



Matter of will: The association between posttraumatic stress symptoms and the will-to-live



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ABSTRACT

The present study examined how posttraumatic-stress-symptoms presented after prolonged traumatic exposure to rocket attacks are related to the perception of the worthiness of life among individuals in the second half of their lives. Additionally, it was questioned whether the subjective evaluation of the time one has left to live affects this relationship. Using an in-region random digit dialing methodology, phone calls made to residents in the south of Israel, we sampled 339 community-dwelling older adults (age range 50–90; $M=65.44$, $SD=9.77$) in Wave 1, 170 of whom were interviewed again in Wave 2 about a year later. Participants completed a phone-questionnaire on posttraumatic-stress-symptoms, subjective nearness-to-death, and will-to-live. The cross-sectional and longitudinal analyses results showed that higher levels of posttraumatic-stress-symptoms were positively related to higher will-to-live in both waves, among individuals who felt further away from death, while higher levels of posttraumatic-stress-symptoms were negatively related or unrelated to lower will-to-live among those who felt close to death in Waves 1 and 2, respectively. The findings emphasize that perceptions regarding one's future perspective may affect the quality of the relationship between posttraumatic-stress-symptoms and will-to-live. Theoretical and practical implications are discussed.

1. Introduction

Individuals who have been under the threat of death may feel an enhanced sense of worthiness in regard to the value of life, in general. Nevertheless, it was found that a higher frequency of exposure to traumatic events and higher levels of posttraumatic-stress-symptoms are often related to lower will-to-live levels (Kira et al., 2014; Ohry et al., 1994). This apparent paradox can be explained by the deleterious consequences associated with exposure to traumatic experience. Yet, it is interesting to examine whether all of the individuals who demonstrate high posttraumatic-stress-symptoms levels are also prone to have a lower will-to-live, or whether for some individuals under certain conditions, the traumatic experience is associated with higher will-to-live levels. Similar ideas were previously mentioned among individuals who developed posttraumatic-stress-symptoms but perceived their death to be farther away. This perception enabled a renewed appreciation of life, resulting in what is known as *posttraumatic growth* (Palgi, 2016). Moreover, trauma in old age may exacerbate the aging process, due to aging-related processes such as poorer physical, social, and financial resources, which often deteriorate in warfare-related situations (Palgi et al., 2015). However, this vicious cycle can be mitigated when individuals hold adaptable perceptions regarding issues related to their own aging and death (Palgi et al., 2014; Shrira et al., 2015), and

may even turn into resilience (Palgi, 2016; Shrira et al., 2016).

The present study examines this question regarding the nature of the association between posttraumatic-stress-symptoms and the will-to-live using a cross-sectional and longitudinal design.

The will-to-live is a psychological inner expression of one's commitment and desire to continue living (Carmel et al., 2013), and includes both instinctual and cognitive levels. The instinctual level is addressed through spontaneous physiological reactions directed at enabling the individual's continuing existence when coping with death threats. The cognitive level refers to the thinking process in which one considers the worthiness of life and living in the face of current and anticipated conditions involving conflict and hardship (Carmel, 2001a, 2001b). Higher will-to-live levels were related to favorable aspects of life such as less physical illness (Chochinov et al., 1999, 2005), and long-term survival (Carmel et al., 2007; Karppinen et al., 2012).

Due to the deleterious results related to posttraumatic-stress-symptoms, one can inquire whether there is a specific factor or factors that may account for higher will-to-live among individuals who suffer from high posttraumatic-stress-symptoms, especially in the second half of life. Previous studies have shown that older age was associated with lower will-to-live (Carmel, 2001a, 2001b; Carmel et al., 2013), probably as a result of age-related physical decline and pain (Chochinov et al., 1999) or negative cognitive perceptions regarding

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life, like losing one's self-dignity (Chochinov et al., 2005). However, it was found that actual nearness-to-death was not significantly related to the will-to-live (Carmel et al., 2013). It was suggested that this finding may be related to the instinctual nature of the will-to-live, which remains high, especially when individuals are close to death (Carmel et al., 2013; Chochinov et al., 1999). However, it is still unknown whether the subjective evaluation of nearness-to-death may account for the association between posttraumatic-stress-symptoms and will-to-live.

Estimating how much time we have left to live helps us determine how to plan the rest of our lives. As this actual information is not available, we all try to somehow evaluate it. In order to do so, we sometimes – unconsciously – use available information about our heredity (the age our parents and grandparents lived to), known information regarding our health, as well as social cues like retirement age (Griffin et al., 2012). Indeed, subjective nearness-to-death is a fairly accurate indicator among older adults of their actual nearness-to-death (Kotter-Grühn et al., 2010). Subjective nearness-to-death was also found to be a good predictor of physical functioning (Griffin et al., 2013) and psychological distress (Shrira et al., 2014). However, subjective nearness-to-death is more than a mere reflection of one's actual distance in years to his/her death (e.g., Kotter-Grühn et al., 2010), as it may also reflect psychological and motivational aspects regarding aging and the time left to live. Previous studies have not yet examined how subjective nearness-to-death (rather than chronological age) is related to motivational aspects related to living or dying, such as the will-to-live. Although these concepts have much in common, subjective nearness-to-death does not usually represent one's motivation to live, but rather serves as a cognitive, subjective evaluation individuals perform regarding how long they expect to continue living. The will-to-live is mainly a subjective evaluation of one's motivation to keep living and only indirectly represents one's actual health condition or nearness-to-death. In that way, individuals may feel they do not want to continue living, although they believe they still have many years to live (e.g., individuals with depressive tendencies who forecast a long future full of suffering). Others may feel a strong willingness to live, and at the same time estimate their remaining time as short (e.g., those who cope with severe illness).

Individuals in the second half of their lives are more occupied with the time they have left to live (Cicirelli, 2006). As their perspective of the remaining time until death becomes shorter, they may change their priorities, in order to provide an enhanced sense of meaning and value to their remaining time (Carstensen et al., 1999). However, as mentioned earlier, the willingness to live also depends on peoples' evaluations of their physical and mental condition, and in cases of impaired physical and mental health, it is not clear whether individuals can maintain this high level of desire to continue living.

It was recently shown that higher posttraumatic-stress-symptoms levels are associated with the perception that one's life is drawing closer to its end (Palgi, 2016). Not surprisingly therefore, older adults exposed to prolonged trauma and stress are expected to be more sensitive towards the relations between their subjective nearness-to-death and will-to-live. This is because their motivational and psychological perceptions of their physical and mental health condition, represented by their subjective nearness-to-death evaluation, may affect their will-to-live. Therefore, it can be assumed that individuals with high posttraumatic-stress-symptoms levels, who hold the perception that they are closer to their death, are assumed to have a low will-to-live. However, it was found that individuals with high posttraumatic-stress-symptoms levels who still believe death is a remote reality may attenuate the deleterious results of the traumatic experience (Palgi, 2016). Thus, in the current study, we propose that these individuals will have a stronger will-to-live.

The study's first hypothesis is that a higher posttraumatic-stress-symptoms level will be negatively associated with will-to-live in a cross-sectional and longitudinal way. The second hypothesis proposes that

feeling closer to one's own death will also be related to a lower will-to-live in both waves. Finally, the third hypothesis posits that subjective nearness-to-death will moderate the association between posttraumatic-stress-symptoms and will-to-live in a cross-sectional and longitudinal manner. Specifically, it is hypothesized that individuals with higher posttraumatic-stress-symptoms levels, who feel close to death, will report a low will-to-live, while higher posttraumatic-stress-symptoms levels, coupled with feeling further away from death, will be associated with higher will-to-live levels. Among those with low posttraumatic-stress-symptoms levels, subjective nearness-to-death will also be related to will-to-live level, but to a lesser degree.

2. Method

2.1. Participants, sampling design and procedure

A polling company sampled Jewish participants residing in the south of Israel, in an area identified by the Israeli home front command as the area with the least time available for seeking shelter (Ben-Ezra et al., 2015). Participants were selected using an in-region random digit dialing methodology. The sample includes individuals aged 50 or above from the national telephone directory, which provides regional and community-specific phone number information. The first wave was conducted between January 12 and February 24, 2014, after 14 "quiet" months with only 63 rockets fired on the area, among them 24 during the time of the interviews. The sample was stratified by age group (50–64, 65–90), gender, and place of residence. For further information, see Palgi (2016).

Out of 930 households that included eligible interviewees (over the age of 50), 254 potential interviewees refused to participate in the survey; 232 additional potential interviewees could not be interviewed because of hearing problems or cognitive incapacity; and 105 participants filled out only the initial part of the demographic details and refused to complete the rest of the interview. This group was characterized by older age ($M=72.09$, $SD=11.24$ vs. $M=65.44$, $SD=9.77$, $t[442]=5.88$, $p<.001$), lower education ($M=11.59$, $SD=4.77$ vs. $M=13.57$, $SD=3.24$, $t[442]=-4.85$, $p<.001$) and lower percentage of participants who were married (59.3% vs. 69.9% χ^2 ($n=444$, 1) = 4.09, $p<.05$) compared to the final sample. No significant differences were found between the percentage of woman in both samples χ^2 ($n=444$, 1) = 2.10, $p=.15$) (see, also Palgi, 2015). The final sample of the first wave (W1) consisted of 339 participants who completed the entire survey, between the ages of 50 and 90, with an average age of 65.44 ($SD=9.77$). About half of the participants were female (56%), most participants were married (69.9%), and the average number of years of formal schooling was 13.57 ($SD=3.24$). Demographic characteristics of the sample are presented in Table 1.

The second wave (W2) was conducted between December 2014, four months after a military conflict between Israel and Gaza known as Operation Protective Edge, and July 2015. During the military conflict, which lasted for a total of seven weeks, more than 4500 rockets were fired on civilian regions in the south of Israel, such that civilians were constantly under the threat of these attacks. Of the 241 participants who agreed to participate in a follow-up survey, 170 participants (71%) completed the second wave interview. Another 46 participants did not respond after five consecutive calls or could not be reached because of wrong or disconnected numbers. An additional 22 participants refused to participate, mostly due to their physical condition, and three participants were reported as deceased. Comparing those who participated in W1 to those who participated in both W1 and W2 showed no significant differences regarding all of the study variables, suggesting that there is no significant bias related to participation in the second wave. For further information regarding attrition, see Table 2.

The telephone interviews were carried out by experienced interviewers in either Hebrew or Russian, lasting an average of about 15–25 min in the first wave and about 20–30 min in the second. Informed

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