

Chapter Five

The Mental Health Response

INTRODUCTION

The magnitude of the Pentagon's destruction, and the number of people who died, made it inevitable that mental health personnel would play a significant role in the response to the attack. The triservice mental health response that followed the attack involved a complex, multidisciplinary, uniformed mental health effort inside the Pentagon, at nearby offices, at the Pentagon Family Assistance Center in Crystal City, Virginia, among the search and rescue and recovery teams at the crash site, and at the Dover mortuary. In liaison with civilian mental health organizations and facilities in the national capital region, the leaders of these services planned and coordinated an evolving, multiphased psychiatric, psychological, and social effort that became known as "Operation Solace." Although the Navy was part of the initial response, Operation Solace was mainly an Army and Air Force endeavor from mid-October until December 2001. "Operation Solace" also refers to the long-term psychological response under the direction of the Army that began in December 2001.^{1(pp12,16),2(pp1,2)}

The chief executors of the initial mental health response were the outreach teams of the Army, Navy, and Air Force, plus about 80 other mental health personnel from Walter Reed Army Medical Center (WRAMC), who were not members of an outreach team but who collectively responded to the mental health mission. The military units involved included a special medical augmentation response team—stress management (SMART-SM) made up of WRAMC personnel under the North Atlantic Regional Command (NARMC); Air Force crisis intervention stress management teams from Andrews, Bolling (both in Maryland), and Keesler (in Mississippi) Air Force bases; and Navy special psychiatric rapid intervention teams from the National Naval Medical Center, in Bethesda, Maryland. Through counseling, after-action reviews, and aggressive outreach programs, these organizations sought in every way possible to help injured survivors, family members

of victims, Pentagon employees, search and rescue workers, recovery personnel, family assistance center staffs, casualty assistance officers, body handlers, and others involved to deal with the emotional trauma associated with the terrorist attack. Although not formally part of the official mental health effort, other individuals and groups provided ancillary support, including military chaplains not associated with the SMART-SM team, fire department chaplains, Red Cross mental health professionals, Salvation Army personnel, Veterans Affairs psychiatric specialists, church volunteers, massage therapists, chiropractors, and even therapy dogs.^{3(pp3,4),4,5(p17)}

INITIAL RESPONSE AND PLANNING

Psychological assistance was immediately needed on the day of the attack. Casualties waiting to be evacuated required counseling. Volunteer responders, some of whom had friends, coworkers, and spouses in the area that was hit, were under great stress. Soldiers with little or no experience in body handling who conducted the early rescue and recovery operation were at risk for emotional distress.

Mental health assistance at the Pentagon the day of the attack was understandably minimal and unstructured, but people did step in. Initial on-site emotional help came from members of the behavioral health staff at the DiLorenzo Tri-care Health Clinic, who spoke to patients in the clinic before evacuation. Military chaplains of diverse faiths, who were attending a meeting in the building at the time of the attack, were also available throughout the day for counseling and prayer. DeWitt Army Community Hospital, in Fort Belvoir, Virginia, sent behavioral health personnel to the Pentagon in the afternoon to counsel anyone in need. Arlington County Fire Department mental health teams likewise arrived at the Pentagon within hours of the crash to support firefighters and other county responders.^{6(pp12,A-58)}

NARMC's SMART-SM team was activated by Major General Harold Timboe, NARMC's commander, immediately after the attack but was initially held in reserve until the medical response stage was completed on 12 September. Psychiatrists, psychologists, social workers, chaplains, nurses, occupational therapists, and technicians made up the 16-member team. Given a mission "to provide timely, world-class mental health and critical event stress management augmentation, technical assistance, and support to medical authorities responding to disaster/mass casualty and other traumatic incidents,"^{11(p1.3)} the SMART-SM team had trained throughout the year to respond to disasters and other traumatic events anywhere in NARMC. The team usually served to augment special units for specific and time-limited missions of about 72 hours, enough time to help an affected community to assess its behavioral health needs and develop a treatment plan. Everyone expected, however, that the Pentagon mission would last much longer: it would involve more than discussion and planning, and it would require a larger mental health response than 16 individuals could provide. Accordingly, all active duty personnel from the various mental health divisions and departments at

WRAMC mobilized to augment the team, raising the total number of WRAMC's mental health responders to nearly 100. From this number of personnel, the Army formed outreach teams that worked at several sites in and outside the Pentagon. The Air Force and Navy activated their outreach mental health teams at this time as well.^{1(pp12.13)5(p7)}

While military medical commanders activated their mental health teams on the morning of 9/11, the Army surgeon general, Lieutenant General James B Peake, directed his behavioral health consultants in psychiatry, psychology, and social work to quickly put together a plan to help survivors, families, Pentagon employees, and active duty personnel recover from the trauma of the attack. Their principal goal would be to minimize long-term emotional consequences for victims of the attack. In the process, however, Peake also expected his people to learn how to prepare better for future terrorist assaults. Thus began the planning for Operation Solace, a sustained mental health response.^{7(p44)}

Three of the surgeon general's most important mental health consultants, the chief of the Behavioral Health Division, Colonel Rene Robichaux; the principal social work consultant, Colonel Virgil Patterson; and the psychiatry consultant, Colonel David Orman, were at Army Medical Command headquarters in San Antonio on 9/11 and unable to fly to Washington because all commercial and most military aircraft in the United States were grounded. Instead Lieutenant Colonel Edward Crandall, a clinical psychology consultant who ordinarily worked at Fort Sam Houston but was in Washington to attend a board meeting, stepped in. Colonel James Stokes of the Clinical and Program Policy Department of the Office of the Assistant Secretary of Defense for Health Affairs, who was considered the Medical Department's leading expert on combat stress and was also in Washington, volunteered to help. Additionally, the surgeon general had at his disposal several senior behavioral health personnel from NARMC: Lieutenant Colonel Steve Cozza, chief of WRAMC's Department of Psychiatry; Lieutenant Colonel Larry James, chief of WRAMC's Department of Psychology; Colonel William Huleatt, chief of WRAMC's Social Work Services; and Colonel Mike Lynch, Fort Belvoir's chief of behavioral health.^{8,9}

Colonels Robichaux, Patterson, and Orman were able to fly to Washington late in the day on Saturday, the 15th. They met with the other planners at the Office of the Surgeon General on Sunday. "We were a good five days into the action," said Colonel Robichaux, "before we could get our arms around . . . the issues, and begin to give the Surgeon General some cause to be optimistic that we can deliver on the kind of plan that he needed and wanted."^{8(p27)}

One cause for optimism was the designation by the end of the first week of NARMC's Lieutenant Colonel Chuck Milliken as the single point of contact to coordinate the Army's mental health responses to the crisis and as the "go to person" for the Office of the Surgeon General on behavioral health issues. Milliken would coordinate the development of the campaign plan and provide information to the surgeon general. According to Colonel Patterson, Milliken also acted as a "gatekeeper." Every mental health professional in the Army wanted to help, and

someone had “to step back and direct traffic.”⁸

Planning for the effort made use, in part, of what the government had learned from its response to the Oklahoma City bombing, where the population of the downtown area around the location of the Murrah Federal Building was nearly equal to that of the Pentagon as a whole. Although the two buildings were different in size, and the total killed and injured was greater in Oklahoma, it was possible for the Army to use the earlier experience to project the number of patients that would result from the Pentagon attack and the services they would need over the following 2 years. Based on Project Heartland, a federally funded effort in Oklahoma that provided outreach programs and counseling activities, the Army Medical Department plan set up levels of care and attempted to determine systematically the needs of Pentagon employees and DoD health beneficiaries in the national capital region. The strategists projected outreach and counseling support as well as clinical demands. Pivotal to the success of the effort would be the behavioral health personnel on the scene such as the SMART-SM team from WRAMC. They and the Pentagon health clinic would provide primary care management, including risk assessment.^{7(p45)}

Planners developed a pyramid of risk categories, keeping in mind that vulnerability was influenced by a person’s previous experience and genetic makeup. At greatest risk for mental health problems were the physically injured, followed by the families of those who had died or been injured. Next came the colleagues of those who died or were injured, the responders and rescue workers, the employees of and visitors to the Pentagon, and the entire population of the national capital region. Individuals within each group would not need the same level of care. Many would require little or no assistance. Others could turn to community or workplace caregivers. Still others would need specialized mental health services. The levels of treatment in each risk category thus included “community, unit-workplace, primary care, and specialty mental-health clinics.”^{7(p45)}

To help with planning and coordination during the first 4 days, as the response was beginning, the Office of the Assistant Secretary of Defense for Health Affairs maintained communication among mental health leaders. Lieutenant Colonel Elspeth Cameron Ritchie and Colonel Stokes, both of the Clinical and Program Policy Department of the Office of the Assistant Secretary of Defense for Health Affairs, which developed and coordinated policy, arranged for daily 2-hour telephone consultations with key mental health leaders from military and civilian agencies. Attending those “hotline conference calls” were representatives from WRAMC, the DiLorenzo Clinic, the Army Medical Command, the Army’s Center for Health Promotion and Preventive Medicine, the National Naval Medical Center, Fort Belvoir Mental Health Service, Andrews Air Force Base Medical Center, and the Veterans Affairs’ National Center for Post-Traumatic Stress Disorder. Those sessions enabled mental health planners to decide where best to deploy their assets. The information they collected went on to other health commanders and to the Army surgeon general at his next staff meeting.^{8,10(p31)}

EXECUTION OF THE RESPONSE

Although the Office of the Assistant Secretary of Defense for Health Affairs helped to maintain communication between mental health leaders while the response was taking shape, it did not lead the mental health effort. There was no senior mental health director to coordinate the actions of mental health teams from different military services and organizations. Direction came from the three surgeons general.

Despite the separate commands, the DiLorenzo Tricare Health Clinic served as headquarters for the mental health response as well as the medical response, attempting to coordinate mental health support at the Pentagon. In reality, the clinic's commander, Colonel James Geiling and his executive officer, Air Force psychiatric nurse Lieutenant Colonel Steven Viera, served as facilitators of the response but not as directors or commanders. On 12 September, Army and Air Force mental health providers met at the clinic to chart mental health relief for Pentagon employees, DoD workers displaced to other federal office buildings in the Washington area, victims' family members at the Pentagon Family Assistance Center, and rescue and recovery workers on site. This meeting was the first of many sessions that discussed what should be done initially and the model to be followed in providing services. Lieutenant Colonel Viera became the mental health contact person and facilitator of behavioral health efforts involving the Pentagon community as well as the search and rescue and recovery workers at the crash site. He worked out of a mental health emergency operations center located in DiLorenzo's Wellness Center.^{3(pp3,4),5(p17),11(p26)}

Old and New Intervention Techniques

As the stress management response plan was being developed, various groups followed different theoretical models to supporting mental health. While the Air Force and the Navy were inclined to follow the civilian model of structured debriefings, although they also did informal counseling of their own casualty assistance officers, the Army preferred to use a combination of approaches depending on the needs of the group. As the response effort evolved, Army mental health workers combined familiar, well-tried techniques with new methods to minimize posttraumatic stress disorders and to prevent long-term behavioral health problems.^{12(p48)} Army units moved informally among the population affected by the attack and provided formal debriefing sessions when requested. Army staff tried to provide psychological education and identify case-by-case those who needed further help.

However, different teams following different approaches while trying to help the same people sometimes ended up in confusing them. In addition, debriefings for group members who did not know each other often were unhelpful. Long-term treatment from Operation Solace workers was made available for people who were debriefed but did not improve. Although the assistance of additional mental

health clinicians was welcome, coordination was necessary to prevent duplication of effort, and to keep from overwhelming the patients by “killing them with kindness” or confusing them with different approaches.^{1(p14),13}

Army mental health leaders decided on an outreach program that adopted a relatively new form of intervention termed “therapy by walking around.” Instead of waiting for clients to come to them, mental health workers would go into the workplace to engage patients or to connect with them as they sought different kinds of medical care in the primary care system. Most important were the teams that deployed to the Pentagon and nearby offices to provide assistance. Those small, multidisciplinary groups included psychiatrists, psychologists, mental health nurses, mental health technicians, and social workers.^{7(p46)}

Employees who went on their own to the Pentagon clinic also received supportive counseling without the requirement to establish a clinical record. Only those persons who received medication or intensive therapy had records opened. The outreach teams also conducted group debriefings, gave information upon request, and made clinical referrals as needed. The intention of the program was to reach as many people as possible by supplementing the support system already available at the Pentagon, and to minimize significant clinical or long-term psychological effects in healthy people who were reacting to abnormal circumstances.^{7(p46)}

Besides the outreach program, the military made available to Pentagon employees and others in need of behavioral health services 10 primary care facilities in the national capital region. The system practiced in these commands was developed by the DoD Deployment Health Clinical Center, located at WRAMC, which had established methods for preventing and treating unidentified clinical symptoms of mental health problems following major deployments. Under that approach, a person presenting for treatment was placed under the care of a manager who was a mental health nurse or social worker. This person facilitated the patient’s treatment and follow-up by being an advocate for the patient and by arranging for supportive sessions that might require more time than the usual 15-minute medical appointment. Outreach teams were able to refer patients to clinics through the care manager.^{7(p47)}

Mental Health Teams Deploy

Early on 12 September, the augmented SMART-SM team deployed outreach teams from WRAMC to the Pentagon and set up 24-hour operations at two sites, one inside the building at the DiLorenzo Clinic, and the other outside at the crash site on the west. Two Air Force stress management teams, each composed of a psychologist, a social worker, and a mental health technician, arrived on 12 September as well. Having lost its command center in the attack, the Navy moved its special psychiatric team into the Navy Annex, the headquarters of the Marine Corps just west of the Pentagon in Arlington, and focused on Navy personnel there. The next day, critical incident stress management personnel from the Air Force stepped in to counsel mortuary workers at the crash site and to provide

liaison with Army planners at the Pentagon. At that time, the three services also started to conduct debriefings for personnel of offices that had been hard hit, particularly those of the Deputy Chief of Staff for Personnel, Army Manpower and Reserve Affairs, and the Naval Command Center (see discussions below). Also, behavioral health personnel from DeWitt Army Community Hospital moved to the Fort Myer Family Assistance Center (which provided support and assistance to military families). The behavioral health personnel held counseling sessions for units at Fort Myer and in the surrounding community and facilitated arrangements for the debriefing of Army first responders.^{3(pp3,4),5(p17),11(pp26,27,29),14(pp2,3),15}

Prior training of the Army's SMART-SM team allowed it to deploy rapidly and arrive on site focused and ready to go to work. SMART team members carried pagers, cell phones, and name and organization rosters, keeping essential channels of support open from the start of the mission. At the Pentagon, the SMART team personnel located outside the building at the crash site (termed the "outside" mission, focused primarily on support of the search and rescue and recovery teams at the crash site) paid close attention to the young soldiers of the 3d Infantry Regiment (the Old Guard), who retrieved containers of human remains and carried them to mortuary affairs areas. To encourage healthy responses to their tasks, members of NARMC's team, including behavioral health specialists from DeWitt Army Hospital and Rader Army Clinic, ate and relaxed with the soldiers, and, after suiting up, accompanied them into the wreckage. The mental health team helped the soldiers maintain good mental hygiene practices by insisting on breaks for sleeping, eating, and keeping hydrated. The team was on hand at all times for individual and group counseling. The Old Guard soldiers felt most comfortable with the Army mental health providers because of their shared military culture.^{1(pp13,14),16}

The NARMC team found it difficult to sustain relationships with soldiers when no prior group affinity existed. Although attempts were made to assign mental health liaisons to specific groups, it was difficult to maintain contact over a long period because of the need to rotate personnel and the fact that the home bases of reserve and civilian organizations were a significant distance from the Pentagon. Follow-up sessions would have to be with a new psychiatrist whom the patient did not know.^{1(p14)}

When the recovery phase of the operation ended on 18 September, the mental health response at the Pentagon shifted its emphasis from preventing mental illness in recovery workers to preventing mental illness in Pentagon employees. This "inside" mission focused on taking care of the Pentagon community, which included over 20,000 workers inside the building and another 20,000 in federal office buildings in Northern Virginia; some of the organizations affected by the attack had elements in both places. Mental health workers had the complex problem of identifying the groups within the Pentagon most distressed by the tragedy and their elements in off-site locations that were also overwrought by the disaster and in need of mental health support. Mental health planning expanded to include developing a means to identify those needing their services.^{1(pp14,15)}

Mental health workers were particularly concerned about the impact on individuals and organizations that the loss of friends, colleagues, workplaces, and functions, and the need to relocate, would have. Responders used a variety of methods to deal with resulting problems. There were formal debriefing sessions, informal group discussions, casual private conversations with employees, and lone clinical sessions when indicated. Counselors looked for those persons and agencies that were most affected, and hence most at risk, and offered them immediate and productive consultation. Army outreach teams started with people whose offices were in the affected wedge and fanned out to workers in neighboring wedges and to those in off-site locations, providing verbal support to employees in their own offices. This informal setting, without the need to consult clinical records or chronicle identifying data, provided Pentagon workers with privacy while minimizing their fear of stigma and what professionals termed the “premature medicalization of normal/nonpathological reactions to the attack.”^{7(p46)} Although the top Pentagon leadership supported the mental health effort and communicated the importance of it, senior DoD chiefs were not directly involved in setting up sessions and providing other services because of the semiindependent status of the various military and civilian groups and agencies. Most services were conducted at lower levels, with communication by “word-of-mouth.”^{1(p15)}

WRAMC’s team leaders were aware of the exposures of their own members to disturbing experiences and “burnout” within the group. They monitored the practice of mental health hygiene among their own members by insisting that team members rest, eat, and sleep.^{1(p14)}

OFFICE OF THE DEPUTY CHIEF OF STAFF OF THE ARMY FOR PERSONNEL

One group targeted for special help were the survivors of the Army Office of the Deputy Chief of Staff for Personnel (ODCSPER), who lost not only their offices but also 24 colleagues, including their chief, Lieutenant General Timothy J Maude, and their sergeant major, Larry L Strickland. On 12 September the group relocated to the Hoffman Building complex in Alexandria, Virginia, where the 2,000-member Army Personnel Command was based. Six days later, as part of the “inside” mission, an Army mental health team consisting of two psychiatrists, a psychologist, a mental health noncommissioned officer, and two mental health technicians joined them. The team offered individual intervention, group therapy sessions, and continual follow-up.^{17(p39),18(p58)}

The mission made considerable demands on the mental health team, who had to treat people who had gone back to work on 12 September to resume their vast responsibilities while still grieving for their lost colleagues. The office’s staff had to handle their routine duties related to Army personnel matters, complete the budget they were working on, make war preparations, and reconstruct records lost in the attack while also adjusting to a new office environment and new leaders, preparing for the move back to the Pentagon, and handling their own personal reactions to the tragedy. “These would be difficult tasks for anyone but were especially challenging for this organization in the wake of their heavy tangle and

intangible losses.” The mental health team had to consider those complexities while trying to prevent mental illness.^{17(p39)}

Another challenge for the mental health team was trying to individually visit all 196 survivors (although most were working at the Hoffman Buildings complex, the acting deputy chief of staff for personnel and his staff had moved to office space in the Pentagon). WRAMC assigned a small full-time cadre of mental health workers to the Hoffman complex, and rotated others to work part time because they also had to maintain their usual responsibilities in the national capital region. Staff adjusted their daily schedules accordingly, but when replacements were unavailable to visit the Hoffman buildings, continuity of mission for the part-time mental health workers suffered. This frustrated and demoralized many of the team members.^{13,17(p39)}

ODCSPER employees received three kinds of services: (1) assistance through “office rounds, (2) walk-in appointments, and (3) group debriefings.”^{17(p40)} During office rounds one or two mental health team members visited offices daily to chat with individuals and hand out reading materials on emotional reactions to disastrous situations and how to handle them. Walk-in appointments permitted people who wished to talk privately with mental health workers to visit the Hoffman medical clinic without an appointment. The clinic served as the mental health team’s headquarters and kept at least one team member on duty at all times.^{17(p40)}

Group debriefings were actually called “psychological after-action reviews” (PAARs), because of sensitivity in the mental health community to outside perceptions of the term “debriefing.” An unpublished executive summary of the PAARs, “Expert Consensus on Mass Violence and Intervention,” dated October 2001,^{17(p40),18(pp58,59)} suggested that professionals should reserve the term “debriefing” for its operational meaning only and refrain from using it to describe a post-traumatic intervention. Debriefings are concerned with the acquisition of information, whereas interventions involve stress management. The typical after-action discussion group session lasted 1 to 2 hours, which gave 10 to 20 people time to relate their experiences and feelings about the disaster, while leaving discussion leaders 20 minutes to describe common stress reactions and hand out educational materials and contact phone numbers. During office rounds and after-action reviews, no one was obliged to talk, no notes were taken, and no names were recorded. This approach ensured employee confidentiality in an informal setting.^{17(pp39,40),18(p58)}

Team members had observed during talks with individuals and during after-action sessions that some employees had anxieties about returning to work in the Pentagon when space became available. To address those fears, team leader Lieutenant Colonel Douglas Waldrep and other members scheduled a formal desensitizing tour of the crash site for ODCSPER survivors accompanied by team members. A tour of the crash site, team members thought, could enable them to better understand employee experiences and give more credibility to mental health workers. Unit leaders would be able to observe employees’ reactions at first hand and could help in the referral process by identifying those needing further assistance. In mid-October, 145 of the 196 survivors boarded three buses

to take the first formal desensitizing tour specifically for ODCSPER personnel. Two mental health professionals accompanied each bus to provide support and observe individual behavior. The team arranged for stops along the route to the building to permit gradual emotional acclimatization before viewing the disaster scene.^{17(pp39,40),18(p58)}

The first stop was on a hill about a quarter mile from the Pentagon. From this location, the damaged building and Arlington National Cemetery could be seen. Here, family, friends, schools, and others had set up a temporary memorial to the victims. Tour participants walked around the area viewing flowers, photographs, letters, and other tributes to the fallen before reboarding the buses. Stress management team members and office colleagues comforted the many who were teary-eyed. In transit to the next stop, mental health workers facilitated discussions of the experience and helped survivors release their emotions. ODCSPER employees who had previously visited the crash site helped the behavioral health team prepare their colleagues for the next stop—a view of the destroyed area that had been their offices. The destruction scene, which still smelled of smoke, evoked emotion-filled memories for many of the employees of escaping by jumping out of windows, crawling through burning debris, and other frightening experiences.^{17(pp39,40),18(pp58,59)}

The final stop was ground zero. Here the ODCSPER chaplain said a prayer, and the survivors left tokens of homage to their fallen colleagues. On the ride back to the Hoffman complex, people discussed what they had seen and how they felt. The stress management team thought their emotions were appropriate then and on the days that followed.^{18(pp58,59)}

Success of the desensitization tour was evidenced by the positive feedback the mental health team received later from unit leaders and individuals during after-action discussions. Team members remarked, “The robust positive changes we noticed in Office personnel immediately following the tour were remarkable.” The expectation was that most of the staff would be able to return to the Pentagon to work. This expectation was fulfilled when various groups returned on a piecemeal basis to the Pentagon during December and January. By March 2002 only one employee, who had physical injuries, stayed home, and only one person was continuing to work part-time. Although the mental health team had difficulty making definitive conclusions about the desensitization approach because of a lack of formal data, team members nonetheless felt that the technique, if carefully fine-tuned, could be used with positive results in the future.^{18(p59)}

As the effort to assist ODCSPER personnel continued, the mental health team opened its services to all employees of the Hoffman complex because many of them were regular visitors to the Pentagon, had built relationships there, and had been deeply affected by the tragedy. With the help of the Salvation Army, the team established a lounge area where people could rest, have refreshments, and chat with each other. As more and more ODCSPER staff returned to the Pentagon, mental health providers gradually closed their services at the Hoffman complex but continued to support this community through e-mail messages, hand-outs, and one-on-one discourse.^{17(pp39,40)}

PENTAGON FAMILY ASSISTANCE CENTER

In addition to the missions inside and outside the Pentagon, uniformed mental health responders had a mission to support the Pentagon Family Assistance Center. The DoD had ordered the establishment of the center on the afternoon of 9/11, and it opened at 7 am the next morning at the Sheraton Hotel in Crystal City, Virginia, on Jefferson Davis Highway just northwest of the Pentagon. Under the leadership of Lieutenant General John Van Alstyne, deputy assistant secretary of defense for military personnel, the center was planned as a place for family members of the deceased and missing to gather together in mutual grief and support. Here they could also receive spiritual, emotional, physical, financial, and legal services; information about benefits; and counseling from different organizations. The center was staffed by representatives of commands, military chaplains, and casualty assistance officers along with Veterans Affairs, Social Security Administration, Department of Justice, Federal Emergency Management Agency (FEMA), and Red Cross representatives, all prepared to offer advice and provide assistance.^{1(p15),19(p68),20(pp21,22)}

The chief coordinator of the mental health response at the Family Assistance Center was Colonel William Huleatt. Besides being the chief of WRAMC's Department of Social Work Services and NARMC's social work consultant, Huleatt served as team leader for the NARMC's stress management team. In these roles, he supervised military officers, government civilian behavioral health specialists, American Red Cross mental health services personnel, and community volunteers who observed and provided emotional support to family members, friends and colleagues of the victims, and the Family Assistance Center's staff itself. Huleatt also screened volunteers with credentials and previous training or experience in disaster mental health for positions as counselors, escorts, or reception staff, depending on their level of expertise. During the first few days, he assembled his official staff. He used people from his department at WRAMC and six Air Force mental health officers, working in shifts, as his core team. Eight were present during the day, two worked the evening shift, and, at first, there were also two people on the night shift. Huleatt soon reduced the night shift to one, however, because there were always chaplains at the Family Assistance Center who could provide extra help. Some mental health workers moved throughout the center to work where they were most needed, and others focused on observing people during the briefings. All looked after one another because they worked long, intense hours with little rest.^{9,19(p69)}

The center was set up in conference rooms on the second floor of the hotel. Mental health workers and family members who were not staying at the hotel passed through an entrance guarded by police and soldiers in battle dress uniform. Once inside, they signed in and picked up a name badge. To distinguish one group from the other, staff and military members wore white name tags, and family members wore blue. Volunteers checked in at a station in the lobby. In a sitting area upstairs, images of the damaged section of the Pentagon were displayed on a poster board.^{4(pp7-13),20(pp21,22)}

Mental health workers paid particular attention to the reactions of family members during briefing sessions and on visits to the crash site. They also closely monitored Family Assistance Center personnel, many of whom had been in the Pentagon during the attack, for signs of stress and a need for rest and relaxation. They also observed volunteers from the military, from other organizations, and from the community because many had never before responded to a disaster. Several volunteers had lost coworkers, and at least two of them had lost loved ones.^{1(p15),9}

Another group under careful watch were the 150 casualty assistance officers working at the center, who came from every military service. Each family received the assistance of a service member from either the victim's branch of service or the US Marine Corps, in the case of DoD contractors. These individuals helped families plan memorials, explained available benefits, served as escorts, and facilitated logistical needs such as transportation and lodging. Casualty assistance officers had a demanding job that permitted families to call upon them 24 hours a day. Because many were inexperienced with the process and soon became close to family members, they were often at risk for stress themselves. At the end of their assignments, all underwent a psychological after-action review, in which they discussed their feelings about their recent experiences as casualty assistance officers and received help in developing coping strategies.^{1(p15),9,19(pp69,70),20(pp21,22)}

The principal mental health service employed at the Family Assistance Center was an unstructured and nonintrusive form of counseling that provided emotional support while encouraging individuals to use their own healthy defense mechanisms and coping skills to deal with the tragedy. The hotel's dining area, where the Sheraton provided meals for those working in and utilizing the Family Assistance Center, was an opportune location for informal counseling. Assistance occurred while family members were in line getting food or at dining tables. One-on-one conversations also took place on the way to briefings or to other services. Although formal psychotherapy sessions never took place, informal chatting between family members and mental health workers often established helpful relationships and served therapeutic purposes.^{9,19(p69)}

Information briefings about the rescue and recovery of victims and other facts occurred twice a day at 1000 and 1400 in the hotel ballroom on the second floor. General Van Alstyne often led the briefings and took questions from the audience of family members, guests, and casualty assistance officers. He and other leaders stayed in the room after the briefings to answer questions and to speak privately to individuals. About 50 to 75 family members, including those from out of town who were staying at the hotel, attended at least one briefing each day. The sessions provided a good opportunity for mental health workers to observe the reactions of family members. Mental health workers also counseled the young Navy enlisted personnel and marines who provided microphones at the meetings and were exposed to much grief and sadness.^{9,20(pp21,22),21(p72)}

Colonel Huleatt also brought in military psychiatrists who specialized in the problems of children and adolescents. Engaging children in conversation both in the center and in the center's childcare room, they helped the children of lost or

injured family members to grieve normally and develop coping strategies. The psychiatrists continually assessed the strengths of children's families and the families' military systems in order to know where the child's support lay because each of these structures could help the child cope.^{9,22(pp79,80)}

Additionally, a group of volunteers from the Veteran Affairs' National Center for Post-Traumatic Stress Disorder in Palo Alto, California, which had developed a model for helping families manage their grief, served as consultants and advisors. Their model, called "brief education and support," was designed to enable disaster victims understand and normalize their reactions to a traumatic experience by promoting effective coping strategies. The model was developed in response to controlled trials indicating that techniques in which participants recounted their traumatic experiences do little to prevent posttraumatic stress disorder and other psychopathologies, and might even promote them in some cases. The brief education and support model avoided exploration of the traumatic experience and instead offered information about stress reactions and how to normalize them. In this way, it provided healthy coping strategies, and helped to identify people who might need more intensive counseling.

During the 2 weeks it was at the center, the Veterans Affairs team counseled the military, civilian, and volunteer staff; mental health professionals; Red Cross workers; casualty assistance officers; restaurant employees; center administrators; escorts; financial helpers; and others. It also trained some employees in the brief education and support model. The group conducted staff psychological after-action reviews because staff workers were trained to subordinate their own concerns to the more imminent need of helping distressed families. In support sessions with families, team members shared their individual experiences and reactions. Then they passed on constructive ways to handle stress, such as taking a day off from work, going for a walk, keeping a journal, talking to friends, limiting exposure to media coverage of the event, getting enough sleep, listening to music, and reading fiction.^{9,23(pp73,74)}

About 17 of these sessions took place at the center, with two to nine staff members participating in each. Attendees related that they found the meetings helpful. Even so, team member Josef I Ruzek believed that a more systematic evaluation of this approach was needed "because some studies of debriefings have shown a lack of correlation between satisfaction ratings and impact on traumatic stress reactions." In other words, the sessions made people feel good, but their long-term effects were unknown.^{23(p74)}

Huleatt also brought American Red Cross mental health professionals who were trained in disaster response into his system when they left the Pentagon during the middle of the second week because recovery operations had slowed. After that, Red Cross volunteers met daily with families to discuss financial matters, and Red Cross Department of Mental Health Services workers sat in on difficult interviews to provide emotional support. Huleatt also turned the screening of volunteer counselors over to the Red Cross, which already had a volunteer screening system.⁹

Most Pentagon employees were civilians and not beneficiaries of the military

health system, so Colonel Huleatt also worked with FEMA and the Health and Human Services Substance Abuse and Mental Health Agency. Through its grants program, FEMA set up additional support services. Once the Family Assistance Center closed, civilians who still needed assistance could receive grants from FEMA and the Substance Abuse and Mental Health Agency by visiting the offices closest to their homes.⁹

While the Family Assistance Center was at the Sheraton, the hotel's ballroom became a memorial to the victims. Families were encouraged to bring in mementos, cards, letters, pictures, flowers, candles, poems, and other memorabilia to place on tables to honor their loved ones. Tables and tablecloths were arranged to resemble the American flag. To the left of a podium at the front of the room stood the flags of the US armed services. To the podium's right was a large board displaying the obituaries of every Pentagon attack victim. Hanging on the walls were banners containing messages and signatures from schools around the nation. The ballroom also held Catholic and Protestant Sunday services for families.^{4(pp8,24),21(p72)}

Because earlier visits to the crash site soon after the attack had helped Pentagon employees, Colonel Huleatt began organizing similar visits to the impact area for family members. Seven busloads left for the Pentagon the first Saturday after the attack, and another seven the following weekend. Each vehicle held 40 to 45 people, 2 counselors, a chaplain, and a medic. Red Cross representatives provided everyone with roses to leave at a memorial near the disaster area that had been created by draping a flatbed trailer with camouflage netting. Site visits were coordinated through Major General Jackson, the commander of the Military District of Washington, and with the SMART-SM team at the Pentagon. The families of the victims found these visits helpful.⁹

Because therapy dogs had proven beneficial to the victims of the Oklahoma City bombing, the Pentagon Family Assistance Center also used the animals. Therapy Dogs International (TDI) offered its services to the Family Assistance Center on 12 September. Sue Peetoom, director of TDI's local Virginia chapter, based in the King George–Fredericksburg area about 50 miles south of the Pentagon, brought her two labrador retrievers to the Family Assistance Center the next day. She was joined at the Center that weekend by additional therapy dog teams (dog and handler). At first, General Van Alstyne was skeptical of using dogs for therapy, thinking they might be more of a nuisance than help. During that first weekend, however, he saw how well-mannered the animals were and how they cheered up both families and staff. "As long as we are here, I want you here as well," he said to several dog owners.^{4(p2)}

Usually three dog teams worked on any given day from 0900 to 1800, or whatever hours the volunteers were able to work. The teams were expected to be present for at least one of the daily family briefings. Otherwise, the dogs were available at any time for anyone at the center. Dog handlers were required to wear visible badges, and some wore khaki polo shirts with TDI logos and the name of their club, "Spiritkeepers," embroidered underneath. The animals wore red collars and yellow therapy dog tags. Because many of the pet owners lived at least an hour away from Washington, Virginia Railway Express gave them free

travel into the Washington area and permission to take their dogs on the commuter trains.^{4(p3)}

Therapy dog teams worked in the hotel lobby, in a therapy dog station on the second floor, and in a children's day care center on the third floor. After signing in and picking up their building passes, owners and pets made themselves available to the staff and others in the hotel lobby, before going upstairs to the second floor conference area. The therapy dog station was across the hall from the ballroom where the briefings were held. Many family members and staff stopped by to see, pet, and talk to the dogs as they passed by the station. Indeed, people approached the dogs wherever they were and whenever they felt the need, which was exactly why the animals were there. The dogs themselves were trained to sit quietly and to let people come to them. Children in particular were drawn to the animals, and the dogs, in turn, soaked up the attention. The dogs sat quietly while the children brushed them with the soft brushes the owners had provided. Boys and girls even played throw and fetch games with the animals, supervised by their owners. Using a second leash, children accompanied the therapy dogs on walks up and down the corridors. While pets and people interacted, the owners answered questions about the animals and the service they provided.^{4(pp8,9,11,16,17)}

Like General Van Alstyne, others who were initially skeptical about bringing therapy dogs to the center changed their minds once they saw how families and



Four therapy dog owners and their dogs take time out at the Pentagon Family Assistance Center.
Photograph: Lisa Nelson-Firing.

staff interacted with the animals. “We all appreciated having the dogs there,” Colonel Huleatt said, “because it was sometimes nice to simply go over there and pet the dogs.”^{9(p26)} One person who favored cats over dogs noticed “a change in the atmosphere at the center for the better.” “To be certain, there was the distant, sad look in a few people’s eyes, and rightly so,” Lisa Nelson-Firing, a therapy dog owner, remembered. “Many faces lit up and smiled when they saw those furry friends.” Everyday family members told her and other owners, “Thanks for being here! This is great work that you all are doing.”^{4(p12)}

In total, 42 certified therapy dog teams, with dogs of many breeds, worked at the Family Assistance Center. The pets brought therapeutic joy to the families and staff during a sad time in their lives. The laughter and smiles the animals elicited helped to heal emotional wounds and brought some sense of normality to people in abnormal times.^{4(p22)} Seventeen therapy dog teams were invited to the memorial service given at the Pentagon on 11 October 2001 and attended by President George W Bush. About 1,200 family members and 100 counselors attended as well. The service was held at the river entrance to the Pentagon, which was two sections away from the attack area. Most therapy dog teams sat in the front row of the VIP section (the area marked on their entrance passes) because that row could accommodate the dogs more easily. Family members passed by that row as they went to their seats, and some visited dogs along the way.^{4(p25),9}

On the day following the memorial service, 12 October, what came to be known as phase one of the Family Assistance Center’s activities closed down at noon, and phase two began. “The intensity of the operation at the Sheraton had served its purpose,” said Colonel Huleatt.^{9(pp38,39)} Phase two, a family assistance resource and referral operation, was a much smaller activity that supported casualty assistance officers who continued to visit families. Two counselors and two chaplains were involved in phase two, which took place at the Pope Building in Crystal City until closing in November 2001. Military families and casualty assistance officers could also still receive help at family assistance centers already located on military bases. Civilian families received help through FEMA and other organizations.^{1(p15)}

LIAISONS WITH CIVILIAN HOSPITALS

Another part of the mission of the mental health team was to develop collaborative relationships with medical and surgical support staffs at the civilian hospitals where Pentagon casualties were being treated. To that end, WRAMC’s Psychiatric Consultation Liaison Service and Social Work Department sent representatives to civilian hospitals to meet with patients during treatment and before discharge. The presence of military mental health workers at the hospitals provided the patients with a connection to the military health system, allowing military case workers to identify patients at risk for psychological problems and coordinate follow-up treatment at military hospitals after discharge from the civilian facility. Post-discharge follow-up appointments were used to continue monitoring patients for signs of stress. Treatment was offered if appropriate.^{1(p15)}

MILITARY CHAPLAINS

Military chaplains deployed with the Army's stress management team to the Pentagon on 12 September. Six individual chaplains and two chaplain assistants provided support during the 3-week Pentagon mission. During this time, chaplains working almost 1,000 hours assisted in more than 300 after-action reviews, personally contacted more than 2,000 individuals, and led two prayer services.^{5(p17)}

WRAMC's chaplains who were assigned to the stress management team had been training with it since its establishment. They had also received 12 months of clinical pastoral education and had worked at least 1 year in a behavioral health clinic, where they provided religious support and pastoral care. Some had performed chaplain duties at previous military and civilian disaster locations.^{5(p17)}

By traveling with the team to the Pentagon, chaplains received security certification early, which enabled them to move from place to place to conduct what they called "ministry of presence" at locations with the most people under stress. At these locations recovery workers who had the unpleasant task of searching for human remains and sorting through rubble for evidence appreciated the presence of chaplains and believed their support was indicative of a concerned command. These workers had on-site counseling available when they most needed it.^{5(p17)}

Chaplains from all the services and from many agencies participated in the Pentagon disaster response. They had varying levels of training, approaches, and goals. More standardized training, according to Army Chaplain Robert Powers, would have produced a more unified and effective result. "Joint doctrine in disaster response lays a foundation on which the Medical Corps and Chaplain Corps of all services can build complementary doctrine and procedures," he said. Because of the potential for harm if traumatic stress issues were inappropriately addressed, Powers saw a need for "joint doctrine supported by clinically validated procedures . . . trained by all branches of the Armed Forces."^{5(p18)}

HELPING THOSE WHO HANDLED HUMAN REMAINS

Military personnel who handle human remains are at risk for psychological problems such as posttraumatic stress disorder. These people pick up body parts from a battlefield or a major disaster site, handle or transport human remains, help identify bodies in mortuaries, or work with graves registration details. Studies have shown that soldiers exposed to human remains suffer more psychological stress illnesses than members of control groups who have not had this kind of exposure. Studies have also suggested that a relationship exists between the amount of exposure a person receives and the degree of psychological distress he or she suffers. Stress levels also rise if mortuary workers can in any way identify with the victims.^{24(p83)}

After 9/11, military healthcare workers, mostly physicians with little direct experience in handling human remains, were assigned to an on-site mortuary affairs unit that had the task of removing bodies from the Pentagon after the victims had been pronounced dead. Physicians made the death pronouncements inside

the building before remains were transported to the morgue. Persons who went into the destroyed wedge to remove the bodies had to wear gloves, gas masks, jumpsuits with hoods, and rubber boots. Team members were directed to examine the contents of the bags containing human remains and assist in loading the bags onto transport vehicles. At the end of the day's work, personnel went through a decontamination chamber before they removed the protective clothing. Beyond these requirements, team members received no instructions; lack of information about what they would be facing added to their "surprise and shock."^{25(p8)}

It is common for persons inexperienced in handling human remains to have anticipatory stress. The inexperienced mortuary team members at the Pentagon had fears about their reaction to viewing the dead and their lack of preparation in experiencing the sights and smells they would encounter. Their anxiety often took the form of restlessness and impatience in driving to the crash site. There was nervousness and apprehension as well about the pronouncement procedure. In response, mental health workers suggested such coping mechanisms as looking at the task as "an occupational duty" or a contribution to a noble and higher cause. Regardless of individual reactions, most of those involved in the work felt that their job was important and even "sacred." They all wanted to contribute "to a group effort with an important mission."^{25(p9)}

Viewing the devastation inside the building provoked additional anxiety. Team members described a damp, dark interior with charred walls, burnt wires, and scorched fixtures. A peculiar smell filled the air—a combination of spent jet fuel, charred human remains, and burnt wires. The scene was described as "surreal . . . like a movie set."^{25(p9)} When one person's mask fogged up from breath condensation, it aroused an "eerie feeling." Most of the bodies were burnt beyond recognition as human. Many of them were headless, and very few skulls were found. Instead, there were body parts such as pelvic girdles or lower extremities. Cadaver pieces recognizable as human were disturbing to team members. One of the dead, "a woman trying to protect herself as though 'frozen in time,' hands in front of her face, with several pieces of clothing and patches of hair still intact,"^{25(p9)} was particularly upsetting. Team members went about their duties quietly, with robot-like movements and little expression, the weight of their tasks visibly showing on their stooped shoulders. Some worried about the integrity of the supports holding up the structure and were concerned about their safety. Most were sensitive to noise of any kind, especially helicopters overhead and the screaming sirens of rescue vehicles. The overriding emotion for some was devastation, for others shock, and for still others simply strong emotion. At least one member felt numb, with no emotion at all.^{25(p9)}

Team members coped in various ways. The most common strategy was for a person to detach himself or herself emotionally and to focus on the task at hand. This practice was known as the "doctor mode" or "function mode." The medical school experience of working on cadavers was helpful to some. Most team members believed that examining human remains was natural and "consistent with their profession." Even so, some experienced unpleasant but temporary psychological effects, including dreaming about human remains, sadness, bouts of cry-

ing, loss of appetite, a sense of the lingering smell of burning flesh, and emotional numbness. None of those symptoms were long-lasting, and none interfered with the work, so structured intervention was not required. Overall, everyone involved considered their Pentagon disaster mission an invaluable contribution that helped them to grow professionally while teaching them about war. They left with a sense of having accomplished something very important, as well as new respect for the various relief agencies on site.^{25(p10)}

At the Dover Air Force Base mortuary, where 188 human remains were processed between 13 September and 16 November 2001, a team of mental health professionals—psychologists, psychiatrists, social workers, chaplains, and others—assisted forensic teams, especially younger volunteers who had little forensic experience, in dealing emotionally with the gruesome environment. Critical incident stress management was the most common intervention technique used with these workers. Strategies employed included debriefings, deploying critical incident stress teams that prepared workers for exposure and provided other education and counseling services, and encouraging workers to focus on something else. The debriefings were the most structured part of the procedure and used infrequently; studies and literature on the process indicated that its effectiveness against posttraumatic stress disorder is limited, that the method works better in small groups, and that some individuals may even be so disturbed by formal debriefings that they develop more symptoms of mental disorder.^{24(pp83,84)26(pp81,82)} Although “several reviews of the literature and published studies have supported the efficacy of CISD [critical incident stress debriefing], . . . numerous other studies have found no effect of CISD or even a worsening of symptoms for those who receive psychological intervention”^{24(p84)}

Critical incident stress team members were divided into two groups (red and white) and wore corresponding badges to be readily identifiable by mortuary affairs workers. The red team, consisting of personnel experienced in handling body parts and in dealing with people exposed to them, focused on the mortuary process area where human remains were being handled. Red team members were permanent Dover staff who had worked as stress managers in the mortuary on numerous occasions. The white team, which engaged individuals in informal therapeutic discussions, operated in the break area of the mortuary (which could accommodate 100 people), where human remains were not on view. Members of the white team included permanent Dover staff and personnel from Wilford Hall Medical Center at Lackland Air Force Base in San Antonio, Texas, who had deployed to Dover to assist.^{24(p84)}

Tasks of both teams included providing new workers with a preexposure presentation to familiarize them with what they were about to see and smell; consulting with every mortuary employee; providing each individual as many as four off-the-record one-on-one interventions; pairing new workers with the more experienced and encouraging the more experienced to assist the less knowledgeable and those who did not appear to be coping well; inviting more grounded employees to ask a team member to speak to an individual who was having emotional difficulties; fostering unit cohesion by getting to know unit commanders, first sergeants, and

supervisors; and educating mortuary workers on coping strategies during early morning briefing sessions before work began.²⁴

Suggested coping strategies that worked included focusing on the task at hand rather than on one's own feelings, maintaining a sense of humor with fellow workers, talking with friends and relatives on off-duty time, recognizing the importance of the task no matter how gruesome the activity, and avoiding media coverage of the event. As groups of workers left the assignment, they attended formal stress management sessions. Armed Forces Institute of Pathology participants believed they performed tasks better because of their interaction with stress management team members.^{24(pp83,85),26(p81)} Air Force mental health specialists believed that the Dover behavioral health consultant model must have been effective because only 2 of 400 mortuary workers were relieved from duty because of stress. The long-term impact on the mortuary affairs workers, however, was unknown.^{24(p85)}

Behavioral health specialists also helped victims' family members who had gone to Dover Air Force Base to provide DNA samples. The staff witnessed individuals displaying emotions of gratitude, anger, and frustration typical of persons who had lost loved ones in such a traumatic way. Family members who had to give blood to obtain DNA identification of a dead relative expressed feelings of closure after the process.^{26(p82)}

AIR FORCE MENTAL HEALTH TEAMS

Besides their work with body handlers at the Dover mortuary, Air Force mental health personnel provided critical incident stress management outreach programs at the Pentagon and at the Pentagon Family Assistance Center in Crystal City. In addition, Air Force mental health personnel went to the crash site to support mortuary workers and to the DiLorenzo Clinic to work with Army planners directing the joint Pentagon response. From 12 September to 1 December 2001, the 89th Medical Group's mental health flight team from Andrews Air Force Base, augmented by 13 mental health professionals from Keesler Air Force Base's mental health flight, worked 5,000 hours in support of Pentagon employees, family members, and mortuary workers.^{11(p26)}

Beginning on 14 September, an Air Force mental health operations center to support Air Force personnel was in operation on the fifth floor of the Pentagon in the deputy chiefs of staff area. Following the approach outlined by the Air Force's critical incident stress management program, two-person teams pairing a mental health worker and a chaplain visited each Air Force office twice a day to talk to individuals and to recommend further intervention if needed. Operations center staff also provided educational lectures, support forums, and debriefings.^{27(p33)}

Except for a few individuals who were having serious reactions (staff recorded their names and recommended further intervention), the mental health teams found that little in the way of stress management services were needed because Air Force offices were not near the impact site and no Air Force personnel were killed. Nevertheless, at the end of the first week the teams were augmented to provide support to Air Force personnel in outlying offices in other parts of the

metropolitan area. One team remained at the Pentagon to handle walk-ins, about two per day. Eventually, the Air Force behavioral health personnel came to believe that their presence was becoming intrusive, more of a nuisance than a help, except for those few individuals who needed intervention. As a result, the Air Force closed the outreach program on 28 September and gave the DiLorenzo Clinic a list of the individuals who required follow-up treatment. Air Force mental health personnel working with the Army in the DiLorenzo Clinic continued the Army/Air Force outreach program in areas of the Pentagon not covered by the Air Force's stress management team.^{27(p33)}

At the Pentagon Family Assistance Center, one social worker from the 89th's family practice residency faculty and two Air Force mental health specialists began work on 14 September. At the request of Colonel Huleatt, the Air Force later added three more mental health staff. Several more were added on a temporary basis to accompany family members to the impact site. In the end, most of the counseling group at the center were members of the Air Force mental health team, and Colonel Huleatt included them in the decision-making process.^{11(pp27,28)}

The Air Force team at the Family Assistance Center operated through 11 October, the day of the memorial service. With the Family Assistance Center's function greatly reduced, one Air Force mental health worker remained another 2 weeks to help families with documentation and to help close the center. Nighttime operations of the mental health group at the DiLorenzo Clinic shut down on 28 September, when the body recovery effort was completed. The mental health daytime staff, however, continued its services in the Pentagon after the anthrax scare of 15 October, with 10 of its members remaining as part of the Army's Operation Solace sustained mental health response. The ten were reduced to five on 9 November and to two on 3 December, as the Army hired civilian social workers to continue the effort. After helping to orient the newly arrived civilian mental health experts, the remnant of the Air Force mental health team returned to its home station at Andrews on 10 December.^{11(pp27-29)}

NAVY MENTAL HEALTH TEAMS

The Navy established a separate psychiatric team to support its staff in the Pentagon shortly after 9/11. It used an augmented special psychiatric rapid intervention team, consisting of three psychiatrists, two psychologists, two social workers, two psychiatric nurses, two chaplains, two enlisted psychiatric technicians, and eight psychiatry residents (used part-time). All had training in postdisaster debriefing techniques. One senior psychiatrist, who had responded to a number of similar missions and had experience working with the Navy's senior leaders, joined the group.^{28(p24)}

Because the Navy Command Center had been destroyed in the attack, its staff relocated to the Navy Annex in Arlington, Virginia, about a half mile from the Pentagon. Other Navy personnel also relocated to the Annex or to federal office buildings at four other locations in the Washington area; none remained at the Pentagon. The psychiatric team deployed from the National Naval Medical Center

in Bethesda, Maryland, to the Navy Annex on the afternoon of 12 September. With logistical support such as office space, debriefing rooms, telephones, and computers provided by the Annex,^{28(p24)} the team began offering services to beneficiaries of the military health system and civilian employees at all the relocation sites on 13 September.

Mental health team members conducted briefings that included information on psychiatric symptoms, advice on handling them, and the availability of psychiatric help. Group debriefings, which numbered between 4 and 10 per day and included 3 to 30 participants each, allowed patients to present personal experiences and describe their symptoms, including sleep disruption, heightened anxiety, enhanced vigilance, feelings of unreality, bereavement, and fatigue. At these meetings, team members assessed participants' psychological health and sometimes recommended more counseling. From time to time, individuals presented for further treatment on their own. During 2 weeks of operations, the team had made more than 1,800 contacts. When the number of patients seeking help began to drop off sharply during the third week, the team left the Annex and returned to the behavioral health clinic at the National Naval Medical Center, where individuals who needed special attention received clinical appointments and continued follow-up.^{28(p25)}

The Navy also provided counseling services to its casualty assistance response team, which assisted family members of the dead and injured. The casualty assistance team was composed of 4 full-time members of the Navy's Casualty Assistance/Prisoner of War and Missing in Action/Retired Activities Branch (PERS-62) and the 28 members of Navy Reserve unit PERS-6, Component 206, which was called up after 9/11. These personnel collected data on the dead, injured, and missing, and their next of kin; contacted casualty assistance coordinators and assigned casualty assistance officers; provided families with information about benefits; processed family benefits; and kept the Navy leadership informed about their activities. The daily tasks of dealing with grieving families under difficult circumstances and collecting macabre information was so grueling that it became necessary for the Navy to provide counseling to the team members themselves.²⁹

Therefore, a counseling support cell of social workers, psychologists, and chaplains was set up within the response team to provide casualty assistance staff with stress management education, counseling, and moral support. As with the Army's support organization, the Navy's counseling support cell avoided formal stress debriefings. Instead, its technique of individual crisis counseling for its casualty assistance staff resembled that of the mental health team supporting the Army's casualty assistance officers.^{29(pp76-78)}

COMMUNITY MENTAL HEALTH IN THE NATIONAL CAPITAL REGION

In the immediate aftermath of 9/11, concern arose about the long-term psychological effects of the tragedy on the people of the national capital region, as well as the area's ability to respond over a long period to the mental health needs of the community. The massive mental health response to the attack revealed splintered delivery systems with redundant services. The American Red Cross, for instance,

undertook tasks that went beyond its usual disaster services. A comprehensive referral plan with an efficient triage system, so that military mental health workers, the Red Cross, local mental health agencies, and others knew who to send to which agency, was lacking. In addition, mental health workers needed to contact hard-to-reach groups such as children, non-English speaking individuals, and friends of the victims who might require help. Red Cross behavioral health staff believed that the organization that existed at the time of the 9/11 attack would never have been sufficient if a longer-term response were necessary.^{30(p87)}

What was needed was an organization of mental health workers who could participate in a discussion of the continuing mental health needs of the community. Finding the participants was not difficult for the Red Cross because many of the mental health professionals at the crash site and at the Pentagon Family Assistance Center already knew each other. On 23 September, the Red Cross met with workers in the area who functioned as representatives of the national Red Cross organization rather than with local participants in order to avoid the meetings being “over-identified” with a particular population, discipline, individual, or organization. Within days, the Red Cross invited a wider range of participants without invoking the appearance of territoriality, and the coalition expanded. By its second and third meetings on 28 September and 5 October, the group had broadened to include not only members of the Red Cross but also military service representatives, the Washington, DC, and Virginia Disaster Response Network (a group of licensed psychologists with training in disaster response who offer volunteer assistance to relief workers), the Capital Area Crisis Response Team (which provides volunteers to assist individuals in times of crisis and meet the emotional needs of traumatized victims of disasters), the National Mass Fatalities Institute (a training program for mass fatalities response located in Cedar Rapids, IA), the American Psychological Association, and other, mostly local, agencies and groups.^{30(p87)}

This organization, which came to call itself the Mental Health Community Response Coalition, was modeled after the Resource Coordinating Committee of Oklahoma City created after the Murrah Federal Building bombing. The group met ten times between 23 September 2001 and 11 March 2002—exactly 6 months after the attack on the Pentagon. The military services were represented at every meeting beginning on 28 September. The coalition focused on sharing information and ideas, preventing duplication of effort, coordinating functions, facilitating partnership and referral, and considering community needs. An anthrax scare in the area, which began on 15 October 2001, added a sense of urgency to the need for a good mental health response in the national capital region.^{30(p87)}

Despite its lack of a government mandate or federal money, the coalition thrived. Factors instrumental in its success were inclusiveness of membership, continuous induction of new members, flexibility, responsiveness, and united leadership. Participating organizations and their resources were identified; processes were discussed; information was shared; and relationships were formed at the monthly meetings. The coalition’s establishment laid the foundation for effective coordination of mental health resources in the national capital region during future crises.^{30(pp87–89)}

SUMMARY

Because of the difficulty in finding data on the success of psychological interventions, it is nearly impossible to measure the Army Medical Department's success in reaching its goal of minimizing long-term psychological problems after 9/11. Semiscientific data from the Pentagon Post Disaster Health Assessment survey^{31(p284)} (a CHPPM initiative to document and assess postdisaster health problems in order to determine how best to respond to future attacks; see Chapter 7, *The Continuing Response*) revealed that approximately 40% of respondents (24.4% of the Pentagon population responded) reported symptoms of emotional distress 1 to 4 months after the attack, and approximately 21% believed that these symptoms interfered with carrying out their daily activities. The rates are very comparable to rates in other populations after terrorist events.^{31(p290)} One respondent, Pentagon employee Marcie Bents of Severna Park, Maryland, who suffered burns while evacuating on 9/11, experienced emotional trauma that spiraled downward until her death on 17 May 2007.³²

Although much remains to be learned about minimizing long-term psychological problems after terrorist attacks, it is most likely that survivors, families, Pentagon employees, and active duty personnel benefitted after 9/11 from the efforts of dedicated and highly motivated mental health providers, versatile and creative counseling, and the judicious use of chaplains, trained volunteers, and professionals from other organizations such as the American Red Cross. At a minimum, these providers offered comfort, someone to talk to about the experience, guidance on the use of natural coping mechanisms, and gateways to further intensive counseling, if needed. Complicating the response, however, were mental health workers with varying levels of training and different approaches to the task. Direction for military providers came from three surgeons general, with very little coordination in the short term.

Coordination of efforts would have been improved by a senior mental health director, a designated chain of command, and practical procedures, if not doctrine, to support a triservice mental health response to a mass casualty incident such as the attack on the Pentagon. Special medical augmentation response teams proved the best way to support the mission, but they continued to need refinement. The Pentagon Family Assistance Center proved a tremendous boon to families of victims, providing them the necessary psychological and administrative support. Finally, the terrorist attack occurred in the national capital region, where many mental health assets were already located, such as training programs in psychiatry, psychology, and social work, as well as military behavioral health professionals. If the incident had happened outside of the Washington area, military mental health resources would not have been as plentiful, and the response would have suffered.^{1,8(pp27,28)}

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