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The Effects of Massive Trauma on Cambodian Parents and Children

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The goal of this chapter is to describe the effects of the Pol Pot trauma on two generations of Cambodians and their families. The time since the end of the Pol Pot era (1979) is still too short to document a second-generation effect, but we now have some data on the psychiatric effects this trauma has inflicted on young and old Cambodians, and the impact refugee status has had on Cambodian family life.

HISTORY OF THE CAMBODIAN TRAUMA

Cambodia, a poor but peaceful country, became involved in the Vietnam War in 1970. It was taken over by radical Khmer Rouge Communists under Pol Pot in 1975, which resulted in an unexpected, massive catastrophe. This brutal regime attempted to isolate the country and replace all Western and traditional influences with a poorly planned agrarian work–concentration camp program. Doctors, teachers, government leaders, Buddhist monks, Chinese, and military leaders as well as their family members were singled out for execution. All other influences were regarded as enemies of the regime and were eliminated. Almost all urban people were moved to tightly controlled country areas and forced into labor. As the list of "enemies" grew when the expected increase in rice production did not occur, the number of executions increased. Disease and starvation killed many more. During the 4 years of Pol Pot, between 1 and 3 million of the 7 million population died (Becker, 1986; Hawk, 1982). The killing ended only with the invasion by the Vietnamese in 1979.

The Cambodian tragedy not only killed individuals but also destroyed the very fabric of Cambodian life and society (i.e., the Buddhist monks, teachers, and government leaders). No one was left untouched by these events, and many became refugees, first in Thailand, then later in a third country (usually the United States, France, or Australia). Our experience over the past 15 years involves those who came to the state of Oregon, in the United States and became

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patients in our Indochinese Clinic. We have also studied a group of young students in the community who did not become our patients.

We began treating primarily Indochinese refugees in 1978 (Kinzie and Manson, 1983). Two years later, we saw the first Cambodians, who seemed different from other refugees; they were more withdrawn, more frightened and affectively numb. Our clinical experience showed that they did not improve with standard treatment for depression, and it took some time before we realized that we were dealing with a severe form of posttraumatic stress disorder (PTSD; Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984). Follow-up study showed that many had improved in 1 year (Boehnlein, Kenzie, Ben, & Fleck, 1985), but all suffered relapses during the next few years. The chronic course of the disorder—with remission, exacerbation of the intrusive symptoms, and marked vulnerability to stress—has been well established (Kinzie, 1988). Continuity of care and medication have been crucial in reducing some major intrusive symptoms. Socialization group experiences also help reduce the social and cultural isolation by focusing on problems these refugees have in adapting to their new country (Kinzie *et al.,* 1988). We have continued to find a very high prevalence of PTSD in Cambodian patients, and also a moderately high level in the Vietnamese (Kinzie *et al.,* 1990).

CULTURE, TRAUMA, MIGRATION, AND FAMILY LIFE

Heller (1982) described how the stressful experience of the Jewish concentration camp survivors greatly influenced their children, who felt an increased sensitivity to culture and ancestry, and to the primacy of ethnic survival.

The family is the primary social unit in all Southeast Asian cultures, with individual identity frequently inseparable from that of the family. Traditional Southeast Asian values include a strong family identity as the foundation of personal identity and self-worth. Elders are placed in roles of authority and are treated with great respect. Their decisions traditionally have gone unquestioned. It was the child's duty (even after reaching adulthood) to follow parents' recommendations. Moreover, elders traditionally were also the first to consult healers when a family member became ill. Attentive, indulgently child rearing from multiple parental figures encourages children to be interdependent, with increasingly strict expectations imposed as they mature (Sack, Angell, Kinzie, & Rath, 1986). The sense of self is defined by the family and the community within which a child lives. Severe trauma, with its symptoms of PTSD and severe depression, although experienced by individuals, has a broad ripple effect on the person's family and social network.

Important precepts of Buddhism strongly influence familial and social norms of communication and behavior in Cambodia. These include correct intent for specific actions, good conduct, honesty, honest effort, and a correct understanding of the sources of unhappiness (Zadrozny, 1955). Religious beliefs also serve as the source of conceptions about the world, the self, and their interrelationship (Geertz, 1973). Basic religious concepts must be considered when attempting to understand the chronic grief of many Southeast Asian families. Ritual mourning of the loss of family members and friends has not been possible for many traumatized refugees (Boehnlein, 1987).

The effects of trauma on individuals—depression, startle reaction, hypervigilance, nightmares, and irritability—greatly affect the way individuals function within the family. Numbness, avoidance, and vulnerability to stress often lead parents to be frightened, confused, or simply uninvested in the basic care of their children.

The effects of trauma (migration and resettlement) on the individual and his or her parents have placed great burdens on family units as a whole and on specific generations within the family. Elders have had to endure diminished status within the family, as well as in society at large, because of a lack of language proficiency, little or no formal education, and no vocational experience transferable to a Western economy. Combined with financial difficulties, these problems have reduced the importance of elders in some "made-up"[1] Southeast Asian refugee families. Cultural conflict regarding what is considered to be retirement ages have a also complicated family matters. In Southeast Asian cultures, elders traditionally are placed in roles of authority because of their age and experience, and reach this status at a relatively early age. They then expect their children to support them financially. Due to greater financial pressure on middle generations in resettlement countries, this has been difficult.

Another significant source of conflict in the refugee family is the relationship between parents and children. Because of the high prevalence of male deaths during the Cambodian trauma, the family unit most often consists of a single parents in a position of authority, most commonly a single mother. For children, the normal developmental struggles of adolescence are heightened by a single parent's diminished authority role. This is further exacerbated when the parents are emotionally disconnected from the children because of psychiatric disorders (PTSD). The children's greater proficiency with the language of the host country and greater access to educational opportunities often lead to a reversal of generational roles within families, with children becoming the cultural brokers and communication facilitators between the nuclear family and the mainstream culture. This transfers much of the authority from elders to the young.

Even the normal life-cycle separation of young adults from the nuclear family represents unique conflicts for refugees. Parents and children have frequently suffered the loss of numerous family members during the war and the process of migration. Surviving family members need to remain particularly close to each other for emotional and physical survival. Anything affecting that closeness may be seen as a threat that can reawaken frighteningly vivid memories of prior losses. This threat may be perceived even in positive transitions, such as marriage, or the move to another city for a better job opportunity. Depression and PTSD, although successfully treated previously, often are exacerbated by these family life-cycle transitions. Dating and marriage may represent additional cultural challenges for young Cambodian adults, because many parents continue to expect to give their approval before their offspring can marry. Interethnic marriages, even among Southeast Asian ethnic groups, frequently are looked upon with displeasure by traditional parents.

Another source of stress for young adult refugees involves separation from the family for educational and career opportunities. Often, the child is faced with choosing between educational opportunities in other locales and traditional loyalties toward the nuclear or extended family. This conflict can be particularly formidable for young women who have been the major care providers for their younger siblings when a single parent has been impaired by illness. Young adults are also saddled with a great deal of emotional pressure because of the enormous expectations for educational performance and financial success their families place on them in the hopes of raising the socioeconomic level of the nuclear family. Drug use, gang activities, and unintended pregnancies may be responses to some young Cambodians' attempts both to acculturate and to improve their family's standard of living. In summary, the

[1]The phrase "made-up" families connotes a family structure often of non-blood-related members, created to substitute for families that were destroyed (Danieli, personal communication, 1997).

individual's psychosocial development is affected by life's transactions, the ongoing stresses of ethnic group acculturation, and family dynamics (Boehnlein, 1987).

Although scant literature exists on longitudinal Southeast Asian refugee family functioning, some studies have examined adjustments by specific generations. Among Vietnamese, for example, parents strongly endorse traditional family values regardless of the amount of time they have lived in the United States, and are ambivalent about privileges for adolescent children (Nguyen & Williams, 1989). A nostalgic orientation to country of origin in adults most likely relates to the severity of stress after resettlement (Beiser, 1987; Beiser, Turner, & Ganesan, 1989). In a recent study, Vietnamese parents reported significantly more difficulties with and problems in their adolescent children than Cambodian parents (Boehnlein *et al.,* 1995). Moreover, Vietnamese were more likely than Cambodians to state that these difficulties and problems adversely affected their health, and that their family life would have been better had they stayed in Southeast Asia. Parents' relationships with their adolescent children had a significant impact on their perceptions of their own health, producing both cognitive and somatic symptoms. This concern existed both with and without evidence of socially disruptive adolescent behavior. A recent longitudinal study of Vietnamese refugees in Norway underscored the significant impact of family factors on long-term adjustment by demonstrating that chronic family separation was a major predictor of long-term psychopathology in resettled refugees (Hauff & Vaglum, 1995). In this study, self-rated distress correlated more closely with chronic separation from a spouse or child than with the severity of a psychiatric disorder.

Clinically, many of the Cambodian families we treated seemed to be "numb" in Danieli's classification (1985). Warmth is lacking and the parents display avoidance and withdrawal behavior, with periodic agitation and irritability. The unrest and tension may lead to domestic violence with spousal and child abuse, alcohol abuse, and dropping out of school.

LONG-TERM EFFECTS OF TRAUMA ON CAMBODIAN CHILDREN

The Cambodian genocide was clearly designed to destroy the basic family structure by separating children from their parents before the ages of 6 to 8, turning young people into informants, forming early teen cadres of armed guards, and publicly and brutally denouncing "crimes" of the older generation. After 4 years of forced labor, starvation, witnessing executions and deaths, and separation from family, many spent several years as refugees in Thailand before migrating to America, France, or Australia. Children arrived in small family groups, very often with no adult males (they had been killed), and almost always had other "missing" family members whose whereabouts had been unknown for years. The following describes our observations of the effects of this trauma and refugee status on Cambodian culture and family.

In 1984, we began to study 40 Cambodian high school students to determine the effects of their experiences, and followed up by interviewing them 3 and 6 years later. Their descriptions of trauma were extremely sad and graphic. Forty-six percent were separated from their family for more than 2 years; 60% of the subjects or their relatives were beaten by cadres; 63% had a parent killed or lost; 63% witnessed killings; 83% suffered malnutrition; 38% were threatened with death (Kinzie, Sack, Angell, Manson, & Ben, 1986).

The average age of the 40 subjects in our original study was 17. They had been in the United States between 1 and 2 years (Kinzie *et al.,* 1986). Interviews were conducted by psychiatrists aided by a Cambodian mental health worker. Fifty percent of the students met the full diagnostic criteria for PTSD, 50% for depression; and 8% for anxiety disorder. Follow-up in-

terviews 3 years later, conducted by the same psychiatrists, revealed that 48% had PTSD, 47% depression, and only one individual (i.e., 4%) had anxiety disorder. A 6-year follow-up using trained lay interviewers demonstrated 38% with PTSD; depression had dropped to 6%. No conduct disorders were found throughout the study. The PTSD diagnosis did not necessarily affect the same subjects (i.e., some cases resolved over time) and a few new ones arose between the first and second study. This confirmed our clinical findings that the course of PTSD will wax and wane over time. At first, we thought that PTSD and depression might be comorbid conditions. In this group, however, depression greatly decreased over time, while PTSD remitted only slightly. Thus, they do have separate clinical courses (Sack *et al.,* 1993).

The family continued to be a source of stress for these young Cambodians. In the 6-year study (average age 23 now), 72% were worried about family left in Cambodia; 31% reported family conflict and family fights over American versus Cambodian ways of doing things. Despite this, our first study (but not subsequent studies) showed that living with family instead of in a foster home afforded some protection against developing PTSD (Kinzie *et al.,* 1986).

COMPARISON OF PTSD AND DEPRESSION IN TWO GENERATIONS OF CAMBODIAN REFUGEES

Rates of PTSD and depression in two generations of Cambodian refugees were examined as part of a large epidemiological study of Cambodian refugees (Sack *et al.,* 1994, 1995). A sample of 209 Khmer adolescents, ages 13 to 25, in two western U.S. communities, Portland and Salt Lake City, was randomly selected to undergo psychiatric assessment. When available, one of the parents, usually the mother, was also interviewed separately. Interviews were conducted in English by a master's level clinician and a Khmer interpreter. The diagnostic portion of the interview was based on the PTSD section of the Diagnostic Instrument for Children and Adolescents (DICA; Welner *et al.,* 1987), as well as sections from the Schedule of Affective Disorders and Schizophrenia for School-Age Children, epidemiological version (Kiddie-SADS-E, Ed. III, Puig-Antich, 1983; Puig-Antich, Orvaschel, Tabrinzi, & Chambers, 1980). The same version of the adolescent interview was also given to the parents, and the results were compared. Four groups were created to compare potential mediating factors of family PTSD concordance: (1 no family or youth PTSD; (2) family only PTSD; (3) youth only PTSD; and (4) parent and youth PTSD. PTSD rates in the mothers were high, 55%, compared with the fathers, 30%, as was depression (20% vs. 14%). The relationship between PTSD in a parent (mother, father, or both) and PTSD in an adolescent was consistently significant. In contrast, the relationship between parent and adolescent diagnoses of major depression and depressive disorder was not found to be significant, although there was a trend in this direction.

A trend for higher PTSD rates among adolescents when both parents were diagnosed with PTSD was also established. When neither parent had PTSD, only 12.9% of youth received the diagnosis. When one parent had PTSD, the adolescent prevalence rate increased to 23.3%. With both parents diagnosed, the rate increased to 41.2% (Sack *et al.,* 1995).

The following case history illustrates the multiple problems that can occur in Cambodian family life due to trauma and refugee experience.

> Pham is a 25-year-old married woman first seen in the clinic 10 years ago. Her husband was also being seen at that time. She was referred because of ongoing depressive symptoms, but her symptoms also included nightmares three or four times a week, along with intrusive thoughts about the past. She lost interest in many things, experienced guilt about the brother she had to leave behind in Cambodia, was angry and irritable, and lost 20 pounds. She had no education and had worked

to help support her family. At age 15, when Pol Pot came to power, she was separated from her family, began forced labor, and faced starvation. She tells of being tied up and severely beaten on the face and hands. Two years later, her father, who had held a minor official position, was executed. Shortly thereafter, her brothers, ages 12 and 9, were killed. Another younger brother starved to death. She remembers the horror she felt in the Pol Pot camp, alone and weak, with no one to care for her. In 1979, she escaped with her younger brother and mother, and went to Thailand. In the Thai camp, she married another Cambodian and gave birth to three children. She arrived in the United States a year before she was seen at the clinic. At that time, she denied any problems with her marriage other than those due to her own irritability.

She was withdrawn, affect constricted, and her expression rarely changed. She shed no tears, even when describing her traumatic events, and displayed no evidence of a thought disorder. She was diagnosed with PTSD and major affective disorder, depressed type. Individual therapy and medication, including imipramine and clonidine, proved helpful, and she also took part in socialization group therapy.

Her husband, Dom, was 31 when first seen. He was very depressed, felt hopeless about trying to fit into this modern country, and expressed some suicidal ideation. He also had been in Pol Pot concentration camps for 4 years, subjected to severe physical harassment, constant starvation, and threats of execution. His parents and six siblings had been executed. Like his wife, Dom was diagnosed with depression and PTSD, and was followed in the clinic, placed on medication, and enrolled in socialization group therapy.

Pham's mother, Chan, came to the clinic 2 years later. She was a depressed 44-year-old woman who had experienced multiple somatic complaints over the past several years. Her symptoms had worsened recently while feeling pressured to search for a job. She felt dizzy, had difficulty concentrating, lost interest in her normal activities, and began having nightmares for the first time. Over and over again, in vivid dreams she would see her husband being tied up and forced underwater as he screamed out her name, but she could not help him. Chan graphically relived the scenario of her children being beaten to death; they, too, called out her name, and she could do nothing to save them. Intrusive thoughts throughout the day made her feel increasingly irritable, and she had a strong startle response to noises. Her future seemed more and more hopeless when she could not force these memories out of her mind.

Augmenting the history given by her daughter, she said that she had borne seven children and was separated from her family in 1975. Apparently, two children died of disease after Pol Pot came to power, and two, as mentioned earlier, were executed. She was cruelly and deliberately told that they had called out her name as they were beaten to death. Her 3-year-old died of starvation. Chan's mother also died of starvation, and her husband was executed in 1976. Chan said that she heard he was shot so many times that his head fell off. Her nightmares centered around her inability to help her family; however, she was not with them when they were killed. She also related how she, her one remaining daughter, Pham, and a son, escaped by going to another part of the country and then survived the trip to Thailand.

A sedate and attractive Cambodian woman, Chan was controlled during the interview but began crying when she talked about her husband's death and the fatal beatings of her two children. Her anguish was appropriate, and she was diagnosed with PTSD and severe depression.

The entire family lived together: the grandmother, Chan, the daughter, Pham, and her husband, Dom, their three children, and Chan's younger son. All three patients remained in treatment for several years, repeatedly denying any stressors at home, yet exhibiting multiple symptoms of PTSD and depression.

About 5 years into the treatment, it became clear that Dom and Pham were having several major marital problems. Abuse was not noted until much later, after a separation, when both Pham and Chan reported that Dom had beaten them. Pham had a brief affair during this time and became very preoccupied with working and earning money. The grandmother and the uncle had become the primary caretakers for the three young children. Subsequently, Dom left the area and did not contest the divorce. Seven years later, Pham terminated treatment and then was able to get

a job. However, 1 year ago, Pham had recurrence of her symptoms, quit her job, and restarted treatment. Chan has continued in treatment for almost 10 years, and has been the primary support for the family. Her posttraumatic stress symptoms have persisted, and she also has developed hypertension. The younger son married outside the culture but continued to live at home and later fathered a child.

Dom recently remarried and lives in another state. He rarely has contact with his children and provides very little financial assistance to them. Pham has a boyfriend and spends the nights with him, but spends afternoons and evenings with her children. The primary family unit consists of Pham, her three children, Chan (who is effectively the mother), Chan's son, the children's uncle (who is effectively the father), and her son's wife and baby.

Pham's three children, Gom, 15-year-old girl, Loo, a 13-year-old boy, and Ann, an 11-year-old girl, were interviewed together, without the other family members present. All had heard about the Pol Pot experience and knew of the deaths of relatives. They had received from their grandmother most of the details, which were consistent with the history we obtained. The only effect, they said, from the story, was that they felt sad about it. They all had seen the film *The Killing Fields,* which made them feel sad about Cambodia. The only current effect that they know of the Pol Pot era is hearing their grandmother scream at night. They, themselves, feel that they are halfway between the Cambodian and American way of life, although they report speaking much more English than Cambodian.

All the children described the previous fighting between their mother and their father, and how much it bothered them. Gom had actually been beaten by the father, who stopped only when she reported it at school. They felt sad when their father left, even though they admitted that they were frightened of him. However, they felt even more afraid when their mother left for a time with a boyfriend. They all felt that "no one loved us," in spite of the fact that the grandmother and uncle stayed. They gave much more personal credit to the family discord than they did to any past effects of the Cambodian experience.

Individually, Gom, who is now a freshman in high school, is very unhappy. A recent disagreement with the grandmother over using the phone and going out with friends had caused her to be profoundly sad. Her school grades have suffered and she began, for the first time, failing some classes. She spent much time in her room alone crying. She sleeps poorly, is tired, and has poor concentration and little energy. She even says she has lost hope fulfilling her dream of becoming a nurse and now is unsure if she will ever even complete high school. She has thought about leaving home and living with her father. Even in the presence of the others, she becomes tearful upon describing her current situation.

Loo, a seventh grader, has a goal of being a basketball player. Recently, his grades also have dropped, and school has become very difficult for him. He says he does not understand it very well. His uncle has offered to help him. He spends much time with his Asian friends and wonders if he will be able to resist group pressure and continue school. He is not sad now, but sees his future as very uncertain.

Only Ann, a sixth grader, who does not have much memory of the family fights, seems bright and happy. She gets excellent grades and plans to be a doctor. She expressed and nonverbally showed confidence in her future.

Comment

It is apparent that at least three of the four people traumatized in Cambodia suffered severely for many years. In addition, Dom and Pham found it impossible to maintain their relationship and, as a result of the abuse, divorce seemed inevitable and necessary. Pham became more concerned about being established in her new country and earning a living than about raising her own family; indeed, at times, she seemed to be totally indifferent to her children's well-being. Fortunately, the grandmother was able to intervene and become involved in this

semiextended family and provide both parenting and continuity of culture for them. However, this has added an ongoing problem for the adolescent children. She is seen as very restrictive. Treatment reduced both the mother's and daughter's symptoms and may also have increased greatly the tolerability of family life.

The effects on the survivors, grandmother, parents, and children are complicated. The events of Pol Pot era have been discussed, and all the children are aware of their country's history and culture. They express a sense of sadness and probably of loss. However, the children do not identify their current problems with that of the effect of Pol Pot but more directly to the fighting between the parents who left them and, most recently, to the conflicts with the grandmother. The latter probably represent a culture and generation difference. The problems for the children are very significant. The oldest girl suffers from clinical depression and sees no way out, and no future for herself. The boy, beginning adolescence, is also finding school difficult and is beginning to identify with peer groups, and he, likewise, is beginning to question his future. Only the younger girl seems unaffected at this time. Whether she will remain so, as adolescence develops, is uncertain.

Although the children do not identify the traumatic events of Pol Pot with their current problems, it is probable that they are a great source of difficulty. The parents' behavior, increased irritability, physical abuse and abandonment, permanently by the father and partially by the mother, is very unlike traditional Cambodian behavior. The posttraumatic symptoms of irritability and numbing of the parents, along with the effects of refugee status in a foreign country, seem to have left a powerful legacy on the growing children.

DISCUSSION

The Cambodian agony is one of the recent reminders of man's inhumanity to man. The severe trauma certainly produced many symptoms of PTSD and, to a lesser extent, depression in victims. Even more than a decade after the Pol Pot regime ended, a large segment of the U.S. Cambodian community still exhibits the full PTSD constellation of symptoms: more than 50% of adult women, 30% of adult men, and 20–30% of adolescents. These very high rates illustrate both the prevalence and the chronicity of this disorder. Of the 150 Cambodians treated in the Indochinese Psychiatric Clinic, more than 80% are in treatment for over 3 years. About 70% of all who began treatment have continued. Patients remain vulnerable to stress despite marked reduction in intrusive symptoms, and life stressors often produce an acute exacerbation of symptoms.

Young Cambodian adults tend to have lower rates, later onset, and less persistence of symptoms over time than do the older adults. Their impairment is also rarely as severe. Despite being separated from parents at an important developmental age, and exposed to (and in some cases, having participated in) violence, they display more resilience than their parents. Early data suggest that they also handle stress in a more private and quiet way, not antisocial acting-out behavior, as is common with other young people in the United States. However, their school dropout rate indicates that academic life is particularly difficult for them.

Adult parents present a more complicated picture, however, because they tend to have more symptoms and more diagnoses. They are more socially and vocationally impaired, and have more trouble learning English and acquiring the skills necessary to adapt to a complicated Western culture. Their children, especially adolescents, remain their major source of worry and contribute greatly to their symptoms. But parents are very poor sources of infor-

mation on how their children are doing psychologically, since they seem unable to connect emotionally with them and therefore usually underestimate their suffering.

The older generation of Cambodians displays the social effects of this disorder. Wife abuse and divorce, as indicated by the case example, are becoming more common. Although such events occurred rarely in traditional Khmer families in Cambodia, now, even our own small Cambodian community of 5,000 people, experiences domestic violence, and there are reports of physical and sexual abuse of children. Today, both mothers and fathers abandon their families with apparent indifference. Alcoholism is evidence in both sexes and accelerates the breakup of families.

The pressure on Cambodian refugee families is intense and unremitting. Not only are individual members often psychiatrically impaired but also they have suffered numerous sociocultural losses. Most painful for many has been loss of the sense of shared values and continuity inherent in a stable, traditional Buddhist culture, where elders and leaders are respected, duties and responsibilities are delineated and accepted, and the extended family provides safety and support. This cultural framework was solid, and a shared acceptance of Buddhism (along with its local folk beliefs) provided a coherent, peaceful worldview. The pervasive violence, wanton destruction, and widespread death of family members and Cambodian leaders shattered this security and rendered life incoherent and devoid of meaning for many. Completely demoralized and traumatized, they came from unstable refugee life in Thailand to the shores of the United States. Here, their isolation was compounded by living among "foreigners," since they usually did not live among many other Cambodians. Confused parents were thrust into new roles. Values, behavior, religion, and basic institutions such as education were much different from what they had ever experienced before. Since children generally learned English faster, they also had new roles, often serving as guides and interpreters. Often unable to find or maintain employment, fathers lost status. Neither parent could help children with such basic activities as homework or take part in afterschool events. Family members often seemed withdrawn, numb, or unresponsive, and became violent periodically.

Our studies demonstrate that PTSD clusters in families. The rate of PTSD among children increases when one parent has PTSD, and greatly increases if PTSD is present in both. Irritability, poor sleep, avoidance, startle reaction, and nightmares are symptoms of PTSD that can greatly impair parents directly, through aggression and avoidance, or indirectly, through being totally exhausted and preoccupied, which, in turn, impacts the children. Vulnerable, these children can and often do develop or maintain the symptoms of PTSD.

Earlier onset of PTSD symptoms in the majority of adult patients suggests that parents suffer more severe forms of PTSD syndrome than do their offspring. Adult sufferers, but not their adolescent children, functioned at a lower level and had lower income levels when they had PTSD (Sact *et al.,* 1995). Likewise, they reported recurrence of traumatic dreams more frequently than did the adolescent group (Sack *et al.,* 1993). Acculturation in the adolescent group appears to proceed relatively smoothly despite underlying PTSD symptoms (Kinzie *et al.,* 1995; Sack *et al.,* 1995).

Disaster research (Three-Mile Island, nuclear accidents, industrial fires, lightning strikes, and the Buffalo Creek Flood) provides some empirical evidence for the intergenerational effects trauma has on children. All of these studies demonstrate that family factors—parental distress, fears, and mental health, and an irritable family atmosphere—have a high correlation with PTSD symptoms following significant trauma (Bromet, Hough, & Connell, 1984; Dollinger, O'Donnell, & Staley, 1984; Green *et al.,* 1991). Green *et al.*'s Buffalo Creek Dam study showed that both the severity of a parent's PTSD symptoms as well as irritability and

depressed family atmosphere independently contribute to PTSD symptoms in children. Data were collected $1^1/_2$–2 years following the disaster (Green *et al.,* 1994). Such studies are compatible with clinical experience and echo Anna Freud's written report from World War II (Freud & Burlingham, 1943).

The Cambodian tragedy provides yet another experience of the effect of severe trauma on individuals and their families. Our studies indicate that younger people and children seem to have fewer symptoms than their parents. However, adults with PTSD in addition to personal symptoms are having severe problems with their parenting roles. These problems may be caused by irritability and numbing from PTSD itself or other social disruption such as divorce, violence, or alcohol abuse. The result is certainly more stress on the children. It is as if Pol Pot won. He destroyed the fabric of Cambodian culture and family life, and left the survivors without a sense of continuity of existence itself. We can hope that young Cambodians can find meaning for themselves and their families, and that the transmission of traumatic anguish ends.

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