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Anger-associated panic attacks in Cambodian refugees with PTSD; a multiple baseline examination of clinical data

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Abstract

Despite the increasing recognition of the importance of anger as a key aspect of post-traumatic stress disorder (PTSD), the presence of anger-induced panic attacks has been understudied in traumatized groups. The present investigation determines the prevalence of anger-associated panic attacks among Cambodian refugees suffering from PTSD. Specific characteristics of these episodes that were examined included frequency, symptoms, and cognitions (in particular, fear of death from bodily dysfunction). In a survey of 100 Khmer patients suffering PTSD, 58% reported anger-associated panic attacks in the last month. These attacks occurred at a mean rate of 6.2 attacks a month and were characterized by extreme arousal and in 81% of these cases, fears of death due to bodily dysfunction during the anger-induced panic. Mechanisms for this high rate of fear of death during anger arousal are discussed with a focus on culture-specific catastrophic cognitions.

Keywords: Anger; Stress disorder; Post-traumatic; Panic; Cognition; Cambodia; Refugees

1. Introduction

Despite the increasing awareness of anger as an important feature of PTSD (Yehuda, 1999) and the need for specific interventions (Novaco & Chemtob, 1998), rates of anger-related panic attacks have not been determined for a PTSD population. Additionally, several studies—ranging

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from Clark's (1986) original formulation of the 'escalating spiral of panic,' physiological monitoring (Freedman, Ianni, Ettedgui, & Puthezhath, 1985), to practical clinical manuals (Taylor, 2000: p. 235)—indicate that anger may trigger panic attacks marked by fear of death or going crazy. Such a reaction to anger-generated arousal is consistent with the cognitive-behavioral model of panic disorder: autonomic arousal, no matter what the manner of induction (e.g. a change of weather, exercise) (Rapee, Craske, & Barlow, 1994), can trigger a panic response either due to catastrophic cognitions (Clark, 1986) and/or interoceptive conditioning (Barlow, 1988).

PTSD is commonly encountered among the Khmer (Cambodian) refugee group; for example, one study revealed a 92% prevalence in a psychiatric clinic population (Kinzie et al., 1990). From clinical experience, the first author noted that his Khmer patients frequently suffer anger-associated panic attacks. Culture-specific catastrophic interpretations of somatic anxiety symptoms are frequent in the Khmer refugee population (Hinton, Um,& Ba, 2000, 2001a,b,c, in press). Among Cambodian refugees, anger-generated autonomic arousal results in fear of death from three somatic events:

1. cardiac arrest (*geung beh doung*), palpitations thought to indicate a heart abnormality (Hinton et al., in press);
2. bursting of the neck vessels (*dac sosai go)*, anger considered to cause an upsurge of both wind (an air-like substance said to travel along the vessels of the body) and blood toward the neck and head, neck tension, facial warmth, dizziness, and tinnitus interpreted as evidence of increased wind and blood flow to that area (Hinton et al., 2001a); and
3. chest-blood overload (*go chieum*), believed to be caused by a rush of blood to the thorax that then compresses the heart and lungs, impeding the normal heart motions and breathing, chest tightness and shortness of breath interpreted as resulting from an acute increase of blood into the confines of the rib cage.

As part of standard clinical practice, we adopted a more systematic approach to the phenomenon of anger-associated panic attacks. In this case series of Khmer patients suffering PTSD, we explore current one-month prevalence rates of anger-associated panic attacks, monthly frequency in particular patients, anger symptomatology, and the commonality of culturally generated catastrophic cognitions concerning anger-induced autonomic arousal. We hypothesized that anger-associated panic attacks would be prevalent in this population as well as episodes of fear of demise from the associated arousal.

2. Method

2.1. Patients

The patients surveyed, received care at freestanding Southeast Asian clinics located in Lowell and Revere, Massachusetts, and all were in psychiatric treatment with the first author. As part of routine psychiatric visit, the patient was assessed using the PTSD module of the structured clinical interview (SCID) for DSM-IV (First, Spitzer, & Gibbon, 1995). Of a series of 100 patients meeting PTSD criteria, 71 were female (71%). The mean age was 48.4 (standard deviation 4.4; range 35–