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Worry, worry attacks, and PTSD among Cambodian refugees: A path analysis investigation

Devon E. Hinton[a,b,*], Angela Nickerson[a,c], Richard A. Bryant[c]

[a] Massachusetts General Hospital and Harvard Medical School, United States
[b] Arbour Counseling Services, Lowell, MA, United States
[c] School of Psychology, University of New South Wales, Australia

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ABSTRACT

Among traumatized Cambodian refugees, this article investigates worry (e.g., the types of current life concerns) and how worry worsens posttraumatic stress disorder (PTSD). To explore how worry worsens PTSD, we examine a path model of worry to see whether certain key variables (e.g., worry-induced somatic arousal and worry-induced trauma recall) mediate the relationship between worry and PTSD. Survey data were collected from March 2010 until May 2010 in a convenience sample of 201 adult Cambodian refugees attending a psychiatric clinic in Massachusetts, USA. We found that worry was common in this group (65%), that worry was often about current life concerns (e.g., lacking financial resources, children not attending school, health concerns, concerns about relatives in Cambodia), and that worry often induced panic attacks: in the entire sample, 41% (83/201) of the patients had “worry attacks” (i.e., worry episodes that resulted in a panic episode) in the last month. “Worry attacks” were highly associated with PTSD presence. In the entire sample, generalized anxiety disorder was also very prevalent, and was also highly associated with PTSD. Path analysis revealed that the effect of worry on PTSD severity was mediated by worry-induced somatic arousal, worry-induced catastrophic cognitions, worry-induced trauma recall, inability to stop worry, and irritability. The final model accounted for 75% of the variance in PTSD severity among patients with worry. The public health and treatment implications of the study’s findings that worry may have a potent impact on PTSD severity in severely traumatized populations are discussed: worry and daily concerns are key areas of intervention for these worry-hypersensitive (and hence daily-stressor-hypersensitive) populations.

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Introduction

Cambodian refugees have passed through multiple traumas. On April 17, 1975, after a brutal civil war in which perhaps 500,000 Cambodians died and many more were injured, displaced, or impoverished by the fighting, the Khmer Rouge took power. Over the next three-and-a-half years, the Khmer Rouge, a group of Maoist-inspired radicals led by Pol Pot, implemented a series of radical socioeconomic reforms in an attempt to enable Cambodia, renamed Democratic Kampuchea (DK), to make a "super great leap forward" into socialism (Becker, 1998; Chandler, 1991). By the time the Khmer Rouge were overthrown in January 1979 by a Vietnamese invasion, almost a quarter of Cambodia’s eight million inhabitants had died of disease, starvation, overwork, and execution. At the time of the Vietnamese invasion, and afterward, many attempted the difficult journey to refugee camps at the Thai border, some then succeeding in being accepted as refugees to the United States. Once in the US these refugees frequently lived in poor and often violent inner-city locations.

Worry and PTSD

Both generalized anxiety disorder (GAD) and posttraumatic stress disorder (PTSD) occur at high rates following trauma (on this issue, see Ghafoori et al., 2009; Grant, Beck, Marques, Palyo, & Clapp, 2008). Severe trauma often results in a self-perceived state of extreme vulnerability——a sense of constant threat——in which these two disorders are highly comorbid (Neria, Besser, Kiper, & Westphal, 2010). GAD and PTSD share the feature of persistent and generalized bias toward threats in the environment (Barlow, 2002). Both disorders are characterized by rumination and preoccupation with catastrophic cognitions about the possibility of threat; whereas PTSD patients tend to focus on distressing memories and external threats (Ehlers & Clark, 2000), GAD patients

* Corresponding author. Arbour Counseling Services, Lowell, MA, United States
E-mail address: devon_hinton@hms.harvard.edu (D.E. Hinton).

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tend to worry about diverse potential threats (Pineles, Shipherd, Mostoufi, Abramovitz, & Yovel, 2009). Despite these differences in emphasis, patients with PTSD and GAD display a cognitive style involving excessive attention to harm that can potentially result from a variety of sources (Smith & Bryant, 2000). A recently developed treatment for PTSD conceptualizes worry as a key therapeutic target owing to evidence of its central role in worsening the disorder (Roussis & Wells, 2008; Wells & Sembi, 2004).

The role of worry is particularly relevant to refugees suffering PTSD. There is much evidence that refugees are typically exposed to numerous ongoing stressors (e.g., concerns about safety, finances, adequate food, and shelter), and that such post-migration living difficulties contribute to PTSD severity, over and above the psychological impact of past trauma (Beiser & Hou, 2001; Miller & Rasmussen, 2010; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Steel, Silove, Bird, McGorry, & Mohan, 1999). It is crucially important then to examine how worry, which is a key subjective correlate of stressors, relates to PTSD severity.

The panic attack–PTSD model: application to worry

Based on our clinical work with Cambodian patients, we have used the panic attack–PTSD model to conceptualize how worry worsens PTSD among traumatized refugees. We originally formulated the “panic attack–PTSD model” (shorthand for the term “arousal–somatic symptom–panic attack model”) to explain how certain triggers bring about arousal, somatic symptoms, and panic attacks in traumatized groups and how these in turn worsen PTSD (Hinton, Hofmann, Pitman, Pollack, & Barlow, 2008). Such triggers include emotions (e.g., anger: Hinton, Rasmussen, Nou, Pollack, & Good, 2009) and various other somatic-symptom-inducing processes, for example, standing up, startle, or encountering certain smells (Hinton, Hinton, Um, Chea, & Sak, 2002; Hinton et al., 2008; Hinton, Pich, Chhean, Pollack, & Barlow, 2004). Here we summarize the “panic attack–PTSD model,” showing how it can be used to explain how worry worsens PTSD among Cambodian refugees (see Fig. 1 for the model as applied to worry).

1. *Arousability hypothesis*. Among trauma victims, there seems to be a trauma-caused reactivity such that arousal and somatic symptoms are easily induced by multiple triggers. Such triggers range from environmental events (e.g., noises, traveling in a car, smells) to various cognitive-emotional states: anger, worry, stress, a feeling of threat (Adenauer et al., 2010; Hinton et al., 2009; McTeague et al., 2010).
2. *Catastrophic cognitions*. Once a trigger gives rise to somatic symptoms and emotional distress, these in turn may give rise to catastrophic cognitions that further increase arousal. Among Cambodian refugees, worry-induced somatic symptoms are often interpreted as the onset of a *khyâl* attack, which gives rise to fear that *khyâl* (considered to be a wind-like substance) and blood are surging upward in the body where they may cause heart arrest, neck-vessel rupture, and syncope, among other disasters (Hinton, Pich, Marques, Nickerson, & Pollack, 2010). And among Cambodian refugees, emotions are often considered dangerous, for example, worry is thought to cause dangerous weakness and potentially to overheat the brain. These catastrophic cognitions may lead to increased arousal and panic (on worry-induced panic, see also, Wells, 2000).
3. *Emotion-triggered trauma networks*. Emotions may trigger trauma recall and arousal by activating trauma networks (Hinton et al., 2009). This may occur for three different main reasons: (a) the current emotion was present during the original trauma and now acts as a retrieval cue (e.g., fear at the present moment may recall a trauma event that involved the person being afraid and hence has the very emotion of fear as a retrieval cue), (b) the similarity in cognitive appraisal during the current emotion and during the trauma event: worry gives rise to a feeling of imminent danger, which activates related trauma networks; and (c) the emotion brings about arousal and somatic symptoms that then trigger trauma recall (on how somatic symptoms trigger trauma recall, see number 4 below). (In respect to Fig. 1, we show a direct pathway from catastrophic cognitions to trauma recall because we hypothesize that catastrophic cognitions will induce the emotion of fear that then activates trauma memory networks; additionally, as also shown in Fig. 1, we hypothesize that catastrophic cognitions will induce trauma recall by producing somatic symptoms that then trigger trauma recall.)
4. *Somatic-symptom triggered trauma networks*. The somatic symptoms that are triggered by an emotional state, catastrophic cognitions, or other processes (e.g., stress) may activate trauma networks that were encoded by somatic symptoms that occurred during the trauma (Nixon & Bryant,

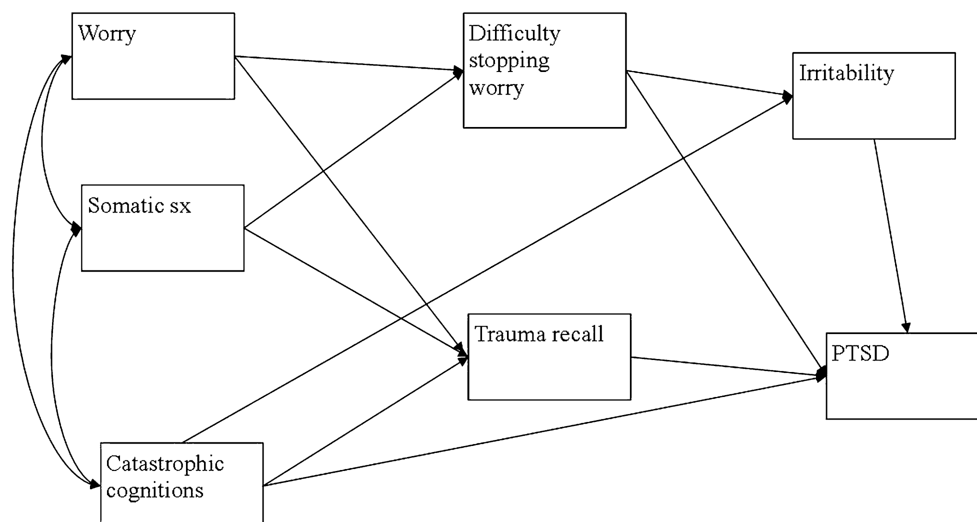

Fig. 1. Model 1 of path analysis from worry, somatic symptoms, and catastrophic cognitions to PTSD.

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