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Counselors have the ethical responsibility to meet the mental health needs of refugees who are forced to leave their home countries. This study examined factors influencing the self-efficacy of counselors (N = 98) working with refugees. The results revealed a relationship between trauma training and secondary traumatic stress and counselor self-efficacy. Implications for clinical practice and research are discussed.

Keywords: refugees, counselor self-efficacy, trauma, training, secondary traumatic stress

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 High Commissioner for Refugees [UNHCR], 2010, p. 3). Recent global political and environmental events have resulted in unprecedented increases in refugees. As of 2018, a total of 70.4 million individuals were forced to leave their homes worldwide (UNHCR, 2019). Until recently, the United States had a long-standing history of admitting refugees because of humanitarian concerns. Since 1975, the United States has admitted over 3 million refugees (Refugee Processing Center, 2020).

Refugees often experience traumatic incidents such as torture, the witnessing of a killing, and separation from family members (Marshall et al., 2005). Although many refugees demonstrate resilience and strength, the adverse experiences associated with migration can have a lasting psychological impact (Murray et al., 2010) that negatively affects their mental health (Higson-Smith, 2013). Reported prevalence rates of post-traumatic stress disorder among refugees range from 20% to 74%, and rates of major depressive disorder among refugees range from 39% to 64% (e.g., Johnson & Thompson, 2008; Sieberer et al., 2011).

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Counselors may encounter refugees in a variety of settings, including nonprofit organizations (Apostolidou, 2016), hospitals (Ellis et al., 2011), and schools (Fazel et al., 2009), and professional associations mandate that counselors advocate for vulnerable populations (American Counseling Association [ACA], 2014, Standard A.7.a.), including refugees, who are often survivors of torture, oppression, and victimization (Lanfranchi & Akinsulure-Smith, 2018). However, exposure to traumatic material might affect counselors' well-being. Clinicians working with refugee clients have reported symptoms of depression such as helplessness and emptiness, as well as emotional reactions such as rage, powerlessness, guilt, anxiety, maladaptive coping mechanisms, and compassion fatigue (Akinsulure-Smith & O'Hara, 2012; Posselt et al., 2019). One counselor-in-training stated, "It often felt overwhelming to work with clients who had experienced extensive violence and were hungry and homeless, with few available options to them" (Lanfranchi & Akinsulure-Smith, 2018, p. 382). Although counselors receive training on theoretical approaches and conduct clinical practice as part of their graduate studies, experiences with clients with trauma histories such as refugees are not a required component of training (Lanfranchi & Akinsulure-Smith, 2018). Although it is imperative that counselors be prepared to address refugee trauma (Bemak & Chung, 2017), they may not feel adequately prepared. Despite Council for Accreditation of Counseling and Related Educational Programs (2016) requirements for programs to include trauma training in their curricula (Section 2, Standards F.3.g., F.5.m., F.7.d.; Section 5, Standard C.2.f.), specific trauma training has seldom been included in the core curriculum in mental health programs (Courtois & Gold, 2009).

In addition to training in trauma-informed interventions, counselors should understand the impact of the migration experience, including resettlement in the United States at a time when refugees are portrayed as a threat to society. Although there is substantial literature focusing on the experience of refugees, research on the experience of counselors working with this population is limited to descriptive data documenting the impact of working with clients who have experienced trauma and the limited resources that exist (e.g., Lanfranchi & Akinsulure-Smith, 2018; Posselt et al., 2019). Furthermore, to our knowledge, no research has examined factors that influence the self-efficacy of counselors working with refugee clients. To truly understand counselors' perceived efficacy with this population and given the importance of self-efficacy in determining counselors' behaviors and perceptions (Bandura, 1993), we decided to investigate factors that influence counselors' sense of self-efficacy about their work with refugee clients.

COUNSELOR SELF-EFFICACY

Counselor self-efficacy is defined as counselors' beliefs about their ability to counsel clients (Larson & Daniels, 1998). High self-efficacy is considered important for counselors to work effectively with clients, including those who have experienced trauma. Factors such as training (Larson & Daniels, 1998) and exposure to traumatic material (Posselt et al., 2019) may influence counselor self-efficacy. Because of the nature of clients' mental health needs, specialized trauma training that

addresses the complexities of trauma and effective interventions, especially with the refugee population, is advised (Warr, 2010). Generally, training to work with trauma survivors is positively associated with counselor self-efficacy (Woody et al., 2015) and the reduction of secondary traumatic stress (Berger & Gelkopf, 2011). Some research has shown that experience among counselors is related to increased self-efficacy levels (Larson & Daniels, 1998). However, Sartor (2012) reported that as the percentage of clients with trauma on a counselor's caseload increased, self-efficacy levels decreased in a sample of 82 mental health professionals who worked with traumatized clients and who practiced in mental health hospitals, treatment centers, and nonprofit and community organizations.

Counselors who work with refugees in any setting are often exposed to narratives of the torture, trauma, and enormous suffering experienced by these clients (Murray et al., 2010). Levels of exposure to clients with trauma have been associated with secondary traumatic stress among counselors (Baird & Kracen, 2006). *Secondary traumatic stress* refers to ways in which individuals are indirectly affected by traumatic events. As counselors listen empathetically to stories of human suffering, they can be at risk of secondary traumatic stress (Hernandez-Wolfe et al., 2015). Moreover, research has shown that continuous vicarious exposure to trauma negatively influenced counselors' levels of self-efficacy (Finklestein et al., 2015).

Although some research (e.g., Finklestein et al., 2015; Larson, 1998) has explored factors influencing the self-efficacy of counselors working with the general population, no research has examined the relationship between perceptions of trauma training, years of experience, percentage of clients with trauma, secondary traumatic stress, and counselor self-efficacy. With the present study, we sought to address this gap in the literature. The research question that guided this study was, "How much variance of counselors' self-efficacy is accounted for by trauma training, years of experience, percentage of clients with trauma, and secondary traumatic stress?"

METHOD

Participants

The participants were a purposive sample of clinicians who were working with refugees. The inclusion criteria were that the participants had to possess a graduate degree in a mental health field and had to provide therapeutic services for traumatized refugees in the United States at the time of the study. We recruited the participants by contacting agencies across the United States that provide therapeutic services to refugees and asylum seekers. This included agencies that form the National Consortium of Torture Treatment Programs, the Philadelphia Refugee Mental Health Collaborative, and the Office of Refugee Resettlement, as well as state refugee health coordinators. Although 193 participants responded to the survey, only 98 met both of the eligibility criteria. Seventy-eight (79.6%) were female, and 20 (20.4%) were male. Most participants (n = 67, 68.4%) identified as White, followed by Middle Eastern (n = 12, 12.2%), Asian (n =

7, 7.1%), African American (*n* = 4, 4.1%), Latino (*n* = 4, 4.1%), multiracial (*n* = 2, 2.0%), and other (*n* = 2, 2.0%). (Percentages may not total 100 because of rounding.) The age of participants ranged from 25 to 80 years, with a mean age of 43.05 years (*SD* = 12.83). With respect to highest educational level, the majority (*n* = 74, 75.5%) had a master's degree, followed by a doctoral degree (*n* = 22, 22.4%), a medical degree (*n* = 1, 1.0%), and other (*n* = 1, 1.0%). Of the participants, 44 (44.9%) were social workers, 26 (26.5%) were counselors, 22 (22.4%) were psychologists, five (5.1%) were marriage and family counselors, and one (1.0%) responded other. The majority of respondents (*n* = 59, 60.2%) worked in nonprofit agencies.

Although 64 of the participants (65.3%) described their trauma training as "substantial," only 38 (38.8%) had taken more than one semester-long course in trauma counseling. Over half of the respondents (*n* = 52, 53.1%) indicated attending more than five workshops. The number of professional development hours ranged between 0 and 3,000, with a mean of 103.38 hours (*SD* = 326.28). The mean number of years of clinical experience reported was 11.50 (*SD* = 10.71). The years of experience serving clients varied from 1 to 50; the median was 8 years. Approximately 41% of the participants (*n* = 40) reported that more than 50% of their current caseload consisted of refugee clients with trauma.

Data Collection Procedures

A web-based survey composed of 73 items, which included demographic questions, was used to collect the data for the study. The survey took approximately 15–20 minutes to complete. All potential participants received a follow-up email 1 week after the original participation request, which was followed by a final reminder 1 week later. The survey remained open for 4 weeks.

Instruments

Demographic questionnaire. The demographic questionnaire consisted of 18 items that included the following: gender, race/ethnicity, professional experience, highest educational level, field of study, licensure status, professional credentials, interventions used when working with traumatized refugees, trauma training, and percentage of clients with trauma in their current caseload.

Perceptions of trauma training. We used one question ("What is your perception of your trauma training?") and four separate semantic differential scales to assess participants' perceptions of their trauma training (Osgood et al., 1957). For each scale, participants had to select one of two bipolar adjectives: *bad* or *good*, *weak* or *strong*, *partial* or *thorough*, and *shallow* or *deep*. Each participant's score was calculated as the sum of eight items (i.e., four pairs of bipolar adjectives). The Cronbach's alpha for this scale was .96, indicating excellent internal consistency.

Counseling Self-Estimate Inventory (COSE). We used the COSE (Larson et al., 1992), which is based on Bandura's (1993) self-efficacy theory, to measure counselor self-efficacy. The assessment consists of 37 items, which are rated on a 6-point Likert scale (1 = *strongly disagree*, 6 = *strongly agree*). Total scores range from 37 to 222, with higher scores indicating higher self-efficacy beliefs. The COSE

has demonstrated validity through positive associations with measures of counselor performance, self-concept, problem-solving appraisal, performance expectations, and course satisfaction and negative associations with measures of state and trait anxiety (Larson et al., 1992). In the current study, the Cronbach's alpha was .91, indicating high internal consistency.

Secondary Traumatic Stress Scale (STSS). The STSS (Bride et al., 2004) is a 17-item instrument designed to measure the frequency of secondary traumatic stress symptoms in the past 7 days. The instrument uses a 5-point Likert-type scale (1 = *never*, 5 = *very often*) to assess respondents' stress related to working with clients who have been exposed to traumatic events. Bride et al. (2004) found sufficient convergent, discriminant, and factor validity, as well as a Cronbach's alpha of .93 for the total score. Total 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). In the current study, the Cronbach's alpha was .89, indicating good internal consistency.

Research Design and Data Analysis

We used a nonexperimental correlational research design to examine the relationship between the four predictor variables of trauma training, years of experience, percentage of clients with trauma, and secondary traumatic stress and the outcome variable of counselor self-efficacy among mental health professionals who work with refugee and asylum-seeking clients who have experienced trauma. To determine the amount of variance in counselor self-efficacy accounted for by the four predictor variables, we conducted a multiple regression analysis. All of the predictor variables were entered into the regression equation at the same time to evaluate each variable's prediction of the outcome variable (Tabachnick & Fidell, 2013). We used SPSS (Version 23) to screen the data for outliers, missing values, normality of distribution, linearity, homoscedasticity of residuals, and multicollinearity prior to running the descriptive statistics and the multiple regression analysis.

RESULTS

The mean score for counselor self-efficacy, as measured by the COSE, was 182.20 (*SD* = 19.86). During development of the COSE, Larson and Daniels (1998) reported a mean of only 147.23 (*SD* = 21.87), indicating that the participants in our study had high levels of self-efficacy. The perception of trauma training scores indicated that the participants had a moderately positive perception of their trauma training (*M* = 16.90, *SD* = 5.08). The STSS scores ranged from 17 to 53, with a mean score of 30.90 (*SD* = 8.82). On the basis of the levels of secondary trauma developed by Bride et al. (2004), 25.5% of the participants in our study (*n* = 25) reported moderate to severe secondary traumatic stress.

Pearson product-moment correlation coefficients for the predictor and outcome variables are reported in Table 1. We found a statistically significant positive relationship between trauma training and counselor self-efficacy ($r = .35$, $p < .01$), suggesting that more trauma training was related to higher levels of counselor self-efficacy. No

TABLE 1

Pearson Correlation Between Predictor and Outcome Variables

Variable	1	2	3	4	5
1. Years of experience[a]	—	–.16	.09	.15	–.04
2. Percentage of clients with trauma[a]		—	–.03	.08	.03
3. Trauma training[a]			—	.35*	–.14
4. Counselor self-efficacy[b]				—	–.38*
5. Secondary traumatic stress[a]					—

[a]Predictor variable. [b]Outcome variable.
*$p < .01$ level, two-tailed.

significant relationship existed between years of experience and counselor self-efficacy. Similarly, the relationship between percentage of clients with trauma and counselor self-efficacy was not statistically significant. Secondary traumatic stress was negatively correlated with counselor self-efficacy ($r = –.38$, $p < .01$), suggesting that individuals with higher levels of secondary traumatic stress symptoms were likely to have lower levels of counselor self-efficacy.

Table 2 presents the results of the multiple regression calculated to determine the amount of variance in counselor self-efficacy that was explained by the four predictor variables. The multiple regression analysis indicated that only two of the four predictor variables, trauma training and secondary traumatic stress, were statistically significant predictors of counselors' self-efficacy levels. The adjusted R^2 value of .24 indicated that approximately one quarter of the variance in counselor self-efficacy can be accounted for by trauma training and secondary traumatic stress. Secondary traumatic stress had the largest and negative standardized regression coefficient (–.34) and semipartial correlation coefficient (–.37). Trauma training had a positive standardized regression coefficient (.30) and semipartial correlation coefficient (.33). Years of experience and percentage of clients with trauma were not related to counselor self-efficacy, and the standardized regression (.13 and .12, respectively) and semipartial correlation (.15 and .14, respectively) coefficients were very small.

DISCUSSION

The findings of this study provide a general picture of the backgrounds and experiences of a group of counselors working with the refugee population. The current study

TABLE 2

Results for Multiple Regression Predicting Counselor Self-Efficacy

Predictor Variable	*B*	β	sr^2	*t*	*p*
Intercept	180.00			18.42	<.01
Trauma training	1.17	.30	.33	3.34	<.01
Years of experience	0.25	.13	.15	1.49	.14
Percentage of clients with trauma	0.07	.12	.14	1.38	.17
Secondary traumatic stress	–0.78	–.34	–.37	–3.84	<.01

Note. $F = 8.55$, $p < .001$, $R^2 = .27$, adjusted $R^2 = .24$.

is one of the few studies that has empirically examined secondary traumatic stress among counselors working with refugees, and it focused specifically on the trauma training of counselors working with this particular population. The findings are timely given recent global political and environmental events that have resulted in an unprecedented increase in refugee and asylum-seeking populations who are escaping persecution, war, human rights violations, or environmental disasters (UNHCR, 2019).

It is noteworthy that 60% of the participants were employed in nonprofit settings, which aligns with the ethical standards of the helping professions, such as facilitating access to counseling services (e.g., ACA, 2014, Standard C.6.e.). The majority of participants in this study reported positive perceptions of their trauma training, although most of their trauma training was obtained through professional development activities rather than through formal education. This finding highlights the limited focus on trauma training in clinical preparation programs. In addition, our results indicated that participants' positive perceptions of their trauma training were related to positive beliefs about their ability to counsel clients, as measured by counselor self-efficacy. This finding is similar to previous research findings (Berger & Gelkopf, 2011; Woody et al., 2015); however, this study extended the findings to counselors working with refugees.

One quarter of the participants in our study reported moderate to severe secondary traumatic stress. This finding is consistent with research by Figley (1995), who established the relationship between exposure to traumatized clients and secondary traumatic stress. Although the literature has focused on secondary trauma among social workers (Bride, 2007), substance abuse counselors (Bride et al., 2009), and counselors working with military clients (Cieslak et al., 2013), this is the first study to assess the relationship between exposure to traumatized clients and secondary traumatic stress among counselors working with refugee clients. Additionally, there is a need to help counselors minimize the likelihood of experiencing secondary trauma by seeking training, supervision, and consultation, as well as using self-care strategies, in order to maintain the ethical obligations of the profession as per the *ACA Code of Ethics* (ACA, 2014; e.g., Standard C.2.b.).

This study did not find a relationship between years of experience and counselor self-efficacy. Previous literature on this relationship has yielded mixed findings. For instance, Goreczny et al. (2015) found a relationship between years of experience and counselor self-efficacy, whereas Larson and Daniels (1998) found the relationship to be minimal. Thus, there is not a clear relationship between years of experience and a sense of efficacy, which is surprising.

Implications

To our knowledge, this is the first study to investigate the factors influencing the self-efficacy of counselors working with refugees. Additional research on counselors working with refugees is needed to better understand factors that influence counselors' self-efficacy. Counselors need to be aware of the risk of secondary trauma and be prepared to take precautions against experiencing secondary traumatic stress through active engagement in self-care practices (Akinsulure-Smith et al., 2012),

supervision (Sprang et al., 2011), and training (Courtois & Gold, 2009). Self-care strategies could include personal therapy, meditation, mindfulness, physical exercise, and social support. Personal strategies such as physical exercise and sleep have also been found to be most effective in reducing counselors' stress (Akinsulure-Smith & O'Hara, 2012). On the basis of our findings, counselors are urged to attend trauma-specific trainings, workshops, and conferences to enhance their competence in working with refugees who have experienced trauma. The relationship between trauma training and counselor self-efficacy highlights the need to include specialized trauma training as a separate course in clinical preparation programs. Guidelines and training programs need to take into account the emotional implications of working with refugees (Roberts et al., 2018).

Limitations

This study has potential limitations. The sample size was small because of the limited population of counselors who work with refugees. Additionally, there was limited racial/ethnic diversity among the participants (68.4% White), which reflects the current demographics of individuals working in the mental health workforce. Finally, social desirability could limit the generalizability of the findings given that the data were self-report, and respondents may have presented themselves in a more favorable manner (Houser, 2015).

Directions for Future Research

Participants in this study ranged in age from young adulthood to late adulthood. Because these developmental stages are navigated uniquely, it would be important for future research to investigate the relationship between counselor self-efficacy and psychosocial development (Erikson, 1994). Future research is recommended to explore other factors related to the self-efficacy of counselors who work with traumatized refugees, such as supervision experiences, consultation, spirituality, and multicultural competence. Also, research that addresses years of experience working specifically with trauma survivors, rather than general years of experience, would add to the existing literature.

Given the political climate that is becoming increasingly anti-immigration (Bemak & Chung, 2017), counselors have a unique role in serving refugees who make up this increasingly marginalized population. Furthermore, we can imagine that counselors might be feeling isolated as well. Because of these cultural shifts surrounding immigration, further research is needed to document the experiences of counselors working in refugee-serving facilities. Using 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.

CONCLUSION

Counselors are in an ideal position for providing services to refugees. This study investigated factors contributing to the self-efficacy of counselors working with refugees. Our findings indicated that trauma training and secondary traumatic stress were statistically

significant predictors of counselors' self-efficacy levels. Counselors who perceived themselves as efficacious in working with refugees had higher perceptions of their trauma training and lower levels of secondary traumatic stress. Future research is recommended that investigates the experiences of counselors working with refugees to better understand additional factors that influence counselors' self-efficacy.

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