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# Walter Reed Army Medical Center's Mental Health Response to the Pentagon Attack

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**The September 11 terrorist attack on the Pentagon captured the attention and concern of America as well as the world. Given the extent of devastation, and the number of deaths at the Pentagon, it was believed that the uniformed mental health services would serve a pivotal role in the recovery and relief efforts. This article provides a synopsis of the complex and multidisciplinary mental health services provided by Walter Reed Army Medical Center in the wake of the September 11 attack on the Pentagon. This article offers an overview of the functions and roles of mental health team members, describes a constellation of services rendered, and describes how missions differed inside and outside of the Pentagon.Additionally, the authors provide the reader with how services were provided at the Family Assistance Center to family members of those killed during the attack. Liaison with civilian medical, mental health, and relief agencies and facilities will be discussed as well. The mental health response was an intensive and complicated experience and has yielded many lesson learned. To this end, the authors will provide the reader with an understanding of how the lessons learned during this mission may assist mental health commanders and leaders in planning and responding to similar deployments in the future.**

## Introduction

The attack on the Pentagon and the World Trade Center on September 11, 2001, drove home a reality that many would prefer to ignore: the United States is not immune to terrorist activities on its own soil. Although military medicine has been preparing for such events for some time, the acts of September 11 confirm that what could have been considered far-fetched scenarios in the past should not be considered out of the realm of current possibility. We must be ready to respond rapidly and effectively to any such incidents in the future. This article describes the activities of the mental health clinical departments (Departments of Psychiatry, Psychology, and Social Work) at Walter Reed Army Medical Center (WRAMC) after the attack on the Pentagon, the nature of the mission, the coordinated response effort, the complexity of the tasks that needed to be completed, and the lessons learned.

## The Nature of the Attack

American Airlines Flight 77 struck the Pentagon shortly after the attacks on the World Trade Center Towers on the morning of September 11, 2001. The plane approached the Pentagon traveling north along the I-395 corridor, barely missing the Navy Annex buildings, and dove to crash into the building's foundation. Fortunately, the aircraft struck the less densely populated Pentagon wedge that was under construction. Impact at the mall entrance side of the Pentagon would have significantly increased casualties and deaths.

Many of the professionals who were working at the DiLorenzo TRICARE Health Clinic at the Pentagon at the time of the crash described not even being aware that the plane had impacted the building until they were called to provide treatment to casualties. The incident was eerily similar to an earlier mass casualty exercise that had been practiced—a plane crashing into the Pentagon. Although strangely coincidental, nothing could fully prepare an organization or a medical team for what had happened and the resulting pandemonium. It was in the midst of this confusion and chaos that the medical and mental health responses were planned and conducted.

## Initial Medical Response

Immediately upon notification of the attack, WRAMC command activated the hospital's emergency response plan. The initial response focus was on providing lifesaving medical care to casualties. A response team from the WRAMC Emergency Department was sent to the Pentagon for this purpose, and the Emergency Department prepared for the arrival of casualties from the event.

In total, 43 patients were hospitalized for physical injuries secondary to the attack. The vast majority of services to these patients were provided through civilian emergency rooms, and only three patients were brought to WRAMC on the first day. By day three, 25 casualties remained in local hospitals; the most serious of these were at the Washington Hospital Center, the region's burn unit. Although WRAMC was prepared to manage hundreds of casualties, this number never materialized. In fact, the most complex WRAMC medical-surgical activity turned out to be the coordination of services at a variety of different local hospitals to ensure that active duty members and civilian employees were being visited by military health care representatives, that their care was being coordinated, and that follow-up care was arranged at appropriate military medical treatment facilities.

## Special Medical Augmentation Response Team-Stress Management

On September 11, 2001, the North Atlantic Regional Medical Command Special Medical Augmentation Response Team-Stress Management (SMART-SM) was activated. This mental health response group was initially held in reserve until the

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medical response phase was completed. The team of 16 individuals is composed of psychiatrists, psychologists, social workers, nurses, chaplains, occupational therapists, and technicians. The North Atlantic Regional Medical Command SMART-SM mission is "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 throughout the North Atlantic Regional Medical Command." The team participates in ongoing training throughout the year and is well prepared to deal with disasters and other traumatic events of various natures.

As the SMART-SM serves primarily as an augmentation team that supports units for specific, time-limited missions, it was anticipated that its small detachment of 16 would not be sufficient to manage the expected large Pentagon attack mission. As a result, all active duty mental health professionals and paraprofessionals within the Departments of Psychiatry, Psychology, and Social Work were activated to augment the existing SMART-SM for the anticipated mission. Unlike SMART-SM members, these individuals had varying levels of experience in dealing with trauma and disaster response. With augmentation, the entire WRAMC mental health response team totaled just fewer than 100 providers.

## Complexity of Mission

There were several factors that made this an extremely complex mission. As mentioned, the size of the mental health responder group was large and somewhat difficult to manage. Additionally, the SMART-SM has no dedicated administrative elements to manage the coordination and logistical requirements inherent in a situation of this scope and magnitude. As the majority of administrative supports within the mental health departments at WRAMC have no inherent military administrative elements, the clinical responders had to handle many of these duties, which proved to be a disadvantage to the team as the mission developed.

Also, as mentioned above, the augmented team included professionals of varying experience and capability in the practice of trauma and disaster response. The leadership within mental health addressed this problem by assigning less experienced members to work with more seasoned SMART-SM personnel.

The following separate missions were identified early in the response time line. Each of these areas will be discussed in greater detail in subsequent sections. Each required substantial mental health resources. First, the "Outside Mission" at the Pentagon described the activity that offered support and monitoring to recovery workers at the site of the crash. The second mission at the Pentagon was referred to as the "Inside Mission," specifically the support and monitoring of members of the Pentagon community itself. Third, mental health resources were required at the Pentagon Family Assistance Center to support the family members of those lost or missing. Fourth, mental health providers were required to assist in liaison with civilian medical facilities that were treating casualties of the attack. Finally, members of the mental health team continued to provide ongoing clinical services at WRAMC and maintained graduate medical education programs.

## The Functions of Mental Health Responders

In each response area, mental health providers offered a core group of services. They provided opportunity for supportive discussion of exposures and experiences. They provided useful psycho-educational information related to expected normal responses to abnormal experiences. This was offered to individuals as well as organizational leaders. They provided mental health hygiene recommendations, reminding everyone to take good care of themselves by maintaining appropriate sleep, eating, and physical fitness schedules, as well as limiting exposure to media coverage of the event. Team members provided mental health surveillance, as well as monitored and maintained contact with high-risk individuals and groups to support wellness. Risk was determined based upon individual and organizational exposure, as well as individual communication after initial contacts. Clinicians also provided clinical services when appropriate and ensured that all individuals had ready access to services, should they desire them in the future.

## The Outside Mission: Assisting the Recovery Teams

The Outside Mission was the mission that focused predominantly on support of the recovery workers at the Pentagon attack site. There was initiation of continuous mental health support almost immediately, 24 hours each day for 7 days a week. This continued throughout the recovery phase of the operation.

The principal roles of recovery workers included the identification and rescuing of casualties from the building, the systematic search of the wreckage site for any living casualties, the collection and handling of human remains, and the documentation of the crime scene. In support of these functions, combat engineers, search and rescue teams, and firefighting teams contributed by inspecting and maintaining the safety of the building to preclude injury to any members of the recovery team.

Members of the Pentagon recovery team included representatives from civilian organizations as well as both active and reserve military units. The following groups were represented: military combat engineers, military and civilian firefighters, FEMA urban search and rescue teams, other civilian extraction teams, graves registration and mortuary affairs personnel, military chaplains, military physicians, the 3rd Infantry Regiment Old Guard units, Army Criminal Investigative Department, Naval Criminal Investigative Service, Air Force Office of Special Investigations, and the Federal Bureau of Investigation.

Mental health responders focused on several issues that were unique to this population of recovery workers. Awareness and monitoring of exposure to disturbing experiences were primary concerns. The nature of preparedness for participation in this mission was variable for the different groups, with some individuals never having participated in such a disaster response before. Additionally, mental health providers monitored whether groups were maintaining good mental hygiene practices by allowing appropriate breaks for food, water, and sleep.

Some mental health providers developed ongoing relationships with some individuals or groups on the recovery team. When this was the case, efforts were made to maintain those relationships. This was true for the 3rd Infantry Regiment Old Guard soldiers who were very actively involved in the recovery mission. These service members assisted in the transporting of

both rubble and human remains containers from the attack site to the mortuary affairs areas. The mental health teams worked hard to develop relationships with this group, which was composed largely of young soldiers. Mental health recovery workers met with the groups when they ate and rested, supporting their healthy responses to completing this mission and providing ongoing support to groups and individuals as required. Some mental health professionals suited up and accompanied the Old Guard soldiers into the wreckage. These soldiers seemed particularly appreciative of working with mental health providers who were known to them and seemed to work best with Army mental health professionals, whom they viewed as culturally similar to themselves.

When no prior relationship existed, attempts were made to assign mental health team members to serve as liaisons to specific groups and to maintain continuity over time. However, this was sometimes complicated by the rotating schedule of mental health providers. Given that many reserve and civilian organizations came to the Pentagon from significant distances, there was little possibility of maintaining supportive contact with them once the recovery mission was complete.

Another complicating factor was that other mental health groups were on the recovery site initially. These groups often worked in ways that were different from efforts that were put in place by the WRAMC team. Although the effort of other teams was welcomed, it was important to coordinate all efforts so there was not duplication of services or an overwhelming of the recovery team by "killing them with kindness," a common complaint early in the recovery effort. Whereas efforts were made to collaborate and coordinate approaches, teams involving clinicians working in differing ways complicated the response effort. At times this led to concerns on the part of the recovery workers themselves. Eventually, in an attempt to organize the effort, the outside mission was transferred to the core SMART-SM, as this was the best-trained team for this purpose and it was best prepared to function as an integrated unit.

Some other challenges existed. Initially, there were varying levels of experience and training among mental health providers, as well as varied theoretical approaches. Some groups more strictly engaged a structured debriefing approach, whereas others made themselves supportively available in more informal ways. The SMART-SM approach tended to be more flexible depending upon the needs of the group that was being worked with. At times, this meant moving informally among the recovery workers and other times sitting down with them as a group for a formal debriefing—generally when requested.

In addition to providing assistance to recovery team groups, the mental health team needed to be cognizant of their own exposure control and to be aware of burnout within their ranks. It was essential for mental health team leaders to monitor everyone's time to rest, sleep, and eat.

## The Inside Mission: Assisting the Pentagon Community

The Inside Mission was different from the Outside Mission and focused on providing mental health response to members of the Pentagon community, as opposed to the recovery teams, which were largely external to the Pentagon. There were complexities inherent within this mission as well. Although many may think of the Pentagon as a monolithic organization, it is actually composed of a complex substructure of military and civilian groups with different chains of authority all of which function semi-independently. So consultation within the group was not as simple as it would initially appear.

Similar to the Outside Mission, continuous services were rapidly made available to anyone in the Pentagon community who requested or required support. All services from the start of the mission were coordinated with the DiLorenzo TRICARE Health Care Clinic. This approach was directed by senior command and served several key purposes. First, it allowed the mental health responders to use DiLorenzo as a primary home base to conduct the mission, allowing much needed physical space and some administrative support. Second, as DiLorenzo was the established and known health care clinic in the Pentagon, it was an existing trusted resource to employees. Finally, the leadership within DiLorenzo had formal relationships within the Pentagon that allowed the mental health responders access to key leaders and policy makers who could assist in supporting the mission.

Concerns for this population largely stemmed from individual exposure to the actual crash, individual loss of friends or colleagues as a result of the crash, organizational losses and impact on organizational function, as well as destruction of physical workplaces, need for office relocation, and the impact of these events on both individuals and organizations. Mental health responders addressed these concerns in a variety of ways, to include formal group debriefing sessions, less formal group meetings that allowed discussion of events impacting on varying organizations, informal individual interactions with Pentagon staff members, and individual clinical sessions when indicated. The attack had impacted more significantly on some organizations than others at the Pentagon, due to the proximity of office space to the crash site. So those agencies that were most affected, and considered most at risk, were identified for more rapid and intensive services.

As mentioned, the organization of the Pentagon did not lend itself to a top-down approach of providing consultation. Although senior leaders both within the line and within the medical command were extremely supportive of the mental health effort and communicated the importance of this effort widely, consultation developed more in a grass roots fashion, through targeting of certain groups, word-of-mouth communication, and geographical canvassing.

The purpose of this latter effort was to provide visible mental health outreach to all organizations within the Pentagon. This exercise was particularly complex. Twenty-thousand personnel work within the Pentagon proper. Twenty-thousand additional personnel work within the organization of the Pentagon, but at different government office buildings throughout Northern Virginia. In some situations organizations that were impacted by the attack had personnel elements in the Pentagon and in these other buildings. This was due to ongoing renovation at the Pentagon that predated September 11. Often, mental health responders had the challenge of not only identifying which organizations within the Pentagon were most affected but also at which sites other organization personnel were located.

Organizations and individuals who were most affected by the attack were also the most likely to be quickly placed outside of the building because of the loss of their office space. The oper-

ation required that mental health recovery teams do detective work. As information was received, it was shared with all group members so that planning could be done to ensure that teams were sent to places both within and outside of the Pentagon where services were most needed.

Challenges of the Inside Mission were several, not the least being the huge scope of attempting to "touch base" at a grass roots level with an organization of 40,000 employees. This was being attempted with a combined staff that included professionals from different military services. Coordinating such efforts when command and control of the group was not unified was challenging, to say the least. Similar to the Outside Mission, an additional challenge was that different professionals from different backgrounds had different approaches to completing the work. Obtaining adequate administrative support and monitoring for burnout of mental health responders was also a challenge.

## Pentagon Family Assistance Center

The third major mission as part of the mental health response was the support of the Pentagon Family Assistance Center. This center was created after the attack and located at the Sheraton Hotel in Crystal City, Virginia. Its purpose was to provide a focal geographical area to bring together family members of missing and deceased individuals so that ongoing information and supportive services could be made available. This assistance was provided to family members of the military and Department of Defense employees in the Pentagon, as well as the family members of victims who were passengers on American Airlines Flight 77.

Mental health resources in the Family Assistance Center provided surveillance during family member briefings and visits to view the crash site, as well as surveillance of Family Assistance Center staff, many of whom were in the Pentagon at the time of the crash. They also were involved in assisting families as part of an interdisciplinary team composed of representatives of commands, casualty assistance officers, mental health clinicians, chaplains, and other emergency response agencies (e.g., Social Security, Veterans Affairs, FEMA, Red Cross, and the Department of Justice). Child and adolescent mental health teams and social work case managers actively participated in the mission at the Family Assistance Center to provide support and services.

Notification of death to family members occurred on an ongoing basis, as remains were identified. For this reason the Family Assistance Center coordinated ongoing memorial services for victims as families desired. The center also was largely responsible for coordinating the memorial service, attended by President Bush, which took place on October 11, 2001, on the grounds of the Pentagon. After this event the Family Assistance Center closed at the Crystal City Sheraton and opened a second phase of operations at a nearby government office building to complete its work prior to closing down entirely in November 2001.

One group that was monitored closely by mental health at the Family Assistance Center was the Casualty Assistance Officers. By regulation, these individuals work as case managers and are assigned to the families of the deceased to help access required resources, provide benefits information, and coordinate appropriate military honors for the funeral. As such a large number of Casualty Assistance Officers was required, many of these individuals had never functioned in this role before, were less experienced in the process, and were considered vulnerable to stress responses due to the closeness that can develop between these individuals and the family members of the deceased. Considered higher risk, Casualty Assistance Officers were monitored and supported more closely.

## Liaison with Civilian Medical Facilities Mission

A fourth extremely important mental health mission was developing consultative and collaborative relationships with civilian medical surgical support teams at the civilian hospitals where casualties were hospitalized. The Psychiatric Consultation Liaison Service and social worker clinicians and case managers from the Department of Social Work at Walter Reed met with hospitalized patients during treatment and prior to their discharge.

The military mental health providers coordinated with civilian treatment teams so as not to conflict with the ongoing care of casualty patients. This contact served several functions. It provided a military cultural presence at the civilian facilities; it allowed patients to feel connected with the military health care system; and it fostered relationships with military mental health providers so that at-risk individuals could be identified and follow-up services could be offered and better coordinated. Upon discharge, appointments with patients were used to monitor for development of symptoms, to provide supportive guidance regarding their normal responses to the trauma that they had endured, and to promote wellness within the group. When appropriate, clinical services were offered to treat identified psychiatric illness.

## Conclusions and Lessons Learned

Although it is essential that organizations prepare to meet the challenge of likely future terrorist events, nothing can fully prepare a group of individuals for the unknown and the chaos that accompanies such an event. As was the experience at the Pentagon, it is likely that different groups of responders will be required to come together to provide a coherent and organized approach to mental health assistance for casualties, family members, recovery team members, and organizations. Planners should be prepared to work in chaotic and disorganized environments. Mental health expertise in the areas of organizational consultation and process definition can be particularly useful at such times.

In the Pentagon attack on September 11, the WRAMC mental health leadership identified four specific missions that required response: the Outside Mission or support of the recovery teams, the Inside Mission or support of the Pentagon community, the support of the Family Assistance Center and family members of the deceased, and support of hospitalized or treated and released casualties. Whereas this particular organization of mission will not necessarily be repeated, it suggests that clarity of mission elements is essential to a coordinated and effective plan.

Other lessons learned included the importance of maintaining flexibility of functioning and collaboration with other mental health teams. As the WRAMC mental health response group was not the only recognized group of responders on site, it was fundamentally important that efforts were coordinated among

different teams so there would be a concerted and nonconflicting effort. In this case, as is possible in the future, single lines of authority may not be clear or possible. Whenever possible, however, clarity of authority should be sought.

There were six areas of concern that hampered the missions at times: command and control, complicated transportation, lack of administrative support, communication problems, lack of sleeping facilities, and differences in theoretical approaches to the work among different teams or team members.

Command and control was difficult to ascertain at the onset of the mission. Chaos is often inherent in this type of mission. In such circumstances, a clear chain of command should be established from the outset to avoid confusion, duplication of services, and disruption in the flow of services.

Communication was difficult at best due to the entire staff (personnel from three WRAMC clinical departments) being either deployed to the site or tasked in other ways to provide support to the staff on site. Additionally, cell phones and pagers were inoperable in certain areas at the crash site and within the building. Thus, effective communication would have required the development of a central command center to manage the flow of information.

Transportation was complicated by distance from WRAMC to the Pentagon, security at the recovery site, and vehicle availability. Often a 12-hour shift became a 16-hour shift because of delays in securing transportation. The identification of dedicated vehicles coupled with police escorts eased transportation concerns.

Sleeping quarters were not initially available for personnel working in the Outside Mission. At first, clinicians were required to walk between the crash site and the interior of the building where they slept, making them less available at times. Later, tents specifically identified for this team's use assisted in solving this logistical problem.

Different teams bring different theoretical perspectives about the appropriate ways of conducting a mental health response. The WRAMC mental health response team approached this mission from a subclinical perspective in which normal response to trauma was focused upon. This approach helped in presenting support in a nonstigmatizing fashion and avoiding overpathologizing. The primary interventions included offering mental health surveillance that directed appropriate immediate response; providing opportunity for supportive discussion of exposures and experiences; providing psycho-educational information related to expected normal responses to abnormal experiences; providing recommendations related to maintaining good mental health hygiene; monitoring and maintaining contact with high-risk individuals and groups to support wellness; and facilitating access to clinical services when appropriate. There was less emphasis on providing formalized debriefing sessions to all individuals and groups, although some were offered. More emphasis was placed on developing helpful, long-standing relationships that would serve both to foster wellness and to identify symptom development in the future. Because collaborative efforts are likely to be necessary again, it would be useful to develop consensus opinions across services for future responses.