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Anger, PTSD, and the nuclear family: A study of Cambodian refugees

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ABSTRACT

This study profiles the family-directed anger of traumatized Cambodian refugees, all survivors of the Pol Pot genocide (1975–1979), who were patients at a psychiatric clinic in Lowell, MA, USA. We focus on the nuclear family (NF) unit, the NF unit defined as the patient's "significant other" (i.e. spouse or boyfriend/girlfriend) and children. Survey data were collected from a convenience sample of 143 Cambodian refugee patients from October 2006 to August 2007. The study revealed that 48% (68/143) of the patients had anger directed toward a NF member in the last month, with anger directed toward children being particularly common (64 of the 143 patients, or 49% [64/131] of the patients with children). NF-type anger was severe, for example, almost always resulting in somatic arousal (e.g., causing palpitations in 91% [62/68] of the anger episodes) and often in trauma recall and fears of bodily dysfunction. Responses to open-ended questions revealed the causes of anger toward a significant other and children, the content of anger-associated trauma recall, and what patients did to gain relief from anger. A type of cultural gap, namely, a linguistic gap (i.e., the parent's lack of English language skills and the child's lack of Khmer language skills), seemingly played a role in generating conflict and anger. NF-type anger was associated with PTSD presence. The effect of anger on PTSD severity resulted in part from anger-associated trauma recall and fears of bodily dysfunction, with 54% of the variance in PTSD severity explained by that regression model. The study: 1) suggests that among traumatized refugees, family-related anger is a major clinical concern; 2) illustrates how family-related anger may be profiled and investigated in trauma-exposed populations; and 3) gives insights into how family-related anger is generated in such populations.

Introduction

The current study investigates anger, specifically the anger of traumatized Cambodian refugees directed toward family members. All patients attended a psychiatric clinic in Lowell, MA, USA, and all were survivors of the Pol Pot period. The Pol Pot genocide occurred from 1975 to 1979, during which about 1.7 million of Cambodia's 7.9 million people died, a quarter of the population; death resulted from execution, starvation, overwork, and illness. Owing to having survived these and other traumas (e.g., living in dangerous refugee camps), Cambodian refugees have high rates of psychiatric disorders. In one study, 56% of the Cambodian refugees attending an outpatient psychiatric clinic had PTSD, and the PTSD scores were quite high (on the Clinician-Administered PTSD Scale; Hinton, Chhean, Pich, Pollack, et al., 2006); in another study, 60% had panic disorder (Hinton, Ba, Peou, & Um, 2000).

Anger appears to play an important role in the psychopathology of traumatized Southeast Asian refugees. In one study, Southeast Asian refugees with PTSD had significantly higher scores on the Anger Reaction Index, including higher levels of both expressed and experienced anger (Abe, Zane, & Chun, 1994). In a study of Vietnamese refugees using the Symptom Checklist (SCL), of the 9 items that were able to differentiate between patients with and without PTSD, 3 were anger items (Hauff & Vaglum, 1994). In a study of Cambodian refugees attending a psychiatric clinic, the patients had elevated rates of anger and much anger associated autonomic arousal, with 58% of the patients with PTSD having anger episodes causing enough somatic arousal symptoms (e.g., palpitations) to meet panic-attack criteria; and they had many catastrophic cognitions about the somatic

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symptoms induced by anger, including culturally specific concerns, such as that the neck vessels might rupture (Hinton, Hsia, Um, & Otto, 2003).

In the study of anger among Cambodian refugees discussed above (Hinton et al., 2003), the authors did not investigate the cause of anger episodes, or whether anger triggered recall of trauma events. Our clinical experience with Cambodian refugees would suggest that anger is often directed toward spouse and children, that the anger is severe (e.g., associated with extreme somatic arousal: palpitations), and that the anger often triggers trauma recall. Anger is a one of the 14 DSM–IV diagnostic criteria for PTSD (First, Spitzer, & Gibbon, 1995), and trauma's main impact on local social worlds may be through anger. The few studies that have examined the effect of anger among trauma victims at the level of the family have only investigated anger directed toward a spouse (see, e.g., Taft, Street, Marshall, Dowdally, & Riggs, 2007); none have examined anger directed toward children. The lack of studies of anger's effect on the family unit of traumatized populations represents a major gap in the literature.

To address this gap in the literature, the current study examines the anger of Cambodian patients directed toward family members, specifically nuclear family (NF) members, here defined as the "significant other" (i.e., spouse or boyfriend/girlfriend) and children. To investigate family-directed anger, we developed an approach informed by the psychological literature on anger (Berkowitz, 1999; DiGiuseppe & Tafrate, 2007; Novaco & Chemtob, 2002) and anthropological theories of emotion (Shweder, 2004). In addition, the approach was influenced by the literature demonstrating that "generational dissonance" (Smith-Hefner, 1999), a difference in acculturation between the first and second generation, may be a key issue in Cambodian diaspora communities, and by our clinical experience showing a linguistic gap to be a key problem in conflict resolution.

Based on this literature review and our clinical experience, we undertook a multidimensional, psycho-sociocultural examination of NF-type anger of Cambodian refugees attending a psychiatric clinic. We determined the number of patients having experienced anger toward NF members in the previous month, whether the source of anger was a significant other or a child, asked the reasons for becoming angry at a NF member, and assessed anger along several dimensions (viz., intensity, frequency, somatic arousal, and acting-out behaviors). To further profile anger episodes, we also investigated whether anger resulted in trauma recall, the content of that trauma recall, and whether anger caused concerns about bodily dysfunction. If the conflict involved a child, we examined whether the child's lack of proficiency in the Cambodian language, conjoined with the parent's lack of English ability, impeded conflict resolution. And we asked patients what they did to gain relief from the anger episode. We also determined the rate of PTSD, its association with NF-directed anger, and whether the effect of anger on PTSD severity resulted in part from anger-associated trauma associations and catastrophic cognitions. [We performed these regression analyses, for one, because previous studies of Cambodian refugees indicate that the effect of panic attacks on PTSD severity results in large part from trauma recall triggered by those panic attacks (Hinton, Chhean, Pich, Um, et al., 2006), and anger episodes, which often trigger strong arousal, would be expected to demonstrate a similar pattern; and second, because catastrophic cognitions about the somatic symptoms in anger episodes would be expected to result in panic-disorder-like panic attacks and a sense of vulnerability, both of which have been shown to worsen PTSD (Clark, 1999; Hinton, Chhean, Pich, Pollack, et al., 2006; Hinton & Good, 2009)].

Methods

Participants

All patients received treatment at a psychiatric clinic in Lowell, MA, home to approximately 30,000 Cambodians, the second largest Cambodian population in the United States. Upon first presenting to the clinic, all patients have PTSD, with comorbid anxiety and depression; very few have bipolar or schizophrenia disorder (<5%). The vast majority (over 90%) are unemployed, many receiving disability benefits. For the current study, we aimed to obtain a sample of at least 60 patients with NF-type anger, and estimated (based on preliminary screenings of rates) that a final sample size of over 140 patients would be needed. Inclusion criteria were having passed through the Pol Pot period and being at least 6 years old at its beginning (in 1975), being clinically stable and not pregnant, and not having a bipolar or psychotic disorder. Eight patients were not eligible for participation; 10 eligible patients declined to be surveyed because of time concerns. The study was approved by the clinic's institutional review board, and all patients gave informed consent.

Procedures

During their clinic visit to receive medications at the clinic, consecutive patients were asked whether they wished to participate in the survey. Data collection with 143 Cambodian refugee patients was undertaken from October 2006 to August 2007. All queries were made by the first author, except those regarding the PTSD Checklist, which was administered by the research assistant. The first author is fluent in both spoken and written Khmer. The research assistant was a physician in Cambodia, and has many years of mental health experience working as a bicultural worker.

We asked whether the patient had become angry at a NF member in the last month, and then asked what the NF member had done to cause anger. If the cause of anger was a child, we asked the child's age. To profile anger episodes, we used 8 scales (see the Measures section). If the conflict involved a child, we used three scales to assess the role of a linguistic gap in generating conflict. We asked patients what they did to feel better in the last month after becoming angry at a NF member. Blind to the patient's response to the anger queries, the research assistant administered the PTSD Checklist.

Measures

In total, there were 12 instruments. Eight instruments profiled the anger episodes; 3 assessed the role of a linguistic gap in generating conflict; and 1 assessed PTSD severity. Several of the scales used to assess anger severity were one-item Likert-type scales. Studies indicate that one-item Likert-type scales have good validity and reliability when the items have clear face validity (Davey, Barratt, Butow, & Deeks, 2007), as is the case here.

Anger Intensity Scale

The intensity of the anger caused by NF members in the last 4 weeks was assessed by asking how angry the patient had become, rating the response on a 0–4 Likert-type scale: 0 (*not at all*), 1 (*a little angry*), 2 (*fairly angry*), 3 (*very angry*), and 4 (*extremely angry*).

Anger episode frequency

The frequency of the anger episodes toward NF members in the last 4 weeks was assessed on a 0–4 Likert-type scale: 0 (*never*), 1 (*1 time*), 2 (*2–3 times*), 3 (*1–2 times/week*), and 4 (*almost every day*).