SELF-PERCEIVED SOCIAL SUPPORT IN CROATIAN WAR VETERANS SUFFERING FROM COMBAT-RELATED POSTTRAUMATIC STRESS DISORDER – WHAT SHOULD NOT HAVE HAPPENED

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SUMMARY – The goal of this study was to evaluate the association between self-perceived social support and chronic combat-related posttraumatic stress disorder (PTSD). The study included 262 male war veterans suffering from chronic PTSD. Their diagnosis was confirmed according to DSM-IV-TR. They were given self-reported measures Trauma Symptom Inventory-A and Multidimensional Scale of Perceived Social Support. No significant correlation was found between peer and family support and PTSD. The authors hypothesize this might be the result of secondary victimization, traumatization, and enduring personality changes during the course of PTSD. The items evaluating satisfaction with health care and state institutional support were correlated with most of the PTSD symptoms indicating the possible importance of improving institutional policies toward this population.

Key words: *Stress disorder, posttraumatic; Social support; Depression; Stress; Family*

Introduction

Posttraumatic stress disorder (PTSD) arises in a person exposed to a traumatic event in which he or she is confronted with possible death and threat to physical integrity of self or others with a response involving intensive fear or selfhelplessness[1]. Although the Diagnostic and Statistical Manual of Mental Disorder IV-Text Revision (DSM-IV-TR) defines chronic PTSD as a disorder lasting for a period greater than three months[2], some authors suggest that the chronic course of this disorder is somewhat different to that described in DSM-IV-TR. In a group of Vietnam War veterans, it was shown that the symptoms of PTSD plateau within a three-year aftermath subsequent to the traumatic experience, followed by chronic unremitting disorder[3]. In a sample of 11,441 Gulf War veterans, the prevalence of PTSD was 12.1% at 6 years of initial trauma[4]. These findings suggest that chronic PTSD should possibly be regarded in a different manner to acute PTSD due to the "unfavorable" course of the disorder. The chronic condition of PTSD was the crucial element of this study.

Self-perceived social support can be defined as "the perceived availability of people whom the individual trusts and who make one feel cared for and valued as a person"[5]. A meta-analysis of the possible risk factors

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Received May 17, 2011, accepted September 12, 2011

contributing to predisposition for the development of PTSD concluded that the lack of social support was one of the highest effect-size factors[6]. Although there is an abundance of literature dealing with social support in the early course of PTSD, its association with chronic PTSD has been neglected to a certain extent.

The main aim of this study was to evaluate the association between self-perceived social support with chronic PTSD. The following hypotheses are proposed: 1) a higher level of perceived personal social support is associated with a lower intensity of PTSD symptoms in war veterans; and 2) a higher level of perceived institutional social support is associated with a lower intensity of PTSD symptoms in war veterans.

Subjects and Methods

Subjects

The study included 278 subjects, male war veterans aged 35-55, who had participated in the Croatian War of Independence (1991-1995) as frontline soldiers for a minimum of 6 months. All subjects were treated as outpatients for chronic PTSD at University Department of Psychological Medicine, Zagreb University Hospital Center. They were consecutively enrolled in the study during their regular check-up appointments. Before enrolling in the study, they were interviewed by a psychiatrist according to DSM-IV-TR criteria for chronic PTSD in order to verify that they were suffering from clinically manifested PTSD[2]. The exclusion criteria were acute psychosis, traumatic brain injury, and a history of alcoholism and other narcotic substance abuse. All subjects signed an informed consent and the study was approved by the appropriate ethics committee of the School of Medicine, University of Zagreb, according to high ethical standards set by the Declaration of Helsinki regarding human experimentation.

Questionnaires

General questionnaire

The general questionnaire consisted of various items including age, marital status, socioeconomic status, disability status, wartime experience, various psychiatric diagnoses, current pharmacological therapy, onset of PTSD symptoms, duration of PTSD and additional somatic disorders. One of the methodological problems the authors faced on designing the study was the lack of an appropriate questionnaire for examining the perceived institutional support. In order to overcome this problem, a special part of the general questionnaire was designed to examine this support, concentrating on, among others, three Likert-type items concerning satisfaction with the central, local and medical health care institutions for the specific problems and needs of the Croatian war veteran population. The response varied from 1 denoting "not at all" to 5 denoting "completely", relating to the subjects' satisfaction with the care provided by these various institutions.

Trauma Symptom Inventory-A

Trauma Symptom Inventory-A (TSI-A) is a specific self-reported measure developed to evaluate the acute and chronic symptomatology of PTSD, regardless of the traumatic event, which may include rape, combat experience, childhood abuse, natural disaster, physical assault, etc.[7]. TSI-A is a shorter version of the original Trauma Symptom Inventory. This measure consists of 86 items in the form of a four-point scale with symptoms rated retrospectively within the preceding six months through answers varying from 0 denoting "never" to 3 denoting "often". Based on this questionnaire, the following clinical scale evaluating specific symptoms was obtained: Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Impaired Self-Reference and Tension Reduction Behavior. An adequate internal validity was found on a sample of war veterans suffering from PTSD with Cronbach α varying from 0.73 to 0.91 depending on the scale[8]. On a community sample, this measure was demonstrated to be able to correctly classify 85.5% of PTSD cases and showed similar results for other measures evaluating PTSD[9].

Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS) is a self-reported measure evaluating social support from the subject's close environment, such as peers and family[11]. It consists of 12 items with a scale ranging from 1 to 7. The intention is for the subject to express agreement with the statements

with answers varying from 1 denoting "very strongly disagree" to 7 denoting "very strongly agree". Clara *et al*. verified this scale on a group of psychiatric patients with adequate psychometric properties[11]. This scale has achieved an appropriate Cronbach alpha value in a sample of PTSD outpatients[12].

Statistical analysis

Upon data collection, due to the specific age of the participants, factorial analysis of the MSPSS was performed in order to obtain three factors: "the significant other", "peers" and "family". The bivariate correlation factors were correlated, followed by linear regression analysis. On linear regression analysis, each clinical scale of TSI-A was used as a dependent variable, while factors obtained from the MSPSS and items describing institutional support were used as independent variables. The analysis was performed using the Statistical Package for Social Science 16.00.

Results

Subjects

Out of 278 subjects initially enrolled in the study, 262 completed the questionnaires properly and these were included in statistical analysis. The mean age of the subjects was 41.76 (SD=0.28). According to marital status, 77% of the participants were married, 11% were single and 7% were divorced; 51.1% of the subjects were retired, 29.6% were employed, whilst the rest were unemployed; the majority of subjects had a monthly income between 150€ and 450€. The mean time of army service during the war was 30.98 months (SD=21.56) as frontline soldiers, and 30.2% of them were injured in combat.

The association of self-perceived social support and chronic PTSD

Descriptive characteristics of various domains from TSI-A are shown in Table 1. Since this self-reported measure has not yet been standardized within the population of Croatian war veterans, it was impossible to obtain z values in order to distribute the participants according to dichotomous variables of TSI-A domains.

Bivariate correlation factors were used to associate specific TSI-A domains with two factors obtained from the MSPSS and three items describing the perceived support from state, local and health care institutions (Table 2). As illustrated in Table 2, none of the factors from the MSPSS correlated significantly with the TSI-A domain, thus further statistical analysis such as linear regression would have been redundant. The first hypothesis of the study, stating that a higher level of perceived personal social support correlates with a lower intensity of PTSD symptoms in war veterans, was rejected. Since the variables describing the participants' satisfaction with the care provided by the state, local and

Table 1. Descriptive data obtained from Trauma Symptom inventory-A

TSI-A	N	Min	Max	M	SD
AA	262	5	24	18.51	3.73
D	262	1	24	17.90	4.55
AI	262	1	27	20.65	4.75
IE	262	2	24	18.27	4.36
DA	262	5	24	17.36	3.10
DIS	262	1	27	17.15	5.91
ISR	262	1	27	17.52	5.05
TRB	262	0	24	10.67	4.80

TSI-A = Trauma Symptom Inventory-A; AA = Anxious Arousal; D = Depression; AI = Anger/Irritability; IE = Intrusive Experience; DA = Defensive Avoidance; DIS = Dissociation; ISR = Impaired Self Reference; TRB = Tension Reduction Behavior

Table 2. Correlation between TSI-A domains and social support

TSI-A	Family	Peers	State	Local	Health care
TRB	-.052	.070	-.171**	-.252**	-.114
ISR	-.086	.025	-.174**	-.225**	-.073
DIS	-.063	-.020	-.194**	-.228**	-.131*
DA	-.074	.023	-.170**	-.140*	-.088
IE	-.042	.021	-.192**	-.107	-.157*
AI	-.056	-.022	-.193**	-.189**	-.193**
D	-.116	-.086	-.226**	-.212**	-.146*
AA	-.015	-.042	-.223**	-.179**	-.217**

*P<0.05; **P<0.01; TSI-A = Trauma Symptom Inventory-A; AA = Anxious Arousal; D = Depression; AI = Anger/Irritability; IE = Intrusive Experience; DA = Defensive Avoidance; DIS = Dissociation; ISR = Impaired Self Reference; TRB = Tension Reduction Behavior

medical health care institutions for their mental health showed significant negative correlation with most of the TSI-A domains, statistical analysis included linear regression where dependent variables belonged to the TSI-A domain, while independent variables included three items, as shown in Table 3.

The set of predictors was shown to statistically significantly predict the TSI-A domains, although the variance being explained was relatively small (R^2 <0.10). Most of the domains were predicted by "the satisfaction with health care institutions", except for "Anxious Arousal", "Intrusive Experience" and "Defensive Avoidance". The "satisfaction with state institutions" predictor was statistically significant for "Defensive Avoidance" and "Depression", while the "satisfaction with local institutions" predictor variable was not statistically significant.

The second hypothesis of our study, stating that a higher level of perceived institutional social support correlates with a lower intensity of PTSD symptoms in war veterans was accepted.

Discussion

The lack of association between PTSD symptoms and perceived interpersonal social support

A crucial element for the understanding of these results is discrepancy between subjective understand-

Table 3. Satisfaction with various institutional supports as predictors of PTSD symptoms

TSI-A	Predictors	B	Beta	F	Sig.	R	R2
AA	State	-0.313	-0.094	4.920	*P*<0.001	0.249	0.062
	Local	-0.315	-0.090				
	Health care	-0.342	-0.122				
D	State	-0.908	-0.218*	6.100	*P*<0.001	0.275	0.076
	Local	0.343	0.079				
	Health care	-0.560	-0.160*				
AI	State	-0.256	-0.061	4.952	*P*<0.01	0.250	0.062
	Local	-0.439	-0.100				
	Health care	-0.514	-0.147*				
IE	State	-0.646	-0.165	2.736	*P*<0.05	0.188	0.036
	Local	0.007	0.002				
	Health care	-0.152	-0.046				
DA	State	-0.780	-0.281*	3.165	*P*<0.05	0.202	0.041
	Local	0.422	0.110				
	Health care	-0.281	-0.092				
DIS	State	-0.780	-0.145	5.534	*P*<0.01	0.263	0.069
	Local	0.308	0.055				
	Health care	-0.892	-0.198*				
ISR	State	-0.917	-0.198	5.719	*P*<0.01	0.267	0.071
	Local	0.725	0.150				
	Health care	-0.771	-0.199*				
TRB	State	-0.429	-0.098	6.486	*P*<0.001	0.283	0.08
	Local	0.214	0.047				
	Health care	-0.907	-0.248*				

*P<0.05; TSI-A = Trauma Symptom Inventory-A; AA = Anxious Arousal; D = Depression; AI = Anger/Irritability; IE = Intrusive Experience; DA = Defensive Avoidance; DIS = Dissociation; ISR = Impaired Self Reference; TRB = Tension Reduction Behavior

ing of social support and objective social support given by a social network. This study was not designed to evaluate objective parameters of social support since the main focus of the authors was on personal evaluation of the participants' disorder and the social support they received *via* various social networks.

The second theoretical point is based on the structure of the MSPSS measure. Social support as a coping strategy analyzed by Carver can be instrumental and emotional[13]. The MSPSS items mainly evaluate emotional support, although there are some items that are concerned with instrumental support as a coping strategy and helping individuals to deal with everyday problems in an active way. In order to expand the evaluation of instrumental support, this study included three items for describing satisfaction with institutional support.

The most curious finding and contrary to other studies was the lack of correlation between the interpersonal social network and PTSD symptoms. In a longitudinal 20-year study carried out on Israeli soldiers, a significant correlation was found between intrusive experiences and defensive avoidance symptoms among 214 soldiers divided into two groups and based on combat related stress[14]. This group showed aggravated marital functioning, although no clear attempt was made to present correlation between family relationships and PTSD symptoms. In a recent study on Croatian war veterans, defensive avoidance and hyper-arousal symptoms were correlated with family support, but the major pitfall of this research was using correlation factors of zero order without using/applying controlling for other variables or using regression analysis[15].

One of the reasons for our findings could be the process of secondary victimization experienced by war veterans suffering from PTSD. Secondary victimization is defined as a social injury from an individual or social network to an individual suffering from PTSD through not acknowledging the primary stressor leading to the disorder, inadequate social support or stigmatization of the disorder *per se*[16]. Croatian experiences with these processes have resulted in a very negative public view of PTSD as an "extremely hetero-aggressive disorder" or a disorder that does not exist, especially due to the "hyper-inflation" of PTSD diagnoses as a means to obtain military pension[17]. The authors of this study hypothesize that this process of repeated social injuries could have led to a stage where the beneficial effect of social support no longer exists in chronic cases of PTSD. Indirectly, this may be supported by our findings, according to which peer support did not correlate with any of the PTSD symptoms defined by TSI-A. One of the possible limitations is the lack of a specific definition of peers as being either fellow war veterans or friends from everyday surrounding. However, during the aftermath of the war, the cohesive veterans' social network has started to weaken, so possibly this specific kind of network is no longer as important now, 15 years after the war, as it once was.

The second possible reason could be secondary traumatization of the family itself. It has been shown that close emotional contact with an individual suffering from PTSD may lead to an accumulation of negative emotions through close contact[18,19]. In a sample of marital spouses of Croatian war veterans, Franciskovic *et al.* found a prevalence of 57% of secondary traumatic stress[20]. The need for family to provide social support, help in the treatment and possible cure of a member suffering from PTSD could lead to a rise in emotions of failure, guilt, resentment, thus further destabilizing an already volatile/unstable family environment. One of the possible reasons is the lack of psycho-education for the patient's family concerning the psychiatric disorder and the insufficiently organized mental health care system in Croatia. During the long years of this fatal process, in the eyes of a war veteran affected with PTSD, marital and family relationships may become insufficient as a coping mechanism and therefore unimportant. This statement may explain the lack of correlation between family support and PTSD symptoms in our sample.

The third possible reason for our findings could be the presence of complex PTSD or Disorder of Extreme Stress Not Otherwise Specified. Although our study did not evaluate this disorder in our sample, indirectly, on analyzing Table 1, a high mean result of impaired self-reference and dysphoria may be noticed, possibly indicating a high probability that a substantial part of our sample suffered from this disorder. Other studies support this relatively high level of complex PTSD in a population of war veterans. A study conducted in The Netherlands found 38% of war veterans to suffer from

this disorder[21]. Complex PTSD is characterized by enduring personality alteration due to prolonged repetitive trauma as in the case of war. This psychiatric phenomenon could be responsible for social malfunctioning of veterans suffering from chronic PTSD, therefore reducing the need for this coping mechanism.

This paper does not contradict the main principles of social psychiatry but it simply provides precautionary warning as to the possible consequences if the treatment is not directed towards a closer network of individuals suffering from chronic PTSD. Education through the media, non-governmental organizations and psycho-education is deemed necessary to avoid this painful experience that afflicts Croatian war veterans. Also, psychotherapy of PTSD should be directed not only towards the individual himself, but also towards his whole family in order to avoid secondary traumatic stress. These actions would help mediate the beneficial effects of social support on PTSD.

When evaluating the results of this study, certain limitations must be considered. One of the possible pitfalls may be the non-application of a semi-structured interview as the principal instrument in PTSD evaluation, as the main focus was the perception of PTSD and social support by the war veterans themselves and not by the psychiatrist. Beck *et al*. have shown that psychiatrists, when evaluating PTSD, often focus solely on the comorbid depressive disorder, whereas patients often state personality changes as a crucial problem of their disorder[22]. The second possible limitation is the non-application of a control group; however, as it was a psychometric study exploring the correlation between certain psychological and social phenomena, the authors did not consider it essential to include a control group. The third limitation is the lack of standardization of these psychometric tests in a group of Croatian war veterans; however, as the principal statistical analysis did not use dichotomous variables, which would require a Z value and presumably cultural differences between Croatian war veterans and other samples where TSI-A was standardized, it was not significant for this study.

Satisfaction with institutional support and chronic PTSD symptoms

This study aimed at presenting the association between self-perceived social support gained from an institutional network and the intensity of PTSD symptoms. The correlation was rather weak based on relatively small bivariate correlation coefficients and a small proportion of variance explained in linear regression, as illustrated in Tables 2 and 3. Another problem while analyzing these results is certainly the usage of only three items to evaluate this type of social support.

In the theoretical framework of the study, these three items were designed in order to assess instrumental support from social network. Unlike the lack of correlation with emotional support, this study revealed a small but important link between an institutional approach to PTSD problems and the disorder symptomatology. "Satisfaction with the state approach" was found to be a significant predictor of depression as a major comorbid psychiatric disorder in PTSD with a prevalence of 25%-50% according to some studies[23,24]. In our study, the prevalence of positive history of major depressive disorders according to ICD10 criteria was 39%. This may indicate that insufficient state care is associated with the resulting disillusionment in the main goal of the war and the failing purpose of the goal in establishing a nation state, therefore possibly leading in part to depressive symptoms. Our results show that good/adequate/appropriate institutional and organized support to this vulnerable population may alleviate depressive symptoms. The lack of correlation between PTSD symptoms and local institutions may be attributed to the centralized organization of Croatia and the relative absence of proper non-governmental institutions dealing with war veterans suffering from PTSD.

Self-perceived health care support was found to be a significant predictor for most of the symptoms. This may be attributed to the health care institution (in)ability to consolidate emotional and instrumental support in its approach to PTSD, but it can also be viewed as a potential patient bias towards psychiatrists, since all of the participants were treated as outpatients at a psychiatric clinic at the time.

Although this study was not able to demonstrate the relationship between PTSD symptoms and social support, our findings show that, in the chronic course of this disorder, social support remains a beneficial and important although (often neglected and) minor factor.

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Sažetak

PERCIPIRANA SOCIJALNA POTPORA VETERANIMA DOMOVINSKOG RATA S POSTTRAUMATSKIM STRESNIM POREMEĆAJEM – ŠTO SE NIJE SMJELO DOGODITI

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Glavni cilj ovoga istraživanja bio je procijeniti moguću povezanost percipirane socijalne potpore i kroničnog posttraumatskog stresnog poremećaja (PTSP) uzrokovanog ratom. U istraživanju je sudjelovalo 262 veterana Domovinskog rata koji pate od kroničnog PTSP-a. Psihijatrijsku dijagnozu potvrdio je psihijatar prema kriterijima DSM-IV-TR. Simptomi PTSP-a ispitani su samoocjenskim upitnikom *Trauma Symptom Inventory-A*, dok je socijalna potpora procijenjena ljestvicom *Multidimensional Scale of Perceived Social Support*. Nije pronađena značajna povezanost između percipirane socijalne potpore od strane obitelji i prijatelja sa simptomima PTSP-a. Ovakav nalaz može se objasniti kao posljedica sekundarne viktimizacije, traumatizacije te trajnih promjena ličnosti uzrokovanih PTSP-om. Istraživanjem je utvrđena značajna povezanost između institucionalne potpore, primarno državne i zdravstvene, sa simptomima PTSP-a. Važnost ovog rezultata se temelji na mogućem poboljšanju institucionalne skrbi radi smanjivanja simptoma unutar ove osjetljive populacije.

Ključne riječi: *Posttraumatski stresni poremećaj; Društvena potpora; Depresija; Stres; Obitelj*