A Psychiatric Response to Disaster— The Beverly Hills Club Fire: A Preliminary Report

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It is not known at this writing how the fire at the Beverly Hills Club in Kentucky started. An investigators' report said that the wiring in the club was "an electrician's nightmare" and that the fire burned within the walls for at least half an hour before erupting in smoke and flames. For 20 minutes club personnel tried to extinguish it themselves. The first warning was thought by most of those watching the entertainment in the cabaret section to be a part of a comedy act. Such are the power and trust in our environment, often resulting in tragic denial.

There were no homes lost, no roads or bridges destroyed, no telephone lines torn, no businesses put out of operation except for the supper club itself, none of the usual effects which cause a President to bring in the U.S. Army engineers and other support teams such as the Department of Housing and Urban Development and its mobile homes. There were 164 deaths and 60 injuries, the latter mostly from smoke inhalation. Aside from the tragedy of 164 dead, the most extensive and longstanding damage of the Beverly Hills fire is psychological.

A journalist, looking back on what Beverly Hills was before the fire, said, "It was a Land of Oz." It was a complex structure of bars, dining rooms, cabaret rooms, all opulently decorated, catering to special dinners, wedding parties, retirement parties, and bar mitzvahs. Advertising regularly appeared in newspapers far from Cincinnati, promoting the popular singers and comedians who played to Las Vegas-like crowds in the largest room in the club. On the night of the fire, a party decided to leave early and noticed the walls were hot. They were in the Zebra Room where the fire was contained and unseen before it finally broke into the banquet and dining rooms with flashes of fire and smoke. It was 9:00 p.m.; soon, the community would be aware of the major disaster.

Police and fire departments responded within minutes, the local hospitals, coroner's office, Red Cross, Salvation Army, police-crisis staff, and clergy within hours. Television and radio stations announced needs for special types of assistance. The sight of the blaze attracted people from miles around, resulting in a convergence of volunteers at the blaze,

clergy at the temporary morgue, and medical personnel at the hospitals (Barton 1970; Quarantelli and Dynes 1967).

Mental health professionals from the University of Cincinnati opened a telephone network, with the General Hosptial psychiatric emergency unit as coordinating point. By midnight, five psychiatrists and two social workers were at the hospital emergency unit. Others, including psychiatric nurses and psychologists, called in their readiness to respond. Before the weekend was over, 60 members of the Department of Psychiatry, University of Cincinnati, participated in delivering mental health services to the survivors and the bereaved. What they saw in those hours and days was similar to reports by other mental health professionals of comparable disasters, such as plane crashes, earthquakes, floods, tornados, and fires (Howard 1972; Blaufarb and Levin 1972; Tuckman 1973; Koegler and Hicks 1972; Vosberg 1971; Leopold and Dillon 1963).

As a result of their work with survivors at Buffalo Creek (Titchener and Kapp 1976; Titchener et al. 1975), the staff of University of Cincinnati Department of Psychiatry was perhaps better prepared than most for handling the potential psychological effects of disaster.

Critical reviews of the literature on mental health response to disaster point out failures to make reference to other people's experiences in this area, to remain essentially descriptive, and to avoid generalization (Taylor et al. 1976). The following narrative represents the largest reported, well-coordinated mental health response to disaster within the impact phase. As such, it may help in building the principles for a more thorough theory of mental health services in disaster.

Planning

While communicating with the people from the Red Cross headquarters, with whom previous contacts had been made, the following information was received: Burned survivors were being evacuated from Beverly Hills to local hospitals (some were to arrive at General Hospital); uninjured survivors, including employees, were being evacuated by bus to Red Cross headquarters in downtown Cincinnati; and the dead were being pulled from the fire, then transported to a temporary morgue which was not yet in operation. The Red Cross workers requested help from the representatives of the University of Cincinnati Department of Psychiatry. The professionals from the department decided that an advance party would go to the Red Cross headquarters to assist their workers with survivors and to keep abreast of further developments as the temporary morgue became operational. Meanwhile, the rest of the team would arrange a reception area in General Hospital for families of burned survivors.

While awaiting casualties at General Hospital, it was learned that Northern

Kentucky hospitals were taking all but those with the most serious burn and inhalation injuries. Seven victims and their families were brought to the Cincinnat hospital. During those hours, the discussion oscillated between wild and fearful imagining of what would be encountered and to careful reasoning. Gradually learning of the extent of the fire, the team realized that three groups of people would be likely to suffer psychologically; (1) surviving patrons and employees (both injured and uninjured); (2) bereaved families; and (3) stressed caregivers.

The team then identified four places where they would be working in the next few hours, days, weeks, months, and years. One would be the morgue which was being organized at an armory in Ft. Thomas, Kentucky. Another would be the hospitals where injured patients were being treated and where families were awaiting the outcome of their relatives' treatment. The third would be the department's psychiatric clinic and other psychiatric clinics in the community. Finally, some of the team would be in the homes of victims and bereaved families.

The psychiatric group had not yet grasped the immensity of the fire. Over 3,000 people had been served dinner at the Club, and 93 families would lose at least one person in the fire. They also had not realized that both team members and the clergy would have to join caregivers in assisting at the morgue.

The Advance Party

Two of the group who had gone to the Red Cross headquarters encountered a different experience. There was no time for anxious waiting; relief operations were in high gear. The Red Cross headquarters was serving two major functions: (1) the evacuation point for relatively uninjured survivors of the fire; and (2) the communication and dispersal point of overall relief resources. A large reception area there held 40 to 50 recent patrons and employees of the supper club. They had been evacuated by bus from the triage point of the fire to the headquarters, where workers tended to them and encouraged them to telephone relatives or friends to arrange transportation home. There was an atmosphere charged with relief and agitation. People were relieved because they realized they were safe, but they were agitated because they did not know the fate of others in the fire. Conversation about the fire, the details of the escape, the black smoke, and the ones left behind who did not get out. There was particular concern over members of large parties who could not be found and were feared to be trapped inside.

The Red Cross workers were clearly in charge but at times seemed unsure of how to respond to the nonmaterial requirements of the survivors. The intent of the psychological team was to be aware of the need for psychological intervention as expressed through concrete requests. They understood the psychological nature of the request but chose to

respond directly to the appeal. In that manner, they hoped to meet the Red Cross workers on their own grounds, to communicate a respect for their work, and to develop relationships of mutual trust and respect that would lead to greater opportunities for collaborative work on the psychological needs of the victims in the difficult hours ahead. Because the members of the team were careful in how they approached the situation, the Red Cross workers used them in several situations and, ultimately, trusting their ability to be of some assistance, asked the team members to accompany them to the morgue.

By 1:00 a.m., radio messages to the Red Cross headquarters indicated that the morgue was nearly operational; 50 bodies had already been received. No one knew how many dead there might be, but estimates were over 200. Officers at Red Cross disaster headquarters felt that mental health professionals could best be used in the morgue by assisting families who would have to confront the reality of the disaster by identifying bodies. The advance party agreed and informed those back at the hospital of plans to change their location.

Between 2:00 a.m. and 5:00 a.m., the advance party assessed ways in which the team from the Department of Psychiatry might be helpful at the temporary morgue. They developed relationships with the many clerical groups that were operating a family reception center there. Members of the advance party contributed to the planning of the center, advised on interagency disputes, saw families when requested to do so, accompanied the clergy and families to view the dead, and assisted troubled relief workers. By 5:00 a.m., the clergy realized that Sunday morning meant many of them would have to return to their congregations for services; the advance party from the psychiatric center decided that mental health workers were useful at the morgue. Although the team had functioned primarily in a consultant role, the growing uncertainty as to whether the clergy could remain there provided an opening which department members could fill. Due to fatigue and staff "burn out," they sent a message back the the psychiatric emergency room saying that, beginning at 7:00 a.m. on Sunday, for an indefinite period, teams of 12 mental health workers should be sent to work for 4-hour periods The morgue, rather than the hospital, became the primary site of their intervention.

The Morgue

The Ft. Thomas facility, originally an army barracks and training center, had been converted into a Veterans Administration domiciliary hospital shortly after World War II. It is a pleasant place, with red brick buildings separated by generous spaces of lawn and fronted by a large clock tower; it has a gymnasium used by a small number of the patients and also by neighborhood children That armory or gymnasium was

where the bodies were brought for identification. In a dispensary about an eighth of a mile away, the administrators, consisting of a balance between the Salvation Army and the Red Cross workers and a group of clergy, set up a reception area where families went to find if one of their relatives had perished in the nightclub blaze. At the apex of administrative concern, and at the center of everyone's anxiety was "the list," and, when people referred to it, they spoke in a careful, solemn way. The list was carefully guarded from newsmen and other curiosity seekers, for it contained the names of the bodies identified by wallets, name tags, and other established means of identification. Each time a body was identified by some method or another, the name was added to the list, which gradually grew as the 4 days the morgue was in operation wore on.

Some ministers with counseling background improvised the following plan: Families of identified dead were called and were met by a clergyman in the waiting area of the reception center. Others heard news of the fire and sought information about missing relatives, and the clergy checked names with the list of identified dead. They stayed with the families as they received the news. To complete the official identification process, a relative had to view the body. When a family was ready, the minister would accompany its members out of the reception center across the 200 yards and into the entrance of the morgue. The immediate entrance was screened off. The family again would be given an adjustment period before proceeding beyond the screen to actually face the morgue. Only two families were to view the bodies at any one time. The clergyman exposed the body for identification. After leaving the morgue, the family processed valuables and signed forms relating to funeral and burial arrangements. They returned to the reception center with the clergyman still available to comfort them with their feelings of grief.

If a name was not on the list and there was good reason to believe that the family member had been in the club, one or more family members were conducted by the minister through the rows of bodies to find the missing family member. It is estimated that two-thirds of the bodies had to be identified by a relative with the aid of either dental charts or fingerprints. As the hours wore on, fatigue, occasional callousness or awkwardness of the caregivers, personnel turnover, and the arrival of increasingly charred bodies — all contributed to breakdowns in the plan. Reconstituting the operation required constant attention.

At 4:00 or 5:00 a.m. on Sunday, 125 bodies had arrived and were on stretchers in the armory. Many bodies in the three rows were still on the left side of the room — the unidentified. The remainder were on the right, awaiting transportation to designated funeral homes. Families, accompanied by a minister and mental health workers, slowly walked up and down the rows, now and then lifting a sheet and trying to identi-

fy the body by means of the hair color, sex, size, etc. They faltered, recoiled; some cried faintly; others held onto each other, while the minister or mental health workers spoke to them.

Yet to come were the less recognizable corpses, and, in the third and fourth day, remains came in plastic bags, the only chance of identification being dental charts and the possibility of finding a finger to take a print from.

Rumors were repeated often in angry or fearful tones during all 4 days of the morgue operation. One was that there had been unconscionable looting of the bodies when they were laid out on the lawn around the Beverly Hills Club, and another was that there had been vicious animal-like clawing, stomping, and fighting to get out of the inadequate doorways. Quarantelli has tested these and similar myths in previous disasters and found them to be just that — myths. The looting reports got little support, as there were only two persons arrested and they appeared to be innocent. The dead bodies did not show signs of clawing and clubbing. Not one of the survivors has since reported panic erupting into clawing and beating of other persons. The psychiatric team continued to get somewhat conflicting information: There was a surge toward the doors; some patrons were knocked down. People who lost relatives in the fire said they had not regained jewelry and other valuables. On the other hand, males were the most identifiable because of the wallets found in their pockets.

How the Mental Health Workers Functioned at the Morgue

A questionnaire sent out to all those who had worked on the teams and to the clergy reveals variation in what the individual mental health workers chose to do, how the clergy perceived what they were doing, how well the two groups worked together, and whether or not people felt their work was valuable and helpful.

It is possible to arrive at a few generalizations on how the mental health workers functioned individually and in collaboration with the clergy. Both men and women drove to the morgue trembling. They wondered whether they would be able to deal with the sights and sounds of the place they were imagining and whether they might be more of a problem than help to the families they were going to be seeing. One worker told how, for a brief moment, she had seemed to be a problem. It was a hot day, and she was wearing open-toed sandals. As she walked down a row, her big toe brushed the toe of one of the bodies. She started forward, grasping the shoulders of the man ahead of her, saying instinctively, "Now be calm, be calm." He turned to her and said, "I'm doing fine. Why don't you go help someone else?" She stayed with his family and was able to respond and be helpful to the man when he broke down when hearing his brother referred to as, "Number 56, he's done" ("done" meaning identified and ready for disposition).

Another worker reported that a woman in one of the families said to her "I don't know how you folks do this . . ."; all the worker could think was, "Lady, this is the first time I've gone through this and I'm afraid I'm going to throw up." However, she did not do so and worked with the woman who would have to tell her young son of his grandmother's death. This son had been the first in his family to know of the fire from television. He had said to his mother, "Grandmother's there. She must be burned. Go and find her."

The problem of informing others about a death was one of the most frequent. Another was the sense of mystification and awe people had about their own reactions. Many in the stage of shock and disbelief wondered why they could not weep and accused themselves of callousness or a strange form of mental illness. The teams were able to assure these people that there would be time for weeping when they had absorbed the shock and were back in their own homes. At the same time, the workers could implant the idea that communication and expression in the family would be helpful now and in the weeks and months to follow. They indicated that there is value in memories and that forgetting could be ill-advised. The family had preparations to make, each with myriad and complex details having deep psychological and emotional connotations with which the workers tried to deal during the brief time they had with them. There were funerals to plan, ministers to contact, and decisions about where they would stay while still in acute stages of trauma from the fire.

Some questions were unexpected: "How fast does a soul get to heaven? Does it wait here? Is it in pain for a while?" The psychiatrist said, "I think it goes to heaven right away." After he heard a minister nearby saying, "The Lord will be there to meet them," he thought that it would be good for the minister to talk with this questioner. After hearing a young man, a stretcherbearer made cynical by the sight of what the fire had done to lives, say, "If God is love, what is this?", a social worker became "theological." She pointed out that he was loving the people he was helping and asked if perhaps that could be a way of restoring the meaning of a loving God.

Because of their training, the workers were able to begin to deal with the grief expressed by some of the people. A 21-year-old girl was informed her father was dead. She confirmed the identification and then had to look for her mother's body. On the way out she shouted "There is no. .God." Her outburst troubled the minister with her, and by talking to them he tried to help her and her husband toward a more quiet and really effective expression of grief.

As the people at the morgue, including the clergy, workers, the FBI, the administrators, the food suppliers, and the coroner and his staff, became more familiar with the psychiatric team and how they worked,

they listened to the team's recommendations for operation and how families might be led through the procedure. On two known occasions, television reporters and newsmen were counseled to be more tactful. One of the team preceded a television interview, which seemed to be leading toward a cool reporter's gathering of sensational stories about mental breakdown in the victims, by asking the exhausted interviewer and cameraman about their own experiences with the disaster. They talked about themselves for 5 to 10 minutes and then conducted a more sensitive interview.

As each team became informed on the ways in which the administrative necessities had an emotional impact on people, they informed the relieving team on these and other problems they could expect. The coldness and mechanical nature of this part of the whole system were a frequent cause for pain and emotional breakdown. However, it had to be done, and there were a number of ways in which the teams were able to modify the system to make it more human. Many suggestions were made about providing various arrangements of curtains and seatings to keep from view some of the charred bodies and the dentists who were looking at teeth with dental charts which had been brought in by families. They had so inured themselves to their grisly work that they could not understand why it should not be performed out in the open, for anyone to see.

On as many as 10 known occasions, the team suggested to some of the clergy and other hardworking individuals that they were beginning to show signs of the many hours and the stresses of their work. In some cases, the caregivers were able to accept offers of relief; others had to keep going, using heroism as a means of attempting to overcome their grief and their own fears of death (Becker 1973). One minister, trained in psychological counseling, was observed to be as sensitive as any of the mental health workers in his work with families, and he became a leader among the clergy by serving as a model for how to comfort and console a stricken family. However, after 12 hours at his work, he was becoming nearly ecstatic, claiming that his legs and his body could keep on doing what was demanded of him until all of it was done. One hour later, he was directed to give his place to one of the people who had arrived to relieve those who had been working for a long time.

On three of four occasions, the team members were able to resolve differences of opinions among families, brought on by the stress of identifying bodies and having to make difficult decisions. In one case, a man, unable to bear the possibility of finding a relative among the victims, felt that his feelings were beyond control and bolted from the building, leaving his wife behind. A psychologist ran after him and persuaded him to return to his wife. The couple was then able to stay together through the remainder of the difficult procedure. A young

man had come to the morgue looking for his father, who had already been identified by other family members. The workers brought the young man and the remainder of his family together so that he could be informed by them rather than by the list.

Friction between psychiatrists and the clergy tended to occur when either group felt there was no place for the other. A few clergy were explicit about their feelings that mental health professionals should function only in a consultant role. A few psychiatrists reported that some of the clergy should not be there because of their lack of psychological training. However, most clergy and most mental health professionals found the presence of the other group to be an asset in the operations at the morgue.

Collaboration worked best when mental health workers accepted the leadership of the clergy, who were the ones to take a family to the list, then to the morgue to identify the dead. The mental health professionals worked best as active listening participants (Caplan 1975) because they had developed familiarity with the family. They could see the need for psychiatric understanding, although this was not necessarily based upon family psychopathology. Eventually, the initial referral system gave way to a more effective pastoral-psychiatric team.

Discussion

Flags flew at half-mast for 30 days after the fire, and Cincinnati was mourning, at least partially, for itself as well as for the 164 dead. The cause and responsibility for the fire have not yet been determined, but it is clear that many measures could and should have been used to prevent it. Accusers and committees to find fault claim headlines, but as the people speak, there is an awareness that everyone is responsible. Profitable nightclubs and other gathering places operate without means of orderly, easy exit, without smoke detectors and sprinklers, and with materials which give off highly toxic gases while burning. Many people visit this type of place (there were many calls to the psychiatric clinic in the first few days after the fire from people who just wanted to say, "I could have been there; I planned to be there; I was there the night before; next week . . .").

The psychiatric group believes that in the first 24 hours they responded well to a major psychological disaster and that the course of events in the next few years will bear them out. Currently, they are involved in organizing an intervention response to provide a preventive psychotherapy for the many disabling and constricting disabilities which may evolve from the Memorial Day weekend catastrophe in Greater Cincinnati.

While they have described what they believe to be a disaster causing psychological effects and their response to it, the psychiatric team feels

that there are many other potential catastrophes which will prove psychologically shattering to communities. The action-oriented person in the various agencies who is ordinarily responsible for planning the disaster relief program is not likely to think about the effects of this type of disaster on an individual's mind and on the dynamics of family systems. Leadership in planning in most community organizations is convinced that the American fiber, American individuality, and adherence to ethics, when hit by disaster, need only some blankets, some hot tea, and the promises of shelter and small business loans. These forms of assistance are expected to bring the strong-hearted and so called rugged-individualist philosophy of the American character back to exactly what it was prior to the catastrophe. This conviction spread through the media and through all the legends and myths that developed around a happening like the Beverly Hills fire. When compared with the actual personal experience of the survivor and of one who has lost a spouse, a child, or a parent, this concept of ignoring stress, compared with the reality of suffering, only makes it worse, forces it to be more private, and makes it less amenable to treatment. Believing that one is expected to recover heroically from the shock of the loss of a daughter or a wife or the memory of the sense of total helplessness to survive and to help others survive will cause the individual victim to react unfavorably when comparing his own memory and his own experiences with what the myths say they should be.

The members of the psychiatric team who were involved in the very beginning of this effort realize that, in a very few seconds, they might have decided not to have been involved. They all could have said to themselves, in effect, "It's terrible and there will be a number of people killed, but what can we do?" Most mental health professionals in this country really believe that there is little they can do in circumstances like these, and the Cincinnati psychiatric team did not distinguish itself from the average in this respect. Yet, because of previous experience with a massive dam break and several tornadoes, this team came to the emergency room, planned meetings, went to the morgue, and realized that more must be accomplished in Cincinnati in the coming months and years. The wish to separate oneself from tragedies is great, sometimes almost irresistible, reinforced by an array of rationalizations.

For example, on the Sunday after the disaster, two of the team visited a hospital ward where seven victims were being treated. An uninterested surgical resident who was reading the comics told them that none of the seven was seriously injured. The members of the team turned away and started back to the clinic where they were expecting survivors to be walking in. As they walked toward the elevator, the younger of the team said, "Jim, maybe we should see if they suffered some losses." They turned back and found that five out of the seven admitted the previous

night had lost a spouse and that the other two had lost at least one close friend in the fire. The team visited each victim, introduced themselves, and indicated that there would be psychiatric consultation with the victims and their families throughout their admission and after discharge if they so wished. In the solarium adjoining the ward, the team found a dozen or so people congregated, the families of the victims having a group meeting and working over their common concerns and hopes. Team members talked with the group briefly and assured them they would be following and working with family and victims throughout the hospital stay and afterward. Sadly, since that time, three of the seven have died: one to the effects of inhalation, and two to a combination of inhalation injury and pulmonary emboli. These patients told the team a great deal about what happened inside the Club and how they experienced their losses and the expectation of death felt by all of them.

The team members, who were not prepared for the morgue and the families they met there, tried to prepare themselves mentally on the way to the disaster scene. Every group was briefed and debriefed about how the morgue worked and what to expect. Although this preparation was far from adequate, most of them functioned in a helpful way, and they have had no evidence from the clergy or anyone else that they were in any way a hindrance.

The lesson that the psychiatric teams learned is that they must respond, they have the capacity to respond, groups in the future can do better than the Cincinnati group at Beverly Hills, and they need to do better with the resistances in themselves as well as those in others. They can use their psychiatric concepts, their points of view, and their special skills to overcome both sources of resistance. As a group they needed and provided for themselves a time to react, process, and begin to integrate their emotional response.

Summary

The group of professionals in the Department of Psychiatry, University of Cincinnati, who began planning a response to the fire at the Beverly Hills Supper Club, anticipated three types of victims who would suffer the psychological consequences: injured and noninjured patrons, bereaved families, and stressed caregivers, including emergency workers, policemen, and firemen. They foresaw acute effects and the need to prevent long-term consequences.

The group feels some steps were sufficiently useful to be considered in future disasters. First, it was important to secure a central mental health communication point for the professionals who responded; second, to open a direct line to the director of overall disaster relief operations for the Beverly Hills fire, the Red Cross headquarters. By assigning an advance party there, the group's deployment decision was

made in the context of a total disaster relief operation. It was useful for an advance party to secure alliance with other relief groups on the site (at the morgue) prior to the arrival in force.

At Red Cross Evacuation Headquarters, they observed and encouraged survivors to ventilate their experience and its affects, particularly rational and irrational feelings of responsibility for those who did not survive. The psychiatric group observed and encouraged surviving groups to help each other with grief and guilt. They supported Red Cross volunteers in their work.

At the temporary morgue, the group helped plan and operate a reception center for bereaved families. They helped inform families of the death, conducted them through the morgue to identify bodies, and were with them as they reacted to the stress. The psychiatric group supported natural help groups (families, neighbors, and friends) and emergency help groups (pastors, police, and volunteers). They diminished unnecessary trauma by giving attention to the timing and doling of news, privacy with families, respect for the dead, humanization of the macabre task, and maintenance of continuity of emotional support. They worked in teams, on short shifts (4 hours), and suggested that overfatigued caregivers be replaced.

They dealt with conscious and unconscious resistances and persuasive rationalizations in other emergency workers and in themselves which militate against participation.