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## Training Manual for Mental Health and Human Service Workers in Major Disasters

### SECTION 3

#### Disaster Reactions of Potential Risk Groups

Although there are many feelings and reactions people share in common after a disaster, there are also expressions that are more specifically influenced by a survivor's age, cultural and ethnic background, socioeconomic status, physical, and psychosocial vulnerabilities. Disaster mental health workers are better prepared to design effective interventions when they have an understanding of how demographic and health factors interact with disaster stress.

This section describes groups commonly found within communities following a disaster and provides suggestions for disaster mental health interventions. Common issues, concerns, and reactions are also briefly presented in this section.

#### Common Needs and Reactions

First is a review of some thoughts, feelings, and behaviors common to people who experience a disaster:

- Concern for basic survival
- Grief over loss of loved ones and loss of valued and meaningful possessions
- Fear and anxiety about personal safety and the physical safety of loved ones
- Sleep disturbances, often including nightmares and imagery from the disaster
- Concerns about relocation and related isolation or crowded living conditions
- Need to talk about events and feelings associated with the disaster, often repeatedly
- Need to feel one is a part of the community and its disaster recovery efforts

## Potential Risk Groups

Each disaster-affected community has its own demographic composition history with disasters or other traumatic events, and cultural representation. When disaster program planners review the groups impacted by a disaster in a community, consideration should be given to the following, as well as to groups unique to the locale:

- Age groups

- Cultural and ethnic groups

- Socioeconomic groups

- People with serious and persistent mental illness

- Human service and disaster relief workers

The majority of survivors are resilient and with time can integrate their experiences and losses and move on. However, survivors who have significant concurrent psychosocial, health, or financial problems are at greater risk for depression, anxiety, post-traumatic stress symptoms or an exacerbation of a pre-existing condition. When survivors have personally sustained several losses (e.g., death of a loved one, devastation of home and community), their reactions are more intensely expressed and over a longer period of time (Solomon & Green, 1992). This section includes a brief overview for each of the disaster reactions described normally resolve over time with sufficient support and physical recovery. References for more detailed information are provided.

## Age Groups

Each stage of life is accompanied by special challenges in coping with the aftermath of a disaster and age-related vulnerabilities to disaster stress. For children, their age and development determine their capacity to cognitively understand what is occurring around them and to regulate their emotional reactions. Children are more vulnerable to difficulty when they have experienced other life stresses in the year preceding the disaster, such as a divorce or the death of a family member or pet (Vogel & Vernberg, 1993). For children, stress associated with family and home disruption, financial setbacks, and school overload predominate. For older adults, concerns regarding health, financial stability, and living independently become primary.

The age groups considered in this section are:

- Preschool (ages 1-5)

- Childhood (ages 6-11)

- Pre-adolescence and Adolescence (ages 12-18)

- Adults

- Older Adults

Reactions and problems vary depending upon the phase of the post-disaster period. Some of the problems discussed appear immediately; many appear months later.

### **Preschool (ages 1-5)**

Small children view their world from the perspectives of predictability, and the availability of dependable caretakers. Disruption in any of these causes distress. Preschool age children often feel powerlessness and face of a disaster, especially if they are separated from parents. Because of their age and small size, they are unable to protect themselves or others. As a result, they may feel considerable anxiety and insecurity.

In the preschool years, children generally lack the verbal and conceptual skills necessary to understand and cope effectively with sudden unexpected events. They typically look to parents and older siblings as behavior models, sources of comfort and stability. Research has shown that children's reactions are related to how their family or caregiver is coping more than the actual characteristics of the disaster itself (Green et al., 1991).

Children who have lost one or both parents are especially in need. Loss of a relative, a playmate, or a pet is also a disturbing event for children. They need opportunities to express their grief. One of the major fears of children is abandonment, so children need frequent reassurance that they will be cared for.

Preschoolers express their upset through regressive behaviors such as sucking, bed-wetting, clinging to their parents, a return of fear of the dark, or wanting to sleep alone. They often have sleep problems and frequent nightmares. These problems are best understood as normal expressions of anxiety resulting from the disruption of their familiar routines and previously secure worlds.

In the natural course of events, small children will try to resolve traumatic experiences by reliving them in their play activities. They may reenact the disaster, earthquake, flood, or tornado repeatedly. Children should be encouraged to verbalize their questions, feelings, and misunderstandings about the disaster. That adults can listen and explain. Relief of disaster fears and anxiety is achieved through reestablishing the child's sense of security. Frequent verbal and physical comforting, more frequent attention, comforting bedtime rituals, and mealtime routines are helpful. As much as possible, young children should be with people with whom they feel most familiar.

### **Childhood (ages 6 - 11)**

School age children are developing the cognitive capacity to understand dangers to family and environment inherent in disasters. They are more able to understand the disaster event and the mitigating role of disaster preparedness. This awareness can also contribute to preoccupation with weather and natural disasters and fears about family members being killed or injured. School age children have a great need to understand what has happened and the concrete steps they can take for protection and preparedness in the future.

Children often have special bonds with playmates or pets. When the disaster causes loss of significant others due to death or relocation, the child may be deeply affected. They experience the full range of human emotions, but may not

words or means to express their internal experience. Adults can assist express these powerful emotions through talking, play, art, and age-appropriate recovery or preparedness activities.

School age children also manifest their anxiety through regressive behavior. Returning to behavior appropriate for a younger age is trying for parents serves an initially functional purpose for the child. These behaviors include irritability, whining, clinging, fighting with friends and siblings, competing with younger siblings for parents' attention, or refusing to go to school. Bedtime sleep problems are common due to nightmares and fearfulness about being alone or in the dark.

Sometimes children's behavior can be "super good" at home, because they are afraid of further burdening their parents or causing more family disruption. They may show disaster stress at school through concentration problems, a decline in academic performance, aggression toward classmates, or withdrawal from social interactions. Some children may have somatic reactions and seek attention from the school nurse for stomach aches, headaches, nausea, or other complaints.

### **Pre-adolescence and Adolescence (ages 12 - 18)**

This age group has a great need to appear competent to the world around them, especially to their family and friends. They struggle with the conflicts in moving toward independence from parents on the one hand and the desire to maintain the dependence of childhood on the other. Approval and acceptance from friends are of paramount importance. Adolescents need to feel that their anxieties and fears are both appropriate and shared by their peers.

Disaster stress may be internalized and expressed through psychosomatic symptoms such as, gastrointestinal distress, headaches, skin problems, muscle aches and pains. Sleep problems such as insomnia, night terrors, or sleeping excessively may signal internal upset. Adolescents may turn to alcohol to cope with their anxiety and loss.

Social or school problems may also occur. Acting out or rebellious behaviors may involve fighting with others, stealing, or power struggles with parents. Older adolescents may express their distress through withdrawal from friends and family and avoidance of previously enjoyed activities. School performance may decline. When the disaster causes major destruction of home and community, an older adolescent may postpone the developmental step of moving away from home.

### **Adults**

Adults are focused on family, home, jobs, and financial security. Many are involved with caring for elderly parents as well. Pre-disaster life often involved maintaining a precarious balance between competing demands. Following a disaster, this balance is lost with the introduction of the enormous time, physical, and emotional demands of recovery. Children in the family are in need of attention and familiar routines, yet parents do not have enough time or energy the day to accomplish all that is before them.

Over time, this stress overload can be manifested through physical symptoms such as headaches, increased blood pressure, ulcers, gastrointestinal problems

disorders. Somatic reactions are especially present in those who are less experienced and express their emotions directly. Cultural, gender-based psychological factors may interfere with emotional expression and seek support.

Emotional reactions often oscillate between numbness and intense expression. Anxiety and depression are common, as adults grapple with both current and future threats and grief about the loss of home, lifestyle, or community. Frustration about relief efforts abound, sometimes reflecting a displacement of the "less rational" anger that the disaster happened to them and was out of their control.

### **Older Adults**

In the normal course of life, older adults typically have coped with losses. The disaster. They may have successfully adjusted to losses of employment, family, home, loved ones, or physical capabilities. For some, coping with prior losses has strengthened resilience. For others, the prior losses may have worn down the individual's reserves and the disaster is an overwhelming event (Norris et al., 1994). As a result of the disaster, irreplaceable possessions, photographs or mementos passed on through generations may be destroyed, or gardens developed over years may be lost. Mental health workers must recognize the special meaning of these losses, if they are to assist with recovery.

Older adults living on limited incomes tend to reside in dwellings that are more susceptible to disaster hazards due to the location and age of the building. Because of financial limitations and age, they may not be able to afford repairs to their homes. Leaving familiar surroundings is especially difficult for those who experience deficits in hearing, vision, or memory, because they rely on known environmental cues to continue living independently.

Many older adults fear that if their diminished physical or cognitive abilities are revealed, they risk loss of independence or being institutionalized. As a result, they may under report the full extent of their problems and needs. They may continue living in damaged or unsanitary conditions, because they do not have the physical strength, stamina, or cognitive organizational ability to undertake disaster clean up. Disaster mental health workers must carefully assess the full extent of problems in living faced by the older survivor. Often, practical assistance for recovery, stabilization, and engagement with available resources allows the older adult to continue living independently.

A larger proportion of older persons, as compared with younger age groups, have chronic illnesses that may worsen with the stress of a disaster, particularly if recovery extends over months. They are more likely to be taking medication that may need to be replaced quickly following a disaster. While older adults may have a more need of multiple services for recovery, they are often especially receptive to accept help and what they perceive as "handouts." Disaster mental health programs can more quickly gain acceptance when they work closely with trusted organizations and employ older adults as outreach workers.

#### *Disaster Reactions and Intervention Suggestions*

##### *Age Groups*

##### *Behavioral Symptoms*

##### *Physical Symptoms*

##### *Emotional Symptoms*

*Intervention Options*PRESCHOOL  
(1 - 5)

- Resumption of bed-wetting, thumb sucking
- Clinging to parents
- Fears of the dark
- Avoidance of sleeping alone
- Increased crying
  
- Loss of appetite
- Stomach aches
- Nausea
- Sleep problems, nightmares
- Speech difficulties
- Tics
  
- Anxiety
- Fear
- Irritability
- Angry outbursts
- Sadness
- Withdrawal
  
- Give verbal assurance and physical comfort
- Provide comforting bedtime routines
- Avoid unnecessary separations
- Permit child to sleep in parents' room temporarily
- Encourage expression regarding losses (i.e., deaths, pets, toys)
- Monitor media exposure to disaster trauma
- Encourage expression through play activities

CHILDHOOD  
(6 - 11)

- Decline in school performance
- Aggressive behavior at home or school
- Hyperactive or silly behavior
- Whining, clinging, acting like a younger child
- Increased competition with younger siblings for parents' attention
  
- Change in appetite
- Headaches
- Stomach aches
- Sleep disturbances, nightmares
  
- School avoidance
- Withdrawal from friends, familiar activities
- Angry outbursts

- Obsessive preoccupation with disaster, safety
- Give additional attention and consideration
- Relax expectations of performance at home and at school tempo
- Set gentle but firm limits for acting out behavior
- Provide structured but undemanding home chores and rehabilitational activities
- Encourage verbal and play expression of thoughts and feelings
- Listen to the child's repeated retelling of disaster event
- Involve the child in preparation of family emergency kit, home drills
- Rehearse safety measures for future disasters
- Develop school disaster program for peer support, expressive arts education on disasters, preparedness planning, identifying at-risk

*Disaster Reactions and Intervention Suggestions (Continued)*

*Age Groups*

*Behavioral Symptoms*

*Physical Symptoms*

*Emotional Symptoms*

*Emotional Symptoms*

PRE-ADOLESCENCE AND ADOLESCENCE

(12 - 18)

- Decline in academic performance
- Rebellion at home or school
- Decline in previous responsible behavior
- Agitation or decrease in energy level, apathy
- Delinquent behavior
- Social withdrawal
  
- Appetite changes
- Headaches
- Gastrointestinal problems
- Skin eruptions
- Complaints of vague aches and pains
- Sleep disorders
  
- Loss of interest in peer social activities, hobbies, recreation
- Sadness or depression
- Resistance to authority
- Feelings of inadequacy and helplessness
  
- Give additional attention and consideration
- Relax expectations of performance at home and school temporarily
- Encourage discussion of disaster experiences with peers, significant others
- Avoid insistence on discussion of feelings with parents
- Encourage physical activities
- Rehearse family safety measures for future disasters
- Encourage resumption of social activities, athletics, clubs, etc.

- Encourage participation in community rehabilitation and reclama
- Develop school programs for peer support and debriefing, prepar planning, volunteer community recovery, identifying at-risk teen

#### ADULTS

- Sleep problems
- Avoidance of reminders
- Excessive activity level
- Crying easily
- Increased conflicts with family
- Hypervigilance
- Isolation, withdrawal
  
- Fatigue, exhaustion
- Gastrointestinal distress
- Appetite change
- Somatic complaints
- Worsening of chronic conditions
  
- Depression, sadness
- Irritability, anger
- Anxiety, fear
- Despair, hopelessness
- Guilt, self doubt
- Mood swings
  
- Provide supportive listening and opportunity to talk in detail about experiences
- Assist with prioritizing and problem-solving
- Offer assistance for family members to facilitate communication effective functioning
- Assess and refer when indicated
- Provide information on disaster stress and coping, children's react families
- Provide information on referral resources

#### *Disaster Reactions and Intervention Suggestions (Continued)*

##### *Age Groups*

##### *Behavioral Symptoms*

##### *Physical Symptoms*

##### *Emotional Symptoms*

##### *Intervention Options*

#### OLDER ADULTS

- Withdrawal and isolation
- Reluctance to leave home
- Mobility limitations
- Relocation adjustment problems

- Worsening of chronic illnesses
- Sleep disorders
- Memory problems
- Somatic symptoms
- More susceptible to hypo- and hyperthermia
- Physical and sensory limitations (sight, hearing) interfere with re
  
- Depression
- Despair about losses
- Apathy
- Confusion, disorientation
- Suspicion
- Agitation, anger
- Fears of institutionalization
- Anxiety with unfamiliar surroundings
- Embarrassment about receiving "hand outs"
  
- Provide strong and persistent verbal reassurance
- Provide orienting information
- Use multiple assessment methods as problems may be under rep (e.g., repeat observations, geriatric screening questions, discuss family)
- Provide assistance with recovery of possessions
- Assist in obtaining medical and financial assistance
- Assist in reestablishing familial and social contacts
- Give special attention to suitable residential relocation
- Encourage discussion of disaster losses and expression of emotio
- Provide and facilitate referrals for disaster assistance
- Engage providers of transportation, chore services, meals progra health, and home visits as needed

### **Cultural and Ethnic Groups**

Disaster mental health programs must respond specifically and sensitiv various cultural groups affected by a disaster. In many disasters, ethni minority groups may be especially hard hit because of socioeconomic c that force the community to live in housing that is particularly vulnerat Language barriers, suspicion of governmental programs due to prior ex rejection of outside interference or assistance, and differing cultural va contribute to disaster outreach programs' difficulty in establishing acce acceptance. Communities that take pride in their self-reliance are reluc seek or accept help, especially from mental health workers.

Cultural sensitivity is conveyed when disaster information and applicat procedures are translated into primary spoken languages and available written forms. Intense emotions are typically experienced and express person's language of origin, so outreach teams that include bilingual, t staff, and translators are able to interact more effectively with disaster Whenever possible, it is preferable to work with trained translators ratl family members, especially children, because of privacy concerns rega

mental health issues and the importance of preserving family roles.

Cultural groups have considerable variation regarding views on loss, death, spiritual practices, use of particular words, grieving, celebrating, mourning, and helping. The role of the family, who is included in the family, and the decisions also varies. Elders and extended family play a significant role in some cultures, whereas isolated nuclear families are the decision-makers in others.

It is essential that disaster mental health workers learn about the cultural traditions, local history, and community politics from leaders and social workers indigenous to the groups they are serving. Program outreach by social workers and mental health staff are most effective when they are bilingual and bicultural. During the program development phase, establishing working relationships with trusted organizations, service providers, and community leaders is helpful. Being respectful, nonjudgmental, well informed, and following through on standards dependably are especially important for outreach workers.

### **Socioeconomic Groups**

Many affluent, middle to upper middle class people live with a sense of security and see themselves as invulnerable to the devastation and tragedy associated with disasters. Because of their financial resources and life situations, they have been protected from crises in the past, and have purchased insurance "protection" in the future. They are more accustomed to planning and controlling life events, rather than unexpected overwhelming events controlling their lives. Disbelief, self blame, and anger predominate in the hours and days following a major disaster, as the reality of losses, danger, and the work that lies ahead begins to sink in.

Higher income families may never have received assistance from social service agencies before. Accepting clothing, food, money, or shelter can be disconcerting and sobering. While they may need emergency assistance initially, they often do not need social, financial, family, or other resources that engage quickly and buffer the disaster's impact.

Affluent families typically rely on known professionals for their support—family physician, minister, or psychotherapist. Disaster mental health programs focus on educating local health care professionals and religious leaders about disaster stress, because these providers are most likely to encounter vulnerable survivors in need. Psychosocial Issues for Children and Families in Disaster: A Guide for the Primary Care Physician (CMHS, 1995) is an informative resource for training. Recovery programs can also coordinate disaster mental health counseling and support groups through these known and trusted entities.

In contrast, low-income survivors have fewer resources and greater personal vulnerability when disaster strikes. While they may have developed more survival skills than the more protected upper class individuals, they often lack the availability of support and housing from family and friends and do not have insurance coverage or monetary savings. Without these, the recovery process is even more arduous and prolonged, and sometimes impossible. Federal disaster assistance programs are designed to meet serious and urgent needs. The intent of these programs is not to replace all losses. Uninsured, poor families have unmet needs and should be referred to non-profit disaster relief organizations and unmet needs committees. If they are renters, they are often faced with unaffordable increases in rent after landlords have invested

repair their properties. They may be dislocated to temporary disaster housing, which is undesirable and removed from their social supports. Relocation may make transportation and getting to appointments more difficult.

Faced with these multiple challenges and assistance that falls short of their needs, low-income disaster survivors can feel overwhelmed. For those with limited reading and writing abilities, obtaining accurate information and completing forms is difficult. Disaster mental health workers are more effective when they provide concrete problem-solving assistance that addresses priority needs. Workers must be knowledgeable about the community resources available to people of limited economic means and engage this resource network with those in need.

### **People With Serious and Persistent Mental Illness**

Clinical field experience has shown that disaster survivors with mental illness function fairly well following a disaster, if essential services have not been interrupted. People with mental illness have the same capacity to "rise to the occasion" and perform heroically as the general population during the aftermath of the disaster. Many demonstrate an increased ability to handle stress without an exacerbation of their mental illness, especially when able to maintain their medication regimens.

However, some survivors with mental illness have achieved only a tentative balance before the disaster. The added stress of the disaster disrupts that balance; for some, additional mental health support services, medication, or hospitalization may be necessary to regain stability. For individuals diagnosed with Post Traumatic Stress Disorder (PTSD), disaster stimuli (e.g., helicopter sirens) may trigger an exacerbation due to associations with prior traumatic events.

Many people with mental illness are vulnerable to sudden changes in their environment and routines. Orienting to new organizations and systems for disaster relief assistance can be difficult. Program planners need to be sensitive to how disaster services are being perceived and build bridges that facilitate access and referrals where necessary. Disaster mental health services designed for the general population are equally beneficial for those with mental illness; stress affects all groups. In addition, when case managers and community health counselors have a solid understanding of disaster mental health issues, they are able to better provide services to this population following a disaster. Responding to the Needs of People with Serious and Persistent Mental Illness: Times of Major Disaster provides a comprehensive discussion of planning, preparedness, and options for service delivery with this population (CMH, 1987).

### **Human Service and Disaster Relief Workers**

Workers in all phases of disaster relief, whether in law enforcement, local government, emergency response, or victim support, experience considerable demands to meet the needs of the survivors and the community. Typical disaster workers are altruistic, compassionate, and dedicated people who occasionally have difficulty knowing when it is time to take a break from their operation. For many, the disaster response takes precedence over all other responsibilities and activities. The brochure, *Prevention and Control of Mental Health Problems Among Emergency Workers-A Pamphlet for Workers*, is an excellent resource for both disaster relief workers and mental health providers (NIMH, 1987).

brochure highlights the importance of having a personal emergency plan, so that workers are assured that their families are safe while they turn themselves to disaster relief for the community.

Relief workers may witness human tragedy and serious physical injuries depending on the nature of the disaster and their role. This contributes to the psychological impact of their work. In disasters in which there is a high exposure to human suffering, injuries, and fatalities, providing psychological support and interventions for workers is especially necessary. In addition, relief workers and first responders should be considered a target group for services during the course of the disaster mental health recovery program.

As some order returns to the community, many workers, particularly women, return to their regular jobs. However, they may attempt to continue with disaster work. Over time, the result of this overwork can be the "burnout syndrome." This state of exhaustion, irritability, and fatigue creeps up on workers unrecognized and can markedly decrease the individual's effectiveness and capability. These workers may be avoiding problems at home by working constantly. Disaster mental health workers should be on the lookout for those whose coping resources have eroded due to their personal vulnerability and seemingly unrelenting workload. The next section in this manual, "Stress Prevention and Management," offers suggestions for identifying, educating, and intervening with those who may be having stress reactions and difficulties.

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