Coll. Antropol. **35** (2011) 3: 673–680
Original scientific paper

Influence of Psychical Trauma through Transgenerational Transfer on the Development of Traumatic Reactions in Women with Diagnosed Breast Cancer

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A B S T R A C T

Earlier experience of psychological trauma of a close person can through a transgenerational transfer influence traumatic reactions of a person going through a trauma at present, resulting in a repetition of earlier traumatic experiences and a development of a variety of mental disturbances. Purpose of our study was to evaluate the influence of transgenerational transfer on the development of Posttraumatic stress disorder (PTSD) in women with diagnosed breast cancer that had a family member with diagnosed cancer. The sample mainly consisted of 120 women treated in a Department of Oncology, Osijek University Hospital Center with diagnosis of newly discovered breast cancer, during the conduction of radio therapy having values Hamilton depression scale (HAM-D) from ≥8 to ≤24 or values Hamilton anxiety scale (HAM-A) from ≥17 to ≤30. Psychotherapeutic interview with a detailed clinical overview and with applying diagnostic criteria according to DSM-IV for mental disorders, specially structured non-standardized questionnaire for etiologic factors evaluation of the beginning of examinees' mental disorder, Los Angeles Symptom Checklist of PTSD symptoms (LASC), Hamilton's scale for anxiety evaluation (HAM-A) and Hamilton's scale for depression evaluation (HAM-D) were used. Results show that 61 (51%) of patients have a family member with diagnosed cancer. The average total value on LASC for examinees that had a family member with diagnosed cancer was slightly higher (22.92) in comparison to those who had no such family member (20.88). No statistically significant connection was found between having a family member with diagnosed cancer and the average total value on LASC. Although no connection was established between having a family member with diagnosed cancer and the average value on LASC in women with diagnosed breast cancer, transgenerational transfer of emotions seems to be important in their traumatic reactions, but it is still insufficiently researched and it is a challenge for future researches leaving many complicated issues open.

Key words: *breast cancer, transgenerational transfer, psychical trauma, liaison psychiatry*

Introduction

Earlier experience of psychological trauma of a close person can through a transgenerational transfer influence traumatic reactions of a person going through a trauma at present, resulting in a repetition of earlier traumatic experiences and a development of a variety of mental disturbances[1,2].

Most researchers agree that the most important period of adjustment to cancer is a year after getting the di-

Received for publication February 4, 2010

agnosis. It's a crisis in a patient's life, but most of them overcome that crisis in a satisfactory way, especially those with a good prognosis[3]. Yet, some people adjust better than others[4]. Many researches emphasize that people with better social support adjust better to the disease[5,6]. Physicians' and other medical staffs' support has a special place, as well as different interrelations during the whole time of treatment, in that they provide sense of security and future insurance[7]. However, as it is often stressed out, psychosocial support cannot be provided for all patients, so it is vital to identify the patients at risk for poor adjustment, so that the support could be directed to them[8].

Thoughts, feelings and behaviour connected to the process of valuation can represent the type of adjustment a person is going to develop.

Psychological answer depends on socio-cultural surrounding in which the treatment is provided (available treatment methods, decision making during the treatment), psychological and psychosocial factors from the environment and medical and physical factor such as stage of the disease, treatment answer and clinical course of the disease.

Though women today have more treatment options, psychological problems remain the same as before. Breast cancer is an immense stress for any woman, but there is a huge variety in psychological response among them. Particularly important are age in which the diagnosis is made, earlier emotional stability, coping skills and human relation support.

Our first contact with the reality and the world is affective, emotional, and only afterwards do we act rationally. Our affective memory, which holds all emotions we have experienced in the past, gives colour to the reality we encounter, so that our image of the world is foremost subjective, and that means partly distorted, because of the affective appraisal of the reality we have made before the rational judgment. Affective assessment of the reality predisposes a person to make and maintain affective state which specifies, and in emotionally immature people often dictates, human behaviour[9,10]. It is a living memory of emotional history of every person. Because it is always at our disposal, it has a great value on judgment and evaluation of everything around us, like a matrix of every experience and activity[11].

A breast is a first object of a child through with it acquires its first experiences[12]. Breast gives food, provides satisfaction and relaxation, but also causes discontent and frustration when it unloads. Breast is a symbol of food, fertility and motherhood.

Growing up, a girl wants to be more like her mother – a woman, so the breast becomes a symbol of femininity, and has a great role in a sexual life of a woman. All that time, in the interaction with her environment, a young girl creates her body image[13]. Her stability and confidence later in life, and her ability to adjust to illness, particularly in the light of necessary mutilation, depends on this self confident body image (which is not the same as the image other people have of us).

Mental suffering is caused by and indicates discordance between mental representations of actual self in a given moment and an »ideal« self.

Lack of self respect, sense of inferiority, shame, guilt and other complex emotions are greatly coming out of a basic sense of pain.

Certain meanings and affective values which are an integral part of the object representation, and also of self representation, have their origin from which also thrives a specific pathology and direction of conduct in human interrelations. It should be said that the usage of emotionally hued words contribute to the affective reality judgment. Such words (i.e. »cancer«) have strong influence on the message receiver so that she/he immediately takes a certain attitude to its conceptual.

The patients transfer their fears to the entire family and their daughters or sisters, who are at greater risk of having cancer themselves, may develop their own fears of getting the illness either by resisting care or caring too much for the ill woman[14,15].

Social support is an important factor on how stressful events influence health, because social factors and human interrelations can protect the individual from dangerous consequences of stress[16]. Stress can mobilize a social network and draw from it support, but it can also have a negative influence i.e. reduce help through deterioration and destruction of relationship. Sources of social support are many and different, yet the major part of emotional support, warmth, belonging, material and instrumental support most people receive from their family[17].

Purpose of research

The object of this research is to evaluate the influence of transgenerational transfer of psychical trauma on the development of Posttraumatic stress disorder (PTSD) in women with newly diagnosed breast cancer who have had a member of her family diagnosed with cancer.

Method

Participants

The sample consisted of 120 women treated at the Department of Oncology, Osijek University Hospital Center, and involved in a liaison psychiatric treatment.

Inclusion Criteria: female sex, age between 18–65, newly diagnosed breast cancer, radiotherapy as part of the cancer treatment, Hamilton depression scale (HAM-D) from ≥8 to ≤24 or values Hamilton anxiety scale (HAM-A) from ≥17 do ≤30, absence of severe physical ailments, no medical history of past or present psychotic disturbances, elementary school as the lowest educational level, adequate conversation ability, signed patients' informed consent.

Exclusion Criteria: unacceptance of participation in research as defined in patients' informed consent, presence of other severe physical diseases, pregnancy, breastfeeding, positive history of past or present psychotic disorder, mental retardation, major personality disorder, permanent personality disorders, psychoactive substance or alcohol abuse during the last 3 months prior to the beginning of research, earlier participation in any form of psychotherapeutic treatment.

Procedure

Subjects were divided into four groups. Every group consisted of 30 subjects.

Subjects' segregation was randomized by researcher--psychiatrist using the random numbers table.

First group was treated by psychopharmacotherapy.

Second group was treated by psychotherapy. This group of patients was further divided in two subgroups:

- A group of subjects treated by individual, dynamic oriented psychoanalytic therapy.
- A group of subjects treated by cognitive-behavioral psychotherapy.

Third group was treated by a combination of psychopharmacotherapy and psychotherapy. This group was further divided in two subgroups:

- A group of subjects treated by a combination of psychopharmacotherapy and dynamic oriented psychoanalytic therapy.
- A group of subjects treated by a combination of psychopharmacotherapy and cognitive-behavioral psychotherapy.

Fourth group was consisted of a control group which was not under any psychiatric treatment.

All psychiatric therapeutic procedures applied were time limited in duration for a year. Psychotherapeutic procedures were conducted once a week for the first two months of research, and afterwards according to clinical presentation and subjects' motivation up to a year in duration.

Apparatus

Prior to the beginning of the research, all subjects have signed an informed consent for the participation in research.

The research included:

1. Detailed clinical examination with psychiatric interview and implementation of diagnostic criteria according to DSM-IV for mental disorders.
2. Application of specifically structured no-standardized questionnaire for detailed assessment of possible etiological factors of subjects' psychic disorder.
3. Assessment of subjects' anxiety and depression using Hamilton Anxiety Scale and Hamilton Depression Scale[19,20].
4. Psychological testing using the Los Angeles Symptom Checklist (LASC), conducted by a psychologist for the assessment of PTSD symptoms at the beginning of the research and development of PTSD symptoms during the course of the illness at the end of research.

The testing was performed the first day of research and two months after the beginning of research.

Results

Demographic data

Average age of participants was 56.52 years (least 24, most 65) with standard deviation of 8.628.

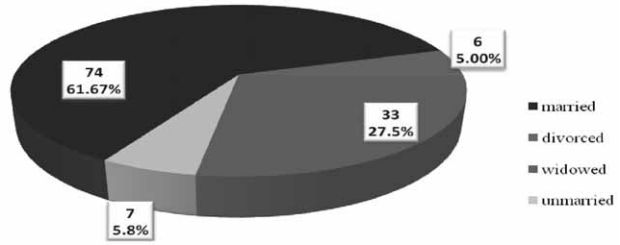

Fig. 1. Distribution of subjects according to their marital status.

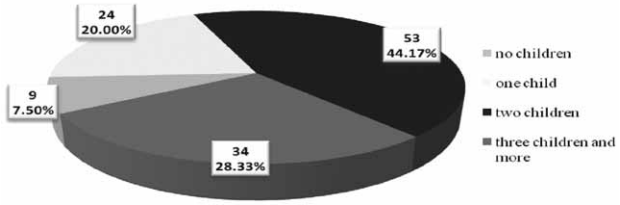

Fig. 2. Distribution of subjects according to the number of children.

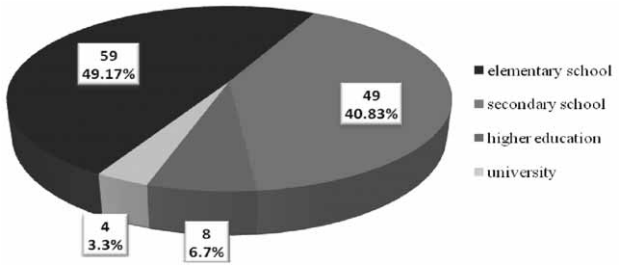

Fig. 3. Distribution of subjects according to education.

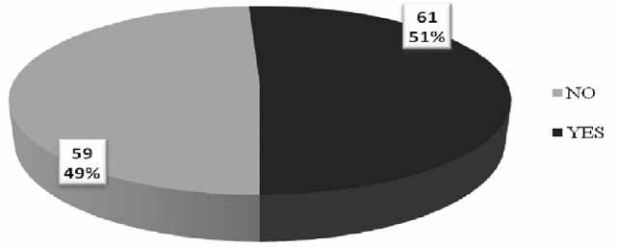

Fig. 4. Distribution of subjects according to positive familiy history of carcinoma.

According to the place of residence, 71 (59.17%) subjects were living in a rural area, and 49 (40.83%) were living in town.

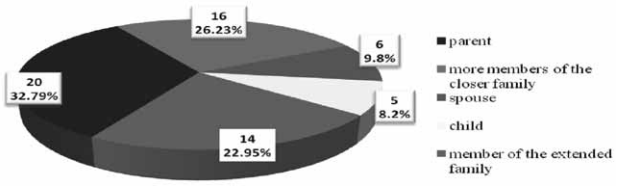

Fig. 5. Distribution of subjects according to familiy members diagnosed with carcinoma (N=61).

Level of psychotraumatization analysis

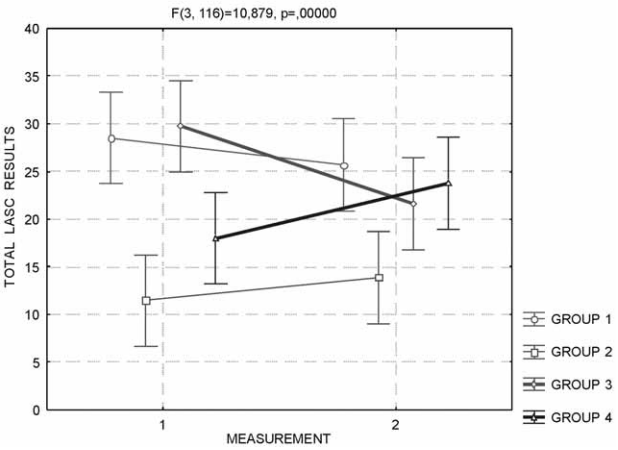

Fig. 6. Total Los Angeles Symptom Checklist of PTSD symptoms (LASC) results overview.

TABLE 1
STATISTICAL RESULTS FOR TOTAL LOS ANGELES SYMPTOM CHECKLIST (LASC) RESULTS

Statistical significance between groups	Group					
(p<)	1–2	1–3	1–4	2–3	2–4	3–4
First and second measurement	0.0417	*	0.0024	0.0052	*	0.0006

* p>0.05

TABLE 2
TOTAL LOS ANGELES SYMPTOM CHECKLIST (LASC) SCORE ACCORDING TO A FAMILY MEMBER DIAGNOSED WITH CANCER

Family member diagnosed with cancer	No	Yes
Number of subjects	59	61
Average total LASC score for the first measurement	20.88	22.92
Maximum total LASC score for the first measurement	56	58
Average total LASC score for the second measurement	22.4	20.17
Maximum total LASC score for the second measurement	55	50

Results analysis according to total Los Angeles Symptom Checklist (LASC) score and a family member diagnosed with cancer

T-test for independent samples showed no statistical significance in relationship between average total LASC score and a family member diagnosed with cancer, either for the first ($p<0.4630$) or the second ($p<0.3852$) measurement.

Also, there was no statistical significance in the first measurement (Median test $p<0.1252$, Kruskal Wallis test $p<0.5176$), or the second measurement (Median test $p<0.1333$, Kruskal Wallis test $p<0.5973$) in relationship between a family member diagnosed with cancer and average total LASC score.

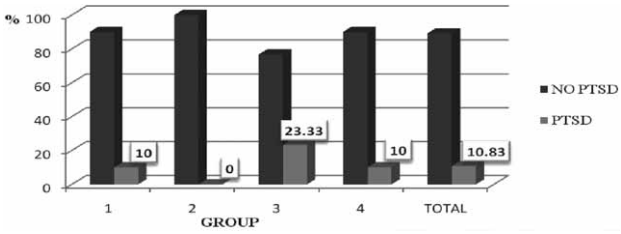

Fig. 7. Posttraumatic stress disorder (PTSD) according to total Los Angeles Symptom Checklist (LASC) results during the whole research.

Discussion

Success of the therapeutic interventions is often evaluated by patients' quality of life. Formerly only the quantity of life (time of survival) was measured. Extension of the patients' time of survival gave thought about the quality of extended life expectance, whether it was good enough, and whether it justifies the treatment costs, which was supported by earlier studies[21]. Psychotherapeutic support, family and friends' support considerably influence the quality of life of the women with breast cancer and indicate the need of psychiatric involvement in the treatment of women who show psychic disturbances in adjustment to physical illness.

During this research, the most prominent fact was that 51% of subjects had a family member diagnosed with cancer. In 32.78% cases it was parents, 26.23% of subjects had more members of the closer family diagnosed with cancer, 9.84% of subjects had a spouse diagnosed with cancer, 8.2% a child, and 22.95% of subjects had a member of the extended family diagnosed with cancer (the term »extended family« encompassed only the »first knee«, e.g. aunt or grandmother of the subject).

Although important, this study will not cover genetic risk for cancer development, but will rather focus on the fact that a positive history of cancer in the family has greatly influenced adjustment and development of fears after facing an illness with which the subjects have had prior negative experiences. Feelings and thoughts connected to earlier traumatic experiences, such as getting

TABLE 3
TOTAL LOS ANGELES SYMPTOM CHECKLIST (LASC) SCORE ACCORDING TO A FAMILY MEMBER DIAGNOSED WITH CANCER

Family member diagnosed with cancer	Number of subjects	Average total LASC score for the first measure-ment	Maximum total LASC score for the first measure-ment	Average total LASC scor for the second measure-ment	Maximum total LASC score for the second measure-ment
Parent	20	25.53	50	22.68	50
More members of the closer family	16	22.09	58	18	48
Member of the extended family	14	20.9	36	20.36	44
Child	5	27.6	39	27	43
Spouse	6	15.2	27	14.6	19
Nobody	59	20.56	56	22.24	55

ill, suffering and dying of close relatives, has often been worked through during psychotherapeutic treatment. It was a superposed trauma.

Psychic trauma is an extremely complex phenomenon, and it occurs when a person is faced with so-called catastrophic experience, one that is very out of common experience (e.g. experience of close death, or complete helplessness). Traumatic event is easily recalled into memory with loss of control, tendency to avoidance, being overwhelmed with fear, mental pain, loss of hope for the future, and a reactions of the autonomic neurovegetative system. Destroying merits and credentials, trauma destroys relationship of trust between a person and her/his world. Diseased person doesn't know how to act in a battle for survival any more, and develops a chronic Posttraumatic stress disorder which leads to diminished capacity for adequate family and parental functioning[22]. This influences also the health of children predisposing them to development of psychic disorders[23].

DSM-IV criteria for the diagnosis of Posttraumatic stress disorder (PTSD) include symptoms such as: repetition of traumatic event, symptoms of hyper arousal, evasive behaviour and diminished psychosocial functioning that are present for at least a month after traumatic event exposure.

Epidemiologic studies indicate that 25–33% of people exposed to traumatic events, including cancer, develop PTSD[24,25]. Results of our study showed that 10.83% of participants developed PTSD during the course of the whole research.

Defining traumatic stressor is a problem in cancer patients, because there are many multiple crises which make the experience of having cancer it is hard to single out one specific stressor. The stressor can be getting the diagnosis, knowing it could be fatal, long periods of strong pain, symptoms and signs of relapse, aversive procedures or sharing a hospital room with a dying or a deceased person. During 1994 DSM-IV revision included getting potentially fatal disease or potentially fatal disease of one's child as stress events that meet the PTSD criteria.

Severity, duration and closeness to traumatic event influence the development of PTSD. Abruptness and threat to life and physical integrity are important provocative of the disorder, whereas the presence of pain and other physical symptoms are in correlation with intrusive thoughts[26].

Earlier findings[27] additionally indicate that PTSD leads to certain social deficiencies (loss of interest of getting back to work, poor work performance, inadequate parenting, diminished participation in home activities and general social functioning) which leads to development of anxiety and depression.

Important child developmental processes are particularly disturbed, such as development of the sense of attachment, separation and individualization, because a diseased parent puts a child into an atmosphere of high anxiety, depression and impulsiveness. Some people are multiply traumatized by so-called cumulative trauma. They are worried for the future and safety without enough adjustment capacities[28].

Far reaching power of posttraumatic consequences stretches across a natural biological barrier, into the next generation (so-called »transgenerational influence of traumatisation«). Research of holocaust survivors' descendants indicates they were more anxious[29], manifested exaggerated narcissistic vulnerability and more aggression[30] and guilt for being survived[31].

Also, family members who were not yet born at the time of traumatic event may develop symptoms of chronic PTSD, as described in Vietnam War veterans' children. They have lower self-esteem and reality testing, are hyperactive, unstable, and aggressive, and have difficulties in dealing with problems and their own feelings such as fear, anger, guilt and distrust. That is why they may have more problems with behavior, relationship with peers and studying. There is a greater percentage of family and partner violence in families of traumatized people, and children exposed to violence may develop psychic disturbances as a result[23,28,32].

Although we are born with our own unique, inherited combination of genetic potential, perhaps emotional development of a child is more influenced by people it is

closes to than its genes. That is how it is possible for so-called »secondary transfer of trauma« to take place. It is called indirect, secondary or empathic traumatisation. It arises as transfer identification and it happens to children, wives or carers of diseased people, including healthy children who play with the traumatized one. That is how traumatic event indirectly gets new victims. A child of a traumatized parent grows up with a distorted idea of roles and conflicts, is ashamed of itself, carries a nucleus of hatred towards itself that is later very hard to abolish. Some children are reticent and cautious, so they wouldn't be emotionally betrayed, others uncritically engage in relationships and repeat disappointments, are emotionally rigid, numb, unreachable and experience positive emotions with difficulty.

In it's essence it is a matter of communication failure, so it is easy to enter a vicious circle of anxiety, frustration and withdrawal, all the way to the sense of complete exclusion. Silence and avoidance most commonly lie at basis of disturbed relationship, as well as inability to show true emotions which the traumatize person cannot deal with, so that the child has no one to ask for help and develop protective feeling that a parent should provoke. Sometimes a parent overwhelms a child with detailed descriptions of traumatic event, which can terrify a child.

To recover after trauma it is necessary to efficiently fight for wellbeing which is recognized by established relationship of trust in one self and the world, healthy patterns of communication and behaviour which strengthen growth and progression. To achieve this, a consistent team approach is required, through elevation of awareness and communication and establishment of quality social support in the community.

A family is a centre in whose relations all psychological processes of the child take place. It is a place of security and support, of identification and formation of relationships, and also of many pathological happenings responsible for later development and functioning of every member of the family, especially a child. A family is under significant influence of cultural, ethnical and socioeconomic factors which together with specificity and expectancies of every family member make a unit that is under continuous dynamic of changes.

That is the milieu which is responsible for early development and relationship of a child. A family is not determined only by its socioeconomic status, but also with experience, knowledge and expectations of every family member, and every of these aspects influence each family member. In this interplay of various factors all psychological influences and problems of the earliest development of a child take place. The child brings these experiences into all other relationships, so it is necessary to assess early family relationships in evaluation of any pathological processes, especially because it is known that these processes are directly connected to acceptance or refusal, love and emotions.

Social learning theories are, just as psychoanalytical learning theories, etiological, each using different mechanisms to stress the importance of the dyadic relationship of child and mother or other carer.

Bowlby concept of attachment holds a special place. According to it, a human being has inherent need for creation of strong relationships with people who provide sense of protection and security, who are emotionally important for the child. Early experience of connection with parents shapes development and quality of close relationships in later life of a person. Unconditional trust in accessibility of object of attachment (parent) and its support are at the basis of person's stability[33].

The states of interruption of these relationships and inability to recreate them lead to strong emotional responses and search for an object. Bowlby believes that established relationship and attachment to a relevant person comes from our need for security and protection. This relationship is established right after birth and is developed in relation to mother, and afterwards to other people important to us (father, brothers, sisters, partner) and lasts during the whole lifetime.

If a mother and a child do not »fit« well, their relationship will be marked by weak attachment, or relationship filled with fear. We experience early losses (abandonment by mother) nearly as death. »To be abandoned« (by mother) in early childhood we can wrongly experience as complete abandonment because we are bad and unloved, and we react to it by feelings of helplessness, guilt, anger, fear and terror. That is why early losses will influence the way of mourning later in life and will aggravate separation and loss overcome[13].

Theory of attachment deals with social behaviour, expectations a person h of him/her self, others and relationships, so it can foresee person's self-respect and ability to make close relationships. Parents remain permanent component in the hierarchy of attachment, but in time they take secondary position, and partners become the most important objects of attachment.

The way in which people perceive existing social support can strengthen their belief that others care for them and that they are valued, but it can also increase their self esteem and confidence in their own abilities to deal with stressful situations in the future[34,35].

Symptoms of anxiety and depression are present in many psychiatric disorders, which often lead to overlap and make it difficult to distinguish between different comorbid states. That can be a problem because making the diagnosis in due time has great theoretical, diagnostic and therapeutic value[36].

Making the diagnosis is further complicated by the fact that carcinoma is not an acute, discreet event but is an experience of strong, repeated traumas of indefinite durance, so, the diseased can show symptoms of PTSP at the time of making the diagnosis, during treatment or at relapse of carcinoma[37].

These annotations indicate further need for continuous evaluation of diagnosis during cancer treatment, because although according to DSM-IV symptoms of PTSD appear in the first three months after trauma exposure,

they can be delayed for months or even years after the traumatic event.

PTSD in women who had a family member diagnosed with carcinoma can be reactivated PTSD when an old clinical presentation of PTSD is newly activated, or it can be presented as a completely new disorder. Second generation PTSD, i.e. reactivated PTSD, lasts longer and is often of same intensity as at the beginning of the disorder[31,38]. Exposure to traumas in second generation, PTSD uncovers hidden sensibility which was not initiated by common life events. The second generation also experiences the deepening feeling of failure, because that generation was raised to redeem the damage experienced by their parents. That feeling is often present in carcinoma treatment. The recovery can also be obstructed by excess of secondary gain which comes from excessive parental protection that was well documented in parents who survived holocaust[31,39].

Furthermore, as breast cancer is more frequent in daughters of diseased women, we should bare in mind transgenerational transfer of present trauma to the next generation (i.e. subjects' daughters) and the prospective influence of present psychiatric interventions and their influences on reduction of graver psychiatric disorders in the future.

Contents of psychotherapeutic process have shown that prolonged and malignant forms of PTSD usually appear in women who are not satisfied with their physical or psychical condition or self care[31,40].

During diagnostic and treatment procedures there are many repeated traumatic experiences which do not necessarily meet criteria for the diagnosis of PTSD but can interfere with development of psychic responses, disorders, or merely levels of anxiety and depression.

Diseased women often transfer their fears to their children, changing their mode of response and intensifying their anxiety and depression. Psychotherapeutic treatment has far reaching influences and can lead to great relationship changes in woman's entire family. Positive therapeutic shifts (through insight, changing responses of the diseased, and attitudes and reactions of the children) can influence the next generation and help children (if they ever be diagnosed with carcinoma) in their psychic adjustment and fight against this grave disease.

Transgenerational transfer of emotions when faced with the diagnosis of carcinoma is important, but not yet sufficiently examined and is a challenge for future research.

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UTJECAJ PSIHIČKE TRAUME KROZ TRANSGENERACIJSKI PRIJENOS NA RAZVOJ TRAUMATSKIH REAKCIJA ŽENA OBOLJELIH OD KARCINOMA DOJKE

S A Ž E T A K

Ranije proživljena psihička trauma bliske osobe kroz transgeneracijski prijenos može utjecati na traumatske reakcije osobe koja u sadašnjosti proživljava traumu, dovodeći do repeticija ranijih doživljaja i razvoja raznih psihičkih poremećaja. Cilj ovog istraživanj bio je procijeniti utjecaj transgeneracijskog prijenosa na razvoj PTSP-a kod žena oboljelih od karcinoma dojke koje su u obitelji imale člana oboljelog od karcinoma. Uzorak se sastojao od 120 žena liječenih na Odjelu za onkologiju KB Osijek pod dijagnozom novootkrivenog karcinoma dojke, u tijeku provođenja radioterapije uz vrijednosti Hamiltonove skale za procjenu depresivnosti (HAM-D) od ≥8 do ≤24 ili vrijednosti Hamiltonove skale za procjenu anksioznosti (HAM-A) od ≥17 do ≤30. Korištene moetode bile su psihoterapijski intervju s detaljnim kliničkim pregledom uz primjenu dijagnostičkih kriterija prema DSM-IV za psihičke poremećaje, posebno strukturirani nestandardizirani upitnik za procjenu etioloških čimbenika u nastanku psihičkog poremećaja kod ispitanica, Los Angeles samoprocjenska lista simptoma PTSP-a (LASC), Hamiltonova skala za procjenu anksioznosti (HAM-A) i Hamiltonova skala za procjenu depresivnosti (HAM-D). Rezultati su pokazali da se član obitelji obolio od karcinoma nalazi kod 61 (51%) ispitanice. Prosječna ukupna vrijednost na LASC-u za ispitanice koje su imale člana obitelji oboljelog od karcinoma bila je nešto viša (22,92) nego onih bez oboljelog člana obitelji (20,88). Nije dobivena statistički značajna povezanost postojanja člana obitelji oboljelog od karcinoma i prosječne ukupne vrijednosti na LASC-u. Iako nije dokazana povezanost postojanja člana obitelji oboljelog od karcinoma i prosječne ukupne vrijednosti na LASC-u kod žena oboljelih od karcinoma dojke, transgeneracijski prijenos emocija u razvoju njihovih traumatskih reakcija je bitan, ali još uvijek nedovoljno istražen i izazov je za buduća istraživanja otvarajući mnoga složena pitanja.