Psychiatric Disorders Among Survivors of the Oklahoma City Bombing

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BACKGROUND
Prior to “911” the Oklahoma City Bombing was the “most severe incident of terrorism ever experienced on American soil.” Our patients are concerned about how to handle such events and as physicians we need to understand these reactions and learn to distinguish effective coping and normal reaction from illness.

AIM
To assess the psychiatric impact of the bombing of the Alfred P. Murrah Federal Building in Oklahoma City on adult survivors directly exposed to the bomb blast. Particular attention is paid to PTSD, psychiatric comorbidity and predictors of postdisaster psychopathology.

METHODS
Subjects (all over 18 years old) were randomly selected from a confidential registry of survivors directly exposed to the bomb blast and were interviewed.

MAIN FINDINGS
87% reported injuries. 77% required medical treatment. The most common predisaster and postdisaster disorders (lifetime prevalence) were: PTSD [15% vs. 34%] and Major Depression [12.6% vs. 22.5%]. 74% of postdisaster PTSD and 56% of postdisaster major depression subjects had not experienced it before the bombing. Conversely, 71% of subjects with no predisaster psychiatric diagnosis remained without a postdisaster diagnosis. Greater than 80% of the
survivors experienced either intrusive reexperiences or hyperarousal systems of PTSD, while only 34% of survivors had all three criteria (including avoidance) of PTSD. The avoidance and numbing criterion was 100% sensitive for detecting PTSD in this population.

CONCLUSIONS
PTSD and Major Depression were the major psychiatric disorders seen after the Oklahoma City Bombing. Avoidance and numbing predicted PTSD in these subjects. Most subjects had some symptoms of PTSD (hyperarousal and reexperiences) immediately after the event but not the full disorder. Of survivors with no predisaster psychiatric disorder greater than 70% remained without a postdisaster psychiatric diagnosis.

LIMITATIONS
This was a retrospective analysis of subjects after the disaster. Bias and inaccuracies associated with memory can occur. Also, these were survivors exposed directly to the blast and not a sample of the general population who had knowledge of the blast. These limit the generalizability to the general population.

IMPACT ON INTERNAL MEDICINE
This study helps us understand potential psychiatric problems of terrorism. PTSD and Major Depression remain at the top of the list. It is striking that over 80% of subjects had either symptoms of hyperarousalability or symptoms reexperiencing the trauma, but only 34% ultimately met criteria for PTSD. Also, the absence of a predisaster psychiatric diagnosis was predictive for absence of any postdisaster psychiatric diagnosis. These data offer reassurance that most people without psychiatric problems before a disaster remain without a psychiatric disorder and that it is part of “normal” experience to have symptoms of hyperarousalability or symptoms reexperiencing the trauma immediately after a traumatic event. As we reported in our 1999 Update, it is important to remember that though traumas associated with terrorism are uncommon, the trauma of the
sudden unexpected death of a love one is the most common trauma that the general population experiences. It carries a conditional risk of PTSD of 14.3% (Breslau et. al. 1998) compared to 34% of people in the Oklahoma City Bombing. In looking at risk factors of subsequent PTSD, lack of social support and continued life stressors after the trauma were more predictive of subsequent PTSD than pretrauma risk factors (e.g. gender, history of prior trauma) (Brewin et al. 2000). If however symptoms persist and meet criteria for full PTSD then there is effective pharmacotherapy and psychotherapy (See Related References).

RELATED REFERENCES:
