposure (vs Adaptive)	OR (95% CI)	P-value
Maladaptive coping	2.18 (1.25–3.80)	0.006

DISCUSSION

Most students in this sample fell within the mild-to-moderate anxiety range. This pattern is broadly consistent with Pakistani and international studies of dental students, although direct prevalence comparisons should be interpreted cautiously because instruments, cut-points, sampling frames, and academic settings differ.[5,8-10] For example, Malghani et al. reported that mild-to-moderate anxiety was common among dental students in Islamabad/Rawalpindi and that problem-solving strategies were frequently used.9 Atif et al. also documented substantial perceived stress and varied coping strategies among Pakistani dental students, reinforcing that psychological distress is common in this population[10].

In our study, higher anxiety was linked with a greater likelihood of maladaptive coping, while students using adaptive strategies were more likely to fall in lower anxiety categories. The GAD-7 showed good internal consistency in this sample (Cronbach's alpha = 0.836), consistent with contemporary evidence supporting its reliability in college and general populations[11-15]. Similar links between maladaptive coping and poorer mental health have been reported in dental trainees, nursing students, Palestinian university students, and post-pandemic student cohorts[20-24].

Multiple recent studies show that maladaptive coping co-occurs with higher anxiety, whereas more adaptive or positive coping profiles are associated with better mental health in university samples[23,24]. This is also consistent with evidence from postgraduate dental trainees, where dental-environment stressors are associated with higher perceived stress and coping may offer only limited buffering in high-stressor settings[22]. Brief stress-reduction activities embedded in training or simulation sessions may offer short-term benefit and could be feasible within dental curricula[25]. Screening with short instruments such as the GAD-7 is supported by contemporary psychometric evidence[11-15].

The study benefited from a high response rate after inviting all eligible BDS students, which strengthens internal validity within this cohort. Nevertheless, several limitations should be considered. Firstly, this was a single-institution study, so selection bias and limited generalizability are possible. Secondly, temporal direction and causal inference cannot be established due to the cross-sectional nature of the study. Coping style was summarized using a pragmatic binary classification based on the relative balance of adaptive and maladaptive domain rather than a formally validated diagnostic cut-point. This may oversimplify the multidimensional nature of coping and could have introduced non-differential misclassification, most likely biasing associations toward the null. Although the Brief-COPE domains used here were specified a priori from the instrument's conceptual framework and existing literature, this grouping has not been psychometrically validated in our sample and should therefore be interpreted cautiously. Because Brief-COPE does not provide a validated clinical threshold for classifying overall coping style, the adaptive versus maladaptive grouping should be viewed as an analytic summary rather than a diagnostic construct[17]. We did not perform factor analysis or other dimensionality checks, so the measure's construct validity in this dataset remains uncertain.

To reduce information bias, we used standard scoring approaches, administered the survey confidentially through an online form, and piloted the questionnaire before full rollout, excluding pilot respondents and refining items that were unclear. Some bias from missing data is possible; we addressed this by using complete-case analysis for each model and reporting the analytic sample size used in modelling. Sex/gender and year of study were not collected, so we could not assess their confounding or effect-modifying roles. The modest model discrimination also suggests that additional unmeasured factors may contribute to student anxiety and coping.

At the institutional level, realistic responses include brief periodic screening, clear referral pathways, faculty mentoring, and short coping-skills sessions integrated into existing teaching or simulation activities[25].

CONCLUSION

Maladaptive coping was associated with greater anxiety among undergraduate dental students in this analytical cross-sectional survey. Although causality cannot be inferred, the findings support feasible institutional responses such as periodic screening,

clear referral pathways, faculty mentoring, and brief coping-skills sessions embedded within existing teaching activities. Future longitudinal and interventional studies should examine whether strengthening adaptive coping reduces subsequent anxiety and improves student functioning.

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CONTRIBUTIONS BY AUTHORS

1. Marium Iqbal:	Conceptualization; Supervision; Approval of final version
2. Sadia Tabassum:	Methodology; Data analysis and critical revision of manuscript
3. Esha Noor:	Writing the original draft, Data collection; Review & editing.
4. Fatima Arshad:	Writing the original draft, Data collection; Review & editing.
5. Osha Sudhamchand:	Writing the original draft, Data collection; Review & editing.
6. Payal Amar Lal:	Writing the original draft, Data collection; Review & editing.

APPENDIX

Generalized Anxiety Disorder-7 (GAD-7)

Instructions: Over the last two weeks, how often have you been bothered by the following problems?

No.	Item	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1	Feeling nervous, anxious, or on edge	□	□	□	□
2	Not being able to stop or control worrying	□	□	□	□
3	Worrying too much about different things	□	□	□	□
4	Trouble relaxing	□	□	□	□
5	Being so restless that it is hard to sit still	□	□	□	□
6	Becoming easily annoyed or irritable	□	□	□	□
7	Feeling afraid, as if something awful might happen	□	□	□	□

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

Scoring GAD-7 Anxiety Severity

Assign scores of 0, 1, 2, and 3 to the response categories “not at all,” “several days,” “more than half the days,” and “nearly every day,” respectively.

GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Adapted 19-item Brief-COPE Used in This Study

Instructions: The following questions ask how you have sought to cope with a hardship in your life. Read each statement and indicate how much you have been using that coping style.

Response options: 1 = I have not been doing this at all; 2 = A little bit; 3 = A medium amount; 4 = I have been doing this a lot.

No.	Item	1	2	3	4
1	I have been receiving comfort from others.	□	□	□	□
2	I have been surrendering to the situation.	□	□	□	□
3	I have been engaging in work and hobbies to distract myself.	□	□	□	□
4	I have been directing my energy toward finding solutions.	□	□	□	□
5	I have been telling myself this is temporary.	□	□	□	□
6	I have been expressing myself to release pent-up emotions.	□	□	□	□
7	I have been seeking guidance from others.	□	□	□	□
8	I have been searching for something satisfactory in what is happening.	□	□	□	□
9	I have been sharing my negative sentiments.	□	□	□	□
10	I have been trying to find peace in my religion or spiritual faith.	□	□	□	□
11	I have been adjusting myself to live with it.	□	□	□	□
12	I have been thinking funny thoughts about the situation.	□	□	□	□
13	I have been cracking jokes to distract my mind.	□	□	□	□
14	I have been watching movies, play games, take a nap or go out for shopping to deal with it.	□	□	□	□
15	I have been carefully considering my actions.	□	□	□	□
16	I have been trying to view it from a fresh perspective, to make it appear more positive.	□	□	□	□
17	I have been too self-critical.	□	□	□	□
18	I have been trying to come up with a solution about what to do.	□	□	□	□
19	I have been leaning on someone for support.	□	□	□	□

Response option key: 1 = I have not been doing this at all; 2 = A little bit; 3 = A medium amount; 4 = I have been doing this a lot.