CHAPTER

10

The Experience of the Nairobi US Embassy Bombing

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INTRODUCTION

On August 7, 1998, at 10.30 a.m., a terrorist bomb exploded in downtown Nairobi. Prior to that a hand grenade had exploded, and many people had gone to their windows to investigate what was going on. Then the main explosion, consisting of 1 ton of TNT, and measuring 2.7 on the Richter scale, went off.

213 people died, 5,000 sustained injuries that took them to hospitals around the city, and many others had minor injuries that did not require medical attention. All these people, their friends and relatives, and many others who witnessed the event directly or indirectly through the extensive TV, radio and newspaper coverage were affected by the event.

According to estimates, Kenya lost 5–10% of its gross domestic product (GDP) as a result of the bombing [1]. 100 buildings and 250 businesses were wholly or partially damaged. Of the 5,000 wounded, 400 people will remain severely disabled.

IMMEDIATE RESCUE RESPONSES

Immediate issues arising included the challenges of the ensuing rescue process, first aid to the injured, transportation to hospital, the very large numbers with open and bleeding wounds, and the chaos that is usual following any major disaster. This was the first real test of the Kenya spirit *Harambee* (Let's Pull Together) following a terrorist attack. Like their counterparts would do in New York on September 11, 2001, Kenyans discharged themselves with honour and decorum. The traditional

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boundaries of race, tribe, religion, class and creed were discarded in the face of disaster that did not itself make these distinctions as it killed and maimed. All Kenyans were equal before the terrorists. Their response was equal to the task.

THE MENTAL HEALTH RESPONSE

Amidst all this, however, it was quickly realized that there would be a lot of psychological, emotional and social issues that would need to be dealt with.

Operation Recovery was the project that was initiated by the Kenya Medical Association to respond to this need. The project brought together medical personnel, corporate firms, professional bodies, government agencies and individuals, with the prime goal of developing and implementing a coordinated psychosocial recovery assistance program for those affected by the bomb blast.

The Red Cross and other organizations put together other initiatives in different parts of the city. The churches were also actively involved. Each collaborating organization brought with it its own unique expertise and resources, and together helped make Operation Recovery the unique organization that it was.

The overall response was planned to alleviate human suffering resulting directly or indirectly from the bomb blast, and to assist the people of Kenya recover from the effects. It was also planned to offer psychological and emotional support through counselling to those injured in the blast, to relatives of those who died, to relatives of those injured, to rescue workers and to medical personnel, as well as to the general public.

THE MEDIA RESPONSE

The media was to prove to be an invaluable asset in the early stages of the tragedy [2]. The first of the media activities was a Cable News Network (CNN) appearance by the author in the afternoon of August 7. This was the first internationally televised statement from a medical doctor regarding the bomb attack. Most Kenyans were still not aware that terrorists had visited the country, resulting in catastrophic damage.

Later the same evening, a 3-hour phone-in program was broadcast on a local FM station. Details of the tragedy and its anticipated traumatic consequences were discussed with the listeners. The message was one of reassurance, that what Kenyans were experiencing at this time was a normal reaction to an abnormal event. The program was followed by several others in the days following and marked the beginning of what was

to become an invaluable tool in the dissemination of information and awareness creation on the psychological effects of the bomb blast.

National and regional radio and TV stations generously gave airtime to mental health experts to disseminate information on the likely psychological sequelae. Question and answer sessions on the electronic media were an early and regular feature.

The purpose of this extensive media program thus became to educate the Kenyan people on what reactions to expect following this trauma, and to reassure them that theirs were indeed normal reactions to an abnormal event. The broadcasts also sought to help sensitize people to the possible mental health needs that could arise subsequently, and to let them know that help was available, and where it could be obtained.

PLANNING LONGER-TERM SERVICES

The planning of service provision proved most challenging. The knowledge base of the Kenyan mental health team was somewhat limited. This was, however, more than compensated for by the enthusiasm, empathy and desire to learn. On the Monday following the Friday event, the army of counselors equipped with varying degrees of knowledge converged at the medical association head office demanding training opportunities to be able to help fellow Kenyans. Some were lay counselors who had attended an afternoon of training in counseling while others (in the minority) were highly seasoned mental health experts. The first 10 days were very busy as the various players sought and found their niche in the novel organization.

By the time the US Secretary of State visited Kenya, the initial scenes of confusion were settling down, American disaster management experts were on the ground and played a crucial role in the planning of services.

CRISIS INTERVENTION

The greatest challenge in the first week was to provide a crisis intervention service to those in greatest need, while sorting out the ragtag army that was to prove so vital in the coming months. One of the collaborating agencies which was church-based organized the 1-day training that enabled the team to adopt a standard format on debriefing and reporting back to headquarters. Three church compounds became walk-in counseling centers in less than a week. We were set to go!

Debriefing, psycho-education and long-term counseling were some of the strategies put in place. A typical debriefing session would involve a group

of 8 to 12 people and last between 1 hour and $1\frac{1}{2}$ hours. However, due to the large numbers of people being dealt with, groups as large as 25 people were held. Sessions as long as 3 hours were also held to give everyone an opportunity to speak. Two facilitators would run each group along the Mitchell model [3].

For many, particularly the men, hearing that other men also cried was very reassuring in view of the African view of men crying! (They simply don't!) It reassured them that such a reaction could indeed be found even in other "real men". This point was emphasized at the first formal session held for the senior officers of the Cooperative Bank, which was housed in the building next to the American Embassy.

For the women in the groups, the main issue was the fear for their families, particularly their children. "What would have happened to my children if I had died?... Who would have looked after them?" was a common question to be heard in such sessions.

Psycho-education was an integral part of debriefing sessions. After each group member had had the opportunity to share their experiences, the counselor facilitating the group session would then educate the group on the effects of trauma and what they could expect. This proved to be very useful, as most people experiencing the acute stress reaction signs and symptoms frequently feared that they could be "going mad". Learning this to be what it was – symptoms of the effects of the trauma they had gone through rather than an additional "illness" – was for many very reassuring.

CHILDREN'S PROGRAM

The government of Kenya requested Operation Recovery to provide counseling services to traumatized children in and around the city. 10% of the 360 schools in Nairobi were considered to be "high risk" due to their proximity to the blast. The project targeted 90 schools with a total population of 72,000. In the intermediate phase alone (November 1998 to April 1999), 2,730 children were seen. A special clinical assessment tool was developed with the help of Betty Pfefferbaum [4], modeled on her experience following the Oklahoma experience.

The children were severely traumatized by the bomb blast. More than 6 months after the blast, the children still remembered with horror the big bang, blood, burning cars, helicopters and many military men. Many feared going into the city in case it happened again, some had nightmares and others worried for their parents' safety whenever the parents came back late.

Different strategies had to be employed to suit different circumstances. Story-writing, discussion and drawing were important tools of communication. The counselors became increasingly creative and confident.

Different school authorities had to be approached with tact. Some were hostile; others were ignorant that children were in need; while some seemed to want a bribe to allow us to help the children! Always, however, whenever we got to children their needs were clear.

There was great variability in the character of schools visited. Kawangware Primary School had an average of 52 children per class. Some had a maximum of 25. Linguistic difficulties were encountered in the larger schools located in the slum areas of Nairobi. The differences in the level of education provided in the different areas of the city schools were very marked. For the different needs, different styles of approach and language were required.

Using young counselors for schoolchildren proved exceptionally effective in the program. The children identified with them easily as they spoke their slang language (Sheng).

OUTREACH SERVICES

Outreach services were provided for the affected communities. These were aimed at not only providing counseling services to the people where they lived and worked, but also increasing awareness of the possible psychological effects of a trauma of this magnitude and reinforcing the message that help was available.

Innovative ways of reaching people were used. Roadshows were an example, and were made possible by the contribution of one of the partners in the project. The large trucks normally used to advertise consumer products attract crowds of 5,000 to 10,000 people in urban and peri-urban centers through the medium of loud secular music. The message of the effect of trauma on normal humans was similarly conveyed through music and dramatization. Counselors were on hand for individual interactions. Many sessions of debriefing took place by the roadside, on Saturday afternoons in the middle of entertainment!

To our knowledge roadshows have not previously been used for medical purposes. They proved a very effective tool of reaching large numbers of people, and causing discussion in an informal atmosphere of mental health issues, something that does not happen very often. This outreach activity was truly creative and emphasized the need to utilize the available resources following disaster.

RESPONDING TO SPECIAL GROUPS

Children, rescue workers and medical workers, as well as the newly handicapped, comprised the special needs groups. Firefighters did not receive as much attention from the teams as we would have wished. We recognized them as a special high-risk group for the development of psychological sequelae of the trauma they experienced in the course of rescue work. We were, however, spread out thin on the ground and this inadvertently became one group that received less attention than would have been adequate for them. Debriefing was the only intervention given to a small number of the firefighters. Long-term effects of this omission can be expected.

The need for help for the helper was recognized from the beginning. Medical workers who had to deal with all the injured people as well as listen to the very horrific stories that many had to tell were exposed to this type of traumatization. Many experienced symptoms of the acute stress reaction.

The medical workers were, however, so busy attending to everyone else that it was not until much later that attention could finally get drawn to themselves. And even then only a very small number took advantage of the services offered. It was largely in the training sessions that contact was finally made with services, and it was common in the debriefing sessions that were held for some to break down and cry, in what was usually their first expression of how they truly felt.

The people who were blinded by the blast, or those who lost the use of their limbs so that they have had to be confined to wheelchairs following the blast, were people who had special needs specific to them. Their needs were scarcely met due to the shortage of resources.

EXTERNAL HELP

One consequence of a disaster of this magnitude is a sense of hopeless isolation and a need to engage informed professional colleagues in the response effort.

Specific requests were made to the American Psychiatric Association and the Royal College of Psychiatrists in the UK. As a result of this a US Federal Government Disaster Management Expert, Brian Flynn, who had experience in the Project Heartland that responded to the Oklahoma City bombing in 1995, came to Nairobi. From the Royal College of Psychiatrists we got David Alexander, who had led the mental health team following the *Piper Alpha* disaster. The US National Medical Association provided the rest

of the overseas body of experts, highly valued by the Kenyans in their hour of need.

The team consciously defined the type of expert, his qualifications and experience before making the requests to the sponsoring bodies. Inexperienced volunteers and "experts" are to be avoided in disasters as they could get in the way of the disaster response before it becomes evident that they are in reality disaster tourists. We had a few such tourists to the disaster. Invited experts, however, were without exception qualified, experienced, and helpful and some have turned out to be "long-term" friends.

Following Brian Flynn's visit to Nairobi, he commended the team on its emergency response strategy, especially that of setting up the documentation unit as an integral part of the services. In his opinion, this response was way ahead of other response programs in the world. "I have never seen such a proactive response to trauma by an organization that can barely pay its telephone bills. Not even the response to the Oklahoma bombing was this fast and elaborate" [5].

Alexander [6] does justice to the hard facts of his visit, captures the spirit at the time, but does not do complete justice to the value of an external audit of our activities 3 months into the project. Following Brian Flynn's initial evaluation, we knew we were on track. We needed to hear it and see it in writing from another expert in the field. That the external auditor described Operation Recovery in the complimentary terms he did was a critical booster to morale at a time when all seemed so depressing, with no money and no promises of any. The value of a 3-month evaluation of a project of this nature is in its own right a morale booster and confirmation that all is well.

OTHER ACTIVITIES

As the end of the year approached, Operation Recovery realized that despair and hopelessness were beginning to take their toll on survivors, and the bereaved. Families that were used to sharing Christmas holidays with their loved ones found themselves empty and lonely as the season approached. Children came for school holidays to find their families dispirited. Christmas was never going to be the same again. The significance of the Christmas season in disaster survivors was driven home.

At the same time, the project was experiencing serious problems and doubt was being expressed regarding viability of the project. Serious cash problems are a constant feature of disaster work as, by their very nature, they are unplanned.

Simultaneous prayers were to signify the peace and unity between the USA and Kenya. A brilliant scheme was hatched and, in spite of significant

planning problems, it took place to the satisfaction and excitement of many. Students in California were going to light 250 candles to signify the number of people killed in the blast. They had also organized the reading out of the 250 names of those killed in the blast.

Because of the time difference between the two cities, Nairobi held its program earlier. This involved a procession by over 40 children injured or orphaned as a result of the blast. Six children held two flags, those of Kenya and Tanzania. The third flag, that of the USA, was carried by a family who had lost one of their sons in the blast. The flag was unique in that it was the one that had been used to drape the casket bearing the remains of the son for burial in the USA. The central role played by symbolism in the recovery process is well documented in literature. There is abundant literature on the value of the spiritual in the recovery process of physical and psychological processes.

Nairobi is a small city and many of the mental health workers knew some of the survivors and readily identified with them. Special attention had to be paid to the team during the emergency and medium phases of the response.

As the team went through the recognized disaster phases (heroic, honeymoon, disillusionment and reconstruction) much energy was expended in holding the team together, as it often came close to disintegration because of various (often financial) constraints. And the process involved program planning and implementation.

Special and specific spiritual and secular activities were put in place for the counselors. A comedy night for the team was donated by the city comedy team and proved a very successful way of getting the team to laugh off their stress in the company of fellow counselors and their families, who, as it turned out, were themselves suffering much pain at the hands of the stressed counselors! The role of humour in alleviating stress in disaster workers is well documented [7].

PREGNANT WOMEN

During counseling sessions, some women reported spontaneous abortions, usually in the first trimester, while some reported spontaneously going into labour early, on the day of the bomb blast, or soon thereafter. Others reported the unanticipated occurrence of their menses while one complained that her breast milk had suddenly dried up.

A group of women who were pregnant at the time were brought together soon after the first anniversary of the bomb blast; 15 of them reported exaggerated startle response in their children, which was materially different from their other children at the same stage of development. They made the observation that their children seemed more nervous,

startled more easily and slept worse. Whereas this could be a reflection of maternal hyperarousal, and part of maternal PTSD, it was an interesting observation as it was a spontaneous observation by experienced mothers. It raises interesting questions regarding maternal exposure to stress and PTSD in the offspring.

REACTIONS BY DIFFERENT GROUPS

Having initially acted with courage and solidarity, the bomb's victims moved to another phase. Anger permeated the culture, inside the embassy and out. Many Kenyans felt, understandably, that had it not been for the American presence, such death and destruction would not have been visited on their capital. Public and private criticism of the American reaction in the hours after the blast rained on them.

Kenyans and Americans were at each other, exactly as the terrorists had intended. The chaos and confusion in the early stages of the response were evident in many spheres, including the media.

The local press reported that the Americans were concerned only with their own people, ignoring the plight and suffering of the many Kenyans who were killed or injured. The horrific scenes of men, women and children lying in large pools of their own blood, freely mingling with pools of blood from others, began to haunt those who crashed into fitful sleep in the early hours.

Immediately after the disaster there was an enormous and sympathetic response, both locally and nationally, and offers of help came from many parts of the country and abroad. The organizers also needed to be able to make the best use of outside "experts" in a way, which did not create antagonism among the local helpers. The first groups of foreigners appeared in military gear, which proved most intimidating to the Kenyan medical teams.

LESSONS LEARNED

There are several lessons that can be learnt from the Nairobi bombing and the responses to it.

In Managing Disasters, Things Can and Do Go Wrong

As the Kenyans responded to the disaster in their own way, the American people who were the principal target of the attack were having problems of

their own. The distance and time differences were to prove problematic. The response was occasionally chaotic and marred by a host of planning and logistical failures, especially in the area of military transportation. The Foreign Emergency Support Teams (FESTs) arrived in Nairobi and Dar es Salaam about 40 hours after the bombings, having experienced delays of 13 hours. There was disjointed liaison between the State Department, as the lead agency, and the Defence Department, FBI and other agencies. The personnel selection of the FESTs was ad hoc and not ideal. Medical and other emergency equipment was not always ready and available for shipment [8].

The chaos was not limited to the air and directly affected the medical care given to the survivors. Kenyan medical professionals at the Nairobi Hospital where the wounded Americans were receiving care claimed that US Air Force medical personnel were insensitive. This misunderstanding was to multiply against the background of allegations of looting at the embassy by Kenyans, who in turn accused the marines of protecting the Embassy grounds at the expense of the lives of Kenyans. Even as the digging in the rubble for survivors continued, sharp words were exchanged between frustrated well-meaning people united in their grief in the face of this tragedy.

As was to emerge later, there was confusion within the ranks of the seemingly organized American team. With the large influx of people from Washington and elsewhere into Nairobi, there were the inevitable coordinating problems with some personnel having to be reminded at times that the Ambassador was ultimately in charge [8].

The Role of Media

The role of media in disasters is well documented. In the Kenyan case, the media proved to be an invaluable asset [9]. In the early stages of the tragedy they provided factual information on what had happened, provided an outlet through which people could vent their feelings and discuss issues arising, and provided an avenue for messages of reassurance and education on the psychological effects to be expected following a tragedy of this magnitude.

Medical personnel in many cases shy away from the media. This can create a vacuum that gets filled with speculative messages. A key lesson from the Nairobi experience was that the media could play a positive role in disaster response. Another was that attention does need to be paid to the media personnel, who, like other people, also suffer the psychological effects of exposure to traumatic scenes [9].

The Importance of Effective Leadership

Kenya, like the rest of the African continent, was at the time a deeply traumatized country, by both natural and man-made disasters. Floods and politically motivated violence, had led to many deaths and much destruction to property [2].

This was the first time that Kenyans responded to any disaster with a mental health component. It was critical to have clear and decisive leadership, which was provided by the Kenya Medical Association.

Dealing with Different Reactions

Tragedy has a way of uniting people. In the Nairobi case there was initially great solidarity and courage demonstrated, with many pledges of help. Anger and harsh loud words blaming others were also notable. Chaos and confusion, especially in the early stages, were there in plenty. Terrorism destroys the sense of cohesion and safety and creates terror in the individual, in communities and in nations.

Anger gripped the people of Kenya, at first directed at Muslims, Arabs and any other groups thought to be even remotely connected with the terrorists. The Americans were the next "obvious" targets, firstly for being there, and secondly for their insensitivity to the Kenyans' needs and feeling in the face of the attacks. These are "normal" reactions to terrorism as the community searches for a scapegoat to heap its anger and frustration on.

The Honeymoon Effect of Disaster Response

This honeymoon phase has been described in disaster responses and was experienced first-hand after the Nairobi bombing. Immediately after the disaster there was an enormous and sympathetic response, both locally and internationally, and offers of help came from many parts of the country and abroad. Many offers of money and materials were made, most in the glare of cameras. Few kept their promises, not because they did not intend to, but because, before they could, other priorities engaged their attention.

The public did not forget the offers and kept calculating its value expecting that the project teams were suffocating under the weight of donations. Sadly, that was not the case.

Health care workers dealing with disaster need to be aware of this honeymoon phase, and to include it in their planning.

Research

Without research results, hypotheses cannot be tested, and well-intentioned approaches become confused with knowledge. Part of the heroic recovery effort was to collect data on those affected by the blast in order to inform treatment strategies in the short and the long term.

In the ideal world, researchers would have had to wait until survivors had finished with vital traditional activities like funeral rites. The sudden and unanticipated nature of the disaster followed by chaos severely challenged research planning. The team was driven by the realization that methodologically sound data are required to understand the mental health effects of terrorism in the region and to inform planning in the event of future disasters. The large convenience sample studied was predominantly educated professionals who witnessed the attack first-hand.

The analyzed sample consisted of 2,627 subjects. Of this group, 47% were female, 62% were married, and the mean age was 33.6 years (SD 9.7). 64 of the women were pregnant. 46% had completed secondary school and 40% had had some college education. The mean number of children per respondent was three (SD 2.1). 96% of the sample was Christian; the next largest religious group was Muslims, making up 2.5%. In all, this was a predominantly well-educated group of adults responsible for the care of many thousands of people.

Factors associated with post-traumatic stress syndrome (PTSS) (our approximation of post-traumatic stress disorder, PTSD), were: female gender, unmarried status, less education; being outside during the blast, seeing the blast, injury, not fully recovering from injury; feeling afraid, helpless, or threatened at the time of the blast; not talking with a friend or workmate about the blast; bereavement; experiencing or anticipating financial difficulty after the blast, inability to work because of injury, and receiving material or financial assistance. Notably, there was no significant association with PTSS symptomatology for age, number of children, religion; assessment of hospital care or immediate medical response; receiving counseling, or the relationship of the person mourned. The data show a strong link between injury and PTSS ($p < 0.0001$).

DISCUSSION

Many questions have been asked about the mental health response effort. Some have wondered what it achieved and what benefits came to the people of Kenya. There are no simple or accurate answers to these

questions. However, as psychiatrists and mental health professionals, we live in a world where the challenges to our profession extend beyond our clinics and hospitals [10].

For this reason, post-disaster mental health response is an integral part of the duty of the mental health team. Controversy continues to surround the usefulness or otherwise of early intervention and in particular debriefing, since studies have shown diametrically opposed results. This valid academic discussion is, however, quickly thrown out in the face of real-life disaster. The community expects and demands help from the mental health experts.

Some of the interventions were as creative as they were untested and may have had little intrinsic long-term value. The roadshows are a good example of this. The people, however, seemed to respond positively to the initiatives, much as the team itself appreciated the comedy nights.

A strong and efficient mental health team came into being. Following other disasters in the region, the team was quickly assembled and was transported across the continent (Ivory Coast) to offer services to survivors of Flight KQ 101 on January 31, 2000.

The question of research following a major disaster is complex as it involves both moral and scientific considerations. Delay in initiating data collection limits opportunities to obtain early information needed to understand mental health effects of disaster. Secondly, if researchers do not act quickly, important data may be lost forever. It is for these reasons that we decided to put in place a research and documentation team, which among other things developed a 57-item self-administered questionnaire, capable of generating the DSM-IV diagnosis of PTSD. In so doing we were fully cognizant of the fact that conducting methodologically solid investigations of mental health is extraordinarily difficult in the chaotic and complex settings of disasters, particularly those associated with terrorism. Some might disagree.

CONCLUSION

Years after the attack, Kenyans continue to ask themselves the question: why us? Why did they pick on a peace-loving island of stability in a most traumatized continent? Has our suffering for our American friends been recognized? What caused this act of terrorism? What has the role of inequitable distribution of world resources to do with terrorism? Will they come again? These and many other questions may never find answers.

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