

Differential Predictors of Transient Stress Versus Posttraumatic Stress Disorder: Evaluating Risk Following Targeted Mass Violence

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Schools have become a common incident site for targeted mass violence, including mass shootings. Although exposure to mass violence can result in significant distress, most individuals are able to fully recover over time, while a minority develop more pervasive pathology, such as PTSD. The present study investigated how several pre- and posttrauma factors predict posttraumatic stress symptoms (PTSS) in both the acute and distal aftermath of a campus mass shooting using a sample with known levels of pretrauma functioning ($N = 573$). Although the largest proportion of participants evidenced resilience following exposure to the event (46.1%), many reported high rates of PTSS shortly after the shooting (42.1%) and a smaller proportion (11.9%) met criteria for probable PTSD both in the acute and more distal aftermath of the event. While several preshooting factors predicted heightened PTSS after the shooting, prior trauma exposure was the only preshooting variable shown to significantly differentiate between those who experienced transient versus prolonged distress. Among postshooting predictors, individuals reporting greater emotion dysregulation and peritraumatic dissociative experiences were over four times more likely to have elevated PTSS 8 months postshooting compared with those reporting less dysregulation and dissociative experiences. Individuals with

less exposure to the shooting, fewer prior traumatic experiences, and greater satisfaction with social support were more likely to recover from acute distress. Overall, results suggest that, while pretrauma factors may differentiate between those who are resilient in the aftermath of a mass shooting and those who experience heightened distress, several event-level and posttrauma coping factors help distinguish between those who eventually recover and those whose PTSD symptoms persist over time.

Keywords: school violence; posttraumatic stress; acute stress; trauma; logistic regression

EXPOSURE TO TARGETED MASS VIOLENCE can result in both acute distress and long-term negative consequences, such as PTSD (Galea et al., 2002; Littleton, Axsom, & Grills-Taquechel, 2009; North, Smith, & Spitznagel, 1994; Schwarz & Kowalski, 1991). Unfortunately, schools have become a common incident site for targeted mass violence, including mass shootings (Stein, 2007). In the specific context of mass shootings, rates of PTSD range from 10 to 36% (Norris, 2007). Although exposure to a potentially traumatic event often results in transient symptoms of distress, most individuals are able to fully recover within a relatively short period of time and experience little or no disruption in healthy functioning (Shalev, 2002). The minority that develop PTSD face considerable difficulties in interpersonal relationships, occupational functioning, and quality of life, as well as high rates of comorbidity with other psychiatric disorders (Kessler, 2000). Thus, determining factors that help identify those at risk for developing PTSD

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following this increasingly occurring trauma type is critical for treatment and prevention efforts. The present study examined both prospective and acute markers of PTSD following a campus mass shooting in a sample of undergraduate women with known levels of pretrauma functioning.

Prior research suggests that people experience a range of reactions following trauma exposure, including transient distress, pathology, and resilience (i.e., overall maintenance of healthy functioning; Bonanno, 2004). In instances of clinically significant distress, a diagnosis of PTSD is made after 1 month or more has transpired since the index trauma. Conversely, acute stress reactions describe trauma-related symptomatology that occur in the initial month following exposure to a potentially traumatic event and before a diagnosis of PTSD can be made (American Psychiatric Association, 2000). Although acute stress reactions may lead to functional impairment in the immediate aftermath of trauma exposure, the majority of individuals fully recover within 6 to 16 months posttrauma (NSW Institute of Psychiatry and Centre for Mental Health, 2000). Thus, while the occurrence of acute stress following a mass shooting can be predictive of later PTSD (e.g., Classen, Koopman, Hales, & Spiegel, 1998), the majority of individuals eventually return to pretrauma levels of functioning. For example, North and colleagues studied the impact of exposure to a public mass shooting 1 month (North et al., 1994), 1 year (North, Smith, & Spitznagel, 1997), and 3 years (North, McCutcheon, Spitznagel, & Smith, 2002) after the event. They found that while 28% of participants met criteria for PTSD 1 month after the event, the prevalence rate at 1 and 3 years later dropped to approximately 18%. Thus, identifying factors that help differentiate among those who are resilient, those who experience transient distress, and those at risk for prolonged impairment would aid response efforts in the immediate aftermath of potentially traumatic events such as mass shootings.

A number of factors that increase risk for the development and maintenance of PTSD following trauma exposure have been identified in prior research (see Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003, for reviews). Specifically, event-level factors, such as severity of exposure to a traumatic event (e.g., physical or emotional proximity), have been shown to be predictive of later pathology. Generally, greater exposure has been shown to predict greater post-traumatic stress symptoms (PTSS; Brewin et al., 2000; Dirkzwager, Grievink, Van Der Velden, & Yzermans, 2006; Ozer et al., 2003), though Hughes et al. (2011) found that low-impact stressors (e.g., inability to confirm the safety of friends

following the Virginia Tech shootings) also contributed to heightened PTSS. Factors implicated in the immediate aftermath of trauma, such as peritraumatic dissociative experiences (i.e., the unusual experience of changes or distortions in one's perception of time, space, or self during or in the immediate aftermath of trauma exposure) have also been shown to substantially increase risk for subsequent PTSD. A common explanation is that dissociation during or shortly after trauma exposure may interfere with the encoding and immediate processing of trauma memories, thereby increasing risk for PTSD (e.g., Briere, Scott, & Weathers, 2005). Other researchers suggest that dissociative experiences normatively occur in response to elevated arousal during trauma exposure, and may not necessarily confer risk for pathology (e.g., Sterlini & Bryant, 2002). Despite competing theories, a meta-analysis of 68 studies by Ozer and colleagues (2003) revealed a medium effect size for the contribution of peritraumatic dissociation to later PTSS, making it one of the strongest predictors of PTSD in their study.

Factors present prior to trauma exposure have also been implicated in the development of PTSD. Specifically, previous traumatic experiences and preexisting PTSS have been shown to increase risk for continued pathology following trauma exposure (Cogle, Resnick, & Kilpatrick, 2009; Suliman et al., 2009), including lifetime histories of abuse and assault (Brewin et al., 2000). Beyond trauma-relevant influences, factors related to general psychological distress, such as symptoms of depression or anxiety and functional impairment due to emotional or physical health concerns also confer risk for greater difficulties posttrauma (Brewin et al., 2000; Dirkzwager et al., 2006; Ozer et al., 2003).

How one relates to his or her emotional experiences has also been shown to predict later functioning. Specifically, emotional coping strategies utilized both before and after exposure to a potentially traumatic event have been shown to differentiate between those who experience distress and those who are more resilient. Experiencing difficulties with emotion regulation (i.e., trouble with both the awareness and acceptance of emotional experiences, as well as difficulty utilizing appropriate and effective emotion regulatory strategies [Gratz & Roemer, 2004]) has been implicated in the onset and maintenance of PTSD (Eftekhari, Zoellner, & Vigil, 2009). More specifically, evidence suggests that avoidant or suppressive emotional responding following potentially traumatic events is associated with higher levels of PTSS (Marx & Sloan, 2005), which may include increased reliance on substances such as alcohol to help manage distress (Kushner, Abrams, &

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