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Coping flexibility predicts post-traumatic stress disorder and depression in human rights advocates

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ABSTRACT

An emerging body of research on individuals exposed to trauma shows that the ability to flexibly employ different coping styles is associated with better adjustment. Specifically, individuals who use both “trauma-focused” (focusing on the experience and significance of a potentially traumatic event) and “forward-focused” (optimism, helping others, goal-oriented thinking) coping styles exhibit less psychological disturbance after trauma exposure than those with less coping flexibility. We investigated whether greater coping flexibility is associated with less Post-traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD) in an international sample of human rights advocates. In an online, cross-sectional study, 346 international human rights advocates completed self-reported measures of PTSD, MDD, trauma exposure, and the Perceived Ability to Cope with Trauma (PACT) scale. Results showed that coping flexibility was associated with lower rates and symptom severity of PTSD and MDD. Whereas both trauma-focused and forward-focused coping were associated with lower rates of PTSD, the inverse relationship between coping flexibility and MDD was driven primarily by less forward-focused coping. These findings are the first to show that lower levels of coping flexibility may be an important factor underlying vulnerability to PTSD and MDD among human rights advocates. Longitudinal studies are needed to clarify whether coping flexibility can mitigate the potential negative mental health impact of traumatic stress over the course of one’s career in international human rights advocacy.

KEYWORDS

Coping flexibility; depression; human rights; PTSD; trauma

Human rights advocates investigate alleged violations of human rights around the world and seek the protection of individuals and groups from abuse. They are a group with high rates of secondary, or “vicarious,” exposure to trauma—many advocates often review documentation and evidence of abuse

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(e.g., forensic reports, videos of assaults), collect testimony from victims and witnesses, and visit physical sites of abuse (e.g., prisons, mass graves) (Joscelyne et al., 2015). Further, human rights advocates often gather information in war zones and other insecure environments, where they may witness human rights violations first-hand or, in some cases, become victims of abuse themselves (Joscelyne et al., 2015).

Consistent with research from other trauma-exposed professions showing elevated levels of adverse mental health conditions, studies of human rights advocates have found high levels of burnout, depression, and Post-traumatic Stress Disorder (PTSD) in the samples surveyed. For example, Holtz et al. (Holtz et al., 2002) found high levels of anxiety, depression, and PTSD among humanitarian and human rights workers in Kosovo. In a recent international survey of human rights advocates, approximately 20% met criteria for PTSD and 15% for Major Depressive Disorder (MDD) (Joscelyne et al., 2015). Furthermore, about 19% of individuals in that survey reported having taken time off work for six months or more due to “psychological distress” or “burnout.” The findings from these studies cannot be generalized to the whole population of human rights advocates since they involved convenience samples. However, they suggest that human rights advocates may indeed experience higher levels of mental health concerns than the general population.

Despite the risks inherent in human rights work, little is known about the factors that underlie advocates’ risk for PTSD and MDD. Considerable research has found that coping styles play an important role in the occurrence of psychological disturbance following trauma exposure. Such coping refers to the range of the dynamic, cognitive, and behavioral efforts undertaken by individuals to manage the external and internal demands that may be associated with stress and trauma (Lazarus and Folkman, 1984). To date, a considerable focus of the coping literature in trauma has been on identifying whether a singular type of coping style is protective or maladaptive. For example, traditional trauma theory suggests that individuals will adjust better post-trauma when employing “trauma-focused” coping styles, which involve focusing on, recalling, and making meaning out of the traumatic events. This theory is supported by evidence that exposure therapy can be beneficial (Foa & Kozak, 1986; Foa & Rothbaum, 1998) and that avoidance is associated with the onset of PTSD and poor-treatment outcomes (e.g., Pineles et al., 2011; Tiet et al., 2006).

Recent research indicates that a far more diverse range of cognitive processes, including optimism, avoidance, and minimization, may aid in coping with stress and trauma (Lazarus & Folkman, 1984; Aspinwall & Taylor, 1997; Block & Block 1980). Rather than privileging one strategy over the other, Bonanno et al. (2011) have recently proposed that a plurality of coping styles, flexibly employed across different contexts, may be an especially important adaptation to traumatic stress. In line with this argument, experimental

and self-report studies have shown that coping flexibility differentiates those with and without mental health problems (Cheng, 2001; Galatzer-Levy et al., 2012; Park et al., 2015).

A growing body of work has assessed coping flexibility with the self-report Perceived Ability to Cope with Trauma scale (PACT) (Bonanno et al., 2011). The PACT is a 20-item self-report measure that asks respondents to rate their perceived ability to apply different coping strategies. Factor analyses found that PACT items cluster into two subscales: *forward focus* (optimism, helping others, goal-oriented thinking, positive emotion, and reducing negative affect) and *trauma focus* (remain focused on and fully experience the emotional and cognitive significance of a potentially traumatic event). The subscales can be combined to create a total coping flexibility index, which has been shown to be associated with better adjustment following potentially traumatic events (Bonanno et al., 2011; Park et al., 2015). The aim of the present study was to examine whether coping flexibility is associated with lower levels of PTSD and MDD symptom severity.

Methods

Participants

Participants were recruited via an online survey distributed to networks of human rights advocates, organizations, and professional networks. This included a variety of international human rights organizations, including Amnesty International, Global Rights, Human Rights First, Human Rights Watch, and Physicians for Human Rights. The notice was also sent to regional and national human rights organizations in many countries, as well as to specialized organizations that focus on specific rights issues. In several instances, senior officials at the organizations sent the recruitment notice to their staff, and, in others, their research and program staff circulated the notice on internal lists after being approached through professional connections. A variety of list-serves circulated the recruitment notice, including lists of women's human rights defenders, LGBTQ advocates, and directors of international human rights law clinics. The notice was also sent to staff at the United Nations (UN) Office of the High Commissioner for Human Rights in Geneva and to field offices in a variety of countries. Twitter and Facebook were also used to disseminate the recruitment notice. The survey was available online for completion from October 2012 to February 2013.

A total of 346 adults agreed to participate in the study and completed all of the measures in the survey. Participants provided informed consent and confirmed that they were at least 18 years old and had experience working in the human rights field, whether as paid staff or volunteers. The study was approved by the New York University's University Committee on Activities Involving Human Subjects.

Measures

Demographics

Participants were asked to indicate their age, gender, nationality, and number of years working in the field of human rights. In addition, participants were asked to indicate on a scale of 1–4 (1 = none, 2 = minimal, 3 = moderate, 4 = a lot) the extent to which they carried out various human rights activities over the course of their career. Participant nationality spanned 55 nations, with the majority being from the United States (58.1%) and the second most represented nation being the United Kingdom (5.5%).

Trauma-exposure

Human rights work-related trauma exposure was assessed through questions concerning types of activities likely to include exposure to traumatic material (e.g., listening to accounts of violations, witnessing human rights abuses, viewing graphic videos or photos, experiencing threats of or having been taken hostage, sexually assaulted, or detained). Participants were asked to indicate if they had been exposed to each of these events and then to estimate on a scale of 1–4 (1 = none, 2 = minimal, 3 = moderate, 4 = a lot) the extent to which they were exposed to each of these events throughout their work in human rights.

PTSD

PTSD symptoms were measured using the PTSD Checklist-Civilian Version (PCL-C) (Weathers et al., 1993). The PCL-C is a 17-item self-report scale based on DSM-IV PTSD criteria that evaluates how much participants have experienced PTSD symptoms in the past month as a result of stressful life events. Each item is scored on a 5-point scale 1–4 (1 = “not at all,” 5 = “extremely”). A diagnosis of PTSD was determined when an individual met DSM-IV symptom criteria defined by the presence of at least 1 B symptom (questions 1–5), 3 C items (questions 6–12), and at least 2 D items (questions 13–17). Symptoms rated as “moderately” or above (responses 3–5 on individual items) were counted as present. In addition to this distribution of symptoms, the total symptom severity score had to be 44 or greater to meet diagnostic criteria. Individuals were determined to meet sub-threshold PTSD when they met criteria for two of the three symptom clusters.

Depression

Depressive symptoms were measured using the Patient Health Questionnaire (PHQ-9) (Spitzer et al., 1999). The measure consists of 9 items, each rated on a 4-point scale (0 = “not at all,” 4 = “nearly every day”) in the past two weeks, resulting in total scores that range from 0–27. The total PHQ-9 score was calculated by summing the responses for each symptom. A cut-off score of 10 was used as an indicator of probable major depression.

Coping flexibility

Coping flexibility was measured using the PACT scale (Bonanno et al., 2011). This measure consists of 20 items, in which participants rate their ability to use two coping strategies in response to trauma on a 7-point scale (1 = not true, 7 = extremely true). The PACT consists of two subscales: (1) forward-focus (12 items), which assesses coping abilities related to thinking optimistically, attending to the needs of others, maintaining plans and goals, remaining calm, and reducing painful emotion; and (2) trauma-focus (8 items), which assesses the ability to remain focused on and fully experience the emotional and cognitive significance of a potentially traumatic event, temporarily withdraw from social interactions, revise goals and plans, and think realistically. A single coping flexibility score is calculated using the averages of the two coping scales in a Negative Acceleration Model (Priester & Petty, 1996; Scott, 1996), $F = [(2S + 1)/(S + L + 2)]$, where S is the smaller mean of 2 means and L is the larger (e.g., if a participant has a mean forward focus score of 5 and trauma focus score of 7, then $F = 0.79$). This method produces a single score, ranging from 0 to 1, where larger scores indicate relatively equal and greater use of both abilities.

Results

Demographics

In total, 524 participants began the survey and 346 participants completed all or almost all measures, resulting in a completion rate of 66%. The remainder of the analyses in this article focuses on the 346 completers, comprising 256 females and 75 males, with a mean age 37.73 years ($SD = 12.01$) (see Table 1 for demographic data).

As previously reported in Joscelyne et al. (2015), the mean PCL-C score was 31.6 ($SD = 12.9$), with 19.4%, of individuals meeting full *DSM-IV* criteria for PTSD. The mean score on the PHQ-9 was 5.4 ($SD = 5.0$), with 14.7% ($n = 55$) of individuals scoring in the range of probable major depression.

Table 1. Demographic and clinical characteristics of participants.

Variable	PTSD M [%]	No PTSD M [%]	<i>p</i> [χ^2]
Age	36.770 (10.455)	37.900 (12.432)	.509
% Male Gender	[27.7%]	[21.3%]	[.270]
PCL	51.269 (9.999)	26.925 (8.191)	<0.001
PHQ	10.000 (6.066)	4.275 (4.056)	<0.001
Trauma Exposure	20.149 (6.051)	16.369 (5.956)	<0.001
PACT Flex	0.819 (0.073)	0.836 (0.068)	0.108
PACT Forward	4.346 (0.917)	4.640 (0.919)	<0.05
PACT Trauma	4.488 (0.787)	4.747 (0.995)	<0.05

Values within parentheses represent standard deviations. PCL = PTSD Checklist, PHQ = Patient Health Questionnaire, PACT = Perceived Ability to Cope With Trauma scale.

Coping flexibility and PTSD

We conducted a repeated-measures analysis of variance (ANOVA) for the within-subjects PACT scales (Forward-Focused, Trauma-Focused) and between-subject variables of PTSD (PTSD+ and No PTSD) with trauma exposure as a covariate. Simple effects were examined to determine directionality and magnitude of observed differences. We then repeated these analyses for MDD.

The repeated-measures ANOVA using PTSD diagnosis revealed significant main effects for PTSD diagnosis, $F(1, 285) = 8.316, p < 0.01, \text{Eta}^2 = 0.028$, and the covariate of trauma exposure $F(1, 285) = 5.199, p < 0.05, \text{Eta}^2 = 0.018$. The within-subject effect of coping type and its interactions with PTSD diagnosis and trauma exposure, however, were not significant ($p > 0.05$). Follow up *t*-tests showed that individuals who met criteria for PTSD reported lower levels of both trauma-focused coping (PTSD: $M = 4.49, SD = 0.79$, No PTSD: $M = 4.75, SD = 1.00, t = 2.187, p < 0.05, d = 0.29$) and forward-focused coping (PTSD: $M = 4.34, SD = 0.92$, No PTSD: $M = 4.64, SD = 0.92, t = 2.192, p < 0.05, d = 0.33$) (see [Table 1](#)).

Coping flexibility and MDD

The subsequent repeated-measures ANOVA using a diagnosis of MDD revealed significant main effects for coping ability type, $F(1, 275) = 4.820, p < 0.05, \text{Eta}^2 = 0.017$, MDD diagnosis, $F(1, 275) = 7.673, p < 0.01, \text{Eta}^2 = 0.027$, and the covariate of trauma exposure $F(1, 275) = 5.402, p < 0.05, \text{Eta}^2 = 0.019$. There were no significant interactions between variables, though the interaction between coping type and MDD diagnosis approached significance ($p = 0.06$). To further explore this potential interaction, paired sample *t*-tests were then performed to assess the mean differences between PACT Trauma and PACT Forward scores between those with and without MDD. The findings revealed that individuals with depression had lower forward-focus scores than those without depression (MDD: $M = 4.22, SD = 0.94$; No MDD: $M = 4.65, SD = 0.91, t = 2.981, p < 0.01, d = 0.46$), whereas there was no difference on scores of trauma-focus (MDD: $M = 4.66, SD = 0.95$, No MDD: $M = 4.70, SD = 0.97, t = 0.267, p > 0.05, d = 0.04$) (see [Table 1](#)).

Coping flexibility and symptom severity of PTSD and MDD

To determine the potential moderating effects of coping flexibility on the relationship between exposure to trauma and PTSD symptom severity, a hierarchical multiple regression was performed. Results from this analysis are included in [Table 2](#). After controlling for age and exposure to trauma, coping flexibility was significantly associated with PTSD symptom severity,

Table 2. Hierarchical regression analyses of coping flexibility on PTSD and depressive symptom severity.

Variable	β	t	R^2	ΔR^2	$F (df)$	$\Delta F (df)$
DV: PTSD symptom severity						
Step 1			0.135	0.135	21.605 (2, 276)***	21.605 (2, 276)***
Age	-0.168	-2.953				
Exposure to trauma	0.357	6.292				
Step 2			0.177	0.042	19.719 (3, 275)***	13.925 (1, 275)***
Coping flexibility	-0.205	-3.732				
Step 3			0.178	0.001	14.862 (4, 274)***	0.417 (1, 274)
Coping flexibility \times exposure to trauma	0.037	0.646				
DV: Depressive symptom severity						
Step 1			0.036	0.036	5.008 (2, 268)**	5.008 (2, 268)**
Age	-0.154	-2.532				
Exposure to trauma	0.141	2.321				
Step 2			0.078	0.042	7.551 (3, 267)***	12.216 (1, 267)**
Coping flexibility	-0.206	-3.495				
Step 3			0.079	0.001	5.736 (4, 266)***	0.347 (1, 266)
Coping flexibility \times exposure to trauma	0.036	0.589				

PTSD symptom severity measured by PTSD Checklist (PCL); Depressive symptom severity measured by Patient Health Questionnaire (PHQ).

* $p < 0.05$.

** $p < 0.01$.

*** $p < 0.001$.

$\beta = -0.21$, $t = -3.73$, $p < 0.001$. Step three of the regression included the interaction of coping flexibility and exposure to trauma, yielding insignificant results, $\beta = 0.037$, $t = 0.646$, $p = 0.519$ (see Table 2).

A second hierarchical multiple regression using the same independent variables from the PTSD regression but instead assessing depressive symptom severity was then conducted. Results from this analysis, which are also displayed in Table 2, yielded similar findings. Coping flexibility was significantly associated with depressive symptom severity when controlling for age and exposure to trauma, $\beta = -0.206$, $t = -3.496$, $p < 0.01$. The interaction between coping flexibility and exposure to trauma, however, did not significantly predict depressive symptom severity, $\beta = 0.036$, $t = 0.589$, $p = 0.556$ (see Table 2).

Discussion

This study is the first to show that greater coping flexibility is associated with lower levels of PTSD and MDD in a sample of international human rights advocates. Empirical studies are just beginning to characterize the occupational and individual mental health risk and protective factors associated with human rights work. The data from this study raise the possibility that greater coping flexibility may be associated with lower rates of PTSD and MDD in this population.

The observed inverse relationship between coping flexibility and the occurrence of PTSD is consistent with findings from other trauma-exposed populations, in which coping flexibility was associated with better adjustment post-trauma (Bonanno et al., 2011; Park et al., 2015; White, 1974). These findings lend further support to the hypothesis that coping flexibility promotes resilience in the face of potentially traumatic events. In particular, these data converge with previous studies in which the PACT was used to assess coping flexibility in relation to trauma-associated mental health outcomes. For example, in a study of Israeli university students with high exposure to terrorist violence, those with high coping flexibility on the PACT reported lower levels of PTSD symptoms (Bonanno et al., 2011). Similarly, trauma-exposed Korean adults with high coping flexibility PACT scores were found to have fewer PTSD and depressive symptoms (Park et al., 2015).

Interestingly, forward-focused, but not trauma-focused, coping strategies were associated with fewer depressive symptoms. In other words, the association of coping flexibility with less MDD was primarily driven by the perceived ability of participants to engage in forward-focused coping strategies. These findings are compatible with previous research showing that impairment in the ability to perceive future events in positive terms is a key feature of depression (e.g., Beck et al., 1987; MacLeod et al., 1996; Williams, 1996). It follows that strategies that target the enhancement of forward-focused

coping skills in trauma-exposed, depressed patients may aid in their recovery. Interestingly, future-directed therapy (FDT), a form of psychotherapy aimed at developing or improving positive cognitions about the future among patients with depression, has been shown to be more effective than traditional forms of psychotherapy, such as cognitive behavioral therapy (Vilhauer et al., 2012).

The findings of the present study suggest that consideration be given to the enhancement of both forward-focused and trauma-focused strategies to mitigate the occurrence of PTSD following exposure to trauma. Trauma-focused treatments, such as exposure therapy, which focus on recalling memories associated with the trauma, have already been shown to be beneficial in the treatment of PTSD (Foa et al., 2005; National Institute for Clinical Excellence; 2005; Foa et al., 2009). However, the present findings suggest that PTSD treatments may benefit from placing greater emphasis on future-oriented cognitive processing to support recovery. In support of this, cognitive models of PTSD suggest that maladaptive appraisals about the future play an important role in the maintenance of PTSD symptoms (Ehlers & Clark, 2000). In that regard, a series of studies in trauma-exposed populations have shown that those with PTSD exhibit greater trauma-focused biases and reduced specificity when imagining themselves in the future (Brown et al., 2013; Brown et al., 2014; Jones et al., 2008). Furthermore, future work would benefit from interventions that guiding individuals to consider different scenarios and how they might use trauma-focused and future-focused coping skills to manage different stressors.

Initiatives aimed at enhancing coping flexibility among human rights advocates may be important both for the treatment of PTSD and MDD and for the primary prevention of these conditions. As a group with predictably high levels of exposure to potentially traumatic events, human rights advocates may benefit from pre-exposure training in forward-focused and trauma-focused coping. Such initiatives are already underway in other high-risk populations, including forward-deployed American troops in Japan (Jones et al., 2008) and Israeli school children exposed to rocket attacks (Wolmer et al., 2011).

The Outpatient Crisis Prevention Program (OCPP) developed by Jones and colleagues (Jones et al., 2008) integrates multiple group treatment modalities (e.g., cognitive-behavioral therapy, dialectical behavioral therapy, crisis counseling, and solution-focused therapy) together with education on specific coping skills. This intervention was found to reduce levels of depression and anxiety for at least 30 days post-treatment among forward-deployed American troops. Similarly, Wolmer and colleagues (Wolmer et al., 2011) found that 14 sessions of teacher-based resilience training prior to a series of rocket attacks was associated with significantly lower levels of PTSD and stress three months after exposure to these attacks among Israeli school children. The coping

training provided to these Israeli children may overlap with elements of both forward-focused coping skills (e.g., “humor and coping” and “positive experiences”) and trauma-focused coping skills (e.g., “working through positive and negative experiences,” “identifying emotions,” and “balancing body tension and negative thoughts”). These studies suggest that pre-exposure coping skills training to improve coping flexibility may also be beneficial among human rights advocates. Such training may have the potential to protect them from the development of PTSD and MDD or from more severe symptoms of these conditions. However, additional research is needed to determine the feasibility and efficacy of such training programs in this population.

Several limitations of the study should be noted. First among them is the cross-sectional design of this study. Future longitudinal or prospective studies in this area could help to elucidate the potential role of coping flexibility in preventing the development of PTSD and MDD. Second, this study relied on self-report measures via a Web-based survey, and therefore, results are subject to potential participant response bias. However, in previous research, scores on the PACT scale were shown to be unrelated to such personal traits as social desirability and neuroticism (Bonanno et al., 2011). Finally, the exclusive focus on human rights advocates in the present study may limit the generalizability of the findings to other populations with high levels of traumatic exposure.

Notwithstanding its limitations, the findings from the present study shed light on the ways in which coping styles relate to mental health outcomes among human rights advocates. Like other trauma-exposed occupations, the ability of human rights advocates to sustain a long-term career and maintain their well-being may be enhanced by attention to strategies that promote flexibility in their coping styles. Future research is needed to understand how the employment of coping flexibility may aid in reducing mental health issues, such as PTSD and MDD, and may help to support the work of those in this profession.

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