



Forgiveness and PTSD among veterans: The mediating role of anger and negative affect



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ABSTRACT

Man-made traumatic events such as combat and terrorism may cause individuals to develop various forms of psychopathology, including Post-Traumatic Stress Disorder (PTSD) and depression. Veterans who engage in combat experienced negative emotions such as anger, hostility and aggression. Forgiveness may buffer these feelings and prevent the development of psychiatric problems, in that it is a way of decreasing negative feelings and increasing positive feelings. The aim of the current study was to examine the mediating role of anger and negative affect on the relationship between forgiveness and both PTSD and depression co-morbid to PTSD among Turkish veterans who were exposed to combat experience because of terrorist attacks during their compulsory military service. Two hundred and forty-seven injured veterans participated in this study. Veterans were assessed using the Traumatic Stress Symptom Checklist (TSSC), Heartland Forgiveness Scale (HFS), State Trait Anger Expression Inventory (STAXI), and Positive and Negative Affect Schedule (PANAS). A path analysis supported the hypothesized model that both anger and negative affect fully mediated the relationship between forgiveness and both PTSD and depression co-morbid to PTSD.

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1. Introduction

Exposure to traumatic events may result in a wide range of mental and physical health consequences. Post-Traumatic Stress Disorder (PTSD) is one of the most common and consistent reaction to all kinds of life-threatening events, particularly after man-made events. Terrorism and combat experience are strong examples of man-made disasters. There are empirical findings indicating that veterans with combat experience suffer from traumatic stress symptoms and PTSD. Forty-four percent of soldiers who completed a tour of duty in Iraq and Afghanistan reported significant levels of depressive and/or PTSD symptoms (Lapierre et al., 2007). PTSD prevalence rates vary from 8 to 16% for soldiers deployed during the First Gulf War (Wolfe et al., 1999). Although time has a decreasing effect on trauma (Ford et al., 2007), 11–12 years after the Vietnam War, 9.1% of veterans were found to be suffering from PTSD (Dohrenwend et al., 2006).

Man-made disasters involve the role of serious injuries. The rapidly growing literature demonstrates that physical injury due to the combat experience increases the risk of developing

PTSD (Koren et al., 2005; Grieger et al., 2006; Gilbar et al., 2010). Bonanno et al., (2006) revealed that physical injury due to terrorist attacks were the second biggest risk factor for the probable PTSD (26.1%). Additionally, 16.7% of injured veterans, but only 2.5% of non-injured veterans met the criteria for PTSD (Koren et al., 2005). Seven months after being hospitalized because of combat injury, 12% of soldiers had PTSD and 9.3% had depression (Grieger et al., 2006). Hence, it is obvious that exposure to war and combat lead to PTSD, however little is known about the factors that may mitigate the symptoms of PTSD among soldiers and veterans for whom exposure to trauma is a routing part of their professional roles.

Personality characteristics may help individuals to lessen the adverse effects of trauma or may lead them to cope with trauma dysfunctionally. According to the South African Truth Commission, forgiveness is a critical component of postwar recovery process (Chapman, 2007). Hence, forgiveness as a dispositional approach to the multiple difficulties that may arise in the course of life (McCullough, 2000) was estimated as a buffering mechanism for the development and prolonging of PTSD and depression. Although studies have recently postulated the impact of forgiving self or others (Hirsch et al., 2011; Webb et al., 2010; Wivliet et al., 2004), the concept of dispositional forgiveness (one's general tendency to be forgiving) may be particularly applicable for veterans or terror victims. Because, knowing the event was

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intentional and that the aim is to cause disruption to individuals and society as a whole through an erosion of a sense of safety and security can make it hard to forgive the transgressors and the situation beyond their control.

Wivliet et al. (2004) reported that among army veterans, difficulty in forgiving self and others was associated with depression and PTSD symptom severity. However, despite there is a relationship between forgiveness and lower levels of stress, no association was found between forgiveness and trauma among victims of September 11 (Friedberg et al., 2005) and individuals who were faced with the brutal nature of civil war and the harsh conditions of Sierra Leone (Doran et al., 2012). Consequently, forgiveness has a complex exploratory effect on PTSD and depression. The complexity can be accounted for by the different factors.

Among combat veterans, symptoms of PTSD were related to anger, hostility and aggression and a range of negative psychological outcomes (Jakupcak et al., 2007). Anger plays a 'mastery role' in the face of trauma by suppressing helplessness (Chemtob et al., 1997). It is a core component of combat-related PTSD (Novaco and Chemtob, 2002). However, it has been difficult to determine whether anger is a risk factor for the development of PTSD or is a consequence of PTSD or both. Vietnam veterans with PTSD exhibited higher frequencies of violent outbursts, aggressive behaviors, and poor anger control than veterans without PTSD (Beckham et al., 2000). Moreover, anger at 1-month post-crime was related to PTSD symptoms at 1-month post-crime whereas 1-month anger measures were not predictive of PTSD symptoms measured 6 months following the traumatic events (Andrews et al., 2000). Vietnam veterans continued to account 40% of the variance in PTSD symptoms after removing the anger items in the Mississippi scale for PTSD (Novaco and Chemtob, 2002). Although the idea of pre-exposure trait anger raises the risk of developing PTSD is supported, few studies have been investigated the role of trait anger on PTSD. A study revealed that trait anger is a risk factor for the PTSD symptoms among police recruits and those PTSD symptoms are also correlated with an increase state of anger (Meffert et al., 2008). Owens et al. (2008) assessed the changes in maladaptive cognitions, anger expression, PTSD and depression among veterans after receiving cognitive therapy. Their findings also revealed that moderate and high levels of pretreatment anger may make it more difficult for the individual to make cognitive shifts required to reduce their PTSD symptoms. Negative affect has also been reported by veterans during and after combat (Crowson et al., 2001). Being exposed to a higher level of terrorist attack was associated with higher levels of avoidance behavior, subjective feelings of insecurity and emotional distress (Korn and Zukerman, 2011).

Thus, it is clear that there are several evidences for a direct effect of anger and negative affect on PTSD and depression such that these affective states heighten the symptoms PTSD and depression. As a human strength or personality trait with positive consequences for individuals, forgiveness may be a key factor in buffering negative affect and anger following PTSD. Supporting this idea, several studies reported that trait forgiveness is likely to be negatively related to trait anger and stable dispositions like hostility and resentment (Kaplan, 1992; Seybold et al., 2001). In another study, it was found that negative affect and anger rumination mediated the relationship between forgiveness and sleep quality (Stoia-Caraballo et al., 2008). Besides, state anger largely mediated the association between forgiveness and psychological distress (Carson et al., 2005). The mediator role of forgiveness reduced the relationship between PTSD and hostility (Snyder and Heinze, 2005). Another study revealed that forgiveness improves psychological and physical health through decreasing anger and hostility (Konstam et al., 2001). As a result, forgiveness may mitigate the symptoms of PTSD and depression co-morbid to PTSD by diminishing anger and negative affect.

There is extensive research focusing on the association between forgiveness, anger, negative affect, and PTSD (Kaplan, 1992; Konstam

et al., 2001; Seybold et al., 2001; Snyder and Heinze, 2005). Understanding trauma better requires exploration of the relationships among related variables. It is obvious that complex associations among forgiveness and PTSD and depression with mediators need to be clarified. It is hypothesized that anger and negative affect are strong variables which can mediate the association between forgiveness and PTSD. The aim of the current study is to test a model examining the mediating role of anger and negative affect on the relationship between forgiveness and PTSD and depression co-morbid to PTSD among Turkish veterans who have been victims of terrorism. The purpose of the mediational model is to explore the direct or indirect association between forgiveness and PTSD. The mediating model would suggest that forgiveness is associated with PTSD and depression co-morbid to PTSD through anger and negative affect. Therefore, anger and negative affect would weaken the association between forgiveness and PTSD. People who have a high level of forgiveness are likely to have lower negative affects and anger resulting in less severe or no PTSD and depression co-morbid to PTSD. We hypothesized that (a) forgiveness would be negatively associated with anger and negative affect; (b) anger would be positively associated with PTSD and depression co-morbid to PTSD; (c) negative affect would be positively associated with PTSD and depression co-morbid to PTSD; (d) anger would mediate the relationship between forgiveness and PTSD and depression co-morbid to PTSD; and (e) negative affect would mediate the relationship between forgiveness and PTSD and depression co-morbid to PTSD.

2. Methods

2.1. Participants and procedure

A total of 247 veterans who had been injured in terrorist attacks while undertaking compulsory military service within the Turkish Armed Forces (TAF) between 1984 and 2010 participated in the present study. The data was collected with the permission of the 'Mehmetçik Vakfı', which was established in 1982 to provide support to veterans and relatives of soldiers killed in military operations. The foundation was provided with a set of questionnaires with envelopes and stamps and these were posted to veterans in May 2011. After 2 months an insufficient number of questionnaires had been returned and so veterans were phoned and asked to take part in the study. The foundation sent the collected envelopes to the researchers at the end of October 2011. There was a 49.4% return rate which represents the 8.46% of the total population.

Veterans were separated into six categories based on their injuries, corresponding to Article 52 of the 5434 Law on the Pension Fund of the Turkish Republic (<http://www.mevzuat.adalet.gov.tr/html/5023.html>). The categorization of veterans is based on the severity of organ loss and the degree of non-functionality in life skills. For instance, first degree corresponds to losing upper or lower limbs of human body whereas sixth degree corresponds to the absence of the thumb with metacarpus. In other words, the lower degree of the categorization represents more serious organ loss. There were a total of 2856 veterans; 152 of whom had suffered first degree injuries, 118 second degree, 311 third degree, 743 fourth degree, 597 fifth degree and 935 six degree. A total of 500 questionnaires were sent to veterans by post; according to the most severe physical injury, all veterans from first and second degrees (270), 90 randomly selected veterans from third degree and 90 randomly selected veterans from fourth degree and 40 randomly selected veterans from fifth and sixth degrees. 24.7% (61) of the participant veterans fell into the first degree, 21.9% (54) were second degree, another 21.9% (54) were third degree, 25.1% (62) were fourth degree, 2% (5) were fifth degree and 4.5% (11) were sixth degree.

The age range of veterans was between 24 and 49 (36.55 ± 5.29) and the years following the physical injury ranged from two to 28 (15.35 ± 5.3). Of the group, 87.4% (216) were married, while 10.9% (27) were single and 1.6% (4) reported themselves as divorced or widowed. The majority, 83% (205), of them had children. 27% of the participants had received a psychological support after the traumatic experience, and 34% of them reported that they need psychological help now.

2.2. Instruments

2.2.1. Traumatic Stress Symptom Checklist (TSSC)

The TSSC consists of 23 items. The first 17 items assess the PTSD symptoms that are listed in DSM-IV, and the last six items assess depression symptoms in relation to 'last week'. It is a 4-point Likert-type scale, ranging from 0 (not at all) to 3 (very much). A score of 25 or more in the first 17 items means that the person is likely to

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