Chapter 18

PSYCHIATRIC EFFECTS OF DISASTER IN THE MILITARY COMMUNITY

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INTRODUCTION

This chapter describes the characteristics of military communities and their responses to disasters. The Gander air disaster is explored in depth to exemplify the mental health approaches to handling such disasters and possible applications to combat stress.

Military Communities as *Gemeinschaft*

In the last several decades, many social and economic changes have occurred that seem to have predicted the end of the small, tightly knit community. It is now unusual for one's neighbors to also be one's friends or coworkers. Especially in metropolitan areas, people commute over longer and longer distances to get to work. Communities-of-place where people live, work, and socialize together are increasingly uncommon. Sarason[1] has described these and other social changes as resulting in a damaging loss of the psychological sense of community that is important to human well-being.

Sociologists have described in greater depth the changes that have led to a loss of the traditional sense of community, changes that primarily have to do with increased industrialization and the shift away from agrarian-based economies and lifestyles. Tonnies[2] provides the useful concepts of *gemeinschaft*, or communities involving implicit bonds, common values, and mutual dependency, and *gesellschaft*, communities where relationships are rule-bound, formalized, and explicit. Durkheim[3] made a similar distinction between an earlier form of community, *mechanical solidarity*, based on shared customs, beliefs, and face-to-face interactions, and the more recent *organic solidarity*, based on the interdependence of functionally distinct units in a society marked by specialization and division of labor. For Durkheim, more so than for Tonnies, the roots of the earlier, more basic form of community are thought to persist, providing an essential framework for social solidarity even as society changes and becomes more specialized.[4] For Tonnies, *gemeinschaft* communities are essentially a thing of the past because societies have grown larger and more industrialized.

Military communities in some ways provide an exception to this rule, still appearing as more *gemeinschaft* than *gesellschaft* in quality. Such communities encompass the families of military personnel assigned to a particular locale or post, as well as nonmilitary workers engaged in providing goods and services for military members and their families. Unlike most modern civilian communities, members of military communities are distinctively bound together by a common overall work mission and by a concentration of services, homes, and activities in a well-defined geographic space, the traditional military post.

Despite their unusual qualities, it would be naive to consider modern military communities as strictly *gemeinschaft*; they are marked by the same division of labor and formalized and highly individuated roles as pertain in modern nonmilitary communities. Still, the lines of *gemeinschaft* (or mechanical solidarity) are still quite strong in military communities. Unlike modern American nonmilitary communities, which increasingly appear as fragmented collections of strangers, American military posts are usually self-contained communities-of-place, with well-defined borders and clear rules of membership. Members of such communities usually reside on or near post, where they have military and community facilities to meet most of their needs (that is, schools, banks, commissary, child-care services, automobile service stations, restaurants, post office, bowling alley, and so forth). This is particularly true in overseas and rural posts. Consequently, there is more face-to-face contact among members of military communities.

Still, it is important to remember that military communities are not immutable, and they are not isolated from the larger communities in which they are embedded. Military families come and go; service members must move to new assignments every few years. Military communities also have various ties to surrounding civilian communities. The most apparent links are based on economic exchange. Many service members live in offpost housing, paying rent to local landlords and interacting with nonmilitary neighbors. Military family members often hold jobs in the civilian sector. Goods and services not available on post (for example, cars, furniture, certain banking services, and entertainment) are purchased from nearby civilian establishments. Thus, a significant amount of economic and social exchange occurs between military communities and their surrounding civilian communities. Members of a military community are members of

other communities as well, with religious, political, social, and family ties that extend far beyond the post borders. The modern military community is united with larger, superordinate communities at the local, state, national, and world levels through the power of print and broadcast media, especially television. Still, the military community retains more *gemeinschaft* qualities of organization than, perhaps, any other large type of American community today. As will be discussed in the sections to follow, this aspect of social organization may have important consequences for how the military community responds to disaster.

Disaster and the Military Community

Even during peacetime, the military occupation entails unusual risks. Military communities routinely confront the loss of some community members through fatal training accidents and, somewhat less commonly, large-scale air disasters or terrorist attacks.[5] Such traumatic incidents require individuals and whole communities to adjust to sudden, unexpected, and sometimes massive loss. Through their actions before and after a disaster, military psychiatrists and mental health workers can influence the course of recovery in either a positive or negative direction. In December 1985, a U.S. Army transport plane crashed in Canada, killing all 248 soldiers on board. This military disaster provided an opportunity to explore responses to trauma in the military community and to observe the effects of various interventions.

THE GANDER AIR DISASTER

The Fatal Crash

On December 12, 1985, a jet chartered by the U.S. Army stopped at Gander, Newfoundland, to refuel. The flight was carrying 248 soldiers home to Fort Campbell, Kentucky, following 6 months of peacekeeping duty in the Sinai. This flight was the second of three flights transporting soldiers back to the United States. After refueling in somewhat icy conditions, the heavily loaded DC–8 departed for its final destination, Fort Campbell. Shortly after takeoff, the plane apparently stalled, lost altitude, and rolled sharply to the right. As it crashed into the heavily forested terrain, the aircraft disintegrated, and fuel tanks exploded, scattering bodies and debris over a wide area. Subsequent fires burned for over 14 hours, while a blizzard covered the crash site with snow and ice.[5]

Early Aftermath

At Fort Campbell, some of the families had already assembled at the airfield to welcome the soldiers home for the Christmas holiday. Word of the tragedy reached the Brigade Headquarters at Fort Campbell about 1 hour after the crash. During the next several hours, efforts to confirm the flight manifest were initiated while families were asked to assemble in the gymnasium. There, the Brigade Commander announced that while the report was still unconfirmed, the awaited plane had apparently crashed in Canada, leaving no survivors.[5]

U.S. officials worked together with Canadian authorities to organize crash-site search and recovery operations. Recovery of remains from the site was a long and gruesome process. The fire that followed the crash had melted snow on the ground, which later froze solid over bodies, body parts, and debris. It was necessary to erect heated tents to free remains from the ice. The smell of burnt and rotting flesh mixed with jet fuel was overpowering for many of the people working in these enclosures. Once recovered, bodies were flown to the mortuary at Dover Air Force Base in Delaware for autopsy and identification. This process continued for nearly 3 months and eventually involved over 120 professional workers and 400 volunteers.[5]

In addition to various support personnel, the army death toll included fully one-third of the infantry peace-keeping battalion. The Gander crash represents the largest single-incident loss to a battalion in U.S. Army history and the worst aviation disaster ever on Canadian soil. Approximately one-third of the dead were married and had maintained homes at Fort Campbell. Thirty-six children were left fatherless.[5]

In the first days following the crash, several memorial ceremonies were held at Fort Campbell, with specialized services provided for bereaved families and friends. The devastated battalion was reconstituted over the Christmas holidays and resumed normal training activities about 2 weeks after Christmas. It was nearly 3 months after the crash before the last set of remains was positively identified at Dover Air Force Base and returned to the family for burial.[5]

Disaster in Two Communities

Although not a "typical" community disaster—involving destruction of homes and disruption of essential services—the Gander crash was a human disaster for both the military communities of Dover Air Force Base and Fort Campbell. At Dover, the large number of bodies commanded the attention and resources of the entire community for over 2 months. Even those who were not directly involved in morgue operations were called on in a variety of ways to respond to the influx of outsiders and the special demands this placed on local supplies and services. Several major planned activities were postponed or canceled. Intensive media scrutiny ensured that the entire community was aware of the progress (or lack thereof) in body identifications. Children, teachers, parents, and clergy discussed the crash itself, the horrific condition of the bodies, the body identification process, the media, and other matters related to the tragedy.[5]

That the event was a major community disaster for Fort Campbell is also clear. Unlike many air disasters in which the victims are strangers from scattered locations, these soldiers all lived and worked together at Fort Campbell for nearly 2 years. Even for those not personal friends or relatives of the dead, there is still a close affinity and identification with them that derive from a shared occupation, lifestyle, and organizational commitment. Not just relatives, but the entire post community was shocked by the news and experienced a collective blow. In the hours and days immediately following the crash, all nonessential activities around the post ceased while attention focused on dealing with the crisis. Regular schedules were suspended, and a series of special responses were initiated. Planned community Christmas activities were canceled or radically modified. Quarantelli[6] defines community disaster as a collective, extreme stress situation disruptive to a community. By this definition, the Gander crash was undoubtedly a community disaster for Fort Campbell.[5]

We examine responses to the Gander crash at the two military posts most directly affected, Dover Air Force Base and Fort Campbell. We consider these communities as essentially *gemeinschaft* in quality, a perspective that we feel is very helpful in identifying effective intervention strategies to facilitate healthy community recovery from disaster. The data on which this report is based come from interviews and observations collected over the 6 months following the crash. During the first 4 weeks, members of the research team observed events and reactions at both locations. Members of the research team in addition to the authors were Larry H. Ingraham, Christine Russell, Mark A. Vaitkus, Robert J. Ursano, Carol Fullerton, and Raymond Cervantes. Activities at Fort Campbell were observed during the first week after the crash and again during week four. Activities at Dover Air Force Base, including inside the mortuary, were observed for 3 day-long periods spread over the first 4 weeks after the crash. Observers functioned unobtrusively as much as possible, focusing on behaviors and events and recording observations in notebooks. Approximately 65 hours of observations were recorded at Dover during this period and 150 hours at Fort Campbell. These observations were assembled and integrated during field meetings of the research team held at Fort Campbell and team meetings held at Walter Reed Army Institute of Research following data collection.

Following this observation period, indepth interviews were conducted at both locations over the 2- to 6-month period after the crash. Specific individuals and groups known to have been intimately involved and affected by events were targeted for interview. The interview procedure followed a debriefing format, which encourages a chronological recounting of events as well as related thoughts, feelings, and actions of respondents.[7] Approximately 60 individuals from Dover were interviewed and 85 from Fort Campbell. These included both military and civilian community leaders, unit commanders, mental health workers, community support providers (for example, post Red Cross and Army Community Service workers), chaplains, medical personnel, morgue workers, casualty workers, widows, soldiers, and friends of the dead. See Wright,[5] Bartone,[8] and Ursano[9] for some of the original interview source material.

Dover Air Force Base

Dover Air Force Base, the Department of Defense port mortuary on the east coast, was selected as the site for processing of remains. The Gander crash occurred on Thursday; the first bodies arrived at Dover the following Monday. Body carrying cases continued to arrive for the next 3 weeks. Each flight carrying bodies from Gander was met by a full ceremonial honor guard to unload the flag-draped coffins. Once inside the mortuary, the cases were opened, and the contents carefully examined and catalogued. Each set of remains was then processed

through a series of workstations in a morgue that had been specially configured for this task.

The attentions of three groups from outside the community converged on Dover. One was the news media. The Gander crash was a national news event, and some reporters went so far as to fly over the morgue in a hot-air balloon to take photographs of the operation. Next were various officials from the army, air force, and other government agencies based in Washington, DC. Many conflicting directives were issued by these outside officials who claimed authority in the situation. Initially there was some confusion because of the magnitude of the disaster itself, and thus, during those first days, time and energy of the Dover Air Force Base personnel were spent satisfying the demands of high-ranking visitors who came through to briefly observe the operation. Finally, many families and friends of the dead converged on Dover. Some travelled to the post and asked to view the remains of their loved one. Many telephoned seeking information. Fritz observed that such "convergence behavior"[10(p678)] was very common in disaster situations and often greatly complicates problems of coordination and control.

It is difficult for anyone not present to imagine the horror of the scene in the "body room" of the mortuary. In the words of one volunteer worker:

> We did not have enough bits and pieces for 256 people. . . . The entire back of the mortuary had transfer cases lined up. Every one of the transfer cases and body bags were opened. There were 50 remains there. There was a big wall with a blackboard that had charts on it. As they opened up the casket, they would look at the chart and give it a number and draw a picture of the torso on the board. They would scratch out on a torso what was missing. When a leg was found, they would go back and see which one of the torsos was missing a leg and see if it would match. It was very gruesome. We were standing there surrounded by gross remains. They had various degrees of completeness, and all of them were burned beyond recognition.

> There were so many of them, and we were right amongst them. It was very depressing. . . . In the first several days, there was a captain whose upper torso was intact. He was in the mortuary on a table for 2 months. We eventually found his legs and put them in a box with him.

Observation and interview data document common stress-related symptoms and problems among the morgue workers. These are described in more detail elsewhere.[5,9,11] The reactions most commonly observed and reported were trouble sleeping, frightening nightmares, depression, jumpiness, dizziness, shaking and trembling, fear of losing control, nausea, a sense of choking, washing compulsions, and heavy alcohol consumption. Problems appeared more common among volunteer morgue workers (who were also younger) than among pathologists and other medical professionals. Regarding eating problems, the following was reported by a supervisor of "body handlers" (volunteer morgue workers):

> The first night someone made the mistake of serving roast beef. Body handlers do not want to eat barbecued ribs. We eat right on the scene. I had to review the menu myself.

Even experienced professionals were not immune from such reactions:

> Dr. (X) of AFIP (Armed Forces Institute of Pathology) cannot eat barbecued chicken to this day. Dr. (Y) cannot eat barbecued ribs, and the dental surgeon in the (UNIT) cannot eat barbecued food.

Several cases of acute stress reaction in the morgue were so severe the workers had to be relieved by their supervisors. Over the next 6 months, there were three documented cases of post-traumatic stress disorder at Dover Air Force Base related to the Gander morgue operation. And although there is no definitive connection to the Gander disaster, a mini-epidemic of suicides and suicide attempts occurred among Dover community adolescents about 3 months after the crash.

Fort Campbell

The residents of Fort Campbell were physically far removed from the grim scenes of the Dover mortuary, a circumstance that contributed to an air of unreality in the community. Initial reactions were primarily disbelief and shock. Less than Dover, the post community still became an object of media attention. Families were of primary concern. There was a memorial service on Monday attended by President and Mrs. Reagan, the Secretary of the Army, and other dignitaries. The overwhelming sense was one of loss felt by the entire community, accompanied by an outpouring of concern for families and friends. Fort Campbell did not appear to experience the confusion in channels of authority and control seen in the early phase at Dover.

A sensitive, charismatic, and highly respected commanding general of the division and post asserted leadership and control from the beginning. He mobilized his staff with clear directions regarding what their actions should be. In several timely public appearances and news conferences, he shared his views and guidance, affirming his leadership role in the crisis. This pattern was repeated by key subordinate leaders so that a consistent message was broadcast to the post community. The essence of this message was as follows:

- We must first care for the grieving families.
- We must recover and pay homage to our dead comrades.
- We must experience and accept our own pain and help each other deal with it.
- We must direct our energies to the continuing mission with renewed commitment and dedication.

This message was reinforced by the example set by the leaders themselves.

Several leaders in the Fort Campbell community assumed critical roles in the mourning process, apparently solidifying the community in the aftermath of the Gander crash. For example, at the planned homecoming in the gymnasium where families were awaiting the arrival of soldiers, the brigade commander stood and spoke to the group. He communicated news of the crash in sometimes emotional tones and assured families that information would be passed on as soon as it became available. He focused attention on the importance of not being alone in grief and expressed empathy with those who had lost friends and family. At times, he wept openly. This willingness to express his own grief seemed to facilitate a healthy abreaction for both families and troops.

The presidential memorial service 4 days later provided additional examples of a phenomenon Ingraham[5] described as grief leadership, that is, behaviors and statements by key community leaders that serve to facilitate healthy coping with loss and grief among members of the group. In confronting grief associated with group loss, effective leaders take actions that have the effect of unifying the community in the mourning process. President and Mrs. Reagan joined the division commander and his wife in a televised memorial service at Fort Campbell. The division commander noted the value of the President's "sharing our sorrow" and walked with the President to greet and console bereaved families. President Reagan indicated that he represented the concerns of the American people and that the entire nation was grieving along with Fort Campbell.[5]

Several days later, a division memorial service was held on the Fort Campbell parade grounds. This service was significant because the entire Fort Campbell community, including adjacent townspeople, participated. The division commander pointedly remembered each "Fallen Eagle" by announcing his or her name, rank, and home state, along with a cannon salute for each. Nearly 3 months later, a special service was held in observance of the positive identification and burial of the final victim. The division commander decreed a 1-minute sounding of post sirens, followed by 2 minutes of silence to honor the 248 soldiers who died. Without fanfare, people stopped their cars and stood quietly with heads bowed.

The priority placed on caring for bereaved families was reflected in an innovative community intervention initiated by the local adjutant general's office on day two. By this time, it was clear that many family members of victims were travelling to Fort Campbell to attend memorial services and to manage administrative details related to the death. Instead of having family members search around the post for various agencies, a centralized family assistance center (FAC) was established for their convenience. Here, families could address any legal issues, provide necessary information to personnel and finance representatives, make decisions about funeral and burial matters, and also talk with chaplains, psychiatrists, and mental health workers who were on hand. Although it was a solemn place, the FAC became a focal point for sharing information, grieving, and providing and receiving psychological support.

Special telephone lines were installed to facilitate communication and information transfer. Both military and civilian volunteers staffed the center around the clock for the first week of its operation. Desks were arranged in a horseshoe shape, with each desk or station representing a separate agency helping the families. In addition, a quiet room was established in an area upstairs from the main activity of the FAC. Here, a psychiatrist, social worker, or mental health specialist was always available for the private counseling and support of individuals experiencing acute grief episodes or conflicts. This quiet room also became an important resource for exhausted or traumatized staff workers and provided an easy means for identifying individuals

who had reached the limits of their endurance and those who might benefit from follow-up care.

Despite the powerful sense of pain and grief at Fort Campbell, there was a discernable community attitude of hope and rebuilding. Ordinarily strict interagency boundaries were relaxed as the post mounted a unified effort to assist families. Many regulations were amended or ignored to provide humane and sympathetic assistance to the bereaved. An enhanced sense of community solidarity was reported by many of those interviewed, as well as a greater sense of meaning in life. Many believed that their actions made a significant difference to suffering families. A similar sense of teamwork and solidarity was observed in the reconstituted unit, where fears that replacement soldiers would be rejected were seen to be unfounded. Instead, they were perceived as allies in the rebuilding of the social unit.[8] Six months after the crash, this unit received several performance awards won in competition with other units across the division. Although a variety of symptoms were reported by many respondents, including sleep disturbances, guilt, and alcohol abuse, these symptoms were usually transitory. No lasting ill-effects were apparent in the community as a whole.

Thus, despite the pain and sadness experienced at Fort Campbell following the Gander crash, there were some clear positive features to the community response. Most notable was the generalized sense of strengthened social cohesion and group solidarity. This reaction was especially apparent in the most severely affected battalion but was also observed throughout the community. Historically, this effect has been observed in other groups affected by disaster. For example, in summarizing a series of flood and tornado studies, Fritz[10] describes disasters as unifying forces that often foster mutual aid and cooperation in communities. Other investigators[12–14] have reported similar beneficial outcomes in social groups confronted by extreme stressful circumstances.

It was also Fritz who observed that disasters frequently "provide an unstructured social situation that enables persons and groups. . . . to introduce desired innovations into the social system."[10(p661)] Several innovative solutions were applied at Fort Campbell in the desire to "find something that works." Some have since been integrated into standard army procedures. The best example is the FAC, which was a creative and effective solution to an unusual set of problems. At one central location, with a minimum of bureaucratic hassles, family members could attend to the myriad details associated with death. The center coincidentally provided a locus around which mental health providers, psychiatrists, psychologists, social workers, chaplains, and enlisted specialists could concentrate their efforts to assist grieving families.

COMMUNITY RESPONSE TO DISASTER

An examination of the literature[6,15,16] on disasters reveals two widely divergent perspectives regarding the psychological effects of disasters on communities. One perspective emphasizes the negative, destructive impact on both individuals and social groups. The other perspective focuses more on the resilient quality of communities exposed to disaster and even allows for positive effects.

An example of the negative impact position is found in descriptions by Titchener and Kapp[17] and Erikson[18] regarding community responses to the Buffalo Creek flood. According to these investigators, this disaster had overwhelming destructive effects on the community. Homes were destroyed, families displaced, and the psychological sense of community that was once shared by neighbors in the valley was permanently damaged. This loss of sense of community appeared related to disabling psychiatric symptoms in over 90% of individuals interviewed.[17]

A contrasting position is taken by researchers who have observed a benign or even positive impact of disasters on individuals and communities. Most of the early National Opinion Research Center (NORC) studies supported such a view.[19,20] The Disaster Research Center (DRC), which grew out of the NORC, has since conducted many disaster studies that take the same position.[18,21,22] For example, one DRC report notes that up to 18 months after a tornado struck the town of Xenia, Ohio, there was an extremely low rate of mental illness.[23] Furthermore, a high proportion of respondents reported improved social relationships and personal growth as a result of the challenges they faced through the disaster.

Exponents of this perspective do not deny the existence of negative psychological effects of disas-

ters for many people but argue that these effects are largely transitory. Which of these seemingly incompatible positions is correct regarding community responses to disaster? The question is an important one for those who want to provide effective psychiatric or mental health interventions. By comparing responses to the Gander disaster at Fort Campbell and Dover Air Force Base, we hope to identify some of the factors contributing to healthy or unhealthy reactions to such events at the community level.

Dover and Fort Campbell Comparison

While not equating the experiences of the Dover Air Force Base and Fort Campbell communities following the Gander disaster, a comparison of the two can suggest reasons why disasters may affect communities in different ways. At both locations, characteristics of the community as well as aspects of the disaster experience itself appear to have influenced responses.

First, for the community of Dover, the crash victims were strangers. This generated a sense of distance from the tragedy; they had little sense of psychological "ownership" over the loss. Although the Dover community sympathized with grieving army families and was certainly horrified by the number and condition of bodies, still the dead "belonged" to somebody else. Dover is an air force base, while the casualties were army soldiers from a distant location. Some mortuary workers described Dover as merely a way-station for the initial processing of bodies that belonged to Fort Campbell.

In contrast, the Fort Campbell community lost a significant portion of its own members. Here, the dead were real people, friends and neighbors rather than strangers. Scattered about the post were literally hundreds of friends, family members, cars, and homes belonging to the dead. The significant loss associated with the Gander disaster unquestionably belonged to Fort Campbell. For Dover, lack of a sense of ownership may have helped initially to establish a kind of community "disidentification" from the disaster, with some short-term prophylactic effects. In the long run, however, this very lack of ownership perhaps contributed to a deeper sense of meaninglessness and alienation. The community of Fort Campbell was shocked and hurt but able to place the loss in a framework of life and death, patriotic sacrifice, and dedication to "the mission." In contrast, the Dover Air Force Base community, while shocked and horrified by the magnitude of the loss, understood that supporting the mortuary was part of their job and their mission. It is clear that the nature of the disaster-related stress was different for the two communities. For Fort Campbell, the Gander disaster meant sudden large-scale death and loss of loved ones. For Dover, the disaster meant close exposure to badly burned and mutilated dead bodies.

Some chronic aspects of community life at Dover could conceivably enhance vulnerability to events like the Gander disaster. As one of the largest mortuary facilities in the world, Dover is called on to manage body recovery and identification operations in disasters and mass casualty events. For example, over 900 bloated and partially decomposed bodies were brought to Dover for processing following the mass-suicide of religious cult members at Jonestown, Guyana, in 1976.[24] In addition, the burned and fragmented bodies of 243 U.S. Marines were brought to Dover after the Beirut barracks bombing in 1983.[25] With this unusually gruesome history comes the communal knowledge that future disasters will mean additional mass casualty mortuary operations at the base. Living at Dover could be somewhat comparable with living near an active volcano or a nuclear reactor because there is a shared chronic sense of risk or dread. The fact that air operations are the primary business of the Dover base could also mean that aircraft disasters are especially disturbing to the community, as potent reminders of their own daily vulnerability to such events.

Another important difference between Dover and Fort Campbell following the Gander crash concerns leadership and lines of authority. In the early postcrash period, command-and-control channels at Dover became quite confused. Several outside officials with some legitimate authority arrived on site and asserted control. There was some dispute over whether the recovery and mortuary operation should be managed by the army or the air force. The usual functional boundaries between the community and outside groups seemed to be ruptured, at least for a time. Local (air force) commanders who had the greatest experience and expertise with mass casualty morgue operations were shunted to the side when it was determined to be an army operation. This may have contributed to a generalized and psychologically damaging sense of lack of control for Dover community members involved in mortuary operations (hundreds of air force volunteers helped) and an exaggerated fear of losing control over one's internal and external boundaries.

The leadership picture at Fort Campbell was markedly different. Not only were lines of authority clearly delineated, but also key leaders were highly visible and provided useful role models for their soldiers to follow. No outside authorities arrived to take charge. Even President Reagan during his visit deferred to the local army commanding general, while offering sympathy and support to the community. Community leaders were both task-oriented and psychologically sensitive. They clearly defined what needed to be done in the interest of community survival and recovery. Further, by their own behavior under duress, they modeled appropriate responses for the rest of the community. Through their words, gestures, and shared grief, they provided permission to the rest of the community to grieve. At the same time, these leaders acted responsibly in emphasizing the need for continued work and task management.

One important benefit of effective leadership in such crisis situations is to help reestablish a sense of control, predictability, and hope in the midst of confusion, chaos, and fear. Leaders at Fort Campbell tried to focus community attention on the opportunities to learn and grow provided by the disaster. A common theme was by having suffered through this tragedy together, we will be stronger and even better prepared for the national defense mission. This quality of positive leadership through disaster was less apparent at Dover.

Community Adaptation to Loss

In the early aftermath of the Gander crash, the Fort Campbell community seemed to revert to a more complete *gemeinschaft* form of social organization. The magnitude of the loss made normal functional divisions within the community seem unimportant because everyone was united in a shared sense of loss and mourning. For some days, the entire community focused on the same event, the violent death of 248 loved soldiers. Key community leaders stepped forward and, by speaking often of the common pain experienced and the need for survivors to support each other, reinforced this sense of community-based solidarity.

Correspondingly, formal roles and relationships in the Fort Campbell community shifted to more informal, implicit bonds based on mutual support in crisis. The shift in formal roles, the blurring of rigid organizational boundaries, and the relaxing of normal rules and regulations permitted several unusual and effective interventions following the crash.

Again, the ad hoc FAC provides a good example of and a metaphor for this phenomenon. It was quickly discovered that the standard organizational structuring of agencies on post, which reflects a division of labor according to function (more *gesellschaft* in quality), was not well-suited to the immediate postdisaster needs of the community. Consequently, a central location was established where representatives of various post agencies were available to assist families and the bereaved. The chaplains office, the mortuary affairs office, the Veterans Administration, the Red Cross, Army Mutual Aid, Army Community Services, the judge advocate general's office, the finance office, and mental health services all provided teams to the FAC.

Other innovative solutions that involved suspension of the standard interagency boundaries were observed. For example, to facilitate sharing of information and caring for the large number of victims' families, daily "skull-sessions" were held that included casualty affairs workers, personnel policy experts, and army legal department representatives. At these meetings, casualty workers could get quick and accurate answers to the many procedural questions raised by family members.

Strong and sensitive community leaders appear to be a necessary ingredient to the positive responses observed at Fort Campbell. As described above, these leaders focused the group on shared values, common goals, and the mutual experience of loss and bereavement. This perspective was reinforced through a series of memorial services that united the community, fostering a sense of integration and solidarity. In the following section, we summarize medical and psychiatric interventions that were applied and consider their effects in the context of a community united in grief.

MEDICAL AND PSYCHIATRIC INTERVENTIONS

In the aftermath of the Gander air disaster, the main goal of the mental health response was prevention of psychiatric problems through early supportive intervention. Of primary concern were the families of the victims, soldiers who were friends and comrades of the dead, and the various support

personnel such as survivor assistance officers, FAC staff, chaplains, and leaders. Modes of psychiatric intervention applied were consultation and liaison psychiatry, mental health education, group therapy, and the identification and treatment of high-risk individuals.

Initially, there was some confusion and anxiety among the Fort Campbell mental health staff regarding what to expect and how to proceed. It was considered highly probable that the hospital mental health clinic would soon be overwhelmed with family members and soldiers experiencing acute grief reactions and related problems. A plan was thus implemented to staff the center 24 hours a day in anticipation of this increased patient load. In addition, the mental health clinic was renamed as a grief counseling center in an effort to make it less stigmatizing and more accessible to the community at large.

The expected flood of distressed individuals in fact never came, leading to a reorientation of mental health efforts in the direction of community outreach. The focus of these efforts was on consultation, outreach, support, and education about the grief process. The strategy was to take mental health services out of the hospital and to locations where affected individuals were gathering.

A three-member team was established to coordinate preventive psychiatric efforts. The division psychiatrist acted as the primary consultant and liaison to the community. The chief of the psychology service focused on mental health clinic readiness, and the chief of child and adolescent services worked with school officials and social work service to aid the affected children.

In keeping with the focus on early preventive interventions, a mental health team was quickly dispatched to the brigade gymnasium where families first received news of the crash. A second mental health team was later placed at the newly formed FAC, and a third team was stationed at the hospital's general medicine clinic to assist in the triage process and help identify any psychiatric problems. These teams were typically composed of two behavioral science specialists and one or more psychiatrists, psychologists, or social workers. It was understood that under the circumstances, grief and distress are normal reactions. The major effort of the teams was thus to identify and assist any soldiers, workers, or family members whose needs appeared extreme or who seemed unresponsive to support available from friends, family, and the FAC.

Special attention was also paid to surviving soldiers. To maximize identification of psychiatric problems through normal medical channels, a behavioral science specialist was stationed in each of the troop medical clinics around post. It is at these clinics that daily sick call occurs. Furthermore, a two-person grief counseling team was assigned to each army unit that lost soldiers in the crash. These teams provided informal classes and workshops on issues related to the grief process, including extensive question-and-answer periods. This approach proved an especially valuable mechanism not only for getting useful information to the soldiers, but for identifying high-risk individuals for more extensive follow-up care.

Of the various interventions tried, those offered under old structural boundaries (for example, mental health services provided in a hospital setting) proved less effective than those more in accord with a *gemeinschaft* community organization. Outreach efforts were most successful where good relationships across structural boundaries existed before the crash. For example, the active consultation role pursued by the division psychiatrist capitalized on an unusually strong command-consultation program already in place before the crisis. The psychiatrist was perceived as a trusted friend in the community, and his presence in the role of mental health expert following the crash was not surprising or threatening to community members. His ability to interact well with members of different post agencies, from administrative officers to chaplains, facilitated a relaxing of organizational boundaries that in turn permitted mental health teams to get involved in many postcrash tasks. This approach placed mental health personnel directly proximate to those in need of, but not always willing to actively seek out, services.

Another intervention strategy that appeared effective in the period of relaxed interagency boundaries was group debriefing. In the days and weeks following the crash, mental health teams visited affected army units to conduct a series of seminar-like debriefings on grief, loss, and related topics. Presented as nonthreatening information meetings, these sessions provided both cognitive and emotional avenues for managing grief, while avoiding the stigma sometimes attached to getting mental health assistance.

The FAC, initially created to centralize agencies and simplify administrative matters for families, soon developed into something broader in scope and function. In addition to helping with administrative details, FAC staff found themselves helping

bereaved families with their emotions and grief surrounding the loss. The FAC evolved into a therapeutic setting in which family members (as well as staff) could express their grief in a supportive social environment. Community chaplains were especially helpful in this setting.

Alert mental health professionals used the opportunity presented by the FAC to place mental health services close to those in need. In addition to trained specialists who moved around the center, a special area was established where family members could grieve in private or with professional support. Unexpectedly, the mental health workers also became a valuable resource for FAC staff members who experienced their own grief reactions.

The grief leadership provided by leaders at various levels in the Fort Campbell community can also be usefully regarded as an effective intervention because it apparently facilitated healthy grief responses for many. By their own example of open, shared expression of grief, leaders consistently emphasized the importance of experiencing the sense of loss within a supportive social network, thereby avoiding a sense of isolation and despair. In addition, leaders provided critical avenues of communication, sharing information with the community as facts became available and local responses were organized.

Memorial services were often emotional events that reinforced the solidarity of the community in the grieving process. The family reception at the brigade gymnasium on the morning of the crash was the first and most spontaneous of these memorials. Under the leadership of the brigade commander, the value of grieving together as a community was reinforced. The same theme was played out in other memorial services held over the next few weeks.

Some agencies and individuals appeared unable to adjust from the highly specialized structures and roles that pertained before the crash. For example, mental health workers who refused to stray from the hospital clinics saw few grief-related cases. Those patients that were seen in the clinics typically had preexisting mental health problems. By rigidly maintaining their agency boundaries and emphasizing their distinctiveness from other groups, these healthcare providers missed an opportunity to provide valuable assistance to the community. Grieving individuals required confirmation of the normalcy of their responses rather than a suggestion of mental defectiveness. Unfortunately, many people still attach a stigma of weakness to seeking mental health services. When mental health teams were provided at community congregation points, this stigma was largely overcome.

SUMMARY AND CONCLUSION

This chapter has described the reactions of two communities to the same air disaster. The important dimensions distinguishing these two communities and accounting for their differential responses involve characteristics of the disaster situation, as well as more persistent or chronic features of the communities themselves. A sense of ownership as regards the disaster emerges as important in defining the general tone of community response. In addition, important are clear (and nonconflicting) lines of authority and leaders who can focus group attention on the work of recovery as well as the ongoing task responsibilities of the organization. Such leaders appear instrumental in imparting a sense of control in an atmosphere of chaos, coherence in the midst of confusion, and hope instead of despair. They help the community direct its energy toward "rising to the challenge" offered by the disaster and in learning useful lessons from the experience.

These findings suggest that the presence (or emergence) of effective leaders in community disasters may be a critical variable in defining how a community responds. Depending on the nature of the disaster, this variable could be more or less important. When entire communities are displaced and dispersed, for example, it might be less relevant. But even in a disaster as fragmenting as the Buffalo Creek flood, one can imagine that the presence of effective community leaders in the immediate aftermath might have galvanized the survivors and led to some very different long-term effects.

In this chapter, we have identified some necessary, although probably not sufficient, factors in accounting for positive community responses to disaster. To recognize that disasters can have positive effects as well as negative ones is not to discount their potential destructiveness for individuals and groups. However, identifying these differences may be essential to an adequate understanding of community responses to disaster and thus to the planning of effective prevention and intervention strategies. This information can be used

to help build psychological disaster plans for addressing the psychological needs of communities stricken by disaster. The documented experiences of the Fort Campbell community as it struggled to process the Gander tragedy should prove especially valuable to leaders and mental health workers who must be prepared to respond to future community disasters.

Understanding the dynamics of community response to disaster can also shed light on another major concern of military psychiatrists: How to prepare individuals and units to withstand the psychological stress of combat. In this regard, it is important to consider what valuable lessons might be taken from noncombat traumatic stressors, such as the Gander crash, that affect military units. By observing how individuals and groups respond to sudden, unexpected trauma outside of war, as well as by noting which interventions are helpful to recovery and which are not, we may be better prepared to reduce and prevent combat stress reactions, war-related post-traumatic stress disorders, and other psychiatric problems associated with exposure to combat.

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