



# Protective role of coping flexibility in PTSD and depressive symptoms following trauma<sup>☆</sup>



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## ABSTRACT

The aim of the study was to examine whether coping flexibility would function as a protective factor for PTSD and depressive symptoms in trauma-exposed adults in Korea. A total of 510 adults with a lifetime history of traumatic events completed the Perceived Ability to Cope with Trauma (PACT), the Korea version of the Posttraumatic Stress Diagnostic Scale (PDS-K), and the Patient Health Questionnaire (PHQ-9). Hierarchical regression indicated that coping flexibility was associated with a reduced level of PTSD or depressive symptoms after controlling for comorbid symptoms, age, and elapsed time since the most distressing traumatic event. The interaction of traumatic events and coping flexibility was significant only on PTSD symptom severity but not on depressive symptom severity. Specifically, individuals with low coping flexibility reported higher levels of PTSD symptoms as the number of traumatic events increased. These findings supported the hypothesis that coping flexibility is a protective factor for PTSD and depression following trauma, and lack of coping flexibility may aggravate the risk for PTSD among people with multiple trauma.

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## 1. Introduction

Epidemiological data consistently have documented high prevalence rates of traumatic experiences across nations. Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) reported that 60.7% of men and 51.2% of women in the US experienced at least one traumatic event in their lifetime. Similarly, Darves-Bornoz et al. (2008) reported that 50.8% of men and 49.2% of women in Europe experienced at least one traumatic event in their lifetime. In Korea, 71.9% out of a combined sample of adolescents and adults reported having been exposed to at least one traumatic event (Seo, Cho, An, & Lee, 2012). Posttraumatic stress disorder (PTSD) and depression are the most common mental health outcomes following trauma, endorsing high rates of comorbidity, although prevalence of PTSD and depression following trauma varies considerably depending on type of trauma with the range of 4.0–29.0% (O'Donnell, Creamer, & Pattison, 2004; Rytwinski, Scur, Feeny, & Youngstrom, 2013; Shih, Schell, Hambarsoomian, Marshall, & Belzberg, 2010). These data indicated that despite high

occurrence rates of traumatic events most people do not develop adverse mental health outcomes following trauma.

Many scholars have highlighted that effective coping can serve as a buffer of the development of adverse mental health outcomes after traumatic exposure (Alim et al., 2008; Feder et al., 2013; Larner & Blow, 2011). In particular, one's ability to cope well with adverse events is a good indicator of psychological well-being and is often conceptualized as resilience (Galatzer-Levy, Burton, & Bonanno, 2012). Resilience, however, is a multidimensional psychological construct that can be defined in various ways. It is generally considered as coping ability or personal characteristics that contribute to psychological and physical balance or homeostasis in the presence of adverse events (Bonanno & Mancini, 2008; Connor & Davidson, 2003). One of such characteristics is the ability to use different types of coping strategies flexibly in response to potentially traumatic events (Bonanno, Pat-Horenczyk, & Noll, 2011).

People who are able to use various coping strategies would adapt better with life threatening situations (Bonanno, Papa, Lalande, Westphal, & Coifman, 2004; Burton et al., 2012; Roussi, Krikeli, Hatzidimitriou, & Koutri, 2007). Despite these assertions, previous studies on effective coping strategies to deal with traumatic events have yielded inconsistent findings (Littleton, Horsley, John, & Nelson, 2007; Perrin et al., 2014; Schuettler & Boals, 2011; Weinberg, Gil, & Gilbar, 2014). The relationships

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between specific types of coping, for instance, problem-focused or emotion-focused coping, and PTSD have been found to be either positive in some studies or negative in others (Eid, 2003; Schuettler & Boals, 2011; Weinberg et al., 2014). According to a meta-analysis regarding trauma coping strategies and psychological distress, avoidant coping was positively associated with PTSD, depression, and general distress whereas there was no consistent association of approach coping with such psychological distress (Littleton et al., 2007). One possible reason for these contradictory findings is that it is not the specific type of coping responses that results in successful coping but rather, it is one's ability to use different types of coping strategies flexibly as needed under a particular situation (Bonanno, Pat-Horenczyk, & Noll, 2011).

Based on the flexibility hypothesis (Bonanno, 2004, 2005), Bonanno et al. (2011) developed the Perceived Ability to Cope with Trauma (PACT) Scale that examines one's perceived ability of using two distinct, seemingly opposing types of coping strategies in response to traumatic events, trauma focus and forward focus coping. Individuals using trauma focus coping may reduce normal activities and process what has happened after experiencing traumatic events, while those using forward focus coping may maintain normal activities and set up goals and plans in order to overcome trauma-related distress. Although both strategies are independently adaptive, the underlying assumption of the flexibility hypothesis is that one who uses different coping strategies flexibly would cope better with trauma. The PACT scale provides a coping flexibility score in which individuals who use both strategies frequently get a higher score.

The fundamental question is then whether people with a higher level of coping flexibility would cope better with trauma. Bonanno et al. (2011) reported that coping flexibility moderated the relationship between trauma exposure and PTSD symptoms such that Israeli college students with high coping flexibility reported lower levels of PTSD symptoms after controlling for age, gender, and trauma exposure.

The current study extended Bonanno et al. (2011)'s findings in that our sample included Korean adults who have been exposed to at least one traumatic event in their lifetime, and we examined the moderating effect of coping flexibility between traumatic events (i.e., number of trauma exposure) and PTSD or depressive symptoms after controlling for comorbid symptoms, elapsed time since the most distressing traumatic event in addition to demographic risk factors. It was hypothesized that coping flexibility would moderate the relationship between traumatic events and PTSD or depressive symptoms, respectively, after adjustment. Prior to hypothesis testing, we examined whether the factor structure and reliability of the Perceived Ability to Cope with Trauma (PACT) scale would be suitable to a Korean sample.

## 2. Method

### 2.1. Participants

Participants of the study were recruited through social networking services (SNS). A web-based survey was posted in online social clubs for people who went through major life events such as divorce or bereavement, or for those who suffer from mental disorders. A total of 1550 adults agreed to participate in the study and completed all the measures. All participants received brief feedback about their responses on psychological measures in return. No monetary rewards were provided for study participation. Inclusion criteria for the study were people with a lifetime history of traumatic events and ages from 18 to 39. We restricted the age range to reduce sampling bias as the proportion of internet

usage of Koreans is almost 100% among 10–30 s and declines gradually from 40 s (Korea Internet and Security Agency, 2013).

Among 1550 participants who completed the survey, 510 fulfilled the inclusion criteria. The mean age was 29.25 years ( $SD = 5.62$ ). The majority of the final sample were women (86.9%) and college graduates (74.6%). Job status of the participants was diverse including permanent worker (29.4%), students (16.5%), non-permanent worker (16.1%), homemaker (15.9%), and unemployed (13.7%).

### 2.2. Measures

Perceived Ability to Cope with Trauma Scale (PACT; Bonanno et al., 2011). The PACT is a 20-item self-report measure that assesses one's perceived ability to use two coping strategies flexibly in response to trauma. Participants were instructed to rate each item on a 7-point Likert scale (1 = *not at all able* to 7 = *extremely able*). The PACT has two factors of trauma focus (8 items; e.g., carefully thinking about experienced traumatic life event, wholly accepting one's painful emotion) and forward focus (12 items; e.g., pay attention to one's present goals and plan, finding some activities to forget the event). Coping flexibility scores are calculated by subtracting the difference score of the trauma focus and forward focus subscales (forward focus – trauma focus) from the sum score of the two factors (forward focus + trauma focus). In this calculation, higher scores reflect relatively greater ability to use both coping strategies. The PACT items were translated into Korean by a doctoral-level psychologist and two graduate students. The factor structure and reliability coefficients of the PACT in the current sample are presented in the Section 3.

Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997). Trauma exposure and symptoms of PTSD were assessed using the PDS (Foa et al., 1997). Participants first were asked to respond whether they have experienced traumatic events and, if exposed, rated 17 items assessing PTSD symptoms on a 4-point Likert scale from 0 to 3 (0 = *not at all or only once a week*; 3 = *five times or more a week or daily*). Then, participants were asked to report elapsed time since the most distressing traumatic event. In this study, the Korean version of the PDS was used (Nam, Kwon, & Kwon, 2010). The Korean version of the PDS assesses the presence of twelve types of traumatic events such as accident or fire, combat, sexual or nonsexual assault, sexual contact prior to the age of 18 with someone 5 years or more (e.g., touching genitals or breasts). The Cronbach's  $\alpha$  of the scale in the present study was .94.

Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). The severity of depressive symptoms was assessed using the PHQ-9. The PHQ-9 includes nine items assessing depressive symptoms on a 4-point Likert scale (0 = *not at all* to 3 = *almost every day*). In the present study, the Korean version of the PHQ-9 (Choi et al., 2007) was used. The Cronbach's  $\alpha$  of the scale in the present study was .89.

### 2.3. Data analyses

Factor analysis was conducted to confirm the two-factor structure of the PACT in the current sample. Next, hierarchical multiple regression was conducted to examine the moderating effects of coping flexibility in the relationship between traumatic events and PTSD or depressive symptoms in separate models. A post hoc test was conducted to confirm whether the relationship between traumatic events and clinical symptoms was significantly different for individuals with high levels of coping flexibility compared to those with low levels (Aiken & West, 1991; Holmbeck, 2002).

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