Trauma related guilt cognitions partially mediate the relationship between PTSD symptom severity and functioning among returning combat veterans

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ABSTRACT

Trauma related guilt, a distressing emotion associated with negative cognitions regarding one’s actions or inaction during a traumatic event, is common among individuals with posttraumatic stress disorder (PTSD). We hypothesized that trauma related guilt cognitions would partially explain the relationship between PTSD symptom severity and functioning. The sample consisted of 254 combat veterans or active duty military personnel who served in Operation Enduring Freedom, Operation Iraqi Freedom or Operation New Dawn (OEF/OIF/OND) who consented to participate in a larger PTSD treatment study. Results revealed a significant relationship between PTSD severity and guilt cognitions (standardized $\beta = 0.40$), as well as PTSD and overall functioning ($\beta = 0.49$). Guilt cognitions ($\beta$s = 0.13 to 0.32) were significantly associated with nearly all domains of functioning, including overall functioning ($\beta = 0.27$), and partially explained the relationship between PTSD and functioning. This study lends support to the addition of guilt as a symptom of PTSD in the DSM-5 as it contributes significantly to functional impairment even when accounting for other symptoms of PTSD, although co-occurring mental health problems may also contribute to functional impairments associated with PTSD. Future studies are needed to investigate whether reductions in traumatic guilt are related to improved functional outcomes in PTSD treatments.

1. Introduction

Difficulties with functioning are highly prevalent among individuals with posttraumatic stress disorder (PTSD, see Schnurr et al., 2009 for review) and can have profound impact on a person’s life. Functional impairments tend to increase with PTSD severity; however, even sub-threshold PTSD is associated with functional deficits (e.g., Norman et al., 2007; Shelby et al., 2008; Stein et al., 1997). In a sample of marines who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND), the strongest predictor of functional impairment within the first year of separation from the military was PTSD symptom severity at the time of separation and at the time impairment was measured (Larson and Norman, 2014). Functional difficulties associated with PTSD cut across many domains including interpersonal difficulties, difficulties in achieving professional or academic goals, and ability to take care of one’s daily and medical needs (Amaya-Jackson et al., 1999; Bovin et al., 2018; Erbes et al., 2007; Marx et al., 2009; Zatzick et al., 1997).

PTSD is associated with interpersonal problems within romantic relationships (Taft et al., 2011), family relationships (Sayers et al., 2009), parenting (Wilson et al., 2017), and social networks and friendships (Fang et al., 2015; McCaslin et al., 2016; Ozer et al., 2003).

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Military and veteran populations with PTSD may be at heightened risk. A meta-analysis revealed a stronger association between PTSD symptoms and relationship discord for military samples than civilian samples (Taft et al., 2011). In one study, severity of PTSD symptoms in male veterans was positively associated with greater likelihood that their female partners would report dissatisfaction with intimacy, shared activities, and responsibilities within the relationship (LaMotte et al., 2015), suggesting that problems impact both the veterans with PTSD and their romantic partners. PTSD also has a negative effect on several aspects of parenting and family functioning, including quality of parent-child relationship (Ruscio et al., 2002), parenting satisfaction (Samper et al., 2004), parenting behaviors (Gewirtz et al., 2010), and family conflicts (Sayers et al., 2009).

PTSD is related to impairments in occupational and academic functioning in both veteran and civilian populations (e.g., Erbes et al., 2011; Momartin et al., 2004; Shelby et al., 2008). Studies with veteran samples have found PTSD to be associated with higher rates of unemployment, underemployment, and lower hourly wages (Savoca and Rosenheck, 2000; Smith et al., 2005). Among OEF/OIF/OND veterans, PTSD was associated with poorer time management, reduced output, difficulties with psychological and interpersonal aspects of a job, greater absenteeism (Hoge et al., 2007), poorer workplace functioning over time (Erbes et al., 2011), and worse academic functioning including lower grade point average (Barry et al., 2012; see Bryan et al., 2014, for an exception).

PTSD may also contribute to difficulties with self-care, which can range from having trouble with daily activities such as keeping up with household chores and personal hygiene to taking care of one’s physical and psychological health (Bovin et al., 2018; Marx et al., 2009). In one study of recently separated OEF/OIF/OND veterans (Sayer et al., 2010), over 35% of 754 veterans reported “some” to “extreme” problems completing tasks needed for work, home, or school, and 45% reported problems taking care of their health. The odds of reporting “some” to “extreme” difficulties in these domains were five to eight times higher among veterans with probable PTSD than those without. Engaging in medical care is another aspect of self-care. Among veterans with PTSD, even among those who present to veterans Affairs (VA) for PTSD treatment, rates of engagement in and completion of PTSD treatments are low (Garcia et al., 2011). While there may be many reasons veterans do not engage in or complete PTSD treatment, not engaging in available recovery oriented care may be a component of difficulties in the functional domain of self-care.

Understanding the relationship between PTSD and functioning difficulties is important for understanding the impact of PTSD and ensuring that treatments not only reduce symptoms but also help people function to their highest potential. In some cases, the connection between certain symptoms of PTSD and functioning difficulties may be straightforward. For example, emotional numbing or feelings of detachment and estrangement contribute to impaired interpersonal functioning (Beck et al., 2009; Kuhn et al., 2003; LaMotte et al., 2015; Nunnink et al., 2010; Riggs et al., 1998; Ruscio et al., 2002). Symptoms such as hypervigilance and problems with concentration may detract from the ability to study for school or succeed in certain jobs (American College on Education, 2014).

PTSD and functioning difficulties may also be connected through more nuanced mechanisms. One possible mechanism is trauma related guilt, a distressing emotion associated with maladaptive cognitions regarding one’s behavior and oneself during the trauma in comparison to valued standards (Kubany and Watson, 2003). Kubany and Watson (2003), identified four types of maladaptive cognitions common in individuals who experience posttraumatic guilt: hindsight-bias (i.e., believing that the outcome was known at the time of the trauma), lack of justification (i.e., believing there was no justification for the course of action one chose to take), responsibility (i.e., believing one was solely or mostly responsible for the traumatic event), and wrongdoing (i.e., believing one purposely did something that was wrong or violated important values). Guilt following trauma is common; 83% of trauma-exposed individuals with probable PTSD report experiencing trauma related guilt in their lifetime, and 34% report experiencing trauma related guilt in the past month (Miller et al., 2013). In fact, guilt is so commonly reported by individuals with PTSD that it is now recognized as a symptom in DSM-5 (American Psychiatric Association, 2013; i.e., criterion D3: distorted cognitions about the cause or consequences of the traumatic event that lead the individual to blame himself/herself or others).

Although some research has found that guilt can be prosocial and associated with adaptive outcomes such as making reparations for one’s actions (see Tangney et al., 2007), guilt specifically related to trauma (e.g., guilt about failing to prevent a trauma, guilt about witnessing a traumatic act that violates one’s values) is associated with a host of negative outcomes and psychopathology. These negative outcomes include more severe PTSD symptoms (Beck et al., 2011; Browne et al., 2015; Held et al., 2011; Kubany and Watson, 2003; Marx et al., 2010), poorer response to PTSD treatment (Owens et al., 2008), more severe depressive symptoms (Browne et al., 2015; Kim et al., 2011; Marx et al., 2010), substance use problems (Wilkins et al., 2013), and suicidal ideation (Bryan et al., 2013; Hendin and Haas, 1991; Tripp and McDevitt-Murphy, 2017). Although trauma-related guilt is linked to worse mental health, there is a dearth of literature examining how trauma related guilt relates to functional impairments among individuals with PTSD.

There are several reasons to suspect that trauma related guilt cognitions may be associated with poorer functioning in PTSD. Trauma related guilt cognitions are associated with emotional distress, even when controlling for PTSD symptoms (Browne et al., 2015), and distress can interfere with how individuals engage with others, work, self-care, and other important activities. Also, guilt can cause individuals to believe they do not deserve to feel happy or that they deserve to suffer (e.g., Norman et al., 2014) which may keep them from pursuing career or educational goals or taking part in self-care activities like treatment. Finally, frequent guilt cognitions may keep individuals focused on the past which could interfere with maximally engaging in and functioning the in the present.

The aim of this study was to evaluate whether the relationship between PTSD symptoms and functioning is mediated by trauma related guilt cognitions in a sample of OEF/OIF/OND veterans. We hypothesized that guilt related cognitions would partially explain the relationship between PTSD symptom severity and functioning. We examined specific domains of functioning, including interpersonal (romantic, family, friendship, and parenting domains), professional (educational and work domains), and self-care, as well as overall functioning. We also examined whether specific guilt cognitions (hindsight bias/responsibility, lack of justification, and wrongdoing) partially mediated the relationship between PTSD symptom severity and overall functioning.

2. Method

2.1. Participants

The study included 254 veterans or active duty military personnel (mean age 35.7 years, 89.4% male) who served in combat during OEF/OIF/OND and consented to participate in a multisite PTSD treatment randomized controlled trial funded by the Department of Defense Between 2011 and 2016 (PROlonGed ExpoSure Sertraline [PROGrESS]: Randomized Controlled Trial of Sertraline, Prolonged Exposure Therapy and Their Combination of OEF/OIF with PTSD). Data for the current study were obtained during evaluation for inclusion into either the primary treatment study or a linked study of combat controls for an fMRI portion of the study (see Rauch et al., 2018, for more information regarding the larger research study). Participant characteristics are presented in Table 1.
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