

7 *Tragedy can strike a college campus in unpredictable and often horrific ways that may lead to traumatic responses for individuals and the entire campus community. Crises on campus demand an appropriate response to support the community, provide assistance to affected individuals and guide healing efforts.*

Mental Health Aspects of Responding to Campus Crises

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A crisis on campus can be precipitated by a range of events that are unexpected, have significant consequences to individuals and the community, and may easily overwhelm the existing structures in place to support students, faculty, staff, and the greater university community. By definition “a time of intense difficulty, trouble or danger” (Oxford Dictionaries, 2015), a crisis brings with it a confrontation with danger that may have physical, psychological, and economic consequences for the individual and the community. The precipitating event may occur in the greater community or on campus, but the rippling effects may be felt across the boundaries of both and extend to family members and alumni across the country and the world. Sadly, most of us will be affected by a traumatic event and its consequences at some time; a large review of the disaster literature (Norris, Friedman, & Watson, 2002) estimated that 69% of us will be exposed to a traumatic event in our lives, and a significant percentage will experience related disruption in our emotional equilibrium (15–24% of those exposed to trauma).

The examples of crises on campus are many and varied; all campus professionals can bring to mind some defining crises that have occurred in academic communities in the past 2 decades. Each of these painful events merits careful study, although the intent here is a more general review of the types of disasters that might befall campuses, the potential mental health consequences, and requisite interventions that follow.

A campus may be affected by natural disasters, vehicular accidents, and death(s) of students, faculty, and staff. Natural disasters, including tornadoes, hurricanes, and flooding, may have effects that involve an entire community in which the university is located. In August 2005, Hurricane Katrina devastated the Gulf Coast from Florida to Louisiana, caused the deaths of over 1,500 individuals, and displaced another 1 million people;

all of the universities in New Orleans were closed for the fall semester. In April 2011, tornadoes struck Tuscaloosa, Alabama, leaving 41 dead, including 6 students at the University of Alabama.

Transportation-related accidents may result in fatality and injury to students, faculty, and staff. The tragic crash of Southern Airways Flight 932 on November 11, 1970 killed 45 members of the Marshall University football team (students and coaches), 25 community boosters, and 5 crew members. Seventy children lost at least one parent and 18 children were orphaned by the crash. Motor vehicle accidents are the most common cause of death of college students (Turner, Bauerle, & Keller, 2011) and often an accident may involve more than one student; on April 22, 2015, seven nursing students from Georgia Southern University were traveling when their cars were struck by a tractor trailer, killing five and injuring two.

Accidents on campus with injury or death may involve one campus member or many. The death of Elizabeth Shin, now attributed to an accidental death by fire, had widespread effects on the campus of the Massachusetts Institute of Technology in 2000. At Texas A & M, the annual bonfire was a campus tradition; the collapse of the structure on November 18, 1999, resulted in the death of 12 current and former students and injured 27.

Both of the authors have directed counseling centers at universities that were affected by a particular type of tragedy when a suicidal student focused his rage on the university community and murdered classmates and faculty. On April 16, 2007, Seung-Hui Cho shot 49 members of the Virginia Tech community, killing 32, before shooting himself as the police approached. Less than a year later, Steven Kazmierczak entered a classroom at Northern Illinois University (NIU) on February 14, 2008, shot and killed 5 students and injured 21 others before killing himself as the police responded. Tragically, there have been similar events on or near college campuses and in K–12 schools since then, including the killings of 27 children and teachers at Sandy Hook Elementary school on December 14, 2012.

Response to Tragedy

Each of the tragedies recounted here brought widespread distress to the university community, to those connected to the campus community from a distance, and to the wider world who were witness to tragedy though media exposure. Initial reactions to a traumatic event include disbelief and shock; it is very difficult to integrate these disastrous events into our daily experience of being in the world. Grief, sadness, anxiety, and fear often follow these events and the intensity of these emotions will vary as a function of a number of factors including proximity to the event, closeness to the victims who were directly affected, as well as individual variability in how we understand the tragedy.

In order to conceptualize the ramifications of tragedy for the campus, the Population Exposure Model (U.S. Department of Health and Human

Services, 2004) provides a helpful framework. The model posits that the traumatic event affects groups differently, from those most directly affected (group A) to those who feel the effects in the wider community (group E). Group A is composed of those who are killed and injured and the families and loved ones of these campus members. Extending outward in concentric circles, the impacts will be felt by (B) those who were direct witnesses to the event who escaped physical injury, (C) more extended family and friends, as well as first responders who intervened at the scene or those who worked directly with bereaved family members and friends, (D) those tasked with responding to the scene, such as mental health providers, clergy or emergency health care providers, and (E) the community at large and others with connection to the victims or campus.

In a university community, the number of those affected can grow exponentially. As an example of this, Virginia Tech is a university community of 30,000 students and 7,500 faculty and staff. In a survey conducted following the shootings of 2007, almost 80% of the students surveyed knew a student or faculty member who was injured or killed; this ranged from 9.1% who were close to one of the deceased, 29.1% who were friends or acquaintances, and far more who were distantly connected (Hughes et al., 2011). Despite being a fairly large university, the majority of the campus was only one degree of separation from a victim of the tragedy. Thus, the entire community of campus and town reverberated from the effects of the shooting—as did alumni and others with a connection to the university.

With the Population Exposure Model as a heuristic, the response to any campus tragedy must encompass the entire community as individuals who may suffer emotionally in the aftermath. A further challenge for the university is that its administrators, mental health providers, faculty, and staff will be personally affected by the trauma and will also be thrust into the role of helping others heal. For mental health professionals on campus, their roles will vary depending on the circumstances of the event and the resources available to the university, but they are typically central to the response effort. In the initial response, there will be multiple interventions directed at different populations and a strong emphasis on coordinated collaborative efforts with the entire response team (Watson et al., 2011).

Immediate Response and Intervention. The immediate response must be directed to care for the injured and for the families and loved ones of the deceased. Police and emergency personnel will usually be first on the scene and will direct emergency efforts. As the injured are stabilized medically, the awareness of their psychological needs must also be assessed. The majority of survivors with posttraumatic stress report that their symptoms began the same day as the traumatic event and 94% reported that symptoms began in the same week as the event (North, 2003). Bereaved family members will require immediate attention and support; a key phrase is “protect, direct, and connect” (Myers & Wee, 2005): they must be directed to a protected environment where they will be insulated from the media and

well-meaning others, given provisions for basic physiological needs, and connected with other family members and loved ones.

Mental health professionals can begin Psychological First Aid (Brymer et al., 2006) immediately with affected community members. Psychological First Aid is widely recommended as an evidence-based practice for application following trauma (Watson, 2008). Psychological First Aid provides emotionally distraught survivors with a human connection to assist in calming and orienting them to care for their immediate needs. The provider offers practical guidance for meeting their basic needs; linking the survivor to extant social support networks, including family and friends; assessing and providing information for other resources in the community, including mental health services; and encouraging active problem solving. The on-campus counseling center may become a central support for the student and university community and survivors may be directed to the center for immediate Psychological First Aid.

The clinicians from the campus counseling center may also provide on-site Psychological First Aid at areas where survivors and other students have gathered. In addition to providing assistance to community members who are present, the clinicians will be able to gain information about other individuals in need of assistance who are not physically present, which can help guide outreach efforts to groups and individuals in greatest need. It is equally likely that the needs of the survivors may require more support than on-campus professionals can provide, so coordination with local and regional resources, including local mental health centers, the American Red Cross, and other networks, will be required. It is very difficult to make this coordination happen in the middle of a crisis, so previously negotiated memoranda of understanding with local and state mental health agencies and universities are very helpful. On one occasion where the authors responded to a tragic event, the governor of the state had to issue an emergency directive waiving the state licensure requirement in order to allow out-of-state providers to respond.

Communications. In the aftermath of tragedy, there is an amplification of the intrinsic human need for knowledge and communication about the event, so crisis communication has great importance (Hincker, 2014). At a minimum, basic information about the tragedy can allay anxiety and communicate messages of relative risk and safety. Crisis communication can direct survivors and community members to immediate resources that provide basic necessities. With electronic resources and social media, campus members can be directed to relevant online resources and alerted to important events on campus. Hincker (2014) notes that key facts should be repeated again and again to ensure that all are informed and that the myriad topics of importance are addressed in an open and transparent manner.

Institutional communications regarding mental health issues should be timely and focused; many of the professional organizations of mental health providers quickly issue fact sheets and bulletins regarding psychological

responses to tragedy that can be made available in print and on a website. In the midst of crisis, there may be ill-informed rumors and misunderstandings that can divide the community; clear and consistent communication can bring the community together and aid healing and resilience. Accurate and regular communication from the institution will address the multitude of media inquiries that will arise. The dissemination of timely and relevant information undergirds all outreach efforts.

Ongoing Needs Assessment. Needs assessment for the campus is both an immediate and an ongoing process. This becomes a foundation for intervention planning after the initial response to critical needs. For the mental health provider, a needs assessment will begin the process of anticipating the campus requirements for initial triage and continuing treatment, as well as the assessment of the adequacy of resources. In the aftermath of tragedy, there is typically a surge in requests for counseling as individuals and families cope with loss, grief, and recovery. Following the tragedies at both Virginia Tech and NIU, there was a dramatic increase in counseling center usage immediately thereafter that continued in the following years—this continuation may follow the increased visibility of counseling on campus as well as reflect increases reported by counseling centers nationally.

Mental Health in the Aftermath of Tragedy

Tragedy brings with it a tremendous variety of responses, reactions, and concerns. It is expected that those most directly affected by tragedy will have very strong reactions and that the course of these reactions will vary in severity and duration. The emotional distress that individuals experience will likely include grief and sadness for the injured, deceased, and their loved ones. These repercussions of tragedy can reverberate in one's psyche for a long period of time, and survivors and loved ones may experience overwhelming stress when trying to integrate the unthinkable into their life and experience as time passes. By and large, these reactions are transient and slowly resolve over time as affected individuals gradually reenter and resume vocational and social involvements. However, this may not be the case for some of those most affected by tragedy, and their distress and responses may be severe and interfere with their previous level of functioning. These individuals may need treatments that serve to aid them to cope and function in their lives. Mental health professionals understand and categorize the individual response to tragedy by the intensity, severity, and length of reaction; assessments may help determine potential treatments and to guide research.

Resources and messaging directed to survivors of traumatic events in the immediate and near aftermath can assist with their emotional response. Survivors should be instructed to honor their emotional response. The healing process can move more smoothly when survivors work to accept how

they are feeling and process those emotions. Survivors need to know that the healing process is not linear—it will often ebb and flow as survivors experience different emotions over time. Each survivor's response will be unique and specific to their experience of the trauma (U.S. Department of Health & Human Services, 2004).

The immediate stress reaction to trauma can include emotional, behavioral, cognitive, and physical effects. Emotionally, individuals experience shock and disbelief following the tragedy in addition to anxiety or fearfulness. As the awareness of the losses becomes evident, sadness and grief that are almost palpable in intensity are present. Physically, individuals may feel faint or dizzy, may experience nausea and gastrointestinal distress, and may become hyperaroused and agitated. In the aftermath, sleep disturbances, including insomnia or hypersomnia, are often present. Behaviorally, survivors of trauma may withdraw socially, isolating themselves and avoiding reminders of trauma. Individuals may increase their use of substances, including alcohol, tobacco, or other drugs. Cognitively, experiences of trauma make concentration difficult and individuals report difficulties with memory. They may feel confused and disoriented, and have difficulty in planning or problem solving. They may experience recurrent and intrusive memories of the event or suffer flashbacks in which the event is reexperienced.

Individual survivors of traumatic events may experience some or all of these effects. The effects may vary in intensity and duration and may feel so overwhelming that psychosocial functioning becomes difficult or impossible. When there is significant impairment in functioning coupled with extreme distress, individuals may meet the criteria for a psychiatric diagnosis (American Psychiatric Association [APA], 2013). Individuals who experience significant, disruptive symptoms (such as intrusive thoughts or flashbacks to the event, sleep disturbances, or difficulty concentrating) for the first several weeks following the incident may meet the criteria to be diagnosed with acute stress disorder (ASD). When those symptoms persist and continue to be disruptive to normal functioning for longer than a month, the more commonly known diagnosis of posttraumatic stress disorder (PTSD) might be applicable.

Not everyone with ASD will go on to develop PTSD; Bryant and colleagues (Bryant, Friedman, Spiegel, Ursano, & Strain, 2010) reported that half of the individuals with ASD do not go on to develop PTSD. However, acute stress disorder may predict the development of PTSD after the initial month; examining PTSD in survivors of the Oklahoma City bombing, North (2003) noted that the vast majority reported that symptoms began immediately after the bombing, 76% on the first day, 94% within the first week, and 98% in the first month. In their review of the relevant literature, Bryant and colleagues (2010) noted that prevalence rates for the full diagnosis of ASD were 7–28% with a mean of 13%; including individuals with partial symptoms raised the prevalence to 10–32% with a mean of 23%.

North (2003) estimates the upper range for a diagnosis of PTSD to be 34% of survivors of the Oklahoma City bombing. By diagnostic criteria, ASD ends at 1 month, but the length of PTSD can be much longer and can become a chronic disorder with half of those individuals diagnosed with PTSD experiencing symptoms lasting a year or longer and as many as one third lasting a decade or more (North, 2003).

Following tragedy, women are more likely to be diagnosed with a stress disorder and/or depression than are men, but men are more likely to be diagnosed with a substance abuse disorder; this parallels the similar difference in elevated rates of depression for women and substance abuse for men in the general population. Individuals with a prior history of depression or substance abuse are more likely to see these disorders exacerbated or continuing after a tragedy (North, 2003).

Individuals do not have to be present at the immediate scene of the tragedy to experience symptoms of a stress disorder. In a study of Virginia Tech students present on campus during the shooting, Hughes et al. (2011) note that the predictors of posttraumatic stress symptoms were closeness to someone who was injured or killed as well as not being able to contact friends in the immediate aftermath of the shooting. Similarly, family members of those directly affected can develop symptoms of a stress disorder as may those who were first responders or treating health professionals providing treatment to those directly affected by trauma.

After the Tragedy: Responding to the Campus

After a large-scale traumatic event has affected a campus community, it is important to prepare all members of the community for the resumption of classes and campus activities. This is of increased importance when a campus has canceled classes or closed following a traumatic event. The university should be intentional in developing a plan to prepare faculty, staff, and students for its return to regular operations; a detailed description of these plans is outlined in *Enough is Enough: A Student Affairs Perspective on Preparedness and Response to a Campus Shooting* (Hemphill & Hephner LaBanc, 2010).

Faculty and staff will need preparation to resume their work with students and to return to work after a campus tragedy. As members of the campus community, faculty and staff will each have been affected by the tragedy to varying degrees; therefore, they can benefit from an awareness of resources to assist them in their own healing. Resources may include an on-campus employee assistance program as well as information regarding off-campus mental health providers. Preparatory meetings can be helpful to all faculty and staff and may be grouped by their academic/staff areas. These meetings can be conducted by on-campus counselors or other mental health professionals and will allow the counselors to provide Psychological First Aid to the faculty and staff.

Throughout their careers, many faculty members have become accustomed to being the “expert” at the front of a classroom; however, the resumption of classes following a campus tragedy will leave some faculty struggling with how to address students about what has transpired. These meetings with faculty and staff are an opportunity to provide guidance for their interaction with students, present resources with which to refer students for assistance, and provide support for the individual faculty and staff. The elements of Psychological First Aid indicate that faculty and staff should be provided with practical information and logistics about the resumption of all campus operations as well as information about emotional healing and possible responses to trauma. The faculty and staff should be educated about signs of emotional distress they may see in students, in themselves, and in one another.

As students return to campus and the classroom following a large-scale traumatic event, having a clinician in the initial meeting of each class can be an excellent intervention to assist students in their transition (Sharma, Bershad, & LaBanc, 2010). The clinician serves as an on-site support person for the faculty member who is teaching the class and will be readily available should anyone become significantly distressed during the class meeting. The clinician’s role is to provide Psychological First Aid and not to provide mental health counseling to the entire class. The clinician can provide psychoeducation about the process of healing and effects of trauma, inform students about on-campus resources, and be available for any student who wishes to talk to a counselor immediately. This intervention expresses a strong message of care and concern to all students. In the aftermath of a tragedy, students will have their sense of psychological security harmed, and the presence of clinicians in the classroom can help to enhance their trust in the healing process.

The use of social media is widespread across all college campuses. Social media provide instant access to information to all members of the campus community. In the aftermath of tragedy, this can be advantageous to inform students about meetings or classes that have been altered or that may be helpful to attend. Many students use social media as a way to connect and support one another. Being able to connect and receive support from fellow students is of critical importance following tragedy. It can also be a venue for the university to share accurate information and dispel myths and rumors. However, social media can also be problematic for the institution; inaccurate information may be shared very quickly via social media platforms, which can increase the anxiety experienced by faculty, staff, and students. Further, there will be members of the community who wish to “take a break” from the constant updates that social media can provide following a tragedy. These individuals may experience the social media updates as frustrating or as exacerbating their distress and should be supported in making that choice.

Strategies and Recommendations

- Identify staff across departments who have the requisite skill set to assist during a large-scale crisis. Staff who have demonstrated an ability to perform effectively when under highly stressful conditions should be identified.
- Have counseling center staff and any adjunct mental health units trained in Psychological First Aid.
- Have staff from multiple campus units participate in tabletop scenarios to gain experience and identify potential deficits in response plans and protocols.
- Establish clear communication guidelines for both internal and external communications to be followed after a large scale event.
- Institutional leaders should be familiar with the Federal Emergency Management Agency (FEMA) training and organizational tools; colleges and universities engaged in proactive emergency management will be better prepared to respond to any traumatic event (see <http://www.fema.gov/national-preparedness-system>).

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