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Crisis Intervention on Campus: Current and New Approaches

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Critical incidents, whether a natural disaster, interpersonal violence, or death of a student, continue to be an unfortunate aspect of campus life. This article discusses the resulting use, potential overuse, and possible misuse of psychological debriefing. Analysis and interpretation of recent scientific data for interventions similar to commonly used methods of campus crisis intervention are provided. Recommendations are offered for potential use of alternative strategies for responding to critical incidents.

The Need for Crisis Intervention

College and university campuses across the country routinely engage in helping students deal with traumatic events, such as the death of a student, violent behavior, and other tragic events. The most recent National Survey of Counseling Center Directors (Gallagher, 2001), a survey of 274 institutions, revealed that 30% of the responding colleges reported at least one student suicide on their campus in the last year. Other tragedies, such as the bonfire deaths at Texas A&M and recent shooting at Case Western University, continue to be an unfortunate aspect of campus life. In addition, continuing anxiety following the terrorist attacks of September 11, 2001 has caused further psychological distress. Given government leaders' warnings of potential future attacks at any location, it would be particularly prudent for

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campus officials to consider how to intervene most effectively when tragedy strikes.

Why Campuses and Counseling Centers May Provide Too Much

Response to survivors of a tragedy is typically coordinated and delivered by the campus counseling center. Clearly some type of crisis intervention is appropriate following a trauma. Exactly what these responses may be are influenced by forces that are well-meaning but at times based on ill-conceived expectations.

External Pressure

In the aftermath of terrorist attacks a number of public and private organizations are promoting debriefing programs to private industry and other groups. There may be a well-intentioned temptation for universities to use these canned programs when other traumas occur.

Concern for grieving or distressed students on the part of administrators, community and other campus and student officials can translate into a "do something to fix the problem" mandate. Essentially, a large response fits the expectations of others, and not doing substantial debriefings may lead some in the campus community to question the necessity of a campus mental health unit.

Internal Pressure

For a variety of reasons, staff in counseling centers are likely to be very eager to assist after a traumatic situation. Specifically, political forces, praise for previous interventions, and an opportunity for *preventing* instead of the more typical *reacting to* dysfunction all serve to push the counselor to intervene.

Politics

In times of budget cuts at colleges across the nation, counseling center staff may be concerned about the outsourcing of their services if they are not intensely active—having a "shining moment" to "prove their worth"—anytime a crisis occurs.

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Previous Compliments

Staff and faculty may note that participants in previous debriefings have expressed appreciation and told counselors that the meeting was helpful. However, as Rose, Bisson, and Wessely (2001) say, ". . .high face validity and client satisfaction . . . should not be regarded as a substitute for evidence" (p. 13). Gurwich (2001) expressed similar sentiments, saying, "Providing the help may feel good to the helper and the helpee but not really be good." Gist (2001) also provides an apt metaphor, "Hungry people will flock for a warm doughnut, relish its flavor and its ability to quiet their appetite, and thank its purveyor—that doesn't make it a nutritious meal."

Finally, a Time for Prevention of Further Distress

As Bisson, McFarlane, and Rose (2000) report, the desire to help those in need is one of the most powerful human motivations. Therapists in particular may feel some degree of frustration and powerlessness because they usually deal with students who have suffered through past situations that later led to distress. In the case of debriefing, the therapist may view the opportunity to intervene immediately after a crisis as an unusual opportunity to prevent this later distress.

Internal Pressure + External Pressure = More Interventions

Given both of these sets of external and internal factors, a very large number of intensive interventions may occur. "Overhelping" has shown deleterious effects even with benign interventions, such as the provision of support or empathy (Gilbert & Silvera, 1996). In the case of crisis intervention, some of these interventions themselves may be harmful, as will be discussed later; thus, adding more could in fact make a problem even worse.

Common Debriefing Models

There are a number of psychological debriefing (PD) models that have been used in this "over-response." The most popular protocol is Critical Incident Stress Debriefing (CISD, Mitchell, 1983, 1988). CISD draws from a number of trauma models, such as (a) the general concept of catharsis (Breuer & Freud, as cited in Bisson et al., 2000); (b) the military "PIE" model of proximity to the event, immediacy of the intervention, and expectancy of returning to normality (described by

Kardiner & Spiegel, 1947); (c) the group therapy model of the trauma membrane (Lindy, Green, Grace, & Titchener, 1983); and (d) the crisis intervention model of Caplan (1964) that focuses on methods to reestablish rational problem solving.

The CISD model was originally developed for the debriefing of ambulance personnel; it specifies that all who witness or survive a large-scale trauma have a one-time, very structured 2 to 3 hour (or longer) group debriefing. Originally, the model suggested that the debriefing take place within 3 days of the trauma; however, more recent formulations permit the CISD to be facilitated up to 14 days post-trauma (Everly & Mitchell, 2000). In this debriefing each person is asked to methodically state his or her role to "recreate" the event, discuss their thoughts at the time, describe the worst part, and discuss their feelings. Following this, the leader will educate the group on trauma, normalize reactions, and allow participants time to provide comments about this process.

The CISD model is highly manualized and is designed such that it can be delivered by paraprofessionals. The procedure has a common-sense feel to it and strives for both symptom relief and prevention of later psychological difficulties. The theory is that if one quickly expresses traumatic memories, these thoughts and feelings will not become feared and suppressed, thus preventing later stress reactions, such as posttraumatic stress disorder (PTSD). PTSD is defined by the American Psychiatric Association's *Diagnostic and Statistical Manual, Fourth Edition* (DSM-IV, American Psychiatric Association, 1994) as a psychological disorder that involves intrusive flashbacks or nightmares, emotional numbing or avoidance, and anxiety.

Research

The CISD Debate

In recent years there has been much controversy surrounding the provision of CISD and PD in the professional literature. Throughout the 1980s and 1990s the creators and chief proponents of CISD, Jeffrey Mitchell and George Everly, advocated for its use, citing positive findings from nonrandomized or noncontrolled studies and meta-analyses of these studies (Bohl, 1991; Chemtob, Tomas, Law, & Cremmiter,

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1997; Flannery & Everly, 2000; Jenkins, 1996; Nurmi, 1999; Wee, Mills, & Koehler, 1999.)

However, in the last decade, critics of CISD pointed to a number of additional pseudo-experimental studies of CISD and group PD that have shown neutral or even negative results in terms of symptom reduction (Carlier, Lamberts, van Uchelen, & Gersons, 1988; Deahl, Gillham, Thomas, Searle, & Srinivasan, 1994; Deahl, Srinivasan, Jones, Thomas, Neblett, & Jolly, 2000; Hytten & Hasle, 1989; Kenardy et al., 1996; Leonard & Allison, 1999; McFarlane, 1988.) Therefore, it is difficult to make a conclusion on the effectiveness of group PD, including CISD, based on these studies. One might note that the vast majority of studies cited by critics of CISD are in academic, peer-reviewed journals, whereas the studies cited by proponents are not. This may suggest a difference in the rigor of the research protocol and resulting validity of the results and conclusions.

Of course an examination of studies of group PD that have used randomized, controlled designs would be ideal. Mental health professionals who follow the scientist-practitioner model will strive to rely on empirically supported (randomized-controlled) evidence of similar interventions to guide their approach (Persons, 2002). However, both proponents and critics of PD concede that there have been no true randomized, controlled studies of group debriefings (Flannery & Everly, 2000; Rose et al., 2001.)

There have been randomized, controlled studies of individual debriefings, similar in content to CISD. There are two extensive reviews of these studies (Litz, Gray, & Brant, 2001; Rose et al., 2001). The Rose et al. (2001) review examined 11 studies, of which three showed positive effects for debriefing, six showed no impact, and two showed adverse impact. All of the studies had some methodological problems. The three studies with positive results (Bordrow & Porritt, 1979; Bunn & Clarke, 1979; Lavender & Walkinshaw, 1998) were some of the weakest methodologically, while the two studies that found a negative impact (Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou, Ehlers, & Hobbs, 2000) were two of only three studies that included both a long-term follow-up and a large sample size.

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The Litz et al. (2001) analysis determined that a smaller number of studies would qualify as randomly, controlled studies of PD. They excluded those that predate the formal diagnosis of PTSD and those that look at the trauma of miscarriage, leaving a total of six studies to be reviewed. The analysis concludes that the studies examined reveal similar changes in PTSD symptoms between control and PD groups. One notable study in the Litz et al. review is that of Deahl et al. (2000). This study attempted to analyze group PD in a controlled fashion; the results showed no clinically relevant differences between PD and non-PD groups, with the exception that those in the PD group reduced alcohol consumption. However, even its authors conclude that it is not a true randomized study. In Litz et al.'s (2001) overall review of all its included studies, they note that "two of the more methodologically rigorous studies" found PD created a degree of PTSD exacerbation. These two studies were the same ones given special mention in the Rose et al. (2001) review.

The first of these more rigorous studies (Bisson et al., 1997) found no statistical difference at 3-month follow-up for those who had PD versus those who did not in terms of levels of depression, anxiety, and overall impact of events or qualification for PTSD diagnosis. However, at 13 months there was a statistical significance in every one of these categories, with those receiving PD doing worse. For example, 26% of those who received PD had PTSD, while only 9% of those who did not receive the PD continued with a diagnosis of PTSD.

The other more rigorous study (Mayou et al., 2000) included follow-up at 3 years. For those participants who initially reported a large impact of a trauma, there was substantial improvement in the group who received no PD but barely any improvement for those who did receive PD. Thus, both of these studies suggest that PD interferes with a natural recovery process. After their extensive review of the literature, Rose et al. (2001) concluded that "the practice of compulsory [individual] debriefing should cease pending further evidence (p. 13)."

Critics of PD argue that there has been no other reliable empirical evidence indicating demonstrable preventative effect, and there is a need for more research (Bisson & Deahl, 1994; Foa & Meadows, 1997; Kenardy & Carr, 1996; Mayou et al., 2000; Stevens, 1997). In addition, critics suggest that any potential benefits derived appear to be no

greater than those provided by simple discussion and social support (Alexander & Wells, 1991; Gist, Lubin, & Redburn, 1998.) Meanwhile, proponents suggest that the individual PD studies have some methodological problems, are stand-alone procedures, and do not strictly adhere to the CISD format (particularly in their being individually administered), while there is quasi-experimental and meta-analytic support for CISD (Everly & Mitchell, 2000).

It is noteworthy that the model of PD advocated by Everly and Mitchell has recently been modified. Everly and Mitchell (2000) note that CISD has been widely believed to be a stand-alone intervention, even though they suggest this was never intended. They call their current suggested form of PD "Critical Incident Stress Management" (CISM), a multicomponent package that includes CISD, as well as pre-crisis education, individual and small-group immediate crisis intervention, and organizational interventions. However, they do not specify which of the components of CISM are minimally needed; thus, there can be no research on CISM in its entirety, and research done on the individual component of CISD (as a stand-alone intervention) has mostly shown it ineffective or harmful, as previously detailed.

There is a muddled picture with regard to the acceptance of PD, CISD, and CISM. A number of prominent organizations have adopted the CISM model, including the Federal Aviation Administration, the Federal Bureau of Investigation, the Massachusetts Department of Mental Health, and the Occupational Safety and Health Administration (as cited in Everly & Mitchell, 2000). However, in the last several years, other organizations have concluded these models should not be used. For example, the British National Health Service now lists CISD as a contraindicated procedure (Gist, 2001), and some other corporate organizations have specifically discontinued its use (Avery & Orner, 1998.) In addition, a group of 19 leading trauma mental health professionals issued a letter cautioning against the use of CISD in the aftermath of the September 11th terrorist attacks (Herbert et al., 2001). Finally, there are ongoing efforts to work with the mental health community to reshape their initial responses to disasters (Academy of Cognitive Therapy, 2002).

The proponents and opponents of group PD draw different conclusions from the research. Table 1 summarizes the differences. The dif-

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ficulty stems from a lack of true randomized, controlled studies of group PD. Proponents suggest that noncontrolled studies be applied, while opponents object and point to negative results from controlled studies that focus on individual interventions. Each group further critiques the primary suggestion of the other group. The proponents say that even the best individual studies have flaws; the opponents argue that the pseudo-experimental research is largely published in nonacademic, nonpeer-reviewed publications.

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Why Debriefing May Be Ineffective or Harmful

The harsh results from the methodologically rigorous individual controlled studies lead to questions about potential problems with debriefing, whether individual or group in nature. One aspect of traditional PD that may be ineffective or harmful is the very quick time frame. Interventions using a similar "exposure" model, but conducted at least several weeks after a trauma, have been shown to reduce and prevent symptoms (Foa & Meadows, 1997.) These researchers hypothesize that immediate intervention may fail because survivors are still in a state of shock.

Furthermore, not only the early time frame but also the single-session aspect of typical PD may be particularly problematic. One very effective treatment for trauma in ongoing psychotherapy is that of "exposure" (Foa & Meadows, 1997.) In this therapy a client repeatedly recalls the traumatic event so that eventually this recollection no longer has a significant impact. In this treatment there is often an initial unwanted side effect of mild exacerbation of symptoms, as these disturbing images and recollections are processed (Pitman, Altman, Longpre, Poire, & Macklin, 1991). As the exposure continues in the context of psychotherapy, the distress and symptomatology lessen as habituation occurs. With a single-session intervention, though, there is no time for habituation; and the debriefing then may act, most unfortunately, as a further traumatic experience (Bisson et al., 1997). From this perspective, the typical college counseling center response of the provision of a single debriefing should be carefully considered.

In addition, researchers note that only 10% to 30% of those witnessing or surviving a disaster will develop PTSD (Stephenson, 2001). There have been consistent findings that most individuals confronted with a disaster will not develop PTSD regardless of whether an inter-

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Table 1
Arguments For and Against Group Psychological Debriefing

	Arguments for Group PD	Arguments Against Group PD
1.	Some pseudo-experimental studies show positive results, and meta-analyses of these studies show a positive effect.	Pseudo-experimental studies are methodologically flawed; any meta-analyses of these studies would, therefore, not be helpful. Furthermore, these studies tend to be published in trade or nonpeer-reviewed publications.
2.	Some studies showing neutral or negative effects did not adhere *strictly* to the CISD protocol.	There are pseudo-experimental studies showing neutral or negative effects of group debriefing that have been published in academic, peer-reviewed publications.
3.	Key Point: There have been no true randomized, controlled studies of group PD; therefore, we should follow the research of pseudo-experimental group studies.	Key Point: There have been no true randomized, controlled studies of group PD; therefore, we should follow the research of controlled, individual studies.
4.	Individual studies deviate too much from the group protocol in the fact that most are individually applied. Also, even the two most methodologically robust studies have flaws.	Individual studies of PD show a variety of results; however, methodologically rigorous studies show negative results—and this cannot be ignored.
5.	The individual studies mostly focus on individuals physically damaged as opposed to rescue personnel or observers, the group for which CISD/CISM was intended; thus, negative results are meaningless.	A difference in type of psychological harm between “primary” and “secondary” survivors of trauma has not been proven; thus, studies of one group can be applied to the other.

Table 1, continued

	Arguments for Group PD	Arguments Against Group PD
6.	Although CISD has been shown effective in pseudo-experimental studies, it is nevertheless only one (optional) part of the CISM package; to base decisions only on the results of CISD studies is to ignore other necessary interventions.	The interventions in CISM are vaguely defined and not specified for particular situations; therefore, CISM cannot be scientifically studied. Some parts of CISM may be called "psychological first aid" and would be recommended. Other parts are also good, practical, common-sense suggestions. Research needs to focus on the aspects that concentrate on interventions that can be measured.
7.	A very large number of important institutions have chosen to use the CISD/CISM system. Many mental health professionals support CISM.	Some institutions have withdrawn support, based on research. CISD has been adopted largely due to marketing and lack of other models. Many leading trauma experts caution against using CISD.
8.	Group PD (similar to CISD has been provided for a number of years, and both those providing the intervention and those receiving it report satisfaction. Various psychological theories also provide support for the interventions.	Face validity does not equal actual validity. There are psychological theories that would explain why CISD is harmful.

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vention occurred (Cook & Bickman, 1990; Helzer, Robins, & McEvoy, 1987; McFarlane, 1988; Rubonis & Bickman, 1991.) Research shows that individuals in general tend to underestimate the ability of people to effectively handle traumatic events (Gilbert, Pinel, Wilson, Blumberg, & Wheatley, 1998). In other words, it is common to think that people will be more harmed by trauma than they actually are. In fact, distress typically reduces over time, and debriefing may unfortunately prolong the process (Kenardy, 2000.)

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One explanation for this process is that debriefing may lead to the expectation for the survivor that further trauma will occur, thereby "medicalising" normal distress (Wessely, Rose, & Bisson, 1999.) Another explanation is that mental health professionals may translate commonly held counseling theories into the realm of crisis intervention—specifically the time-honored belief that discussing a trauma is therapeutic, and that attempting to deny it is not (Rose et al., 2001). In fact, recalling the event may bring about secondary traumatization, while attempting to forget or distance oneself could be an adaptive response. As Rose et al. (2001) reported, "Intervention may interfere with adaptive defense mechanisms. . . . Treatments that are effective in those with an established disorder cannot be assumed to be effective in prevention" (pp. 13–14).

Apparently, a key problem with PD is the mandatory nature of participation. While some may benefit, others do much better not being coerced into these debriefings. Although there is a small percentage of survivors that will develop PTSD and may benefit from certain types of debriefings, there is a larger percentage of survivors that will not develop PTSD and may be harmed by the debriefings.

Until such time as a number of true randomized, controlled group PD studies are completed, there will be uncertainty regarding the direction that a campus response should take. In briefly summarizing the positions of those who favor particular approaches to crisis management, it is fair to say there are reasonable points made by both sides in the debate. As previously detailed, there are good arguments for continuing with traditional debriefings that resemble CISD. There is a theory and tradition behind this type of intervention. Those who favor this approach tend to argue that research provides sufficient evidence for group PD or that randomized, controlled research is not possible or relevant. There are also good arguments for modifying standard approaches. Some believe that it is crucial to focus on randomized, controlled studies, that the research of individual PD is sound and generalizes to the group situation, and that these factors necessitate new methods of crisis intervention.

Alternatives

The previous sections note that campus crises are unfortunately frequent, that various external and internal pressures may lead to more intervention than is necessary, and that research is unclear on how helpful this intervention might be, with some research suggesting it could be potentially harmful. This section provides alternatives for consideration by providers on campus.

One alternative to current approaches focuses on the structure but not the content of group debriefings because one major criticism of CISD, or even the components of CISM, is that it appears to be a "one size fits all" approach. Other alternatives involve radical changes in conducting debriefings or even the abolition of debriefings.

Changing the Structure of Debriefing

Whether one uses a CISD-like approach or other type of group debriefing, one suggestion is to divide participants into several subgroups, based on amount of trauma impact. This may help to prevent those more severely impacted from creating additional trauma for those less affected. Studies show that individuals react differently to trauma (Stephenson, 2001.) Creating different types of debriefings (or not having any for some) may then provide the ideal "treatment." Several studies provide criteria to use in determining this best treatment.

Stephenson (2001) proposed breaking a group debriefing into three subgroups, based on the level of impact of a disaster, starting with those that cause the most potential for psychological response: (a) People personally threatened with possible injury or death (or actually injured); (b) family members, friends, coworkers, and rescue and recovery workers; and (c) those exposed indirectly, such as watching a disaster on television. One might also consider other variables for subgroup identification, such as severity, duration, and proximity to the traumatic event, as these are likely to influence the development of PTSD, according to the DSM-IV (1994, fourth edition).

Ekeberg and Hem (2001) suggested a clinical screening instrument be used to determine who might benefit from debriefings. For example,

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those with preexisting mental disorders are likely to be more greatly impacted (Stephenson, 2001.) Similarly, Litz et al. (in press) suggested an initial screening instrument be provided to those affected. The instrument would inquire as to the individual's experience with previous trauma, prior psychological problems, level of social support, ongoing stressors, and exposure to particularly grotesque aspects of the event. This information could be provided in the form of a self-scoring instrument, with recommendations that those who score in different ranges attend certain types of group debriefings or individual therapy.

Of course, having the time and administrative structure to administer such screenings or even to arrange different subgroups for group debriefings can be challenging, particularly in the face of a large-scale disaster, such as the September 11th terrorist attacks. One approach to deal with this dilemma is to consider the type of trauma for the entire group affected, as different traumas may suggest specific interventions. For example, a meta-analytic study by Rubonis and Bickman (1991) showed greater psychopathology following a disaster if there were many casualties and if the cause of the disaster was of natural as opposed to human origin. These authors suggest the inclusion of bereavement counseling as part of the intervention when there are casualties and, in the case of natural disaster, helping survivors understand causes of the disaster.

Changing Any Mandatory or Peer-Pressure Debriefings

In addition to creating subgroups in debriefings and tailoring these debriefings for type of trauma, those who organize interventions may also want to work to avoid making any organized debriefing mandatory or seemingly mandatory, particularly given the uncertainty of research in this area. For example, if a tragedy occurs involving members of the college Greek system, would all members in a chapter be mandated to attend a debriefing? What about those in a residence hall? Even if there is no stated mandatory aspect of a debriefing, there may be an unstated message that attending the debriefing is the correct or expected course of action. Survivors of trauma may be in a state of shock and have difficulty determining what to do, including whether to attend a debriefing. Campus staff can help any group orga-

nizing a debriefing by making clear, in an overstated way, that attendance is not necessary and may not be helpful or needed by all. The message announcing a debriefing should be framed as an invitation to interested individuals rather than an expectation.

The issue here may be viewed as one of informed consent. It is ethical to explain potential risks to participants in an intervention. There may be adverse effects to certain types of PD, and staff should strive to keep from pushing a particular approach onto survivors. Professionals who react negatively to this suggestion may wish to consider the writings of Beahrs and Gutheil (2001), who suggest that professionals should be alert for warning signs of being entrapped within a "problematic therapeutic fad." These signs include a sense of ungrounded certitude in traditional methods in the face of controversial data, a sense of sociopolitical mission, or polarization.

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Moving Away from Debriefings

In addition to modifying the traditional large-group debriefing or attempting to make attendance appear less mandatory, a number of authors have suggested a move away from the entire debriefing framework. This idea to move away from group PD has support from reviews by Bisson and Deahl (1994) and Raphael, Meldrum, and McFarlane (1995), who concluded that factors other than the presence or absence of PDs determine the outcome for those exposed to trauma (i.e., social support helps while previous psychopathology hurts). Given current research on possible deleterious effects, some have even cautioned against debriefings for legal reasons, suggesting that sanctioning PD goes against duty-to-care obligations (Avery & Orner, 1998.)

Other Options

There are a number of options that may be used in replacing or supplementing group PD. Should both group PD and other options be offered, it would be important to stress that the alternatives may be very effective, given that this would be a move away from the traditional methods for both staff and students.

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Individual Therapy

Research by Foa (2001) has shown that the vast majority of those surviving or witnessing a trauma will recover naturally within five months; in addition, she has shown that using individual cognitive-behavioral exposure therapy expedited this process, reducing PTSD by 90% within 2 months. While most will not need this intensive therapy, those who experience a trauma can be directed toward this type of intervention as a possibility. Also, some may simply need reassurance. In either case, individual therapy, while not as efficient (and at times perhaps not even practical), provides an excellent opportunity for more in-depth screening to determine the best course of treatment, if any.

Natural Support Systems

Campus officials can help survivors use their natural support systems and also work before crises occur to have such support systems in place as much as possible (Gist et al., 1997). The suggestion for more helpful support "comes down to a few simple aphorisms: People are resilient; friends are important; conversation helps; time is a great healer; look out for others while you look out for yourself" (Gist et al., 1997, p. 28).

Similarly, Stephenson (2001) encourages survivors to talk to each other, get rest and respite, and return to normal routines. Additionally, social support is listed in the DSM-IV as having some evidence for being an ameliorating variable in the development of PTSD (APA, 1994). One key study (Cook & Bickman, 1990) showed a direct correlation between perceived social support and less symptomotology, although the benefits did not occur until one week after the trauma. The type of perceived social support that is later most helpful is that of provision of resources and availability of a social network, but not direct advice or assistance (Cook & Bickman, 1990). Critics of PD specifically call for the support of community structures that people naturally call upon in times of grief and suffering (Goode, 2001.) These ideas certainly can be applied on the college campus.

The "Foa Guidelines"

A specific set of guidelines has been written by Foa (personal communication, 2001), a leading trauma researcher, following the September 11th terrorist attacks:

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1. People should be encouraged to use natural supports and to talk with those they are comfortable with—at their own pace. They should follow their natural inclination with regard to how much and to whom they talk.
2. If someone wants to speak with a professional in the aftermath of a crisis, a helpful response will be to:
   a. listen actively and supportively but not probe for details and emotional responses, and
   b. validate and normalize natural recovery.
3. People should not be debriefed for single-session interventions in the initial aftermath. People should be scheduled for 2 to 3 more visits over 2 to 6 weeks.
4. Traumatic experiences may stir up memories or exacerbate symptoms related to previous traumatic events, as in "opening old wounds." These symptoms should be normalized and are likely to abate with time. It may be helpful to ask people what strategies they have used in the past and encourage their use.
5. Those individuals who continue to have severe distress that interferes with functioning after 3 months are at higher risk and should be seen for appropriate treatment.

The "ACT Guidelines"

In January 2002, the Academy of Cognitive Therapy (ACT) also issued recommendations for mental health professionals responding to trauma that are based on research in the area (ACT, 2002). They suggest that within the first month after a trauma professionals provide "psychological first-aid," which includes helping individuals with physical safety, practical needs, connecting with social supports, education regarding typical trauma symptoms, and support for making necessary decisions. In addition, it is suggested that any discussion of the trauma include only what the individual wishes to discuss—that therapists should not encourage any retelling of the trauma.

Planned Campus Coordination

In addition to these clinical suggestions, meetings amongst college counselors, administrators, residence life staff, and others who might be involved in critical incidents should take place before such occurrences. This will facilitate a more coherent response when a tragedy

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strikes, as these are times of high emotion. It is important to stress that alternatives to CISD may be very effective. National or regional experts in crisis intervention may contact the campus and suggest they come to campus and intervene, often planning to use the CISD/CISM model. They can sometimes doubt the abilities of those at the campus to handle crises appropriately (Stone, 1993). This questioning of ability, in addition to a natural surge in emotionality, will undoubtedly complicate the campus response. Given the prepackaged and long-standing stature of CISD/CISM, many have chosen this intervention. Campus officials may want to consider developing their own pre-arranged plan, including their response to those who advocate for the CISD approach. The suggestion of specific planning for crises have been well presented by Stone (1993) and Miller (1995), although new research regarding their suggestions for using CISD as a crisis intervention model may suggest some modifications.

In this planning campus officials may arrive at a combination approach—one that allows for group PD but removes the older CISD elements that may be problematic. This type of group PD would exclude any emphasis on asking survivors to recount events, and facilitators would avoid probing for thoughts and feelings. Facilitators can set up a less structured group PD that allows those in the group freedom to say whatever they wish. The role of the facilitator then shifts from someone who tries to get participants to process thoughts and feelings to someone who provides empathy, support, resources, and a safe place for discussion. There appears to be no research showing any detriment for counselors to provide empathic support for students after a crisis. This approach may be the latest consensus of mental health professionals (as cited in Goode, 2001). After a thorough review, researchers from U.S. Army, National Center for PTSD, and the Boston Veterans Administration (Litz et al., in press) conclude, "In general, it may be that PD provides an opportunity for individuals in a homogenous group to feel validated, empowered, and de-stigmatized by their organization and peers, and that the group-based approach contributes to better functioning in the work environment after a high-stress incident. It appears that the form and content of PD needs to be structured, however, in ways different than those prescribed by CISD" (p. 45).

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Summary and Conclusion

Campus officials will be called upon to deal with campus crises—an unfortunate aspect of campus life. A variety of pressures, such as an administrator's need for quick response, the counseling center staff's need to demonstrate their capabilities, and a history of providing one-off debriefings all lead towards this traditional response, often modeled after the CISD approach. Research on this type of intervention yields unclear results, as pseudo-experimental studies sometimes show positive findings, while randomized controlled trials of somewhat similar approaches show not only a lack of positive effect but also a negative impact. Given the potentially problematic nature of standard responses, campus officials may wish to consider alternatives, such as separate debriefings for different levels of trauma, less-mandatory debriefings, creating structures to boost social support for those affected, and individual therapy.

At this point in time an examination of the research does not reveal a best alternative or show definitively that any are superior to traditional models. However, as the preceding discussion illustrates, there may be an emerging paradigm shift, one that suggests moving beyond the now classic one-time debriefing. It is hoped that this article will be provocative, stimulating thinking and opening new or additional dialogue by campus professionals into the various options available for campus crisis intervention.

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