FACTORS INFLUENCING COUNSELOR SELF-EFFICACY OF MENTAL HEALTH PROFESSIONALS WORKING WITH REFUGEES AND ASYLUM SEEKERS

by

Dana Tamer Isawi

A dissertation submitted to the faculty of
The University of North Carolina at Charlotte
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in
Counseling

Charlotte

2016

Approved by:

_____
Dr. Phyllis Post

_____
Dr. Sejal Parikh Foxx

_____
Dr. Daniel Gutierrez

_____
Dr. Claudia Flowers

_____
Dr. Anita Blowers

_____
Dr. Hank Harris

ABSTRACT

DANA TAMER ISAWI. Factors influencing counselor self-efficacy of mental health professionals working with refugees and asylum seekers. (Under the direction of DR. PHYLLIS POST)

Since 1975, the United has admitted over three million refugees (U.S. Department of State, Bureau of Population, Refugees, and Migration, 2016). Mental health professionals are called upon to the psychological needs of this unique population. Nevertheless, there is limited research that focuses on factors that influence the work of therapists who work with refugees who have experienced trauma. Investigating counselor self-efficacy is a significant area of inquiry because self-efficacy may be an important determinant for effective counseling (Larson, 1998). The purpose of this research study was to examine how perceptions of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress are related to counselor self-efficacy of mental health professionals who work with refugee who have experienced trauma. The study also examined how perceptions of trauma training, experience, and percentage of traumatized clients are related to counselor self-efficacy after controlling for secondary traumatic stress.

A total of 98 participants were included in the study. The sample was recruited through contacting agencies and establishments that focused on providing mental health services to refugees and asylum seekers. The participants completed an Internet based survey which included a perceptions of trauma training scale, the Secondary Traumatic Stress Scale, the Counseling Self-Estimate Inventory, and a demographic questionnaire.

A standard multiple regression and a hierarchical multiple regression analyses were conducted to analyze the data. The standard multiple regression analysis indicated that perception of trauma training was positively related to counselor self-efficacy and secondary traumatic stress was negatively related to counselor self-efficacy. The independent variables accounted for 24% of the variance in counselor self-efficacy. The hierarchical multiple regress analysis indicated that secondary traumatic stress alone accounted for 14% of the variance in counselor self-efficacy, while all the independent variables accounted for 24% of the variance in counselor self-efficacy. The implications of the results to mental health professionals and counselor education programs are discussed. It is crucial that mental health professionals and counselor education programs consider trauma training and secondary traumatic stress as important factors that contribute to counselor self-efficacy. Future research is warranted to explore other factors that influence counselor self-efficacy of mental health professionals working with refugees who have experienced trauma.

ACKNOWLEDGMENTS

There are several individuals who have contributed to my success and without their support this work would have not been possible. To my dissertation committee, I am grateful for your support and guidance. To Dr. Phyllis Post, my chair and mentor, I am forever thankful for your continuous support, patience and guidance throughout this process. You have mentored me for several years and encouraged me to follow my passion and trust my professional judgment. Your dedication, generosity and compassion have inspired me to take risks. Thank you for sharing my passion and helping me overcome challenges. Your genuineness and care have contributed to my growth as a professional and as a person. To Dr. Sejal Parikh Foxx, I thank you for your wisdom and encouragement. Your passion for social justice is truly exemplary. Your scholarship and leadership in the counseling field are truly inspiring. To Dr. Claudia Flowers, thank you for giving your time and intellect throughout this process. You were always available and ready to help me find solutions for any problems. To Dr. Danielle Gutierrez, thank you for sharing your passion for research and providing thorough and careful feedback. I enjoyed your valuable feedback that was delivered with wittiness. Your dedication and knowledge make you an outstanding educator. To Dr. Anita Blowers, I appreciate your willingness to take on this project and for your continued support. Your feedback, questions and support contributed to the enhancement of my study.

To my wonderful parents, this accomplishment would not have been possible without you. Your endless love and support are the motivation for my accomplishments.

You have set wonderful examples for me through your tremendous accomplishments in your prospective fields. Thank you mom for you unconditional love and encouragement. Your kindness, intellect, and genuineness make you one of a kind and an incredible mother. You have always modeled altruism and generosity that are inspiring. Dad thank you for believing in me and for always setting high expectation for me. I know that you will always be there to push me for all that I am capable of. If it weren't for your constant encouragement I wouldn't have made it this far. You have raised the bar and set an example of a remarkable educator who is committed, passionate and courageous. I hope that I can only accomplish a portion of what you have accomplished. To my little sister and lifelong companion, Tala, your generosity, wisdom and compassion have given me strength and a sense of security. Thank you for always being by my side. You've always helped me overcome challenges. Without your support, this accomplishment wouldn't have been possible. Thank you for being my technology expert. To my husband, thank you for your support and the many sacrifices that you've made throughout this long journey. Your encouragement and kindness gave me strength in the face of challenges. I am grateful to have you as my partner and share this accomplishment with you. To my aunts, uncles, and cousins, thank you for being the warm and loving family that you are. You are dependable and are always there to lift me up. I am truly blessed to have all of you by my side as I fulfill my dreams.

To my UNCC professors and peers, thank you for contributing to my success through providing a conducive teaching environment and for challenging me to further expand my horizons. A long due thank you to my refugee and asylum seeking clients

who have inspired me through their resilience to pursue this research in order to better be able to serve this unique population that I hold tremendous respect for. I would also like to thank the participants of the study who provided their valuable time and expertise, without you this research wouldn't have been possible. Special thanks to the agencies and establishments that supported disseminating this study including but not limited to the following: Northern Virginia Family Services, (ACCESS) Community Health and Research Mental Health & Family Counseling Department, Boston Children's Hospital Center for Refugee Trauma and Resilience, Heartland Alliance, The Philadelphia Refugee Mental Health Collaborative, Nationalities Service Center, New England Survivors of Torture and Trauma, Utah Health and Human Rights Project, Jewish Family Service of Buffalo & Erie County, True Thao Counseling Services, Ingham Community Health Centers, Arab American and Chaldean Council, New American Services, Jewish Child and Family Services, Lutheran Immigration and Refugee Service, Center for Victims of Torture, Chaldean-Middle Eastern Social Services, Gulf Coast Jewish Family and Community Services, Office of Refugee Resettlement, Multicultural Clinical Center, Ingham Community Health Centers, Refugee and Immigrant Center-Asian Association of Utah, Utah Health and Human Rights, Trauma Recovery Center and CASARC, and State Refugee Health Coordinators.

DEDICATION

It is with great pride that I dedicate this achievement to my grandparents Rifqa and Hasan, the resilient refugees. Your resilience and determination are as strong and deep as the roots of an olive tree. Your love and wisdom have lit my path.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

Recent global political and environmental events have resulted in an unprecedented increase in refugee and asylum seeking populations who are escaping persecution, war, human rights violations or environmental disasters. By the end of 2015, the United Nations High Commissioner for Refugees (UNHCR) predicted that 63.9 million individuals were forced to flee their homes worldwide. Over 14 million refugees and 2 million asylum seekers were identified worldwide. Children younger than 18 years of age constitute half of the world's refugees. In 2014, conflict and persecution forced approximately 42,500 individuals per day to leave their homes and seek protection elsewhere either within their own country or in other countries. The ongoing war in Syria, has forced more than 4.2 million people to seek protection outside of the country and has resulted in the internal displacement of more than 7.6 million Syrians (United Nations High Commissioner for Refugees, UNHCR, 2015).

Refugees are individuals who are forced to leave their home country based on a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion" (United Nations, 1951, p. 16). This definition has been expanded to include individuals who leave their home country due to war or civil conflict (UNHCR, 2003). Asylum seekers are people

requesting refuge outside their home country while they are in the host country (UNHCR, 2009).

The United States has a longstanding history of admitting refugees of humanitarian concern. The United States offers humanitarian protection through two channels: refugee resettlement and asylum status (thereafter referred to as refugees). The Refugee Act of 1980 included the United Nations definition of refugee and provided the legal basis for standardized resettlement services for all refuges admitted to the United States (Kennedy, 1981). Since 1975, the United States has admitted over three million refugees from countries all over the world. In 2016, the United States resettled 59, 099 refugees (State Department's Worldwide Refugee Admissions Processing System, WRAPS) and in 2013 granted asylum status to 25,199 people (Martin & Yankay, 2014). In response to the recent humanitarian crisis, the United States proposed to increase the refugee admission ceiling from 70,000 in 2015 to 85,000 in 2016 and 100,000 in 2017, including increasing the number of Syrian refugees admitted to at least 10,000 for the year 2015 (U.S. Department of State, Bureau of Population, Refugees, and Migration, 2015).

Refugees and Mental Health Issues

Refugees often experience a varied and high number of traumatic incidents such as personal injury and torture, witnessing the torture and killing of others, and the separation from family members (Marshall, Schell, Elliott, Berthold, & Chun, 2005; Mollica, McInnes, Poole, & Tor, 1998). While many demonstrate incredible resilience and strength, the adverse experiences associated with migration can have a lasting

psychological impact (August & Gianola, 1987; Beiser & Hou, 2001; Bemak et al., 2003; Carlson & Rosser-Hogan, 1993; Carswell et al., 2011; Murray et al., 2010). The refugee experience is described in three stages: pre-migration, migration, and post-migration. The pre-migration stage may include physical and emotional trauma to individuals or families and the witnessing of violence. The migration stage often involves a dangerous trek that may end at refugee or detention camps where there are continued issues of safety (Bemak & Chung, 2014). Children and adolescents are often separated from their families in this stage (Lustig et al., 2004). During the post-migration process, refugees learn to navigate a new environment, while coping with the loss of their home and family (Arthur, Merali, & Djuraskovic, 2010; Bemak, Chung, & Pederson, 2003; Birman & Tran, 2008; Carswell, Blackburn, & Barker, 2011; Lustig et al., 2004; Murray, Davidson, & Schweitzer, 2010; Prendes-Lintel, 2001; Yakushko, Watson, & Thompson, 2008).

According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013), trauma's definition is "when an individual person is exposed to actual or threatened death, serious injury, or sexual violence" (American Psychiatric Association, 2013, p. 271). In their definition of trauma, McCann and Pearlman (1990) focused on the individual's reaction to an event rather than the nature of the event itself. Thus, the event is considered traumatic if the individual experiencing it views it as traumatic considering its influence on the individual's life. Traumatic events may include war, natural disasters, accidents, sexual, physical or emotional abuse, or death of a loved one. Traumatizing events can be either a single episode such as accidents or chronic experiences such as prolonged exposure to abuse or

war (Malchiodi, 2015).

The refugee experience may adversely affect mental health (Steel, et al., 2004; Robjant, Hassan, & Katona, 2009). Research findings indicate there is a relationship between trauma and mental health issues (Arthur et al., 2010; Betancourt, Newnham, Layne, Kim, Steinberg, Ellis, & Birman, 2012; Johnson & Thompson, 2008; Mollica, 2006). The common mental health diagnoses associated with refugees and war affected populations include post-traumatic stress disorder (PTSD) (Bemak et al., 2003; Murray et al., 2010; Renner, Banninger-Huber, & Peltzer, 2011), major depression (Higson-Smith, 2013), generalized anxiety, panic attacks, adjustment disorder, and somatization (Johnson & Thompson, 2008; Marshall et al., 2005; Mollica, et al., 1998; Turner, Bowie, Dunn, Shapo, & Yule, 2003). Refugees are more likely to have PTSD than the general population (Fazel, Wheeler, & Danesh, 2005). Symptoms of PTSD in DSM-5 include recurrent involuntary and intrusive memories of the trauma, flashbacks and re-experiencing of the traumatic event, inability to recall significant features of the trauma, and impaired concentration (American Psychiatric Association, 2013). Studies have reported rates of PTSD prevalence among refugees to range from 20-74% and major depression to range from 39-64%, (Carswell et al., 2011; Gerritsen et al., 2006; Johnson & Thompson, 2008; Laban, Gernaat, Komproe, van der Tweel, & De Jong, 2005; Mares & Jureidini, 2004; McColl & Johnson, 2006; Steel et al., 2009; Sieberer, Ziegenbein, Eckhardt, Machleidt, & Calliess, 2011). Nevertheless, rates typically vary depending on variables such as the severity and chronicity of traumatic events encountered in the home country or during migration (Bhugra & Becker, 2005).

Mental health professionals such as counselors, psychologists, social workers, and school counselors (hereafter referred to as therapists) might be the first respondents to the mental health needs of refugees (Marotta, 2003). Work with refugees fall under the ethical mandate for developing cultural competence. Specialized psychological interventions by qualified mental health professionals are necessary to respond to the needs of this population (Bemak & Chung, 2014). The majority of the studies that have been conducted focus specifically on client factors and psychological interventions. Since therapists are called upon to meet the needs of the increasing number of refugees who have experienced trauma and given the importance of self-efficacy in determining therapists' behaviors and perceptions, it is essential to examine the factors that influence their sense of self-efficacy about their work. While there is substantial literature focusing on the experience of refugees, to date limited research is conducted by researchers to examine the experience of mental health professionals working with traumatized refugees. There is a scarcity of empirical research investigating factors influencing the effectiveness of therapists working with refugees who have experienced trauma.

Counselor Self-Efficacy

Research has shown that self-efficacy is significant to effective counseling (Larson, 1998). Self-efficacy is defined as individuals' confidence in their ability to perform certain behaviors or achieve desired outcomes (Bandura, 1982; 1977). Since self-efficacy has been linked to favorable outcomes, it is important to explore factors that may influence the self-efficacy of mental health professionals.

Counselor self-efficacy is defined as individuals' beliefs about their ability to

counsel clients (Larson & Daniels, 1998). Counselor self-efficacy is an indication of confidence in performing therapeutic work (Lent et al., 2006), therefore is considered an important concept for therapists working effectively with clients who have experienced trauma that has been overlooked in the literature (Cooper et al., 2015). A variety of factors may influence the self-efficacy of mental health professionals working with refugee populations including specialized training and experience level (Warr, 2010), client and counselor characteristics, and interventions used (Lusting et al., 2004; Tyrer & Fazel, 2014).

While research has explored the relationship between counselor self-efficacy and variables such as training, aptitude and experience, little attention has been directed to counselor self-efficacy among mental health professionals working with traumatized refugees. Furthermore, there have been no studies exploring the relationship between counselor self-efficacy, perceived trauma training, experience, percentage of traumatized clients and secondary traumatic stress among mental health professionals working with refugees. It is necessary to understand how factors such as perceived trauma training, years of experience, percentage of trauma clients and therapist's secondary traumatic stress relate to the self-efficacy of mental health professionals working with refugees who have experienced trauma since these factors have been found to influence counselor self-efficacy.

Secondary Traumatic Stress

Therapists must be vigilant for signs of secondary traumatic stress as they are often exposed to narratives of the torture, trauma, and enormous suffering experienced by

their refugee clients (Murray et al., 2010). Continuous exposure to trauma vicariously may negatively influence therapists' counselor self-efficacy (Finklestein, Stein, Greene, Bronstein & Solomon, 2015). As mental health professionals listen empathetically to stories of human suffering, they are at risk of secondary traumatic stress, which is often underemphasized in training programs (APA Task Force, 2009; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015; Arnold, Calhoun, Tedeschi, & Cann, 2005).

Trauma Training

There is evidence that increased counselor self-efficacy is positively associated with level of training (Friedlander & Snyder, 1983; Lent et al., 2006; Melchert, Hays, Wiljanen, & Kolocek, 1996; Urbani et al., 2002). However, the relationship between counselor self-efficacy and counselor level of training seems to be more complex. Some researchers suggested that the relationship follows a curvilinear pattern (Johnson & Seem, 1989). Undergraduates seem to have a considerably high level of counselor self-efficacy despite having limited training. Advanced-level graduate students had the highest level of counselor self-efficacy, while beginning-level graduate students had lower counselor self-efficacy compared to undergraduate students (Goreczny, Hamilton, Lubinski, & Pasquinelli, 2015). Mental health professionals must receive specialized trauma training to deal with the complexities of trauma, especially with the refugee population (McKinney, 2007). Training is positively associated with counselor self-efficacy in mental health professionals working with trauma survivors (Woody, Anderson, & D'Souza, 2015). Specifically, trauma training aimed at enhancing trauma-related counseling skills may improve trauma-related professional self-efficacy and

reduce secondary traumatic stress (Berger & Gelkopf, 2011; Harrison & Westwood, 2009).

Experience

As therapists gain more experience, they gain self-efficacy in performing similar tasks in the future (Barbee, Scherer, & Combs, 2003). Studies have found significant correlations between counselor self-efficacy and years of counseling experience (Goreczny et al., 2015; Melchert et al., 1996; Tang et al., 2004). Larson and Daniels (1998) found that more experienced counselors reported higher levels of self-efficacy than those with no counseling experience. However, after gaining some experience, the relationship between counselor self-efficacy and experience appears minimal (Larson & Daniels, 1998). Furthermore, therapist's experience level may be associated with lower secondary traumatic stress (Adams & Riggs, 2008; Finklestein et al., 2015).

Percentage of Traumatized Clients

The percentage of traumatized clients seen by the therapist might be associated with the perceived counselor self-efficacy. There are mixed results regarding the exact relationship, however levels of self-efficacy appeared to decrease as the percentage of trauma clients increased (Sartor, 2012). Furthermore, the frequency and duration of exposure to traumatized clients have been associated with higher levels of therapist secondary traumatic stress (Brady, Guy, Poelstra, & Browkaw, 1999).

Significance of the Study

Since 1975, the U.S. has welcomed over three million refugees (U.S. Department of State, Bureau of Population, Refugees, and Migration, 2016). Mental health

professionals are in a unique position to work with these clients. Although mental health preparation programs, internships, and continuing education courses emphasize cultural competence as a fundamental area of training (Akinsulure-Smith & Ohara, 2012), there is limited research that focuses on factors that influence the work of therapists who work with refugees who have experienced trauma. Investigating counselor self-efficacy is a significant area of inquiry because self-efficacy may be an important determinant for effective counseling (Larson, 1998). Mental health professionals providing services for refugees should believe in their ability to effectively work with this unique population (Murray et al., 2010).

Most of the empirical literature to date has addressed interventions used with refugees, while there is a dearth of literature that has examined therapist factors related to working with refugees (Kinzie, 2001). To address this need, this study examined factors that relate to the self-efficacy of therapists working with refugees who have experienced trauma. The findings from this study will be useful for practitioners developing psychosocial programs in the field of refugee mental health as well as for training and preparation programs interested in preparing culturally competent mental health professionals to work with refugees who have experienced trauma.

Purpose of the Study

The purpose of this research study was to examine the relationship between perception of trauma training, experience, percentage of traumatized clients, secondary traumatic stress and counselor self-efficacy of mental health professionals who work with refugee and asylum seeking clients who have experienced trauma. The study also

examined the partially mediating effect of secondary traumatic stress on the relationship between the independent variables and the dependent variable.

Research Questions

1. How are perceptions of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress related to counselor self-efficacy among mental health professionals who work with refugee and asylum seeking clients who have experienced trauma?
2. How are perceptions of trauma training, experience, and percentage of traumatized clients related to counselor self-efficacy after controlling for secondary traumatic stress?

Operational Definitions of Variables

The following operational definitions were used in this study:

Counselor Self-Efficacy

Counselor self-efficacy refers to therapists' beliefs about their ability to perform counseling activities competently (Lent et al., 2006). Counselor self-efficacy will be measured using the Counseling Self-Estimate Inventory (COSE) (Larson et al, 1992). The total score of this instrument will be used in the data analysis.

Secondary Traumatic Stress

Secondary traumatic stress refers to the emotional and behavioral disruptions experiences by individuals who are in close constant contact with trauma survivors (Figley, 1995). Bride, Robinson, Yegidis, and Figley (2004) operationalized secondary traumatic stress as intrusion, avoidance, and arousal symptoms resulting from indirect

exposure to traumatic events through a professional helping relationship with individual(s) who have directly experienced traumatic events. Secondary traumatic stress will be measured using the Secondary Traumatic Stress Scale (Bride, 1999). The total score of responses on this instrument will be reported.

Trauma Training

Training refers to trauma-specific training that mental health professionals received. It will be a self-report measure on the demographic questionnaire in which respondents will report the number of courses, workshops and trainings in trauma.

Experience

Experience refers to the number of years of clinical experience that the mental health professionals have acquired. It will be measured using a self-report question on the demographic questionnaire to indicate their total number of years of clinical experience.

Percentage of Traumatized Clients

Percentage of traumatized clients will be assessed by a self-report question on the demographic questionnaire to indicate the percentage of clients in their current caseload who experienced traumatic event(s).

Assumptions

The following assumptions were made in this study:

- Mental health professionals have indicated that they have had some experience related to trauma.
- Participants responded honestly to the self-report survey.
- The survey being used was valid and measures the variables accurately.

- Participants accurately comprehended and responded to the survey items to the best of their ability.

Delimitations

The following delimitations were associated with this study:

- Only graduate level mental health professionals were included in the study.
- Only individuals who are currently working with refugees who have experienced trauma were included in the sample.
- Participants were limited to those who are able to read and respond in English.

Limitations

The following limitations were associated with this study:

- Because the participants are limited to mental health professionals who at least possess a master's degree working with refugees who have experienced trauma, the results cannot be generalized to all graduate level mental health professionals.
- The participants of this study were only include graduate level professional counselors, clinical social workers, and psychologists, so the results cannot be generalized to other types of therapists.
- The sample was not randomly selected. It was a convenience sample. Mental health professionals were recruited through contacting mental health agencies and professional organizations.
- Participants with particular characteristics such as higher levels of training, secondary traumatic stress, or counselor self-efficacy may be more prone to take the survey, which may limit the generalizability of the results.

- The study was a correlational study; therefore, the researcher cannot make causal inference.
- The data collected in this study was self-reported by participants. Therefore social desirability may have impacted the results of this study. Participants may have attempted to answer in a way to present themselves more favorably (Houser, 2015). For example, participants may have been hesitant to report secondary traumatic stress.

Threats to Internal Validity

Internal validity is associated with the extent to which the results of the study can be accurately interpreted (Johnson & Christensen, 2004). Surveys have the potential to compromise internal validity. To minimize threats to internal validity in this study, the counselor self-efficacy and secondary traumatic stress instruments that were used have been evaluated for validity and reliability in previous studies. Another threat to internal validity might be the accuracy of self-report measures. To address this threat, there was a pilot phase where two mental health providers who met the eligibility criteria took the survey and provided feedback specifically on the items on the demographic questionnaire to further address the content validity of those items. Even though participants were asked to provide honest answers and the survey was anonymous, therapists' social desirability to present themselves more positively may have been a threat to validity.

Threats to External Validity

External validity is associated to the extent to which the results of the study can be generalized (Johnson & Christensen, 2004). The current study examined the

perceptions of graduate level mental health professionals working with refugees who have experienced trauma so the results are generalizable only to other professionals who work with refugees or clients who have experienced trauma. Therapists who have certain years of experience and training may have been more inclined to participate in the study. To minimize possible threats to external validity, therapists from a variety of geographic locations in the United States were invited to participate in the study.

Summary

Chapter one provides background information on refugees and asylum seekers including definitions and statistics, mental health issues, and interventions. With the rapidly increasing number of refugees in need of mental health services, therapists are called upon to meet the unique needs of this vulnerable population through providing culturally responsive services. There are a number of factors that might influence the work of therapist's working with refugees who have experienced trauma. Counselor self-efficacy is an indication of perceived therapeutic work and confidence in performing therapeutic work (Lent et al., 2006). It is considered especially important for therapists working with clients who have experienced trauma (Cooper et al., 2015). To address the identified gaps in the literature, the purpose of this study was to examine how perception of trauma training, years of clinical experience, percentage of traumatized clients, and secondary traumatic stress are related to counselor self-efficacy among mental health professionals who work with refugee and asylum seeking clients who have experienced trauma.

Organization of the Study

This study is comprised of five chapters. Chapter one consists of background information, an introduction to the variables, hypotheses, and the professional significance of the proposed study. In Chapter two, the conceptual and empirical literature related to the relevant variables and the relationships between the variables is synthesized. The methodology for the study is presented in Chapter three. This chapter includes a description of participants and procedures related to data collection. Instruments used in this study are described as well as the design of the study, research hypotheses and data analysis. Chapter four consists of the results of the study including a description of the participants, instrument reliabilities, bivariate correlations and the results from the statistical analyses. Finally, in chapter five the results of the study are discussed. This section includes an overview of the study, discussion of the results, contributions and limitations in this research study, implications of the findings, recommendations for future research and concluding remarks.

CHAPTER 2: REVIEW OF THE LITERATURE

Global social and political events have forced over 3 million refugees and asylum seekers to resettle in the US in the past several decades (U.S. Department of State, Bureau of Population, Refugees, and Migration, 2015). Refugees are individuals who flee their home country due to fear of being persecuted based on race, religion, nationality, membership in a particular social group, or political opinion (United Nations, 1951). According to the United Nations High Commissioner for Refugees, asylum seekers are individuals requesting refuge outside their home country while they are in the host country. Due to conflict, poverty and human rights violations, the number of people seeking refuge is on the rise. Mental health professionals are called upon to meet the psychological needs of this population. However, working with refugees presents mental health professionals with a unique set of challenges. Many refugees have experienced persecution, physical and emotional trauma, and forced migration, which in some cases have caused serious psychological impact (Murray et al., 2010). Whereas the majority of studies examining the effects of trauma have focused on trauma survivors, information about the effect on mental health professionals delivering trauma treatment is scarce. The limited research available on this topic suggests that mental health professionals feel overwhelmed by their clients' stories and that working with this population can foster

feelings of hopelessness, helplessness, incompetence and fear (Barrington & Shakespeare-Finch, 2013). Thus empirical research focusing on factors affecting the self-efficacy of mental health professionals working with this growing and sometimes highly traumatized population is warranted.

The current study attempted to fill this gap by relating mental health professionals' counselor self-efficacy to some of the major components of social cognitive theory, namely therapist characteristics and professional environment. The purpose of this study was to examine how perceptions of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress are related to counselor self-efficacy among mental health professionals who work with refugee and asylum seeking clients who have experienced trauma. The study also examined the partially mediating effect of secondary traumatic stress on the relationship between the independent variables and the dependent variable. This review of literature provides a rationale for the need for this study through a review of the conceptual and empirical literature related to these variables. The review is organized into six sections. The first section covers the relevant literature on trauma and refugee clients. The second section provides information on the dependent variable, counselor self-efficacy. The third section provides information on the mediating variable, secondary traumatic stress and its relationship to the dependent variable, counselor self-efficacy. The following three sections provide conceptual and empirical literature on the relationship between the independent variables (trauma training, experience, percentage of traumatized clients, and secondary traumatic stress) and the dependent variable, counselor self-efficacy. Overall,

the information in this chapter is intended to summarize the relevant literature highlighting the paucity of empirical data on the variables and unique population included in this study.

Trauma

In this first section, trauma is defined and conceptualized. Trauma experiences specific to the refugee population, prevalence rates, and effective interventions are also discussed. Finally, a discussion of gaps in the literature and the need for this study to fill those gaps is presented.

Definition

Traumatic experiences are ubiquitous (Beck & Sloan, 2012). The prevalence rate of trauma-exposure in the general population in the U.S. ranges from 21% to 89% (Solomon & Johnson, 2002). The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) defines trauma as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (American Psychiatric Association, 2013, p. 456).

The definition of trauma extends beyond the DSM-5 definition in the literature to include negative events that overwhelm the individual's internal coping resources and produces lasting psychological impact (Briere & Scott, 2014). Types of trauma that have been recorded in the literature include but are not limited to torture, war, child abuse, mass violence, natural disasters, transportation accidents, fires, motor vehicle accidents,

rape and sexual assault, physical assault, intimate partner violence, sex trafficking, witnessing homicide or suicide, life-threatening medical conditions, and emergency worker exposure to trauma (Duckworth & Follette, 2012). Trauma can be a single incident or multiple incidents (Briere & Scott, 2014). Transient acute distress is a typical response to trauma. However, a small percentage of individuals who experience traumatic events exhibit severe prolonged distress (Benight & Bandura, 2004). The degree and complexity of psychological symptoms caused by trauma may vary significantly based on preexisting vulnerabilities such as onset and frequency (Ogle, Rubin, Berntsen, & Siegler, 2013) and gender (Andrews, Brewin, and Rose, 2003).

Trauma has been associated with a variety of psychological diagnosis, Post Traumatic Stress Disorder (PTSD) being the most common (Hagenaars, Fisch, & van Minnen, 2011). The DSM-5 provides PTSD criteria that apply to adults, adolescents, and children older than 6 years. A new preschool subtype PTSD was introduced with behaviorally and developmentally sensitive criteria for children younger than 6 years. The diagnostic criteria for PTSD are:

> (a) exposure to death, serious injury, or threat to the physical integrity of a person, or learning about the unexpected death or serious injury of a family member or other close associate, or repeated exposure to details of a traumatic event; (b) characteristic symptoms resulting from exposure to the traumatic event including persistent re-experiencing of the traumatic event, or intrusive recollections of the traumatic event and distressing dreams; (c) persistent avoidance of trauma-related thoughts, feelings, activities, places and people; (d) and negative cognitions and mood such as inability to remember important details of the traumatic event, exaggerated negative beliefs, distorted cognitions, persistent negative emotional state, inability to experience positive emotions, or feelings of detachment; (e) and persistent symptoms of increased arousal such as an exaggerated startle response, sleep disturbance, irritability and difficulty concentrating; (f) symptoms must be present for at least one month; and (g) symptoms must cause significant distress

> or impairment in social, occupational or other areas of functioning (American Psychiatric Association, 2013, p. 258).

The Neurobiology of Trauma

There is consensus that trauma reactions are both psychological and physiological experiences. Therefore it is critical that therapists are knowledgeable about the neurobiology of trauma (Malchiodi, 2015). The human brain is comprised of three main parts: the brainstem and cerebellum, the limbic system and the cerebral cortex. The brainstem controls basic functions and the cerebellum is responsible for movement. The limbic system is the sources of emotions and instincts. The cerebral cortex is responsible for communion and logic (Curran, 2010). In response to traumatic events, the limbic system is activated and emotions are trapped in the nervous system causing emotional and physical distress (Levine, 2012). Furthermore, understating the function of memory as it relates to traumatic events is important. Explicit memory is conscious while implicit memory stores sensory and emotional data. In response to traumatic events, implicit memory is omitted from explicit storage (Rothschild, 2000) causing loss of context and emotions as well as inability to verbalize responses to the event (Malchiodi, 2015).

Refugees and Trauma

Refugees and asylum seekers are typically exposed to a high number of traumatic events including war, personal injury, torture, sexual assault, family separation, food shortages, and violence (Carswell et al., 2011; Gerritsen et al., 2006; Marshall et al., 2005; Mollica, 2006; Steel et al., 2009; Tempany, 2009). In a study conducted with 179 Karen refugees, frequencies of primary and secondary torture were 27.4% and 51.4%,

respectively. Furthermore, war trauma was reported by 86% of the participants (Shannon, Vinson, Wieling, Cook, & Letts, 2015). Such adverse experiences can increase the risk of developing chronic psychological disorders such as PTSD and major depressive disorder (Steel et al., 2009). Although the majority of these refugees may be resilient and will not need help for psychological problems (Bemak& Chung, 2014), a significant minority will present with psychological issues. Traumatic experiences may lead to feelings of grief, anger, shame, humiliation, immense loss and helplessness (Burnett & Thompson, 2005). Some of the common symptoms among refugees include negative long-term effects on cognitions, emotions, and behavior. Cognitive problems may include concentration difficulties, impaired information processing and memory difficulties, lowered interest levels, feelings of hopelessness, intrusive memories about the event, and hyper-arousal and hyper-vigilance; emotional problems may include depression, irritability, phobic disorders, stress, and anxiety; and behavioral problems include avoidance, startle reactions, diminished energy, substance abuse, insomnia, and nightmares (Bemak & Chung, 2008; Fenta, Hyman, & Noh, 2004; Gavagan & Martinez, 1997; Kinzie, 2001; Mollica et al., 1998).

Prevalence of Trauma-related Disorders among Refugees

Experiencing several traumatic events often leads to high prevalence of trauma-related psychological disorders among refugees (Bemak & Chung, 2008; Fazel et al., 2005; Gerritsen, et al., 2006; Johnson & Thompson, 2008; Laban et al., 2005; Slobodin & de Jong, 2015; Steel et al., 2004). Refugees typically show greater levels of psychological distress than the general population (Fazel et al., 2005). The most common mental health

problems among refugees are PTSD and major depression (Acarturk et al., 2015). The high prevalence of PTSD among refugees has been well documented (Fazel et al., 2005; Steel et al., 2009). Specific data about the prevalence of trauma related disorders among refugees is scarce due to methodological issues, which makes the comparison of the results of these studies difficult (Gerritsen et al., 2004). Several studies have documented the impact of trauma on the mental health of refugees. Even though many recover spontaneously from traumatic events, estimates of the prevalence of PTSD among refugees have ranged from 20% to 74%, and depression ranges from 39% to 64% (Gerritsen et al., 2006; Laban et al., 2005; Mares & Jureidini, 2004; McColl & Johnson, 2006; Sieberer et al., 2011). Thus, the prevalence of PTSD among refugees is higher than that in the general population, which is estimated to be 8% (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

A systematic review of studies about the prevalence of serious mental disorders in 6743 refugees resettled in western countries reported rates of PTSD to be 9% for adults and 11% for children, and major depression rates to be 5% for adults with a high degree of comorbidity (Fazel et al., 2005). Similarly, in their meta-analysis with over 80,000 refugees, Steel and colleagues (2009) reported high prevalence of both PTSD and major depression, with averages of 30.6% and 30.8%, respectively. Slewa-Younan and colleagues (2012) found that PTSD (48%) was the most commonly reported disorder followed by major depressive episode (36%) and dysthymia (36%) among Iraqi refugees resettled in Australia. Schweitzer, Brough, Vromans, and Asic-Kobe (2011) studied 70 adult refugees from Burma who resettled in Australia and found PTSD rates to be 9%,

anxiety to be 20%, depression to be 36%, and somatization symptoms to be 37%. A study examining war-related trauma among Kosovar refugees reported rates of PTSD to be 60.5% (Ai, Peterson & Ubelhor, 2002). Another study reported that around 60% of the sample of Tuareg refugees in a camp in Burkina Faso met the criteria for PTSD (Carta et al., 2013). PTSD diagnosis was met by 50% of Afghan refugees living in the U.S. (Malekzai et al., 1996). Clinical assessments of war-affected children indicated high rates of PTSD (30.4%), generalized anxiety (26.8%), somatization (26.8%), general behavioral problems (21.4%), and traumatic grief (21.4%) (Betancourt et al., 2012). Trauma can also have a prolonged effect on the mental health of refugees, as one study with Cambodian refugees conducted 20 years after resettlement reported high rates of PTSD (62%) and depression (51%) (Marshall et al., 2005). Another study found that Cambodian refugees reported high levels of PTSD, dissociation, depression and anxiety 10 years after leaving their homes (Carlson & Rosser-Hogan, 1993).

In a sample of 178 refugees and 232 asylum seekers from Afghanistan, Iran and Somalia living in the Netherlands, asylum seekers reported more PTSD symptoms than refugees (28% and 10.6% respectively) and depression (68% and 39.4% respectively). Overall, 20.6% of this population reported symptoms of PTSD and 55.6% reported depression and anxiety symptoms (Gerritsen et al., 2006). In another sample of 104 refugees and asylum seekers in contact with mental health services in London, 41 % were diagnosed with PTSD and 50% were diagnosed with depression (McColl & Johnson, 2006). Higher prevalence rates were reported in a study conducted using a sample of 16 adults and 20 children in immigration detention in Australia. Fifty six percent of the

adults and 100% of the children were diagnosed with PTSD, and 87% of adults had major depression diagnosis (Mares & Jureidini, 2004).

Counseling Refugees

A variety of treatment interventions have been designed for traumatized refugees and asylum seekers (Hinton, Hofmann, Pollack, & Otto, 2009; Murray et al., 2010; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). Treatments include cognitive behavior therapy (Basoglu, Ekblad, Baarnhielm, & Livanou, 2004; Hinton et al., 2009), trauma focused cognitive behavior therapy (Otto et al., 2003), eye movement desensitization and reprocessing (Acarturk et al., 2015), exposure therapy (Paunovic & Ost, 2001), testimony therapy (Lustig et al., 2004), narrative exposure therapy (Neuner et al., 2008), and pharmacotherapy (Murray et al., 2010; Palic & Elklit, 2011). Cognitive-behavioral therapy is found to be one of the most commonly utilized and researched interventions for PTSD with the general population (Hinton et al., 2009; Lustig et al., 2004; Otto et al., 2003; Palic & Elklit, 2011). Similarly, the majority of studies with traumatized refugees confirmed the suitability of cognitive-behavioral therapy (CBT) and narrative exposure therapy (NET) in reducing trauma-related symptoms (Neuner et al., 2010; Palic & Elklit, 2011).

Although there is a growing body of literature describing interventions for traumatized refugees (de Jong & Van Ommeren, 2002), the complex problems of refugees present unique challenges to mental health professionals (Slobodin & de Jong, 2015). Additionally, it has been suggest that effective interventions should utilize culturally responsive approaches to engage refugees that honor cultural beliefs and values

to facilitate recovery and resilience (Murray et al., 2010). Furthermore, limited attention has been paid to understanding the emotional and professional impact of this work on mental health professionals who provide these services (Barrington & Shakespeare-Finch, 2013). There is some evidence suggesting that such work brings potential benefits and risks for therapists (e.g., Barrington & Shakespeare-Finch, 2013; Century, Leavey & Payne, 2007; Sabin-Farrell & Turpin, 2003).

Summary

Trauma has been defined in the DSM-5 and the literature has expanded its definition to include extremely upsetting events that overwhelm the person's internal resources and produces lasting psychological symptoms (Briere & Scott, 2015). Although many refugees are resilient, some refugees and asylum seekers who have experienced traumatic events may develop chronic psychological disorders. PTSD and major depressive disorder are the most common psychological disorders among refugees with high prevalence rates among this population. Although there is a growing body of literature exploring the effect of trauma on survivors and describing effective interventions for trauma survivors, little research has been conducted to understand the impact of working with refugees on those who provide these services. More information is needed to better understand factors that influence the work of mental health professionals. The current study hoped to shed the light on the impact of working with refugees who have experienced trauma on mental health professionals especially with regard to the impact on their counselor self-efficacy since counselor self-efficacy had been found to play a significant role in effective functioning of therapists.

Self- Efficacy

In this section, counselor self-efficacy is conceptualized and related to major constructs in the Social Cognitive Theory (Bandura, 1986, 2001), including therapist characteristics, personal agency, counselor performance and professional environment variables. Additionally, a brief description of the most common instruments measuring counselor self-efficacy is presented. Lastly, the significance of the current study is highlighted.

Social Cognitive Theory

Social cognitive theory (SCT; Bandura, 1986, 2001) proposed by Albert Bandura subscribes to a human agency model which views people as agents who make things happen by their intentional actions (Bandura, 2001). Through this perspective, STC provides a significant framework in understanding the cognitive processes in the brain. Cognitive processes play a significant role in behavioral changes (Bandura, 1977). STC maintains that human behavior is explained through the interactions between the environment, individual factors, and behavior. These factors influence each other bidirectionally within the individual. Therefore, this theory emphasizes self-regulation as a key mechanism for human behavior (Bandura, 1986). Self-efficacy is a key construct in SCT and plays an important role in human motivation and performance.

Definition and Conceptualization of Self-Efficacy

Self-efficacy is a construct rooted in Bandura's social cognitive theory (1986). Self-efficacy is defined as confidence in individuals' capabilities to perform certain actions to achieve desired outcome (Bandura, 1982). Efficacy beliefs "influence how

people feel, think, motivate themselves, and behave" (Bandura, 1993, p. 118). Self-efficacy beliefs can influence cognitions to be self-enhancing or self-debilitating (Bandura, 1986). Perceived self-efficacy influences level of motivation, which predicts people's actions, effort spent on certain tasks, perseverance in the face of challenges, and actual performance (Bandura, 1977). Self-efficacy beliefs also influence how individuals respond in the face of adversities and their level of coping in threatening situations (Bandura, 1977). When individuals persevere in the face of challenges, self-efficacy increases. Therefore, successful experiences improve self-efficacy, which in turn increases behaviors leading to future successes. Bandura stated, "weak self-efficacy beliefs are easily negated by disconfirming experiences, whereas people who have a tenacious belief in their capabilities will persevere in their efforts despite innumerable difficulties and obstacles" (Bandura, 1997, p. 43). Perseverance in the face of obstacles will help enhance people's self-efficacy (Bandura, 1977). Thus, people who possess stronger perceived self-efficacy will persist in the face of threatening experiences and overcome challenges through corrective experiences. Mastery of challenging tasks presents evidence of enhanced competence. Thus, self-efficacy is essentially an individual's beliefs about his or her capabilities and therefore influences cognitions, emotional reactions and behaviors related to achieving certain tasks (Larson et al., 1992).

Bandura suggested that self-efficacy beliefs stem from four sources of information: successful personal experiences, vicarious learning, verbal persuasion, and emotional arousal (Bandura, 1997). Successful experiences usually enhance mastery experiences, while failures may weaken self-efficacy beliefs (Bandura, 1977). However,

certain challenges could be valuable in teaching persistence and providing a resilient sense of efficacy when faced with obstacles. Once self-efficacy is established after overcoming adversity, it is generalized to other situations (Bandura, Adams, & Beyer, 1977). According to Bandura (1977, 1997) successful experiences are the most influential source of information in providing evidence of successful experiences to build stronger self-efficacy. Vicarious learning is the second source of self-efficacy information. Witnessing success of others in certain activities can promote efficacy beliefs within an individual. Modeling also helps set an expectation of what is possible through perseverance (Bandura, 1997). Although vicarious learning may be a less reliable source of self-efficacy information than personal experiences, it still provides individuals with a motivation for increasing their own self-efficacy (Bandura, 1977). The third source of information is verbal persuasion. It includes suggestion, encouragement, self-instruction, and interpretive treatments. Although, this source can enhance the sense of personal efficacy, it has limited influence since it does not provide actual experiences. Finally, emotional arousal is a source of information that can influence perceived self-efficacy in coping with stressful situations. Typically, high emotional arousal debilitates performance and may impede coping in the face of adversities (Bandura, 1977). In sum, perceived self-efficacy is the extent to which individuals perceive themselves as capable of performing a particular behavior. People's belief in their own capabilities is likely to influence their activities and coping efforts. The effect of self-efficacy on the behavior of people is well documented in the literature (e.g., Bandura, 2001). Furthermore, research has shown that self-efficacy is associated with effective counseling (Bandura, 1995;

Larson & Daniels, 1998).

Counselor Self-Efficacy

Several authors have adapted Bandura's self-efficacy construct to the counseling context. For the purposes of this study, counselor self-efficacy is defined as "one's beliefs or judgments about her or his capabilities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p. 180). Larson and Daniels asserted that counselor self-efficacy is the major mechanism for the effective delivery of counseling. Counselor self-efficacy contributes to determining counselors' actions and decisions when providing counseling services to clients (Larson, 1998). Counselors must continuously utilize multiple skills to manage constantly changing conditions. Introduction of such counseling behaviors depends on therapists' perceived beliefs of their capabilities. Self-efficacy beliefs affect counseling actions through cognitive, affective, and behavioral responses (Larson & Daniels, 1998). Counselor self-efficacy will influence the effort exerted in counseling tasks when facing challenges. Therefore, the stronger the therapist's counselor self-efficacy, the greater effort and engagement in counseling tasks, and perseverance in the face of obstacles (Larson et al., 1992). The therapist's counselor self-efficacy level could influence the specific interpretation of stressful situations. For instance, anxiety could be viewed as a challenge to overcome or it could lead to debilitating perceptions (Larson & Daniels, 1998). Tang et al. (2004) noted that self-efficacy is an important factor in determining therapists' ability to assume their professional roles effectively and competently. Larson et al. (1992) found five dimensions of counseling self-efficacy: confidence in performing microskills, attending to process, dealing with difficult

behaviors, cultural competency, and an awareness of one's values (Larson et al., 1992).

Applying the four sources of self-efficacy discussed in the previous sections to counselor self-efficacy, mastery experiences and vicarious learning can be obtained through training programs, supervision and working with clients. Vicarious learning can also be acquired by watching demonstrations or role-plays of counseling sessions. Verbal persuasion can take place through feedback from professors, supervisors and colleagues or clients. Emotional arousal may be present through all learning situations. If therapists are able to interpret situations in a positive manner during stressful situations, then self-efficacy will increase.

Empirical Research on Counselor Self-Efficacy

There has been a proliferation of literature on counselor self-efficacy in the past few decades. This section aims to accomplish two main goals. First, it is hoped to establish the relationship between counselor self-efficacy and effective counseling in order to provide a rationale for including counselor self-efficacy as the dependent variable in the current study. The second goal is to present empirical research on factors that affect counselor self-efficacy.

Many of the studies addressing counselor self-efficacy have suggested that counselor self-efficacy is fundamental to counselor performance and effective counseling (Larson & Daniels, 1998; Larson et al., 1992; Lent et al., 2003). In their review of 32 studies on counselor self-efficacy, Larson and Daniels (1998) concluded that counselors in-training who had stronger counselor self-efficacy were more effective with clients. More specifically, research suggest that therapists with stronger counselor self-efficacy

are more confident in the implementation of basic therapeutic skills and managing difficult situations with their clients (Lent et al., 2003). Strong support for an association between counselor self-efficacy and client outcome has been demonstrated in the literature. Outcome expectancy is “a person's estimate that a given behavior will lead to certain outcomes" (Bandura, 1977, p. 193). Sipps, Sugden, & Faiver (1988) found a large positive correlation (r = .77) between counseling self-efficacy and outcome expectations while Lent et al. (2003) found a small correlation (r = .24) between the same variables. It is notable that the participants in the studies described above were counseling trainees. Moreover, it is important to note that the studies that were reviewed above are related to outcome expectancies rather than actual outcomes (Heppner, Multon, Gysbers, Ellis, & Zook, 1998), which restricts making inferences about actual client outcome.

Knowing that counselor self-efficacy is related to client outcome warrants a discussion of factors that influence counselor self-efficacy. The studies described below present the major factors contributing to counselor self-efficacy. Factors that affect counselor self-efficacy are discussed within the framework of the Social Cognitive Theory which include therapist characteristics, personal agency, counselor performance and professional environment factors. Counselor self-efficacy has been linked to several factors in the literature including experience, training and education, age, and supervision. Research studies have found that counselor self-efficacy is positively related to therapist’s training and education, years of experience, and supervision. In other words, counselor self-efficacy increases as training and education (Larson et al., 1992; Larson & Daniels, 1998; Melchert et al., 1996; Sipps et al., 1988), years of counseling

experience (Melchert et al., 1996; Tang et al., 2004), and supervision (Cashwell & Dooley, 2001; Potenza, 1990) increase. Tang and colleagues (2004) investigated whether age, experience, number of courses taken, and number of internship hours are associated with counselor self-efficacy among 116 counseling students. The results revealed that counselor self-efficacy was most strongly associated with course work (r = .59), internship hours (r = .47), and clinical experience (r = .40). The relationship between counselor self-efficacy and therapist's level of training is complex and has yielded mixed results (Larson & Daniels, 1998). Several studies have found a significant relationship between counselor self-efficacy and training (Leach, Stoltenberg, McNeill, & Eichenfield, 1997; Melchert et al., 1996), whereas others have found that counselor self-efficacy follows a curvilinear pattern rather than a linear one (Goreczny et al., 2015; Potenza, 1990; Sipps et al., 1988). A more detailed discussion is provided in later sections.

Supervision has been identified as a factor contributing to counselor self-efficacy. In a study involving professional counselors in a community setting and doctoral level students found that counselors receiving clinical supervision reported a higher level of counselor self-efficacy than those who did not receive supervision (Cashwell & Dooley, 2001). Additionally, moderate to strong relationships were found between counselor self-efficacy and perceptions of fraudulence (Alvarez, 1995). Job satisfaction was also found to correlate moderately with counselor self-efficacy (Alvarez, 1995; Larson et al., 1996). There was a significant but small relationship between counselor self-efficacy and aptitude, achievement, personality type, and defensiveness (Larson et al., 1992). In a

study exploring the influence of emotional intelligence on counselor self-efficacy of counseling students and professional counselors, researchers found a significant correlation between counselor self-efficacy and the ability of counselors-in-training to identify their own emotions and the emotions of others (Easton, Martin, & Wilson, 2008). Mindfulness has also been suggested to be a predictor of counselor self-efficacy. Counseling interns and doctoral counseling students who demonstrated high levels of mindfulness, had high counselor self-efficacy (Greason & Cashwell, 2009).

Some researchers have explored other factors that influence counselor self-efficacy. Results indicated that counselor self-efficacy is positively associated with counselor performance, self-concept, problem-solving appraisal, performance expectations, and class satisfaction, whereas it is negatively associated with state and trait anxiety. A minimal association was found between counselor self-efficacy and aptitude, achievement, personality type, and defensiveness (Larson et al., 1992).

Factors that were found to have a negative relationship with counselor self-efficacy include state and trait anxiety (Alvarez, 1995; Barnes, 2004; Friedlander, Keller, Peca-Baker, & Olk., 1986; Larson et al., 1992), emotional exhaustion, depersonalization, and negative affect (Alvarez, 1995; Daniels, 1997; Friedlander et al., 1986; Larson et al., 1992). Counselor self-efficacy has also been found to be negatively associated with secondary traumatic stress and percentage of traumatized clients (Finklestein et al., 2015). Finally, factors that were not found to have significant relationships with counselor self-efficacy are gender (Larson et al., 1992), age (Tang et al., 2004) theoretical orientation (Larson et al., 1992; Potenza, 1990), and ethnicity (Larson et al., 1992).

It is important to note that the vast majority of the reviewed empirical studies have explored the self-efficacy beliefs of counselors in training rather than those of professional counselors and there is a dearth of research about therapists in the community. Nevertheless, the study conducted by Chandler, Balkin, and Perepiczka (2011) is one of the first studies to examine the self-efficacy beliefs of more experienced therapists, i.e. licensed substance abuse counselors. The findings of this study found a lack of association between therapists' perceived self-efficacy and the number of practicum and internship clock hours, percentage of clients with substance abuse issues, number of substance abuse continuing education hours, and number of substance abuse courses completed. The results of this study contrast the results of previously discussed studies in that it did not find a significant relationship between training and education, experience, and percentage of substance abuse clients and counselor self-efficacy.

In sum, the studies discussed above establish the influence of counselor self-efficacy on effective counseling and client outcome. Examining variables that affect counselor self-efficacy is crucial since therapists with low counselor self-efficacy may influence the effectiveness of therapists. Variables that have been found to influence counselor self-efficacy include therapist characteristics, personal agency, counselor performance and professional environment variables. Through further training and clinical experience, mental health professionals can enhance their effectiveness in performing counseling activities, which in turn contributes to increase their perceived self-efficacy (Melchert et al., 1996). Nevertheless, results on factors affecting counselor self-efficacy yielded mixed results, therefore the proposed study may add to professional

knowledge regarding these variables by investigating how training, experience, percentage of trauma clients, and secondary traumatic stress relate to counselor self-efficacy. Furthermore, the current study addressed counselor self-efficacy as it relates specifically to mental health professionals working with refugees and asylum seekers who have experienced trauma. This was the first study to examine these variables with this specific population of therapists.

Measuring Counselor Self-Efficacy

Several instruments were developed to measure counselor self-efficacy in the past decades (Larson & Daniels, 1998). In a literature review on counselor self-efficacy, Larson and Daniels (1998) identified 10 instruments. Some of these instruments focus on individual counseling, including the Interpersonal Skills Efficacy Scale (ISES; Munson, Zoerink, & Stadulis, 1986), Counselor Behavior Evaluation-Self-efficacy (CBE-SE; Munson, Stadulis, & Munson, 1986), Counselor self-efficacy Scale (CSES; Johnson, Baker, Kopala, Kiselica, & Thomposon, 1989), Counseling Self-Estimate Inventory (COSE; Larson et al., 1992), and the Counselor Activity Self-Efficacy Scales (CASES; Lent et al., 2003). Other instruments focus on group counseling, such as the Counselor Self-Efficacy Scale (COSES; Melchert et al., 1996), and other areas in mental health professionals' roles, including Self-Efficacy Inventory (S-EI; Friedlander & Snyder, 1983). Some measures pertain to specific specialties, such as school counseling (Counselor Self-Efficacy Survey CSS; Sutton & Fall, 1995), career counseling (Career Counseling Self-Efficacy Scale (CCSES; O'Brien et al., 1997), and psychiatry (Self-Efficacy Questionnaire SEI; Margolies, Wachtel, & Schmelkin, 1986). The psychometric

properties of these instruments vary. Most of the measures have alpha coefficients above .85 and have adequate test-retest reliability. Furthermore, the COSE, CSS, and CCSES have shown initial construct validity.

Of the measures described above, the COSE (Larson et al., 1992) seems to be the most utilized instrument and has the most sufficient psychometric properties (Larson & Daniels, 1998). It is also one of the few measures that focus on multicultural competence. The COSE has consistently exhibited adequate internal consistency reliability, test-retest reliability, and construct validity through factor analysis and comparisons with related variables. Further details on the psychometric properties of the measure are presented in the methodology section. Two hundred and thirteen graduate-level students enrolled in an introductory counseling course participated in development of the instrument. The measure consists of 37 items that address both basic and advanced counseling activities. The scale was designed to yield a total counselor self-efficacy score using five subscales: use of microskills, counseling process, difficult client behaviors, cultural competence, and awareness of personal values. Scores range from 37 to 222 with higher scores indicating stronger counselor self-efficacy (Larson et al., 1992). The use of the COSE was merited in this study since it is a suitable and well-established measure.

Summary

Self-efficacy is a construct based on the social cognitive theory created by Bandura (1986, 1997). Applying Bandura's construct to the counseling field, counselor self-efficacy refers to counselors' perceptions about their capabilities to effectively counsel clients. Since counselor self-efficacy has been associated with favorable client

outcomes, it is important to explore factors that may promote or hinder counselor self-efficacy. Studies have found that counselor self-efficacy is positively related to counselors' training and experience levels and negatively associated with secondary trauma and percentage of traumatized clients. While research has briefly explored the association of counselor self-efficacy with these variables little attention has been paid to counselor self-efficacy among mental health professionals working with traumatized refugees. To date, the majority of research on counselor self-efficacy has focused on counselors-in-training rather than on mental health professionals because counselor self-efficacy begins to develop while therapists are in the initial phases of their career development. In fact, no studies were found to examine the counselor self-efficacy of professional therapists working with traumatized refugees. The current study contributes significantly to the literature on counselor self-efficacy of professional therapists working with traumatized refuges. Furthermore, this study was the first to explore how perceptions of trauma training, experience, percentage of traumatized clients and secondary traumatic stress relate to counselor self-efficacy among this specialized population of trauma therapists.

Secondary Traumatic Stress of Counselors

In this section, secondary traumatic stress is defined, measurement tools are identified and empirical literature related to this construct is reviewed. Studies that have been conducted to explore the association between secondary traumatic stress and counselor self-efficacy are examined. Finally, gaps in the literature are identified and the contribution of the current study is emphasized.

Definition and Conceptualization

Secondary trauma refers to the situation in which individuals are affected indirectly by traumatic events. The negative psychological impact of secondary exposure to traumatic material has been portrayed in the mental health literature. The most recent revisions of the diagnostic criteria for PTSD in the DSM-5 (American Psychiatric Association, 2013) state that secondary exposure can result in the development of impairing symptoms requiring intervention (Hensel, Ruiz, Finney & Dewa, 2015). Different terms have been used to describe the psychological implications on mental health professionals who work with trauma survivors. These terms include compassion fatigue (Figley, 1995), vicarious traumatization (McCann & Pearlman, 1990), and secondary traumatic stress (Bride et al., 2004). The definitions of these constructs share the following features: secondary exposure to traumatic events, PTSD like symptoms, and negative shits in cognitions (Cieslak et al., 2013). For the purposes of this study secondary traumatic stress was defined as the "natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). Therapists who are exposed to their clients' traumatic material are at particular risk and may exhibit various levels of secondary traumatic stress (Hensel et al., 2015). The symptoms of secondary traumatic stress are parallel to those of primary exposure to a traumatic events experienced by a client (Figley, 1995) including: intrusive imagery (Courtois, 1988; McCann & Pearlmann, 1990); avoidant responses (Courtois, 1988); physiological arousal (McCann & Pearlmann, 1990; Figley, 1995);

distressing emotions (Courtois, 1988); and functional impairment (Figley, 1995; McCann & Pearlmann, 1990). Secondary traumatic stress focuses mainly on symptomatology delineated in the DSM-V (American Psychiatric Association, 2013). Secondary traumatic stress is linked with a number of additional negative consequences including disruptions in therapists' sense of identity, worldview, emotions, and cognitive schemas related to beliefs about the world (McCann & Pearlmann, 1990). It can also result in therapist burnout (Ballenger-Browning et al., 2011). Given the increasing documentation of secondary traumatic stress among mental health professions, some consider it as an occupational hazard of clinical work with traumatized populations (Figley, 1995; Pearlman, 1999).

Prevalence of Secondary Traumatic Stress

Prevalence of secondary traumatic stress varies among studies and instruments used to measure the effect of indirect exposure to trauma material. When using the Secondary Traumatic Stress Scale (STSS; Bride, 1999), 15.2% of social workers (Bride, 2007), 16.3% of oncology staff (Quinal et al., 2009), 19% of substance abuse counselors (Bride, Hatcher, & Humble, 2009), 19.2% of therapists working with military (Cieslak et al., 2013), 20.8% of family or sexual abuse therapists (Choi, 2011), 32.8% of emergency nurses (Dominguez-Gomes & Rutledge, 2009), 34% of child protective services workers (Bride, Jones, & MacMaster, 2007), and 39% of juvenile justice workers (Smith Hatcher, Bride, Oh, Moultrie King, & Franklin Catrett, 2011) met secondary traumatic stress symptoms. To take a closer look at the specific symptoms, in a study with 225 substance abuse counselors, Bride et al., (2009) found that 56% of the participants met at least one

core diagnostic criteria for PTSD, 28% met two, and 19% met all three. Similarly, Cieslak et al. (2013) found that 19.2% of military mental health providers met all three core criteria for PTSD. Participants mostly reported intrusion (57.6%), arousal (35.3%) and avoidance (29.9%) symptoms. It is important to note that there are no known estimates of the prevalence of secondary traumatic stress among mental health professionals working with traumatized refugee and asylum seeking clients.

Empirical Research on Secondary Traumatization

Mental health professionals working with traumatized populations are at particular risk of experiencing some symptoms of secondary traumatic stress (Akinsulure-Smith, Keatley, & Rasmussen, 2012). The severity of those experiences varies across studies from mild to severe symptoms similar to those of individuals in outpatient treatment for PTSD (Bride, 2004). The adverse consequences of secondary traumatic stress negatively impact therapists' work with traumatized clients and may contribute to therapists leaving the field (Figley, 1999). There is emerging evidence on behavioral and emotional implications of indirect exposure to trauma material on mental health professionals. Akinsulure-Smith and colleagues (2012) examined the secondary stress experience of 43 mental health professionals within the National Consortium of Torture Treatment Programs in the United States. A significant correlation was found between anxiety and depression ($r = .49$) among those mental health professionals providing services to torture survivors.

Findings have been mixed regarding the relationship between exposure to traumatized clients and secondary traumatic stress. More recently a significant body of

research has established the relationship (e.g. Adams, Figley, & Boscarino, 2008; Bride, 2004; Hensel et al., 2015). Nevertheless, some studies failed to establish an association and concluded that exposure to clients' traumatic material has little impact on the development of secondary traumatic stress (Devilly, Wright, & Varker, 2009; Kadambi & Truscott, 2004). These findings contradict the research of the originators of these constructs (e.g. Figley, 1995). Furthermore, some studies found that the level of symptoms did not, on average, fall within the clinical range within the sample of therapists (Chrestman, 1995; Devilly et al., 2009). Other studies failed to find a relationship between exposure to traumatized clients and disruption in cognitive schemas. For instance, greater exposure to sexual abuse clients was associated with trauma symptoms but was not associated with higher levels of disrupted cognitive schemas (Brady, Guy, Poelstra, & Brokaw, 1999). Similarly, Pearlman and Mac Ian (1995) found that the greater the proportion of trauma work, the fewer disruptions in self-trust were present in 188 trauma therapists. Bride (2004) stated that empirical research is in its infancy with only 15 published studies. Thus, the current study will build upon this work by examining the interaction between various risk and protective factors as they relate to secondary traumatization.

Literature examining the effects of working with traumatized refugees and asylum seekers on mental health professionals is scarce. Barrington and Shakespeare-Finch's (2014) longitudinal qualitative study is one of three studies that were identified in this literature review to address this topic. The researchers interviewed 12 clinicians providing psychological services to refugees and asylum seekers who have experienced

trauma. The participants reported both distressing and positive effects of their work. Over eighty three percent of the clinicians reported symptoms of vicarious trauma, whereas 91% of the clinicians reported elements of vicarious posttraumatic growth as a result of their work. Another qualitative study that explored the effects of working with refugees revealed similar findings. A group of 13 counselors providing psychological services to refugees shared personal narratives surrounding their work that paralleled client experiences. Hearing the refugees' stories had a profound effect on the majority of the counselors. Feelings of anger, helplessness and exhaustion were prominent in the counselor's narratives (Century et al., 2007). And finally, Akinsulure-Smith and colleagues (2012) examined the secondary stress experiences of providers within the National Consortium of Torture Treatment Programs and found a significant correlation between rates of anxiety and depression.

There is an extensive body of literature discussing the factors associated with secondary traumatic stress among therapists working with trauma survivors (Hensel et al., 2015). Recent studies have examined possible risk factors associated with secondary traumatic stress among counselors in training and mental health professionals. Such factors include personal history of trauma (Pearlman & Mac Ian, 1995), experience level (Chrestman, 1995; Pearlman & Mac Ian, 1995), trauma training (Pearlman & Mac Ian, 1995), and caseload (Chrestman, 1995; Hensel et al., 2015; Schauben & Frazier, 1995). Several research studies suggest that mental health professionals with personal trauma histories may be at higher risks of secondary traumatic stress than those without such histories (Figley, 1995; Hensel et al., 2015; Pearlman & Mac Ian, 1995). Similarly, the

lack of trauma-specific training was also found to be associated with vicarious trauma symptoms (Adams & Riggs, 2008). Several research studies suggested that increased percentage of traumatized clients was associated with increased trauma symptoms among therapists (Bride et al., 2009; Chrestman, 1995). On the other hand, increased professional experience (Chrestman, 1995; Pearlman & Mac Ian, 1995) and higher income (Chrestman, 1995). Attention to the issue of secondary traumatic stress is crucial in mitigating the negative factors influencing the helping professionals.

Measuring Secondary Traumatic Stress

Numerous measures were developed to assess secondary trauma symptoms. However, most of these measures were either modeled on assessment instruments for primary trauma or based on theoretical information (Weitkamp, Daniels, & Klasen, 2014). In response to the paucity of instruments designed to specifically measure secondary trauma symptoms in mental health professionals, Bride et al. (2004) developed the Secondary Traumatic Stress Scale (STSS). A sample of 287 licensed social workers was surveyed during the construction of the STSS. The STSS is a 17-item instrument designed to measure intrusion, avoidance, and arousal symptoms associated with indirect exposure to explicit narratives of traumatic events through one's professional relationships with traumatized clients Bride et al. (2004). More recently, Weitkamp and colleagues (2014) developed a lifetime version and an acute distress version of the Questionnaire for Secondary Traumatization (FST). A sample of 371 psychotherapists, 80 trauma therapists in training, and 197 refugee counselors filled out an online questionnaire during the construction of the instrument. The instrument consists of 31

items designed to measure the four PTSD symptom cluster according to the DSM-5, as well as items measuring sense of threat and safety behavior. The two versions of the measure only differ regarding the instructions (Weitkamp et al., 2014). The Secondary Traumatic Stress Scale (STSS) was used in this study due to its adequate reliability and reasonable number of items.

Empirical Research on Secondary Traumatic Stress and Counselor Self-Efficacy

The effects of direct trauma on perceived self-efficacy have been described in the literature. Studies have concluded that trauma severely reduces perceived self-efficacy to cope with challenging situations (e.g. Benight, Ironson, & Durham, 1999). Similarly, mental health professionals working with trauma survivors are indirectly exposed to traumatic material, which is considered stressful and taxing to the resources of therapists (Pearlman & Mac Ian, 1995). Pearlman and Saakvitne (1995) noted that mental health professionals who work with trauma survivors might feel less confident in their abilities as a result of secondary trauma. Perceived self-efficacy to manage stressful situations affects how individuals view threats and how well they cope with them. Furthermore, self-efficacy beliefs help alleviate anxiety through activating coping efforts (Benight & Bandura, 2004).

There is only limited empirical research exploring the relationship between secondary traumatic stress and counselor self-efficacy among mental health professionals. Only three of the five identified studies were conducted with a sample of professional therapists; additionally one study was conducted with lay counselors and another study was conducted with nurses. Nevertheless, all those studies indicated that

higher levels of secondary traumatic stress are associated with lower levels of self-efficacy (Berger & Gelkopf, 2011; Finklestein et al., 2015; Ortlepp & Friedman, 2002; Sartor, 2012). In one study of 99 mental health professionals working in communities exposed to high levels of trauma, PTSD and vicarious trauma symptoms were negatively correlated with professional self-efficacy (Finklestein et al., 2015). Similar findings were also reported in a study with nonprofessional trauma counselors working with bank employees who have been exposed to a bank robbery. Ortlepp & Friedman (2002) found statistically significant associations between self-efficacy and secondary traumatic stress. Meaning, the stronger the counselors' perceptions of their capabilities and their perceived effectiveness in the counselor role, the less they reported secondary traumatic stress symptoms. In a study conducted with a sample of well baby clinic nurses, improvement on all secondary traumatization measures covaried with the improvement on the professional self-efficacy assessments following an intervention that aimed at providing the nurses with psycho-educational knowledge on trauma in infants, young children and parents (Berger & Gelkopf, 2011). Additionally, two unpublished dissertations asserted that higher levels of secondary trauma were associated with lower levels of counselor self-efficacy (Sartor, 2012; Wilson, 2005). There is an evident need to conduct empirical research exploring the relationship between secondary traumatic stress and counselor self-efficacy among therapists working with traumatized refugee clients since a search in the counseling, psychology, and social work literature yielded no results of such studies.

Summary

Researchers have debated that clinicians working with traumatized clients are at a

higher risk for the development of secondary traumatization, compared to other mental health professionals. Secondary traumatic stress refers to the negative psychological impact of secondary exposure to traumatic events. The symptoms of secondary traumatic stress are very similar to those of primary exposure to a traumatizing events experienced by a client. There has been a paucity of research to date that has empirically assessed this assertion. Although, there is a significant body of research dealing with the variables associated with secondary traumatic stress, the findings are inconsistent and inconclusive. Given this background, the present study aims to fill the gap in existing research. There are no known estimates of the prevalence of secondary traumatic stress among mental health professionals working with traumatized refugee and asylum seeking clients. The current study attempted to add to the literature in this area.

Trauma Training

In this section of the literature review, the variable trauma training is defined and studies examining the relationship between trauma training and counselor self-efficacy are reviewed. Furthermore, studies examining the relationship between trauma training and secondary traumatic stress are reviewed. Lastly, the gaps in the literature and the contribution of the current study to the professional literature are discussed.

Definition and Conceptualization

Counselor training was defined as "all the curricular experiences in counselor education" (Barnes, 2004, p.57). Thus, trauma- training refers to educational experiences specifically addressing trauma related topics. In this research, trauma training included graduate level courses dedicated to working with trauma survivors, seminars, workshops

and other educational opportunities that aim to expand the therapists' knowledge, skills and attitudes about working with trauma survivors.

Therapists working in any mental health settings may be working with trauma survivors; therefore, it is crucial that their training incorporates foundational knowledge regarding working with trauma survivors and trauma interventions (Layne, Briggs-King, & Courtois, 2014). Despite the importance of such training, many mental health professionals working with trauma survivors are not prepared for this work. For instance, Bride and colleagues (2009) surveyed 242 substance abuse counselors regarding their trauma training and found that only 39% of participants acquired academic coursework, 19% had completed an internship, and 82% completed continuing education on trauma or trauma interventions. Furthermore, 21% completed in-service training, 39% attended professional meetings or conferences, and 35% attended workshops or seminars on trauma or trauma interventions. Generally, the results indicate that the majority of substance abuse counselors were not adequately prepared to work with trauma survivors, and most have completed continuing education experiences that focus on working with trauma survivors rather than lengthier trainings. This points to the need for trauma training to be integrated across preparation programs, organizational, continuing education and conference offerings (Courtois & Gold, 2009).

Empirical Research on Training and Counselor Self-Efficacy

There is evidence that training is associated with self-efficacy. In two of the first published studies addressing the relationship between training and self-efficacy, Munson, Zoerink, and Stadulis (1986) and Munson, Stadulis, and Munson (1986), found a positive

correlation between training and self-efficacy among undergraduate students in the recreation and leisure services department. These findings indicate that self-efficacy increases with more training. The relationship between therapist's level of training and counselor self-efficacy seems to be complex and has yielded mixed results (Larson & Daniels, 1998). All of the reviewed studies have found a relationship between training and self-efficacy (e.g. Kozine et al., 2010; Leach et al., 1997; Melchert et al., 1996; Tang et al., 2004; Urbani et al., 2002). Some studies have found that counselor self-efficacy follows a curvilinear pattern rather than a linear one (e.g. Goreczny et al., 2015; Potenza, 1990; Sipps et al., 1988).

Much of the research on counselor self-efficacy has focused on counselors in training rather than professional therapists. Strong evidence for an association between training level of counseling students and counselor self-efficacy has been demonstrated in the literature (Johnson & Seem, 1989; Larson et al., 1992; Leach et al., 1997; Melchert et al., 1996). In a study of 142 master's-level and doctoral-level counseling students, Leach and colleagues (1997) found that more advanced students reported significantly stronger self-efficacy than students with less training. In a study of 138 counseling students and licensed professional psychologists, Melchert and colleagues (1996) found noteworthy results suggesting that level of training accounted for slightly more of the variance in counseling self-efficacy scores than amount of clinical experience. Similarly, in a study examining the effect of age, work experience, training, and internship hours on counseling self-efficacy of 116 counseling students, the findings revealed that self-efficacy was most strongly associated with course work (r = .59) (Tang et al., 2004).

Such findings assert the importance of extended training in addition to clinical experience to further enhance counselor self-efficacy. This is also an indication that training contributes to increases in counseling self-efficacy that cannot be obtained merely through acquiring clinical experience (Melchert et al., 1996). More recently, Kozina and colleagues (2010) conducted a study with 20 graduate practicum students and found an overall increase in total COSE scores overtime with training. .

The studies described above found a linear relationship between the variables among counselors in training. Another group of studies found that counselor self-efficacy does not follow a linear path; rather the researchers have found a curvilinear relationship between training and counselor self-efficacy among counselors in training. In a study with 78 graduate counseling students, Sipps et al. (1988) found that third- and fourth-year counseling students had higher levels of self-efficacy than first-year or second-year students. However, second-year students' self-efficacy was reported to be lower than first-year students, which indicates a curvilinear relationship. In a more recent inquiry, Goreczny et al. (2015) also found curvilinear relationships across level of training for self-efficacy. The sample consisted of 97 participants. Within this sample, there were 21 undergraduate students taking an undergraduate Abnormal Behavior course and 76 graduate students enrolled in a counseling psychology program. One possible explanation for these findings is that undergraduate students without sufficient knowledge and experience may overestimate their efficacy (Kruger & Dunning, 1999) and as students progress to graduate training they may have increased their knowledge enough to know what they do not know, which may have resulted in their relatively lower self-efficacy.

Finally, once advanced-level graduate students begin to perform counselor activities, they begin to positively appraise their self-efficacy (Goreczny et al., 2015).

While most studies examining counselor self-efficacy have been conducted with graduate students, two of the identified studies focused on professional counselors. Chandler and colleague's (2011) national study examined the relationship between training and perceived self-efficacy among licensed substance abuse counselors. The results suggested that regardless of amount of training, counselors identified moderately high levels of perceived self-efficacy. For these counselors, being licensed and having clinical experience working with clients in the field might have provided the necessary experience to increase their perceived self-efficacy in a manner that training alone may not have been able to do. These results contrast the results of the studies conducted by Melchert et al. (1996) and Tang et al. (2004) that suggested that the level of training accounted for slightly more of the variance in counseling self-efficacy scores than amount of clinical experience.

In another inquiry, Ben-Porat and Itzhaky (2011) studies the differences between domestic violence therapists who had received specialized training and those who had not. The sample consisted of 143 social workers employed at domestic violence centers and shelters. The results yielded significant differences between the two groups with regard to their sense of role competence. Thus, social workers that had received specialized training on domestic violence reported higher levels of competence and problem solving than did those who had not received training. The results of the abovementioned studies support the large body of literature suggesting a relationship

between training and self-efficacy.

Empirical Research on Trauma Training and Counselor Self-Efficacy

All of the studies discussed earlier focused on general counseling training as it relates to self-efficacy. Very limited empirical research was found to explore the relationship specifically between trauma training and self-efficacy among therapists working with trauma survivors. Furthermore, no studies were found to focus specifically on therapists working with traumatized refugees.

Only one study was identified that focused specifically on trauma training among mental health professionals. Woody and colleagues (2015) assessed the self-efficacy of 33 community practitioners who received specific training in trauma-focused cognitive behavioral therapy (TF-CBT). The participants completed a pre-survey at the basic training level and then a post-survey six months later after completing an advanced training. The survey was specifically developed for this study to measure self-efficacy for TF-CBT. The researchers found that therapist's counselor self-efficacy increased from the basic to the advanced level of training. In another study conducted with 90 well baby clinic nurses, participants were randomly assigned to the experimental intervention and a waiting list group. The intervention provided the participants with psycho-educational knowledge pertaining to stress and trauma. The participants in the intervention group improved significantly on the professional self-efficacy measure as a result of the training (Berger & Gelkopf, 2011).

While training has been reported as statistically significant predictor of the degree of counselor self-efficacy in the literature (Larson & Daniels, 1998; Melchert et al.,

1996), studies have yielded varied results on the pattern that it follows. For example, some studies found a linear relationship between training and self-efficacy (e.g. Tang et al., 2004), while others found a curvilinear relationship (e.g. Goreczny et al., 2015). One possible explanation for these results could be due to using different instruments to measure self-efficacy. The current study added to the literature through exploring the relationship between trauma training and counselor self-efficacy among mental health professionals working with trauma survivors, specifically refugees. This was the first study to focus on specialized trauma training as it related to counselor self-efficacy among mental health professionals.

Empirical Research on Trauma Training and Secondary Traumatic Stress

Some scholars maintain that providing trauma specific training programs is necessary for working with trauma survivors (Ben-Porta & Itzhaky, 2011; Courtois & Gold, 2009). Inadequate trauma training may be a key reason for high prevalence of burnout, vicarious trauma, and secondary trauma (Zimering et al., 2003). Encouraging ongoing professional education in the area of trauma will help to broaden clinicians' professional resources while reducing stress (Brady et al., 1999) and perhaps work through personal traumatic experiences and strengthen resilience (Berger & Gelkopf, 2011). Appropriate and sufficient trauma training provides therapists with theoretical knowledge to better understand their clients, acquire skills for intervention, and develop boundaries and coping skills (Kanter, 2007). Furthermore, with the theoretical knowledge in the field of therapy with trauma survivors and awareness of the implications of working with this population, therapists may be better equipped to overcome feelings of

isolation and avoid secondary traumatization (Bell, Kulkarni, & Dalton, 2003; Harrison & Westwood, 2009). Sommer (2008) expanded this idea and argued that raising awareness of therapists on the risks associated to working with trauma survivors is not only an essential aspect of appropriate training, but is the ethical obligation of professionals who train therapists in the field. Additionally, trauma training was found to improve counselor self-efficacy and reduce secondary traumatic stress (Berger & Gelkopf, 2011).

While there is growing consensus supporting the need for training in working with trauma survivors (Figley, 1995), some therapists indicate that their academic training did not provide them with the basic skills for working with trauma survivors (Alpert & Paulson, 1990). Adams and Riggs (2008) insinuated that graduate programs often offer minimal information regarding trauma interventions, while few programs offer extensive training related to trauma in a semester long course or intensive workshop. Research findings suggest that limited lectures or class discussions are not sufficient to prepare mental health professionals to work effectively with trauma survivors, rather, therapists need substantial trauma training in the form of a full semester course or multiple intensive workshops (Adams & Riggs, 2008).

The risks of insufficient trauma training among therapists working with trauma survivors have been documented in the literature. Pearlman and Saakvitne (1995) argued that without formal trauma specific training, trauma therapists are vulnerable to confusion and potential impairment by the work. The authors also asserted that certain strategies could help reduce the influence of secondary traumatic stress such as training (Pearlman

& Mac Ian, 1995). Furthermore, research indicated that the degree of trauma-specific training was negatively correlated with secondary traumatic stress (Berger & Gelkopf, 2011). Consistent with existing research, Adams and Riggs (2008) reported that novice counselors in training who had insufficient trauma-specific training are more vulnerable to vicarious trauma.

There is evidence that even for more experienced therapists ongoing training and professional development have been advocated as means of preventing vicarious trauma (Courtois & Gold, 2009; Voss Horrell et al., 2011). In one study, Sprang, Clark & Whitt-Woosley (2007) found that specialized trauma training was associated with lower levels of compassion fatigue among 1,121 mental health providers, suggesting that specialized training might mitigate the negative effects of trauma exposure. Similarly, Chrestman (1995) concluded that training as assessed by number of CEUs acquired, was associated with decreased avoidance, thus supporting the premise that more training is associated with reduced secondary traumatic stress.

On the other hand, two of the reviewed studies concluded that there is no association between trauma training and secondary traumatic stress. In a study conducted with a sample of emergency care workers no significant correlation between training and posttraumatic symptoms was found (Warren, Lee, & Saunders, 2003). In another study by Ben-Porta & Itzhaky (2011) no significant differences were found between social workers who received trauma training and those who had not with regard to secondary traumatization as measured by the STSS (Bride, 1999).

Although the literature has emphasized the importance of professional training in

enhancing competency (Strand, Abramovitz, Layne, Robinson, & Way, 2014) and reducing secondary traumatic stress (Harrison & Westwood, 2009) among mental health professionals working with trauma survivors, limited empirical studies examined the contribution of training to reducing secondary traumatic stress among those therapists (Ben-Porat & Itzhaky, 2011), and to date no research has been conducted among therapists working with refugees who have experienced trauma. Furthermore, there remains a paucity of specific training focusing on trauma and secondary traumatic stress in mental health preparation programs and professionals development opportunities despite the prevalence of trauma exposure among clients (Courtois & Gold, 2009; Layne et al, 2014; Strand et al., 2014).

Summary

Trauma training specifically refers to trauma specific training opportunities such as graduate level courses dedicated to working with trauma survivors, seminars, workshops and other professional development opportunities that aim to expand the therapists' knowledge, skills and attitudes on working with trauma survivors. There is empirical evidence suggesting that there is a relationship between training and self-efficacy, however there is a paucity of studies focusing on specialized trauma training and counselor self-efficacy. Similarly, strong support for an association between trauma training and secondary traumatic stress has been demonstrated in the literature. Nevertheless, studies have been mixed and inconclusive on this topic. The contradictory findings and lack of research on the relationships between those variables, and the need to reduce secondary traumatic stress among therapists, highlight the importance of

research aimed at enhancing knowledge about the issue. The current study attempted to fill this gap by exploring the relationship between trauma training and counselor self-efficacy, in addition to examining the partially mediating effect of secondary traumatic stress.

Experience

In this section, therapists' experience is defined and empirical literature on the association between therapists' years of clinical experience and counselor self-efficacy is reviewed. Additionally, studies examining the relationship between experience and secondary traumatic stress are reviewed. Lastly, a discussion of the gaps in the literature and the significance of the current study in attempting to fill this gap are provided.

Definition and Conceptualization

Experience in this study was defined as the years of clinical experience that therapists have obtaining after receiving a master's degree in the mental health field. Experience may be particularly important when working with refugees who have experienced trauma to have the needed knowledge, skills and attitudes to provide effective services to this unique population. Therefore, it is essential to explore how experience may influence the work of mental health professionals working with traumatized refugees.

Empirical Research on Experience and Counselor Self-Efficacy

Experience is a construct that has been found to have a significant impact on self-efficacy in the literature (Leach et al., 1997; Melchert et al., 1996). A group of studies examined the relationship between experience and counselor self-efficacy. In a study

examining self-efficacy theory and counselor development, Melchert and colleagues (1996) found significant differences in clinical experience and training amongst four participant groups of graduate counseling students. The findings yielded that counseling self-efficacy was stronger for therapists who had some or more counseling experience than none at all. Furthermore, Leach and colleagues (1997) examined counselor self-efficacy in relation to theoretical domains within the Integrated Developmental Model of supervision (IDM). The findings indicated that students with more counseling experience had greater self-efficacy in utilizing microskills, dealing with difficult behaviors, counseling culturally diverse clients, and achieving a greater awareness of one's values and relationship to other clients (Leach et al., 1997). Similarly, Friedlander and Snyder (1983) and Goreczny and colleagues (2015) found statistically significant correlations between years of counseling experience and counselor self-efficacy. Finally, in a study examining the effect of age, work experience, training, and internship hours on counseling self-efficacy of 116 counseling students, the findings revealed that internship hours and work experience were positively correlated with counseling self-efficacy (Tang et al., 2004).

Previous research has consistently, found that more experienced counselors reported higher levels of self-efficacy (Larson & Daniels; 1998; Lent et al.; 2003) and counselor self-efficacy is stronger for individuals with at least some counseling experience than for those with none (Melchert et al., 1996; Tang et al., 2004). However, there is some evidence that after gaining some experience and receiving supervision the relationship becomes minimal (Larson & Daniels, 1998; Potenza, 1990).

Empirical Research on Experience and Secondary Traumatic Stress

Investigations of the relationship between years of experience and secondary traumatic stress have yielded mixed results. The results can be organized in three categories: no relationship, negative relationship and positive relationship. First, some studies have failed to show a relationship between years of experience and secondary traumatic stress (e.g. Bride et al., 2007; Ortlepp & Friedman, 2002) and the relationship between secondary traumatic stress and years spent in trauma work (Deighton, Gurris, & Traue, 2007). Second, several studies suggested that increased years of experience is associated with decreased secondary traumatic stress (Chrestman, 1999; Kadambi & Pearlman & Mac Ian, 1995). Third, other studies found that more years of experience were related with more severe secondary traumatic stress symptoms (Meyers & Cornille, 2002) and burnout and compassion fatigue were positively correlated with number of years spent in trauma work (Birck, 2001).

Overall, the majority of the reviewed studies found that novice therapists with minimal work experience were more vulnerable to experiencing secondary traumatic stress than more experienced therapists (Adams & Riggs, 2008; Jenkins & Baird, 2002; Chrestman, 1995; McCann and Pearlman, 1992; Nuemann & Gamble, 1995; Pearlman, 1995; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). Specifically, Jenkins and Baird (2002) found that novice counselors reported more emotional exhaustion when compared to experienced counselors. Furthermore, less experienced therapists reported more somatic symptoms, anxiety, and depression than more experienced therapists (Pearlman & Mac Ian, 1995). Additionally, novice therapists were more likely than more

experienced therapists to experience mental intrusions of their clients' traumatic imagery and symptoms consistent with burnout (Maslach, 2003).

On the other hand, more clinical experience predicted lower burnout scores (Ballenger-Browning et al., 2011). Furthermore, age and experience were found to have a negative correlation with the development of secondary traumatic stress. Younger and less experienced counselors exhibited the highest levels of distress (Pearlman & Mac Ian, 1995). These results indicate that novice therapists may have had less opportunity to develop effective coping strategies, thus are less experienced in dealing with the impact of secondary traumatic stress than older and more experienced therapists (Neumann & Gamble, 1995). Lastly, Chrestman (1995) found that professionals with more experience tend to cope better with the presentation of trauma material. The majority of the reviewed studies suggest that years of experience ameliorate work stress and burnout.

Several studies using therapist samples have found that possessing less experience providing trauma treatment is associated with more difficulty, including increases in avoidance, dissociation, anxiety, intrusions, and other trauma symptoms (Chrestman, 1995; Pearlman & Mac Ian, 1995; Way, vanDeusen, Martin, Applegate, & Jandle, 2004). Consistent with existing research, results from Adam and Riggs' (2008) study concluded that clinical and counseling psychology graduate students with less experience reported higher levels of secondary traumatic stress. As expected, therapists in training with less than two semesters of applied experience working with trauma clients reported significantly higher levels of impairment than those with more experience. Furthermore, newer therapists reported more somatic symptoms, anxiety, and depression than more

experienced therapists (Pearlman & Mac Ian, 1995). Finally, Michalopoulos and Aparicio (2012) reported that more professional experience and increased support were likely to decrease the vulnerability for vicarious trauma among social workers.

Summary

Experience was defined as the years of clinical experience that therapists have obtaining after receiving a master's degree in the mental health field. The relationship between experience and counselor self-efficacy has been widely researched. There seems to be consensus in empirical literature that counseling self-efficacy was stronger for therapists who had some or more counseling experience than none at all (e.g. Goreczny et al., 2015. Additionally, more professional experience is associated with decreased vulnerability to secondary traumatic stress among therapists working with trauma survivors (Bride et al., 2007). The current study added to trauma literature by exploring the relationship between experience and counselor self-efficacy among mental health professionals working with the traumatized refugees, which has been a neglected population in the literature.

Percentage of Traumatized Clients

In this final section of the literature review, the variable percentage of traumatized clients is defined and empirical literature on the association between percentage of traumatized clients and counselor self-efficacy is reviewed. Additionally, studies examining the relationship between percentage of traumatized clients and secondary traumatic stress are reviewed. Lastly, a discussion of the gaps in the literature and the significance of the current study in attempting to fill this gap are provided.

Definition and Conceptualization

Percentage of traumatized clients refers to the percentage of trauma cases under the current care of the therapist. This variable is the least researched variable in the literature. A dearth of empirical literature exists on the percentage of traumatized clients in relation to other factors. It is hypothesized that the percentage of traumatized clients may affect the performance of mental health professionals working with trauma survivors. Thus this section will review past literature that addressed this topic.

Empirical Research on Percentage of Traumatized Clients and Counselor Self-Efficacy

No studies were found that examined the association between the percentage of traumatized clients and counselor self-efficacy, except for one dissertation that found that as the percentage of trauma clients increased, counselor self-efficacy decreased (Sartor, 2012). Participants ($N = 82$) were mental health professionals working with traumatized clients practicing in mental health hospitals, treatment centers, and non-profit and community organizations in Texas. In this study, it was hypothesized that there is an association between the current percentage of traumatized clients and counselor self-efficacy such that the higher the percentage of traumatized clients in the therapist's caseload, the weaker the counselor self-efficacy will be. A statistically significant negative correlation between the two variables was found, $r = -.45$, $p < .001$, ($R^2 = .2$), with high levels of vicarious trauma associated with low levels of self-efficacy. The current study will build upon this work by empirically examining the relationship between the variables and adding to professional knowledge regarding the relationship between the percentage of traumatized clients and counselor self-efficacy.

Empirical Research on Percentage of Traumatized Clients and Secondary Traumatic Stress

The majority of the reviewed studies revealed that higher percentages of trauma clients are associated with more symptoms of secondary traumatic stress in mental health professionals (Brady et al., 1999; Bride et al., 2007; Chrestman 1995; Dagan et al., 2015; Schauben & Frazier, 1995). However, some studies found contradicting results where the percentage of sexual abuse history was not associated with trauma symptoms (Follette et al., 1994). For example Follette et al., 1994 conducted a study with 164 licensed psychologists and 307 marriage and family therapists (MFT) and found that the percentage of therapists' caseload reporting a sexual abuse history was not significantly predictive of trauma symptoms. Similarly, Adams, Figley, & Boscarino (2008) found that having a high percentage of clients who were victims of violence was not statistically associated with secondary trauma among 236 social workers living in New York City 20 months following the September 11 terrorist attacks.

The relationship between the percentage of traumatized clients and secondary traumatic stress has empirical support in the literature. Generally, a large caseload per week, continuous client contact and long work hours were predictive of higher burnout among mental health professionals (Ballenger-Browning et al., 2011; Maslach, 2003). Mental health professionals who are exposed to extensive trauma material through a higher caseload of trauma clients may be at a higher risk for developing cognitive disturbances associated with secondary traumatic stress (Chrestman, 1995; Neumann & Gamble; 1995; Pearlman & Mac Ian; 1995). In a survey of 148 counselors, Schauben and

Frazier (1995) found that counselors who worked with a higher percentage of sexual violence survivors reported more symptoms of posttraumatic stress disorder and greater disruptions in their beliefs about themselves and others than did counselors seeing fewer sexual violence survivors. Similarly, women psychologists and sexual violence counselors with a higher percentage of sexual violence survivors in their caseload reported more symptoms of PTSD, more self-reported secondary traumatic stress, and more disruption in their cognitive schemas (Brady et al., 1999; Schauben & Frazier; 1995). Chrestman (1995) found that therapists who had higher caseloads of trauma clients reported more trauma-related symptoms. On the other hand, research has shown that having a more diverse caseload is associated with decreased secondary traumatic stress. Such diversity may help therapists better manage the traumatic material and prevent the development of secondary traumatic stress (Pearlman & Saakvitne, 1995). In a study of child protective services workers ($N = 187$), secondary traumatic stress symptoms were positively correlated with caseload size ($r = .171$), meaning higher caseloads were associated with increased secondary traumatic stress symptoms (Bride et al., 2007).

The extent of influence of the percentage of traumatized clients on secondary traumatic stress many vary depending on the study. In their meta-analysis, Cieslak et al. (2013) found that the ratio of traumatized clients in therapists' professional career was associated with secondary traumatic stress among 224 mental health providers working with the military. Similarly, research suggested that the percentage of traumatized clients might be a common stressor among therapist working with traumatized clients (Bride et

al., 2009). In a study conducted with 259 therapists, hours per week spent counseling traumatized clients was the best predictor of trauma scores; therefore, the best preventive measure against trauma symptoms among therapists seems to be a balanced workload (Bober & Regehr, 2006). In a meta-analysis of 38 published studies, Hensel et al. (2015) examined risk factors associated with secondary traumatic stress among professionals and found small significant effect sizes for trauma caseload volume (r = .16), caseload frequency (r = .12), caseload ratio (r = .19). This suggests that a balanced caseload may help mitigate likelihood of experiencing secondary traumatic stress. Schauben & Fraizer (1995) assessed the relationship between working with sexual violence survivors and psychological functioning and that counselor who had higher percentages of survivors reported more disruptions in basic schemas, more PTSD symptoms and greater vicarious trauma.

Summary

Percentage of traumatized clients refers to the current percentage of clients who have experienced traumatic event(s) in the therapist's caseload. There is very limited empirical research on the relationship between the percentage of traumatized client and counselor self-efficacy. Only one dissertation was reviewed where counselor self-efficacy appeared to decrease as the percentage of trauma clients increased (Sartor, 2012). The percentage of traumatized clients in the therapist's caseload has been also found to relate to levels of secondary traumatic stress. Mental health professionals who are exposed to more trauma material may be at even a higher risk for developing secondary traumatic stress (Chrestman, 1995; Neumann & Gamble; 1995; Pearlman & Mac Ian; 1995). Given

the paucity of empirical evidence on the relationships between percentage of traumatized clients, secondary traumatic stress and counselor self-efficacy, the current study attempts to fill this gap and add to the body of literature in this area.

Summary

In this chapter a review of conceptual and empirical literature relevant to the variables was presented. The review of literature provides a rationale for the need for this study. This section opens with relevant literature on trauma and refugee clients, and then presents conceptual and empirical literature on counselor self-efficacy. The third section provides information on secondary traumatic stress and its relationship to counselor self-efficacy. The following three sections provide conceptual and empirical literature on the relationship between the independent variables (perception of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress) and the dependent variable, counselor self-efficacy. Finally, evidence of the relationship between secondary traumatic stress and the independent variables was presented in order to provide basis for its mediating effect. Overall, the information in this chapter was intended to summarize the relevant literature highlighting the paucity of empirical data on the variables and unique population targeted in this study. In addition, this section provided support for the inclusion of the different variables in the study.

CHAPTER 3: METHODOLOGY

Introduction

This chapter provides a description of the methodology used in completing the study, including a description of participants and procedures related to data collection. Instruments used in this study will be described as well as the design of the study, research questions and data analysis. The purpose of this study was to examine how perceptions of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress are related to counselor self-efficacy among mental health professionals who work with refugee and asylum seeking clients who have experienced trauma. The study also examined the partially mediating effect of secondary traumatic stress on the relationship between the independent variables and the dependent variable.

Description of Participants

The population of interest in this study was mental health professionals who work with refugees and asylum seekers with trauma history. In order to obtain a representative population of therapists, the participants were recruited through contacting agencies and professional organizations across the United States specializing in working with refugees and asylum seekers, such as the 34 member organizations of the National Consortium of Torture Treatment Programs (NCTTP). The participant pool was expanded to include participants from professional organizations including members of the National

Association of Social Workers who specialize in trauma work and the Florida Counseling Association, and other mental health professionals who specialize in working with refugees. Professionals meeting the following criteria were included: (1) those who have a graduate degree in a mental health field including counseling, psychology, psychiatry, or social work and (2) those who currently provide therapeutic services for traumatized refugees and asylum seekers in the United States. The participants in the study consisted of a purposeful sample selected to focus on particular characteristics that are of interest (Sheperis, 2010). The target sample size was 200 participants in order to have reasonable power and adequate statistical precision for a path analysis (Kline, 2016).

One hundred and ninety three participants attempted to complete the online survey however only 98 mental health professionals met the eligibility criteria. The majority of participants who did not meet the eligibility criteria were not providing therapeutic services for traumatized refugees and asylum seekers in the United States at the time of the study. There were no missing or invalid data; therefore 98 participants were included in this study.

Data Collection Procedures

Several procedures were used to collect the data for the study. In recent decades, we have witnessed the proliferation of web-based surveys since it is a relatively inexpensive, efficient and a fast way to collect data. Thus, a web-based survey was utilized to collect the data for the current study. Strategies that have been found to efficiently improve the response rate were taken into consideration. First, personalizing communication through addressing participants using their names helped establish a

connection with participants. Second, the emails specified how the survey results would be useful to others. Third, monetary incentives were used to improve the survey response rate (Dillman, Smyth, & Christian, 2014).

The survey was comprised of two instruments that were used to measure counselor self-efficacy and secondary traumatic stress. A third instrument was developed for the purposes of this study to measure perceptions of trauma training. A demographic questionnaire was developed to gather information about participants' trauma training, work experience and percentage of traumatized clients and to enable a detailed description of the sample. The final survey was comprised of 73 items and took approximately 15-20 minutes to complete. Prior to conducting the study, a small pilot test was conducted with two therapists who meet the inclusion criteria to assess participants' comprehension of instructions, the time needed to complete the survey, and the appropriateness of items for the target population. The survey was also reviewed with these therapists to ensure comprehension of content and interpretation of questions.

A list of agencies working with refugees and asylum seekers was assembled using the National Consortium of Torture Treatment Programs website and other Internet sources. Additionally, a list of members of the National Association of Social Workers who specialize in trauma work was purchased. Consequently, contact information of therapists working at these organizations was acquired and an email list of potential participants was developed. In accordance with Dillman and colleagues' (2000) suggestions for survey implementation sequence, upon receiving approval from the University of North Carolina at Charlotte's Institutional Review Board, the researcher

sent an initial email describing the purpose of the study and directing the participants to complete the survey (see Appendix A). All potential participants were sent a follow-up email (see Appendix B) one week after the original participation request. This reminder email thanked those who had participated and requested participation again from those who had not yet completed the survey. A second reminder and final email (see Appendix C) was sent to the participants to thank them for their participation and provide them a final opportunity to complete the survey before the closing of the data collection period. Information regarding the results of a prize drawing was also provided.

The researcher used SurveyShare, a web-based based survey for rapid and efficient dissemination. The email included a secure electronic link to the survey and by clicking on the link participants acknowledged their voluntary participation in the study. The survey opened with instructions, the informed consent (see Appendix D), which established confidentiality, the risks and benefits of participating in the study, the importance of respondents' participation, an estimate of time needed to complete the survey, and the voluntary nature of participation. After consenting to participate, participants were asked to complete the web-based survey. The survey remained open for four weeks. To thank participants for their time, upon completion of the survey, all participants were offered the opportunity to provide their name and contact information for a random drawing to win one of four $50 Amazon eGift cards (see Appendix E). The information collected for the drawing was not connected to the survey responses. The use of incentives in web-based surveys has been shown to increase the response rate (Göritz, 2006). Furthermore, Bosnjak and Tuten (2003) found that random prize draws resulted in

a greater response rate than other types of incentives such as prepaid or promised monetary incentives in web-based surveys. Participants' names and contact information for this drawing were not connected to their survey responses in order to assure anonymity of responses. The prize drawing took place upon completion of the data collection and four participants received $50 Amazon electronic gift cards. All data collected with the electronic survey was kept securely on password-protected Google drive.

Instrumentation

Several instruments were used in the data collection process. The final survey included a demographic measure that also included information on trauma training, experience and percentage of traumatized clients questionnaire, the Counseling Self-Estimate Inventory (COSE), the Secondary Traumatic Stress Scale (STSS). Permission was requested and granted from the developers of the instruments (see Appendices F and G). The following section includes descriptions of each of these instruments.

Demographic Questionnaire

The demographic questionnaire (See Appendix H) was comprised of 19-item survey developed specifically for this study. Items were designed to obtain descriptive information about the participants' gender, ethnicity, and education. In addition, information about the subjects' professional experience was collected regarding their highest educational level, field of study, licensure status, and professional credentials. Participants were also asked to identify which intervention approaches they use primarily when working with traumatized refugees. A list of the most commonly used interventions

were provided and the participants selected one intervention that they primarily use when working with traumatized refugees.

For the purposes of data analysis, information about participants' trauma training, work experience and client caseload was obtained. To gather information about therapists' training, participants were asked to indicate whether they had substantial (e.g., multiple workshops, semester-long course, other extensive formal training), minimal (e.g., one workshop or seminar), or no trauma- training. They also indicated the number of courses, workshops and continuing education hours they have completed on the subject of the treatment of trauma and trauma survivors. To learn about therapists' work experience, participants answered a question about previous number of years spent working in the capacity of a therapist after completing a master's degree. Finally, participants answered a question regarding the percentage of traumatized clients in their current caseload.

Perceptions of Trauma Training

The survey also included one question with four items related to participants' previous trauma training. Participants' perception of their trauma training was assessed using a seven-point semantic differential scale (Osgood, Susi, & Tannenbaum, 1957). Semantic differential scales measure the subjective meaning and value of concepts in terms of ratings on bipolar scales defined with contrasting adjectives. Osgood found that three dimensions of affective meaning were universal: evaluation (e.g., good-bad), potency (e.g., strong-weak), and activity (e.g. active-passive). In this research, four semantic differential scales were developed to generate a score that indicated the

participants' perception of their trauma training. Each score was the sum of six items with two bipolar pairs of adjectives.

Counseling Self-Estimate Inventory (COSE)

The Counseling Self-Estimate Inventory (COSE) is a suitable instrument for measuring counselor self-efficacy since it is based on Bandura's self-efficacy theory. Furthermore, the COSE was found to be the most widely used measure to assess self-efficacy beliefs (Larson & Daniels, 1998). The assessment was developed through five studies to assess counselors' perceived confidence in counseling performance. The studies included a total of 213 counseling trainees, master's level counselors, and counseling psychologists (Larson et al., 1992). A factor analysis resulted in five dimensions that reflect counselor's confidence in using microskills, attending to counseling process, dealing with difficult client behaviors, cultural competence, and awareness of one's own values. The COSE consists of 37 items (see Appendix I) with a six point Likert-type scale ranging from 1 (strongly disagree) to 6 (Strongly Agree) to indicate degree of confidence to completing various counseling-related tasks. The total score ranges from 37 to 222, with higher scores indicating higher self-efficacy beliefs (Larson et al., 1992). Scores closer to one indicated strongly disagree whereas scores closer to six indicated strongly agree. Questions 2, 6, 7, 9, 16, 18, 19, 21, 22, 23, 24, 26, 27, 28, 31, 33, 35, 36 and 37 were reversed from strongly disagree to strongly agree. As noted above, the instrument includes the five subscales. Microskills subscale (12 items) reflects the effectiveness of a therapist's responses; an example is "I am confident that I will be able to conceptualize my client's problems." The counseling process subscale (10

items) refers to actions that are mutually determined by the client and the therapist; a sample item is "I am uncertain as to whether I will be able to appropriately confront and challenge my client in therapy." The difficult client behaviors subscale (7 items) refers to the knowledge and skills required in dealing with challenging client issues; an example is "I am uncomfortable about dealing with clients who appear unmotivated to work toward mutually determined goals." Cultural competence subscale (4 items) refers to one's competence with respect to ethnicity and social class; a sample item includes "I will be an effective counselor with clients of a different social class." Finally, the values subscale (4 items), refers to therapists' self-awareness of their own biases; a sample item includes "I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my counseling abilities" (Larson et al., 1992). The total score of this measure was used in the study as per the recommendation of the author of the instrument.

The COSE indicated an acceptable level of reliability with internal consistency for the total score having Cronbach alpha levels of .93; Microskills = .88; Process = .87; for Difficult Client Behaviors = .80; for Cultural Competence = .78; and for Awareness of Values = .62. The item-total correlations ranged from .32 to .65 with the exception of 3 items. A three-week test-retest reliability of .87 for the overall COSE score, for Microskills, r = .68; for Process, r = .74; for Difficult Client Behaviors, r = .80; for Cultural Competence, r = .71; and for Awareness of Values, r = .83. Initial validity estimates show that the instrument is positively related to counselor performance, self-concept, problem-solving appraisal, performance expectations, and class satisfaction, and negatively related to state and trait anxiety. Discriminant validity revealed that the COSE

is minimally related to aptitude, personality, defensiveness, and achievement (Larson et al., 1992). In summary, the psychometric properties are well established and it is one of very few scales that assess multicultural competence. Thus, the use of this scale with therapists working with refugees seemed appropriate.

Secondary Traumatic Stress Scale (STSS)

The Secondary Traumatic Stress Scale (STSS; Bride, 1999) is a 17-item instrument (see Appendix J) designed to measure the frequency of secondary traumatic stress symptoms in the past seven days. It is comprised of the Intrusion subscale (5 items), the Avoidance subscale (7 items), and the Arousal subscale (5 items) that are congruent with the PTSD symptom clusters in the DSM-IV-TR (American Psychiatric Association, 2000). The scale uses a five point Likert-type scale, ranging from 1 (never) to 5 (very often) to evaluate frequency of each symptom in relation to participants' work with clients who had been exposed to traumatic events. Sample items for intrusion include "I had disturbing dreams about my work with clients," for avoidance "I felt emotionally numb," and for arousal include "I had trouble sleeping." The total score of the instrument were used in this study.

With regard to the psychometric qualities of the assessment, a sample of 287 licensed social workers completed a mailed survey containing the STSS and other relevant survey items. Bride and colleagues (2004) conducted a confirmatory factor analysis to assess whether the items divided into the three subscales as projected. Each item loaded on its intended factor, with factor loadings ranging from .58 to .79, and the symptoms were clustered into the three subscales as predicted. The STSS indicated

sufficient convergent, discriminant, and factor validity, as well as Cronbach alpha levels, for the Total Scale having an alpha of .93; Intrusion = .80; Avoidance = .87; and Arousal = .83 (Bride et al., 2004). Bride and colleagues (2004) identified different ways to score the STSS including using the total score or using the subscale scores. The total score of the measure was used in this study to indicate the overall level of secondary traumatic stress and examine its relationship with other variables. Total scores below 28 indicate little or no secondary traumatic stress, scores ranging from 28 and 37 indicate mild secondary traumatic stress, scores between 38 and 43 suggest moderate secondary traumatic stress, scores between 44 and 48 indicate high levels of secondary traumatic stress, and scores of 49 or higher indicate severe secondary traumatic stress (Bride, 2007).

Research Design

A non-experimental correlational research design was employed to examine the relationship between the independent variables: perception of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress and the dependent variable, counselor self-efficacy. The selection of the variables in the current study was based on theory and the literature. Multiple regression analyses were conducted in order to examine the relationships among the variables.

Research Questions

1. How are perceptions of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress related to counselor self-efficacy among

mental health professionals who work with refugee and asylum seeking clients who have experienced trauma?

2. How are perceptions of trauma training, experience, and percentage of traumatized clients related to counselor self-efficacy after controlling for secondary traumatic stress?

Data Analysis

The data was collected from the web-based survey and downloaded to the data analysis software. Regression analyses were utilized to answer the research questions. Regression analyses allow the investigation of the relationship between one dependent variable and several independent variables (Tabachnick & Fidell, 2013). The Statistical Package for the Social Sciences (SPSS) software program was used for data preparation, gather descriptive statistics, and conduct multiple regression and hierarchical multiple regression analyses. The following sections provide further details on the analyses.

Descriptive Statistics

SPSS was used for descriptive statistical analysis. Descriptive statistics were used to describe the participants of the study, including the number of participants, gender, race/ethnicity, region, educational level, field of study, work setting, and licensure information. In addition range of scores, and coefficient alphas, mean scores, and standard deviation for all the variables in the study were calculated.

Standard Multiple Regression

Standard multiple regression analysis was used to analyze the data. The independent variables were perception of trauma training, experience, percentage of

traumatized clients and secondary traumatic stress, while the dependent variable was counselor self-efficacy. Multiple regression is a statistical technique that permits the researcher to assess the relationship between one dependent variable and several independent variables. In this analysis all the independent variables were entered into the regression equation at once where each variable's prediction of the dependent variables is evaluated (Tabachnick & Fidell, 2013). Analysis was performed using IBM SPSS REGRESSION and EXPLORE for evaluation of assumptions.

Hierarchical Multiple Regression

In this study a hierarchical multiple regression analysis was performed to examine how much counselor self-efficacy variance is accounted for by perception of trauma training, experience, and percentage of traumatized clients after controlling for secondary traumatic stress. In hierarchical multiple regression, independent variables are entered in the equation in a specific order and each variable is evaluated of what is contributes to the equation (Tabachnick & Fidell, 2013). In this study, first secondary traumatic stress was entered into the equation to assess what it adds to the equation. Next, the remaining independent variables (perception of trauma training, experience, and percentage of traumatized clients) were entered to the equation. Analysis was performed using IBM REGRESSION and EXPLORE for evaluation of assumptions.

Summary

In this chapter, the participants of the study and a description of the sampling method were provided. Data collection procedures were described and the instruments used for data collection were also discussed. The final survey included a demographic

measure that also included information on trauma training, experience and percentage of traumatized clients questionnaire. In addition a perception of trauma training measure, the Counseling Self-Estimate Inventory (COSE), the Secondary Traumatic Stress Scale (STSS) were utilized in this study. Furthermore, a description of the data analysis procedures in the study was provided. Standard multiple regression analysis was used to analyze the data. The independent variables were perception of trauma training, experience, percentage of traumatized clients and secondary traumatic stress, while the dependent variable was counselor self-efficacy. Additionally, a hierarchical multiple regression analysis was performed to examine the partially mediating effect of secondary traumatic stress on the relationship between the independent variables (perception of trauma training, experience, and percentage of traumatized clients) and the dependent variable (counselor self-efficacy). This helped in determining how much do the other independent variables predict of counselors self-efficacy after secondary traumatic stress have contributed its larger share to the prediction.

CHAPTER 4: RESULTS

The purpose of this research study was to examine how perceptions of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress are related to counselor self-efficacy of mental health professionals who work with refugee and asylum seeking clients who have experienced trauma. The study also examined how much counselor self-efficacy variance is accounted for by perception of trauma training, experience, and percentage of traumatized clients after controlling for secondary traumatic stress. The main research question was the following: how are perceptions of trauma training (trauma training), years of experience (experience), percentage of traumatized clients, and secondary traumatic stress related to counselor self-efficacy among mental health professionals working with refugees who have experienced trauma? A secondary research question was the following: How are perceptions of trauma training, experience, and percentage of traumatized clients related to counselor self-efficacy after controlling for secondary traumatic stress? The Statistical Package for the Social Sciences was used to analyze the data.

In this chapter, the results of this study are presented. The first section presents information regarding instrument reliabilities. The second section consists of a description of the participants in the study. The third section presents the bivariate

correlations and the fourth section describes the results from the statistical analyses used to examine the research questions. Finally, the chapter will conclude with a summary.

Reliability of Instruments

This section provides information regarding instrument reliabilities. Researchers often assess the degree to which their instruments possess internal consistency reliability (Huck, 2012). Reliability is defined as "consistency across the parts of a measuring instrument, with the "parts" being individual questions or subsets of questions" (Huck, 2012, p. 71) with acceptable values of alpha, range from 0.70 to 0.95 (DeVellis, 2003). Cronbach's alpha internal consistency measures were used to estimate the reliability of the perception of trauma training scale, the COSE and the STSS. In Table 1 the alpha coefficients, number of items, means, and standard deviations for perception of trauma training, STSS, and COSE are shown.

The perception of trauma training semantic differential scale consisted of four items that used four bipolar adjectives (e.g. good –bad). Total scores of the perception of trauma training semantic differential scale were used. Participant scores could range from zero to 24. Scores closer to zero indicate a more negative perception of their trauma training and scores closer to 24 indicate a more positive perception of their trauma training. The mean score illustrated that the participants had a moderately positive perception of their trauma training. The Cronbach's reliability estimate for the training scale yielded an alpha of .96 indicating excellent internal consistency.

Participants' scores on the STSS ranged from 28 and 37 indicating mild secondary traumatic stress with a mean of 30.9 (SD = 8.82). The reliability estimate was

.89 which indicates adequate internal consistency. The COSE consists of 37 items based on a six point Likert scale. Higher scores indicate more confidence completing various counseling-related tasks. The total score could range from 37 to 222, with higher scores indicating higher self-efficacy beliefs. The mean score of the COSE was 182.2 (*SD* = 19.86) indicating higher self-efficacy beliefs. The reliability estimate was .91 indicating excellent internal consistency.

Table 1: *Cronbach's alpha, number of items, means, and standard deviations*

Instrument	Coefficient α	Items	M	SD
Training	.96	4	16.9	5.08
STSS	.89	17	30.9	8.82
COSE	.91	37	182.2	19.86

Description of Participants

The population of interest in this study was mental health professionals who work directly with refugees and asylum seekers with a trauma history. Participants were recruited through contacting agencies all over the United States specializing in working with refugees and asylum seekers. The agencies included 34 member organizations of the National Consortium of Torture Treatment Programs (NCTTP), members of the National Association of Social Workers who specialize in trauma work, and other mental health professionals who specialize in working with refugees. One hundred and ninety three

participants attempted to complete the online survey however only 98 mental health professionals met the eligibility criteria. Professionals meeting the following criteria were included: (a) those who had a graduate degree in a mental health field including counseling, psychology, psychiatry, or social work and (b) those who were currently providing therapeutic services for traumatized refugees and asylum seekers in the United States. There were no missing or invalid data; therefore 98 participants were included in this study.

Demographic data was collected to describe the population. The frequencies and percentages of the demographic variables in this study are provided in Table 2. Demographic data indicated that of the total number of participants 78 (79.6%) were female and 20 (20.4%) were male. The majority of the participants self-identified their race as White 67 (68.4%), 12 (12.2%) self-identified as Middle Eastern, 7 (7.1%) self-identified as Asian, 4 (4.1%) self-identified as African American, and 4 (4.1%) self-identified as Hispanic.

The age of participants ranged from 25 to 80, with a mean age of approximately 43 years. The participants were from varying parts of the country. Participants were mainly from the Northeast, the South and the Midwest; the percentages were 31.6%, 22.4%, 19.4%, and 14.3% respectively.

The participants responded to questions pertaining to their education and qualifications, including highest educational level attained, field of study, primary work setting, licensure status and type of licensure. The majority of the participants reported

holding a master's degree 75 (75.5%), and 22 (22.4%) reported holding a doctoral degree.

Of the 98 total participants, 44 (44.9%) were social workers, 26 (26.5%) were counselors, 22 (22.4%) were psychologists, and five (5.1%) were marriage and family counselors. Participants were given seven options for the setting in which they primarily work, and the majority of respondents, 59 (60.2%), reported working in non-profit agencies. Fourteen (14.3%) reported working in private practice, seven (7.1%) reported working in a hospital setting, four (4.1%) reported working in college settings, and 10 (10.2%) reported working in other settings.

When examining the intervention approach primarily used by the participants when working with refugee clients who have experienced trauma, the majority 32 (32.7%) reported using Cognitive-behavioral therapy (CBT). Seventeen (17.3%) reported using Person-centered, 9 (9.2%) reported using Narrative therapy, 4 (4.1%) reported using psychoanalytic, 4 (4.1%) reported using Solution-focused, 2 (2%) reported using Adlerian, 2 (2%) reported using Play therapy, 2 (2%) reported using EMDR, 1(1%) reported using Existential, 1 (1%) reported using Behavioral and finally 24 (24.5%) reported using other approaches.

With regard to the licensure status of the participants, 85 (86.7%) identified as licensed mental health professionals. Participants were asked to indicate their professional license affiliation. Twenty-six (26.5%) of the licensed participants identified as Licensed Clinical Social Workers (LCSW), 19 (19.4%) identified as Licensed Professional Counselors (LPC), 11 (11.2%) identified as licensed psychologists, six

(6.1%) identified as Licensed Marriage and Family Therapists (LMFT), six (6.1%) identifying as Licensed Manta Health Counselors, and finally 30 (30.6%) reported having other licensures or currently working towards licensure.

Table 2: *Numbers and percentages of demographic variables*

Variable	Frequency	Percent
Gender		
Female	78	79.6%
Male	20	20.4%
Race/Ethnicity		
White	67	68.4%
African American	4	4.1%
Asian	7	7.1%
Hispanic/Latino	4	4.1%
Middle Eastern	12	12.2%
Multiracial	2	2.0%
Other	2	2.0%
Region		
Northeast	31	31.6%
South	22	22.4%
Southwest	4	4.1%

Midwest	19	19.4%

Table 2: (Continued)

West	14	14.3%
Other	8	8.2%
Educational Level		
Medical	1	1.0%
Doctoral	22	22.4%
Master's	74	75.5%
Other	1	1.0%
Field of Study		
Counseling	26	26.5%
Marriage and Family Therapy	5	5.1%
Social Work	44	44.9%
Psychology	22	22.4%
Other	1	1.0%
Work Setting		
College/University	4	4.1%
Private Practice	14	14.3%
School	2	2.0%
Hospital	7	7.1%
Government	2	2.0%
Non-profit	59	60.2%

Other	10	10.2%

Table 2: (Continued)

Licensure		
Yes	85	86.7%
No	13	13.3%
License Affiliation		
LPC	19	19.4%
LCSW	26	26.5%
LMFT	6	6.1%
Psychologist	11	11.2%
LMHC	6	6.1%
Other	30	30.6%

Additionally, the data were examined for normality of distribution. Kurtosis and skewness generally did not indicate major departures for normality. In the demographic questionnaire, participants provided additional information related to their trauma training. Participants indicated the extent of training specific to the treatment of trauma and trauma survivors. They had three options to choose from: no training, minimal training (e.g., one workshop, seminar, and/or in-service training), and substantial training (e.g., multiple workshops, semester-long course, certificate, other extensive formal training). The majority of respondents 63 (64.3%) reported receiving substantial training

specific to the treatment of trauma and trauma survivors. Participants also indicated the number of semester-long courses they have attended on the treatment of trauma and trauma survivors since undergraduate work. Over half of the respondents reported attending zero to one semester-long course. Participants also indicated the number of workshops they have attended on the treatment of trauma and trauma survivors since undergraduate work. Over half of the respondents indicated attending more than five workshops. The descriptive data are shown in Table 3.

Table 3: *Numbers and percentages of trauma training variables*

Variable	Frequency	Percent
Extent of Training		
No Training	3	3.1%
Minimal Training	32	32.7%
Substantial Training	63	64.3%
Courses		
0	40	40.8%
1	20	20.4%
2-3	22	22.4%
4-5	6	6.1%
> 5	10	10.2%
Workshops		

0	1	1.00%
1	12	12.2%
2-3	20	20.4%
4-5	13	13.3%
> 5	52	53.1%

Finally, participants reported the number of professional development hours they have earned on the subject of the treatment of trauma and trauma survivors since undergraduate work. The number of professional development hours ranged between zero and 3000. The mean number of professional development hours was 103.38 (*SD*= 326.28).

Descriptive data pertaining to the dependent and independent variables in the study, namely participants' perception of trauma training, years of experience, percentage of clients whose primary presenting problem is related to their trauma history, secondary traumatic stress and counselor self-efficacy are shown in Table 4.

Table 4: *Descriptive statistics of predictor and outcome variables*

	Training	Experience	% of TC	STSS	COSE
Mean	16.92	11.51	46.63	30.83	182.21
Median	16.50	8.00	42.50	29.00	183.50
Std. Deviation	5.08	10.71	36.00	8.78	19.86

Variance	25.85	114.70	1295.89	77.03	394.52
Skewness	-.56	1.38	.29	.32	-.48
Range	22	49	100	36	90
Minimum	2	1	0	17	127
Maximum	24	50	100	53	217

Note. Trauma training= training; Years of experience = experience; percentage of traumatized clients = % TC; secondary traumatic stress = STSS; counselor self-efficacy = COSE.

In addition to collecting demographic data related to participants' trauma training, participants indicated their perception of their training specific to the treatment of trauma and trauma survivors using a seven-point semantic differential scale (Osgood, Susi, & Tannenbaum, 1957). Examples of the bipolar adjectives are bad –good and shallow – deep. The scores ranged from 2-24, with a higher score indicating a better perception of trauma training. The mean score was 16.92 (*SD* = 5.08).

The questionnaire also included questions related to therapists' years of clinical experience and percentage of clients in their current caseloads whose primary presenting problem is related to their trauma history. Years of experience ranged between 1-50 years, with a mean of 11.5 years and a standard deviation of 10.71. Half of the participants 49 (50%) had less than eight years of experience as a mental health professional. With regard to percentage of clients in the therapists' current caseload whose primary presenting problem is related to their trauma history, the percentage ranged from 0%-100%, with a mean of 46%. Furthermore, over 40% of the participants

reported having more than 50% of their current caseload as traumatized clients (see Table 5).

Table 5: *Numbers and percentages of percent of traumatized clients*

	Frequency	Percent
Less than 50%	58	59.2%
More than 50%	40	40.8%

Participants' secondary traumatic stress was assessed using the Secondary Traumatic Stress Scale (STSS). The total score of the measure were used in this study to indicate the overall level of secondary traumatic stress. Participants' scores ranged from 17-53, with a mean score of 30.8. Based on the development of the scale by Bride (1999), total scores below 28 indicate little or no secondary traumatic stress, scores ranging from 28 and 37 indicate mild secondary traumatic stress, scores between 38 and 43 suggest moderate secondary traumatic stress, scores between 44 and 48 indicate high levels of secondary traumatic stress, and scores of 49 or higher indicate severe secondary traumatic stress. Over 25% of the participants reported moderate to severe secondary traumatic stress (see Table 6).

Table 6: *Numbers and percentages of secondary traumatic stress scale*

	Frequency	Percent
Below 28	40	40.8%
28-37	33	33.7%
38-43	15	15.3%
44-48	9	9.2%
49 and higher	1	1.0%

Counselor self-efficacy was assessed using the Counseling Self-Estimate Inventory (COSE). The total score could range from 37 to 222, with higher scores indicating higher self-efficacy beliefs (Larson et al., 1992). In the current study, the scores ranged from 127-217, with a mean score of 182. There is no research to date indicating a standard score to indicate a positive or negative perception of counselor self-efficacy. During the development of the COSE, Larson and colleague (1992) reported a mean of 147.23 and standard deviation of 21.87. The current study's mean (M = 183.5) was higher than that reported by the developers of the scale; however, the standard deviation (SD = 19.86) was slightly smaller, which indicated that the scores of participants in this sample were closer to the mean.

Screening Data

The researcher carefully screened for accuracy of data, outliers, missing values, normality of distribution, linearity, and homoscedasticity of residuals, and multicollinearity prior to running the analysis using SPSS. There were no missing values. Outliers were examined and considered to be acceptable. Therefore, the data were not transformed. Kurtosis and skewness generally did not indicate major departures for normality. Additionally, a visual inspection frequency distribution suggested that the distribution of the variables were approximately normally distributed. In Table 7 the skewness and kurtosis for each variable is shown. A scatterplot did not indicate areas for concern. Multicollinearity was assessed by examining the variable tolerance and Variation Inflation Factors (VIF). Small tolerance values indicate high correlation among the independent variables. The statistical analysis of the full model indicated variable tolerances ranging from .97 to .98, which means that multiple correlations between the independent variables were very small and Variation Inflation Factors (VIF) ranged from 1.02 to 1.03. Tolerance scores were well above .2 and VIF scores were well below 5, indicating that there were no violations of the multicollinearity assumption.

Table 7: *Skewness and kurtosis values*

Variable	Skewness	Kurtosis
Training	-.599	.137
Experience	1.380	1.585

% of TC	.286	-1.454
STSS	.319	.244
COSE	-.475	-.299

Bivariate Correlations

The Statistical Package for the Social Sciences was used to analyze the data. The survey included multiple items to assess trauma training; however, the semantic differential scale was selected to examine the relationship with counselor self-efficacy for two reasons. The first is that the semantic differential scale showed excellent reliability ($\alpha = .96$). The second reason was due to the difficulty in combining the quantitative variables (number of courses, number of workshops and number of professional development hours specific to trauma treatment) into one measure of trauma training. Although the perception of trauma training variable was used in this study to examine the relationship with counselor self-efficacy, it is important to bring attention to the statistically significant correlation ($r = .32$, $p < .01$) between perception of trauma training and the number of courses specific to the treatment of trauma as well as the statistically significant correlation ($r = .43$, $p < .01$) between perception of trauma training and number of workshops courses specific to the treatment of trauma.

A Pearson product-moment coefficient was conducted to examine the correlations of the predictor variables (experience, training, percent of traumatized clients, STSS) and the outcome variable (COSE). The Pearson correlation matrix is displayed in Table 8. There were two statistically significant correlations between the variables. Perception of

trauma training was significantly positively correlated with the COSE scores ($r = .354$, $p < .001$). This is considered a medium relationship and suggests that the more training participants receive, the more likely to have higher counselor self-efficacy beliefs. In contrast, the COSE was negatively correlated with STSS ($r = -.383$, $p < .001$). This is also considered a medium relationship and suggests that individuals with higher counselor self-efficacy beliefs were less likely to have secondary traumatic stress symptoms.

Table 8: *Pearson correlation matrix between predictor and outcome variables*

Variable	Experience	%TC	Training	COSE	STSS
Experience	1	-.161	.088	.153	-.038
%TC		1	-.033	.080	.034
Training			1	.354**	-.135
COSE				1	-.383**
STSS					1

Note. ** Indicates significant correlation at $p < .01$ level (2-tailed).

Multiple Regression Analyses

A standard multiple regression analysis was conducted to examine the relationship between perception of trauma training, experience, percentage of traumatized clients and secondary traumatic stress and counselor self-efficacy. The unstandardized regression coefficients *(B)* and intercept, the standardized regression coefficients *(β)*, and

semipartial correlations *(sr_i^2)* are reported in Table 9. The variance accounted for *(R^2)* equaled .27 (adjusted $R^2 = .24$), which is significantly different from zero ($F(4, 93) = 8.55$, $p < .001$). Two of the four independent variables, perception of trauma training and secondary traumatic stress, contributed significantly to the prediction of participants' counselor self-efficacy. The adjusted R^2 value of .24 indicates that around a quarter of the variability in counselors' self-efficacy is predicted by the predictor variables. Secondary traumatic stress had the largest negative standardized beta and semipartial correlation coefficient. Perception of trauma training had a positive standardized beta and semipartial correlation coefficient. Years of and percentage of traumatized clients were not related to counselor self-efficacy and the standardized beta and semipartial correlation coefficients were very small. Secondary traumatic stress had a negative correlation ($B = -.778$). These results suggest that as therapists' levels of secondary traumatic stress increases, their perception of their counselor self-efficacy decreases. Furthermore, perception of trauma training had a positive correlation ($B = 1.173$) indicating that a more positive perception of therapists' quality of training contributed to higher levels of counselor self-efficacy.

Table 9: *Unstandardized regression coefficients (B) and intercept, the standardized regression coefficients (β), standard error (std. error), semipartial correlation, t-values, and p-values*

Independent Variable [a]	B	β	std. error	sr_i^2	t-value	p-value

Intercept	180		9.79		18.42	<.01
Training	1.17	.30	.35	.33	3.34	<.01
Experience	.25	.13	.17	.15	1.49	.14
% TC	.07	.12	.05	.14	1.38	.17
STSS	-.78	-.34	.20	-.37	-3.84	<.01

Note.[a] $R^2 = .27$, F = 8.55, p <.001.

Hierarchical Multiple Regression Analysis

A two-step hierarchical multiple regression analysis was conducted to examine the amount of variability in counselor self-efficacy that perception of trauma training, experience, and percentage of traumatized account for after controlling for secondary traumatic stress. In the first step of the hierarchical regression procedure, the secondary traumatic stress variable was entered. In step two, the remaining predictor variables, perception of trauma training, experience, and percentage of traumatized clients, were entered. The results of the hierarchical regression are reported in Table 10. The results of step one of the analysis indicated that the variance accounted for (R^2) with the first predictor (secondary traumatic stress) equaled .15 (adjusted R^2= .14), which was significantly different from zero ($F(1, 96)=16.63$, $p<.001$). In step two, perception of trauma training, experience, and percentage of traumatized clients were entered into the regression equation. The change in variance accounted for (R^2 change, ΔR^2) was equal to .12, which was a statistically significant increase in variance accounted above the variability contributed by the previous predictor variable entered in step one ($F(3, 93)$ =

5.14, $p<.001$). Experience and percentage of traumatized clients were not related to counselor self-efficacy. In conclusion, secondary traumatic stress accounted for 14% of the variance in counselor self-efficacy, however after adding the remaining predictor variables to the equation, they improved R^2 and all variables contributed 24% of the variance, meaning that one of the other predictor variables accounted for the variance in the outcome variable. These results indicate that secondary traumatic stress does not mediate the relation between the remaining predictor variables and counselor self-efficacy.

Table 10: *Two-step hierarchical multiple regression analyses measuring the relationship between predictor and outcome variables*

Measures	R	R^2	ΔR^2	ΔF	df	β
Step 1	.38	.15	.15	16.63	1, 96	
STSS						-.38*
Step 2	.52	.27	.12	5.14	3, 93	
STSS						-.34*
Training						.30*
Experience						.13
% TC						.12

Note. * Indicates statistical significance at $p < .01$ level.

Summary of Open-Ended Question

Participants responded to an open-ended question regarding factors they believed were related to their self-efficacy or confidence in working with refugees. The purpose was to acquire an in depth understanding of the experience of mental health professionals working with refugees who have experienced trauma. Ninety-two participants answered this question. Of these respondents, 37 (40%) identified training (e.g. education, professional development, conferences, workshops, trauma-focused trainings) as factors related to their self-efficacy or effectiveness and 36 (39%) identified experience as a factor related to their self-efficacy. Regarding training, one participant wrote: "Diversity workshops attended to aid in understanding additional issues refugees may be facing including trauma related to home country and immigration trauma." Participants acknowledged the importance of possessing knowledge and understanding of trauma, refugee history and experience as well as effective treatment modalities. Furthermore, one respondent addressed the lack of adequate training as follows: "Much of my graduate training, while benefiting me in considering a social justice ecological systemic perspective, was too theoretical and assumed that clients are self-referred and know why they are seeing a therapist and what a therapist does." Another respondent wrote the following about experience: "As my experience in the field grows, my work becomes more efficacious."

Other factors that the respondents identified as related to their self-efficacy were supervision, consultation, client feedback and mentorship. The following is a participant's response identifying factors that influence self-efficacy: "Supervision and

consultation with trauma experts, receiving trauma specific training and clinical experience." Participants identified the work environment and support from colleagues as factors that influenced their effectiveness. Other factors included access to resources, the therapeutic relationship and therapist skills. Cultural competence was another factor that was identified by several respondents (e.g. "sensitivity and cultural competency"). Participants stated that knowledge of refugee history, experience, culture, beliefs and values as important. A few participants referred to cultural barriers as important factors as evident by the following statement: "While some principles hold true across cultures, I am finding there are many cultural differences and barriers that challenge my usual trauma-focused approach." Self-care, meditation, faith and spirituality were also factors that were mentioned. Additionally, compassion, commitment, empathy, humility, and humbleness were factors that were important to the participants. Finally, three of the participants identified as refugees themselves or were family members of refugees. These participants believed their personal experiences helped them better relate to their refugees clients and was related to their self-efficacy.

Summary

The purpose of this research study was to examine the relationships between perception of trauma training, experience, percentage of traumatized clients, secondary traumatic stress and counselor self-efficacy of mental health professionals who work with refugee and asylum seeking clients who have experienced trauma. The study also examined the amount of variability in counselor self-efficacy that perception of trauma training, experience, and percentage of traumatized accounts after controlling for

secondary traumatic stress. The Statistical Package for the Social Sciences was used to analyze the data.

An analysis of the demographic data indicated that the majority of the 98 participants were female, White, from the Northeast, between 25 and 80 years old, and held a master's degree. Participants were mostly licensed professionals, social workers, working in non-profit agencies, were licensed mental health professionals and used Cognitive-behavioral therapy (CBT) in the treatment of refugees who have experienced trauma. The majority of participants reported having positive perceptions of their perception of trauma training, had one to three years of experience as a mental health professional and over 40% of the participants reported that more than 50% of their current caseloads were traumatized clients. Participants reported little or no secondary traumatic stress and moderately high counselor self-efficacy beliefs. This chapter also examined the reliability of the instruments used within this study and established that the instruments demonstrated good reliability.

The first research question was: how do perception of trauma training, years of experience, percentage of traumatized clients, and secondary traumatic stress relate to counselor self-efficacy among mental health professionals working with refugees who have experienced trauma. Using a standard multiple regression to analyze the data, the results indicated that perception of trauma training was positively related to counselor self-efficacy and secondary traumatic stress was negatively related to counselor self-efficacy. Overall, the hypothesized model was effective in predicting counselor self-efficacy in that it accounted for 27% of the variance. These results suggest that therapists

with higher levels of secondary traumatic stress have lower perceptions of their counselor self-efficacy. On the other hand, more positive perceptions of the quality of their training were related to more positive counselor self-efficacy beliefs. Experience and percent of traumatized training were not related to counselor self-efficacy.

A secondary research question was the following: Is there a relationship between perception of trauma training, experience, and percentage of traumatized clients with counselor self-efficacy after controlling for secondary traumatic stress? Using a hierarchical multiple regression, the results indicated that secondary traumatic stress accounted for 15% of the variance in counselor self-efficacy, however after adding the remaining predictor variables to the equation, they improved R^2 and all variables contributed 27% of the variance. These results indicate that after controlling for secondary traumatic stress, the relation between the remaining predictor variables and counselor self-efficacy still exists.

CHAPTER 5: DISCUSSION

The purpose of this research study was to examine how perceptions of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress are related to counselor self-efficacy of mental health professionals who work with refugee and asylum seeking clients who have experienced trauma. In this chapter, the results of this study are discussed. This section includes an overview of the study, discussion of the results, contributions and limitations in this research study, implications of the findings, recommendations for future research and concluding remarks.

Overview

Since 1975, approximately three million refugees were admitted to the United States. As of July 2016, the United States resettled 59, 099 refugees (State Department's Worldwide Refugee Admissions Processing System, WRAPS) and in 2013 granted asylum status to 25,199 people (Martin & Yankay, 2014). Refugees often experience a wide range and high number of traumatic events such as personal injury and torture, witnessing the torture and killing of others, and the separation from family members (Marshall, Schell, Elliott, Berthold, & Chun, 2005; Mollica, McInnes, Poole, & Tor, 1998). While many demonstrate incredible resilience and strength, the adverse experiences associated with forced migration can have a lasting psychological impact (August & Gianola, 1987; Beiser & Hou, 2001; Bemak et al., 2003; Carlson & Rosser-

Hogan, 1993; Carswell et al., 2011; Murray et al., 2010).

Mental health professionals such as counselors, psychologists, social workers, and school counselors are uniquely positioned to respond to the mental health needs of refugees (Bemak & Chung, 2014). Self-efficacy is a construct rooted in Bandura's social cognitive theory (1986) and provides a significant framework for this study. Research has shown that self-efficacy is an important aspect of effective counseling (Larson, 1998); therefore, examining factors that influence the counselor self-efficacy of therapists working with this highly traumatized population is warranted. The empirical research in this area is extremely scarce. While research has explored the association of counselor self-efficacy with variables such as counselor training, aptitude and level of experience mainly among counselors in training (Larson & Daniels, 1998; Melchert et al., 1996; Tang et al., 2004), little attention has been paid to counselor self-efficacy among mental health professionals working with traumatized refugees. Furthermore, there have been no studies exploring the relationship between perceived trauma training, experience, percentage of traumatized clients and secondary traumatic stress as related to counselor self-efficacy among mental health professionals working with refugees. This study was designed to address this need. The findings from this study will be useful for practitioners developing psychosocial programs in the field of refugee mental health as well as for training and preparation programs interested in preparing culturally competent mental health professionals to work with refugees who have experienced trauma.

There were three instruments used in the study: a demographic questionnaire that also included information on trauma training, experience and percentage of traumatized

clients, the Counseling Self-Estimate Inventory (COSE), and the Secondary Traumatic Stress Scale (STSS). Mental health professionals, including counselors, psychologists and social workers were invited to partake in this research study. A total of 193 mental health professionals responded to the survey, however only 98 of the respondents met the eligibility criteria and were included in the study. Professionals meeting the following criteria were included in the study: (a) those who had a graduate degree in a mental health field including counseling, psychology, psychiatry, or social work and (b) those who were currently providing therapeutic services for traumatized refugees and asylum seekers in the United States.

Conclusions and Discussions

Demographic Data

An examination of the demographic data indicated limited diversity in the mental health professionals who responded to the survey. Most participants were White (68.4%). Nevertheless, it is worth noting that this is one of few studies to include "Middle Eastern or Arab American" as a separate ethnic group. This decision was made based on the recommendation of the Census Bureau's 1997 U.S. Office of Management and Budget standards to conduct further research to improve data on the Middle Eastern and North African populations in the Census Bureau. The Census Bureau is testing this category to possibly include it on the 2020 decennial census (U. S. Census Bureau, 2015). Approximately 12% of the sample was comprised of this group. One explanation for these findings is that in this study "Arab American or Middle Eastern" was a separate ethnic category while in the past individuals from this group had to identify as White.

Another explanation could be that Middle Eastern participants are more likely to seek working with refugees as a result of their own immigration experience and difficulties.

Furthermore, most participants were female (79.6%). The limited diversity in the sample is consistent with the limited diversity in the mental health workforce where racial minorities are underrepresented. For example, physicians and doctoral level psychologists are more likely to be male and White; conversely, the social work and counseling fields are heavily female, 78 % and 71% respectively (Robiner, 2006). Furthermore, according to the Substance Abuse and Mental Health Administration (2004) the percentage of racial minorities in the mental health field was estimated to be 5.5% for marriage and family therapists, 6.2% for psychology, 8.7% for social work, 15.4% for counseling, and 24.2% for psychiatry. It is alarming that minorities are underrepresented in the mental health field while the society is becoming increasingly diverse. By 2055, it is expected that over half of the population would be ethnically diverse and by 2065, one-in-three Americans would have an immigrant background (Pew Research Center, 2015). One possible reason for the underrepresentation of minorities in the mental health field is the institutional barriers within the preparation programs and mental health field that may impede the professional development of minority groups.

In spite of the small sample size, participants were from varied regions across the country. Specifically, 31% of participants were from the Northeast, 22.4% from the South, 19.4% from the Midwest and 14.3% from the West. The main reason for obtaining this national sample was using national consortiums in the recruitment of the sample such as the National Consortium of Torture Treatment Programs.

The majority of the participants were master's level therapists (75.5%), which is reasonable since this was one of the inclusion criterions. However it is remarkable that 22.4% of participants were also doctoral level therapists. This may be in part due to the current social justice movement and emphasis on multicultural competence in the mental health field. The majority of the therapists who responded to the survey were social workers (44.9%), followed by counselors (26.5%) and psychologists (22.4%). This finding suggests that social workers may be more inclined to work with this population. One reason could be that social workers possess the needed skills to meet the basic client needs (e.g. food, housing) and advocate for community resources, especially in the initial stages post-migration. Immediately post-migration treatment should focus on meeting their basic needs and a restoration of coping skills (Laban, Hurulean, & Attia, 2009). It is noteworthy that 60% of the participants were employed in non-profit settings, which adheres to the ideal ethical standards of the counseling profession to facilitate access to counseling services and contribute to the public good (e.g. ACA, 2014, C.6.e.). In addition, the majority of participants were licensed professionals. These results indicate that therapists providing services to traumatized refugees were experienced and met the licensure requirements of their disciplines.

The intervention approach primarily used by the participants in the treatment of refugees who have experienced trauma was cognitive-behavioral therapy (CBT). This finding is consistent with the literature base asserting that cognitive-behavioral therapy is found to be one of the most commonly utilized interventions for PTSD with the general population (Hinton et al., 2009). Some studies also found that it was an effective

approach with traumatized refugees (Palic & Elklit, 2011).

The majority of the participants (50%) who took part in the study had less than eight years of experience as a mental health professional. This finding suggests that less experienced therapists may be more inclined to work with refugees who have experienced trauma. This could be attributed to the emphasis on multicultural competencies and ethical practice in the mental health training programs and accreditation bodies that strongly endorsed effectively working with diverse populations and the responsibility to advocate for marginalized populations. Specifically, the Council for Accreditation of Counseling and Related Educational Programs encourage advocacy efforts to address barriers that hinder client success (CACREP, 2016; Section 2; F, 1e) and to identify strategies to eliminate oppression and discrimination (CACREP, 2016; Section 2; F, 2h). Furthermore, over 40% of the participants reported having more than 50% of their current caseload as traumatized refugee clients. These results confirm the high PTSD prevalence rates among refugees. Studies have reported PTSD prevalence among refugees to range from 20-74% (Sieberer et al., 2011).

Variables of Interest

With regard to the variable, perception of trauma training, it is important to consider the findings in light of the fact that there was a correlation between perception of trauma training and the number of courses and workshops specific to the treatment of trauma. This suggests that therapists' perception of their training is related to their actual training. That said, the majority of participants reported having positive perceptions of their trauma training; however, they indicated that the majority of their training was

obtained through professional development activities, such as workshops rather than through formal education as part of mental health preparation programs. These findings highlight the limited focus on trauma training in preparation programs when the prevalence rate of trauma-exposure in the general population in the United States ranges from 21% to 89% (Solomon & Johnson, 2002).

Most of the participants reported moderately high counselor self-efficacy beliefs with a mean score of 182 where scores could range from 37 to 222. The mean score is slightly higher than that reported by the developers of the scale which was 147 (Larson et al., 1992). This finding is significant and indicates that therapists working with traumatized refugees believe that they can effectively work with this population. One explanation is that therapists' positive perception of their trauma training has contributed to more positive counselor self-efficacy beliefs.

Findings have been mixed regarding the relationship between exposure to traumatized clients and secondary traumatic stress. There is emerging evidence on behavioral and emotional implications of indirect exposure to trauma material on mental health professionals (Akinsulure-Smith et al., 2012). The majority of participants in this study reported little or no secondary traumatic stress, which is consistent with some previous studies (e.g. Devilly, Wright, & Varker, 2009). On the other hand, 15% of the participants reported moderate secondary traumatic stress, 9% reported high levels of secondary traumatic stress, and one 1% reported severe secondary traumatic stress. These higher levels of secondary traumatic stress are consistent with the findings of Bride (2007) where 15.2% of the 287 sampled licensed social workers met secondary traumatic

stress symptoms. Furthermore, these results are consistent with the findings of the originators of these constructs (e.g. Figley, 1995) that established the relationship between exposure to traumatized clients and secondary traumatic stress. This study is one of the few studies, with the exception of Barrington and Shakespeare-Finch's (2014), Century and colleagues' (2007), and Akinsulure-Smith and colleagues' (2012) studies, that empirically examined secondary traumatic stress among mental health professionals working with refugees.

This study examined factors related to counselor self-efficacy. Overall, 27% of the variability was accounted for by the predictor variables. The results of this study indicated that two of the four independent variables, perception of trauma training and secondary traumatic stress, contributed significantly to the prediction of participants' counselor self-efficacy. Secondary traumatic stress was the strongest predictor, and it was negatively correlated to counselor self-efficacy, such that the counselors who participated in this study who experienced higher levels of secondary traumatic stress felt less confident in their abilities as therapists. This study confirms past findings and adds to the body of knowledge. Previous studies have also indicated that higher levels of secondary traumatic stress are associated with lower levels of self-efficacy (Berger & Gelkopf, 2011; Finklestein et al., 2015; Ortlepp & Friedman, 2002; Sartor, 2012). In other words, disruption in cognitions caused by secondary exposure to traumatic material alters therapists' beliefs about their capabilities to effectively counsel clients who have experienced trauma. This relationship could be because secondary traumatic stress may negatively influence therapists' effectiveness in working with trauma survivors, which in

part will also result in a more negative perception of counselor self-efficacy. As therapists think they are being ineffective with clients, their counselor self-efficacy decreases. This study was the first to examine this relationship among professionals working with refugees.

The results of this study indicate that a more positive perception of therapists' trauma training was related to higher self-efficacy. These findings support the majority of previous research that as therapists have more positive perceptions of their trauma training (e.g. Berger & Gelkopf, 2011; Larson & Daniels, 1998; Melchert et al., 1996), their beliefs about their capabilities to effectively counsel clients are enhanced. For instance Woody and colleagues (2015) assessed the self-efficacy of community practitioners who received training in trauma-focused cognitive behavioral therapy (TF-CBT) and found that therapist's counselor self-efficacy increased from the basic to the advanced level of training. One plausible explanation for the relationship between trauma training and counselor self-efficacy is that as therapists acquire knowledge and skills through receiving trauma training, they are more likely to work effectively with trauma survivors and consequently perceive themselves as more efficacious with this population. In addition, since this study found a correlation between perception of trauma training and actual trauma training, it is reasonable to suggest that actual trauma training was related to counselor self-efficacy. This finding would support the study by Woody and colleagues (2015) that established such a relationship.

The findings of this study do not suggest that experience was related to counselor self-efficacy. These findings contradict previous research of Goreczny and colleagues'

(2015); however, the results are consistent with Larson and Daniels' (1998) findings that after gaining some experience, the relationship between counselor self-efficacy and experience was minimal. This may partially explain the reason for the findings in this study, given that almost half of the participants had moderate experience with a mean number of years of experience of 11.5. One explanation for these findings is that there is a threshold of when experience contributes to higher counselor self-efficacy. Additionally, the lack of relationship may be in part due to the fact that the survey asked participants to indicate years of their clinical experience rather than asking about years of their experience as it related to working with trauma survivors or refugees. These findings indicate that years of specialized experience in working with trauma survivors may be more significant for counselor self-efficacy than general years of clinical experience. Future research should ask participants to indicate their years of experience working specifically with trauma survivors in order to verify the stated explanation.

The findings of this study did not find a significant relationship between percentage of traumatized clients and counselor self-efficacy. There is only one other dissertation that examined this relationship in the past and found that as the percentage of trauma clients increased, counselor self-efficacy decreased (Sartor, 2012). One explanation for the insignificant relationship could be that there are other factors, such as trauma training and compassion for this unique population that may mediate the relationship between percentage of traumatized clients and counselor self-efficacy.

This study examined the impact of perception of trauma training, experience, and percentage of traumatized on counselor self-efficacy after controlling for secondary

traumatic stress. The results indicated that secondary traumatic stress accounted for 15% of the variance in counselor self-efficacy, and all variables contributed 27% of the variance. These findings suggest that after controlling for secondary traumatic stress, the remaining variables still significantly contribute to counselor self-efficacy. Thus, secondary traumatic stress does not necessarily impact the relationship between perception of trauma training, experience, and percentage of traumatized clients and counselor self-efficacy. One plausible explanation for lack of relationship is that there is no relationship between secondary traumatic stress and the remaining predictor variables.

Contributions of the Study

While research has explored factors related to counselor self-efficacy, no studies have focused on counselor self-efficacy among mental health professionals working with traumatized refugees. The current study contributed to the body of literature focusing on counseling refugees and adds to the scarce literature examining the impact of working with traumatized refugees and asylum seekers on self-efficacy of mental health professionals. Second, this was the first study to empirically examine how perception of trauma training, experience, percentage of traumatized clients and secondary traumatic stress relate to counselor self-efficacy among therapists working with refugees. Furthermore, the findings provide a general picture of the background, experience and challenges facing therapists working with this unique population. Third, this is one of few studies that focused on the experience of mental health professionals rather than on refugees. Fourth, to date, the majority of research on counselor self-efficacy has focused on counselors-in-training rather than on mental health professionals, with the exception

of Chandler, Balkin, and Perepiczka's (2011) study that examined the counselor self-efficacy of licensed substance abuse counselors. In examining a sample of professional therapists with at least a master's degree, this research provides valuable information on factors contributing to the counselor self-efficacy of more experienced therapists. Fifth, this study provides evidence that refugees report high rates of trauma as the participants indicated that over half of their current caseload was traumatized refugee clients.

Furthermore, a major strength and contribution of this study is that it was comprised of a national sample. This study included a diverse group of mental health professionals from different regions across the country, practiced in various settings, and had varying years of clinical experience. Additionally, participants were from varying disciplines including counseling, marriage and family therapy, psychology, and social work, where as the majority of previous studies focused on participants form one discipline. The heterogeneity in disciplines is an illustration of how mental health professionals from different training backgrounds serve this highly marginalized population that has been increasing in the past decade. Furthermore, this study provided significant information on mental health professionals working with traumatized refugees, including demographic data, trauma training perceptions, years of experience, percentage of traumatized clients, secondary traumatic stress and counselor self-efficacy beliefs.

This study is one of the few studies that empirically examined secondary traumatic stress among mental health professionals working with refugees. Additionally, this research study confirms the relationship between secondary traumatic stress and

perception of trauma training with counselor self-efficacy. This is also one of the few studies that focused specifically on trauma training rather than only focusing on general training. Finally, this study sheds the light on a very important and timely topic given the influx of refugees that is expected in the United States. Specifically, this study highlights the challenges and training needs of mental health professionals working with refugees.

Limitations of the Study

There are several notable limitations associated with this study including the generalizability of the study, social desirability, and the population surveyed. First, the results of this study cannot be generalized to all mental health providers for a variety of reasons. The participants of this study were graduate level mental health counselors, social workers, and psychologists who currently provide therapeutic services for traumatized refugees in the United States; therefore, the results cannot be generalized to other types of mental health providers such as bachelor level providers or providers who do not work with refugees. Another reason for the limited generalizability is that the sample was not a random sample rather it was purposefully selected through targeting specific institutions that provide services for refugees including 34 member organizations of the National Consortium of Torture Treatment Programs (NCTTP), members of the National Association of Social Workers who specialize in trauma work, and other mental health professionals who specialize in working with refugees. Additionally, while the small sample size may indicate the scarcity of services offered for refugees in the United States, it also limits the generalizability of the results. Perhaps modifications to the inclusion criteria and better sampling methods can be made to reach a larger and more

diverse population of mental health professionals.

Second, social desirability poses a limitation to the results. The data collected in this study was self-reported and the participants were at risk of providing answers that were socially desirable. Although the participants were reassured that their answers would be kept anonymous and confidential, respondents may have responded to perceptions of trauma training, counselor self-efficacy beliefs and secondary traumatic stress in ways to present themselves more favorably (Houser, 2015).

Another limitation is that the sample was self-selected rather than randomly assigned. Participants with particular characteristics such as those with higher levels of training, higher counselor self-efficacy, or lower secondary traumatic stress, may have been more likely to take the survey than counselors with lower levels of training, higher counselor self-efficacy, and higher secondary traumatic stress. Even though a random sample would have been ideal, given the limited number of therapists working with this population this was not viable.

Fourth, this study included mental health professionals from varying disciplines including counseling, marriage and family therapy, psychology, and social work due to the limited number of service providers working with refugees. Combining professionals from different training fields may have influenced the results such that participants from some of the fields may have had more trauma training than participants from other fields.

Another limitation associated with this study is related to measuring the trauma training variable. Although the measure that was developed to measure trauma training was highly reliable, it only measures the perception of therapists about their trauma

training rather than their actual trauma training. Future research should identify a realizable measure that assesses therapists' actual trauma training.

Implications of the Findings

The findings of this study add to the counseling literature by providing empirical research on factors that contribute to counselor self-efficacy of mental health professionals working with refugees. The results of this study have significant implication for both counselors and counselor preparation programs. This section will first discuss implications for counselors and then implications for counselor preparation programs.

It is important to note that the number of refugees resettling in the United States is increasing significantly. Mental health professionals have the ethical and moral responsibility to advocate for vulnerable populations such as refugees. The counseling profession needs to become more prepared to provide culturally sensitive and effective services to this population as well as adequately train and protect the wellbeing of counselors serving this population. An important implication for the mental health profession pertains to the scarcity of services targeting refugees. Accessing and recruiting participants for the study was a challenge due to the scarcity of such services. This highlights the need for therapists who are competent to work with refugees especially with the significant increase in the numbers of refugees resettling in the United States. Additionally, the majority of participants worked in non-profit. One implication of this finding is that counselors in other settings (e.g. private practice) might consider providing

pro bono services to marginalized populations in accordance to the ACA (2014) ethical code.

Mental health professionals can benefit from the findings of this study to better understand the effects of secondary exposure to trauma, because it could influence their counselor self-efficacy. With this awareness, professionals could take precautions against experiencing secondary traumatic stress such as seeking supervision and consultation as well as implementing self-care strategies including personal therapy, meditation, mindfulness, physical exercise, and social support to reduce the risk of secondary traumatic stress. Additionally, personal activities have been found to be most effective in reducing therapists' stress (Akinsulure-Smith et al., 2012). Clinical supervisors also have the responsibility to raise awareness and provide strategies to reduce secondary traumatic stress symptoms among their counseling trainees. Additionally, counselors should seek training opportunities specific to the treatment of trauma and trauma survivors to enable them to work effectively with traumatized refugees. In addition, mental health facilities and clinical supervisors should also provide trauma specific training and encourage therapists to attend trauma trainings, workshops, and conferences.

The findings of this research have implications for counselor education programs. First, the underrepresentation of minorities in the sample demonstrates that preparation programs should advocate for the inclusion of a diverse student body into their programs in accordance to the CACREP Standard that states: "The academic unit makes continuous and systematic efforts to attract, enroll, and retain a diverse group of students and to

create and support an inclusive learning community (CACREP, 2016; Section 1; K).

Second, the findings indicate a strong need to include trauma training in counselor preparation programs by incorporating trauma training within their existing courses or by offering specialized courses that will increase counselor self-efficacy around working with traumatized refugees. Given that 40% of the participants in this study indicated that they did not receive any semester-long courses on the treatment of trauma and trauma survivors, and given that there was a positive relationship between trauma training and counselor self-efficacy, counselor education programs should consider incorporating trauma training as part of their curriculum to better prepare counselors to work with diverse populations of trauma survivors across different settings. Furthermore, this study supports the use of trauma training as means to enhance counselor self-efficacy among counselors who work with traumatized refugees, since there was a significant relationship between perceptions of trauma training and counselor self-efficacy.

Another reason for incorporating trauma and refugee issues in counselor education programs is that the participants reported a high percentage of traumatized clients in their caseload; therefore, preparation programs should incorporate trauma training to prepare counselors to work effectively with this population. It is essential to incorporate trauma trainings with an emphasis on multicultural competencies that strongly endorse working with diverse populations and the responsibility to advocate for marginalized groups.

Third, the findings of this study can also be used in multicultural and social justice courses to raise awareness and highlight the experience of a special group of

mental health professionals who work with marginalized populations such as refugees. Another implication from the results of this study is that counselor education programs should be aware of the effects of secondary traumatic stress and incorporate strategies to mitigate this negative effect that can influence counselor self-efficacy. Additionally, education programs must raise awareness and provide strategies to reduce secondary traumatic stress symptoms among their counseling trainees.

The implications of this study can be extended beyond the counseling field. The literature review presented in this study and the findings are not only applicable to counseling, but also have broad use for all who provide services to refugees, such as interpreters, nurses or physicians, and those who educate these professional groups. Providing sufficient trauma training and addressing secondary traumatic stress issues is essential in preparing other professionals who work with traumatized refugees. Furthermore, professionals ought to incorporate prevention and intervention strategies such as meditation, supervision, personal activities, and exercise is warranted to ensure the effectiveness of these professionals.

Recommendations for Future Research

This was the first study to examine counselor self-efficacy of mental health professionals working with traumatized refugees. Continuing research to further understand factors that contribute to counselor self-efficacy of mental health professionals working with traumatized refugees is imperative. Future research is recommended to further explore factors such as supervision, consultation, spirituality and multicultural competence in relation to counselor self-efficacy among counselors who

work with traumatized refugees. Participants identified these variables as factors that they believe are related to they self-efficacy or confidence in working with refugees. Additionally, although the majority of participants reported using CBT as the main treatment modality, future research should further examine the effectiveness of CBT with the refugee population. This study did not find a significant relationship between years if experience and counselor self-efficacy; however, future research should also ask participants to indicate their years of experience working specifically with trauma survivors rather than general years of experience to better gauge their trauma experience.

Accessing and recruiting participants for the study was a challenge; therefore, future researchers should attempt to use other recruitment procedures to reach a larger sample of mental health professionals working with refugees. Researchers might have to dedicate extensive efforts and resources in reaching more participants such as purchasing lists from licensure boards. Also accessing professionals who work with refugees outside of the United States will significantly provide a larger sample. The limited number of professionals working with this population also warrants the need for qualitative research to gather valuable information regarding the experience of mental health professionals. Utilizing focus groups and interviews to gather qualitative data on this topic could provide valuable information on factors influencing counselors' self-efficacy in working with refugees.

Over half of the participants in this study reported mild to severe rates of secondary traumatic stress. The rates of secondary traumatic stress were as follows: 33.7% reported mild secondary traumatic stress, 15.3% reported moderate secondary

traumatic stress, 9.2% reported high levels of secondary traumatic stress, and 1% reported severe secondary traumatic stress. These mild to severe rates of secondary traumatic stress warrant further investigation to continue to explore factors that contribute to secondary traumatic stress among mental health professionals.

Research is needed to explore the experiences of mental health professionals working with traumatized refugees to better understand why these therapists reported high levels of counselor self-efficacy. To this end, exploring how supervision, consultation and professional development relate to counselor self-efficacy should be further investigated. Lastly, although multicultural competence was included as a subscale of the COSE, this study did not include a measure of multicultural competence. Due to the importance of multicultural competence in working with diverse populations, future research could explore the relationship between multicultural competence and counselor self-efficacy with this unique population of mental health professionals working with refugees.

Finally, there was no consistent way of combine different types of training (e.g. workshops, courses, professional development hours). Thus, future researchers should develop an instrument that measures actual trauma training rather than perception of trauma training in order to gauge actual training of mental health professionals.

Concluding Remarks

Refugees often experience trauma, and they are in dire need of counseling services. Mental health professionals including counselors are uniquely positioned and trained to meet the needs of this population, and they have a moral and ethical obligation

to meet the needs of diverse populations. Research on factors influencing the experience of mental health professionals working with traumatized refugees has been very limited. To address this critical issue, this was the first study to examine how perception of trauma training, experience, percentage of traumatized clients, secondary traumatic stress relate to counselor self-efficacy of mental health professionals who work with refugee and asylum seeking clients who have experienced trauma. The findings indicate that trauma training and secondary traumatic stress had a significant relationship with counselor self-efficacy.

The results of the study reiterate the importance of trauma specific training to help counselors work effectively with refugees who have experienced trauma. In addition, preparation programs must offer courses specific to the treatment of trauma and trauma survivors to prepare potential mental health professionals to effectively work with trauma survivors and to minimize the risk of secondary traumatic stress, which can debilitate therapists. Despite the significant contributions of this research study, the empirical literature on counseling refugees remains scarce. Both future qualitative and quantitative research must continue to explore factors that influence counselors' effectiveness in working with traumatized refugees clients.

It is clear that mental health professionals can benefit from the results of this study by seeking appropriate trauma training work with this population, which in turn will contribute to a more positive perception of their trauma training. Similarly, counselor preparation programs can benefit by incorporating trauma training specifically focusing on counseling with trauma survivors. Additionally training programs may include

"refugees" as a population in cultural groups. Finally, this study highlights a very important issue in light of the United States' commitment to continue to admit refugees. Mental health professionals are in a unique position to alleviate the suffering of a highly marginalized population and can provide needed support and services that can change the lives of refugees. Nevertheless, the findings of this study indicate that trauma training will further enhance these therapists' efficacy. In this way, mental health professionals can play a significant role in addressing human rights violations and helping refugees overcome challenges in their lives and attain stability and safety.

REFERENCES

Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Cuijpers, P., & Aker, T. (2015). EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. *European Journal of Psychotraumatology*, *6,* 27414.

Adams, R. E., Figley, C. R., & Boscarino, J. A. (2008). The Compassion Fatigue Scale: Its use with social workers following urban disaster. *Research on Social Work Practice*, *18,* 238-250. doi:10.1177/1049731507310190

Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education In Professional Psychology*, *2*(1), 26-34. doi:10.1037/1931-3918.2.1.26

Ai, L., A., Peterson, C., & Ubelhor, D. (2002). War-Related Trauma and Symptoms of Posttraumatic Stress Disorder Among Adult Kosovar Refugees. *Journal of Traumatic Stress*, *15*(2), 157.

Akinsulure-Smith, A. M., & O'Hara, M. (2012). Working with Forced Migrants: Therapeutic Issues and Considerations for Mental Health Counselors. *Journal of Mental Health Counseling*, *34*(1), 38-55.

Akinsulure-Smith, A. M., Keatley, E., & Rasmussen, A. (2012). Responding to secondary traumatic stress: A pilot study of torture treatment programs in the United States. *Journal of Traumatic Stress, 25*, 232-235.

Alpert, J. L., & Paulson, A. (1990). Graduate-level education and training in child sexual abuse. *Professional Psychology: Research and Practice*, *21*, 366-371. doi:10.1037/0735-7028.21.5.366

Alvarez, A. (1995). *Perceptions of fraudulence, counseling self-efficacy, and satisfaction with work.* (Unpublished doctoral dissertation). State University of New York,

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Annapolis Coalition. (2007). An action plan for behavioral health workforce development: A framework for discussion. Substance Abuse and Mental Health Administration. Shortage Designation: HPSAs, MUAs & MUPs.

Andrews, B., Brewin, C. R., & Rose, S. (2003). Gender, social support, and PTSD in victims of violent crime. *Journal of Traumatic Stress*, *16*, 421-427

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious Posttraumatic Growth in Psychotherapy. *Journal of Humanistic Psychology*, *45*, 239-263. doi:10.1177/0022167805274729

Arthur, N., Merali, N., & Djuraskovic, I. (2010). Facilitating the journey between cultures: Counselling immigrants and refugees. In N. Arthur & S. Collins (Eds.), *Culture-infused counselling* (pp. 285-314). Calgary: Counselling Concepts.

August, L. R., & Gianola, B. A. (1987). Symptoms of war trauma induced psychiatric disorders: Southeast Asian refugees and Vietnam veterans. *International Migration Review, 21*, 820-831.

Ballenger-Browning, K. K., Schmitz, K. J., Rothacker, J. A., Hammer, P. S., Webb-Murphy, J. A., & Johnson, D. C. (2011). Predictors of Burnout Among Military Mental Health Providers. *Military Medicine*, *176*, 253-260.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*, 191-215. doi:10.1037/0033-295X.84.2.191

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, *37*, 122-147. doi:10.1037/0003-066X.37.2.122

Bandura, A. (1993). Perceived Self-Efficacy in Cognitive Development and Functioning. *Educational Psychologist*, *28*, 117.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York, NY, US: W H Freeman/Times Books/ Henry Holt & Co.

Bandura, A. (2001). Social Cognitive Theory: An agentic Perspective. *Annual Review of Psychology*, *52*(1), 1.

Bandura, A. (Ed.). (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs: Prentice Hall.

Bandura, A., Adams, N. E., & Beyer, J. (1977). Cognitive processes mediating behavioral change. *Journal of Personality and Social Psychology*, *35*, 125-139. doi:10.1037/0022-3514.35.3.125

Barbee, P., Scherer, D. & Combs, D. (2003). Pre-practicum service-learning: Examining the relationship with counselor self-efficacy and anxiety. *Counselor Education and Supervision, 43,* 108-119.

Barnes, K. L. (2004). Applying self-efficacy theory to counselor training and supervision: A comparison of two approaches. *Counselor Education and Supervision, 44*(1), 56-69.

Barrington, A. J., & Shakespeare-Finch, J. (2013). Working with refugee survivors of torture and trauma: An opportunity for vicarious post-traumatic growth. *Counselling Psychology Quarterly*, *26*(1), 89-105. doi:10.1080/09515070.2012.727553

Barrington, A. J., & Shakespeare-Finch, J. (2014). Giving voice to service providers who work with survivors of torture and trauma. *Qualitative Health Research*, *24*, 1686-1699. doi:10.1177/1049732314549023

Başoğlu, M., Ekblad, S., Bäärnhielm, S., & Livanou, M. (2004). Cognitive-behavioral treatment of tortured asylum seekers: A case study. *Journal of Anxiety Disorders, 18*, 357-369.

Beck, J.G., & Sloan, D.M. (2012). *The oxford handbook of traumatic stress disorders.* New York: Oxford University Press.

Beiser, M., & Hou, F. (2001). Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: A 10-year study. *Social Science & Medicine, 53,* 1321-1334.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families In Society: The Journal Of Contemporary Social Services*, *84*, 463-470.

Bemak, F., & Chung, R. C. (2008). Counseling refugees and migrants. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, J. E. Trimble, P. B. Pedersen, J. G. Draguns, ... J. E. Trimble (Eds.), *Counseling across cultures* (6th ed.) (pp. 307-324). Thousand Oaks, CA, US: Sage Publications, Inc. doi:10.4135/9781483329314.n18

Bemak, F., & Chung, R. C. (2014). Immigrants and refugees. In F. L. Leong, L. Comas-Díaz, G. C. Nagayama Hall, V. C. McLoyd, J. E. Trimble, F. L. Leong, ... J. E. Trimble (Eds.), *APA handbook of multicultural psychology, Vol. 1: Theory and research* (pp. 503-517). Washington, DC, US: American Psychological Association.

Bemak, F., Chung, R. C., &, Pedersen, P. B. (2003). *Counseling refugees: A psychosocial approach to innovative multicultural interventions*. Westport, CT: Greenwood Press.

Ben-Porat, A., & Itzhaky, H. (2011). The contribution of training and supervision to perceived role competence, secondary traumatization, and burnout among domestic violence therapists. *The Clinical Supervisor*, *30*(1), 95-108. doi:10.1080/07325223.2011.566089

Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery:

The role of perceived self-efficacy. *Behaviour Research And Therapy*, *42*, 1129-1148. doi:10.1016/j.brat.2003.08.008

Benight, C. C., Ironson, G., Carver, C. S., Wynings, C., Burnett, K., Greenwood, D., & ... Klebe, K. (1999). Conservation of resources and coping self-efficacy predicting distress following a natural disaster: A causal model analysis where the environment meets the mind. *Anxiety, Stress & Coping*, *12*(2), 107.

Berger, R., & Gelkopf, M. (2011). An intervention for reducing secondary traumatization and improving professional self-efficacy in well baby clinic nurses following war and terror: A random control group trial. *International Journal of Nursing Studies*, *48*, 601-610. doi:10.1016/j.ijnurstu.2010.09.007

Betancourt, T. S., Newnham, E. A., Layne, C. M., Kim, S., Steinberg, A. M., Ellis, H., & Birman, D. (2012). Trauma history and psychopathology in war-affected refugee children referred for trauma-related mental health services in the United States. *Journal of Traumatic Stress*, *25*(6), 682-690. doi:10.1002/jts.21749

Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. *World Psychiatry: Official Journal of The World Psychiatric Association (WPA)*, *4*(1), 18-24.

Birck, A. (2001). Secondary traumatization and burnout in professionals working with torture survivors. *Traumatology*, *7*(2), 85-90. doi:10.1177/153476560100700203

Birman, D., & Tran, N. (2008). Psychological distress and adjustment of Vietnamese refugees in the United States: Association with pre- and postmigration factors. *American Journal of Orthopsychiatry, 78,* 109-120.

Bollen, K. A. (1989). *Structural equations with latent variables*. New York, NY: John Wiley.

Bosnjak, M., & Tuten, T. L. (2003). Prepaid and promised incentives in web surveys: An experiment. *Social Science Computer Review, 21*, 208–217.

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, *30*, 386-393. doi:10.1037/0735-7028.30.4.386

Bride, B. E. (2004). The Impact of Providing Psychosocial Services to Traumatized Populations. *Stress, Trauma & Crisis: An International Journal*, *7*(1), 29-46.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work 52(*1), 63-70.

Bride, B. E., Hatcher, S. S., & Humble, M. N. (2009). Trauma training, trauma practices, and secondary traumatic stress among substance abuse counselors. *Traumatology*, *15*(2), 96-105. doi:10.1177/1534765609336362

Bride, B., Jones, J., & MacMaster, S. (2007). Correlates of secondary traumatic stress in child protective service workers. *Journal of Evidence-Based Social Work*, *4*(3), 69-80.

Bride, B., Robinson, M., Yegidis, B., & Figley, C. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice*, *14*(1), 27-35.

Briere, J., & Scott, C. (2014). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed.). Thousand Oaks, CA: Sage.

Burnett, A., & Thompson, K. (2005). Enhancing the psychosocial well-being of asylum seekers and refugees. In K. H. Barrett & W. H. George (Eds.), Race, culture, psychology, and law (pp. 205–224). Thousand Oaks, CA: SAGE.

Carlson, E. B., & Rosser-Hogan, R. (1993). Mental health status of Cambodian refugees ten years after leaving their homes. *American Journal of Orthopsychiatry*, *63*, 223-231.

Carswell, K., Blackburn, P., & Barker, C. (2011). The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *International Journal of Social Psychiatry*, *57*(2), 107-119. doi:10.1177/0020764008105699

Carta, M. G., Oumar, F. W., Moro, M. F., Moro, D., Preti, A., Mereu, A., & Bhugra, D. (2013). Trauma- and stressor related disorders in the tuareg refugees of a cAMP in burkina faso. *Clinical Practice and Epidemiology In Mental Health: CP & EMH*, *9,* 189-195. doi:10.2174/1745017901309010189

Cashwell, T. H., & Dooley, K. (2001). The impact of supervision on counselor self-efficacy. *The Clinical Supervisor, 20*(1), 39-47.

Century, G., Leavey, G., & Payne, H. (2007). The experience of working with refugees: Counsellors in primary care. *British Journal of Guidance & Counselling*, *35*(1), 23-40. doi:10.1080/03069880601106765

Chandler, N., Balkin, R. S., & Perepiczka, M. (2011). Perceived Self-Efficacy of Licensed Counselors to Provide Substance Abuse Counseling. *Journal of Addictions & Offender Counseling*, *32*(1-2), 29-42.

Choi, G. (2011). Secondary traumatic stress of service providers who practice with

survivors of family or sexual violence: a national survey of social workers. *Smith College Studies In Social Work (Haworth)*, *81*(1), 101-119. doi:10.1080/00377317.2011.543044

Chrestman, K. R. (1995). Secondary exposure to trauma and self reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 29–36). Lutherville, MD: Sidran.

Cieslak, R., Shoji, K., Luszczynska, A., Taylor, S., Rogala, A., & Benight, C. C. (2013). Secondary trauma self-efficacy: Concept and its measurement. *Psychological Assessment*, *25*, 917-928 12p. doi:10.1037/a0032687

Cooper, Z., Doll, H., Bailey-Straebler, S., Kluczniok, D., Murphy, R., O'Connor, M. E., & Fairburn, C. G. (2015). The development of an online measure of therapist competence. *Behaviour Research and Therapy*, *64,* 43-48. doi:10.1016/j.brat.2014.11.007

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy*, *1*(1), 3-23. doi:10.1037/a0015224

Crockett, S. A. (2012). A five-step guide to conducting SEM analysis in counseling research. *Counseling Outcome Research and Evaluation, 3*(1), 30-47.

Curran, L. A. (2010). *Trauma competency: A clinician's guide*. Eau Claire, WI: PESI.

de Jong, J. M., & Van Ommeren, M. (2002). Toward a culture-informed epidemiology: Combining qualitative and quantitative research in transcultural contexts. *Transcultural Psychiatry*, *39*, 422-433. doi:10.1177/136346150203900402

Deighton, R. M., Gurris, N., & Traue, H. (2007). Factors affecting burnout and compassion fatigue in psychotherapists treating torture survivors: Is the therapist's attitude to working through trauma relevant. *Journal of Traumatic Stress, 20*, 63–75. doi:10.1002/jts.20180

DeVellis R. (2003). *Scale development: theory and applications: theory and application.* Thousand Okas, CA: Sage.

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal of Psychiatry*, *43*, 373-385. doi:10.1080/00048670902721079

Dillman, D. A. (2000). *Mail and internet surveys: The tailored design method*, (2nd ed.). New York: John Wiley.

Dillman, D. A., Smyth, J. D., Christran, L. M. (2014). *Mail and internet surveys: The tailored design method,* (4th ed.). Hoboken, N.J: Wiley.

Dominguez-Gomez, E., & Rutledge, D. (2009). Prevalence of secondary traumatic stress among emergency nurses. *JEN: Journal of Emergency Nursing*, *35*, 199-204. doi:10.1016/j.jen.2008.05.003

Duckworth, M. P., & Follette, V. M. (2012). *Retraumatization: Assessment, treatment, and prevention*. New York, NY, US: Routledge/Taylor & Francis Group.

Easton, C., Martin, W. E., & Wilson, S. (2008). Emotional Intelligence and Implications for Counseling Self-Efficacy: Phase II. *Counselor Education and Supervision*, *47*, 218-232.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet*, *365*(9467), 1309-1314.

Fenta, H., Hyman, I., & Noh, S. (2004). Determinants of Depression Among Ethiopian Immigrants and Refugees in Toronto. *Journal of Nervous And Mental Disease*, *192*, 363-372. doi:10.1097/01.nmd.0000126729.08179.07

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. Philadelphia, PA, US: Brunner/Mazel.

Figley, C. R. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 3-28). Lutherville, MD: Sidran.

Finklestein, M., Stein, E., Greene, T., Bronstein, I., & Solomon, Z. (2015). Posttraumatic stress disorder and vicarious trauma in mental health professionals. *Health & Social Work*, *40*(2), e25-e31. doi:10.1093/hsw/hlv026

Follette, V. M., Polusny, M. M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. *Professional Psychology: Research and Practice*, *25*, 275-282. doi:10.1037/0735-7028.25.3.275

Friedlander, M. L., & Snyder, J. (1983). Trainees' expectations for the supervisory process: Testing a developmental model. *Counselor Education and Supervision*, *22*, 342-348. doi:10.1002/j.1556-6978.1983.tb01771.x

Friedlander, M. L., Keller, K. E., Peca-Baker, T. A., & Olk, M. E. (1986). Effects of role

conflict on counselor trainees' self-statements, anxiety level, and performance. *Journal of Counseling Psychology*, *33*(1), 73-77. doi:10.1037/0022-0167.33.1.73

Gavagan, T., & Martinez, A. (1997). Presentation of recent torture survivors to a family practice center. *The Journal of Family Practice*, *44*, 209-212.

Gerritsen, A., Bramsen, I., Devillé, W., Willigen, L., Hovens, J., & Ploeg, H. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry & Psychiatric Epidemiology*, *41*(1), 18-26. doi:10.1007/s00127-005-0003-5

Goreczny, A. J., Hamilton, D., Lubinski, L., & Pasquinelli, M. (2015). Exploration of counselor self-efficacy across academic training. *The Clinical Supervisor*, *34*(1), 78-97. doi:10.1080/07325223.2015.1012916

Göritz, A. S. (2006). Incentives in web studies: Methodological issues and a review. *International Journal of Internet Science, 1*(1), 58–70.

Greason, P. B., & Cashwell, C. S. (2009). Mindfulness and Counseling Self-Efficacy: The Mediating Role of Attention and Empathy. *Counselor Education & Supervision*, *49*(1), 2-19.

Hagenaars, M. A., Fisch, I., & van Minnen, A. (2011). The effect of trauma onset and frequency on PTSD-associated symptoms. *Journal of Affective Disorders*, *132*(1-2), 192-199. doi:10.1016/j.jad.2011.02.017

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training*, *46*, 203-219. doi:10.1037/a0016081

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-Analysis of Risk Factors for Secondary Traumatic Stress in Therapeutic Work With Trauma Victims. *Journal of Traumatic Stress*, *28*(2), 83-91. doi:10.1002/jts.21998

Heppner, M. J., Multon, K. D., Gysbers, N. C., Ellis, C., & Zook, C. E. (1998). Examining the relationship of counselor self‐efficacy and selected client process and outcome measures in career counseling. *Journal of Counseling Psychology, 45*, 393‐402.

Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D. (2015). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *Journal of Humanistic Psychology*, *55*, 153-172. doi:10.1177/0022167814534322

Higson-Smith, C. (2013). Counseling torture survivors in contexts of ongoing threat: Narratives from sub-Saharan Africa. *Peace And Conflict: Journal Of Peace Psychology*, *19*, 164-179. doi:10.1037/a0032531

Hinton, D. E., Hofmann, S. G., Pollack, M. H., & Otto, M. W. (2009). Mechanisms of Efficacy of CBT for Cambodian Refugees with PTSD: Improvement in Emotion Regulation and Orthostatic Blood Pressure Response. *CNS Neuroscience & Therapeutics*, *15*, 255-263. doi:10.1111/j.1755-5949.2009.00100.x

Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., & ... Westermeyer, J. (2002). Measuring trauma and health status in refugees: A critical review. *JAMA: Journal of The American Medical Association*, *288*, 611-621. doi:10.1001/jama.288.5.611

Houser, R. (2015). *Counseling and educational research: Evaluation and application*. Thousand Oaks, California: SAGE.

Huck, S.W. (2012). *Reading Statistics and Research.* Boston, MA: Allyn and Bacon.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*, 423-432.

Johnson, E., & Seem, S. (1989, August). Supervisory style and the development of self-efficacy in counseling training. Poster session presented at the annual meeting of the American Psychological Association, New Orleans.

Johnson, E., Baker, S. B., Kopala, M., Kiselica, M. S., & Thompson, E. C. (1989). Counseling self-efficacy and counseling competence in prepracticum training. *Counselor Education And Supervision*, *28*, 205-218. doi:10.1002/j.1556-6978.1989.tb01109.x

Johnson, H., & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review*, *28*(1), 36-47. doi:10.1016/j.cpr.2007.01.017

Johnson, R.B., & Christensen, L.B. (2004). *Educational research: Quantitative and Qualitative and mixed approaches*. Boston, MA: Allyn and Bacon.

Kadambi, M. A., & Truscott, D. (2004). Vicarious trauma among therapists working with sexual violence, cancer, and general practice. *Canadian Journal of Counseling, 38*, 260–276.

Kanter, J. (2007). Compassion fatigue and secondary traumatization: A second look. *Clinical Social Work Journal*, *35*, 289-293. doi:10.1007/s10615-007-0125-1

Kennedy, E. M. (1981). Refugee Act of 1980. *International Migration Review, 15*, 141-156.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, *52*, 1048-1060. doi:10.1001/archpsyc.1995.03950240066012

Kinzie, J. D. (2001). Psychotherapy for massively traumatized refugees: The therapist variable. *American Journal of Psychotherapy*, *55*, 475-490.

Kline, R. B. (2016). *Principles and practice of structural equation modeling.* New York: The Guilford Press.

Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one' s own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology, 6,* 1121– 1134.

Laban, C. J., Gernaat, H. E., Komproe, I. H., van der Tweel, I., & De Jong, J. M. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *Journal of Nervous and Mental Disease*, *193*, 825-832. doi:10.1097/01.nmd.0000188977.44657.1d

Laban, C. J., Hurulean, E., & Attia, A. (2009). Treatment of asylum seekers: Resilience oriented therapy and strategies (ROTS): Implications of study results into clinical practice. In: J. de Joop, & S Colijn (Eds.), Handboek Culturele Psychiatrie en Psychotherapie (pp. 127–146). Utrecht, The Netherlands: De Tijdstroom.

Larson, L. M. (1998). The social cognitive model of counselor training. *The Counseling Psychologist, 26*, 219–274. doi:10.1177/0011000098262002.

Larson, L. M., & Daniels, J. A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist, 26*, 179–218.

Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. (1992). Development and validation of the Counseling Self-estimate Inventory. *Journal of Counseling Psychology, 39*(1), 105–120. doi:10.1037/0022-0167.39.1.105.

Layne, C. M., Briggs-King, E., & Courtois, C. (2014). Introduction to the Special Section: Unpacking risk factor caravans across development: Findings from the NCTSN Core Data Set. *Psychological Trauma: Theory, Research, Practice & Policy, 6*, S1–S8. doi:10.1037/ a0037768

Leach, M. M., Stoltenberg, C. D., McNeill, B. W., & Eichenfield, G. A. (1997). Self-efficacy and counselor development: Testing the integrated developmental model.

Counselor Education And Supervision, *37*, 115-124. doi:10.1002/j.1556-6978.1997.tb00537.x

Lei, P. W., & Wu, Q. (2007). Introduction to Structural Equation Modeling: Issues and Practical Considerations. *Educational Measurement: Issues and Practice, 26*(3), 33-43.

Lent, R. W., Hoffman, M. A., Hill, C. E., Treistman, D., Mount, M., & Singley, D. (2006). Client-specific counselor self-efficacy in novice counselors: Relation to perceptions of session quality. *Journal of Counseling Psychology*, *53*, 453-463. doi:10.1037/0022-0167.53.4.453

Levine, P. (2012). *In an unspoken voice: How the body releases trauma and restores goodness.* Berkley, CA: North Atlantic Books.

Lustig, S., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D., . . . Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 24–36. doi:10.1097/00004583-200401000-00012

MacCallum, R. C., Browne, M. W., & Sugawara, H. M. (1996). Power analysis and determination of sample size for covariance structure modeling. *Psychological Methods,* 1, 130–149.

Malchiodi, C. A. (2015). *Creative interventions with traumatized children* (2nd ed.). New York, NY, US: Guilford Press.

Malekzai, A. B., Niazi, J. M., Paige, S. R., Hendricks, S. E., Fitzpatrick, D., Leuschen, M. P., & Millimet, C. R. (1996). Modification of CAPS-1 for diagnosis of PTSD in Afghan refugees. *Journal of Traumatic Stress*, *9*, 891-893. doi:10.1007/BF02104111

Mares, S., & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention -- clinical, administrative and ethical issues. *Australian & New Zealand Journal of Public Health*, *28*, 520-526.

Marotta, S. A. (2003). Unflinching Empathy: Counselors and tortured refugees. *Journal of Counseling & Development*, *81*(1), 111-114. doi:10.1002/j.1556-6678.2003.tb00232.x

Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M., & Chun, C. (2005). Mental Health of Cambodian Refugees 2 Decades After Resettlement in the United States. *JAMA: Journal of The American Medical Association*, *294*, 571-579. doi:10.1001/jama.294.5.571

Martin, D.C. & Yankay, J.E. (2014). *Refugees and asylees: 2013.* Office of Immigration Statistics, Policy Directorate. U.S. Department of Homeland Security. Washington, D.C. Retrieved from: dhs.gov/sites/default/files/publications/ois_rfa_fr_2013.pdf

Maslach, C. (2003). Job Burnout: New Directions in Research and Intervention. *Current Directions In Psychological Science*, *12*, 189-192. doi:10.1111/1467-8721.01258

McCann, I. L., & Pearlman, L. A., (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131-149.

McColl, H., & Johnson, S. (2006). Characteristics and needs of asylum seekers and refugees in contact with London community mental health teams. *Social Psychiatry & Psychiatric Epidemiology*, *41*, 789-795. doi:10.1007/s00127-006-0102-y

McKinney, K. (2007). Culture, power, and practice in a psychosocial program for survivors of torture and refugee trauma. *Transcultural Psychiatry*, *44*, 482-503. doi:10.1177/1363461507081643

Melchert, T. P., Hays, V. L., Wiljanen, L. M., & Kolocek, A. K. (1996). Testing models of counselor development with a measure of counseling self-efficacy. *Journal of Counseling & Development, 74,* 640- 644.

Meyers, T. W., & Cornille, T. A. (2002). The trauma of working with traumatized children. In C. R. Figley, C. R. Figley (Eds.), *Treating compassion fatigue* (pp. 39-55). New York, NY, US: Brunner-Routledge.

Michalopoulos, L. M., & Aparicio, E. (2012). Vicarious Trauma in Social Workers: The Role of Trauma History, Social Support, and Years of Experience. *Journal of Aggression, Maltreatment & Trauma*, *21*, 646-664 19p. doi:10.1080/10926771.2012.689422

Mollica, R. F. (2006). *Healing invisible wounds: paths to hope and recovery in a violent world*. New York, NY: Harcourt, Inc.

Mollica, R. F., McInnes, K., Poole, C., & Tor, S. (1998). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *The British Journal of Psychiatry*, *173,* 482-488. doi:10.1192/bjp.173.6.482

Mueller, R. O., & Hancock, G. R. (2008). Best practices in structural equation modeling. In J. W. Osborne (Ed.), *Best practices in quantitative methods* (pp. 488- 508). Thousands Oaks, CA: Sage.

Munson, W. W., Stadulis, R. E., & Munson, D. G. (1986). Enhancing competence and self-efficacy of potential therapeutic recreators in decision-making counseling. *Therapeutic Recreation Journal, 20*, 85-93.

Munson, W. W., Zoerink, D. A., & Stadulis, R. E. (1986). Training potential therapeutic recreators for self-efficacy and competence in interpersonal skills. *Therapeutic Recreation Journal, 20,* 53-62.

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. *American Journal Of Orthopsychiatry*, *80*, 576-585. doi:10.1111/j.1939-0025.2010.01062.x

Muthen, L. K., & Muthen, B. (2006). *Mplus: Statistical analysis with latent variables: user's guide*. Los Angeles, CA: Muthén & Muthén.

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy, 32,* 341–347.

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A Comparison of Narrative Exposure Therapy, Supportive Counseling, and Psychoeducation for Treating Posttraumatic Stress Disorder in an African Refugee Settlement. *Journal of Consulting And Clinical Psychology*, *72*(4), 579-587. doi:10.1037/0022-006X.72.4.579

O'Brien, K. M., Heppner, M. J., Flores, L. Y., & Bikos, L. H. (1997). Career Counseling Self-Efficacy Scale. *Psyctests*, doi:10.1037/t04298-000

Ogle, C. M., Rubin, D. C., Berntsen, D., & Siegler, I. C. (2013). The frequency and impact of exposure to potentially traumatic events over the life course. *Clinical Psychological Science*, *1*, 426-434. doi:10.1177/2167702613485076

Ortlepp, K., & Friedman, M. (2002). Prevalence and Correlates of Secondary Traumatic Stress in Workplace Lay Trauma Counselors. *Journal of Traumatic Stress*, *15*, 213.

Otto, M. W., Hinton, D., Korbly, N. B., Chea, A., Ba, P., Gershuny, B. S., & Pollack, M. H. (2003). Treatment of pharmacotherapy-refractory posttraumatic stress disorder among Cambodian refugees: a pilot study of combination treatment with cognitive-behavior therapy vs sertraline alone. *Behaviour Research and Therapy*, *41*, 1271-1276. doi:10.1016/S0005-7967(03)00032-9

Palic, S., & Elklit, A. (2011). Psychosocial treatment of posttraumatic stress disorder in adult refugees: A systematic review of prospective treatment outcome studies and

a critique. *Journal of Affective Disorders*, *131*(1-3), 8-23. doi:10.1016/j.jad.2010.07.005

Paunovic, N., & Öst, L. (2001). Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. *Behaviour Research and Therapy*, *39*, 1183-1197. doi:10.1016/S0005-7967(00)00093-0

Pearlman, L. A. (1999). Self care for trauma therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* Lutherville, MD: Sidran Press.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology, 26*, 558.

Pearlman, L.A., & Saakvitne, K. W. (1995). Treating therapist with vicarious trauma and secondary traumatic stress disorders. *Compassion Fatigue,* 150-177.

Pew Research Center. (2008). U.S. population projections: 2005- 2050. Retrieved September 7, 2016, from http://www.pewhispanic.org/2008/02/11/us-population-projections-2005-2050/

Potenza, M. (1990). *The counselor self-efficacy inventory: Implications for counselor training* (Unpublished master's thesis). University of Nebraska, Lincoln.

Prendes-Lintel, M. (2001). A working model in counseling recent refugees. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 729-752). Thousand Oaks, CA, US: Sage Publications, Inc.

Quinal, L., Harford, S., & Rutledge, D. N. (2009). Secondary traumatic stress in oncology staff. *Cancer Nursing*, *32*(4), E1-E7. doi:10.1097/NCC.0b013e31819ca65a

Refugee Act of 1980, Public Law No. 96-212, 94 Stat. 102 (1980).

Renner, W., Bänninger-Huber, E., & Peltzer, K. (2011). Culture-Sensitive and Resource Oriented Peer (CROP)-Groups as a community based intervention for trauma survivors: A randomized controlled pilot study with refugees and asylum seekers from Chechnya. *Australasian Journal of Disaster and Trauma Studies*, *2011*(1), 1-13.

Robiner, W. N. (2006). The mental health professions: Workforce supply and demand, issues, and challenges. *Clinical Psychology Review*, *26*(5), 600-625. doi:10.1016/j.cpr.2006.05.002

Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: Systematic review. *The British Journal of Psychiatry*, *194*, 306-312. doi:10.1192/bjp.bp.108.053223

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* New York: Norton.

Sabin-Farrell, R., & Turpin, G. (2003). *Vicarious traumatization: Implications for mental health workers? Clinical Psychology Review, 23,* 449-480. doi: 10.1016/S02727358(03)00030-8

Sartor, T.A. (2012). The relationship between vicarious trauma and self-efficacy among mental health professionals (Doctoral dissertation). Retrieved from ProQuest Database.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19,* 49–64.

Schumacker, R. E., & Lomax, R. G. (2010). A beginner's guide to structural equation modeling (3rd ed.). Mahwah, NJ: Lawrence Erlbaum.

Schweitzer, R. D., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: Contributions of pre-migration and post-migration experience. *Australian and New Zealand Journal of Psychiatry*, *45*, 299-307. doi:10.3109/00048674.2010.543412

Shannon, P. J., Vinson, G. A., Wieling, E., Cook, T., & Letts, J. (2015). Torture, War Trauma, and Mental Health Symptoms of Newly Arrived Karen Refugees. *Journal of Loss & Trauma*, *20*, 577-590. doi:10.1080/15325024.2014.965971

Sheperis, C., Young, J. S., & Daniels, M. H. (2010). *Counseling research: Quantitative, qualitative, and mixed methods*. Boston: Pearson.

Sieberer, M., Ziegenbein, M., Eckhardt, G., Machleidt, W., & Calliess, I. T. (2011). Psychiatric expert opinions on asylum seekers in Germany. *Psychiatrische Praxis*, *38*(1), 38-44. doi:10.1055/s-0030-1248552

Sipps, G. J., Sugden, G. J., & Faiver, C. M. (1988). Counselor training level and verbal response type: Their relationship to efficacy and outcome expectations. *Journal of Counseling Psychology*, *35*, 397-401. doi:10.1037/0022-0167.35.4.397

Slewa-Younan, S., Chippendale, K., Heriseanu, A., Lujic, S., Atto, J., & Raphael, B. (2012). Measures of psychophysiological arousal among resettled traumatized Iraqi refugees seeking psychological treatment. *Journal of Traumatic Stress*, *25*,

348-352. doi:10.1002/jts.21694

Slobodin, O., & de Jong, J. M. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy?. *International Journal of Social Psychiatry*, *61*(1), 17-26. doi:10.1177/0020764014535752

Smith Hatcher, S., Bride, B., Oh, H., Moultrie King, D., & Franklin Catrett, J. (2011). An assessment of secondary traumatic stress in juvenile justice education workers. *Journal of Correctional Health Care*, *17*, 208-217. doi:10.1177/1078345811401509

Solomon, S. D., & Johnson, D. M. (2002). Psychosocial treatment of posttraumatic stress disorder: A practice-friendly review of outcome research. *Journal of Clinical Psychology*, *58*, 947-959. doi:10.1002/jclp.10069

Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. *Counselor Education And Supervision*, *48*(1), 61-71. doi:10.1002/j.1556-6978.2008.tb00062.x

Sprang, G., Clark, J.J., Whitt-Woosley, A., 2007. Compassion fatigue, compassion satisfaction and burnout: factors impacting a professional's quality of life. *Journal of Loss and Trauma 12*, 259–280.

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA: Journal of The American Medical Association*, *302*, 537-549 13p. doi:10.1001/jama.2009.1132

Steel, Z., Momartin, S., Bateman, C., Hafshejani, A., Silove, D., Everson, N., & ... Mares, S. (2004). Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian & New Zealand Journal of Public Health*, *28*, 527-536.

Stephanie, A. C. (2012). A Five-Step Guide to Conducting SEM Analysis in Counseling Research. *Counseling Outcome Research and Evaluation, 3(*1), 30-47.

Strand, V. C., Abramovitz, R., Layne, C. M., Robinson, H., & Way, I. (2014). Meeting the Critical Need for Trauma Education in Social Work: A Problem-Based Learning Approach. *Journal of Social Work Education*, *50*(1), 120-135.

Sutton, J. M., & Fall, M. (1995). The relationship of school climate factors to counselor self-efficacy. *Journal of Counseling & Development*, *73*, 331-336. doi:10.1002/j.1556-6676.1995.tb01759.x

Tang, M., Addison, K. D., LaSure-Bryant, D., Norman, R., O'Connell, W., & Stewart-Sicking, J. A. (2004). Factors That Influence Self-Efficacy of Counseling Students: An Exploratory Study. *Counselor Education and Supervision*, *44*(1), 70-80. doi:10.1002/j.1556-6978.2004.tb01861.xs

Ted, B., & Cheryl, R. (2006). Strategies for Reducing Secondary or Vicarious Trauma: Do They Work?. *Brief Treatment & Crisis Intervention*, *6*(1), 1-9.

Tempany, M. (2009). What research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: a literature review. *Transcultural Psychiatry*, *46*, 300-315. doi:10.1177/1363461509105820

Turner, S. W., Bowie, C., Dunn, G., Shapo, L., & Yule, W. (2003). Mental health of Kosovan Albanian refugees in the UK. *The British Journal of Psychiatry*, *182*, 444-448. doi:10.1192/bjp.182.5.444

Tyrer, R. A., & Fazel, M. (2014). School and Community-Based Interventions for Refugee and Asylum Seeking Children: A Systematic Review. *Plus ONE*, *9*(2), 1-10. doi:10.1371/journal.pone.0089359

U.S. Census Bureau (2015*). Forum on Ethnic Groups from the Middle East and North Africa.* Retrieved September 21, 2016, from census.gov/library/working-papers/2015/demo/2015-MENA-Experts.html.

U.S. Department of State, Bureau of Population, Refugees, and Migration. (2016). *Historical arrivals broken down by region (1976-present)*. Retrieved from wrapsnet.org/Reports/AdmissionsArrivals/tabid/211/Default.aspx

U.S. Department of State, Bureau of Population, Refugees, and Migration. (2015). *Proposed Refugee Admissions for Fiscal Year 2016.* Retrieved from state.gov/documents/organization/247982.pdf

U.S. Department of State. (2015). *Department's Worldwide Refugee Admissions Processing System, WRAPS*. Retrieved from wrapsnet.org/Reports/AdmissionsArrivals/tabid/211/Default.aspx

United Nations High Commissioner for Refugees. (2003). *Refugees by numbers*. Retrieved from unhcr.ch/cgi-bin/texis/vtx/publ United Nations

United Nations High Commissioner for Refugees. (2015). *UNHCR Mid-Year Trends 2015*. Retrieved from unhcr.org/56701b969.html

United Nations. (1951). *Convention and protocol relating to the status of refugees*. Retrieved from unhchr.ch/html/menu3/b/o_c_ref.htm

Urbani, S., Smith, M. R., Maddux, C. D., Smaby, M. H., Torres-Rivera, E., & Crews, J. (2002). Skills-Based Training and Counseling Self-Efficacy. *Counselor Education & Supervision*, *42*(2), 92.

Voss Horrell, S. C., Holohan, D. R., Didion, L. M., & Vance, G. T. (2011). Treating traumatized OEF/OIF veterans: How does trauma treatment affect the clinician?. *Professional Psychology: Research and Practice*, *42*(1), 79-86. doi:10.1037/a0022297

Warr, S. (2010). Counselling Refugee Young People: An Exploration of Therapeutic Approaches. *Pastoral Care In Education*, *28*, 269-282.

Warren, T., Lee, S., & Saunders, S. (2003). Factors influencing experienced distress and attitude toward trauma by emergency medicine practitioners. *Journal of Clinical Psychology In Medical Settings*, *10*, 293-296. doi:10.1023/A:1026305521677

Way, I., vanDeusen, K. M., Martin, G., Applegate, B., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence*, *19*(1), 49-71. doi:10.1177/0886260503259050

Weitkamp, K., Daniels, J. K., & Klasen, F. (2014). Psychometric properties of the Questionnaire for Secondary Traumatization. *European Journal of Psychotraumatology*, *5.* doi:10.3402/ejpt.v5.21875

Woody, J. D., Anderson, D. K., & D'Souza, H. J. (2015). Dissemination of Trauma-Focused Cognitive-Behavioral Therapy with Community Practitioners: Focus on Self-Efficacy. *Journal of Evidence-Based Social Work*, *12*, 623-635. doi:10.1080/15433714.2014.950128

Yakushko, O., Watson, M., & Thompson, S. (2008). Stress and coping in the lives of recent immigrants and refugees: Considerations for counseling. *International Journal for the Advancement of Counselling, 30,* 167-178.

Zimering, R., Munroe, J., & Gulliver, S. (2003). Secondary traumatization in mental health care providers. *Psychiatric Times*, *20*(4), 43-47.

APPENDIX A: INTRODUCTORY EMAIL

Dear Mental Health Professional,

My name is Dana T. Isawi, and I am a doctoral candidate in University of North Carolina at Charlotte's Counselor Education and Supervision program. You are invited to participate in a dissertation research study titled *Counselor Self-Efficacy of Mental Health Professionals Working with Refugees and Asylum Seekers*. The overall objective of this research study is to explore factors that affect the counselor self-efficacy of mental health professionals working with refugees who have experienced trauma.

Findings from this study will add to the trauma counseling literature and provide insight to further research in clinical practice, training, and supervision of mental health professionals working with a diverse population. Your participation in this study is entirely voluntary and you may withdraw your consent and terminate participation without consequence at any time. As a 'thank you' for your participation, you are eligible to enter into a random drawing for one of four $50 Amazon gift cards. After completing the survey you will be directed to a separate page to provide your email for the drawing.

You are eligible to participate in this study if you meet the following criteria:

1. You hold a graduate degree in a mental health field including counseling, psychology, psychiatry, or social work **and**
2. You currently provide therapeutic services for traumatized refugees and asylum seekers living in the United States.

The online survey will take approximately 15 to 20 minutes to complete and special measures will be taken to protect your confidentiality to the extent possible.

Please click the following link to begin the survey and provide your consent:
http://www.surveyshare.com/s/AYAWFFB

Please direct any questions or concerns about this study to the principal investigator, Dana T. Isawi (disawi@uncc.edu) or my faculty advisor, Dr. Phyllis Post (ppost@uncc.edu). This research has been reviewed and approved by the University of North Carolina at Charlotte Institutional Review Board (IRB).

If you decline participation, I ask that you please share this invitation with other professionals who may be eligible. Thank you in advance for your time and participation! Your time is greatly appreciated.
Sincerely,
Dana Isawi

APPENDIX B: FIRST REMINDER

Dear Mental Health Professional,

Earlier Last week I sent you an email asking for your participation in my research study titled *Counselor Self-Efficacy of Mental Health Professionals Working with Refugees and Asylum Seekers*. If you have already completed the survey, thank you again for your participation.

If you have not had the opportunity to participate, please take approximately 15-20 minutes to complete this brief survey. The overall objective of this research study is to explore factors that affect the counselor self-efficacy of mental health professionals working with refugees who have experienced trauma.

To complete the survey, simply click on this link:
http://www.surveyshare.com/s/AYAWFFB

Please direct any questions or concerns about this study to the principal investigator, Dana T. Isawi (disawi@uncc.edu) or the faculty advisor, Dr. Phyllis Post (ppost@uncc.edu).

I very much appreciate your help with this study.

Many thanks,

Dana Isawi

APPENDIX C: SECOND AND FINAL REMINDER

Dear Mental Health Professional,

This is a final reminder for those of you who have not had the opportunity to participate in my dissertation research titled *Counselor Self-Efficacy of Mental Health Professionals Working with Refugees and Asylum Seekers*. If you already completed the survey, I would like to thank you very much. I truly appreciate your help.

The survey will close in three days (DATE). If you have not had the opportunity to participate, I would like to urge you to do so. It should only take about 15-20 minutes to complete. Simply click on the link below to begin answering the questions.

http://www.surveyshare.com/s/AYAWFFB

Please direct any questions or concerns about this study to the principal investigator, Dana T. Isawi (disawi@uncc.edu) or my faculty advisor, Dr. Phyllis Post (ppost@uncc.edu). This project has been reviewed and approved by the University of North Carolina at Charlotte's Institutional Review Board (IRB).

Thank you for your help, and best wished.

Sincerely,

Dana Isawi

APPENDIX D: INFORMED CONSENT

Department of Counseling
9201 University City Boulevard, Charlotte, NC 28223-0001
t/ 704-687-8960 f/ 704-687-8960 http://education.uncc.edu/counseling

Informed Consent for

Counselor Self-Efficacy of Mental Health Professional Working with Refugees and Asylum Seekers

Dear Participant,

You are invited to participate in an online research study conducted as part of the requirements for a doctoral degree.

Purpose of the Study
The purpose of the study is to examine how trauma training, experience, percentage of traumatized clients, and secondary traumatic stress relate to counselor self-efficacy among mental health professionals who work with refugee and asylum seeking clients who have experienced trauma. The study will also examine how secondary traumatic stress has a mediating effect on the relationship between the independent variables and the dependent variable

Investigator
This study is being conducted by Dana Isawi in the Department of Counseling at the University of North Carolina at Charlotte as part of the requirements for a doctoral degree. The responsible faculty member is Dr. Phyllis Post, Department of Counseling, UNCC.

Eligibility
You are invited to participate in this study if you (a) have a graduate degree in a mental health field including counseling, psychology, psychiatry, or social work and (b)

currently provide therapeutic services for refugees and asylum seekers who have experienced trauma living in the United States.

You may not participate in this project if you (a) do not possess a graduate degree in a mental health field including counseling, psychology, psychiatry, or social work and (b) do not currently provide therapeutic services for refugees and asylum seekers who have experienced trauma living in the United States.

Description of Participation
You will be asked to complete an online survey that consists of 73 items. The questionnaire asks for demographic information, ratings of your counselor self-efficacy, and ratings of secondary traumatic stress. You will not include your name on the survey and your responses will be kept in a secure electronic drive only accessible to the primary researcher.

Length of Participation
Your participation will take approximately15-20 minutes.

Risks and Benefits of Participation
POTENTIAL RISKS: There are no known risks to participation in this study. However, there may be risks which are currently unforeseeable.

POTENTIAL BENEFITS: Although your participation in this research may not benefit you personally, it will benefit the mental health field in contributing to a better undersatnding of factors that influence the effectiveness of mental health professionals working with diverse populations. This intervention will also benefit clients by providing information on the necessary factors that contribute to the effectiveness of mental health professionals.

Volunteer Statement
You are a volunteer. The decision to participate in this study is completely up to you. If you decide to be in the study, you may stop at any time. You will not be treated any differently if you decide not to participate in the study or if you stop once you have started.

Confidentiality Statement
The survey does not ask for identifying information such as name or email address. However, you have the choice to provide your email in order to enter for a drawing for one of four $50 Amazon gift cards. Any identifiable information collected as part of this study will remain confidential to the extent possible and will only be disclosed with your permission or as required by law. The data will be stored securely in a secure drive folder. Each survey will be assigned a code and will not include any participant names.

The surveys will be discarded once all of the data has been entered into SPSS software by the primary investigator.

Statement of Fair Treatment and Respect
UNC Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the university's Research Compliance Office (704-687-1871) if you have questions about how you are treated as a study participant. If you have any questions about the actual project or study, please contact Dana Isawi (disawi@uncc.edu) or Dr. Phyllis Post (ppost@uncc.edu).

Participant Consent
I have read the information in this consent form. I am at least 18 years of age, and I agree to participate in this research project.
This form was approved for use on *June, 3, 2016* for use for one year.

If you want to be in this study, click on the "I Agree" button to begin.

APPENDIX E: REWARD LINK PAGE

(This page appears when participants have completed survey)

Thank you for your response!

Because I realize your time is valuable and as a 'thank you' for your participation, you are eligible to enter into a drawing for $50 gift certificate from Amazon.com. The drawing will be held within five weeks and you will be notified of the outcome via email. If you are interested in entering the drawing, please enter your name and email address. This information will not be connected to your responses.

If you are interested in entering the drawing, please click on the link below:

http://www.surveyshare.com/s/AYAWFNC

APPENDIX F: PERMISSION OF AUTHOR TO USE COSE

Dr. Larson,

I am a doctoral student at the University of North Carolina at Charlotte. I am currently working on my dissertation and am interested in using the Counseling Self-Estimate Inventory (COSE) in my study, which will use an online survey.

My dissertation is aimed at examining the relationship between mental health professionals' level of counseling self-efficacy and trauma training, experience, percentage of traumatized clients and secondary traumatic stress.

I am writing to request your permission to use the COSE instrument in my dissertation. Please let me know where I can find the most appropriate form of the instrument. Thank you in advance for your time and I look forward to hearing from you.

Sincerely,

Dana Isawi
Doctoral Student
University of North Carolina at Charlotte

May 11, 2016

Thank you for your interest in using The Counseling Self-Estimate Inventory (COSE). I am happy to grant you permission to use the instrument for **one year for one study**.

I have attached a copy of the instrument and a list of references in which the COSE has been used. The instructions read for people to indicate their answers on the instrument. An alternative that we are doing is to use answer sheets so the inventories can be reused. Also there is no place for the person to indicate demographics and identification. You need to include this on a separate sheet of your own design.

The following items on the COSE are reversed scored: Items 2, 6, 7, 9, 16, 18, 19, 21, 22, 23, 24, 26, 27, 28, 31, 33, 35, 36, & 37.

The factors consist of the following items:

Factor 1: Microskills: Item 1, 3, 4, 5, 8, 10, 11, 12, 14, 17, 32, 34.

Factor 2: Counseling Process: Items 6, 9, 16, 18, 19, 21, 22, 23, 31, 33.

Factor 3: Dealing with Difficult Client Behaviors: Items 15, 20, 24, 25, 26, 27, 28.

Factor 4: Cultural Competence: Items 29, 30, 36, 37.

Factor 5: Values: Items 2, 7, 13, & 35.

I recommend use of the total score rather than the factor scores separately. I have also included some reliability information and validity information for you regarding the measure.

Best wishes in your research endeavors.

APPENDIX G: PERMISSION OF AUTHOR TO USE STSS

From: **Brian Edward Bride** bbride@gsu.edu
Subject: **Re: STSS- permission request**
Date: **April 28, 2016 at 4:41 PM**
To: **Isawi, Dana** disawi@uncc.edu

BE

Hi Dana,

Permission granted. Attached is a copy of the STSS for your use.

Brian

From: "Isawi, Dana" <disawi@uncc.edu>
Date: Saturday, April 23, 2016 at 9:49 PM
To: Brian Bride <bbride@gsu.edu>
Subject: STSS- permission request
Resent-From: Brian Bride <bbride@gsu.edu>

Dr. Bride,

I am a doctoral student at the University of North Carolina at Charlotte. I am currently working on my dissertation and am interested in using the Secondary Traumatic Stress Scale (STSS) in my study, which will use an online survey.

My dissertation is aimed at examining the relationship between counseling self-efficacy and trauma training, experience, percentage of traumatized clients and secondary traumatic stress among mental health professionals.

I am writing to request your permission to use the STSS instrument in my dissertation. Please let me know how I can obtain the most appropriate form of the instrument.

Thank you in advance for your time and I look forward to hearing from you.

Sincerely,

Dana Isawi

Dana Isawi, MA, NCC
Doctoral Student I Counseling and Supervision
Department of Counseling
University of North Carolina at Charlotte
College of Education

APPENDIX H: DEMOGRAPHIC QUESTIONNAIRE

Inclusion criteria:

- Do you hold a graduate degree in a mental health field including counseling, psychology, psychiatry, or social work?
- Do you currently provide therapeutic services for traumatized refugees and asylum seekers living in the United States?

INSTRUCTIONS: Please answer the following questions.

1. **How many years of clinical experience as a mental health professional do you have since completing your Master's degree?**
   _____ (Fill in the blank)

2. **Please indicate the extent of training you have received specific to the treatment of trauma and trauma survivors.**

   □ No training
   □ Minimal training (e.g., one workshop, seminar, and/or in-service training)
   □ Substantial training (e.g., multiple workshops, semester-long course, certificate, other extensive formal training)

3. **Please indicate the number of semester-long courses on the treatment of trauma and trauma survivors you have attended since undergraduate work (include ones currently attending).**
   □ 0
   □ 1
   □ 2-3
   □ 4-5
   □ More than 5

4. **Please indicate the number of workshops on the treatment of trauma and trauma survivors you have attended since undergraduate work (include ones currently attending).**
   □ 0
   □ 1
   □ 2-3
   □ 4-5
   □ More than 5

5. **Please indicate the approximate number of professional development hours you have earned on the subject of the treatment of trauma and trauma**

survivors since undergraduate work: _____

6. **What is your perception of your trauma training:**

Bad Good
0 1 2 3 4 5 6

Weak Strong
0 1 2 3 4 5 6

Partial Thorough
0 1 2 3 4 5 6

Shallow Deep
0 1 2 3 4 5 6

7. **Please indicate the total number of clients in your caseload:**

_____ (Fill in the blank)

8. **Please indicate the percentage of clients in your current caseload whose primary presenting problem is related to their trauma history:**
_____ (Fill in the blank)

9. **What factors do you believe are related to your self-efficacy or confidence in working with refugees?**

_____
_____.

10. **Please select the intervention approach that you are most likely to use when working with refugee clients who have experienced trauma (select one):**

□ Psychoanalytic Therapy
□ Adlerian Therapy
□Existential Therapy
□Person-Centered Therapy
□Gestalt therapy
□Behavior Therapy
□Cognitive Behavioral Therapy (CBT)
□ Reality Therapy
□ Solution-Focused Brief Therapy
□ Testimony Therapy
□ Narrative Therapy

□ Play Therapy
□ EMDR
□ Other _____

Answer the following questions about yourself:

11. Gender:

□Male
□Female
□Other

12. Race/ Ethnicity:

□ European American/White
□ Black/African American
□ Native American
□ Asian/Asian American
□ Hispanic
□ Middle Eastern/Arab American
□ Pacific Islander
□ Multiracial
□ Other, please describe: _____

13. Age: _____

14. Region:

□ Northeast
□ South
□ Southwest
□ Midwest
□ West
□ US Territories
□ Other, please describe: _____

15. Indicate your highest educational level attained:

□ Medical Degree
□ Doctoral Degree
□ Master's Degree
□ Other, please indicate _____

16. Indicate your primary work setting:

□ College/University
□ Private practice
□ School
□ Hospital

- Government
- Non profit
- Other _____

17. Indicate your field of study:

- Counseling
- Marriage and Family Therapy
- Social Work
- Psychiatry
- Psychology
- Other _____

18. Are you a licensed mental health professional?

- Yes
- No

19. Under what active professional license do you practice?

- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Psychologist
- Psychiatrist
- Other _____

APPENDIX I: COUNSELING SELF-ESTIMATE INVENTORY

COUNSELING SELF-ESTIMATE INVENTORY

This is not a test. There are no right or wrong answers. Rather—it is an inventory that attempts to measure how you feel you will behave as a counselor in a counseling situation. Please respond to the items as honestly as you can so as to most accurately portray how you think you will behave as a counselor. Do not respond with how you wish you could perform each item—rather answer in a way that reflects your actual estimate of how you will perform as a counselor at the present time.

Below is a list of 37 statements. Read each statement, and then indicate the extent to which you agree or disagree with that statement, using the following alternatives:

1 = Strongly Disagree
2 = Moderately Disagree
3 = Slightly Disagree
4 = Slightly Agree
5 = Moderately Agree
6 = Strongly Agree

PLEASE — Put your responses on this inventory by marking your answer to the left of each statement.

APPENDIX J: SECONDARY TRAUMATIC STRESS SCALE

SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: *"Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)	1	2	3	4	5
4. I had trouble sleeping	1	2	3	4	5
5. I felt discouraged about the future	1	2	3	4	5
6. Reminders of my work with clients upset me	1	2	3	4	5
7. I had little interest in being around others	1	2	3	4	5
8. I felt jumpy	1	2	3	4	5
9. I was less active than usual	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to	1	2	3	4	5
11. I had trouble concentrating	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients	1	2	3	4	5
13. I had disturbing dreams about my work with clients	1	2	3	4	5
14. I wanted to avoid working with some clients	1	2	3	4	5
15. I was easily annoyed	1	2	3	4	5
16. I expected something bad to happen	1	2	3	4	5
17. I noticed gaps in my memory about client sessions	1	2	3	4	5

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score _____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)	Avoidance Score _____
Arousal Subscale (add items 4, 8, 11, 15, 16)	Arousal Score _____
TOTAL (add Intrusion, Arousal, and Avoidance Scores)	Total Score _____

Citation: Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14,* 27-35.