Does the Repressor Coping Style Predict Lower Posttraumatic Stress Symptoms?

Richard J. McNally, PhD*; John P. Hatch, PhD†; Elizabeth M. Cedillos, MS‡; Cynthia A. Luethcke, BA†; Maj Monty T. Baker, USAF BSC(Res)‡‡; Lt Col Alan L. Peterson, USAF BSC (Res.) ‡‡; Brett T. Litz, PhD§

ABSTRACT We tested whether a continuous measure of repressor coping style predicted lower posttraumatic stress disorder (PTSD) symptoms in 122 health care professionals serving in Operation Iraqi Freedom. Zero-order correlational analyses indicated that predeployment repressor coping scores negatively predicted postdeployment PTSD symptoms, $r = -0.29, p = 0.001$, whereas predeployment Connor–Davidson Resilience Scale (CD-RISC) scores did not predict postdeployment PTSD symptoms, $r = -0.13, p = 0.14$. However, predeployment trait anxiety was chiefly responsible for the association between repressor coping and PTSD symptom severity, $r = 0.38, p = 0.001$. Four percent of the subjects qualified for a probable PTSD diagnosis. Although service members with relatively higher PTSD scores had lower repressor coping scores than did the other subjects, their level of predeployment anxiety was chiefly responsible for this relationship. Knowing someone’s predeployment level of trait anxiety permits better prediction of PTSD symptoms among trauma-exposed service members than does knowing his or her level of repressive coping.

INTRODUCTION

Most people exposed to traumatic events do not develop posttraumatic stress disorder (PTSD), revealing that victims vary in their vulnerability for developing the disorder. Accordingly, researchers have sought to identify variables that heighten risk for PTSD among those suffering from trauma. More recently, they have inverted the traditional emphasis on risk, seeking instead to identify resilience variables that buffer people against PTSD. Resilience programs may bolster stress-buffering traits, helping individuals acquire skills to recover from exposure to serious stressors.

Variables that foster resilience are not necessarily the mirror image of risk factors. For example, lower scores on intelligence tests prospectively predict severity of PTSD symptoms among veterans even after researchers have adjusted statistically for the severity of combat exposure. Yet the mean IQ score of veterans without PTSD lies within the above average range, whereas it lies within the normal range for those with PTSD. Likewise, children with above average IQ scores are less likely to develop PTSD following subsequent trauma exposure compared to children whose scores were in the normal or low range. Yet risk for PTSD among traumatized children of low intelligence is not greater than among those of average intelligence. These studies imply that above average intelligence is a resilience variable rather than below average intelligence being a risk factor.

Another variable potentially relevant to resilience is the repressor coping style. Repressors are people who report low levels of anxiety, but who score high on a measure of social desirability (i.e., defensiveness about acknowledging emotional distress). Although repressors report little distress when encountering stressors, they sometimes exhibit physiological activation. Results such as these might seem to suggest that repressors minimize their true level of anxiety. Yet research does not support this interpretation. Not only do repressors differ from highly anxious people, they also differ from low anxious people who do not exhibit high levels of defensiveness. For example, highly anxious people, including those with PTSD, exhibit delayed color naming of threat words as do highly anxious people. If repressors were actually anxious people who downplay their distress, they would exhibit at least as much Stroop interference for these words than nondefensive, low-anxiety people do. If repressors were actually anxious people who downplay their distress, they would exhibit at least as much Stroop interference for threat words as do highly anxious people.

In fact, repressors seem to have exceptional control over their attention in the presence of threat, a process that may foster resilience in the face of trauma. Consistent with this possibility, the repressor coping style is associated with less distress among people who lost loved ones to suicide. Ginzburg et al. found that repressors are less likely than other people to develop PTSD after suffering a heart attack. Bonanno et al. found that conjugal bereaved individuals who...
exhibited low self-reported distress and high physiological arousal had a mild grief course through 25 months post-loss. Taken together, these results suggest that repressive coping may buffer people against developing psychopathology following exposure to extremely stressful events.

In this study, we investigated possible predictors of resilience among health care professionals who had served in a combat support hospital in Iraq. Although professionals who treat seriously wounded and dying combatants encounter gruesome situations, the potential risk for PTSD in this population is not as clear as it is in service members with greater risk for direct personal life threat. Nevertheless, we assessed exposure to both military health care stressors and combat-related stressors.

We tested whether Mendolia’s Index of Self-Regulation (ISE), a dimensional measure of the repressor coping style, prospectively predicts PTSD symptoms in deployed military health care professionals. We hypothesized that higher predeployment ISE scores would predict lower PTSD scores postdeployment. We also tested whether the CD-RISC, a measure of attitudes for coping with adversity, prospectively predicts PTSD symptoms. Consistent with previous research on veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), we hypothesized that higher predeployment scores on this measure would predict lower PTSD symptom severity postdeployment. Finally, we compared subjects with a probable postdeployment diagnosis of PTSD on the putative resilience measures.

METHOD

Administrative Approval

Before initiating our study, the institutional review board of Wilford Hall Medical Center at Lackland Air Force Base reviewed and approved the protocol and materials. The study was also reviewed and approved by the Air Force Personnel Survey Program and the U.S. Army’s Joint Combat Casualty Research Team. Subjects provided a unique identifier so that we could link their surveys over time without the subjects revealing their identity to us.

Subjects

The subjects were 122 U.S. Air Force medical personnel who served in support of OIF at a large combat support hospital in Iraq and who volunteered to participate in a prospective longitudinal study of risk and resilience. To help maintain anonymity, we collected some demographic information on subjects (e.g., age, rank) in ranges rather than specific item responses.

Of subjects who completed the demographic portion of the questionnaire, most were married (67.2%, n = 82). Unfortunately, many subjects did not indicate their sex, apparently because of the inconspicuous location of this item on the questionnaire, rendering it easy to overlook. Our best estimate is that about 50% were male. The ethnic composition of the study sample was Caucasian (73.8%, n = 90), African-American (6.6%, n = 8), Latino (11.5%, n = 14), Asian-American (3.3%, n = 4), and others (2.5%, n = 3).

Subjects ranged widely in age. The percentages for different age groups were 18 to 24 (14.8%, n = 18), 25 to 29 (21.3%, n = 26), 30 to 34 (18%, n = 22), 35 to 39 (17.2%, n = 21), 40 to 44 (15.6%, n = 19), and 45 years or older (12.3%, n = 15). A slight majority were officers (54.9%, n = 67), whereas the rest were enlisted personnel (43.5%, n = 53).

Testing Procedures

Subjects completed predeployment questionnaires during their processing through Lackland Air Force Base before departure for Iraq. They completed postdeployment questionnaires approximately 5 months later, 1 month after returning to the United States. We mailed the postdeployment questionnaires to the subjects’ military work address, and they returned them to us via interdepartmental mail. The study group comprised a series of cohorts that deployed to Iraq every 4 months beginning in September 2004 until January 2009. During this interval, cohorts departed for Iraq every 4 months.

One of the investigators explained the study to the medical personnel at the predeployment session and asked them to complete a voluntary survey comprising the demographic questions and several questionnaires. The cover sheet provided instructions, informed subjects that their participation was voluntary, and emphasized the confidentiality of their responses. Subjects completed predeployment questionnaires in an auditorium. An investigator was present to provide instructions, answer questions, and ask if subjects would allow us to recontact them to ask them to complete mid-deployment and postdeployment surveys. Completion of the predeployment surveys took about 45 minutes. Health care personnel inserted surveys, whether completed or not, into envelopes such that the investigators were unaware of who had participated in the study.

Questionnaires Completed at Predeployment

The predeployment survey packet contained a demographic questionnaire, the short form of the Manifest Anxiety Scale (MAS), the short form of the Marlowe-Crowne Social Desirability Scale (SDS), and the CD-RISC.

Questionnaires Completed at Postdeployment

The postdeployment survey packet contained the PTSD Checklist-Military version (PCL-M), the Combat Exposure Scale (CES), and the Military Health care Stressor Scale (MHSS).

Description of Measures

Manifest Anxiety Scale

The original MAS consists of 50 true/false questions drawn from the Minnesota Multiphasic Personality Inventory that tap trait anxiety. A study of 59 undergraduates indicated a three-week test–retest reliability of r = 0.89, and a study of
64 neuropsychiatric patients yielded a validity coefficient of $r = 0.60$ between MAS scores and clinician ratings of behavioral manifestations of anxiety. Psychometric scrutiny of individual questions led to the deletion of items of dubious validity, resulting in the 20-item short form of the MAS. Despite its brevity, the short form has a coefficient of internal consistency indistinguishable from that of the original MAS ($r = 0.76$ versus 0.82, respectively). We used the short form of the MAS.

Marlowe-Crowne SDS

The SDS consists of 33 true/false items that measure defensiveness or the tendency to present oneself in an unrealistically favorable light. Items include "I have never intensely disliked someone" (T) and "I like to gossip at times" (F). Psychologists have developed a short form of the SDS comprising 13 optimal items identified via factor analysis. Its Kuder-Richardson reliability ($r = 0.76$) compares favorably with the original version, and the correlation between the original and short versions is $r = 0.93$. The six-week test–retest reliability of the short version is $r = 0.74$. We used the short form of the SDS in this study.

Index of Self-Regulation

Typically, researchers identify repressors categorically as people who score low on the MAS and high on the SDS. Yet as Mendolia argued, categorical conceptualizations of the repressor coping style have limitations relative to continuous measures of this style. Following Mendolia, we calculated an ISE score for each subject by using the formula $20 - (MAS - SDS)$. Higher ISE scores signify a stronger repressor coping style evinced by the tendency to report low anxiety symptoms and high social desirability scores. Mendolia used the short form of the MAS and the long form of the SDS, whereas we used the short forms of both scales. Hence, the highest score that one can get on the ISE would be 33 (i.e., $20 - [0 - 13]$), and the lowest score would be 0 (i.e., $20 - [20 - 0]$).

Connor–Davidson Resilience Scale

The CD-RISC contains 25 items tapping attitudes toward coping with adversity. Respondents indicate their degree of endorsement on 5-point scales ranging from 0 ("not true at all") to 4 ("true nearly all the time") of items such as "Having to cope with stress makes me stronger." Connor and Davidson reported a Cronbach’s $\alpha$ of 0.89 for 577 general population subjects and a test–retest reliability of 0.87 among 24 patients with either PTSD or generalized anxiety disorder who had failed to respond favorably in a psychopharmacology clinical trial. Evidence for convergent and divergent validity includes a positive correlation with a hardness scale ($r = 0.83$) and a negative correlation with a perceived stress scale ($r = -0.76$).

PTSD Checklist—Military Version

Our measure of PTSD symptoms was the widely used PCL-M. Keyed to PTSD symptoms for the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, items appear on 5-point Likert scales ranging from 1 (“not at all”) to 5 (“extremely”). The PCL-M has 17 items, and scores range from 17 to 85. The sensitivity and specificity of the PCL-M for detecting clinician-diagnosed PTSD ranges from 0.85 to 0.39 and from 0.73 to 0.97, respectively, depending on cutoffs and prevalence of the disorder in target population.

Combat Exposure Scale

The CES is a rationally derived, 22-item questionnaire based on the Peacekeeping Incidents and Experiences Scale. It measures the occurrence and psychological impact of combat-related stressors such as "being attacked or ambushed" and "patrolling areas (or riding in areas) where there were landmines." Respondents mark each item on a Likert scale ranging from 1 to 6: 1 is for stressors the respondent indicated "Does not apply;" 2 is for "Did Not Experience." For experienced stressors, respondents indicate how much the event affected them ranging from 3 ("no impact at all") to 6 ("extreme impact").

Military Healthcare Stressor Scale

The MHSS is a 21-item questionnaire that measures the occurrence and impact of stressors associated with providing healthcare in a war zone. We developed the MHSS after consulting focus groups comprising military medical personnel who had served in Iraq and who had served on the Air Force Critical Care Aeromedical Transport Team. Items include a wide variety of medical stressors such as "exposure to a patient who cried or screamed in agony and fear," "exposure to patients with severe burns," and "exposure to patients that I didn’t have a clue how to help." Respondents mark each item on a Likert scale ranging from 1 to 5: 1 is for stressors the respondent did not experience. For experienced stressors, respondents indicate how much the event affected them ranging from 2 ("no impact") to 5 ("extreme impact").

RESULTS

To test our main hypotheses, we used zero-order correlations. Because we had a priori predictions, we did not adjust $p$ values for multiple tests.

Consistent with our hypothesis, higher predeployment ISE scores predicted lower postdeployment PCL-M scores ($r_s = -0.29, p = 0.001$; however, predeployment CD-RISC scores did not, $r_s = -0.13, p = 0.14$). However, because predeployment social desirability scores were unrelated to PTSD symptoms ($r_s = -0.02, p = 0.84$) and predeployment reports of trait anxiety were moderately correlated ($r_s = 0.38, p = 0.001$), it appears that the relationship between repressive coping and PTSD symptoms chiefly pertains to the relationship between trait anxiety and PTSD. In fact, the magnitude of positive correlation between predeployment trait anxiety and postdeployment PTSD symptoms was numerically greater than the magnitude of the negative correlation between predeployment repressor coping and PTSD symptoms. Hence, the association between repressor coping scores and PTSD symptoms appears attributable to predeployment trait anxiety.
Because the meaning of resilience presupposes exposure to a stressor, we identified subjects who reported at least one stressful event (scored at a level 4, 5, or 6, i.e., at least "A little" impact) by the mid-deployment or postdeployment CES. Unfortunately, not all subjects elected to complete the CES and the MHSS. Among the 90 subjects reporting at least one stressful event and for whom we did not have missing data, we conducted an ordinary least squares multiple regression analysis with PCL-M scores as the dependent variable and predeployment MAS scores, predeployment CD-RISC scores, predeployment social desirability scores, CES scores, and MHSS scores as the independent variables. Because the PCL-M scores were not normally distributed, we used a bootstrap method to estimate standard errors. The $R (0.68)$ for regression was significantly different from zero, $F(5, 84) = 10.95, p < 0.001$, and the $R^2$ was 0.40 (adjusted $R^2 = 0.36$). However, in this model, only the CES, $\beta = 0.26$, $p = 0.007$, the MAS, $\beta = 0.33$, $p < 0.001$, and the MHSS, $\beta = 0.30$, $p < 0.001$, significantly predicted variance in PCL-M scores.

We next identified those subjects whose postdeployment PCL-M scores suggested probable PTSD and compared their responses on the predictor measures with subjects whose postdeployment PCL-M scores did not qualify for probable PTSD. Using conventional criteria for caseness, we classified a subject as qualifying for probable PTSD if he or she scored at least 50 on the PCL-M and endorsed sufficient B, C, and D criteria symptoms. Five subjects (4%) met these criteria, whereas 117 did not.

To compare these two groups, we used a robust test for medians (Harrell–Davis) and estimated the 95% confidence intervals with a bootstrap method. Unsurprisingly, the median PCL-M score for these five subjects was substantially higher than for the remaining subjects, $M_y = 65.2$ (95% CI = 54.5 to 75.9) versus $M_x = 22.1$ (95% CI = 20.6 to 23.7), $p < 0.00001$. Relative to the other subjects, those with probable PTSD also scored significantly higher on the measures of combat exposure, $M_y = 71.4$ (95% CI = 60.1 to 82.7) versus $M_x = 54.8$ (95% CI = 51.8 to 57.8), $p < 0.00001$, and health care stress, $M_y = 82.7$ (95% CI = 79.1 to 86.2) versus $M_x = 61.5$ (95% CI = 57.1 to 66.0), $p < 0.00001$.

On Mendolia’s ISE measure of repressive coping, the probable PTSD subjects scored only slightly and nonsignificantly lower than the other subjects did, $M_y = 21.1$ (95% CI = 16.2 to 26.0) versus $M_x = 24.1$ (95% CI = 22.7 to 25.6), $p = 0.27$. As for the components of this index—the measures of anxiety and social desirability—the probable PTSD subjects, relative to the other subjects, scored higher on the former, but did not differ significantly on the latter: $M_y = 6.4$ (95% CI = 4.9 to 7.9) versus $M_x = 3.2$ (95% CI = 2.4 to 4.1), $p < 0.00001$ for trait anxiety; $M_y = 7.8$ (95% CI = 3.9 to 11.7) versus $M_x = 8.5$ (95% CI = 7.8 to 9.1), $p = 0.74$ for social desirability. Finally, the probable PTSD subjects scored indistinguishably from the other subjects on the CD-RISC: $M_y = 79.2$ (95% CI = 74.8 to 83.5) versus $M_x = 80.0$ (95% CI = 76.7 to 83.4), $p = 0.67$.

**DISCUSSION**

In this prospective longitudinal study, we investigated candidate predictors of resilience for health care personnel serving in support of OIF. Specifically, we tested whether higher scores on Mendolia’s index of repressive coping and Connor and Davidson’s measure of resilience predict lower scores on a continuous measure of PTSD symptoms. Although Mendolia’s measure was significantly and negatively associated with PTSD symptoms, lower self-reported trait anxiety drove this effect. Indeed, the positive correlation between predeployment trait anxiety and postdeployment PTSD symptoms was numerically greater than the negative correlation between predeployment repressive coping and postdeployment PTSD symptoms. Hence, our data suggest that knowing a person’s predeployment level of trait anxiety will enable greater prediction of subsequent PTSD than knowing a person’s predeployment level of repressive coping.

These relationships persisted even after we adjusted the analysis for exposure to combat and health care stressors. Our findings are consistent with results of a study of Australian civilians whose pretrauma levels of neuroticism and symptoms of anxiety and depression significantly predicted PTSD symptoms in response to subsequent exposure to severe bushfires. Using conventional criteria, we also identified subjects whose PCL scores indicated probable PTSD. Four percent of the subjects ($n = 5$) had scores suggestive of PTSD. Subjects with probable PTSD did not differ significantly from the remaining subjects on Mendolia’s index of repressive coping or its social desirability component, but they did report predeployment trait anxiety levels that were approximately twice as high as those of the subjects without probable PTSD. Connor and Davidson’s CD-RISC was unrelated to PTSD symptom severity or caseness. Indeed, the medians of the probable PTSD group and the non-PTSD group were similar (79.2 versus 80.8, respectively), and nearly identical to the mean for the general population in Connor and Davidson’s original study (80.4). Hence, the CD-RISC was unhelpful in predicting resilience.

Interestingly, our findings contrast with those of Pietrzak et al., who found that CD-RISC scores were negatively associated with both continuous and categorical measures of PTSD in OEF/OIF veterans approximately 26.9 months postdeployment. Their subjects came primarily from Army National Guard units whose direct combat exposure was likely much higher than that of our health care professionals. As Pietrzak et al. emphasized, their design was cross-sectional, not prospective. Unlike us, they did not administer the CD-RISC before deployment. Moreover, even their non-PTSD subjects had resilience scores that were significantly lower than that of Connor and Davidson’s healthy civilian sample.

It is critical for the military to identify modifiable predictors of resilience suitable for incorporation in training and intervention programs for reducing risk for PTSD. Yet, a conceptual issue arises in resilience prediction when nonpathological outcomes are the norm, not the exception. That is, epidemiologists...
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tend to focus on predicting disease, not health, and predicting resilience when most people do not fall ill is akin to predicting health. Indeed, 95% of our study group did not have PTSD, resilience when most people do not fall ill is akin to predicting disease, not health, and predicting combat arms, and this likely reduces the incidence of PTSD. Finally, performing their professional tasks of reducing suffering and saving lives in the war zone may itself buffer health care professionals from developing PTSD.

ACKNOWLEDGMENT
This work was supported by a grant to Alan L, Peterson from the United States Air Force Surgeon General's Operational Medicine Research Program (FA7014-07-C-0036).

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