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Avoidant Coping and Treatment Outcome in Rape-Related Posttraumatic Stress Disorder

Amy S. Leiner¹, Megan C. Kearns², Joan L. Jackson³, Millie C. Astin¹, and Barbara O. Rothbaum^{2,a}

¹Atlanta VAMC, Decatur, Georgia

²Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Atlanta, Georgia

³Department of Psychology, University of Georgia, Athens, Georgia

Abstract

Objective—This study investigated the impact of avoidant coping on treatment outcome in rape-related PTSD.

Method—Adult women with rape-related Posttraumatic Stress Disorder (PTSD; $N = 62$) received nine sessions of prolonged exposure (PE) or eye movement desensitization and reprocessing (EMDR). Mean age for sample was 34.7 years old, and race or ethnicity was reported as 67.7% Caucasian, 25.8% African American, 3.2% Latina, and 3.2% Other. PTSD was assessed with the PTSD Symptom Scale-Self Report and avoidant coping was assessed using the Disengagement Subscale of the Coping Strategies Inventory (CSI-D).

Results—Pretreatment avoidant coping was negatively associated with posttreatment PTSD symptom severity even when controlling for initial severity of total PTSD symptoms and when removing PTSD avoidance symptoms from the analysis to account for potential overlap between avoidant coping and PTSD avoidance symptoms ($\Delta R^2 = .08$, $b^* = -0.31$, 95% CI $[-0.17, -0.01]$, $t(60) = -2.27$, $p = .028$). The CSI-D mean score of 100 predicted a 96% likelihood of experiencing clinically significant change (CSC) during treatment. A CSI-D mean score of 61 was associated with a 40% likelihood of experiencing CSC.

Conclusions—PE and EMDR appear to be beneficial for women who frequently engage in avoidant coping responses following rape. A small subset of women with initially low levels of avoidant coping are unlikely to experience a therapeutic response from PE or EMDR.

Keywords

PTSD; sexual assault; coping; treatment outcome

Posttraumatic Stress Disorder (PTSD) is characterized by the development of reexperiencing, avoidance, numbing, and hyperarousal symptoms following exposure to a traumatic event (American Psychiatric Association, 2000). Raped women comprise the

^aCorresponding author: Barbara O. Rothbaum, Emory University School of Medicine, 1256 Briarcliff Rd, Atlanta, GA 30306, 404-712-8866 (phone), 404-727-3700 (fax), brothba@emory.edu.

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largest proportion of PTSD sufferers, which is estimated at 8% in the general population (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). A number of psychotherapies have proven effective for PTSD including exposure therapy, stress inoculation training, and eye movement desensitization and reprocessing (EMDR) (Chambless et al., 1998). The International Society for Traumatic Stress Studies found the strongest evidence for cognitive behavioral techniques (CBT; Foa, Keane, Friedman, & Cohen, 2009), and of the CBT techniques studied, prolonged exposure (PE) had the most evidence for its efficacy from the most well controlled studies (Cahill, Rothbaum, Resick, & Follette, 2009).

Despite the availability of effective psychotherapies, a significant minority of women with rape-related PTSD do not respond to these treatments. In four studies of rape victims treated with empirically supported therapies (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rothbaum, 1997; Rothbaum, Astin, & Marsteller, 2005), 41% of those who started psychotherapy and 23% of those who completed psychotherapy continued to meet criteria for PTSD at the end of treatment. Given these rates of nonresponse, it is particularly important to understand who is likely to respond to psychotherapy and why.

One way to predict who may benefit from PTSD treatment is to investigate variables that impact naturalistic recovery from rape. One such variable is a woman's coping response. Although potential coping responses may be varied and complex, all may be conceptualized as approach or avoidance methods (Roth & Cohen, 1986). Research suggests that raped women use both methods to some extent, but only avoidant coping is consistently associated with variability in recovery. Specifically, avoidant coping is related to poorer psychological adjustment (Cohen & Roth, 1987; Santello & Leitenberg, 1993) and more severe PTSD symptoms (Boesch, Koss, Figueredo, & Coan, 2001; Valentiner, Foa, Riggs, & Gershuny, 1996).

In their seminal paper on coping, Roth and Cohen (1986) defined avoidant coping as cognitive and emotional activity oriented away from threat. Avoidant coping generally reduces immediate stress but may disrupt daily life, lead to emotional numbness, and interfere with more appropriate action. Avoidant coping responses to rape have been characterized as attempts to "block out memories of [the] rapes or minimize or rationalize [the] rape experiences" (Boesch et al., 2001, pp. 211) or as wishful thinking that encompasses "self blame and denial by fantasy" (Valentiner et al., 1996, p. 457). There may be theoretical and real overlap between avoidant coping and avoidance symptoms of PTSD, but studies of naturalistic recovery have not accounted for this potential confound. If we assume that the process of naturalistic recovery is similar to the process of treatment recovery, then we would hypothesize that higher levels of avoidant coping are related to more severe PTSD symptoms after treatment.

However, the process of naturalistic recovery and treatment recovery may not be similar. In fact, cognitive-behavioral theories of PTSD and its treatment (e.g., Foa, Steketee, & Rothbaum, 1989; Harvey, 1999) posit that recovery is associated with decreases in trauma-related avoidance. Both PE and EMDR encourage engagement with traumatic memories, a behavior incompatible with trauma-related avoidance. Therefore, women who use avoidant coping strategies to deal with rape before treatment may be particularly good candidates for PE or EMDR and may benefit more from these therapies than woman who do not rely as heavily on avoidant coping strategies. If this suggestion is true, then high levels of avoidant coping would be associated with lower levels of PTSD symptoms following treatment.

Thus the purpose of the current study was to investigate two competing hypotheses regarding the impact of avoidant coping on treatment outcome in rape-related PTSD. The

first hypothesis, based on naturalistic recovery from PTSD, was that pretreatment avoidant coping would be positively associated with posttreatment symptom severity. That is, more avoidant coping before treatment would predict more PTSD symptoms following treatment and vice versa. The second hypothesis, based on cognitive-behavioral theories of PTSD and its treatment recovery, was that pretreatment avoidant coping would be negatively associated with posttreatment symptom severity. Specifically, higher levels of avoidant coping before treatment would predict less severe PTSD symptoms after treatment and vice versa. If we found a significant relationship (in either direction) between pretreatment avoidant coping and posttreatment symptom severity, we planned an exploratory analysis. The exploratory analysis would utilize logistic regression to estimate the likelihood of responding to treatment given pretreatment avoidant coping scores. Such an analysis would help clinicians determine which individuals with PTSD would be likely to benefit from treatment.

Method

Participants

We utilized data from an existing study comparing PE, EMDR, and waitlist (WL) for the treatment of rape-related PTSD (Rothbaum, Astin, & Marsteller, 2005). Participants were adult females who met criteria for PTSD as a primary diagnosis and had experienced a completed rape at least three months prior to study participation. A more specific description of inclusion and exclusion criteria can be found in the original study. The current sample was comprised of women who were originally randomized to PE or EMDR and those randomized to PE or EMDR following WL. Of the women entered into the original study, 23 started PE and 25 started EMDR at randomization. Of the 24 women randomized to WL, 15 continued to have PTSD following WL and were subsequently randomized to PE ($n = 8$) or EMDR ($n = 6$). Therefore, the current study includes 31 women who started PE and 31 women who started EMDR. Written and verbal informed consent was obtained after procedures were fully explained and before pretreatment assessment. The Institutional Review Board of Emory University approved the consent form and study protocol.

Measures

To assess PTSD severity, we administered the *PTSD Symptom Scale-Self Report* (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993) at pre- and posttreatment. The PSS-SR has 17 items corresponding to each DSM-IV symptom; yields severity scores for total, reexperiencing, avoidance and numbing, and hyperarousal symptoms; and has demonstrated good validity, internal consistency, and test-retest reliability (Foa et al., 1993). Avoidant coping was measured pre- and posttreatment with the *Coping Strategies Inventory-Disengagement Subscale* (CSI-D; Tobin, Holroyd, Reynolds, & Wigal, 1989). The CSI was derived from hierarchical factor-analysis using items reflecting empirically-supported coping methods. The 36-item Disengagement Subscale taps into coping strategies that are associated with avoidance of stressor-related thoughts, failure to initiate behaviors that might change the stressful situation, and “wishful thoughts and fantasies [that] draw attention away from the stressor” (Tobin et al., 1989, p. 350). The items from this scale are rated on a 5-point scale according to the extent to which the strategy is used to manage a particular life stressor (1 = not at all to 5 = very much). Each item describes an example of avoidant coping (e.g., “I went along as if nothing were happening.” “I avoided thinking of doing anything about the situation.”). The participants of the current study were asked to make ratings in regard to the index rape. The disengagement subscale has good internal consistency ($\alpha = .89$) and test-retest reliability ($\kappa = .79$; Tobin et al., 1989).

Procedure

PE and EMDR were delivered in nine, 90-minute, twice-weekly sessions. Experts in PE and EMDR reviewed 25% of session tapes and evaluated therapist skill as “very good” for both. Descriptions of therapies and integrity measures may be found in the original study (Rothbaum, Astin, & Marsteller, 2005).

Results

Demographic characteristics of the sample are reported in Table 1. Descriptive statistics for avoidant coping and PTSD measures are reported in Table 2.

We conducted preliminary analyses comparing PE and EMDR. First, we found no group differences at pre-treatment on the CSI-D or PSS-SR scales in independent samples *t*-tests. Next, we conducted two 2-way repeated measures ANOVAs with time (pretreatment and posttreatment) as the within-participants factor and treatment group as the between-participants factor. We found no interaction effects on the CSI-D, $F(1, 49) = 0.02, p = .89$, partial $\eta^2 < 0.001$, or on the PSS-SR total score, $F(1, 51) = 0.003, p = .95$, partial $\eta^2 < 0.001$. Therefore, treatment groups were collapsed for subsequent analyses.

Our competing hypotheses were tested with hierarchical linear regression. The dependant variable was posttreatment PSS-SR score and the predictor variable was pretreatment CSI-D score. Bivariate correlations between CSI-D and PSS-SR scores are reported in Table 3. To account for variance due to symptom severity at pretreatment, we entered the pretreatment PSS-SR total symptom score in the first step of the regression. In the second step, we added the pretreatment CSI-D. We did find that pretreatment CSI-D scores significantly predicted posttreatment PSS-SR scores when accounting for pretreatment PSS-SR scores, $\Delta F(1, 49) = 5.72, p = .032, \Delta R^2 = .08$. This relationship was negative, $b^* = -0.31, 95\% \text{ CI} [-0.21, -0.01], t(51) = -2.21, p = .032$. This supports the second hypothesis that pretreatment avoidant coping was inversely associated with symptom severity after treatment and vice versa.

Next, to address the potential overlap between avoidance symptoms and avoidant coping, we repeated this analysis with the avoidance items on the PSS-SR removed from both the pre- and posttreatment scores. We found that when avoidance symptom items were removed from pre and posttreatment PSS-SR, pretreatment CSI-D scores continued to significantly predict posttreatment PSS-SR scores $\Delta F(1, 49) = 5.16, p = .028, \Delta R^2 = .08$. Again, this relationship was negative, $b^* = -0.31, 95\% \text{ CI} [-0.17, -0.01], t(51) = -2.27, p = .028$. Table 4 reports the results of these multiple linear regression analyses.

Since we found that pretreatment avoidant coping significantly predicted symptom severity following treatment, we did an exploratory analysis to estimate the likelihood a woman would respond to treatment given her initial level of avoidant coping. To do this, we first needed to define treatment response. We chose to define treatment response as clinically significant change (CSC) in the total PSS-SR. CSC is improvement on an outcome measure beyond that expected by measurement error (Jacobson & Truax, 1991). The premise of CSC is that change in symptom severity scores from pre- to posttreatment may be due to the therapeutic effect of treatment and also to measurement error. To justify a therapeutic effect and claim CSC, a pre-to-posttreatment score difference must be 1) greater than score deviations expected from a scale's test-retest reliability coefficient and 2) be in the direction indicating improvement. Utilizing Jacobson and Truax's (1991) formula to calculate CSC, we determined that CSC in the total PSS-SR score would be a reduction of at least 10 points over the course of treatment. Based on this rule, we found that 47 women (75.8%) experienced CSC.

Next, we used logistic regression to verify that pretreatment CSI-D scores did predict CSC, $OR = 0.96$, 95% CI [0.93, 0.99]. Finally we used the values of the logistic regression equation to calculate the likelihood of responding to treatment given four CSI-D values. We chose the CSI-D values of 61, 79, 100, and 122 because these represented the measure's 10th, 25th, 50th, and 75th cumulative percentiles, respectively. We found that women who had a CSI-D score of 61 had 40% likelihood of experiencing CSC. Women with a CSI-D score of 79 had a 78% likelihood of CSC; women with a CSI-D of 100 had a 96% likelihood; and women with a CSI-D of 122 had a greater than 99% likelihood.

Discussion

We explored the impact of avoidant coping on treatment response in women with rape-related PTSD. We tested two competing hypotheses: that pretreatment avoidant coping would be either positively or negatively associated with PTSD symptom severity following treatment. Our analysis supported the hypothesis that pretreatment avoidant coping is negatively associated with posttreatment PTSD symptom severity. That is, in the sample, initially higher levels of avoidant coping were associated with less severe PTSD after treatment (and vice versa). This relationship was significant even when controlling for pretreatment PTSD severity levels and accounting for potential overlap in PTSD avoidance symptoms and avoidant coping. This finding is consistent with cognitive behavioral theories of PTSD and its recovery (e.g., Foa, Steketee, & Rothbaum, 1989; Harvey, 1999). These theories posit that recovery is associated with decreases in trauma-related avoidance. Both PE and EMDR encourage engagement with traumatic memories, a behavior incompatible with trauma-related avoidance. Therefore, women who use avoidant coping strategies to deal with rape may be particularly good candidates for PE or EMDR.

The competing hypothesis was not supported. We did not find a significant positive relationship between pretreatment avoidant coping and posttreatment PTSD severity as suggested by studies of naturalistic recovery (e.g., Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). It is difficult to explain why the association between avoidant coping and PTSD severity is positive in samples of naturalistic recovery and negative in the current sample. One possibility is that the processes of natural recovery and treatment are very different. Another possibility is that these two types of samples are not comparable. Whereas samples of raped women in naturalistic recovery likely have individuals seeking and not seeking out improvement, all women in our sample were treatment-seeking.

Taken together, the results implied that among women with rape-related PTSD, PE and EMDR were most beneficial for those women who frequently engage in avoidant coping responses, as they report more severe PTSD symptoms at pretreatment and experience significant symptom reduction over the course of treatment. The findings, however, imply an unfortunate corollary. It appears that a small subset of women with initially low levels of avoidant coping are unlikely to experience a therapeutic response from PE or EMDR. It is possible that this study revealed a floor effect for treatment response in PE and EMDR. Perhaps low-avoidance individuals are unlikely to respond to treatment because their efforts to reduce avoidance further during the course of therapy may be futile. This possibility is intriguing given that some theories of PTSD posit avoidance behavior as the maintaining factor in PTSD (Creamer, Burgess, & Pattison, 1992; Foa et al., 1991).

The current investigation represents the first known attempt to describe the relationship between avoidant coping and treatment response of women with rape-related PTSD. This study utilized a female sample of rape survivors treated with either PE or EMDR. Thus the present findings may not extend to male trauma survivors, individuals exposed to other

traumas, or to patients treated with other therapies. The study included a relatively small sample and used self-report questionnaires to measure the variables of interest.

This study points to the need for further research regarding the role of avoidant coping in PTSD treatment response, particularly with more heterogeneous samples and other therapies. More research is also needed to better understand the overlap between avoidance coping and the avoidance symptoms of PTSD. A greater understanding of the association between avoidant coping and PTSD treatment may stimulate the modification of existing treatments or the development of new interventions. As a result, clinicians may be better able to match individual trauma survivors with particular interventions and reduce suffering associated with trauma exposure.

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Table 1

Demographic Characteristics of Participants

Characteristics	Value
Age, years, M (SD)	34.7 (11.3)
Race, % of Total Sample	
African American	25.8
Caucasian	67.7
Latina	3.2
Other	3.2
Education, % of Total Sample	
Some Graduate School	24.2
University Graduate	19.4
Some University	35.5
High School Graduate	19.4
Some High School	1.6
Marital Status, % of Total Sample	
Single	48.4
Married	25.8
Living Together	1.6
Divorced or Separated	24.2
Have Children, % of Total Sample	35.5
Employment Status, % of Total Sample	
Not Working	19.4
Working Part-Time	16.1
Working Full-Time	46.8
Student	3.2
Working at Home	14.5
Household Income, % of Total Sample	
\$50,001 or more	19.4
\$40,001 to \$50,000	8.1
\$30,001 to \$40,000	9.7
\$20,001 to \$30,000	21
\$10,001 to \$20,000	17.7
\$10,000 or less	24.2

Table 2

Means and Standard Deviations for Psychopathology Measures

Measure	<u>Pretreatment</u>	<u>Posttreatment</u>
	n = 62 <i>M (SD)</i>	n = 53 <i>M (SD)</i>
Posttraumatic Stress Scale-Self Report		
Total	26.7 (9.3)	9.2 (9.8)
Reexperiencing	6.5 (3.4)	1.7 (2.6)
Avoidance	3.9 (1.8)	0.9 (1.8)
Numbing	7.5 (3.6)	3.2 (3.5)
Hyperarousal	8.7 (3.4)	3.3 (3.6)
Total minus Avoidance Items	22.8 (8.3)	8.2 (8.4)
Coping Strategies Inventory		
Disengagement Scale	100.4 (29.6)	65.0 (22.0)

Table 3

Correlations between the Coping Strategies Inventory-Disengagement Subscale (CSI-D) and the Posttraumatic Stress Scale-Self Report (PSS-SR)

PSS-SR	CSI-D	
	Pretreatment n = 61	Posttreatment n = 52
Pretreatment		
Total	.348**	.211
Reexperiencing	.173	.050
Avoidance	.364**	.185
Numbing	.345**	.316*
Hyperarousal	.214	.106
Total minus Avoidance Items	.307*	.199
Posttreatment		
Total	-.130	.477**
Reexperiencing	-.162	.409**
Avoidance	-.089	.418**
Numbing	-.138	.432**
Hyperarousal	-.061	.385**
Total minus Avoidance Items	-.132	.467**

* $p < .05$,

** $p < .01$,

*** $p < .001$.

Table 4
 Summary of Hierarchical Regression Analysis for Variables Predicting Posttreatment PSS-SR Scale Scores

PSS-SR Scale	Pretreatment Predictor Variables	B	SE B	95% CI	ΔR ²
Total Symptoms	Step 1				.10*
	Total Symptoms	0.33*	0.14	[0.05, 0.60]	
	Step 2				.08*
	Total Symptoms	0.45**	0.14	[0.17, 0.74]	
	Avoidant Coping	-0.11*	0.05	[-0.21, -0.01]	
	Total without Avoidance Symptoms				
Total without Avoidance Symptoms	Step 1				.13**
	Total without Avoidance Symptoms	0.36**	0.13	[0.10, 0.62]	
	Step 2				.08*
	Total without Avoidance Symptoms	0.48***	0.14	[0.20, 0.75]	
	Avoidant Coping	-0.09*	0.04	[-0.17, -0.01]	