Jacqueline Jones PhD RN FAAN

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Protocol for qualitative metasynthesis of Posttraumatic Growth (PTG) at the intersection of nursing and veteran and military health care.

Introduction

Suicidal ideation and harm to self within the US military and veteran population are skyrocketing. It is thought approximately 30,177 active-duty service members and war veterans of the post 9/11 wars have died by suicide (Suitt, 2021). Post-traumatic stress disorder (PTSD) is a psychiatric classification (DSM V), often with co-occurring depression and anxiety, that may be seen as a consequence of trauma from combat conflicts such as Iraq or Afghanistan (OIF/OEF) and historically, the Vietnam war. Data such as '22 veterans die by suicide every day or one every 60 minutes' have fueled pre and postvention community mental health initiatives to stem the tsunami of loss (Beehler et al. 2021). Not all veterans seek care with the VA and not all military persons and their families are exclusively served by Tricare in the US. Thus, military and veteran risk of harm to self or others is not the exclusive domain of veteran and military health care providers. Nurses will encounter veterans, military, and their family members wherever nurses work. However, contemporary thought suggests life altering trauma can also lead to posttraumatic growth.

Posttraumatic Growth

Posttraumatic growth (PTG) is a concept that was identified by Tedeschi and Calhoun (1996). It was coined " to refer to positive personal changes that may result in one's struggle to deal with trauma and its psychological consequences" (p415). For PTG to be possible, a traumatic event that is encountered must be considered seismic or significant enough to shake their core beliefs and assumptions about the world (Tedeschi and Calhoun 2004). Shattered world assumptions and the cognitive and emotional processes that develop alongside can also help trauma survivors rebuild their lived realities.

Contemporary theory of PTG moves beyond psychological labels to embrace existential and social construction of suffering and meaning in being human even in the most extreme circumstances. Drawing on Viktor Frankl, Tedeschi et al posit, 'what matters, therefore, is not the meaning of life in general but rather the specific meaning of a person's life at a given moment (2020, p21)'. The struggle of the individual to grapple with life and meaning in light of seismic trauma is the soil within which PTG arises.

Human (existential) growth and distress can and do coexist simultaneously during the process of PTG without negative meaning (Tedeschi, Calhoun and Cann 2007). PTSD and PTG can develop from the same trauma and they can coexist together. PTSD is not required for PTG, but PTG may arise from PTSD; they are not polar opposites. PTG is a complex universal personal phenomenon that is 'both an outcome (i.e., positive changes) and a process that someone goes through over time (2020, p7).' It can occur without professional care but being human in providing care (Watson 2018) can augment and facilitate the process. This is firmly within the

domain of nursing, its metaparadigm of health, nurse, environment and person, ultimately fostering healing and growth. Caring science as a theoretical lens for nursing helps orient nurse facilitation of PTG to nurse presence and to the practice of nursing being grounded in human connections (Watson 2018). Tedeschi and colleagues (2020) argue veterans and military persons offer a unique window to posttraumatic growth because of a 'culture rife with struggle yet abundant with growth (p67).' This text, *Transformed by Trauma,* was written prior to the COVID-19 pandemic but lays out a contemporary landscape for PTG thought and experiences.

The field of PTG has been expanded and practice interventions developed to facilitate PTG in veterans and military persons. "Perceived growth within the military has been associated with lower levels of depression, stress and suicidal ideation, optimal physical health and psychological functioning (Moore and Penk, 2018, p. 418)." Current research suggests that PTG can serve as a protective factor against PTSD in recent trauma up to about 2 years post-event. PTG can also result in a level of functioning that exceeds or is better than their pre-trauma state when viewed as an ongoing process rather than a static goal (p.421). Ali and colleagues (2021) argue there is an interplay of cumulative effects of shared trauma where resilience and growth are also part of transgenerational, contextual, and, historical contexts. They further argue the COVID-19 pandemic has produced a shared trauma experience resulting in PTSD and PTG opportunities.

Collective trauma is defined 'as being closely tied to impacted social identity… a soul wound (Ali et al. 2021, p, 2)' and a collective stressor with impacts on individual mental health. Military

culture and historical combat trauma are initial 'shared experience' examples of how PTG can be used to augment current community prevention and postvention military initiatives around the risk of harm to self and others. PTG can be used to help individuals move beyond the struggle of surviving to thriving with new meaning and life purpose.

A powerful simultaneous historical context and 'soul wound' is that nurses, in their work towards facilitating healing and growth in others, are also themselves experiencing shared trauma, and shared growth, and have the potential for their own PTG as individuals. The International Council of Nurses identified that nurses during the COVID-19 pandemic were experiencing 'unprecedented levels of stress, high risk for full-blown stress response syndromes, anxiety, depression, post-traumatic stress disorder, chronic illness and burnout' (Barnett 2021).

The intersection of nursing and veteran and military health care in a *post*-pandemic world occurs in the nurse-patient interaction. Therefore, we can also glean lessons about how nurses can facilitate PTG by looking to research on their PTG as nurses providing nursing care during this complex time. Shared growth refers to 'positive effects of a shared traumatic reality on health care [professionals] providers beyond resilience to the insult' (Ali et al. 2021, p2). Nurses can walk the line of 'humble expert companion' which is suggested by Tedeschi as an essential posture needed to facilitate PTG rather than that of an authoritarian professional. We can learn about what it means to be an expert companion by looking at nurses' lived experiences of PTG

during the pandemic to augment knowledge of PTG across veterans and military persons' research.

Qualitative research focuses inquiry on the situated meaning of experience and the context of multiple realities that can be constructed and re-constructed through sharing of that experience by persons. It provides the context within which lived experiences are interpreted. Qualitative research exists on the experience of posttraumatic growth, some focused on veterans or military persons yet more recent examples (2020-2022) include nurses themselves who have worked through the shared trauma of the COVID-19 pandemic. The aim of this qualitative metasynthesis is to answer the research question, 'How can nurses facilitate posttraumatic growth in veterans and military personnel?'

Methods

Our well-established four-step qualitative metasynthesis will be used to bring together primary qualitative research (Goins, 2014) and is reported using international Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) standards (Tong, 2012). Using a critical realist perspective, each published primary study is considered a data unit as an interpretive research act and is taken as a whole with socially constructed multiple realities expressed through language. The metasynthesis study steps are 1). Structured research question and search strategy; 2) Data immersion and quality review (McMaster tool); 3) Thematic synthesis (Thomas and Harden 2008); 4) Reciprocal translation and interpretation. Reflexive team-based analytic approaches provide data and investigator triangulation. The final team composition will

add to the interpretive credibility of the meta-synthesis findings. The proposed multidisciplinary team: include: Jacqueline Jones PhD RN, (VMHC student, Caritas Coach) Mona Pearl-Treyball PhD RN, (VMHC faculty, veteran), research librarian (TBC), Emma Baker BS, MSW, LCSW (Behavioral Health DOD, Military Spouse).

The team will meet in cycles over 5-8 weeks to analyze the data set of primary qualitative research studies. Each investigator will review a subset of primary research articles for research quality using the McMaster tool. This provides a characterization of each study and the results will constitute Table 1- study characteristics. Each study is reviewed and discussed in pairs and then the team decides on the final inclusion or exclusion, characteristics, and preliminary patterns of meaning. Each study is considered as an individual study then within and cross-study analysis across the whole dataset will occur.

A line by line approach is taken initially for each study by each investigator ('first order'). Descriptive themes ('second order') are then developed using a team-based inductive-deductive analytic toolkit informed by Thomas and Harden's (2008) approach to thematic synthesis. Key concepts from individual studies are taken and 'recognized' within other studies not in the exact words but as a 'line of argument or conceptual idea'. The most important work is that of going beyond each study and creating a synthesis of new knowledge. Thorne et al. state, 'metasynthesis are integrations that are more than the sum of the parts…they offer novel interpretations of findings. These interpretations will not be found in any one research report but rather are inferences derived from taking all of the reports in a sample as a whole (2004, p

1358)'. Descriptive themes are developed by close reading and staying close to the data while analyzing for the research question. The whole article is read including the background and introduction, results including any participant quotes, and then the discussion and conclusions. Analytic themes ('third order') that are more conceptually abstract are then developed based on team discussions and theoretical insights. The analytic themes represent a stage of interpretation that goes beyond the descriptive level where implicit and explicit patterns of meaning are sought. Attention is paid to what is said, not said, included or excluded. The PTG domains are also looked for within each primary study as a complex and layered interpretation of data, sense-making, and PTG theory are interwoven.

Once the team has determined key themes, thematic structure, and definitions, the process of reciprocal back translation of these emergent themes to the original primary research studies will be performed across the dataset to re-contextualize the findings. A final reciprocal translation table will be produced as an evidentiary matrix and audit trail. Once the relationships across the 'third order' analytic themes have been theorized within and across the team, a figure illustrating these relationships will be developed.

Results

An initial search strategy was conducted to prepare this protocol. The following search terms were used: veteran, military, nurs*, posttraumatic growth, and qualitative research. All subsets of keywords and mesh terms associated with the above descriptors were used in PubMed, Google Scholar, and online databases at the University of Colorado Strauss library. Hand

searching strategies were also used to augment the structured database search including author names, research study groups, and references from articles retrieved. Further refinement of the search strategy will occur with consultation with our research librarian, e.g. Ben Harnke.

The total yield from the first search strategy conducted from April-May 2022 was 6825 articles. Each title and abstract from the primary yield was reviewed for duplicates, if they included veterans or military, or nurses as study participants, and if they were a primary qualitative research study. All qualitative research approaches are acceptable for inclusion within a qualitative metasynthesis. Mixed methods research and reviews were excluded from this qualitative metasynthesis. Mixed methods synthesis employs different synthesis strategies and components relying on both qualitative and quantitative elements, and if adequate mixed methods analysis has occurred, there will be little or no direct contextual meaning from qualitative data alone available for analysis there. No time limit was applied to the dataset although consideration of the development of PTG in 1996 could be applied as a limiting factor. With the onset of the COVID-19 pandemic in 2020, there is evidence of a proliferation of shared trauma-related research on health professionals and nurses in particular. From 2021 key research teams such as Charnley et al. were publishing rapidly to ensure any interventions that were being deployed were available to other organizations to ameliorate the impact of trauma-related stress.

An initial dataset of 15 primary qualitative research studies has been identified. A sample size of 3-20 primary research studies is common and considered adequate to conduct a qualitative metasynthesis. Although many qualitative metasynthesis reports are published with 5-8 studies only. Once the team of investigators meets and commences the structured review process this number may vary. A PRISMA diagram illustrating the final yield and decision tree will be produced after consultation with the research librarian.

The Theory of PTG (Tedeschi et al 2020, p17-20) suggests people can grow in one or more of five different areas that can be referred to as domains of growth. These are: personal strength; relationships with others; new possibilities; appreciation for life; and spiritual and existential change. As individuals can grow across many domains interpretive analysis will not limit PTG to strict thematic boundaries. A synthesis of PTG domains and the 10 Caritas Processes from Watson (2018) will be performed. These Caritas Processes (#) are:

#1: Practicing Loving-Kindness, Compassion and Equanimity Toward Self and Others

#2: Being Authentically Present: Enabling Faith/Hope/Belief System; Honoring Subjective Inner Life-World of Self and Others

#3: Cultivating One's Own Spiritual Practices; Deepening Self-Awareness; Going Beyond Ego-Self

#4: Developing and Sustaining a Helping/Trusting Authentic Caring Relationship

#5: Being Present to, and Supportive of, the Expression of Positive and Negative Feelings

#6: Creatively Problem-Solving, 'Solution Seeking' Through Caring Process

#7: Engaging in Transpersonal Learning Within Context of Caring Relationship; Staying Within Others' Frame of Reference

#8: Creating a Healing Environment at All Levels

#9: Assisting with Basic Needs as Sacred Acts, Touching Mind/Body/Spirit of Others; Sustaining Human Dignity

#10: Opening to Spiritual, Mystery and Unknowns; Allowing for Miracles

Summary

The thematic structure and patterns of meaning identified in this qualitative metasynthesis will provide a framework to guide nurses in their practice when working alongside veterans, military persons, and their families. A caring science lens provides a nursing perspective to the phenomenon of PTG and how nurses can facilitate such growth within the nurse-patient encounter. Together, caring science, Caritas processes and the PTG framework will also provide an opportunity for nurses to recognize healing for themselves in PTG work.

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