

COPING STRATEGIES AND FACTORS ASSOCIATED WITH RESILIENCE AMONG FLOOD SURVIVORS IN SAMBA DISTRICT, JAMMU AND KASHMIR: A CROSS-SECTIONAL STUDY

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ABSTRACT

Background: Floods are recurrent natural disasters that disrupt communities, causing not only physical and economic damage but also significant psychological distress. Survivors often rely on coping strategies and resilience to adapt and recover, yet these processes remain underexplored in many flood-prone regions. **Aim:** The study aimed to assess coping strategies and resilience among individuals affected by severe flooding and to examine coping strategies, resilience levels, and factors associated with resilience among flood survivors. **Methodology:** A cross-sectional study was conducted among 400 flood survivors from affected communities in Samba District of Jammu & Kashmir. Data were collected using the Brief COPE Inventory to assess coping strategies and the Connor-Davidson Resilience Scale (CD-RISC) to measure resilience levels. Descriptive statistics, correlation, and regression analyses were applied to examine associations between coping strategies, socio-demographic variables, and resilience. **Results:** Findings showed that religious coping (68%), active problem-solving (62%), and seeking social support (59%) were the most frequently adopted strategies. Maladaptive strategies, including denial (21%) and substance use (14%), were less common but negatively correlated with resilience. The mean resilience score was 61.4 (SD = 12.7), with higher resilience observed among men and those with strong community ties (age was not a significant predictor in the regression model). Regression analysis indicated that adaptive coping, social support, and community participation significantly predicted resilience, explaining 41% of the variance. **Conclusion:** The study concludes that resilience is shaped by both individual coping strategies and community-level resources. Interventions should focus on strengthening adaptive coping, enhancing social support systems, and integrating culturally sensitive mental health services into disaster preparedness and recovery programs.

Keywords: Floods, coping strategies, resilience, psychosocial impact, community recovery

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INTRODUCTION

Natural disasters, particularly floods, represent a profound global public health challenge, causing not only immediate physical devastation but also a persistent psychosocial crisis (World Health Organization [WHO], 2022). Beyond the visible destruction lies a complex and prolonged mental health burden. Flood survivors often exhibit significantly elevated rates of post-traumatic stress disorder (PTSD), anxiety, and depression, with systematic reviews reporting substantial PTSD prevalence across natural disaster survivors (Beaglehole et al., 2018). These psychological effects are frequently exacerbated by chronic post-disaster stressors such as financial instability, displacement, and grief, which can hinder individual and community recovery for years (Mason et al., 2010).

Central to navigating this adversity are the interconnected psychological constructs of coping and resilience. Coping refers to the conscious cognitive and behavioral efforts individuals employ to manage, tolerate, or reduce stress (Lazarus & Folkman, 1984). These strategies range from adaptive approaches like active problem-solving and seeking emotional support to maladaptive responses such as denial or substance use. Resilience, in turn, is the dynamic process of adapting and 'bouncing back' from significant trauma, representing not the absence of pathology, but the presence of protective factors that foster successful adaptation (Windle, 2011).

Based on Lazarus and Folkman's Stress and Coping Theory and Community Resilience Theory (Norris et al., 2008), resilience was conceptualized as an outcome influenced by adaptive coping, social support, and community participation. The foundational work of Lazarus and Folkman (1984) distinguishes between problem-focused and emotion-focused coping, both of which are

essential in disaster contexts. Operationalized by instruments like the Brief COPE Inventory (Carver, 1997), these strategies have been consistently linked to post-disaster mental health outcomes. Adaptive strategies predict better adjustment, while maladaptive ones are associated with higher levels of psychopathology (Cicognani et al., 2009; Oni et al., 2015). In many cultures, including India, religious coping is a particularly salient and effective strategy for finding meaning and solidarity, serving as a critical psychosocial resource (Pargament, 2001; Goldmann & Galea, 2014).

Contemporary understandings of resilience have evolved from an innate individual trait to a dynamic process nurtured by community resources (Masten, 2018). While individual capacities like optimism and self-efficacy, often measured by tools like the Connor-Davidson Resilience Scale (CD-RISC), are crucial (Connor & Davidson, 2003), resilience is profoundly social. It is embedded in community resilience the collective ability to withstand and recover from adversity (Norris et al., 2008). Key components include social capital, the networks of trust and reciprocity that provide emotional and instrumental aid, and collective efficacy, the shared belief in a group's power to effect change (Aldrich & Meyer, 2015; Patel et al., 2017).

Despite this growing body of knowledge, the intricate interplay between coping and resilience remains underexplored in specific, high-risk regions. The Jammu & Kashmir region, particularly the Samba District, is highly susceptible to floods, yet systematic research into its communities' psychosocial responses is scarce (Meraj et al., 2018). This study, therefore, addresses a critical gap by examining the coping strategies and resilience levels among flood-affected individuals in Samba District. By identifying the predominant strategies and key predictors of resilience, this research aims to inform the development of

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effective, evidence-based, and culturally sensitive mental health interventions that foster long-term psychosocial well-being and sustainable community recovery.

MATERIALS & METHODS

Research Design and Setting: A quantitative, cross-sectional research design was employed to investigate the coping strategies and resilience of flood survivors at a single point in time. This design is appropriate for assessing the prevalence of certain phenomena (like coping strategies) and examining associations between variables (like coping and resilience). The study was conducted in the Samba District of the Jammu division in Jammu & Kashmir, India. This district was selected due to its recurrent exposure to severe flooding from the Basantar River and other tributaries, which has caused widespread damage to residential and agricultural land in recent years. Data collection took place in month of September 2024. (Mega Health Relief Camp AIIMS Jammu).

Participants and Sampling: The target population was adult individuals (aged 18 years and above) who had been directly affected by the recent floods, defined as having experienced displacement, significant property damage, or economic loss. A multistage convenience sampling strategy was employed. Three severely affected administrative blocks were purposively selected, followed by random selection of villages. Participants were subsequently recruited through convenience sampling at the AIIMS Jammu Mega Health Relief Camp. Finally, a convenience sampling approach was used to recruit participants from within these villages, with the assistance of local community leaders and health workers. This approach was chosen due to the challenges of accessing a displaced and scattered population in a post-disaster environment.

Although some participants had been temporarily displaced, all were contacted at the designated relief camp (AIIMS Jammu Mega Health Relief Camp) and confirmed their original residence in the selected villages, satisfying the inclusion criterion of village-level flood exposure. The sample size was determined using Cochran's formula for cross-sectional studies: Assuming a 95% confidence level ($Z = 1.96$), a prevalence estimate of 50% ($p = 0.50$) due to the absence of prior local data, and a margin of error of 5% ($d = 0.05$), the minimum required sample size was calculated as 384 participants. To account for potential non-response and incomplete questionnaires, the sample size was increased, and a total of 400 participants were included in the study.

Inclusion & Exclusion Criteria:

Inclusion criteria were: (1) residence in the selected affected villages at the time of the flood, (2) direct experience of flood-related loss or damage, and (3) willingness to provide informed consent. Exclusion criteria included individuals with severe cognitive impairments or active psychosis that would preclude them from providing reliable data. A total of 430 individuals were approached, and 400 completed the survey, yielding a response rate of 93%. ethical permission was taken from the Institutional Ethics Committee.

Tools: Indexed questionnaire/scales were used to collect data on socio-demographic variables, coping strategies, resilience, and social support.

Socio-Demographic Profile: A custom-designed section collected data on age, gender, marital status, education level, occupation, monthly family income, and extent of property damage due to the flood.

Coping Strategies: The Brief COPE Inventory (Carver, 1997) was used to assess coping

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styles. It consists of 28 items measuring 14 distinct coping subscales (2 items per subscale): self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame. Responses are rated on a 4-point Likert scale ranging from 1 ("I haven't been doing this at all") to 4 ("I've been doing this a lot"). Adaptive coping included active coping, planning, positive reframing, acceptance, humor, religion, and use of support. Maladaptive coping included denial, substance use, behavioral disengagement, venting, and self-blame and Cronbach's alpha was $\alpha = 0.82$.

Resilience scale: The Connor-Davidson Resilience Scale (CD-RISC 25) was used to measure resilience (Connor & Davidson, 2003). This 25-item scale assesses an individual's ability to cope with stress and adversity. Respondents rate items on a 5-point Likert scale from 0 ("Not true at all") to 4 ("True nearly all the time"). Total scores range from 0 to 100, with higher scores indicating greater resilience and Cronbach's alpha was $\alpha = 0.91$.

Social Support and Community Participation: Perceived social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988), a 12-item instrument assessing support from family, friends, and a significant other. Community participation was assessed with three items developed for the study, asking about frequency of involvement in community meetings, volunteer activities, and collective decision-making since the flood and Cronbach's alpha was $\alpha = 0.88$.

Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 25.0. Descriptive statistics

(frequencies, means, standard deviations, correlation) were used to summarize the socio-demographic characteristics of the sample, the prevalence of different coping strategies, and the overall level of resilience.

RESULTS

Table-1: Socio-Demographic Characteristics of the Study Sample (N=400).

Variable	Category	Frequency (n)	Percentage (%)
Age (in years)	18-35	168	42.0
	36-50	152	38.0
	>50	80	20.0
Gender	Male	232	58.0
	Female	168	42.0
Marital Status	Married	288	72.0
	Unmarried/Divorced/Widowed	112	28.0
Education	No formal education	88	22.0
	Primary/Middle	132	33.0
	Secondary & above	180	45.0
Occupation	Agriculture	160	40.0
	Daily Wage Labor	100	25.0
	Salaried/Private Job	80	20.0
	Others (Student, Retired)	60	15.0
Income Level	Below District Average	260	65.0
	At/Above District Average	140	35.0
Property Damage	Minor/No Damage	120	30.0
	Major Damage	280	70.0
Age	Mean±SD	38.5±12.3	

The final sample consisted of 400 flood survivors. The socio-demographic profile is presented in Table 1. The mean age of the participants was 38.5 years (SD = 12.3), with a range from 18 to 72 years. The majority of the sample was male (58%) and married (72%). In terms of education, 45% had completed secondary school or higher. Agriculture was the primary occupation for 40% of the participants, followed by daily wage labour (25%). A significant portion of the sample (65%) reported a monthly family income below the district average. Regarding the impact of the flood, 70% reported major damage to their home.

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Table-2: Frequency of Coping Strategies Used by Participants (N=400).

Coping Strategy	Category	% Reporting Frequent Use
Religious Coping	Adaptive	68
Active Problem-Solving	Adaptive	62
Seeking Social Support	Adaptive	59
Positive Reframing	Adaptive	45
Planning	Adaptive	42
Acceptance	Adaptive	38
Denial	Maladaptive	21
Self-Blame	Maladaptive	18
Venting	Maladaptive	16
Substance Use	Maladaptive	14
Behavioral Disengagement	Maladaptive	12

The frequency of use of different coping strategies, as measured by the Brief COPE, is detailed in Table 2. The most frequently adopted strategies fell into the adaptive category. Religious coping was the most common, with 68% of participants reporting that they “often” or “very often” engaged in prayer or sought spiritual comfort. This was followed by active problem-solving (62%) and seeking social support (59%). Positive reframing (45%) and planning (42%) were also moderately common. Among the maladaptive strategies, denial was the most prevalent, though still relatively low, with 21% of participants endorsing it. Substance use (14%) and behavioral disengagement (12%) were the least common strategies reported.

Table-3: Pearson’s Correlation Coefficients between Coping, Support, and Resilience (N=400).

Variable	Resilience	Social Support	Community Participation	Adaptive Coping	Maladaptive Coping
Resilience	-	.61**	.48**	.52**	-.38**
Social Support		-	.55**	.43**	-.29**
Community Participation			-	.39**	-.22**
Adaptive Coping				-	.15*
Maladaptive Coping					-

P value: * 0.05. **=0.01

Pearson’s correlation analysis (Table 3) showed that resilience was positively associated with social support ($r = .61, p < .01$), community participation ($r = .48, p < .01$), and adaptive coping ($r = .52, p < .01$). This indicates that higher support, participation, and constructive coping were linked with greater resilience. Conversely, resilience was negatively correlated with maladaptive coping ($r = -.38, p < .01$), suggesting that avoidant or harmful coping lowered resilience. Social support and community participation were also positively related, while maladaptive coping showed consistent negative associations with other variables. Overall, these findings highlight that social and adaptive resources enhance resilience, whereas maladaptive coping undermines it.

Table-4: Multiple Regression Analysis Predicting Resilience (N=400).

Predictor	B (Unstandardized)	SE B	β (Standardized)	t-value	p
(Constant)	25.41	3.12	—	8.14	.001
Age	-0.08	0.05	-0.07	-1.60	.11
Gender (Male = 1, Female = 0)	3.85	1.25	.15	3.08	.01
Education	0.92	0.61	.08	1.51	.13
Adaptive Coping	0.45	0.09	.25	5.00	.001
Maladaptive Coping	-0.51	0.11	-.19	-4.64	.001
Social Support	0.62	0.10	.31	6.20	.001
Community Participation	0.38	0.12	.18	3.17	.01

Table-4: shows a multiple linear regression analysis was conducted to determine the unique contribution of the predictor variables to resilience scores. The model included socio-demographic variables (age, gender, education), adaptive coping, maladaptive coping, social support, and community participation. The overall model was statistically significant, $F(7, 392) = 33.76, p < .001$, and explained 41% of the variance in resilience scores (Adjusted $R^2 = .41$). The

strongest significant predictors of resilience were social support ($\beta=.31, p<.001$) and adaptive coping ($\beta=.25, p<.001$). Community participation was also a significant positive predictor ($\beta=.18, p<.01$). Among the socio-demographic variables, gender (coded male=1, female=0) was a significant predictor, with men tending to have higher resilience scores ($\beta=.15, p<.01$). Age and education were not significant predictors in the final model when controlling for other factors. Maladaptive coping was a significant negative predictor ($\beta=-.19, p<.001$).

DISCUSSION

This study plan out to investigate the coping strategies and resilience of individuals affected by severe flooding in the Samba District of Jammu & Kashmir. The findings provide valuable insights into the psychosocial dynamics of a disaster-affected community in a specific cultural context and have significant implications for disaster management and mental health policy.

The socio-demographic finding that Male participants demonstrated significantly higher resilience scores than females. However, this finding should be interpreted cautiously as resilience may be influenced by sociocultural roles, reporting tendencies, and access to social resources, is consistent with some previous disaster literature (e.g., Tolin & Foa, 2006). Although age was examined as a potential correlate, it did not emerge as a significant independent factor associated with resilience in the multivariable model., it did not emerge as a statistically significant independent predictor in the regression model ($B=-0.08, p=.11$), indicating that its apparent effect is accounted for by coping and social support when these variables are controlled. This could be due to a variety of factors, including traditional gender roles that may burden women with greater caregiving and domestic stressors post-disaster. However,

these findings must be interpreted with caution, as they may also reflect gender biases in the measurement of resilience itself. The fact that gender remained a significant predictor even after controlling for coping and support suggests that other unmeasured factors are at play.

Study revealed that the most striking finding was the overwhelming reliance on adaptive coping strategies, with religious coping, active problem-solving, and seeking social support being the three most frequently used. The high prevalence of religious coping (68%) aligns with research conducted in other South Asian contexts, where faith and spirituality often serve as primary resources for meaning-making and emotional regulation during crises (Goldmann & Galea, 2014). In the culturally rich region of Jammu & Kashmir, turning to prayer, religious gatherings, and spiritual leaders is not just a personal act but a communal one, reinforcing social bonds and a sense of shared destiny. This highlights the critical importance of incorporating religious and faith-based organizations into disaster response frameworks as key partners in psychosocial support. The positive association between social support and resilience is consistent with findings reported by Aldrich and Meyer (2015), who identified social capital as a critical determinant of disaster recovery.

The high use of active problem-solving (62%) and seeking social support (59%) demonstrates a proactive and socially-oriented approach to recovery. Survivors were not passively enduring their situation but were actively engaged in rebuilding efforts and leveraging their social networks for both emotional and instrumental aid. This finding challenges a narrative of victimhood and instead paints a picture of agency and resourcefulness. It underscores the resilience inherent in community structures, where neighbors, family, and friends form the first

line of support.

Conversely, the relatively low use of maladaptive strategies like denial and substance use is encouraging. While these behaviors were present and, as expected, negatively correlated with resilience, they were not the norm. This could suggest that the strong social fabric of the community acts as a deterrent to socially isolating or harmful behaviors. Though, the 14% rate of substance use still warrants attention, as it represents a vulnerable subgroup that may require targeted interventions.

The mean resilience score of 61.4 (SD = 12.7) indicates a moderately high level of resilience in the sample contextually, Connor & Davidson (2003) reported a mean CD-RISC score of 80.4 in a general population sample, placing the present sample's score of 61.4 in the lower-moderate range relative to non-disaster populations, though comparable to means reported in other post-disaster studies (range typically 55–65). This is consistent with the finding that adaptive coping was prevalent. It suggests that despite the significant hardship faced, the majority of individuals possessed the inner and outer resources to cope effectively. However, the wide standard deviation also highlights the substantial variability in resilience, emphasizing that resilience is not a given but is distributed unevenly across the population. The regression analysis provided the most critical insights by identifying the key predictors of this resilience. The finding that social support was the strongest predictor ($\beta = .31$) powerfully confirms the central thesis of community resilience theories (Norris et al., 2008). It is not just an individual's psychological makeup but the quality of their connections to others that most robustly predicts their ability to bounce back. This aligns with the work of Aldrich and Meyer (2015), who demonstrated that social capital is a more powerful predictor of recovery than

physical or financial capital.

The significant contribution of adaptive coping ($\beta = .25$) and community participation ($\beta = .18$) reinforces this. Resilience is an active process; it is built through doing through solving problems, reaching out to others, and participating in collective life. These findings suggest that interventions that simply provide aid without fostering engagement and self-efficacy may be less effective in the long run. The negative impact of maladaptive coping ($\beta = -.19$) also serves as a clear indicator that mental health services need to identify and address these harmful behaviors early on.

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IMPLICATIONS

- *Integrate MHPSS in Disaster Plans:* Make mental health and psychosocial support a key part of disaster preparedness, with training for community workers and first responders.
- *Use Community and Religious Networks:* Deliver interventions through trusted local channels like religious leaders and community groups to enhance acceptance.
- *Reinforce Social Networks:* Design aid programs that strengthen community

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cohesion through collective rebuilding and peer-support initiatives.

- *Target Vulnerable Groups:* Develop specific programs for women, older adults, and those using maladaptive coping (e.g., women's circles, elderly outreach, counseling).
- *Promote Adaptive Coping:* Introduce psycho-educational programs to teach problem-solving, positive reframing, and stress management skills.

LIMITATION & FUTURE DIRECTION

The cross-sectional design limits causal interpretation of findings. Data were collected through self-report measures, which may be subject to recall and social desirability bias. Participants were recruited using convenience sampling from a relief camp, limiting generalizability to all flood-affected populations. Community participation was assessed using a brief study-specific measure that requires further psychometric validation. Future longitudinal and mixed-method studies are recommended to better understand resilience trajectories following disasters. Future studies should employ longitudinal designs to examine changes in coping and resilience over time. Qualitative approaches may provide deeper insights into cultural and religious coping processes. Intervention studies evaluating community-based resilience-building programmes are also warranted.

CONCLUSION

The study demonstrated that adaptive coping strategies, social support, and community participation were positively associated with resilience among flood survivors in Samba District. Social support emerged as the strongest factor associated with resilience. Findings highlight the importance of strengthening community networks, promoting adaptive coping skills, and integrating

psychosocial support within disaster management programmes.

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