Organizing the Mental Health Response to Human-Caused Community Disasters With Reference to the Oklahoma City Bombing

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Disasters require interventions related to acute, and sometimes enduring, medical and psychological trauma. The advent of terrorist attacks on U.S. soil—the bombings of the World Trade Center in New York City in 1993 and the federal building in Oklahoma City in 1995—forever altered our view of disasters in this country. No longer does our response focus exclusively on the wrath of nature. Now, we must confront the wrath of humanity, which may include massive death and mutilating injury, and we must contemplate the dread and vulnerability associated with the deliberate and calculated violent acts of people. This article describes the elements of the formal mental health response to human-caused community disaster using the Oklahoma City bombing as an example. We discuss the government’s role, the role of charitable organizations such as the American Red Cross, and the involvement of professional organizations and academic institutions. Also, we identify challenges that result from limitations in the current approach.

Communities have geographic reference and boundaries, but they are much more. They are composed of individuals and groups with complex interpersonal bonds and interactions guided by formal and informal rules and codes of behavior. Communities have the potential to confer risk and to promote resilience. Perhaps the best descriptions of the potentially powerful impact of a disaster on a community are the rich accounts of the Buffalo Creek dam collapse. Not only were many residents killed, the community was destroyed. Relationships that had once provided emotional support were shattered, and the sense of security and strength that neighbors had known from being part of a larger whole was gone forever.

The Oklahoma City bombing was similar to the Buffalo Creek disaster in many ways. Oklahoma City, although much larger than Buffalo Creek, is a relatively small and stable community. The bombing, similar to the Buffalo Creek flood, was caused by humanity. There were 168 deaths in Oklahoma City; more than one-third of the population reported knowing someone who had been killed or injured. The
rescue effort involved more than 12,000 professional responders and lay volunteers, and it was protracted. Unlike Buffalo Creek, the Oklahoma City community itself was not destroyed and the shock and resulting sense of vulnerability united the Oklahoma City community in the rescue and mourning processes. Like Buffalo Creek, the incident has been integrated into the history and concept of the place.

THE MENTAL HEALTH RESPONSE

The Structure of the Response

The primary official responsibility for disaster and emergency management rests with local government. When local resources are inadequate, state government, under the direction of the governor, assists by directing federal and state resources. In these situations, the governor charges the state office for emergency services with disaster management; this office, in turn, assigns tasks to other state agencies responsible for disaster relief and recovery. If state and local resources are insufficient for the response, federal assistance is available.

The Disaster Relief Act of 1974, later amended by the Stafford Disaster Relief and Emergency Assistance Act, established the mechanism for federal intervention in presidentially declared disasters. The Federal Emergency Management Agency (FEMA) coordinates the federal response by providing financial resources through the Emergency Services and Disaster Branch of the Federal Center for Mental Health Services (CMHS) of the U.S. Public Health Service. FEMA empowers the state mental health authority to provide care and, in especially large or complex disasters, may direct a number of federal agencies and departments to assist under the Federal Response Plan.

Application for support involves several steps. Within 10 days of the date at which the President declares the disaster, the state must initiate an assessment of need to be eligible for funding. Support is available first through an Immediate Services Grant and later through a Regular Services Grant. The Immediate Services Grant must be requested within 14 days of the date of disaster declaration. It provides support for up to 60 days after that date. Within 60 days of the date of disaster declaration, the Regular Services Grant must be submitted. It provides funding for 9 months with a possible extension of up to 3 months in situations with extenuating circumstances. In especially large or complex disasters, the grant period has been extended for a longer period.

In the aftermath of the bombing, the Oklahoma Department of Mental Health and Substance Abuse Services (DHMHSA) was the designated state agency to organize, coordinate, and conduct the official mental health response. The DHMHSA established Project Heartland, which itself, and through subcontracts, provided an impressive array of services. Funding in Oklahoma City was extended to almost 3 years, and the Department of Justice continued to provide resources for a considerably reduced operation into a fourth year.

The Role of the American Red Cross

The American Red Cross, an independent humanitarian organization funded through donation but under congressional mandate, has a central and unique role in disaster response. Its mission is to ensure nationwide disaster planning and preparedness, community disaster education, disaster mitigation, and response. Local chapters form the first line of response, assisted by the national organization when needed.

In 1991, the American Red Cross officially announced the formation of the Disaster Mental Health Services (DMHS) with the goal of providing mental health services in all disasters. Volunteer mental health professionals are an important component of the DMHS effort. In Oklahoma City, the American Red Cross, in conjunction with other charitable and professional organizations and individuals, established the Compassion Center for crisis support and death notification. The Compassion Center operated for a period of 19 days following the bombing.

Clinical Services

The philosophy underlying the federal program focuses on normal responses to disaster. Services are designed to address mental health problems caused or aggravated by the disaster and prevention. They are available to residents of the community in which the disaster occurred, those who work in areas impacted by the disaster, and those who were present at the disaster. The federal approach emphasizes crisis intervention, supportive counseling, outreach, community liaison, public education, and referral. Programs are adapted to local cultural, geographic, and political needs and limitations. They do not supplant already existing services or programs. A comprehensive description of the Federal Crisis Counseling and Training Program can be obtained at no cost from the Emergency Services and Disaster Relief Branch at the CMHS.

Crisis intervention following a disaster focuses on numerous activities not commonly associated with traditional mental health treatment. It may involve assistance with physical needs, relocation and shelter, and financial matters. Outreach, including public information and education about likely responses and potential sources of assistance, is also provided.

In Oklahoma City, Project Heartland subcontracted with a host of providers to work with special populations, such as children, the elderly, minority groups, and those with preexisting serious mental illness. Project Heartland and its
subcontracted partners have seen almost 9,000 clients. Services have included screening, evaluation, and referral; crisis intervention in person and on the telephone; counseling; and support services. Countless more hours have been spent on programmatic activities and outreach.

Among the programmatic innovations of Project Heartland was a subcontract with an existing community self-help program serving adults with severe and persistent mental illness. A number of clients in this program resided in the area adjacent to the bombing and were displaced as a result. They suffered additional stigma related to their mental illnesses because all around them they heard that this incident must have been perpetrated by "a crazy person." The subcontract with this organization provided funds to add staff and to reach out into the community to those with preexisting mental illnesses who were having difficulty coping following the bombing.

Although the federally funded program focuses on crisis management for those with nonpathologic reactions to disaster, it also provides for identification and referral of those with more severe psychiatric disorders. The initial focus of the American Red Cross was also on the emergency phase of disaster,11 but in Oklahoma City, the American Red Cross and other charitable, professional, and volunteer organizations assisted by providing mental health services directly or by funding services offered by others. These services, which are beyond the scope of the crisis program established by the government, form a vital part of the response. They include, for example, comprehensive evaluation and long-term treatment for those with severe and chronic responses, treatment with psychoactive medication, and impatient and partial hospitalization.

Committees addressing unmet needs are necessary to identify and address the complex and enduring problems of individuals and the community, to pool resources, and to prevent duplication of services.12 A committee established in Oklahoma City following the bombing continues to function more than 3 years later.

Training

The federally funded program, the American Red Cross, professional organizations, and academic institutions support and offer an array of training activities for professional and volunteer responders, community and religious leaders, and mental health professionals who provide direct services.11,14 This training, which traditionally has not been included in the formal training of many professionals, is essential. It focuses on the specific issues associated with immediate concerns.14

The Role for Academic Institutions

Academic health institutions may have a key role in disaster response by providing clinical service, education, and training, and by conducting research. Within hours of the bombing in Oklahoma City, the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center (OUHSC), located approximately 1 mile from the bomb site, became actively involved, providing needed clinical crisis services and developing research studies. Faculty have assisted in numerous aspects of the response through activities with other organizations such as Project Heartland, the American Red Cross, the Oklahoma Psychiatric Association, and the Oklahoma Psychological Association.

Project Heartland has focused on outreach and crisis intervention. In the school-based program of Project Heartland, graduate students from local academic institutions, under the supervision of their faculty, provided much of the direct care. Clinicians at the OUHSC and other professionals in the community have provided comprehensive evaluations and intensive treatment. Grants from the Robert Wood Johnson Foundation, the Oklahoma City Community Foundation, the Children's Medical Research Institute, and other charitable organizations have made it possible to initiate formal treatment programs for adults and children and to offer long-term care. Drug companies have assisted by providing medication free of charge for those without resources.

Academic programs commonly have formal programs in anxiety and posttrauma care and they may have faculty experienced in disaster response. They can be helpful, therefore, in the broad-based training that must occur in the aftermath of an incident. In Oklahoma City, faculty from a number of institutions have provided in-service training, assisted in a community forum, and helped with public education efforts.

Every disaster has unique features, but each can be instructive for the next, making it important to document and study what has occurred. The Oklahoma City bombing offered the opportunity to examine the effects of domestic terrorism not previously explored. Concerned about the exploitation of victims, and the need to obtain meaningful and valid data, the governor identified the OUHSC as the agency responsible for overseeing research after the bombing. This resulted in a centralized approach that was integrated with clinical services and that facilitated cooperative efforts with investigators from other institutions.15-17 An extensive mental health database has been established with information on direct victims, the bereaved, rescuers and responders, and general adult and child populations.

The OUHSC Institutional Review Board (IRB) has also played a key role by agreeing to review or approve research requests in an expeditious manner and with heightened focus on protecting victims.16,17 The IRB also provided guidelines about conducting research in this set-
ting to IRBs across the country and informed
the division director for disaster/emergency
research at the National Institute of Mental
Health of the coordinated effort. ¹³

Major disasters present many opportunities
for creative and mutually beneficial public-acade-
mic linkages. Although training and research
programs involving mental health professionals
are among the most common, other opportuni-
ties exist but seldom come to fruition. For exam-
ple, schools of education could be enormously
helpful in fashioning school-based interventions
for children and their families. Law schools
could play a therapeutic role in helping victims
and survivors of human-caused disasters—espe-
cially criminal and terrorist incidents—under-
stand the legal process and their role in it.
Schools of public health could lend expertise
in how to inform the public about health and men-
tal health consequences and could assist in
designing and evaluating service programs.
Computer science departments could be helpful
in pre-event data systems design, selection, or
both.

CHALLENGES

The formal response directed by govern-
ment, education, and other agencies involves well-
defined roles in disaster response and manage-
ment. This is not true of many individuals and
professionals and lay volunteer groups. As events
unfold, initial feelings of altruism are replaced
by a more complex array of interpersonal
dynamics and a host of challenges. Mental
health professionals must examine the roles and
relationships among the various disciplines as
each seeks to create and preserve a unique pro-
essional identity with shared responsibilities.
This may be particularly difficult during disas-
ters, when confusion and chaos reign and when
service demands are increased. Therefore, it is
essential that thought be given to the appro-
riate roles and relationships before disaster
strikes. These issues should be incorporated into
the curricula that inform trainees and practi-
tioners of the various disciplines and in the
preparation and planning for future disasters.

The provision of mental health services fol-
lowing major disasters has evolved considerably
during the past two decades. Preparedness
occurs at many levels. A strength of the federal
response is in providing accessible community-
based services to large numbers of people. The
goal of the federally supported program is to
work closely with experienced mental health
professionals to establish a well-coordinated
network of services and to refer those in need of
comprehensive evaluation and treatment. It is
therefore imperative that crisis counseling pro-
grams include staff skilled not only in crisis
intervention, but also in the recognition of signs
and symptoms of serious disorders.

The federal crisis counseling program has
developed primarily through experience with
natural disasters within the United States. The
Oklahoma City bombing made it clear that the
program must address the additional challenges
posed by human-caused disasters, especially
large-scale events involving many casualties. In
particular, these programs must be developed to
deal with more serious and enduring psychologi-
cal sequelae in greater numbers of victims. The
financial, programmatic, training, and adminis-
trative consequences resulting from the need for
long-term specialized care must be anticipated
and addressed in the earliest phases of disaster
response while concerned individuals and orga-
nizations can be mobilized to assist.

Although personal injury, death, and prop-
erty damage may be of primary concern follow-
ing a disaster, emotional responses and psycho-
logical sequelae can be overwhelming and
enduring. Our knowledge about the critical
factors that influence disaster response and the
application of increasingly sophisticated and
rigorous research methodology used to study it
must be translated into improved clinical
approaches that can be used to guide future
planning and response.

It is important that academic institutions
and professional societies develop educational
curricula and materials to prepare better for all
disasters. Finally, thought must be given to the
development of a coordinated clinical and
research database to inform response to future
disasters. This would be particularly useful for
human-caused disasters such as terrorist inci-
dents, especially given the recent attacks on our
citizens and institutions abroad.

As we begin to take comfort in our
accomplishments, the specter of more alarming
types of events, for which we are woefully under-
prepared, is emerging. Terrorism and the threat
of terrorism are increasing. Terrorism involving
nuclear, chemical, or biological weapons pre-

dents staggering challenges with respect to pre-
paredness, response, and recovery. If we fail to
learn from our experiences, if we fail to reach
new levels of collegial and collaborative plan-
ing, and if we fail to think as creatively as
those who would use these weapons, we will fail
to serve those who will need our services more
than ever before.

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