University of Delaware
Disaster Research Center

PRELIMINARY PAPER
#58

CRISIS INTERVENTION IN
SMALLER COMMUNITIES

Barbara Baisden

The problems that any program addresses and the means by which it does so is determined by the ways those problems are initially defined. Since problem definition is often a function of local perspectives, it is important to look at how smaller communities differ from larger ones and how they are alike and the variations within each of the setting types.

The term "small town America" is misleading, evoking as it does images of uniformity and dichotomy - that is, there is a single small town lifestyle holding constant from west coast hamlet through midwestern farmland to the villages of the seaboard region, and further, that everything about small towns is "other" or opposite to life in large cities. In actuality, there is a tremendous range of categories between X (the farm) and X_n (the great metropolitan center) (Smith and Zopf, 1970), depending on factors of population size, density, economic base, social differentiation and stratification and income level. Social scientists, moreover, have noted considerable urban to rural diffusion with mass communications, mass macro economics, industrialization and mobility combining to make country life increasingly like that of cities.

Smaller communities have indeed become more familiar with social and economic problems that have long been characteristic of metropolitan areas. For this reason, some argue that standard planning for major service programs is justified (Hofstatter, et al, 1972). Views like these are prompted by a real concern for providing services where none exist and a realistic interest in efficiency. Unfortunately, the assumption seems to be that "boilerplate" programs, designed at federal and state levels for use primarily in cities and larger towns, will be equally acceptable elsewhere. Smaller communities are not yet identical with cities, however, and while they are moving in this direction,

moderate to substantial differences will persist, particularly in those
kinds of attitudes and behavior that are likely to be relevant to
mental health issues (Glenn & Hill, 1977). These differences tend to
vary by community size and will not diminish. The rural segment of our
population, including inhabitants of towns of 2,500 or less, has remained
stable over the past fifty years at about 25%. In addition, approxi-
mately 31% were identified by the 1970 census as living in intermediate
sized communities of 2,500 to 250,000 (Taeuber, 1972). Clearly, a sub-
stantial number of people live in towns that are relatively isolated
from the resources and cultural values of major centers. Developing
strategies of service delivery more closely tailored to their needs is
thus an important priority.

Characteristics of Life in Smaller Communities

In a provocative work on rural/urban differences, Dewey (1960)
observed that variation occurred around five basic qualities found to a
lesser degree in more rural settings and to a greater degree in more
urban settings. These are: anonymity; division of labor; heterogeneity;
impersonal and formalized relationships; and symbols of status which are
independent of personal aquaintance.

More recent research shows that some of the sharpest demarcations
between smaller communities and urban-metropolitan settings fall into
two broad categories: those concerning beliefs, values and interpersonal
relations; and those relating to socio-economic status.

Studies on attitude and behavior (Glenn and Hill, 1977), political
structure (Knoke and Henry, 1977) and the rural church (Nelson and
Potvin, 1977) indicate that conservatism is still a way of life outside
of large cities. In the opinion of Knoke and Denry (52) this conserva-
tism "has been a more durable, pervasive orientation...suffusing not

only politics but religion, morality and lifestyle." It is manifested in guarded views on big government, big business and big labor, and in resistance to social change and to newcomers, particularly if these are perceived as "different," "strange," or "other than the native stock" (Knoke & Henry, 1977). Dependence on self remains a major virtue. The moral value attached to being able to help oneself and the implied moral failure if one is not, is evident in the fact that when people from small towns do go outside the immediate family for help, they often turn to the church.

With regard to socio-economic matters, it is well documented that there are several areas of deprivation among rural populations, although some urban groups (minorities, youth and women) are severely impoverished. The proportion falling below the poverty level is twice as high in rural as in metropolitan areas. Unemployment rates for agricultural workers are higher; underemployment is widespread, chronic and severe. The result is that nearly as many rural people fall into marginal income brackets as into outright poverty (Segal, 1973).

Substandard housing, crowding, inadequate plumbing and poor quality of drinking water are actually twice as prevalent in many smaller communities as in metropolitan areas (Dillman and Tremblay, 1977). Lower educational attainment levels are another problem, as is functional illiteracy (Segal, 1973). And finally, rural regions suffer from relatively high rates of health impairment, particularly from chronic conditions (Hollister, et al, 1973; Segal, 1973).At the same time these same areas have fewer health and social service resources and a shortage of professional manpower, while geography and mobility problems limit accessibility to those resources that do exist.

With specific regard to mental health, there has been an historic, widesprea . belief that the coldness of the city and the stresses and strains o ' "making it" in a competitive environment generate mental illness, rhile the more tranquil quality of small town life and relative closenes: to family, neighbors and the land are conducive to emotional well-bei ig. Research indicates that this may be another stereotype.

Du·ing this century, numerous epidemiological·studies have been conduc† ed on mental disturbance. Dohrenwend and Dohrenwend (1974) found that n ne of these studies reported data from both rural and urban popul:.tions, thus giving some comparisons of relative impairment·rates. They found that in seven studies rates were higher in urban settings, but none of the differences were very large, with the median difference for total rates being around 1%. In another study of data collected in the early 1960's, Leo Srole (1977) found that people in rural areas and intermediate sized towns reported 20% more symptoms of psychological disturbances than did big city residents.

Several studies have looked at rural areas only (Hollister, et al, 1973; Schwab & Warheit, 1972; Leighton, et al, 1967). The findings are somewhat inconsistent, as they have been in studies looking only at urban populations. However, one of the similarities in both types of settings is that the same general groups tend to be more exposed and vulnerable to stress. High risk groups in non-urban areas are:

- the unmarried (single, divorced, widowed) as opposed to married.

- the less educated, unskilled and lower income, as opposed to middle class.

- those living in outlying areas as opposed to small town residents

- women rather than men.

- the elderly rather than the young.

- non-whites rather than whites.

The most universal relationship, as it has been since Hollingshead and Redlich published their classic Social Class and Mental Illness (1958), is the one between lower socio-economic status and high rates of impairment. Interestingly, although rural populations in general show slightly lower rates than do city dwellers, within rural areas per se, those living in outlying districts tend to be more susceptible to stress than do town dwellers (Segal, 1973). Relating this to data showing higher impairment rates for single people and those of lower socio-economic status, it would appear that a salient factor in the incidence of mental disorder is that of isolation - whether it be emotional, social or physical.

Research in non-metropolitan areas is showing increasing levels of acceptance of both mental illness and of mental health services, at least at the attitudinal level. In surveys, most persons recognize mental disorder to be an illness, consider conditions such as alcoholism and drug abuse to be a form of mental illness, and agree that much can be done to help people with problems concerning mental health.

On the behavioral level, however, the situation is improving at a slower pace. Rabkin's (1974) review of the literature on public attitudes suggests that educational campaigns have resulted mainly in cognitive acceptance. It is easier to express tolerance than to act upon it, especially, perhaps, in smaller towns where sanctions on behavior are more effectively applied.

In much the same manner, residents of smaller communities welcome mental health practitioners in their midst - for others. While growing

numbers seek professional services, the majority continue to turn to ministers, family doctors, and that group comprised of friends, bartenders, beauticians and the like who are collectively termed "natural helpers."

It would be a serious mistake to attribute failure to seek professional help only to negative attitudes since the decision is affected just as much by knowledge of and accessibility to resources. In recent decades, there has been a significant increase in the quantity and variety of mental health resources in all sections of the country, but it is still true that such resources decline in number, size and professional expertise as population density decreases. Given this relative scarcity in more rural areas, it is not surprising that fewer people are aware of or utilize them. Neither is it surprising that existing agencies are patronized mainly by the white middle class. Unfortunately, except where good working relationships with welfare and other social service agencies generate referrals, members of the highest risk groups are absent from caseloads. Yet, the presence of mental health resources invariably creates a market for their services, so that treatment becomes more common where it is more readily accessible (Rabkin, 1974). Thus, the basic issue in mental health delivery in the small city is not the mere acquisition and application of professional expertise, but a sensitivity to the peculiar, unique qualities of the town and its people.

A number of the special characteristics of smaller communities have been touched on and are summarized below:

- proportionately large numbers of the socially and economically disadvantaged

- pride in independence and self-sufficiency

- lower levels of acceptance of the label of
  mental illness, resulting in a tendency to under-
  estimate mental health problems

- general tendency to reject the unfamiliar and
  the specialized

- propensity, when seeking help, to go first to
  family, friends, doctors and ministers

- physical limitations of distance, transportation,
  and professional manpower shortages

With these in mind, programs can be designed that are compatible with

existing community patterns and which will then have a better chance

of acceptance, both in normal times and in times of collective crisis,

as in disaster.

Happily, the types of service delivery that have been found to be

effective in helping disaster victims will suit the small city. Or,

to put it another way, the town that has provided for meeting the

psychological needs of its citizens in the manner smaller town dwellers

find most acceptable will find that it already has the structure and

the basic strategies for an excellent disaster intervention program.

MENTAL HEALTH CONSEQUENCES OF DISASTER

Before discussing crisis intervention as a strategy of choice
in disaster mental health and human service delivery, some clarifica-
tion needs to be made about the imagined and actual psychological ef-
fects of these collective stress situations.

The folk wisdom has long held that when people are faced with
the threat or the actual occurrence of a major disaster, they disin-
tegrate physically, mentally, and morally. They engage in irrational
and antisocial acts, such as wild and disorderly panic, looting, and
other forms of criminal deviance. Popular beliefs about how people
react to extreme stress situations are so grim that hysterical break-
downs and psychotic episodes are thought to be common among disaster
victims in the short run and a wide variety of forms of severe psycho-
pathology are expected to be manifest among victims in the long run.
In short, the image is essentially that disasters create or exacer-
bate severe forms of mental illness for their victims.

Such beliefs have historically been reinforced by the mass media.
In recent studies to determine if people actually concur with what
they read and hear about, Wenger et al (1975) and Blanshan (1975)
found that the general public does indeed believe that disasters e-
volve extreme reactions in victims. Likewise, many members of the
mental health professions expect that debilitating emotional sequelae
result from disasters.

Most of these conjectures have been based on isolated anec-
dotes and occasional clinical cases of severe post-disaster impairment.
Only in the past five or six years has systematic research been under-
taken to determine how individuals actually react psychologically and

emotionally to disaster. The findings tend to agree that severe incapacitating emotional breakdown is quite rare, and that, if anything, the seeking of professional mental health assistance is notable for its absence. At the same time there are strong indications that disaster is not entirely without psychological impact.

Victim populations do seem to undergo considerable stress and strain and do experience varying degrees of concern, worry, depression, anxiety, together with numerous problems in living and adjustment in time of disaster. Approximately ten studies have been undertaken in disaster-stricken communities that tend to corroborate this view. The communities include: Wilkes-Barre, Pennsylvania (flood); Omaha, Nebraska, (tornado); Topeka, Kansas, (tornado); Los Angeles, California, (earthquake); Monticello, Indiana, (tornado); and Buffalo Creek, (flood). Except for the Buffalo Creek study, none of the research found a link between disaster and severe psychopathology. However, the studies agree almost unanimously that disasters do induce symptoms of psychological stress among victims and fairly extensive problems in living which may, in turn, contribute to further emotional difficulties. Incidentally, most of the studies also point out that mental illness was falsely anticipated in the first few days after impact. When these reactions failed to materialize, existing mental health agencies usually found it difficult to gear up to adequately meet the actual kinds of mental health and human service needs which did exist among victims.

Interestingly, it appears that it is not only, or even mainly the impact of the disaster itself which affected psychological well-being. The longer-term impact of somewhat inefficient, ineffective

and frustrating governmental relief efforts accounts for much of the stress manifested by victims.

The needs generated by disaster are many, complex and interrelated. Some examples, mentioned in the reports of crisis intervention projects instituted in recent disasters, include: persons so overwhelmed by demands that they could not decide what to do first having to adjust to temporary housing, having experienced other extreme difficulties close to the time of disaster (McGee, unpublished); the need to relate disaster experiences to someone willing to listen, to be informed about obtaining a range of disaster related services (Bowman, 1975); lack of leisure time, interpersonal stress, children getting underfoot, depression, sense of loss, and the consequent grieving process that must be worked through (Omaha Tornado Project, 1976). An important finding with implications for disaster related service delivery is that victims did not consider themselves potential "clients" in need of mental health services.

Another aspect of post-disaster needs involves the time dimension. Research indicates that communities go through stages in their response to and recovery from disasters. Community needs and subsequently organizational tasks are known to vary according to the disaster phase in which a community finds itself. For example, Dynes (1974), following Powell, divides disaster impact into eight time stages: predisaster conditions, warning, threat, impact, inventory, rescue, remedy and recovery. Dynes notes that these stages are characterized by the differential involvement of various community organizations, by varying types of organizational behavior and by different community norms.

The needs of individuals, or groups of affected individuals, may also be seen as occurring in phases, with different problems coming to the fore in different post-disaster periods. For example, the most common needs manifested in the immediate post-impact emergency period may be for food, shelter, first aid, information about the whereabouts of loved ones, and an opportunity to ventilate feelings in the presence of a sympathetic listener. These kinds of needs may be superseded in later days by the need for help with clean-up, the need for information about available material aid and social services and the need for assistance in coping with exhaustion, frustration and discouragement at the amount of work that still remains to be done. During the long-term recovery period--six months to 18 months after the disaster--the most acutely felt needs of victims may be for legal aid or for more and different kinds of community programs. At this time, some people may still be struggling with insurance problems or with unemployment, or may be experiencing difficulty adjusting to the long-term consequences of the disaster.

CRISIS INTERVENTION: A STRATEGY FOR MEETING DISASTER-GENERATED NEEDS

Up until the early 1970's, little attention was paid to meeting mental health needs of victim populations. About this time, local and outside groups, encouraged by the then newly established Disaster Assistance Section of the National Institute of Mental Health, began to launch psychological support programs to victims of at least ten major disasters. The nature and scope of these early efforts varied considerably from case to case. Some programs consisted of reaching

out to provide emergency mental health and crisis services, but there were, in the beginning at least, an equal number of attempts to offer traditional clinical and psychotherapeutic treatments. Over time, however, crisis intervention and the provision of supportive services have come to be defined by those actually involved in service delivery in time of disaster as the most appropriate and effective techniques.

This judgment seems to rest on several foundations. One is the finding cited above that disasters do not result in serious or sustained psychiatric impairment for any significant segment of the victim population. Another is the apparent lack of increase in demand--and often, the decrease in demand--for psychotherapy and related clinical services following disasters.

Perhaps most important, those involved in post-disaster mental health service delivery have witnessed first-hand the great variety and cumulative nature of victims' post-disaster psychological reactions and, therefore, have become aware of the necessity of adopting an open, flexible approach to the provision of mental health services. Often, they learned the overwhelming need of victims is for the rendering of immediate, tangible aid on a number of fronts.

Three other themes predominate in the reported experiences of those faced with providing mental health services in times of disaster which indicate why an outreaching, crisis intervention model seems appropriate. One is the notion that victims require services where they are, rather than in a mental health facility or in some other traditional setting. Another is that the mental health worker in disaster must act as a resource for knowledge about other community

services and must be aware at all times of what other agencies and
groups are doing. Again, there is the notion that providing this
kind of information and referral during times of extreme uncertainty
--and indeed even physically bringing the victim to the place where
he or she can receive aid--is performing a real mental health func-
tion. A third theme expressed in writings on disaster mental health
services stresses the use of paraprofessionals and volunteers in
outreach and crisis intervention activities. It is seen as especially
important to enlist the aid of individuals who are already perceived
as friendly helpers or resources by community members; e.g., clergy.

In a study done at the Disaster Research Center on mental health
needs and resources in twelve small cities, we found that these com-
munities and probably the majority of like communities across the
country, are happily not so resource poor as they might appear. We
were able to locate a variety of formal and informal caregivers who
typically function in response to demands for psychological first
aid. On the basis of this research, we concluded that those interested
in planning for crisis intervention programs already have available
on the local level the wherewithal to at least begin that work. The
remainder of this paper, then, will outline some recommendations for
program planning and implementation in both the predisaster period
and the weeks immediately following impact.

Although the focus here is on what can be done at the local
level, in line with the thrust of the Conference on the Small City,
it should be noted that regional and particularly state government
has an important facilitative role to play. Briefly, this includes
disseminating relevant information, sponsoring disaster related legis-
lation, making funding available for both planning and emergency

operations, appointing liason personnel, establishing standards for service delivery.

PREIMPACT PHASE: PLANNING FOR SERVICE DELIVERY

1. Be aware of disaster relevant legislation on both the federal and the state levels, and of sources of information available to the local community. Section 413 of the Disaster Relief Act of 1974 specifically provides for the granting of mental health assistance in federally declared disasters. A number of state disaster plans and laws have related provisions. The Disaster Assistance Section of NIMH is an important resource in these matters.

2. Become involved in local disaster planning activities. There may already be community-wide committees concerned with preparedness issues, typically represented by the Red Cross, police and fire departments, Civil Defense and the local hospital. Mental health personnel may find it difficult to integrate their efforts with those of other disaster relevant organizations following disaster if they have not worked with these agencies beforehand. Where community-wide disaster planning has not begun, mental health and human service staff can act as a catalyst.

3. Develop a plan for crisis intervention. This plan should include provisions for the services to be delivered as well as when, where, how and by whom they will be provided. Planning should occur not merely within organizations but among them.

4. Know your community. Because of the dynamic nature of interorganizational relationships, crisis intervention workers need to have comprehensive, accurate and current knowledge about local social service resources. Also needed is an understanding of what informal

networks exist that routinely meet urgent needs of residents and an awareness of the identity and location of high-risk groups in the population since these are the groups upon which disasters have a marked impact.

5. Educate human service and mental health personnel about human behavior and needs in disaster. An annotated bibliography on disaster mental health is available from DRC, and a comprehensive training manual for crisis intervention workers has been prepared by the Los Angeles Suicide Prevention Center under contract with NIMH.

6. Assign responsibility for agency disaster planning to specific individuals. This will help counteract the low priority frequently given to disaster planning.

7. Upgrade agency record-keeping procedures. Postdisaster needs assessment and possible application for funding will be based in part on statistical data including baseline data on mental health problems, number and nature of cases treated, etc. Even if a disaster never occurs this kind of information will benefit local agencies.

IMPACT AND EMERGENCY PERIOD: THE PROVISION OF PSYCHOLOGICAL FIRST AID

The benefits of planning will be immediately apparent when disaster strikes. However, even if planning has not occurred it is still not too late to mount an effective response in the postimpact emergency period. Three main tasks must be performed simultaneously: integration with the emergent community general service delivery system; delivery of direct and indirect human (including crisis intervention) services to victims; and needs assessment.

1. Conduct an initial meeting with other providers of emergency health care services. Groups and organizations involved in providing

supportive services to victims should devise a clear division of labor
to avoid duplication of effort. All information about damage and
injury reports, the location of evacuees, location of the emergency
operations center, and the availability of resources should be ex-
changed. Provisions for briefing or training volunteers or para-
professionals may also be made.

2.   Integrate with the emergent care-giving system. The emergency
system will be marked by changes in the every day operations of many
organizations and by the emergence of new groups; it may also see
the arrival on the local scene of state and federal representatives.
Part of the task of providers of crisis intervention services will be
to coordinate their efforts with the efforts of these and other groups
involved in the emergency response by becoming aware of the functions
of these agencies and participating in their coordinating meetings.

3.   Provide direct services to disaster victims. As has been noted,
crisis intervention techniques are probably the most effective in
dealing with disaster related mental health needs. These are char-
acterized by: 1) frequent contact over a short period of time; 2)
emphasis on the present problem rather than on past or chronic diffi-
culties; 3) the use of paraprofessionals with trained volunteers in-
stead of the exclusive use of professionals; and 4) emphasis on help-
ing the person deal positively with the current situation rather than
on seeking overall personality reorganization (Caplan, 1964).

In designing crisis intervention programs consideration should
be given to several questions:

Of what should services consist? Frequently, provision of
tangible aid is the best and only way to reduce symptoms of emotional

disturbance. Information and referral is extremely valuable, but also complicated in the postimpact period because of the general chaos.

How should services be delivered? Ane major point is that services should not carry the mental health label. Another is that they should focus on solving current problems rather than on the treatment of symptoms. If long standing psychological problems do appear, a referral to a traditional mental health agency may be in order.

Where should services be delivered? An outreaching stance should be adopted: help should be offered on evidence of need, not only by formal request. In addition to home visiting, outreach can occur unobtrusively and effectively in shelters, one-stop centers, hospital emergency rooms and morgues.

By whom should services be provided? While professional mental health and human service workers should exercise leadership and super-vision of crisis intervention efforts, paraprofessionals, trained in-digenous volunteers and members of existing informal care-giving net-works are effective outreach workers, especially in smaller communi-ties.

For whom should services be provided? This depends on the in-dividual community and on the disaster itself. In general, major target groups would be those most directly affected by the disaster, those who were agency clients before the disaster, and physically, socially and emotionally isolated segments of the population.

4. Provide indirect services to the community. Community education efforts via the mass media can convey the message that it is normal to be somewhat upset following a disaster experience, provide suggestions

for working through these feelings, and tell people where various social, financial and emotional help is available.

5.   Engage in needs assessment for use in planning and future service delivery.   Services should be based upon actual need rather than an expectations of need or on visible demand.   Assessment can be performed in several ways: population surveys, which are expensive, time consuming and very difficult in the chaos following disaster; indirect indicators, found in official records of health care organizations, mental health facilities, social service agencies, nursing homes and other residential facilities, and disaster relief organizations; community informants, mainly those active in the disaster response; and clinical evaluations of professionals working in disaster settings.

The foregoing recommendations have very briefly touched upon some of the basic strategies for planning and providing crisis intervention in disaster.   Those interested in this area of service delivery should avail themselves of the literature on the subject, and most importantly, begin working with others at the state and local level. Each community is unique.   The best laid plans are those tailored to the special complex of needs, resources and qualities that make a community what it is.

REFERENCES

Blanshan, S. *Disaster Myths of Mayhem and Their Implications: A Replication.* Unpublished paper.

Bowman, S. (1975) *"Disaster Intervention: From the Inside."* Paper presented at APA (American Psychological Association), Chicago.

Caplan, G. (1964) *Principles of Preventive Psychiatry.* New York: Basic Books.

Dewey, R. (1960) "The Rural-Urban Continuum: Real but Relatively Unimportant." *American Journal of Sociology 66:* 60-66.

Dillman, Don A. and Kenneth R. Tremblay, Jr. (1977) "The Quality of Life in Rural America." *The Annals 429:* 115-129.

Dohrenwend, Bruce P. and Barbara Snell Dohrenwend. (1974) "Psychiatric Disorders in Urban Settings," Chapter 29. *American Handbook of Psychiatry II:* 424-447. New York: Basic Books.

Dynes, Russell R. (1974) *Organized Behavior in Disaster.* Monograph Series # 3: 235 pp. Columbus, Ohio: The Disaster Research Center, The Ohio State University.

Glenn, Norval and Lester Hill, Jr. (1977) "Rural-Urban Differences in Attitudes and Behavior in the U.S." *The Annals 429:* 36-50.

Hofstatter, L., Ulett, G. A., Thompson, W. A., Ameiss, A. and Gannon, P. J. (1972) "A Modern Psychiatric Delivery System for Urban and Rural Areas." *Southern Medical Journal 65, # 7:* 875-881.

Hollingshead, A.B. and F. C. Redlich (1958). *Social Class and Mental Illness.* New York: Wiley and Sons, Inc.

Hollister, William, J.W. Edgerton, W.K. Bentz, F.T. Miller and J.F. Aponte (1973). *Experiences in Rural Mental Health.* Under contract to NIMH. Chapel Hill, North Carolina: University of North Carolina.

Leighton, D.C., A.H. Leighton and R.A. Armstrong. (1967) "Community Psychiatry in a Rural Area: A Social Psychiatric Approach." Chapter 7. *Handbook of Community Psychiatry and Community Mental Health.* New York: Grune and Stratton.

McGee, Richard K. (1973) *"The Role of Crisis Intervention Services in Disaster Recovery."* Paper presented at NIMH meeting.

Nelson, Hart M. and Raymond H. Potvin (1977). "The Rural Church and Rural Religion: Analysis of Data from Children and Youth." *The Annals 429:* 103-114.

Omaha Tornado Project (1976). *Final Report to Federal Disaster Assistance Administration.* Omaha, Nebraska: Eastern Nebraska Human Services Agency.

Rabkin, Judith (1974). "Public Attitudes Toward Mental Illness: A Review of the Literature." *Schizophrenia Bulletin 10:* 9-33.

Schwab, J.J. and G. J. Warheit (1972). "Evaluating Southern Mental Health Needs and Services." *Journal of Florida Medical Association* (January).

Segal, Julius, ed. (1973). *The Mental Health of Rural America: The Rural Programs of NIMH.* DHEW Publication # (HWM): 73-9035.

Smith, T. Lynn and Paul E. Zopf, Jr. (1970). *Principles of Inductive Rural Sociology.* Philadelphia: F.A. Davis Co.

Srole, Leo (1977). "Mentally, the Urban Life Beats the Rural." *The New York Times,* May 8.

Taeuber, Irene B. (1972) "The Changing Distribution of the Population in the U.S. in the Twentieth Century." *Population, Distribution and Policy,* .U.S. Government Printing Office.

Wenger, Dennis E., James D. Dykes, Thomas B. Sphak and Joan L. Neff (1975). "It's a Matter of Myths: An Empirical Examination of Individual Insight Into Disaster Response." *Mass Emergencies 1:* 33-46.