

# Caregiver Burden and Burnout in Partners of War Veterans with Post-traumatic Stress Disorder

Miro Klarić<sup>1</sup>, Tanja Frančišković<sup>2</sup>, Mirjana Pernar<sup>3</sup>, Iva Nemčić Moro<sup>4</sup>, Ruža Milićević<sup>1</sup>, Edita Černi Obrdaj<sup>5</sup> and Amela Salčin Satriano<sup>1</sup>

<sup>1</sup> Department of Psychiatry, Faculty of Medicine, University of Mostar, Mostar, Bosnia and Herzegovina

<sup>2</sup> Department of Psychiatry and Psychological Medicine, School of Medicine, University of Rijeka, Rijeka, Croatia

<sup>3</sup> Department of Psychology, University Hospital Center Rijeka, Rijeka, Croatia

<sup>4</sup> Department for Psychological Medicine, University Hospital Center Zagreb, Zagreb, Croatia

<sup>5</sup> Department of Family Medicine, Faculty of Medicine, University of Mostar, Mostar, Bosnia and Herzegovina

## ABSTRACT

*War veterans diagnosed with chronic post-traumatic stress disorder (PTSD) experience serious difficulties in social, professional and family life. Consequently, their wives often become indirect victims of their husbands' dysfunction. The purpose of this study was to assess the caregiver burden and burnout level in partners of veterans suffering from PTSD, especially in cases where partners suffer from their own PTSD symptoms. The experimental group consisted of 154 wives or partners of war veterans treated for PTSD caused by the war trauma in University Hospital Mostar. The control group was made of 77 wives or partners of war veterans without PTSD. The study was based on the General Demographic Questionnaire, the Harvard Trauma Questionnaire, Bosnia-Herzegovina version, Caregiving and the Experience of Subjective and Objective Burden and the Maslach Burnout Inventory. The wives of PTSD affected veterans scored significantly higher in all subscales of the Caregiver Burden Questionnaire and the Burnout Inventory. The results indicated that subjective demand burden, subjective stress and burnout were significantly higher in relationships in which both partners suffer from PTSD compared to couples in which only the veteran suffers from PTSD and couples in which none of the partners has PTSD. Living with a veteran diagnosed with PTSD places a heavy burden on the wife and poses a serious risk of burnout, which has to be taken into account in treatment planning.*

**Key words:** PTSD, veterans, partners, caregiver burden, burn out

## Introduction

The concept of caregiver burden was primarily used to describe exhaustion of caregivers looking after dementia patients and elderly people with chronic illnesses<sup>1</sup>. However, in the last two decades the concept was extended to the wide realm of family mental health. Caregiver burden encompasses an objective burden of caregiving, but also includes a subjective experience of stress and overload. Conceptualization of chronic post-traumatic stress disorder (PTSD) as a burden to the patients' partners agree with the results of studies showing negative impacts of psychiatric disorders on persons living with the patients<sup>2,3</sup>.

It is generally known that veterans with PTSD often experience considerable difficulties in social, professional and family life, along with personal suffering<sup>4-6</sup>. As a result, their wives face many stressors related to taking

care and living with a person with PTSD, which includes frequent relationship crises, family violence in many cases, changes in family role distribution, social isolation, financial problems and adjustments to the veterans' illness progress<sup>7-9</sup>. It has been determined that the intensity of the veterans' PTSD symptoms correlates with significant burden and psychological pain felt by their wives<sup>4,10</sup>. A demanding and intensive task of caregiving and providing emotional support, without adequate gratification, often leads to burnout<sup>11,12</sup>. Wives in traditional cultures are expected to provide care and emotional support. Such expectations are not held only by veterans, but by the entire community, and often by women themselves<sup>13</sup>. Long-standing exposure to such emotionally strenuous situations can lead to a condition which Figley called »compassion fatigue«<sup>14</sup>.

Family situation is more complex when both partners suffer from PTSD, which is often the case in massive psycho trauma, such as war traumatisation<sup>15</sup>. Coping with changes in family role distribution and providing the expected emotional support is harder for women who suffer from their own PTSD symptoms.

The recent war in Bosnia and Herzegovina exerted profound effects on most of the citizens. A large number of men fought in battles, while the civilians went through a string of traumatic events such as everyday shelling, wounding and displacement. A large number of the veterans and civilians developed PTSD as an effect of their experiences<sup>15,16</sup>. It is presumable that the wives of these veterans have been exposed to a substantial objective and subjective burden of caregiving and that living with their PTSD-diagnosed husbands contributes to the wives' burnout. If the wives suffer from their own PTSD symptoms, it is even more difficult for them to cope with their husbands' illness and that their level of burnout is likely to be higher.

The purpose of this research is to compare caregiver burden and burnout in partners of war veterans with PTSD and partners of war veterans without PTSD, especially in situations where the partners are also PTSD affected. The obtained results are a part of the research on effects of veterans' PTSD on their family members<sup>17,18</sup>.

## Participants and Methods

The experimental group consisted of partners of war veterans treated for PTSD in University Hospital Mostar. The control group consisted of partners of veterans without PTSD. The veterans were taken as the starting point in forming the samples. PTSD caused by war trauma and the state of being married or cohabiting were set as the inclusion criteria for veterans forming the experimental group. The exclusion criteria were alcoholism and history of mental disorders prior to the war. Absence of PTSD and the state of being married or cohabiting were set as the inclusion criteria for veterans forming the control group, while the exclusion criteria were the same as in the experimental group.

### Methods

In order to form the experimental group (wives of PTSD affected veterans), we contacted all the veterans who have undergone treatment in University Hospital Mostar for PTSD. The veterans were contacted based on the order of their applying for treatment. Out of 409 contacted veterans, 317 were married or had a partner; they were informed on the research and asked if they were willing to participate. None of them had a history of mental disturbances prior the war. 69 veterans (21.8%) refused to participate in the research. The rest of the veterans gave their written informed consent to participate in the research.

The next step was to determine alcohol addiction by using the CAGE questionnaire<sup>19</sup>.

The CAGE consists of four »yes« or »no« questions (C-»cut down«; A-»annoyed«; G-»guilty«; E-»eye opener«). Two affirmative answers by a middle-aged person denote an alcohol problem or alcoholism. In case of younger respondents, only one affirmative answer indicates the problem.

All the participants of our research who had two or more affirmative answers were considered alcohol-addicted. Alcohol addiction was determined in 37 (15.0%) of the participants and they were therefore excluded from the research. The research continued with 211 veterans. They were asked to inform their wives about the research and hand them a copy of research notification form and participation consent form. After receiving information about the research, 57 (27.0%) of the veteran wives refused to participate. Finally, the experimental sample consisted of 154 wives of PTSD affected veterans.

In order to form the control group (wives of veterans without PTSD), we contacted veterans through veterans associations and then applied the snowballing method<sup>20</sup>. Based on previous arrangement with representatives of two war veterans associations, the principal investigator paid a visit to the associations' facilities where the veterans gather on a daily basis. The principal investigator gave the research notification form to the present veterans, explained the purpose of the research and asked if they were willing to participate. Principal investigator also asked the veterans to hand the research notification form to veterans who were absent on the day of the visit and ask if they were also willing to participate. The veterans who were willing to participate in the research contacted the principal investigator and his associates by phone and, based on arrangements, they contacted the Psychiatric Ward at the University Hospital Mostar or arranged a visit of the principal investigator to the association facility. Each participant was again asked to inform their married or cohabiting fellow-soldiers of the research and ask if they were also willing to participate. The participants first responded to the HTQ questionnaire<sup>21</sup>. The respondents who had reported war trauma based on the HTQ, but had not met the PTSD criteria, responded to CAGE<sup>19</sup> for identifying alcohol addiction. The respondents with negative results (not addicted to alcohol) were included in the research. With their consent, we contacted their wives and gave them the research notification form. The wives and their husbands who agreed to participate and gave their written informed consent responded to the same battery of questionnaires, according to the same principles applied to the experimental group. Twelve out of 118 contacted veterans (10.2%) met the PTSD criteria and they were hence excluded from the research. Seven out of 106 veterans left (6.6%) met the alcohol addiction criteria, and they were excluded from the research. Out of 99 contacted wives, 22 (22.2%) refused to participate in the research. The final control sample consisted of 77 wives. All the participants could seek therapy or medical intervention in case they needed it and they could refuse to participate in the research at any time.

## Instruments

General demographic data, social and economic status were determined by using the General Demographic Questionnaire designed specially for the purpose of the research. To determine the presence of posttraumatic symptoms, we used the Harvard Trauma Questionnaire (HTQ): Bosnia-Herzegovina version<sup>21</sup>. The HTQ was developed in 1998, through collaboration of Harvard Program in Refugee Trauma, mental health associations and experts from Bosnia and Herzegovina and Croatia. The HTQ is used in the form of a structured interview. The fourth HTQ module, used in our research, contains a list of 40 statements referring to psychosocial difficulties caused by trauma. The first 16 statements are derived from DSM-IV criteria for PTSD. These symptoms are grouped around three clusters of symptoms: flash-backs, avoidance and psychological hyperarousal. The rest of the statements refer to participants' perception of the impact of trauma on their everyday abilities. Answers to each question are scored as follows: 1=not at all, 2=very little, 3=quite, 4=very much. The total score is the mean value of all 40 statements, while the score indicating PTSD is the mean value of the first 16 statements. Participants whose total score or PTSD score is >2.5 are considered positive for PTSD. Separate samples of the HTQ, B-H version had not been validated before the implementation of the study, therefore we noted the >2.5 score as positive. This score is comparable with the scores of patients clinically diagnosed with PTSD<sup>21</sup>. The internal consistency of the instrument was high (Cronbach alpha ranged from 0.88 to 0.97).

We used the Caregiver Burden Questionnaire (Caregiving and the Experience of Subjective and Objective Burden)<sup>22</sup> in order to identify how helping or having contact with the persons of whom the participants take care affected aspects of their lives. The questionnaire consists of 14 questions, of which 6 questions assess caregiver objective burden and two sets of 4 questions assess subjective demands burden and subjective stress burden. Answers to each question are grouped as follows: »a lot less«, »a little less«, »the same«, »a little more«, »a lot more«. Answers to the six questions assessing objective burden are scored 5–1 (»a lot less«=5, »a lot more«=1). Answers to two sets of four questions assessing subjective demands burden and subjective stress burden are scored 1–5 (»a lot less«=1, »a lot more«=5). Objective burden score above 23, subjective demand burden score above 15 and subjective stress burden score above 13.5 are viewed as very high. Internal consistency coefficients (Cronbach alpha) ranged from 0.88 to 0.91.

In order to determine burnout in partners of PTSD affected veterans, we used Maslach's self-reporting scale (»The Maslach Burnout Inventory«) designed for measuring the symptoms of caregiver burnout<sup>23</sup>. The statements relate to emotional, cognitive, behavioural and somatic consequences that can arise from close relationships with traumatised persons. The scale has 30 »yes« or »no« questions, with the sum of positive answers indi-

cating the level of burnout. Internal consistency coefficient (Cronbach alpha) in this sample was 0.92.

## Statistical analysis

Basic descriptive parameters (arithmetic mean±standard deviation [SD]) were calculated for all the measures used in the research. The differences between the groups were tested using the  $\chi^2$ -test for nominal variables and t-test and ANOVA for interval variables. In order to carry out a more detailed analysis, we used the one-way analysis of variance and post hoc tests (LSD). The level of statistical significance was set at  $p < 0.05$ . Statistical analysis has been performed by using the Statistical Package for Social Science for Windows, version 11 (SPSS Inc., Chicago, IL, USA).

## Results

Women in the experimental group had the mean age of 45.08±9.30, while the mean age of women in the control group was 44.40±11.19 years ( $t=0.46$ ;  $p=0.649$ ). Differences between the groups regarding socio-demographic variables were examined using the Chi-square test. The results showed that women in the experimental and the control group significantly differ regarding their education level ( $\chi^2=11.05$ ;  $p=0.004$ ) and economic status ( $\chi^2=17.51$ ;  $p < 0.001$ ), while there were not any differences regarding their employment status, duration of marriage, the number of marriages and the number of children (Table 1). The experimental group had more women with secondary education level and a low economic status, while the control group had more women with a higher education level and a good economic status.

Women in the experimental group had significantly higher scores in all subscales of the Caregiver Burden Questionnaire (objective burden, subjective demand burden and subjective stress burden) and of the Caregiver Burnout Inventory (Table 2).

The first step was to identify the women from both groups which meet the criteria for PTSD based on the HTQ results. Two subgroups of the experimental group were formed as a result: group A-1, in which both partners suffer from PTSD ( $n=62$ ), and group A-2 ( $n=92$ ), in which only the husband suffers from PTSD. Five couples in the control group in which only the wife had PTSD were excluded from further analysis.

One-way analyses of variance were used to calculate the differences among the three groups of respondents in all variables of the Caregiver Burden Questionnaire and the variable of the Caregiver Burnout Inventory. The analysis of all the variables revealed significant differences among the three groups of respondents (Table 3).

Subsequent analyses which compared particular couples in the groups (LSD test) indicated that the women in group B (couples in which none of the partners has PTSD) obtained significantly lower scores in objective burden variable than women in groups A-1 and A-2. There was not any significant difference between groups

**TABLE 1**  
DEMOGRAPHIC CHARACTERISTICS OF WOMEN IN THE EXPERIMENTAL AND THE CONTROL GROUP

	The number (%) of women		$\chi^2$	p
	Experimental group (n=154)	Control group (n=77)		
Education			11.05	0.004
Elementary	20 (13.0)	9 (11.7)		
Secondary	108 (70.1)	40 (51.9)		
Higher	26 (16.9)	28 (36.4)		
Employment status			4.89	0.180
Employed	56 (36.4)	38 (49.4)		
Unemployed	72 (46.8)	31 (40.3)		
Temporarily employed	15 (9.7)	3 (3.9)		
Retired	11 (7.1)	5 (6.5)		
Economic status			17.51	<0.001
Low	40 (26.0)	5 (6.5)		
Medium	96 (62.3)	51 (66.2)		
Good	18 (11.7)	21 (27.3)		
Marriage			4.035	0.133
First	152 (98.7)	74 (96.1)		
Second	2 (1.3)	1 (1.3)		
Third	0 (0)	2 (2.6)		
Duration of marriage			4.682	0.197
Up to 10 years	22 (14.3)	18 (23.4)		
10–20 years	46 (29.9)	24 (31.2)		
20–30 years	56 (36.4)	19 (24.7)		
Over 30 years	30 (19.5)	16 (20.8)		
The number of children			3.294	0.349
No children	7 (4.5)	4 (5.2)		
One	17 (11.0)	15 (19.5)		
Two	77 (50.0)	33 (42.9)		
Three or more	53 (34.4)	25 (32.5)		

**TABLE 2**  
SCORES IN THE CAREGIVER BURDEN QUESTIONNAIRE AND THE CAREGIVER BURNOUT INVENTORY OF WIVES OF PTSD AFFECTED VETERANS AND WIVES OF VETERANS WITHOUT PTSD

Caregiver burden and burnout	Score ( $\bar{X}\pm SD$ )		t	p
	Experimental group (n=153)	Control group (n=77)		
Objective caregiver burden	24.33±3.52	19.35±4.29	9.39	<0.001
Subjective demand burden	14.84±3.20	10.39±3.10	10.07	<0.001
Subjective stress burden	16.89±2.26	11.17±3.22	15.64	<0.001
Burnout	12.42±7.18	4.60±5.01	8.57	<0.001

A-1 and A-2. As for the other two variables (subjective demand burden and subjective stress burden), group A-1 had significantly higher scores than the other two groups, while group A-2 had significantly higher scores than group B.

The burnout variable also pointed to significant differences among the three groups of women. Subsequent analyses (LSD test) indicated that women from group A-1 had significantly higher results than women from

the other two groups, while women group A-2 had significantly higher scores than women in group B (Table 3).

### Discussion

Wives of veterans suffering from PTSD are exposed to greater burden of life and suffer from stronger cumulative physical, emotional and behavioral effects of prolonged stress, i.e. burnout when compared to wives of

**TABLE 3**  
DIFFERENCES BETWEEN COUPLES WITH PTSD AND COUPLES WITHOUT PTSD REGARDING THEIR SCORES IN THE CAREGIVER BURDEN QUESTIONNAIRE AND CAREGIVER BURNOUT INVENTORY

	$\bar{X} \pm SD$			F	p
	men and women with PTSD – A-1 (n=62)	men with PTSD, women without PTSD – A-2 (n=92)	men and women without PTSD – B (n=72)		
Objective burden	24.89±4.11	23.97±3.00	19.15±3.94*	50.65	<0.001
Subjective demand burden	15.52±3.21	14.40±3.10	10.25±3.06‡	55.21	<0.001
Subjective stress burden	17.53±2.12	16.44±2.23	11.04±3.20‡	131.15	<0.001
Burnout in relationships	16.95±5.51	9.41±6.49	3.82±4.35‡	91.33	<0.001

\* Men and women without PTSD significantly differ from the other two groups. LSD test ( $p < 0.001$ )

‡ All the groups significantly differ in the mean value. LSD test ( $p < 0.05$ )

veterans without PTSD (Table 2). The situation is aggravated when the wife also suffers from PTSD. It has been determined that two out of three variables of caregiver burden (subjective demand burden and subjective stress burden) and burnout are significantly higher if both of the partners suffer from PTSD than in the cases when only the veteran has PTSD.

These results correspond to the results of other research on the effect of veteran's PTSD on his family members<sup>4,7,10,13</sup> and suggest that the veteran's PTSD is directly related to specific psychosocial and physical problems of their wives. Given the years of exposure to many difficulties of life with a veteran suffering from PTSD<sup>5,8,9,13</sup>, this result does not come as surprise, but points out the stress of being married to man suffering from PTSD.

As previously stated, the veteran's PTSD causes damage to family life in many ways<sup>4-6,8,9</sup>. For instance, joint impact of numbing and avoidance symptoms on family life of a veteran creates emotional emptiness and serious functional loss to their wives too<sup>24</sup>. Bad anger management, aggression and family violence also present real and serious problems<sup>5,8,13</sup>. Owing to the veteran's dysfunction at work<sup>25</sup>, the burden falling on the wives also include financial difficulties, which is confirmed by our results of a significantly higher number of wives of PTSD affected veterans that have a lower economic status, while the wives of veterans without PTSD have a significantly higher economic status.

Scaturo i Hardoby wrote of »blocking pathologies« in couples where one of the partners has PTSD<sup>26</sup>. Mason described her own behavior and behavior of other wives of Vietnam veterans as »codependent«, i.e., wives take on the responsibility of resolving their husbands' problems<sup>27</sup>. Guilt, low self-esteem and fear, as well as mixed feelings of responsibility towards their husbands, children and social community, leads them into taking over the role of the »responsible person« or the family »caretaker«<sup>28-30</sup>. The extent of the wives' shouldering the responsibility depends on their education level, the level of their relationship dedication, the will for the struggle against difficulties and the changes in her own self in the progress of coping with problems<sup>31</sup>.

Given the fact that traditional cultures, such as ours, often view women as homekeepers, and this is often the way the women view themselves, they tend to take over the most of, or all the responsibilities, in order to maintain the family's well being and emotional security<sup>27-29</sup>. However, their efforts in fulfilling the roles traditionally pertaining to men often become counter-productive and cause additional stress. Unpredictable and distrustful due to their illness, their husbands may think that the wives consider them incapable<sup>30,32</sup>, even though they contribute to the changes in role distribution by their passivity and neglecting of their duties<sup>33</sup>. If there are children in the family, the wife is trying to help them understand the unpredictable behavior of their father who has PTSD, and protect them from an imaginary or actual danger posed by their father<sup>27,34</sup>. In any case, the wife's effort to understand and explain her husband's behavior builds up her own stress. Moreover, the wives of veterans with PTSD often believe that they have no rights to ask for support. A lack of available support or assumption of her own weakness (»I wasn't capable of helping my husband«) holds them back from getting the necessary help, which contributes to a chronic feeling of insecurity and loneliness. Finally, the situation brings them to a condition of psychophysical exhaustion typical for the wives of PTSD affected veterans. Although the condition of psychophysical exhaustion is not a diagnostic entity, it is definitely correlated with many physical<sup>35,36</sup> and mental illnesses<sup>3,37</sup>.

In cases where the wife also suffers from PTSD, her abilities of helping her husband are narrowed, since her emotional response is reduced by the same psychopathology as of her husband. As a result, the feeling of subjective demand burden and subjective stress burden is stronger in women when both partners have PTSD. However, it has to be noted that there is no difference in objective caregiver burden between couples in which both partners suffer from PTSD and couples in which only the veteran has PTSD. Caregiving in terms of taking on most of family responsibilities and often providing financial security is obviously on the wife's shoulder, regardless of her own mental condition. She is expected to assume most of the family duties regardless of her condi-

tion. Nevertheless, in cases where the wife also suffers from PTSD, she has insufficient personal capacities for an adequate coping with mental demands and suffers from a lack of support, especially the lack of husband's support. Her dysfunction becomes another source of stress, since most often there is nobody else who would take on her family role. This leads to increased feelings of subjective burden and stress and a lack of support, which, in turn, produce a stronger chance of burnout.

This study contains several potential limitations, among which is relying only on self-assessment of veteran wives' psychophysical exhaustion, without clinical assessment. Relatively small number of respondents and a reduced scope of the research limit the possibility of generalizing our results. Furthermore, it is hard to come to complete causal conclusions considering the fact that

this is a cross-sectional study. Inhomogeneous sample in several demographic variables which can serve as mediators and modify the effect of veterans' PTSD on the wives also limits the possibility of generalization. However, identified demographic differences between the groups of respondents were expected, since the veterans with and without PTSD were used as the starting point in the sample formation.

The future research on the issue should certainly include more factors, such as the intensity of the veteran's PTSD symptoms, or family violence, which can heavily affect the level of caregiver burden and burnout. Finally, we can come to the conclusion that living with a veteran suffering from PTSD places a heavy burden on the wife and poses a serious risk of burnout, which has to be borne in mind in treatment planning.

## REFERENCES

1. DUNKIN JJ, ANDERSON-HANLEY C, *Neurology*, 51 (1998) 53.
2. WALTON-MOSS B, GERSON L, ROSE L, *Issues Ment Health Nurs*, 26 (2005) 627.
3. LOUKISSA DA, *Journal of Advanced Nursing*, 21 (1995) 248.
4. BECKHAM JC, LYTEL BL, FELDMAN ME, *J Consult Clin Psychol*, 64 (1996) 1068.
5. BECKHAM JC, FELDMAN ME, KIRBY AC, HERTZBERG MA, MOORE SD, *J Clin Psychol*, 53 (1997) 859.
6. DEKEL R, SOLOMON Z, *J Fam Psychol*, 20 (2006) 709.
7. GALOVSKI T, LYONS JA, *Aggression and Violent Behavior*, 9 (2004) 477.
8. CHRYSOS ES, TAFT CT, KING LA, KING DW, *Violence Vict*, 20 (2005) 549.
9. DEKEL R, GOLDBLATT H, KEIDER M, SOLOMON Z, POLLACK M, *Fam Relat*, 54 (2005) 24.
10. CALHOUN PS, BECKHAM JC, BOSWORTH HB, *J Trauma Stress*, 15 (2002) 205.
11. PINES AM, ARONSON E, *Career burnout: Causes and cures* (Free Press, New York, 1988).
12. WILLIAMS CM, *The veteran system with a focus on woman partners*. In: WILLIAMS T (Ed) *Post-traumatic stress disorders: A handbook for clinicians* (Disabled American Veterans, Cincinnati, 1987).
13. FIGLEY CR, *Burnout as systemic traumatic stress: A model for helping trauma-tized family members*. In: FIGLEY CR (Ed) *Burnout in Families: The Systematic Costs of Caring* (CRC Press, New York, 1998).
14. FIGLEY CR (Ed) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (Brunner/Mazel, New York, 1995).
15. KLARIĆ M, KLARIĆ B, STEVANOVIĆ A, GRKOVIĆ J, JONOVSKA S, *Croat Med J*, 48 (2007) 167.
16. BABIĆ D, SINANOVIĆ O, *Psychiatr Danub*, 16 (2004) 137.
17. KLARIĆ M, *Vicarious traumatization in war veterans' spouses suffering from posttraumatic stress disorder*. In: *Croat* (University of Rijeka, Rijeka, 2008).
18. KLARIĆ M, FRANČIŠKOVIĆ T, KLARIĆ B, KVESIĆ A, ANA KAŠTELAN A, GRAOVAC M, DIMINIĆ LISICA I, *Croat Med J*, 49 (2008) 491.
19. EWING J, *JAMA*, 252 (1984) 1905.
20. SALGANIK MJ, HECKATHOM DD, *Sociol Methodol*, 34 (2004) 193.
21. HARVARD PROGRAM IN REFUGEE TRAUMA, *HTQ-Harvard Trauma Manual* Bosnia-Herzegovina Version (Harvard, MA, 1998).
22. MONTGOMERY RJV, GONYEA JG, HOOYMAN NR, *Family Relations*, 34 (1985) 19.
23. MASLACH C, JACKSON SE, *Maslach Burnout Inventory* (Consulting Psychologists Press, Palo Alto, 1984).
24. ROSENHECK R, THOMSON J, *Fam Process*, 25 (1986) 559.
25. SAVOCA E, ROSENHECK R, *J Ment Health Policy Econ*, 3 (2000) 199.
26. SCATURO DJ, HARDOBY WJ, *Mil Med*, 153 (1988) 262.
27. MASON PHC, *Recovering from the war: A woman's guide to helping your Vietnam veteran, your family, and yourself* (Viking Penguin, New York, 1990).
28. VERBOSKY SJ, RYAN DA, *Issues Ment Health Nurs*, 9 (1988) 95.
29. COUGHLAN K, PARKIN C, *J Psychosoc Nurs Ment Health Serv*, 25 (1987) 25.
30. SOLOMON Z, *Psychiatry*, 51 (1988) 323.
31. GILBERT K, *Understanding the Secondary Traumatic Stress of Spouses*. In: FIGLEY CR (Ed) *Burnout in Families: The Systematic Costs of Caring* (CRC Press, New York, 1998).
32. BLEICH A, GARB R, KOTTLER M, *Br J Psychiatry*, 148 (1986) 493.
33. DEFAZIO VJ, PASCUCI NJ, *J Contemp Psychother*, 14 (1984) 76.
34. MATSAKIS A, *Vietnam wives: Women and children surviving life with veterans suffering post traumatic stress disorder* (Woodbine House, Kensington, 1988).
35. BECKHAM JC, BURKER EJ, RICE JR, TALTON SL, *Behav Med*, 20 (1995) 171.
36. DRAPER BM, POULOS CJ, COLC AM, POULOS RG, EHRLICH R, *J Am Geriatr Soc*, 40 (1992) 896.
37. MANGUNO-MIRE G, SAUTTER F, LYONS J, MYERS L, PERRY D, SHERMAN M, GLYNN S, SULLIVAN G, *J Nerv Ment Dis*, 195 (2007) 144.

M. Klarić

Department of Psychiatric, Faculty of Medicine, University of Mostar, Mostar, Bosnia and Herzegovina  
e-mail: klariemiro@gmail.com

## TERET ŠKRBNIKA I PREGORIJEVANJE U PARTNERSKIM ODNOSIMA SUPRUGA VETERANA S KRONIČNIM POST-TRAUMATSKIM STRESNIM POREMEĆAJEM

### SAŽETAK

Veterani s kroničnim post-traumatskim stresnim poremećajem (PTSP-om) imaju značajne poteškoće i u društvu, profesionalnom i obiteljskom funkcioniranju. Stoga i njihove supruge često postaju posrednim žrtvama izmijenjenosti i nefunkcionalnosti svojih partnera. Cilj ovog istraživanja bio je ispitati teret skrbnitstva i stupanj pregorijevanja u partnerskim odnosima kod suprugova veterana s PTSP-om, posebice kada i one same imaju PTSP. Ispitnu skupinu činilo

je 154 supruga/partnerica veterana koji se zbog PTSP-a uzrokovanog ratnom psihotraumatizacijom liječe u KB Mostar, a kontrolnu skupinu činilo je 77 supruga/partnerica ratnih veterana koji nemaju PTSP. U istraživanju je korišten Opći demografski upitnik, Harvard trauma upitnik-verzija za BiH, Upitnik procjene tereta skrbnika (Caregiving and the Experience of Subjective and Objective Burden) i Upitnik pregorevanja (Maslach Burnout Inventory). Rezultati su pokazali da su Supruge veterana s PTSP-om postigle značajno više rezultate na svim subskalama upitnika tereta skrbnika i na upitniku pregorevanja u partnerskim odnosima. U situacijama kada oba partnera imaju PTSP teret subjektivnih zahtijeva i subjektivnog stresa, te pregorevanje u partnerskim odnosima značajno su veće u odnosu na parove gdje PTSP ima samo veteran, ili kada partneri nemaju PTSP. Na osnovu dobivenih rezultata možemo zaključiti da život uz veterana koji boluje od PTSP-a predstavlja ozbiljan teret njihovim suprugama i veliki rizik od pregorevanja, a što treba imati u vidu kod planiranja terapijskih programa.