



Short communication

Posttraumatic growth among spouses of combat veterans: Adaptive or maladaptive for adjustment?

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ABSTRACT

We examined the relationship between posttraumatic growth (PTG) and distress in spouses of trauma survivors. A sample of spouses of combat veterans of the 1973 Yom Kippur War were assessed using questionnaires pertaining to PTG, depression, anxiety, and posttraumatic stress, in 2004 and 2011. Applying cross-lagged modeling strategy, higher PTG levels predicted higher depression and anxiety levels above and beyond initial distress. Thus, psychological growth in spouses of survivors appears to signify subsequent distress.

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1. Introduction

The negative psychological effects of trauma exposure on direct survivors have been repeatedly documented, particularly in symptoms of posttraumatic stress (Kessler et al., 1995) and high prevalence of depression in the long-term (Dekel et al., 2014). Yet, survivors also report positive changes in their lives resulting from the emotional struggle with the trauma (Tedeschi and Calhoun, 2004). This positive perspective on trauma has been receiving growing scientific attention over the past years. A commonly used term coined to describe these salutogenic effects is “posttraumatic growth” (PTG; Tedeschi and Calhoun, 2004). PTG pertains to the perception of positive changes with respect to new life priorities, closer relations to others, increased appreciation of life, greater sense of personal strength, and spiritual change (Tedeschi and Calhoun, 2004). PTG has been described in more than 200 studies as evident in survivor reports following a wide range of traumatic events (see Cho and Park, 2013, for a review).

It has been suggested that the psychological implications of trauma are not limited to trauma survivors, but may also be experienced by individuals who have intimate ties with the traumatized, as described by the term secondary traumatization

(Figley, 1986). Studies have repeatedly documented that increased psychiatric symptoms in the spouses of trauma survivors may be evident, as well as complaints of depression and anxiety (Klarić et al., 2012; Solomon et al., 1992). Only recently has the psychological growth of spouses been described (Klarić et al., 2012). This type of growth pertains to positive changes resulting from indirect exposure to the partner's trauma, and can be coined the term secondary PTG. For example, caregivers of patients with advanced cancer reported PTG at six months following their partner's diagnosis (Moore et al., 2011). Likewise, wives of former prisoners of war reported PTG as far as 30 years after the war (Dekel, 2007).

An issue of important clinical relevance is the relationship between secondary traumatization and secondary PTG. The underlying and pertinent factors promoting mental health in secondary traumatized individuals are relatively unknown. To the best of our knowledge, no study has examined the role of secondary PTG in relation to distress. Previous studies exclusively report on samples of direct trauma survivors, and their findings are inconsistent. Positive, negative, and null findings have been reported on the relationship between PTG and mental health (e.g., see Helgeson et al., 2006, for a review). Therefore, the current investigation intends to address this research gap.

It could be speculated that the PTG of the spouses would promote adjustment and ameliorate their distress. This is consistent with the view of PTG as a constructive coping strategy and an adaptive trauma response. While traumatic events pose a threat to the person's world assumptions (Janoff-Bulman, 1992), the process

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of growth entails the rebuilding of positive world assumptions (Janoff-Bulman, 2004), offering a construal of meaning and benefit attribution (Davis et al., 1998). Primary PTG was previously associated with reduced stress, as evident in decreased mental fatigue in residents three months following the Great East Japan earthquake (Nakagawa et al., 2014). PTG was also found to predict better adjustment five years after diagnosis in breast cancer patients (Carver and Antoni, 2004). In a similar vein, secondary PTG may promote alleviation of secondary distress.

Alternatively, PTG of the spouses may hinder their adjustment. In accord with the Janus-Face model (Maercker and Zoellner, 2004), PTG has a constructive but also a self-deceptive side. PTG may serve an illusory self-enhancing function to counterbalance distress (Zoellner et al., 2011) and is likely to be associated with avoidance and denial strategies (Taylor, 1983). The self-enhancing function may be adaptive in the short-run (Bonanno et al., 2005) but in the long-term has negative effects on adjustment (Maercker and Zoellner, 2004). Previous studies of direct trauma survivors have shown that higher levels of PTG are linked with higher levels of distress, incorporating symptoms of depression (e.g., Kleim and Ehlers, 2009) symptoms of anxiety, and posttraumatic stress in the long-term following the trauma (e.g., Dekel et al., 2012). Hence, it could be expected that secondary PTG may predict subsequent secondary distress.

To address the relationship between presumed secondary psychological growth and secondary distress in this longitudinal study, we collected data from spouses of veterans of the Yom Kippur war and examined the associations between their reports of PTG and symptoms of depression and anxiety.

2. Method

2.1. Participants and procedure

This study is part of a longitudinal study of Israeli combat veterans of the 1973 Yom Kippur War and their spouses (Solomon et al., 2014). The group of veterans was comprised of individuals who were exposed to battlefield stressors, including encounters with injured people and dead bodies, active fighting, and exposure to life-threatening events. 15.6% and 21.3% of the veterans met PTSD DSM-IV symptoms criteria in 2003 and 2008, respectively. Here we analyzed data from 171 female spouses of these veterans, among whom 149 participated in the assessments conducted 30 (Time 1, 2004) and 37 (Time 2, 2011) years after the war, resulting in a 13% attrition rate. The sample did not differ from the initial one with respect to distress and demographic variables. Spouses were between 36 to 79 years old ($M=58$, $SD=5.87$), married/cohabitated between three to 53 years ($M=27.82$, $SD=6.54$), and had 15 years of education ($SD=2.20$). Following approval from Tel Aviv University Review Board, participants (veterans and their spouses) were identified using updated Israel Defense Force (IDF) files. Participants completed the research questionnaires either in their homes or in a location of their choice. All participants read and signed an informed consent agreement.

2.2. Measures

PTG was measured by the commonly used self-report Post-traumatic Growth Inventory (PTGI; Tedeschi and Calhoun, 1996), listing 21 items on a 4-point scale, comprising of five subscales: Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life (α was .94 for the total score and between 0.89 and 0.96 for the subscales). Participants were asked to report the extent of positive change that occurred in their life following the Yom Kippur war. They were specifically instructed to

report on the changes in their life as a result of living with a combat veteran following the war.

Depression and anxiety were assessed by the widely used self-report checklist-90 (SCL-90, Derogatis, 1977) targeting symptoms and symptom clusters on a 5-point scale. Participants were asked to report how frequently they experienced each symptom in the past two weeks. Based on SCL norms from psychiatric outpatients (Derogatis, 1977) mean scores for depression and anxiety equal to or above 0.73 were considered as symptom endorsement (α for depression and anxiety was 0.85 and 0.91, respectively).

Posttraumatic stress symptoms were measured by the Post-traumatic stress disorder (PTSD) inventory (Solomon et al., 2014), targeting 17 symptoms in accord with DSM-IV-TR (APA, 2000). Participants were asked to rate how often they suffered from each symptom in the previous month on a 4-point scale. They were also instructed to report about their reactions to their partner's experience of combat (e.g., "I have nightmares about my partner's combat experience/ captivity", "I have recurrent thoughts about my husband's captivity") (α was 0.91 for the total score).

2.3. Statistical analysis

The magnitude of associations between PTG, depression, anxiety, and posttraumatic stress symptoms (i.e., related to secondary traumatization) at T1 and T2 were examined via a series of Pearson correlations. Next, we examined the bidirectional association between depression and PTG over the two time-points.

To this end, we employed an autoregressive cross-lagged modeling strategy (ARCL; Anderson, 1960). This form of analysis provides an indicator of temporal precedence in the absence of an experimental design (Anderson, 1960). It allows for simultaneous assessment of whether earlier measures of PTG predict later measures of depression, and whether earlier measures of depression predict later measures of PTG. Because PTG consists of five clusters, we used latent variables in a structural equation model (SEM) environment to represent the PTG underlying construct. We estimated the model's fit by using the comparative fit index (CFI), the incremental fit index (IFI) and the root mean square error of approximation (RMSEA). A model is judged as fitting well when CFI, IFI and 1-RMSEA are larger than .95 (Bollen and Curran, 2006). The second analysis was conducted adding the measure of anxiety to the model.

3. Results

Table 1 presents the means, standard deviations, and inter-correlations between our main study measures. Significant relations were found between PTG, depression, and anxiety both cross-sectionally and between T1 and T2. The more PTG spouses

Table 1
Means, standard deviations, and inter-correlations between main study measures.

Measure	1	2	3	4	5	6
1. PTG, T1	1	0.66**	0.43**	0.44**	0.48**	0.35**
2. PTG, T2		1	0.37**	0.37**	0.43**	0.32**
3. Depression, T1			1	0.55**	0.85**	0.52**
4. Depression, T2				1	0.59**	0.72**
5. Anxiety, T1					1	0.51**
6. Anxiety, T2						1
<i>M</i>	2.25	2.24	0.76	0.70	0.64	1.02
<i>(SD)</i>	(0.85)	(0.88)	(0.73)	(0.54)	(0.69)	(0.74)

Note. PTG=posttraumatic growth, GSI=global severity Index. T1 and T2=assessments in 2004 and 2011.

** $p < 0.01$.

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