A BASELINE EXPLORATORY STUDY OF MARRIAGE AND FAMILY THERAPISTS PERCEIVED PREPAREDNESS TO WORK IN THE DISASTER MENTAL HEALTH FIELD

By

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A BASELINE EXPLORATORY STUDY OF

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CHAPTER I

INTRODUCTION

Natural Disasters and Marriage and Family Therapists

In one year, the American Red Cross responds to more than 70,000 disasters worldwide including natural disasters (American Red Cross (ARC), 2007). Natural disasters, including hurricanes, volcanoes, wild fires, avalanches, mudslides, tornadoes, earthquakes, tsunamis, and floods affect millions of people each year through the destruction of property, the loss of family members and loved ones, and the development of lasting mental disorders including depression and Posttraumatic Stress Disorder (PTSD; Conran, 2006). While most people find ways to slowly rebuild their lives many times, the lasting effects of a natural disaster outweigh the resources available, leaving some individuals and families without the necessary tools to overcome the catastrophe (Conran, 2006).

In the wake of these natural disasters, many mental health professionals travel to the scene to offer services and expertise in mental health recovery. Nearly 50,000 mental health professionals responded during the September 11 terrorist attack in 2001 (ARC, 2007). Although many of the mental health professionals traveling to offer mental health services at these disasters scenes are marriage and family therapists (MFTs), there is a lack of research reflecting whether MFTs feel prepared to work with this unique population of natural disaster survivors. Because of MFTs systemic approach in working

with multiple people in therapy, much of the research on disaster treatment supports a family theory based model (Boss, 2002; Catherall, 2004; Patterson, 2002; Walsh, 1996; 2003). Catherall (2004) suggests that the quality of attachment individuals have to their family system is one of the most important and critical factors impacting short and long-term mental health of individuals following a disaster. Much of the literature suggests that social support and family dynamics play a vital role in recovery after a traumatic experience (Wantanbe, Okummura, Chiu, & Susumu, 2004). MFTs offer a way to incorporate these social networks into the therapeutic process which is unique compared to other therapeutic modalities.

Along with their family systems training, Licensed Marriage and Family Therapists (LMFTs) are trained in key factors in the literature which are related to disaster mental health, including psychopathology and social support. However, the lack of empirically based literature on MFTs effectiveness to work with trauma victims and effective family based interventions puts into question MFTs preparedness to work with survivors following a disaster. While many experts in the field of traumatology support a family-based approach when working with trauma survivors, there is no research to indicate whether MFTs perceive themselves as prepared to work with this population (Figley, 2008). The proposed research study strives to begin identifying the gap in current research by examining whether MFTs perceive themselves as prepared to work in the disaster mental health field.

CHAPTER II

REVIEW OF LITERATURE

Natural Disasters

The International Strategy for Disaster Reduction (ISDR, 2006) defines a natural disaster as an event that is unforeseen or unexpected, which causes human suffering or distress and requires intervention or extreme assistance from national or international resources. From 1990 to 2005, there were over 16,000 natural disasters worldwide. In 2004, following the December 26th tsunami that devastated the western coast of Indonesia, the average number of people killed in a year as a result of a natural disaster peaked to nearly 250,000 (ISDR, 2006). In 2007, the Federal Emergency Management Association's (FEMA) report on disaster declarations indicated that most states in the United States requested some sort of government aid after a natural disaster. Towns, states, and even countries spend millions of dollars and a countless amount of time cleaning up after a natural disaster and rebuilding structures that were damaged or even demolished. The toll that natural disasters take on individuals, families, communities, and countries unfortunately does not stop with the death toll and the structural devastation. Central to the widespread impact of natural disasters is the significant psychological toll that natural disasters can have on individuals and families (Catherall, 2004).

The Diagnostic and Statistical Manual of Mental Disorders fourth edition revised (DSM-IV-TR, American Psychological Association [APA], 2000), categorizes natural disasters as significant traumatic stressors. Traumatic stressors involve witnessing or experiencing an event perceived as threatening to one's life or having the potential of causing injury to one's person (APA, 2000). Other traumatic stressors include, but are not limited to being imprisoned while at war, military combat, terrorist attacks, robberies or muggings, automobile accidents, or being diagnosed with a terminal illness.

The literature presents overwhelming evidence that adults, as well as children can experience a range of negative symptoms after a natural disaster (Brown, 2005; Vernberg & Vogel, 1993). It is estimated that 20 to 36% of adults and children develop Posttraumatic Stress Disorder (PTSD) after a traumatic event (Elsesser, Sartory, & Tachenberg, 2005). PTSD is the diagnosis most commonly associated and researched as a psychological consequence of trauma. The most common symptoms of PTSD are, hypervigilance, reexperiencing the traumatic event, and avoidance. The onset can be acute, lasting only a few months, or chronic lasting more than six months. While trauma survivors may display PTSD symptoms immediately following the event, a formal diagnoses of PTSD does not occur until the symptoms have persisted for one month following the disaster or traumatic experience (APA, 2000). While both children and adults can be diagnosed with PTSD, the literature suggests that their symptoms may take on very different forms. Due to children's inability to verbalize and cognitively process such traumatic events as a disaster, research suggests that symptoms of PSTD may be more difficult to recognize in children and may be displayed through repetitive traumatic

play, enactment of the traumatic event, or through drawings (La Greca, Silverman, Vernberg, & Roberts, 2002).

Differential Diagnosis

When assessing the psychological impact of trauma after natural disaster, it is important to differentiate PTSD symptoms from other possible diagnoses. Survivors of natural disasters can also develop Acute Stress Disorder (ASD), Separation Anxiety, and Depression (Brown, 2005; Elsesser et al., 2005). Some of the literature suggests that ASD is a strong predictor of PTSD (Classen, Koopman, Hales, & Spiegel, 1998). In a study of 92 accident survivors, Harvey and Bryant (1998) found that 78% of individuals who had been diagnosed with ASD within one month after the accident met the full criteria for PTSD at a six month follow-up. In a follow-up study conducted two years later, 63% of those originally diagnosed with ASD, 70% of individuals who had originally had subclinical levels of ASD, and 13% of individuals who had not originally experienced any negative symptoms met the criteria for PTSD (Harvey & Bryant, 1999). In addition, this study found that depersonalization and numbing were key risk factors for the development of PTSD. The authors suggested that the ASD symptoms of depersonalization and numbing may prevent individuals from reaching out to family and friends for support, further perpetuating PTSD symptoms (Harvey & Bryant, 1999). This systemic hypothesis regarding the development of PTSD is supported by Catherall (2004), who suggested that PTSD symptoms could prevent individuals from seeking the social support or help that they need to recover after such a traumatic event.

The Difficulty of Identifying the Impact of Natural Disasters

While the full impact that natural disasters have on individuals can seldom be predicted or foreseen, current research has identified some common risk factors for negative psychological outcomes after a traumatic event. Gender, ethnicity, length of exposure, proximity to exposure, and individual characteristics such as coping styles have been seen throughout the literature as mediators to the development of psychological symptoms after a disaster (Mercuri & Angelique, 2004; La Greca, Silverman, Vernberg, & Prinstein, 1996).

While gender and ethnicity are the most commonly reported individual risk factors seen in the literature there is much debate throughout the literature on whether risk factors can even be assessed (Olff, Langeland, Draijer, & Gersons, 2007). In a study looking at survivors of a flood in Poland, Bokszczanin (2007) reported a significant relationship between gender and PTSD symptoms, with women meeting full criteria for PTSD significantly more than men. In this study of 533 participants, age was also seen as a significant risk factor for PTSD. Risk factors associated with ethnicity are debated in the literature and the literature in this area is very limited. A meta analysis including the results of 77 articles with a overall samples size of over 1149 participants, examined individual risk factors for PTSD in adults who were exposed to some sort of trauma (Brewin, Andrews, & Valentine, 2000). While the authors did identify race, social support, and gender to be moderate predictors of PTSD across all studies, they concluded that due to the enormous differences between individuals, it is unrealistic to suggest that researchers can predict PTSD. The authors caution that in addition to the primary individual predictors listed, age, education, previous trauma experience, childhood

experiences (especially adverse experiences as a child), and family psychiatric history are also commonly significant factors (Brewin et al., 2000).

Negative coping mechanisms and coping strategies are also discussed as possible risk factors for negative psychological outcomes after a traumatic stressor. Little, Axford, and Morpeth (2004) defined coping as “a response to demands appraised by an individual as taxing or exceeding their available resources” (p. 110). Some individuals cope with the trauma from natural disasters in positive ways by problem solving and dealing with their emotions, while other individuals cope in negative ways through disengaging from the situation and cutting off from social support available to them (Wadsworth, Faviv, Compas, & Connor-Smith, 2005).

Current research suggests that natural disasters can have far-reaching effects on individual lives. While some risk factors have been identified, literature suggests that individuals react to the trauma of disasters in many different ways (Brewin et al., 2000). However, the outcomes do not always have to be negative. While many individuals do develop lasting mental problems, the majority of individuals go on to live healthy, well-adjusted lives (Patterson, 2002). In a study on mental illness and suicidality after hurricane Katrina, Kessler et al. (2008) found that only 14.9% out of 815 individuals presented with PTSD. At a five and eight month follow-up, only 20.9% of individuals met full criteria for PTSD. While this is a significant amount, this research demonstrates that the majority of people who experience a natural disaster do not develop lasting negative effects (Kessler et al., 2008). Research on posttraumatic growth and resiliency explore these positive outcomes after a traumatic event.

Positive Outcomes, Posttraumatic Growth and Resiliency

While natural disasters can have many negative effects on individuals, some people find that these types of traumatic experiences can have a positive impact on their lives (Tedeschi & Calhoun, 1995). Research on posttraumatic growth and resilience suggest that some people can live through overwhelming and traumatic experiences and come out on the other side well-adjusted, and perhaps stronger (Tedeschi & Calhoun, 1995). Tedeschi and Calhoun (2004) describe posttraumatic growth as, "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (p.1). The idea that individuals can live through a traumatic experience such as a natural disaster and come out on the other side with psychological gains has transformed the research on trauma (Walsh, 2003). Instead of concentrating on negative psychological outcomes, more recent research on posttraumatic growth has begun to look at the positive exceptions.

Powell, Rosner, Butollo, Tedeschi, and Calhoun (2003) identify three common factors of posttraumatic growth: 1) changes in self and having positive life attitudes, 2) changes in philosophy of life, and 3) changes in relating to other people. Some research argues that people who experience posttraumatic growth do not actually have less distress or negative symptoms during or after a traumatic event, but that individuals who do experience positive posttraumatic change create a meaning of the experience that leads them to eventually see positive outcomes of the experience (Hobfoll et al., 2007). The concept of meaning making following the traumatic event is similar to a key component identified within the literature on family resilience.

Resilience is another theory of how individuals go on to prosper in their lives after a disaster. Resilience is defined as "… key processes over time that foster the ability to struggle well, surmount obstacles, and go on to live and love fully" (Walsh, 2003, p. 1). Resiliency research originally began by exploring and identifying personality and environmental characteristics in individuals who experienced positive outcomes following a traumatic event. Werner (1989) pioneered this area of research by conducting a 40-year longitudinal study looking at resiliency factors in children who experienced long exposure to trauma. One of the key findings of this research suggests that individuals who experienced resiliency often have a close parent, friend, or family member who they can talk to and rely on for support (Llabre & Hadi, 1997; Watanbe et al., 2004).

The Importance of Social Support

Social support can have a huge impact on recovery for the individual who experienced the trauma after a natural disaster. Research has suggested that strong ties to a marital relationship, family, friends, neighbors, churches, or communities can serve to buffer for the trauma survivor (Catherall, 2004). Much of the literature on disasters and other traumatic events suggest that social support is a key factor in individuals' and families' coping that can lead to resilience or posttraumatic growth after a disaster (Werner, 1989).

Current literature looks at the impact of social support in three ways: 1) as a direct link between negative outcomes of a traumatic event and positive outcomes, 2) as a mediator serving as an important link between negative outcomes after a traumatic event and positive outcomes, and 3) as a moderator where social support is viewed as a

“buffer” for negative and positive outcomes (Llabre & Hadi, 1997). Studies like that of Watanabe et al. (2004) have looked at social support as a critical link between negative and positive outcomes after a disaster. In a study of 54 individuals who lived through the Chi-Chi, Taiwan earthquake in 1999, Watanabe et al. found that social support from immediate family members, extended family members, neighbors, and the community related negatively to levels of depressive symptoms 6 and 12 months following the disaster. In a longitudinal study exploring the impact of three types of social support among 222 survivors of a severe flood, Kaniasty and Norris (1993) found that people with non kin support had significantly less negative symptoms after the flood then individuals with the other types of support. The three types of social support explored were support from kin, non kin, and other social systems such as communities, churches and neighborhoods.

Whether it comes as a mediator or a moderator, the literature suggests that social support has a significant effect on outcomes after a natural disaster (Llabre & Hadi, 1997). Individuals who experience positive or effective social support are generally able to cope better with the trauma, and are therefore more likely to experience fewer negative effects after the trauma (Kaniasty & Norris, 1993; La Greca, Silverman, Vernberg, & Prinstein, 1996).

Family Dynamics and Trauma

To this point the review of the literature has primarily focused on the effects natural disasters have on the individual through lasting mental disorders, posttraumatic growth and resiliency, and social support and recovery. Although the individual experiences the natural disaster, the effects of disaster often are more widespread beyond

the individual survivor. Posttraumatic responses not only impact the individual trauma or disaster survivor, but can also impact those people in close relationships to the survivor (Figley, 1988, Radey & Figley 2007). These post-trauma family dynamics highlight the secondary effects of trauma on family members and friends.

Figley (1988) offers that many times individuals helping people who have experienced a trauma can also develop symptoms of PTSD. Secondary traumatization is a term introduced by Figley (1983), which highlights the process by which close family members, friends, or even a therapist of the individual trauma survivor can be indirectly traumatized by the disaster or traumatic event (Carbonell & Figley, 1996). The symptoms that traumatized individuals face, coupled with the secondary traumatization of family members and friends can undoubtedly cause the family support systems to be strained (Catherall, 2004; Figley, 2008). With the individual suffering and family suffering, often times family members withdraw from the family system and are left to deal with the traumatic event alone (Catherall, 2004).

While secondary traumatization does not always occur, systems theory offers another explanation of how family dynamics play a part in the recovery process after a traumatic event. This idea of the "ripple effect" that trauma and disasters may have on families is the core of systems theory. Walsh (2003) suggests that "serious crises and persistent adversity have an impact on the whole family. These stresses can derail the functioning of a family system, with ripple effects to all members and their relationships" (p. 15). As a founding father in the field of family systems theory, Gregory Bateson asked the following questions in

one of his essays, “How do ideas interact” and “What are the necessary conditions for stability (or survival) of such a system or subsystem” (Bateson, 1971, p. vviii). Bateson was describing was the idea that people do not act independently of each other but rather interdependently upon each other (Bateson, 1971; Phillips, 1981). General systems theory assumes that it is not a single event or person which causes an outcome, but the interaction of all the part of the system which leads to the system changing or recovering after a traumatic event (Phillips, 1981).

In general systems theory, wholeness is described as the whole being greater than the sum of its parts. In other words individuals in the family come together to create a bigger and greater whole as a family system, than when evaluated or considered in isolation as individuals (Phillips, 1981). This holistic approach is an important concept when working with individuals after disasters. Since the literature identifies the importance of social support and family support as protective factors to negative psychological distress, it is important to note the important role that families play in the recovery process after a traumatic event (Patterson, 2002; Walsh, 2003; Walsh, 1996). Family resilience is a concept which addresses the systemic nature of disaster recovery and addresses the process that families go through after a traumatic which can lead to recovery.

Family Resilience

The concept of family resilience is based on the assumption that although it may be an individual who experiences the trauma, the family is an integral part of the recovery and ongoing symptomology for the individual and the family system (Patterson, 2002). This role that the family plays in the positive outcome

of the individual within the family system is the definition of family resilience (Patterson, 2002; Walsh, 1996; 2003). There are two key family protective factors and processes that the literature has talked about in length, meaning and adaptation. Meaning is the definition the family gives to the risk or crisis (Walsh, 1996). By defining their situation and putting meaning to it, families are potentially accessing their stance as a family, communicating, collaborating together (becoming cohesive), assessing their resources, and determining a course of action. Meaning can be affected by many different things, such as the family's beliefs, values, spirituality, and available community resources (Walsh, 1996). By coming to a collaborative definition or meaning of the situation families can also be forming more cohesion or becoming a more enmeshed unit (Hawley & DeHaan, 1996).

Patterson (2002) suggests that family meaning and appraisals of the situation work together to create a pattern towards family adaptation. As the Chinese explain crisis in their pictographs, the experience of a crisis also brings about opportunity (Walsh, 1996). This opportunity from trauma and disaster is for change; and family adaptation is this change (Walsh, 1996). Crisis brings about the process of change through meaning, protective factors, collaborating, and coping skills. Either a family does it in a healthy way, increasing the likelihood of resilience, or an unhealthy way, leading towards dysfunction.

Why MFTs are Uniquely Qualified to Work in Trauma

As just examined, the literature suggests the effects of a natural disaster reach far beyond the individual who experienced the trauma and that the family

system plays an essential role in recovery after a natural disaster (Figley, 1983). MFT is a mental health profession focusing on families and family interaction or dynamics in a therapeutic manner (Pinsof & Wynne, 1995). While many mental health professionals, including counselors, clinical psychologists, and social workers primarily focus on the individual in therapy, the field of MFT offers a different perspective incorporating not only the individual but the entire family system. Contrary to other mental health professionals, MFTs are trained in systems theory which, as mentioned previously, suggests that it is the interactions of individuals within the family system which causes change or leads to recovery (Phillips, 1981). Because of this systemic focus, MFTs have an opportunity to incorporate and utilize the literature on social support and family dynamics in therapy by working with multiple people in the therapy room. Regarding natural disasters, MFTs have training which would allow them to not only work with the individual victim but any family member or friend that is part of that individual's life and therefore an essential part of their recovery and change. Figley, a leader in the field of traumatology suggests that because of the incorporation of social networks to the therapeutic process, family therapy is an essential part of the recovery after a traumatic event (Figley, 2008).

Along with their unique systemic framework, the MFT field has been validated throughout the literature as an effective catalyst for therapeutic change. In 1995, the Journal of Marital and Family Therapy published a series of articles on the effectiveness of MFT as a mental health field (Pinsof & Wynne, 1995). These articles highlighted a wide variety of mental health issues for which MFT

has been empirically supported as an effective treatment as in the treatment of families dealing with schizophrenia (Goldstein & Miklowitz, 1995), affective disorders, such as depression (Prince & Jacobson, 1995), behavioral disorders, such as attention-deficit disorders and anxiety disorders (Estrada & Pinsof, 1995), conduct disorders or delinquency seen in adolescents (Chamberlain & Rosicky, 1995), alcoholism and drug abuse (Edwards & Steinglass, 1995; Liddle & Dakof, 1995), physical illness (Campbell & Patterson, 1995), and marital conflict and divorce (Bray & Jouriles, 1995; Cambell, 1997; Pinsof & Wynne, 1995).

Since this journal series, the field of MFT has been shown through research to be effective in the treatment of other areas such as couple's treatment when there couple distress exists. Shadish and Baldwin (2003) conducted a meta analysis exploring the overall effectiveness of couples therapy compared to control groups (no therapy). Results indicated that at termination, couples receiving couples therapy reported more positive results then 80% of the couples in the control group. Researchers indicated little differences in effectiveness of treatment when controlling for different family therapy models used. At a six month follow up, Shadish and Baldwin (2003) reported a small amount of reduction in satisfaction but positive effects where still significant. In a second study, Shadish and Baldwin (2005) reported a 72% effectiveness rate compared to control groups. Of couples in the treatment group, 40-50% reported improvement at termination. In their concluding remarks, Shadish and Baldwin (2003) stated that the results of their meta-analysis clearly showed that MFT is an empirically supported field and clearly works for a multitude of different couple problems.

While MFTs have been shown to be effective in the above areas, there is no empirically based research supporting their effectiveness to work with survivors of natural disasters.

Regarding their training, MFT training programs help diversify their students by offering an array of classes. Along with systems theory, MFTs who graduate from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) are required to take a wide range of courses. COAMFTE is the accreditation board for the training in Marriage and Family Therapy. Programs that are COAMFTE accredited fall under set guidelines and undergo extensive internal and external evaluation. Accreditation standards are set by a national consensus from professionals in the Marriage and Family Therapy field (American Association for Marriage and Family Therapy [AAMFT], 2005). One of the areas in which educational institutions have to meet accreditation standards is academic courses offered. COAMFTE accredited Marriage and Family Therapy programs offer a wide range of courses including but not limited to: diversity issues; theoretical knowledge of family therapy and empirical foundations; family therapy models; psychopharmacology from a systemic perspective; sex therapy, violence, addictions and abuse; development across the lifespan; ethics; and research methods and statistics (AAMFT, 2005). While some individuals who work in this area will seek out additional training, the accreditation requirements for MFTs do not require them to receive any specific training on trauma or natural disasters.

Family Based Interventions for Natural Disasters

While training in systems theory and incorporating the family system into the therapeutic process makes MFTs uniquely qualified to work with this population of natural disaster survivors, there is a lack of empirically based family interventions to support MFT work in the area of trauma (Figley, 2008). Different trauma models cited throughout the MFT literature include: a contextual model, a family crisis intervention model, a group model, object relations couple therapy, emotionally focused couples therapy, critical interactions therapy, and cognitive behavioral therapy (Catherall, 2004; Figley, 2008). While these interventions are being developed and used, there is no empirically based research to suggest their effectiveness.

Figley's (2008) research in traumatology speaks to the lack of empirically based family interventions (Figley, 2008). Figley suggests that there are family-based treatments for trauma but a lack of support that would suggest their effectiveness. While Figley suggests that often times a systemic treatment is more effective for children, there is no empirically based research to support this. Figley suggests the need for more research in this area so practitioners can be confident on what types of treatments are working and what are not.

Summary of the Literature

The effects of a natural disaster can be far reaching not only to the individual who experienced the traumatic event but to their loved ones (Catherall, 2004). The literature suggests that not only can individuals experience symptoms of PTSD but so family and friends through secondary traumatization (Figley,

1983). The literature also suggest that the family dynamics that take place after a natural disaster can be a deterrent to healthy social support which has been seen as an essential part of positive recovery after a natural disaster (Figley, 1988; Walsh, 2003). While many researchers in the field of traumatology suggest that MFTs are uniquely qualified to work with this population of trauma survivors because of their incorporation of the family into therapy, the lack of empirically based research on family based trauma therapy models, lack of empirically based research on MFTs effectiveness to work with this population, and the lack of specific training in this area puts into question MFTs preparedness to work with this population of natural disaster survivors.

The Current Study

The present study is a baseline exploratory study examining whether MFT students and professional perceive themselves as prepared to work in the disaster mental health field. After reviewing the literature it is clear that while research supports a family based model of treatment, the lack of empirically based family interventions and research on MFTs effectiveness in this area, and the lack of specific training in trauma could leave MFTs feeling less than prepared to work with these individuals. While the literature suggested this question, there is no literature in this area to suggest that MFTs feel prepared or unprepared to work with this population of disaster trauma survivors. This baseline study hopes to bridge this gap in the literature by exploring MFTs natural disaster perceived preparedness (NDPP).

Research Questions:

1. How prepared do MFT students and professionals perceive themselves to be to work with individuals who have experienced a natural disaster from the training they received or are receiving in their training programs?
2. How do personal and professional demographic variables impact MFTs NDPP?

Primary Hypotheses:

1. MFT professionals will report low NDPP.
2. MFT students will report lower NDPP than MFT professionals.
3. MFTs with more clinical experience will report higher NDPP than MFTs with less clinical experience.
4. MFT students or professionals with personal trauma history will report higher NDPP than MFTs without personal experience with trauma.

CHAPTER III

METHODOLOGY

Procedure

The purpose of the exploratory baseline study was to examine MFTs NDPP. Specifically, the researcher hoped to identify whether MFTs feel prepared to work in the disaster mental health field and what, if any, factors influence perceived preparedness. In designing the methodology for this research, a mixed methodology approach, combining both quantitative and qualitative measures was chosen. The study was conducted using an online survey method.

Human Subjects Procedures-IRB

Prior to the initiation of the current study, approval was sought and obtained from the Institutional Review Board (IRB) at Oklahoma State University to assure that the welfare and rights of human subjects were being protected. A copy of the first three sections of the research project along with a copy of the voluntary consent form and the IRB application was submitted to the board. The committee also reviewed the online survey located on SurveyMonkey. IRB approval was gained on October 8, 2008 (see Appendix A).

Participant Recruitment

The volunteer sample for the current study was derived over a 2-week period among current students and graduates of five COAMFTE accredited MFT programs throughout the Midwest: Oklahoma State University, Texas Tech University, Michigan State University, Kansas State University, and Saint Louis University. In order to obtain the desired sample of participants, MFT program directors and administrators at six MFT programs were briefly informed of the procedures and purpose of the current study by email. These emails resulted in five primary recruitment sites who agreed to assist with the current study. Potential participants were briefly informed of the study, sent a link to access the online survey, and provided an explanation of voluntary consent via an email from the PI, which was forwarded on by their perspective MFT graduate program director or administrator. A total volunteer sample of 46 participants began participation in the study. Two participants chose to end the research protocol before completion, resulting in a total sample of 44 participants.

Voluntary Consent

Voluntary consent (see Appendix B) was obtained by the subjects choosing to complete the online survey via the link sent to them through an email. The email sent to participants and the voluntary consent form found on the first page of the survey explained their right to refuse to participate in the study and their right to exit the study at any time. Recruited participants were informed that the study includes a number of questions about their past life experiences, specifically previous difficult or traumatic events.

Demographic Questionnaire and Measures

Participants who accessed the online survey were asked to respond to a list of questions (see Appendix C). The purpose of these questions was to gather demographic data used to describe the sample. The first section of the online questionnaire consisted of basic demographic information, including age, gender, race/ethnicity, education, occupation, and general information regarding the participants' profession as an MFT, such as training background and years of clinical experience.

In addition to the demographic data, participants were also asked to complete questions regarding additional training and trauma experience. Because MFTs are not required to take a specific course on natural disasters or trauma it was deemed important to control for and assess MFTs' perceived preparedness with and without additional training in natural disasters. Additionally, because knowledge and confidence of clinical skills can increase with length of time, number of practicing years of clinical activity and licensure status (i.e., licensed MFT or not licensed MFT) were assessed.

Trauma History. To assess for each participant's personal traumatic experience, The Trauma History Questionnaire (THQ) was used (Green, 1996). The THQ is a measure that assesses a series of traumatic life events and consists of 24 questions all that can lead to an Axis I diagnosis of PTSD based on DSM-IV-TR criteria. This measure is designed to be used for both general use and clinical use. In a study of 30 participants who had a history of mental illness, Mueser et al., (2001) measured the reliability and test-retest reliability of the THQ. Interrater reliability was determined by randomly sampling 57% of the 30 baseline interviewers. Results suggest that interrater reliability of the THQ range from .76 (88% agreement) to 1.0 (100% agreement). Test-retest of the

THQ ranged from .75 (79% agreement) to .89 (97% agreement) acrossed the two testing times. Follow-up assessments for the test-retest reliability were completed two weeks after the initial interview. For the current study, the number of events the participant reported experiencing was summed, in order to obtain a total trauma exposure score.

Perceived Preparedness. The lack of training and empirically supported interventions for natural disasters and trauma has lead to this question of perceived preparedness. Perceived preparedness among MFT professionals was measured using a four-point Likert scale from 1 (very unprepared) to 4 (very prepared). Respondents were asked how prepared they perceive themselves to be to work in the disaster mental health field. The DSM-IV-TR recognizes many other types of traumas, some of which may be more common than natural disasters. Perceived preparedness among MFT professionals in working with different types of traumas derived from the DSM-IV-TR and FEMA will be assessed using the same four point Likert type scale. Professional status was determined using clinical hours. Participants, who had completed over 500 clinical hours, which is the amount of hours needed to complete a master's degree in MFT, were considered professionals in their field.

Total scale and subscale scores for perceived preparedness were calculated by computing the values taken from the four-point Likert scale. Individual score from the four-point Likert scale were summed for both natural and manmade disasters to create the two subscales. Responses were used to assess perceived preparedness on the subscales of natural disasters (NDPP) and manmade disasters (MDPP), as well as an overall scale score for disaster perceived preparedness (DPP). The total scale score for DPP range from 20-80, with higher scores indicating greater perceived preparedness and lower

scores indicating lower perceived preparedness. The subscale scores for NDPP range from 11-44, and the total scale scores for MMDPP range from 9-36. Due to the exploratory nature of the current baseline study, there are no defined cutoffs for the current scales. Rather scores were used primarily to describe the sample of MFT students and professionals.

Data Analyses

After the data were collected, SPSS (16.0) was used to analyze the data. Data were initially screened for outliers and missing data. Since less than 7% of the cases for each variable were missing, replacement procedures were used and new variables were created. Missing data were replaced with mean scores. Even though replacement procedures have limitations, it was assumed that the low percentage of missing data would have little effect on the data analysis outcome. Cronbach's alpha was computed to examine internal consistency for each of the scales. Descriptive statistics were computed in order to assess the composition of the sample.

Pearson's correlations among the predictor and outcome variables were conducted to assess the hypothesized associations among overall perceived preparedness and personal exposure to natural disasters and other traumas. The data were further analyzed to determine significant group differences between perceived preparedness and demographic variables. Basic Univariate Analysis of Variances (ANOVA) was used to determine variance between groups using demographic information and perceived preparedness (DPP).

Qualitative analysis procedures were also conducted as a secondary analysis to analyze open-ended questions. Qualitative content analysis procedures were used to first

determine themes throughout responses and then to calculate frequencies (how often themes were addressed). Content analysis procedures were conducted by 1) reading through the data to determine key words or key themes, 2) writing down phrases that go with key themes, 3) determining frequency of themes by calculating the number of times each theme was referenced in the data (Leech & Onwuegbuzie, 2007).

Qualitative content analysis is an empirically based method of analysis which not only looks at the content of the material but also differentiates between levels of content (i.e., themes) (Mayring, 2000). There are several advantages to using qualitative content analysis procedures. This method provides a way for researchers to interpret and communicate data in a reliable, empirically supported manner through a step by step method of analysis. Through this step by step method of analysis, material and themes are continuously evaluated which insure the reliability of the measure (Mayring, 2000).

The main idea of qualitative content analysis is to formulate overall concepts based on research questions and to derive themes from participants' answers. The main advantage to using content analysis is to be able to communicate qualitative data through the use of an empirically based analysis (Mayring, 2000). Therefore, qualitative content analysis procedures were chosen for use within the current study as an empirically supported approach to further analyze and communicate the differing effects on perceived preparedness that were expressed by participants in seven open-ended questions.

CHAPTER IV

RESULTS

Demographic Characteristics

The current study consisted of a total volunteer sample of 44 (n = 44) participants. Demographic data revealed that 43.2% (n = 19) were 25-29 years of age, 27.3% (n = 12) were 20-24 years of age, 20.5% (n = 9) were 30-34 years of age, 2.3% (n = 1) were 35-39 years of age, 2.3% (n = 1) were 45-49 years of age and 4.5% (n = 2) reported being 50 years of age or older. Participants were predominantly European-American (White) 86.4% (n = 38) with 2.3% (n = 1) American Indian/Alaskan native, 2.3% (n = 1) African American, and 9.1% (n =4) describing their ethnicity/race as "other." Regarding gender, 75% (n = 33) of participants were female and 25% (n = 11) were male.

In reporting the highest level of education in the field of MFT, 47.7% (n = 21) of participants where current MFT doctoral students, 18.2% (n = 8) had completed their MFT masters degree, 20.5% (n = 9) were currently clinically active second or plus year of MFT masters work, and 9.1% (n = 4) were first year masters students not yet clinically active. Of the 40 participants who were clinically active, participants reported having face to face clinical contact with clients for 15% (n = 6) 50-99 hours, 15% (n = 6) 100-299 hours, 15% (n = 6) 300-499 hours, 25% (n = 10) 500-1499 hours, 15% (n = 6) 1500-3000

hours and 15% (*n*= 6) 3000 plus hours. Regarding clinical hours working with trauma victims, 70% (*n* = 28) reported that the majority of their hours were not spent working with victims of trauma and 30% (*n* = 12) reported the majority of their hours were spent working with victims of trauma. Of the 40 participants who indicated that they were practicing clinicians, 47.5% (*n* =19) indicated they were currently working in a university run training facility or practicum site, 12.5% (*n* =5) reported they were currently working in a non/not for profit setting, 12.5% (*n* =5) reported they were currently working in multiple settings, 7.5% (*n* =3) reported they were currently working in an agency setting, 7.5% (*n* =3) reported they were currently working in an employee assistant program (EAP), 5% (*n* =2) reported their current work setting as "other" and 2.5% (*n* =1) reported they were currently working in a private practice. When asked about their current occupational title participants reported working as research assistants, family counseling interns, assistant directors of counseling and career developments services, behavioral health coordinators, EAP therapists, medical family therapists, substance abuse counselors, program facilitators, child and family counselors, family therapists, clinical supervisors, instructors, and clinic coordinators.

In regard to MFT licensure, a majority of participants (56.8%, *n* = 25) reported that they are not currently licensed as MFTs, 22.7% (*n* = 10) reported they are currently applying for licensure, and 20.5% (*n* = 9) reported that they were currently licensed as MFTs. Among the nine participants currently licensed 4.5% (*n* = 2) reported that they had been licensed for 0 to 6 months, 4.5% (*n* = 2) reported being licensed for 7 months to one year, and 11.4% (*n* = 5) reported being licensed for 2 to 3 years. Of the 44 participants, 9 (20.5%) reported currently holding a mental health license other than MFT, which

included Licensed Professional Counselors (LPC; 18.2%, *n* = 8) and Licensed Masters in Social Work (LMSW; 2.3%, *n* = 1). Of the 44 participants, a majority (75%, *n* = 33) reported that they were currently registered members of the American Association for Marriage and Family Therapy (AAMFT) and their state division of AAMFT.

Regarding their training to work with natural disasters, 54.5% (*n* = 24) reported having no formal training in this area, 13.6% (*n* = 6) reported attending a seminar or workshop on natural disasters, 11.4% (*n* = 5) reported having an academic class devoted to trauma as part of MFT training, 11.4% (*n* = 5) reported having other academic training outside of their MFT training program, and 9.1% (*n* = 4) reported having other nonacademic training. When asked to describe in detail the amount of training they received in their MFT training programs on natural disasters, participants predominantly (52.3%, *n* =23) reported having no specific training on natural disasters in their training program. Only 2 participants (4.5%, *n* = 2) reported having had an entire class devoted to natural disasters, while 8 participants (18.2%, *n* = 8) reported having one or more class periods devoted to the subject and 6 participants (13.6%, *n* = 6) reported only touching briefly on the subject during a class. Results for trauma training were similar. Participants predominantly (45.5%, *n* = 20) reported having no training on trauma in their training programs, 12 participants (27.3%, *n* = 12) reported having some sort of class discussion on trauma or several class periods, 8 participants (18.2%, *n* = 8) reported having an entire class devoted to trauma, and 1 participant (2.3%, *n* = 1) reported having an internship during their training program that focused on trauma. One additional participant (2.3%, *n* = 1) reported gaining research experience on the subject of trauma during MFT training.

In reporting previous work with natural disasters, a majority (84.1%, n = 37) reported no previous provision of mental health services following a natural disaster and 14% (n = 6) reported providing mental health services after a natural disaster. Of those that indicated having provided mental health services after a natural disaster, 4.5% (n = 2) reported providing 1 to 2 weeks, 2.3% (n = 1) reported providing 2 to 3 weeks, and 2.3% (n = 1) reported providing 3 to 4 weeks of mental health services at a particular natural disaster. Participants reported providing an array of services while working with survivors after a natural disaster. Participants reported providing specific services, including individual (2.3%, n = 1), 2.3% (n = 1) marriage and family therapy (2.3%, n = 1), and multiple services (6.8%, n = 3) including individual, family and shelter related mental health work. When asked about being certified as a red cross mental health care provider, a majority of participants (93.4%, n = 41) indicated that they were not certified, with only 1 participant (2.3%) indicating they were red cross certified, and 1 participant (2.3%) indicating they were currently applying for certification.

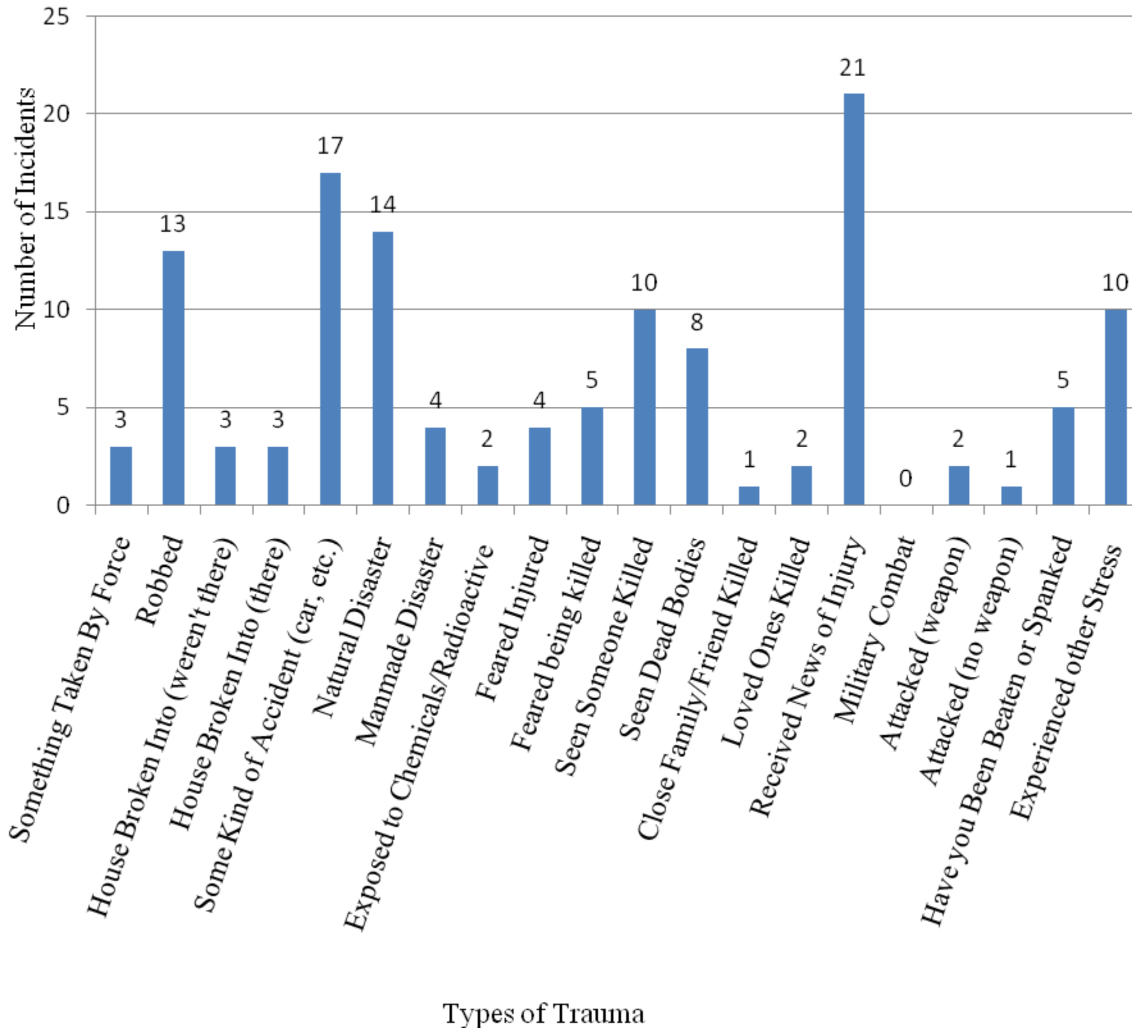
Trauma History Characteristics

In reporting trauma history on the THQ, 36 (81.8%) participants reported a previous trauma experience. In describing the specific trauma experience, 14 (31.8%) participants indicated having directly experienced at least one natural disaster. A total of 4 (9.1%) participants indicated having directly experienced at least one manmade disaster trauma. Specific trauma history data are reported in Figure 1.

Descriptive Statistics of Study Measures

It was hypothesized that MFT professionals would report low NDPP. For the purpose of the current study, professional status was determined by total clinical hours

*Figure 1.*Total number of participants reporting specific traumas on the THQ.



reported. Participant who had completed more than 500 clinical hours were considered professionals. In the current sample, 22 of the 44 participants reported over 500 clinical hours. Descriptive statistics revealed that 68.2% (n = 15) of participants were female and 31.8% (n = 7) were male. In regard to age, 54.5% (n = 12) of participants were 25-29 years old, 31.8% (n = 7) were 30-34, one was 20-24, one was 35-39, and one was 50 plus years old. In reporting ethnicity, 86.4% (n = 19) were European-American (white), 9.1% (n = 2) identified themselves as "other", and 4.5% (n = 1) indicated American Indian/Alaskan Native. Individual perceived preparedness scores for professionals were compiled and summed to create an overall DPP scale and two subscales, NDPP and MMDPP.

On average, professionals indicated the highest perceived preparedness for the individual natural disaster of tornado (M = 2.80, SD = .67, *Range* = 1-4) and the lowest for mudslides, avalanches, volcanoes and tsunamis (M = 2.32, SD = .84 and .78 for tsunami, *Range* = 1-4). Among items on the MMDPP, professionals indicated the highest perceived preparedness for the individual manmade disaster of automobile accidents (M = 3.0, SD = *.44, Range* = 1-4) and the lowest for terrorist attacks (M = 2.5, SD = .44, *Range* = 1-4). Based on these means taken from the individual disasters and the overall scale scores, results indicate that MFT professionals generally feel unprepared to work with natural disasters and manmade disasters. Thus hypothesis one was supported. The only disaster professionals reported feeling prepared to work with was automobile accidents.

Table 1

MFT Professionals Perceived Preparedness to Work with Natural Disasters: NDPP

Type of Natural Disaster	*M (SD)*	*Range*
Tornadoes	2.80 (.67)	1-4
Hurricanes	2.64 (.66)	1-4
Mudslides	2.32 (.84)	1-4
Avalanche	2.32 (.84)	1-4
Volcano	2.32 (.84)	1-4
Tsunami	2.32 (.78)	1-4
Flood	2.70 (.78)	1-4
Earthquake	2.36 (.80)	1-4
Wildfire	2.36 (.79)	1-4
Blizzard	2.41 (.85)	1-4
Drought	2.45 (.80)	1-4

Table 2

Perceived Preparedness to Work with Manmade Disasters: MMDPP

Type of Natural Disaster	*M (SD)*	*Range*
Automobile Accident	3.0 (.44)	1-4
Terrorist Attack	2.5 (.86)	1-4
Bombings	2.6 (.85)	1-4
Building Collapse	2.55 (.8)	1-4
Shooting	2.68 (.73)	1-4
Plane Crash	2.52 (.73)	1-4
War Combat	2.95 (.84)	1-4
Bridge Collapse	2.59 (.73)	1-4
Robberies	2.77 (.69)	1-4

Table 3

Descriptive Statistics for DPP, NDPP and MMDPP

	Mean (SD)	*Range*
DPP	51.13 (12.1)	26-80
NDPP	26.98 (7.39)	11-44
MMDPP	24.15 (5.37)	12-36

Correlations

It was hypothesized that personal trauma history would be significantly related to perceived preparedness. Pearson's correlations were calculated to determine significant relationships between personal trauma history and perceived preparedness. No significant relationships were found between personal trauma history and perceived preparedness to work with natural disasters or manmade disasters. Thus, Hypothesis four was not supported.

Univariate Analyses of Variance

Two separate ANOVAs were conducted to determine group differences on perceived preparedness among the 40 clinically active participants in the sample based on level of MFT training, hours of clinical experience, and licensure status.

It was hypothesized that MFT students would report lower DPP then MFT professionals. Professional status was determined by using level of MFT training. Participants who had completed a master's degree were considered professionals in their field. An initial ANOVA was conducted to determine group differences on disaster perceived preparedness based on level of MFT education. Participants who were clinically active (n = 40) were classified into three groups for analysis: 1) Second year or higher masters student (22.5%, n = 9), 2) completed masters degree (20%, n = 8), 3) current doctoral student (52.5%, n = 21), and 4) completed doctoral degree (5%, n = 2). These mutually exclusive categories where defined so that each participant was classified into only one category based on the highest level of MFT education completed.

In the preliminary ANOVA, the results revealed significant differences among the four groups in perceived preparedness, F (3, 40) = 3.67, p = .02, partial η^2 = .23. Post

hoc results indicated that participants in the completed masters degree group significantly (p = .05) differed from participants in the second year or higher masters student group. Participants with a completed masters degree reported higher disaster perceived preparedness (M = 54.57, SD = 13.17) than participants who were currently in the second year of a master's program or higher (M = 40.00, SD = 13.31). Thus hypothesis two was supported.

It was also hypothesized that MFTs with more clinical experience would report higher NDPP then MFTs with less clinical experience. An additional ANOVA was conducted to determine group differences on perceived preparedness based on current number of clinical hours completed. Participants who were clinically active (n = 40) were classified into six groups for analysis: 1) 50-99 hours (15%, n = 6), 2), 100-299 hours (15%, n = 6), 3) 300-499 (15%, n = 6), 4) 500-1499 hours (25%, n = 10), 5) 1500-3000 hours (15%, n = 6), and 5) 3000 plus hours (15%, n = 6). In the preliminary ANOVA, the results revealed no significant differences among the six groups in perceived preparedness, F (5, 40) = 1.74, p = .14, partial η^2 = .20. Thus hypothesis three was not supported.

Qualitative Analyses

As a result of qualitative analyses, five predominant themes emerged from the data and within each primary theme several subthemes are indentified. The main thematic categories, themes and sub-themes based on the participants' qualitative description of their personal experiences in disaster work and training are presented below. Some themes stand alone, while others have relevant sub-themes organized around them. Table

4 provides a detailed outline of the thematic structure, illustrating all the thematic categories, themes, and sub-themes that emerged from the current study.

Category 1: Suggested Changes for Training Programs. Several themes emerged among participants' individual explanations of the trauma and disaster specific training elements they wish they would have had as a part of their MFT training programs. A predominate theme expressed by participants was a desire for more training regarding specific populations. One participant reported that it would have been beneficial to have, "more specific focus on techniques to use for specific populations rather than learning to 'think systemically and the rest is details.' Eight out of the thirty-one participants who responded to this question reported wanting more exposure to trauma or the systemic nature of trauma in their training programs. Two participants expressed being completely satisfied with the training they received from their training program.

Category 2: Natural Disaster Perceived Preparedness. After participants completed reporting their perceived preparedness to work with individual who had experienced several different types of natural disasters, those participants who indicated feeling 'very prepared' or 'very unprepared' were asked to provide explanation regarding their perceived preparedness. Sixteen participants responded to this question. Lack of specific training in natural disasters emerged as a theme reported by six participants who considered themselves to be very unprepared for natural disaster mental health work. "I

Table 4

Outline of Qualitative Thematic Structure

Category I. Suggested Changes for Training Programs

- Theme I. More training on specific populations
- Theme II. More training on MFT theories
- Theme III. More training in pharmacology
- Theme IV. Nothing more needed

Category II. Natural Disaster Perceived Preparedness

- Theme I. Lack of specific training
- Theme II. Personal and/or professional experience

Category III. Manmade Disaster Perceived Preparedness

- Theme I. Lack of specific training
- Theme II. Personal and/or professional experience

Category IV. Natural Disaster Training

- Theme I. Seminars or Workshops
- Theme II. Specific class
- Theme III. "On the job" training
- Theme IV. American Red Cross training

Category V. What Most Prepared You to Work with Natural Disasters?

- Theme I. Specific training on trauma or disasters
- Theme II. Having general knowledge
- Theme III. Systemic training
- Theme IV. "On the job" training
- Theme V. No training received affected preparedness

feel very unprepared to work with clients who have experienced some natural disasters because I do not know a lot about those specific disasters and because I have not received a lot of training on how to work with those clients," reported a MFT student.

Three participants who indicated feeling very prepared to work with victims of tornados described how their personal experience with tornados and/or previous professional work with clients who have experienced these types of disasters increased their perceived preparedness. A licensed MFT stated, "[My state] deals with tornadoes all the time and from experiences in life plus training I feel very prepared to deal with people suffering from this disaster." Subsequently five participants indicated feeling very unprepared to work with victims of a natural disaster because of their lack personal and/or previous professional work with clients who have experienced these types of disasters. Another licensed MFT reported, "Those disasters typically do not happen where I live so I don't feel as prepared to use my existing skill-set for those types of disasters."

Category 3: Manmade Disasters Perceived Preparedness. Participants were asked to comment on why they had marked "very unprepared" or "very prepared" on any of the questions regarding manmade disasters. Fifteen participants responded to this question. Themes emerging from participants' descriptions were similar to themes for natural disaster perceived preparedness. A portion of participants (n =6) described feeling as though their training in manmade disaster mental health issues was insufficient to adequately prepare them to work with this population. A licensed MFT reported, "In general, I do not feel that I've had the training to do triage counseling. I think I have the basic personal skills to calm someone but I don't think I've been trained to help someone

who has dramatically had their world changed so quickly." Another participant who had specific training in PTSD and trauma expressed that this additional training had served to increase manmade disaster perceived preparedness. Similar to the theme that emerged regarding natural disaster perceived preparedness, a theme also emerged among participants' descriptions regarding the impact of personal and/or professional experience on manmade disaster perceived preparedness. However, while two participants indicated that their own experiences with the specific disaster or their professional experiences working with survivors of a specific disaster served to heighten their preparedness to work with other victims, two other participants expressed that their lack of their own past experience or professional experiences working with survivors of a specific manmade disaster served to decrease their preparedness to provide professional mental health services for victims.

Category 4: Natural Disaster Training. Participants who reported specific natural disaster mental health training were asked to describe their training experiences. Sixteen participants responded to this question. Several participants (*n* =7) reported their training had come from seminars or workshops outside of their training programs. Many of these participants reported that these seminars were required by the agency for which they were currently working. Four participants reported having a class that covered trauma related subjects. One participant indicated this class was taken during their MFT training program, one participant indicated this class was taken in a masters of social work program and the two other participant did not specify where they took this class. However, these four participants all reported that natural disasters were not specifically covered in their trauma-focused course. Three participants reported having "on the job

training" where they learned to work with survivors of trauma through their hands on work with that population. Two participants reported having American Red Cross training specifically on natural disasters.

Category 5: What Most Prepared You to Work with Natural Disasters? Participants were asked to describe the parts of their training they believe had most prepared them to work with natural disasters. Of the 31 participants who responded, 9 described special trainings, classes or workshops specifically on trauma or disasters as most beneficial. Several other participants (n =7) reported that gaining a general knowledge about trauma and the effects of trauma, such as what clients needs are, normative reactions to trauma, how to recognize trauma or PTSD, and hearing how others provide services to this population had been most helpful to them. Five participants reported that MFT specific systemic training most prepared them to work with this population. A participant who currently works at an EAP stated, "I had no formal training for natural disasters, and yet, I am confident that I could be of some assistance to people who are dealing with this stressor due to the flexibility of MFT". Other participants also described how their systemic training allows them to look at the effects on the entire family system. Four participants described how their on the job training and work with this population had most prepared them to work with this population and five participants reported that no training they received in their training programs prepared them to work with this population of disaster trauma survivors.

CHAPTER V

DISCUSSION

The purpose of the current baseline exploratory study was to examine MFTs perceived preparedness to work in the disaster mental health field. Research in the field of traumatology suggests that there are many factors that affect recovery after a traumatic event or natural disaster (Conran, 2006). While researchers have implied that MFTs would be uniquely qualified to work in the area of traumatology due to the systemic nature of recovery, there has been no research exploring whether MFTs are qualified to work with this population or whether they feel prepared to work with this population (Catherall, 2004). This exploratory research hoped to identify the gap between these two separate fields, traumatology and MFT, by empirically exploring MFTs perceived preparedness to work in the disaster mental health field and other factors which might influence perceived preparedness.

Quantitative Results: MFTs Disaster Perceived Preparedness

The results of this study suggest that professionals in the field of MFT feel generally unprepared to work in the disaster mental health field. Besides automobile accidents, MFT professionals felt unprepared to work with both manmade and natural disasters. Literature in the field of disaster mental health suggests that the lack of empirically based research could affect preparedness (Figley, 2008). This research supports the current

This research supports the current findings by suggesting that MFTs feel unprepared to work with the disaster mental health field due to the lack of empirically based models or interventions. Shoaf and Rottman (2000) also suggest that preparedness may be affected by a lack of understanding of roles in these chaotic situations. Shoaf and Rottman suggest that with so many mental health providers entering the scene of a disaster, it is sometimes difficult for these professional to understand what their specific roles are and what services they are to provide. This literature suggests that both the lack of empirically based interventions and lack of understanding of roles could influence perceived preparedness.

Current findings also suggest that participants felt as equally unprepared to work with manmade disasters as they did with natural disasters. Natural disasters were looked at as a separate category because of the uniqueness and isolation of these events but all analyses suggested no differences between these two subcategories in terms of level of preparedness. Results also indicated that professionals or participants who had completed a master’s degree perceived themselves as more prepared to work in the disaster mental health field than participants currently working on their master’s degree. No significant differences were found between number of hours completed and perceived preparedness. These results could suggest that it is amount of training rather than amount of general professional experience which increases or decreases perceived preparedness.

Qualitative Themes: The Role of Personal Trauma Experience and Trauma Training

Qualitative analysis suggests that participants feel it would be beneficial to spend more time discussing and training students on specific populations including trauma and natural disasters. This theme immerged in several categories throughout the analysis.

Participants also expressed that in general if they were going to get specific training in trauma or natural disasters they would have to receive that training outside of their MFT training programs. This theme of training also immerges in the literature. In a study looking at the efficiency of disaster mental health after the Oklahoma City bombings, 34 mental health providers emphasized the importance of preparedness through specific training and education in disaster mental health (Norris, 2005). In a qualitative study looking MFT satisfaction with their training programs, Maggio Marcotte, Perry, and Trauax (2001) found that former students reported desiring more training on specific populations including some types of trauma.

Participants in the current study also reported that their previous personal and/or professional experiences with disaster specific populations was associated with feeling either “very unprepared” or “very prepared” to respond to specific disasters Participants had mixed feelings about how their systemic background influenced their perceived preparedness. Some MFTs suggested that their systemic training was broad enough to allow them to work with any population, while other participants suggested that there should be more of a focus on learning about specific populations, rather than focusing solely on systemic training and generalizing those skills.

Interpretation of Results

These results coupled with the quantitative results suggest that MFT professionals may feel unprepared to work in the disaster mental health field because of their lack of specific trauma or disaster focused training. Lack of training was referenced more frequently in the qualitative analyses than any other theme. Several participants also spoke to the systemic nature of their programs by suggesting that just focusing on

systems theory can either increase perceived preparedness or decrease perceived preparedness. The majority of participants who responded to the qualitative question about perceived preparedness to work with natural disasters and manmade disasters suggested that a strict focus on systems theory did not necessarily prepare them to work with specific populations.

The qualitative analysis on perceived preparedness also suggested that specific training on natural disasters may not be necessary for MFTs to feel adequately prepared to work with this population. Several participants who reported feeling very prepared stated that training in traumatology in general was enough to make them feel prepared. These findings suggest that it may be unnecessary to specifically teach classes on natural disaster, but rather training on trauma in general would be sufficient.

COAMFTE accredited MFT programs must document that they are teaching students and evaluating students on the core competencies as set forth by AAMFT. The six core competencies represent the minimum standard of knowledge that MFTs should have to practice therapy (AAMFT, 2005). Training in specific areas such as trauma and natural disasters are not part of the core competencies, rather training programs are required to teach general knowledge of domains which comprise the practice of MFT (AAMFT, 2005). The current research puts into question whether specific training on trauma should be incorporated into the core competencies. Quantitative and qualitative analyses suggest that "general knowledge" may not be sufficient in preparing MFT students and professionals to work with this population of disaster survivors. More research is needed to determine whether specific training on trauma should be added to the core competencies of MFT.

Another interesting finding in this research is that MFTs felt prepared to work with survivors of automobile accidents while reporting feeling unprepared to work with all other types of disasters. There are a couple possible explanations for this finding. Most of the natural and manmade disasters measured are rare and isolated events which the majority of MFTs will probably never encounter. Automobile accidents however, are very common and a part of every community life. Not only do MFTs have more potential to work with clients who have experienced an automobile accident, but they are much more likely to have experienced a car accident personally. This finding suggests that more research should be done to determine factors which influence perceived preparedness such as personal experiences and exposure to clientele.

The difference in perceived preparedness between the two groups of students and professionals, suggests that MFTs who have graduated have more confidence in their skills than MFTs who are currently completing their education. Another possible explanation could be that professionals in the field are getting more exposure to diverse populations and therefore feel more competent to work with various presenting problems and populations then students. This possible interpretation was supported in the qualitative analysis by participants who felt "very prepared" to work with natural disaster and manmade disasters. These participants suggested that their exposure to clientele that have experienced trauma directly increased their perceived preparedness. The qualitative analysis also suggested that many of the participants who had gotten outside training in trauma or natural disasters had received training through sources outside of their MFT training program. This may suggest that MFT professionals are more apt to seek out

further training as than current students, therefore increasing their perceived preparedness.

Regarding personal trauma history, qualitative results may suggest that rather than influencing perceived preparedness for disasters as a whole, personal trauma history only influences perceived preparedness for the specific disasters experienced. Future studies should control for these variables and look at the possible effects personal traumas may have on MFTs' ability to work with different types of disasters and also MFTs' perceived preparedness.

Strengths and Limitations to the Current Study

This study provides important exploratory information about MFTs perceived preparedness in disaster mental health work. The current study is one of the first studies to explore MFTs perceived preparedness to work in the disaster mental health field. This study opened new doors for research in this area and highlighted implications for future research.

However, a number of limitations to the current study are worthy of discussion. First, only 44 participants completed the study measures. Originally, this study was to be a national sample of licensed marriage and family therapist who were members of their individual state division of AAMFT. With 12,134 members in AAMFT, the study was intended to have a sample size of 983 participants to reach a 95% confidence rate (AAMFT, 2008). Due to restrictions from AAMFT, changes had to be made in the recruiting strategies. The low number of participants and the wide range of levels regarding practice and experience made it difficult to compare groups within the study. Although the study was designed to be an exploratory pilot study, the small sample size

limits the ability to generalize the findings. Also, participants reported a variety of personal and professional experiences (i.e., additional training, personal trauma experience), which may have contributed to perceived preparedness. More generalizable conclusions could be drawn if all participants had reported similar personal and professional experience (i.e., hours of clinical activity, training background).

As with the other measures, there are several limitations, which may have influenced the results comparing personal trauma history to perceived preparedness. Due to limitations on the study, several questions were removed from the original THQ making the questionnaire less comprehensive and less valid then the published version.

Research Implications

This study presents several implications for future research. A more diverse sample of participant regarding ethnicity and education would result in further understanding of DPP from therapists with a variety of backgrounds. Research in this area could offer further knowledge into how training programs can best prepare clinicians to work with this population. It also may be beneficial for future research to focus on specific groups of MFT students and/or professionals. The broad sample in this study made it difficult to assess and compare between groups.

Because results suggested that perceived preparedness did not differ between natural disasters and manmade disasters, future research should explore if there are differences between perceived preparedness when looking at subgroups of trauma such as natural disasters, manmade disasters, sexual assault, domestic violence, or any other area of trauma. This research could be used to inform training programs on how to best prepare MFTs to work in the field of traumatology.

Current qualitative finding suggest a relationship between personal disaster experience and DPP. Research is needed that explores the impact of specific disasters on DPP. Future work may also help in understanding the outcomes of specific trauma/disaster focused courses within MFT programs. This research could help determine what elements of each course students feel are most beneficial in preparing them to work in the field of traumatology.

Clinical Implications

While the majority of the analyses were exploratory and should be viewed with caution, there are several clinical implications regarding perceived preparedness and level of clinical practice. The major clinical implication derived from the current study seems to be that MFTs generally feel unprepared to work in the disasters mental health field and lack of training in disaster mental health seems to result in MFTs feeling unprepared. The current study suggests the need for additional training in the field of trauma and disaster within MFT training programs. While specific training on natural disasters may not be needed, most participants who reported feeling very unprepared to work with disasters reported that it was their lack of training on trauma that left them feeling as though they did not have sufficient knowledge to effectively work with this population. Participants reported that hands on training and general knowledge of the population were helpful in increasing their perceived preparedness, so training programs should look at incorporating these aspects into their training. This could be incorporated as a specific course or as part of the practicum experience.

While not supported through the quantitative research, another clinical implication derived from the qualitative research suggests that a personal experience with

trauma does affect perceived preparedness. These findings suggest that clinicians should be aware of how their own personal experiences are influencing their therapy with clients who have experienced the same disasters. Training programs can facilitate this type of 'self as a therapists' work by encouraging beginning therapists to explore who they are and how that influences their work with clients.

While this study represented a first step in this direction, more exploratory research needs to be done further exploring MFTs' disaster and trauma related perceived preparedness and effectiveness. However, due to restrictions within AAMFT, it is difficult to access a nationally representative sample of MFT professionals. Changes made within the professional association representing MFTs would allow for more access to this population for research.

Conclusion

Previous literature on the systemic effects of natural disasters and the systemic process of recovery guided the research questions and hypotheses for the current study. The analyses from this exploratory baseline study suggest that, in general, MFTs professionals feel unprepared to work with a disaster survivor population, and that clinical and educational experience may be associated with perceived preparedness. Analyses revealed that professionals who have graduated with their master's degree in MFT perceive themselves as significantly more prepared to work in the disaster mental health field then individuals who are currently working on their master's degree in MFT. Qualitative findings suggest that specific training in the field of traumatology or natural disasters may have a significant impact on MFTs preparedness.

While quantitative analyses suggest no significant differences between personal trauma experiences and perceived preparedness, qualitative analyses suggest that personal experiences do influence perceived preparedness to work with disasters. While there were many limitations to this study including sample size and confounding variables, this exploratory study may serve as a preliminary step for more advanced research in this area. Clinical implications from this research suggest that MFTs would benefit from more specific training focused on trauma and disaster populations.

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APPENDICES

APPENDIX A

Oklahoma State University Institutional Review Board

Date:	Wednesday, October 08, 2008
IRB Application No	HE0862
Proposal Title:	Perceived Preparedness to Work in the Disaster Mental Health Field
Reviewed and Processed as:	Expedited

Status Recommended by Reviewer(s): Approved Protocol Expires: 10/7/2009

Principal Investigator(s):

Lyda Fincham	Kami L. Schwerdtfeger
105 W. Golf Street	233 HES
Stillwater, OK 74075	Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

☑ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North (phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,

Shelia Kennison, Chair
Institutional Review Board

APPENDIX B

Informed Consent

VOLUNTARY CONSENT TO TAKE PART IN A RESEARCH STUDY

You are invited to take part in a research study exploring Marriage and Family Therapists perceived preparedness to work in the disaster mental health field. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information.

STUDY TITLE: Marriage and Family Therapists Perceived Preparedness to Work in the Disaster Mental Health Field

INVESTIGATOR: Lyda E. Fincham, BGS
(785)282-8778 fincham@okstate.edu

ADVISOR: Kami L. Schwerdtfeger, Ph.D.
(405)744-8351 kami.schwertfeger@okstate.edu

INSTITUTION: Oklahoma State University

PURPOSE OF THE RESEARCH:
- Learn about Marriage and Family Therapy students and professionals perceived preparedness to work in the disaster mental health field.
- Learn more about how past life experiences impact perceived preparedness to work in the disaster mental health field.
- Learn more about how Marriage and Family Therapy students and professional view their training in natural disasters from their accredited training programs.
- Identify other demographic factors that might influence perceived preparedness to work in the disaster mental health field.

WHAT WILL HAPPEN DURING THIS STUDY?
This session will take about 20-25 minutes of your time.
- You will be asked to read this voluntary consent form.
- You will then complete an online survey consisting of four sections and submit your answers online.

VOLUNTARY PARTICIPANT RIGHTS:
You were invited to participate in this study because you are a graduate or student of an accredited Marriage and Family Therapy program. Taking part in this study is your choice. You may choose not to be in the study. If you decide not to be in the study, it will not affect your standing in your MFT program. If you do, discuss it with the researcher, who will help you leave the study in the safest manner.

WHAT ARE THE RISKS/DISCOMFORTS ANTICIPATED?
Some of the questions asked will specifically deal with your personal experiences with trauma. You may feel upset thinking about these traumatic experiences. These risks are similar to those you experience when talking about personal information with others. If you feel upset while answering these questions, you can exit the questionnaire at any time. You can also contact the researchers who can inform you available resources to help. At any time you are free to stop and take a break. Potential risks include:
1) increased distress from thinking or talking about previous traumatic experiences

WHAT ARE THE BENEFITS ANTICIPATED?
We cannot promise any direct benefit for taking part in this study. However, we hope the information we get from this study may help develop a greater understanding of Marriage and Family Therapists perceived preparedness to work in the disaster mental health field. Other possible benefits include:
1) increased awareness personal experiences with trauma on perceived preparedness
2) increased awareness length of practice on perceived preparedness
3) increased awareness perceived preparedness to work with other types of traumas
HOW WILL INFORMATION ABOUT ME BE KEPT PRIVATE?
- Questionnaires will be filled out using SurveyMonkey which is a secure online survey site.
- Only the primary investigator and the committee advisor will have access to completed surveys.
- Any identifying information (ex: email addresses) will be deleted once the data have been cleaned of any duplicates.
- Study results will not use any personal identifying information.
- Should participants report undue distress as a result of participating in the study, the Oklahoma State University Institutional Review Board for the Protection of Human Subjects must be notified. This may involve sharing of anonymous responses.

PERSONS TO CONTACT:
If you have questions or need more information about this study, you can contact the researchers, Lyda E. Fincham by dialing (785)282-8778 or Kami L. Schwerdtfeger, Ph.D. by dialing (405)744-8351. If you have questions regarding your rights as a research participant, or if problems arise which you do not feel you can discuss with the Investigator, you may contact Dr. Shelia Kennison, IRB Chair, Oklahoma State University, 219 Cordell North, Stillwater, OK 74078; (405)744-1676 or irb@okstate.edu.

PARTICIPANT VOLUNTARY CONSENT:
- I understand this project is research, and that my participation is completely my choice. I also understand that if I decide

APPENDIX C

Study Questionnaire

Disaster Mental Health

Basic Demographics

1. Gender:

- Male
- Female

2. What is your age?

3. In what state do you currently reside?

4. What is your racial/cultural/ethnic origin?

- American Indian or Alaska Native
- Asian or Pacific Islander
- African-American (Black), not of Hispanic origin
- Mexican-American (Hispanic)
- European-American (White)
- Other

5. What is your highest level of education that you have completed?

- Less than one year graduate work
- One year graduate work
- Completed master's degree
- Completed doctorate

6. What is your highest level of education in MFT?

- 1st year masters student - clinically active
- 1st year masters student - not yet clinically active
- 2nd year or plus year masters student - clinically active
- Completed MS degree
- Completed some doctoral work
- Completed doctoral work

7. How many hours of MFT clinical experience do you currently have?

- ☐ less than 49 hours
- ☐ 50-99 hours
- ☐ 100-299 hours
- ☐ 300-499 hours
- ☐ 500-1499 hours
- ☐ 1500-3000 hours
- ☐ 3000 plus hours

8. Did the majority of these hours deal with individuals who were suffering with some sort of trauma?

- ☐ No
- ☐ Yes (if yes please explain below)

Please explain the nature of the population and approximately the percent of your client load with this specific population:

9. Are you a licensed Marriage and Family Therapist?

- ☐ No
- ☐ Yes (If yes specify what state below)
- ☐ Have applied/currently applying (specify what state below)
- ☐ No specific MFT license in my state

Please specify what state you are licensed in or applying for licensure in:

10. If you answered "yes" to being a licensed MFT, how long have you been licensed?

- ☐ Not licensed
- ☐ 0-6 months
- ☐ 7 months-1 year
- ☐ 2-3 years
- ☐ 4-6 years
- ☐ 7-9 years
- ☐ 10-14 years
- ☐ 15-19 years
- ☐ 20-29 years

☐ 30 plus years

11. Do you hold any other license in mental health other than MFT?

☐ No

☐ Yes (If yes specify license below)

Please specify other license:

12. Employment: (Check the one that best describes your status)

☐ Employed full-time

☐ Employed part-time

☐ Unemployed (Not disabled)

☐ Unemployed (Due to disability)

☐ Retired

☐ Full-time student

☐ Part-time student

☐ Full-time homemaker

13. How long have you been practicing Marriage and Family Therapy?

☐ 0-6 months

☐ 7 months - 1 year

☐ 2-3 years

☐ 4-6 years

☐ 7-9 years

☐ 10-14 years

☐ 15-19 years

☐ 20-30 years

☐ 30 plus years

14. What is the nature of your clinical work?

☐ practice

☐ Group practice

☐ Agency

☐ EAP

☐ Non/not for profit

☐ University run training clinic/practicum cite

☐ VA

☐ Other (if other please specify below)

Please specify if your clinical work was not listed above:

15. Check one of the following that best describes your current clinical work.

☐ Full time

☐ Part time

☐ Not clinically active

16. What is your current occupational title?

17. Are you a registered member of AAMFT?

☐ Yes (If yes specify what level below)

☐ No

Specify what type of member you are: Student, Associate, or Clinical

18. Are you a registered member of your state division of AAMFT?

☐ Yes

☐ No

19. What do you wish you had in your MFT training program that you did not have?

Perceived Preparedness

Using the scale provided, please indicate how prepared you perceive yourself to be in providing mental health services in response to each of the following events.

20. How prepared do you feel to work with individuals, couples, or families who have experienced the following natural disasters?

	very unprepared	somewhat unprepared	somewhat prepared	very prepared
1. Tsunami:				
2. Mudslide:				
3. Earthquake:				
4. Drought:				
5. Tornado:				
6. Avalanche:				
7. Wildfire:				
8. Hurricane:				
9. Blizzard:				
10. Volcano:				
11. Flood:				

If you either answered either "very unprepared" or "very prepared" on any of the above question please indicate why you feel this way:

21. How prepared do you feel you are to work with individuals, couples, or families who have experienced the following manmade disasters and traumatic stressors?

	very unprepared	somewhat unprepared	somewhat prepared	very prepared
1. War:				
2. Terrorist Attack:				
3. Plane Accident:				
4. Automobile Accident:				
5. Shooting:				
6. Robberies:				
7. Bridge Disaster:				
8. Bombing:				
9. Building Collapse:				

If you answered either "very unprepared" or "very prepared" on any of the above question please indicate why you feel this way:

Professional experience

22. What is your training regarding natural disasters or treatment of natural disasters? (If you have received training please describe below)

- ☐ No formal training
- ☐ Academic class devoted to trauma as part of MFT training
- ☐ Other academic training
- ☐ Outside training
- ☐ Seminar/Workshop

Description of Training:

23. What parts (if any) of your training do you feel most prepared you for working with natural disasters?

24. Describe the depth of training you received in your training program on natural disasters (ex: no training; 1 class period; etc.)

25. Please rank the following in regard to natural disaster training.

	Very Unsatisfactory	Unsatisfactory	Satisfactory	Very Satisfactory

1. MFT Practicum

2. Overall Program

3. Intern/Practicum Experience

4. Courses offered in MFT training Program

26. Describe the depth of training you received in your MFT training program on trauma (ex: no training; 1 class period; etc.)

27. Have you ever provided mental health services in response to a natural disaster?

☐ No

☐ Yes (if yes please list disasters below)

List disaster experience:

28. If you answered "yes" to the previous question and have worked as a mental health provider in response to a natural disaster, how long ago did this occur?

☐ N/A

☐ 0-6 months ago

☐ 1-2 years ago

☐ 3-4 years ago

☐ 5-6 years ago

☐ 7-9 years ago

☐ 10-14 years ago

☐ 15 plus years ago

29. If you have provided mental health service in response to a natural disaster, how long did you provide services?

☐ N/A

☐ 1-2 weeks

☐ 3-4 weeks

☐ 5-6 weeks

☐ 7-8 weeks

☐ 9 weeks-1 year

☐ 1-2 years

☐ 2 plus years

30. If you have provided mental health services in response to a natural disaster, what type of service did you provide?

☐ N/A

☐ Group work

☐ Individual work

☐ Shelter work

☐ Marriage or family therapy work

Other (please specify)

31. Are you currently certified as Red Cross Disaster Mental Health provider?

☐ No

☐ Yes

☐ Currently Applying

If you are certified please indicate how long you have been certified and if you have received Red Cross disaster training:

Personal Experiences

As much as you feel comfortable, please describe your personal experience with the following life events.

32. Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?

☐ No

☐ Yes (If yes please specify below)

Please identify number of times and approximate age:

33. Has anyone ever attempted to rob you or actually robbed you (i.e. stolen your personal belongings)?

☐ No

☐ Yes (If yes please specify below)

Please identify number of times and approximate age:

34. Has anyone ever attempted to or succeeded in breaking into your home when you weren't there?

☐ No

☐ Yes (If yes please specify below)

Please identify number of times and approximate age:

35. Has anyone ever tried to or succeeded in breaking into your home while you were there?

☐ No

☐ Yes (If yes please specify below)

Please identify number of times and approximate age:

36. Have you ever had a serious accident at work, in a car or somewhere else?

☐ No

☐ Yes (If yes please specify below)

Please identify type of accident, number of times and approximate age:

37. Have you ever experienced a natural disaster such as a tornado, hurricane, flood, major earthquake, etc. where you felt you or your loved ones were in danger of death or injury?

☐ No

☐ Yes (If yes please specify below)

Please specify what kind of event and identify number of times and approximate age:

38. Have you ever experienced a "man made" disaster such as a train crash, building collapse, bank robbery, fire, etc. where you felt you or your loved ones were in danger of death or injury?

☐ No

☐ Yes (If yes please specify below)

Please specify what kind of event and indentify number of times and approximate age

39. Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?

☐ No

☐ Yes (If yes please specify below)

Please specify what kind of event and indentify number of times and approximate age:

40. Have you ever been in any other situation in which you were seriously injured?

☐ No

☐ Yes (If yes please specify below)

Please identify event, number of times and approximate age:

41. Have you ever been in any other situation in which you feared you might be killed or seriously injured?

☐ No

☐ Yes (If yes please specify below)

Please specify what kind of event and indentify number of times and approximate age:

42. Have you ever seen someone seriously injured or killed?

☐ No

☐ Yes (If yes please specify below)

Please specify who and indentify number of times and approximate age:

43. Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason?

☐ No

☐ Yes (If yes please specify below)

Please describe and indentify number of times and approximate age:

44. Have you ever had a close friend or family member murdered, or killed by a drunk driver?

☐ No

☐ Yes (If so please specify relationship below)

Please specify relationship (mother, grandson, etc.), number of times and approximate age:

45. Have you ever had a spouse, romantic partner, or child die?

☐ No

☐ Yes (If yes please specify relationship below)

Please specify relationship, number of times and approximate age:

46. Have you ever received news of a serious injury or unexpected death of someone close to you?

☐ No

☐ Yes (If yes please indicate)

Please describe and identify number of times and approximate age:

47. Have you ever had to engage in combat while in military service in an official or unofficial war zone?

☐ No

☐ Yes (If yes please indicate where)

Please indicate where, number of times and approximate age:

48. Has anyone, including family members or friends, ever attacked you with a gun, knife or some other weapon?

☐ No

☐ Yes (Please specify below)

Please specify number of times and approximate age:

49. Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?

☐ No

☐ Yes (Please specify below)

Please specify number of times and approximate age:

50. Has anyone in your family ever beat, "spanked" or pushed you hard enough to cause injury?

☐ No

☐ Yes (If yes please specify below)

Please specify number of times and approximate age:

51. Have you experienced any other extraordinary stressful situation or event that is not covered above?

☐ No

☐ Yes (Please describe below)

Please indicate event, number of times experienced and approximate age:

Please submit your results and then use the address below to be entered to win one of two

$50 gift certificates to Amazon.com

Step 1: write down the address below

Step 2: submit your survey results

Step 3: type in the address to go to a separate secure site and enter your email address

(this is optional)

VITA

Lyda Elizabeth Fincham

Candidate for the Degree of

Master of Science

Thesis: A BASELINE EXPLORATORY STUDY OF MARRIAGE AND FAMILY THERAPISTS PERCIEVED PREPAREDNESS TO WORK IN THE DISASTER MENTAL HEALTH FIELD

Major Field: Human Development and Family Sciences, Specialization in Marriage and Family Therapy

Biographical:

Personal Data: Born in Pratt, Kansas, December 17, 1982, daughter of Vicki and Russell Fincham

Education: Bachelor of General Studies, The University of Kansas, May 2005

Completed the requirements for the Master of Science in Human Development and Family Sciences at Oklahoma State University, Stillwater, Oklahoma in December, 2008.

Name: Lyda Elizabeth Fincham Date of Degree: December, 2008

Institution: Oklahoma State University Location: Stillwater, Oklahoma

Title of Study: A BASELINE EXPLORATORY STUDY OF MARRIAGE AND FAMILY THERAPISTS PERCIEVED PREPAREDNESS TO WORK IN THE DISASTER MENTAL HEALTH FIELD

Pages in Study: 73 Candidate for the Degree of Master of Science

Major Field: Human Development and Family Science, Marriage and Family Therapy Specialization

Scope and Method of Study: Through the current exploratory baseline study, it was hypothesized that Marriage and Family Therapists (MFTs) would perceive themselves as unprepared to work in the disaster mental health field (Hypothesis 1). It was also hypothesized that MFT students and those with less clinical experience would perceive themselves as less prepared to work in the disaster mental health field then professional and MFTs with more clinical experience (Hypotheses 2 and 3). The final hypothesis was that those participants with personal trauma history would perceive themselves as more prepared to work in the disaster mental health field than those without personal experiences (Hypothesis 4). Perceived preparedness was measure by creating an overall disaster perceived preparedness scale. Professional status and clinical hours were measured using Univariate ANOVA. Persons correlations were computed to measure trauma history.

Findings and Conclusions: The purpose of the current exploratory baseline study was to examine the perceived preparedness of 44 current and past Marriage and Family Therapy students of COAMFTE accredited programs in working in the disaster mental health field, and to identify specific factors influencing levels of perceived preparedness. Results of the current study suggest that, in general, MFTs feel unprepared to work disaster survivors and that individual clinical activity level significantly affects perceived preparedness. Qualitative results suggest that the lack of specific training in trauma directly influences perceived preparedness. Limitations, as well as research and clinical implications are discussed.

ADVISER'S APPROVAL: Dr. Kami Schwerdtfeger