PROJECT HEARTLAND

Project Heartland: Oklahoma's Mental Health Response to the Bombing

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Abstract

The April 19, 1995 Murrah Building bombing in downtown Oklahoma City resulted in the largest mass murder in American history. One hundred sixty eight people were killed, 782 people were injured, 312 buildings were damaged, and 5 buildings were destroyed. The Oklahoma City bombing was a disaster. Disasters constitute a mental health danger to survivors. Within one month of the bombing the Oklahoma Department of Mental Health and Substance Abuse Services was designated the lead agency in crafting a community mental health response targeted to reduce long-range impairment to those directly and indirectly affected. On May 15, 1995 Project Heartland and Project Heartland Center opened. Project Heartland and Project Heartland Center are the first of their kind in America. They are the first American community mental health program and facility designed to intervene with the survivors of a major U.S. terrorist event in the short-to-medium term post attack. The lessons learned by Oklahoma's effort need to be studied by others for the benefit of survivors of future terrorist attacks in other American cities.

INTRODUCTION

At 9:02 am CDT April 19, 1995 a yellow Ryder rental truck, containing an ANFO bomb composed of thousands of pounds of ammonium nitrate and fuel oil stored in blue plastic drums, exploded in front of the Alfred P. Murrah Federal Building in downtown Oklahoma City. This explosion resulted in the largest mass murder in American history (168 people dead); the largest criminal assault in American history (over 700 people injured); the largest crime scene in American history (almost 50 square blocks including 312 buildings damaged, 25 damaged severely, and 5 buildings ultimately destroyed); and the most costly crime in American history (estimated $652 million dollars in property damage) (S. Gonzales, personal communication, September 26, 1995[1]; Boehler, Lowrance, and Allen, 1995). Sixteen thousand seven hundred and forty-four people worked or lived in the bomb area. Seven percent of Oklahoma City's residents were within one mile of the bomb site at the time of the explosion. An additional 20 percent were less than five miles away. Almost all of the citizens of Oklahoma City heard the explosion.

Twelve thousand three hundred eighty-four workers were involved in the rescue, with 11 Urban Search and Rescue Teams from other cities assisting in the recovery work. The disaster mental health response was equally notable. Eighteen hundred volunteers, many licensed mental health professionals, counseled and supported thousands of people during the immediate post impact phase of the bombing (Boehler, Lowrance, and Allen, 1995). Personnel associated with the Disaster Mental Health Services (DMHS) of the American Red Cross (ARC) reported 19,327 clinical contacts (Jacobs, 1995). The last three bodies were recovered on May 29, 1995, 41 days after the bombing. The Oklahoma City bombing was a disaster of major proportions.

Disasters constitute a mental health danger for survivors. It is also recognized that disasters require the implementation of preventive strategies via specialized programs targeted to reduce or prevent long-range impairment (Myers, 1994). One way preventive programs can be categorized is in relation to time of service with respect to original disaster impact. Thus one can focus on

programs which implement preventive strategies immediately; programs that provide preventive strategies in the short-to-medium term post impact; and programs that furnish preventive strategies to disaster survivors in the medium-to-long term post impact (Zarle, Hartsough, and Ottinger, 1974; Heffron, 1977; Lindy, Grace, and Green, 1981; Creamer, Buckingham, and Burgess (1991).

The aim of this article is to describe and discuss the development, implementation, and lessons learned to date of Project Heartland and Project Heartland Center. (With respect to this latter task the reader should note that the ideas, concepts, and/or suggestions presented are based on the author's interviews and observations and thus is qualitative not quantitative research. Likewise, the conclusions and opinions expressed are the author's alone and should not be attributed to any other individual or organization.) Project Heartland is a specially designed mental health program under the direction of the Oklahoma Department of Mental Health and Substance Abuse Services. Its purpose is to provide crisis intervention, support groups, outreach, and education to individuals and organizations who are affected by emotional or physical proximity to the Oklahoma City bombing. Project Heartland Center is the central clearinghouse and primary provider of all activities related to crisis counseling and outreach. Project Heartland and Project Heartland Center are unique. Project Heartland is the first American community mental health program specifically designed to intervene with the survivors of a major U.S. terrorist event in the short-to-medium term post attack. Project Heartland Center is the first community mental health facility designed to provide services to such survivors (B. Flynn, personal communication, June 3, 1996[2]). Project Heartland and Project Heartland Center opened on May 15, 1995 in Oklahoma City and are designed to provide services for approximately two to three years (S. Boehler, personal communication, January 5, 1996[3]).

THE DISASTER

The Oklahoma City bombing can best be described as a human-made, social disaster; one that is centripetal in nature. As such its impact has unique characteristics and, thus, unique

consequences for the populace. Hodgkinson (1989) notes that both natural and human-made disasters are sudden and powerful. However, natural disasters are seen as uncontrollable, as "Acts of God'. Human-made disasters, though, are usually perceived as avoidable; if it were not for the negligence or criminal activity of some person or persons the disaster would not have occurred.

Lindy et al. (1981) compare and contrast centrifugal disasters with centripetal disasters. Examples of a centrifugal disaster are a plane crash, train wreck, or a deadly restaurant fire. Prior to the disaster, the victims neither live nor work in the disaster area. Following disaster impact the survivors scatter centrifugally away from the site of death and destruction. On the other hand, examples of a centripetal disaster are a tornado, flood, or the bombing of a city's downtown area. Prior to the disaster, the victims live or work in the disaster area. The community itself becomes a victim and a survivor. This has occurred in Oklahoma City.

Social disasters are those that threaten the social structure of a given population through civil and political unrest. A recent example is the 1992 Los Angeles unrest. Social disasters are hypothesized to be particularly demoralizing for those effected (Scott, 1992; Aguilera and Planchon, 1995).

The Oklahoma City bombing physically and emotionally impacted more than just the Alfred P. Murrah Federal Building and those within it. Seven hundred and eighty-two individuals reported being physically injured by the blast and attempts to escape the area. While it is true that over 45% of the Murrah Building occupants were killed, only 387 of the injuries occurred inside the Murrah Building and in four adjacent buildings; the rest were injured by the blast at more distant locations. A further 71 injuries, including one death, were reported by individuals involved in the rescue and recovery efforts. Nineteen children were killed and 46 injured. Thirty children were orphaned and 219 children lost a parent. Four hundred and sixty two people were left homeless (A. Lowrance, personal communication, January 5, 1996[4]; Boehler, Lowrance, and Allen, 1995).

Aguilera and Planchon (1995), quoting personal communication from D. Bowencamp, report that :

> The 1995 Oklahoma City bombing of a federal building brought to the fore the effects of unexpected social disaster on individuals and a community. Acute shock reactions were witnessed at a much higher degree, grief reactions were more dramatic and extreme, there was more initial anger, somatic symptoms such as strokes and headaches were more pronounced, posttraumatic stress symptoms usually seen weeks or months after the initial incident were apparent before the initial responders had left the incident site (p. 555).

Epidemiological research has begun. This work is being performed by the Gallup organization in association with the University of Oklahoma and the Oklahoma State Department of Health. Also, the faculty of the Department of Psychiatry at Washington University in St. Louis School of Medicine in association with the Oklahoma State Department of Health are performing research with direct survivors of the blast. However, the data is not presently available for publication.

One piece of data which is of public record is the results of a survey of mental health providers performed in the months following the bombing by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). Results indicated an 8.4% increase in practice load and 12% of all patients had bomb related needs. A second survey performed in September 1995 indicated 17.7% of the patients had bomb related treatment needs (Boehler, Lowrance, and Allen, 1995).

Another piece of data stems from a survey of the Oklahoma City Public School District. Of 39,000 students enrolled in 88 schools, students or staff suffering the loss of a close relative are in 47 of 64 elementary schools, 9 of 10 middle schools, all 9 high schools, and 3 of 4 special schools.

Over 40% of teachers and staff sampled reported worrying about personal safety, approximately 70% of the youth sampled expressed fear for the well-being of a family member, and approximately 15% of the youth sampled stated that they did not feel safe (Boehler, Lowrance, and Allen, 1996).

This data, plus subsequent clinical reports from Project Heartland Center staff, underscores the correctness of the original decision, made on April 24, 1995 by Oklahoma's Governor Frank Keating, for ODMHSAS to develop and implement a short-to-medium term community mental health response to the bombing .

THE HEROIC PHASE: PLANNING PROJECT HEARTLAND

Disasters can be understood in terms of phases (Dynes, 1974; Titchener & Ross, 1974; Farberow, 1978; Cohen & Ahern, 1980; Farberow, 1985; Lechat, 1990; Aptekar, 1990; and Omer & Alon, 1994). The model that has been most helpful for Project Heartland staff is that described by Farberow (1985) and adapted by Myers (1994). Farberow describes a four phase paradigm. These are termed the heroic phase, the honeymoon phase, the disillusionment phase, and the reconstruction phase.

The heroic phase occurs during, what other authors term, the impact phase. The disaster strikes and the individual attempts to survive and help others. According to Farberow the next phase, the honeymoon, lasts from 3 to 6 months and is characterized by optimism as survivors look forward to reconstructing their lives. The disillusionment phase, which Farberow states lasts from one month to one to two years, is characterized by anger, cynicism, and frustration as the promises of proffered aid fail to materialize as hoped and expected. The last phase, reconstruction, occurs as the people and community work to rebuild their lives. The present author has observed that these phases are not necessarily mutually exclusive.

On the day of the bombing the American Red Cross, in cooperation with many other community agencies and individuals, including representatives of the Oklahoma Psychological Association's Disaster Response Network (DRN), established a notification center at the First

Christian Church in Oklahoma City (J. Tassey, personal communication, May 17, 1996[5]). This later became known as the Compassion Center. A second center, called the Shelter, was opened at St. Luke's Methodist Church. The Compassion Center and the Shelter provided crisis intervention and support for affected families and friends. It was during this heroic phase of the bombing disaster that eighteen hundred volunteers, most of whom were mental health professionals, counseled and supported thousands of people in the Oklahoma City area.

A thorough analysis of the immediate post disaster mental health response is not the focus of this article. However, Jacobs (1995) notes that in Oklahoma City during the heroic phase "mental health services were delivered in a timely and well-coordinated manner despite the large loss of life and prolonged recovery efforts involved...(p. 546)." Yet, according to Aguilera and Planchon (1995), again citing Bowencamp, ARC disaster workers "were met initially by an extremely limited number of appropriately trained mental health professionals, by well-meaning but inexperienced community members attempting to deal with grieving families (without supervision), and by a continued reluctance to create resources for victims following the exodus of trained professionals (p.552)." Information from the person who administratively directed the Compassion Center from April 27 until it closed suggest that she felt enmeshed in "chaos" (G. Allen, personal communication, May 20, 1996[6]).

Nevertheless, by April 24, planning was underway at ODMHSAS, which had been selected as the lead state agency for coordinating, organizing, and conducting the mental health crisis response efforts. The American Red Cross provides only immediate post impact crisis intervention services. Thus the Compassion Center and the Shelter were scheduled to close within a relatively short time frame. The ODMHSAS executive team, composed of the Commissioner, the Assistant and Deputy Commissioners, and the Chief of Staff grappled with the many issues of developing a short to medium term community mental health intervention program to take these centers' place. The following decisions were made.

First, a "shadow staff" was selected and placed in the Compassion Center. This "shadow staff" included the future director of Project Heartland. Their job was to interact with both the staff of the Compassion Center as well as the survivors; to provide services, administrative and clinical, as well as develop a visibility or presence. As a part of developing an identity and to help the survivors prepare for the transition from an immediate crisis center to a longer term center, ODMHSAS staff developed a list of possible center names. Three of these were selected and an informal poll was conducted of affected families at the Compassion Center. The name ultimately selected was Project Heartland. Soon all the "shadow staff" were wearing Project Heartland name tags. Likewise, banners were placed within the Compassion Center and families and the media were briefed about Project Heartland.

The transfer of responsibility for the Compassion Center between the ARC and the ODMHSAS occurred on April 27. Unfortunately, it was not an easy one. Tension developed between certain members of the ARC, both national and local, and the ODMHSAS staff which hindered the smooth transition between the two organizations.

Another decision made, which was designed to aid in the survivors' transition from the Compassion Center, was the hiring of several staff members to work at Project Heartland Center who were actively involved at the crisis intervention center. This was believed helpful since rapport had already been established with several families and they would not have to rehash their stories and history.

The next decision undertaken was Project Heartland Center's location. It was decided Project Heartland Center should be, as close as possible, in the same part of the city as the Compassion Center and easily within reach of public transportation. Next, for the sake of confidentiality, it was decided Project Heartland Center not be located as the sole tenant in a separate, readily identifiable building. Thus, a two story office complex was selected. Within this complex are many different businesses and offices, such as dentists, accountants, attorneys, etc. It

was believed potential clients, particularly police officers and fire personnel, would feel more comfortable with the anonymity of visiting such a multitenant building. To date clinical report indicates this decision was correct.

Fourth, a computerized data base was developed. By April 20 the Compassion Center staff had begun developing a data base. This data base proved invaluable both immediately post impact and for Project Heartland. Initially, the database included volunteer information such as professional licensure, areas of specialty, contact information, etc. Also recorded was survivor information including basic demographic data as well as number and type of contacts made with the center. Presently, the Oklahoma Mental Health Information System (OMHIS) is logging pertinent client information for Project Heartland.

On May 8, Project Heartland and Project Heartland Center was announced and on May 15 the facility was opened. Generally, ODMHSAS staff realized Project Heartland should provide crisis counseling, support groups, outreach, and education for individuals affected by the bombing. Important information regarding program development was obtained through formal and informal consultation with representatives of the Los Angeles County Mental Health Department, the California Department of Mental Health, and from a draft copy of Myers (1994) (G. Allen, personal communication, May 20, 1996).

Likewise, it was felt crucial to obtain further input from the community as a whole. Thus on May 31, ODMHSAS sponsored a statewide forum in Oklahoma City to develop a mental health disaster recovery plan (A. Lowrance, personal communication, January 5, 1996).

One hundred stakeholders were invited to participate in one of five, half-day facilitated workshops designed to develop specific goals for mental health disaster recovery. These were entitled Community Outreach; Needs of Ethnic Populations; Children; Needs of Other Populations (Veterans, Geriatric, etc.); and Public Information and Education. Each work group was asked to develop and prioritize a list of five crucial needs. Representatives from professional organizations,

such as the Oklahoma Psychological Association; the Oklahoma Medical Association; the police and fire department; the city, county, and state government; the school system; various charitable organizations; and various ethnic groups, among others, attended.

This half day workshop was not a cross agency disaster planning meeting, but rather a state wide forum composed of invited citizens asked to develop overarching objectives for mental health recovery. The results of this workshop were incorporated into Project Heartland's agenda and used by the ODMHSAS as a guide in developing overall service goals (A. Lowrance, personal communication, January 5, 1996).

Serendipitously, the workshop acted as significant healing tool for the participants, helping them gain some measure of control and focus in their personal and professional response to the bombing. This use of a quasi-public disaster relief planning workshop involving approximately 70 prominent and concerned citizens appears unique in the reported disaster literature.

In summary, the primary recommendations were as follows. With respect to Community Outreach, it was recommended agencies providing services should clarify what those services are and what populations they serve. Duplication of services should be avoided. There should be quality control of services and services should be coordinated. Service information should be centralized, computerized and regularly updated. Summer programs for children must be provided and they should be culturally, language, and developmentally appropriate.

With respect to Needs of Ethnic Population it was urged all care givers be culturally competent and sensitive. Social and mental health services normally provided to nonminority populations should be available and accessible to minority populations. Family centered, community based services should be available to address the needs of special minority populations--including the elderly, adolescents, children, handicapped, etc. A multidisciplinary team approach should be used in the provision of services. There should be geographic access to disaster related services.

Regarding Children the goals selected were to educate the media concerning children and their reactions to trauma. Likewise, it was felt that the media should be educated about children's normal reactions to stressful events. Other recommendations were to specifically address the bombing's potential impact on youth ten years of age and older, involve parent teachers associations, and develop youth support groups.

With respect to the Needs of Other Populations particular concern was raised in respect to rescue workers, survivors, those already affected by mental illness, and what was termed *lost individuals*. This latter group was defined as persons effected by the blast but who had not sought nor received services they may need, such as homeless persons and civilian workers in the area. It was also recommended a central clearinghouse be developed and utilized to make sure care givers were qualified to provide services to these special populations.

Finally, in regards to Public Information and Education recommendations were to use a central information clearing house, become proactive with the media, utilize both traditional and nontraditional ways to disseminate information, and spend time and effort assessing the special information and education needs of the various unique survivor groups (A. Lowrance, personal communication, January 5, 1996; Boehler, Lowrance, and Allen, 1995).

Lessons Learned and Recommendations

First, a state's Department of Mental Health (DMH) needs to develop an intermediate and long term post disaster crisis counseling plan prior to having a disaster thrust upon them. Likewise, it is important that a number of a state's DMH staff obtain and maintain ARC disaster relief training. Local mental health professionals will always have better knowledge of their community in comparison to mental health professionals who come in from other states. To bypass potential leadership transition problems, such as occurred between certain ARC and ODMHSAS staff, as well as to provide consistency in leadership it is believed prudent that the immediate post impact counseling center be administratively directed by staff from the DMH who have a solid background

of ARC disaster training and who have been responsible for developing and maintaining the DMH's post disaster crisis counseling plan.

In the case of the Oklahoma City bombing, ODMHSAS staff had no written model to follow in developing Project Heartland and Project Heartland Center. In fact, there is no comprehensive written procedural guide or model available (B. Flynn, personal communication, June 3, 1996). Since no up-to-date written plan for an intermediate and long term post disaster crisis counseling program for a major terrorist bombing exists then it is recommended that the strengths and weaknesses of Project Heartland be studied in more detail and used as such a model.

Finally, although the OPA DRN has existed since the early 1990's no memorandum of understanding has been developed between it and the ODMHSAS. It is recommended that all state psychological associations' DRNs approach their DMH and negotiate a working relationship. This would insure better communication and interaction.

THE HONEYMOON PHASE: IMPLEMENTING PROJECT HEARTLAND

Early work in developing community psychological support systems following a disaster dealt principally with outreach programs using primarily indigenous personnel with short term goals (Heffron, 1977; Zarle et al. 1974). This work is valuable and continues to be performed in disaster situations (Frattaroli, 1991).

With respect to designing a multi-faceted community based disaster recovery program Creamer et al. (1991) state that there are six elements that should be considered. These are the survivors' need for information about the disaster; the survivors' need for education about typical trauma responses; the survivors' need to be encouraged to confront their traumatic memories; the survivors' need for social support; the survivors' need for reestablishing control over their environment; and the survivors' need for accessible professional assistance. These authors developed a one year program following a mass shooting in downtown Melbourne.

With respect to postdisaster long-range programs, Farberow (1985) states that ongoing needs assessment is crucial. Statistical and clinical information should be obtained from professionals, hospitals, disaster relief organizations, social welfare organizations, etc. in an effort to understand the nature and extent of the problems. The postdisaster medium and long-range program is not designed to replace the existing caregiving complex. Rather it is "built into and linked with the preexisting system" (p. 52). As time goes by most survivors will not need services; and, eventually, the long-range program ends.

Project Heartland Center was initially designed to have 22 staff members. This included a director; four support personnel; three professionals who provide counseling and lead support groups; 11 individuals who perform outreach services; and three professionals who interact with the school system. All nonclerical staff were selected because of their prior work experience in local community mental health centers. Education levels of clinical staff range from Ph.D. psychologists to bachelor level personnel (G. Allen, personal communication, May 20, 1996).

Likewise, it was decided the staff needed their own consultant. It was expected (and this expectation has proved true) the staff would be exposed daily, and for a long period of time, to intense survivor pain and anger. To help avoid emotional burnout and to promote the staff's mental health, a licensed psychologist, with training and experience in the disaster field and who was a member of the Oklahoma Psychological Association's DRN, was employed. This consultant was asked to meet with the clinical and outreach staff weekly, the center administrator every other week, and the support personnel once a month for debriefing and case consultation. By report Project Heartland Center is the first disaster crisis counseling center in the nation to utilize a psychological consultant in this manner. Again, clinical report indicates this decision was correct (G. Allen, personal communication, May 20, 1996; A. Lowrance, personal communication, January 5, 1996; Boehler et al., 1995).

Project Heartland and Project Heartland Center are funded by the Federal Emergency Management Agency (FEMA). Project Heartland, primarily through the Project Heartland Center, was designed to provide crisis intervention, support groups, outreach, and consultation and education services free of charge. Project Heartland also has eight subcontract partners. These subcontractors focus primarily on providing outreach, crisis counseling, support groups, and referral services to certain predefined populations. Cope, Inc. targets African-American citizens; the Latino Community Development Agency targets Hispanic-Americans; the Associated Catholic Charities targets Asian-Americans; the Oklahoma Mental Health Consumer Council targets persons with pre-existing mental/emotional disorders; the Community Counseling Center targets the elderly; and the Oklahoma City, Norman, and Guthrie Public Schools target children and youth. The total number of paid staff, including Project Heartland Center, is presently sixty-six.

All involved staff of Project Heartland's eight subcontractors work under the auspices of Project Heartland, are required to attend regular staff meetings, and coordinate all activities with Project Heartland's director. However, each subcontractor is also functionally independent of Project Heartland in that they develop and implement their individual programs and supervise their own staff. This blend of state and private organizations working together is believed both unique and highly desirable (B. Flynn, personal communication, June 3, 1996).

The center's potential clients are anyone who is affected by the Oklahoma City bombing because of emotional or physical proximity to the blast. Services provided by the center are short term. Most people are seen fewer than eight times. FEMA guidelines mandate a ten session limit for crisis counseling but place no limit on a client's number of support group contacts. Those individuals who require long term mental health services are referred to licensed mental health professionals.

If the referred client is a family member of a deceased victim or a direct survivor of the blast or a family member, then the mental health provider is reimbursed through a voucher system by the

Governor's Fund and the Mayor's Fund in the amount of $70 per hour. The use of subcontract partners and referral sources has likely been helpful in lessening the survivor convergence phenomenon wherein numerous helping agencies and professionals converge on victims and their families offering services and competing for their attention (G. Allen, personal communication, May 20, 1996; Boehler et al., 1995).

Project Heartland was fully staffed by July 5, 1995 and the outreach program became fully operational in August of 1995. The eight subcontract partners became active in November 1995.

Support Groups

Initially there were 21 different support groups developed by Project Heartland. These were (1) Parents who lost young children; (2) Parents who lost adult children; (3) Parents of children from the YMCA; (4) Adult siblings of victims; (5) Individuals who lost spouses; (6) State employees directly affected; (7) Downtown workers and residents; (8) Rescuers and responders; (9) School personnel; (10) School counselors; (11) Regency Towers residents; (12) HUD employees; (13) Water Resources Board employees; (14) Journal Record Building employees; (15) Government Services Administration employees; (16-20) General survivor groups; and (21) Group for homeless persons (Boehler et al., 1995).

The support groups are held both at the center and off-site, be it a school, work, or client's house. Most support groups meet weekly and support groups have the greatest number of clients and have required the greatest amount of service hours. Support groups are led by two staff; one of which is always a licensed mental health professional.

Individual and Crisis Counseling

When people come to Project Heartland they are usually seen individually first, since most are not initially comfortable participating in a group situation. However, nearly all of those individuals who are seen more than one time are eventually transitioned into an appropriate support group.

Center staff also provide crisis counseling. This occurs both person to person at the center as well as at the client's workplace, home, or via two telephone hotlines. Both of the telephone hotlines are equipped with TDD services. Crisis services have typically centered on suicide prevention or family violence problems. Likewise, center staff have observed increased use of crisis counseling during stress trigger events such as birthdays of victims, important family anniversaries, and holidays (G. Allen, personal communication, January 31, 1996; Boehler et al., 1995). All clinical staff provide crisis counseling.

Outreach

Project Heartland staff identified 36 target populations believed requiring contact. These were (1) civic clubs; (2) Native Americans; (3) parents of small children; (4) neighborhood associations; (5) social service agencies; (6) gay/lesbian community; (7) state employees; (8) Regency Tower residents; (9) other displaced persons; (10) cab drivers/bus drivers; (11) professional associations; (12) domestic violence; (13) colleges and universities; (14) businesses; (15) middle eastern community; (16) libraries; (17) law enforcement; (18) Federal Credit Union; (19) spouses of victims; (20) homeless; (21) adults who lost parents; (22) churches; (23) injured; (24) sibling support; (25) medical examiner's office; (26) city employees; (27) city recreation centers; (28) military; (29) health departments; (30) Department of Human Services; (31) doctor's offices; (32) door-to-door; (33) hospitals; (34) chamber of commerce; (35) in-home care providers; and (36) parents of adult children.

Outreach has been accomplished in a number of ways. The outreach staff performed door-to-door visits of every home and business within a one-mile radius of the blast. They performed home visits with survivors, victims' families, and rescuers. They stationed staff at the FEMA Disaster Center and the American Red Cross Center as long as those centers were open. They attended meetings and reunions of the Murrah Building Survivors Groups and the Journal Record survivors group. They planned and attended two intensive retreats with persons directly impacted

by the bombing. These retreats included debriefings, assessments, and planning for specialized services. They assisted apartment dwellers return to the Regency Towers apartment building which had been completely evacuated for many months. They regularly correspond with survivors and survivors' families regarding new programs, events, and projects. Finally, Project Heartland staff have developed and mailed traumatic bereavement informational material to victim's families and injured survivors.

Seven different types of informational brochures have been developed. These brochures (1) describe Project Heartland's services; (2) provide special mental health information relating to children, adolescents, parents and teachers, and older adults; and (3) address two special topics, i.e. PTSD and traumatic grief. Likewise, two informational booklets have been developed. One is designed to be distributed through primary health care providers and the second is designed for parents and other adults and is distributed in cooperation with the Institute for Mental Health Initiatives (Boehler et al., 1995). Finally, TV and radio messages have been periodically aired beginning in the latter part of December 1995. All written and media material was developed or adapted by Project Heartland staff (G. Allen, personal communication, May 20, 1996).

Consultation and Education

Project Heartland and ODMHSAS have sponsored over 11 different training sessions which have provided disaster related education and training to over 10,500 people. Topics have included (1) helping children with disasters; (2) role of the media in healing the community; (3) critical incident stress debriefing; (4) traumatic bereavement; (5) PTSD; (6) PTSD and substance abuse; and (7) planning school based services. During the latter part of November 1995 a special one day series of seven workshops was offered to all state employees affected by the bombing. The workshop topics were (1) Recognizing and Treating Depression; (2) The Trial: What Can We Expect?; (3) Drugs, Alcohol, and PTSD; (4) For Directors/Managers: Assisting Employees with Stress Related Problems; (5) Helping Your Child Get Back on Track; (6) Accessing Community Services; (7)

Turning Anger Into Positive Energy. Several of these workshops were later modified and presented in February and March 1996 in two neighboring communities as well as downtown Oklahoma City (G. Allen, personal communication, May 20, 1996; A. Lowrance, personal communication, January 5, 1996).

Besides formal programs and seminars, Project Heartland staff also consult on an informal basis with business, government, and organization administrators regarding how to support staff who were affected by the blast (Boehler et al., 1995).

Lessons Learned and Recommendations

Project Heartland staff manage the subcontract partners through contract compliance mechanisms. All staff of the subcontract partners are invited to participate in training. However, not all accept. One recommendation for future programs is to expressly require, in writing, training participation as a part of the contractual relationship. Another recommendation is to contractually require all subcontract partner's clinical staff to have at least a Masters degree and be licensed, or licensable, in a mental health profession. Important training areas are how to perform outreach; how to keep uniform records; and how to perform crisis and grief counseling and treatment referral instead of traditional case management and psychotherapy.

With respect to crisis counseling it has proved crucial that a staff member see or talk to the potential client the day they call the program. It is also believed important that support groups be homogenous in makeup or at least that the members have significant commonalties. Project Heartland staff also report that the most effective outreach techniques have been the door-to-door visits, the radio and television notices, and the outreach tent placed near the bombing site for several weeks prior to the one year anniversary. Finally, community education programs have been the most effective when they are planned with the help of people who will be the participant/students, i.e. such as occurred during the November 1995 program for the state employees.

THE DISILLUSIONMENT AND RECONSTRUCTION PHASES: EVOLUTION OF PROJECT HEARTLAND

Hodgkinson (1989) notes that both post traumatic stress disorder (PTSD) and bereavement by disaster are the primary cause of survivors emotional difficulties. Two other elements of particular interest are the concepts of nurturance conflicts and displaced anger (Aptekar, 1990; Hodgkinson, 1989). The first refers to the antipathy survivors often display toward offers of help from outsiders. The second refers to victims' anger which is directed, more often than not, toward public and relief organizations.

With respect to the first problem, Lifton (1983) conjectured that possible reasons for such suspicion are feelings of weakness or a sense of being demeaned by such offers. Lindy et al. (1981) also discussed this problem and an associated phenomenon they term the *trauma membrane*. They noted that:

> Severely traumatized individuals were often found to be surrounded by a small network of trusted people or an individual--a spouse, older children, parents, a special friend or professional. These people served to protect and buffer the survivor from perceived further external psychic stress, and attended to and monitored their needs. Those who functioned at this membrane tended to define for the survivor what was helpful and what constituted further trauma (p. 476).

Lindy et al. (1981) further hypothesized that nurturance conflicts, or lack of acceptance of formal mental health outreach, would be greater in centrifugal disasters as compared to centripetal disasters. In the latter type of disaster the community itself experiences the assault. The trauma membranes around the individual survivors become fused to include the community as a whole. Therefore, mental health outreach is perceived as more helpful, since it comes from within.

With respect to the second problem, Aptekar believes that the theme of human vulnerability and the seeming randomness of harm are key. "Victims who could not resolve their losses tended to rigidly focus their attention and thoughts on the dysfunction of the helping agencies. They continually expressed their anger about being denied what they once had owned and deserved to own again" (p. 95).

Finally, disaster survivors can also experience a rekindling of emotional difficulties at different times post impact. A common precipitating cause of such resurgence is the anniversary date of the disaster (Myers, 1994). Likewise, in those disasters that are man-made and where there is litigation, the trial often becomes a trigger tool for re-experiencing emotional trauma (Creamer et al., 1991).

All of the above phenomena have significance for the survivors of the Oklahoma City bombing. First, the extent and depth of grief, anger, and rage the survivors have expressed is much greater than was originally expected by Project Heartland staff. Furthermore, the emotional trauma is being sustained by the lengthy trial process of the two defendants. Resistance to seeking emotional support has been observed, particularly among some downtown business managers, older Vietnamese citizens, illegal aliens who are Latino, police, and fire fighters. The problems here appear to be cultural in nature, whether it is the macho culture of law enforcement, the focus on the financial bottom line of the business manager, or the insularity of the older Vietnamese who remember the Viet Nam war.

On the other hand, because of the centripetal nature of the disaster it is believed that the trauma membrane includes Project Heartland and its staff. In fact, the number of new client contacts has increased monthly beginning with the six month anniversary of the bombing in October 1995 through April 1996.

Finally, displaced anger abounds. For example, one survivor has made public statements expressing anger toward the ARC for not providing funds for travel expenses to Colorado to view

the trial and for not providing funds which were specifically donated to particular survivors but sent to the ARC. Others have initiated lawsuits to force distribution of state and federal funds earmarked for survivors (G. Allen, personal communication, May 20, 1996).

Presently, the greatest number of Project Heartland Center's service hours is related to providing support groups, followed by crisis intervention, outreach, consultation/education, and individual counseling. From June 1, 1995 through April 30, 1996, 4,982 identified persons have received services. (Identified persons are those for whom service delivery information as well as information to construct a client ID was collected.) In that same time frame 113,646 unidentified persons received services. (Unidentified persons are those served by emergency contact, group educational activity, group crisis intervention stress debriefing services, or outreach efforts for whom identifying data was not collected.) (Boehler et al., 1996).

During all phases of the Oklahoma City bombing disaster, Project Heartland has been faced with special challenges. Some of these involve participating in community healing rituals, interacting with the media, clinical staff development, and preparing for the trial in Denver.

Special Challenges: Community Healing Rituals

Community healing rituals are those ceremonies designed to help the public, both as a group and as individuals, grieve, remember, and emotionally share a disaster's aftermath. Such rituals help integrate the disaster experience and aid in reconstruction of a new normality for the survivors and their community. Since its inception Project Heartland staff have been involved in all major memorials. For example, staff helped plan the May 3, 1995 Memorial Walk and provided emotional support to survivors and victims' families along with many other mental health volunteers. During the 1995 Christmas season, Project Heartland staff were involved in an "angel tree" ceremony held at the state capitol building. Beginning two weeks before the one year anniversary Project Heartland staff set up and manned a tent near the bomb site. On some days the clinicians at the tent would interact with 200 to 300 individuals. During the one year anniversary memorial held at the Myriad

Building twenty teams made up of a Project Heartland clinician, a clergyman, and a physician were available to provide support for those present who requested assistance (G. Allen, personal communication, May 20, 1996).

Special Challenges: Media Policy

Of note is the fact that Project Heartland Center has become the clearing house for media contact, particularly national media, with victim's families and survivors. Project Heartland staff have developed media guidelines and policy which must be followed by all subcontractors working with Project Heartland clients. Staff and subcontractors are not allowed to release any information regarding clients without advance written consent. Actions that are considered to be release of information are (1) confirming that a person is a client; (2) discussing specifics of a client's case or situation that might identify the client even without giving a name; (3) permitting interviewing or recording of a client on Project Heartland premises; and (4) allowing a media representative to attend any therapeutic service such as a support group meeting. Likewise, staff and subcontractors are given the responsibility of informing clients of a news media request only if, in their professional opinions, participating in an interview would not be harmful to the client's emotional health (A. Lowrance, personal communication, January 5, 1996).

Also one month before the one year anniversary of the bombing a special press conference was held. It was designed to invite the media to use restraint and sensitivity in their reporting as well as to provide an update on certain key issues involving the emotional aftermath of the bombing one year later.

Special Challenges: Clinical Staff Development

The importance of clinical staff support and training was recognized during the planning stage of Project Heartland. On the average Project Heartland clinical staff have attended 103 hours of special education and training over the past year. Likewise, they have developed a noticeable esprit d'corp. Staff meet every Friday and undergo a debriefing. Even so the depth of the erosion

of staff morale caused by daily interaction with the survivors' grief, anger, and rage has come as a surprise. Vicarious traumatization is a problem (Pearlman and Mac Ian, 1995). This has necessitated a change in the use of psychological consultants.

First, a licensed psychologist with expertise in group and individual psychotherapy was employed to provide the staff individual and group counseling. Next, a second licensed psychologist with expertise in crisis counseling was employed to provide one hour of case consultation to the clinical staff every two weeks. Presently, this consultant reports that this level of consultation is sufficient given the high level of expertise of the current counselors (E. King, personal communication, May 31, 1996[7]).

A second round of staff hiring occurred in January 1996. The director of Project Heartland states that her criteria for a sound clinical staff member is an older person, with solid life experience, who has at least a Masters degree in a mental health specialty (G. Allen, personal communication, May 20, 1996).

Special Challenges: The Trial

In February 1996, just before the Change of Venue hearing requested by the two defendants charged with the bombing, representatives of the U.S. Attorney's office asked that Project Heartland provide three counselors to support the survivors and victims' family members who were present in the courtroom. On the second day of the hearing the U.S. Attorney's office requested four counselors. On the third day they requested five counselors.

With the move of the trial from Oklahoma City to Denver, the U.S. Attorney asked that Project Heartland provide services to survivors and victims' family members who attended the trial in Colorado. Thus, the *Safe Haven* project was developed. Safe Haven will be located in downtown Denver, near the federal courthouse. It will be a place where survivors and victims' family members can go during the day and in the evening after each day of trial. Project Heartland staff will train Colorado mental health volunteers as well as provide three clinicians who will be available for crisis

counseling and support groups as required (Lynn Anderson, personal communication, March 11 and 12, 1996[8]; G. Allen, personal communication, May 20, 1996).

Lessons Learned and Recommendations

A key issue for any program is the expertise and morale of its clinical staff. It is recommended that clinical staff be mature individuals with solid life experience. They should have at least a Masters degree and be licensed, or licensable, in a mental health profession. They should have significant work experience in community mental health centers or in a similar work environment. Likewise, it is helpful to have clinical staff who are culturally diverse, i.e. Vietnamese, Latino, Black, etc., as well as staff who have had military experience in combat theaters, i.e. Viet Nam and Desert Storm.

Since vicarious traumatization is a problem, special consultants are required. First, a mental health professional with experience in individual and group emotional support work with mental health professionals is necessary. This person should not do case consultation.

One or more mental health professionals with appropriate experience should be available to do case consultation. For example, a mental health professional with experience in crisis and/or grief counseling with children could perform case consultation with those clinical staff working with children. Another with experience in adult PTSD could perform case consultation with those clinical staff working with adults.

CONCLUSION: THE FUTURE OF PROJECT HEARTLAND

Emotional trauma caused by disasters can have long standing effects. Hodgkinson (1989), citing Raphael (1986), observed that in those human-made disasters where there was severe destruction and shock, such as occurred in the Oklahoma City bombing, 30% of the survivors continued to demonstrate symptoms two years post impact.

Project Heartland is designed to provide services for approximately two years. It is expected the trial of the alleged terrorists, during the latter part of 1996 and first part of 1997, will

precipitate a significant outpouring of anger and grief. Likewise, efforts are being made to seek funding for the long term mental health needs of Oklahoma City residents; and it is hoped the federal government will see fit to grant Oklahoma the necessary appropriation. Finally, criteria for exactly how and when to close Project Heartland are being developed. Practically speaking the criteria will revolve around need and funding.

Clinical report from Project Heartland staff suggests good acceptance of the center by Oklahoma City's citizens. It is hypothesized that because the bombing was a centripetal disaster as described by Lindy et al. (1981), the trauma membrane includes Project Heartland and its staff. Therefore, Project Heartland Center appears to have become the buffer for many of the direct survivors with respect to potentially stressful outside contact (A. Lowrance, personal communication, January 5, 1995).

The services provided by Project Heartland are client driven and not designed as traditional mental health assistance. Project Heartland staff and the ODMHSAS have been creative and flexible in first researching, then designing, and finally implementing assistance to survivors. Likewise, they recognize this is an ongoing task and services will continue to evolve as the disaster winds through the various phases and differentially impact the victims (G. Allen, personal communication, May 20, 1996). The lessons Project Heartland Center has learned to date, and those they will learn in the future, need to be studied by concerned professionals for the benefit of survivors and victims' families of future terrorist attacks in other American cities (T. Gore, personal communication, April 23, 1996[9]).

Footnotes

1. Sam Gonzales, Chief of Police, Oklahoma City Police Department.

2. Brian W. Flynn, Ed.D., Chief of the Emergency Services and Disaster Relief Branch in the Federal Center for Mental Health Services.

3. Sharron Boehler, RN, Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services.

4. Ann Lowrance, M.S., Deputy Commissioner for Victim's Services, Oklahoma Department of Mental Health and Substance Abuse Services.

5. John Tassey, Ph.D., Coordinator, Oklahoma Psychological Association's Disaster Response Network.

6. Gwen Allen, M.S.W., Director, Project Heartland Center, Oklahoma Department of Mental Health and Substance Abuse Services.

7. Edith King, Ph.D., Psychologist, Oklahoma County Crisis Intervention Center.

8. Lynn Anderson, J.D., Assistant United States Attorney, Oklahoma City, Oklahoma.

9. Tipper Gore, Wife of the Vice President of the United States.

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