WORKING WITH REFUGEE TORTURE SURVIVORS:

ASSESSMENT OF COMPETENCY AND TRAINING

by

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DISSERTATION ABSTRACT

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Doctor of Philosophy

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This study presents the development and validation of a measure of counseling competency with refugee torture survivors. The Refugee Torture Counseling Competency Assessment (REFTOR) measure was adapted from the Multicultural Awareness Knowledge and Skills Survey – Counselor Edition (MAKSS-CE-R; Kim et al., 2003) and was theoretically developed based on the limited literature available on refugee torture survivors. The 37-item REFTOR measure was administered to a sample of 179 psychologists and trainees in clinical and counseling psychology who were actively engaged in clinical work. Results of an exploratory principal axis factor analysis with oblimin (oblique) rotation revealed a two-factor structure for the measure with 37 total items and that explained 43.64% of the total variance. The first factor included 29 items and was labeled "Efficacy," accounting for 38.90 % of the variance, and the second factor included 8 items and was labeled "Awareness," accounting for 4.74% of the variance. Evidence of concurrent validity was supported by factor correlations with other

scales and items, and internal consistencies for the subscales and the full scale were acceptable. Information regarding current training experiences relevant to clinical work with refugee torture survivors and attitudes towards torture among study participants was also assessed. Results revealed that training experiences are limited, with the majority of information participants received relevant to working with refugee torture survivors coming from non-empirical articles (67% of participants). Attitudes towards torture varied considerably with a sizable proportion of participants endorsing torture in some circumstances (32.4%) and reporting uncertainty about the morality of psychologists' professional involvement in torture (12.3%). Recommendations for future research and implications of study findings for training are discussed.

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CHAPTER I

INTRODUCTION

Despite growing numbers of torture survivors in the U.S. and worldwide, a stark inadequacy of services for this population, as well as training for service providers, persists. The unfortunate reality is that politically motivated torture is on the rise across the globe and survivors are coming to the United States in unprecedented numbers (Gorman, 2001), with the number of admitted refugees up by over 80% from 2006 to 2009 (Department of Homeland Security, 2010a). Between 2001 and 2005 the United States received the largest number of asylum seekers in the world (United Nations High Commission for Refugees, 2006). In the past 30 years alone, more than 2.5 million refugees have been resettled in the United States through the Office of Refugee Resettlement (ORR, 2009). It has been estimated that 35-50% of refugees (Chester, 1990; ORR, 2011) and more than 80% of asylees (Piwowarczyk, 2007) are survivors of torture.

Services for survivors of torture are likely to be long-term and need to involve collaboration among medical, social, vocational, psychiatric, and counseling service providers (Center for Victims of Torture; CVT, 2005a; Engstrom & Okamura, 2004, Prendes-Lintel, 2001; Sansani, 2004; Short et al., 2010). Coordination with medical doctors may be most important because survivors often first present for services in a medical setting (Campbell, 2007). Currently, there are only 28 recognized centers nationwide that provide services for torture survivors, more than half of which are less than five years old (National Consortium of Torture Treatment Programs, 2009). The lack of qualified therapists available to work with survivors is a significant barrier to treatment (Gorman, 2001; Singh, 2005).

Additional barriers for survivors exist in the current United States political context. Macrosytem level barriers including racism, xenophobia, classism, and sexism are evident in policies created by the U.S. government in an effort to restrict certain types of immigration to the U.S. (Coates & Carr, 2005; Dumper, 2002; Kogan, 2004). For example, following 9/11 the number of refugees admitted to the U.S. dropped by more than 60% (Department of Homeland Security, 2010b). Further, research has shown that the climate of reception has a lasting impact on mental health and overall well-being of refugees (Portes & Rumbaut, 2001; Yakushko et al., 2008). These barriers also are present in the struggle that the American Psychological Association (APA) has faced in creating and enforcing torture resolutions (APA, 2006, 2007). Although APA now has in place much stronger policies based on the incorporation of input from diverse members (APA 2008, 2010), the process through which APA has arrived at the current resolution calls into question the organization's, and by extension the training provided and supported by that organization, ability to respond ethically and effectively to issues related to torture. Given the state of U.S. politics, national attitudes about the use of torture, the long history of psychologists participating in torture (Greenberg & Dratel, 2005; Greenburg & NYU, 2006; Thomas, 2011), and our own APA torture resolution controversy (see Pope, in press, for a summary), it is important to explore clinicians' current (a) attitudes towards torture, and (b) competency related to working with refugee torture survivors.

The following literature review was conducted based on results from a comprehensive search conducted using the PsycINFO database from 1975 to 2011. I entered the following index terms into PsycINFO: "refugees", "torture survivors",

"torture", "multicultural competency", "multicultural competency assessment", "treatment", "interventions", "training", and "training assessment". Search results yielded 33 journal articles and 14 book chapters relevant to this study. This review indicated that to date there are no published empirical studies about the training of clinicians, nor of clinicians' attitudes toward, torture. There were however a limited number of empirical articles with descriptive statistics about diagnosis, symptoms, and type of torture. Moreover, there were no studies discussing the training of counseling competencies related to working with refugee torture survivors. As such, conducting research to document current training, attitudes about torture and ability to provide effective services to refugee torture survivors is a clear first step to enhancing training to improve clinician understanding of torture, the migration experience, and their competencies in working with refugee torture survivors. Research of this nature will also inform the service field in how to begin to improve service collaboration, assessment, and research that improves the health outcomes of refugee torture survivors.

The purpose of this study, therefore, is to expand upon the limited extant conceptual literature related to clinician training and service provision for refugee torture survivors. In this study I examine counselor trainees' and practicing clinicians' (a) training experiences related to the mental health treatment of refugee torture survivors, (b) attitudes about torture, and (c) counseling competency with refugee torture survivors. This study provides the preliminary information that is necessary to increase our understanding of the relationship between different training experiences and clinicians' competency, as well as expand our understanding of what clinicians currently think about

torture. Additionally, this study enhances our ability to measure clinician variables related to providing culturally appropriate services for torture survivors.

CHAPTER II

LITERATURE REVIEW

Definition of Torture

Definitions of torture have changed historically and across contexts, depending on who is defining it and why. Although there is no universally accepted definition of torture, the definition created by the United Nations (1984) is perhaps the most widely recognized definition and is also used by the American Psychological Association. The United Nations has defined torture as:

> Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a pubic official or other person acting in an official capacity. It does not include pain or suffering arising only from – inherent in or incidental to – lawful sanctions.

Torture can be distinguished from many other forms of trauma by the complete dependency, helplessness, unpredictability, and isolation the victim experiences. Torture also is a process that begins from the time of threat until the release or death of the victim (Basoglu & Mineka, 1992).

Amnesty International (1992) has documented torture techniques that are currently used around the world. The methods of torture vary and include both physical and psychological techniques designed to help the perpetrators accomplish their goals. Amnesty International and the American Psychological Association (2007) recognize the following as examples of torture: beating, shoving, squeezing/pressure techniques, pinching, insertion of objects into bodily orifices, exposure to extreme or prolonged physical exertion, strangulation, obstruction of airways, near drowning, chemical exposure, exposure to extreme temperature, electrocution, sensory deprivation or over-stimulation, water-boarding, sexual humiliation, mock executions, rape, cultural or religious humiliation, exploitation of phobias or psychopathology, hooding, forced nakedness, stress positions, the use of dogs to threaten or intimidate, isolation, or the threatened use of any of the above techniques to the individual or to members of the individual's family. The above list is not exhaustive or all encompassing.

A critique of the UN definition of torture is that by focusing on torture at the hands of public and official figures, torture inflicted by non-governmental agencies is overlooked (Campbell, 2007). Alternatively, the World Medical Association (WMA; 1975) defines torture as the "deliberate, systematic, or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason." The WMA definition is broad enough to capture all forms of torture regardless of who the perpetrator is; however, it is so broad that acts that may not fit our instinctive ideas of torture would also be labeled so (e.g. a guard shouting at a prisoner who is about to break a rule; Campbell, 2007). For this study, torture will be defined using the United Nations

(1984) definition while also recognizing that torture does not solely occur at the hands of public officials.

Definition of Refugee

The United States defines refugees as:

> any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (U.S. Citizenship and Immigration Services, 1952).

Refugee status can be difficult to obtain, as the number of refugees admitted each year is set by Congress and varies with political climate and xenophobia, and must be completed prior to arrival. Further, only 4% of the world's refugees are accepted for migration by the United States (United Nations, 2004). Thus, torture survivors may be refugees, legal or illegal immigrants, or asylees and the legal categories in which they are placed cannot be used as indicators of migrants' pre-arrival experience.

The literature on migrant groups is often unclear and inconsistent in how various groups are defined. For this study, the term "refugee" will be used to refer to any person fleeing a country because of persecution or fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion, regardless of actual U.S. legal status. The term "refugee torture survivor" will be used to

refer to any person meeting the above definition of refugee who has survived torture as defined above.

Prevalence of Torture

Torture is a secretive practice, which makes accurately capturing its prevalence difficult. Estimates are based on found documentation and willful disclosure and because both perpetrators and survivors underreport (and because victims are often tortured until death), it is likely that estimated prevalence rates are lower than actual rates. Nonetheless, there is evidence that the use of torture is becoming more common. In 1992, Amnesty International reported that government sanctioned torture occurred in 60 countries across the globe. In 2004 this number more than doubled to an estimated 132 countries found to be practicing torture (Amnesty International, 2004). The occurrence of torture is not linked to a particular ethnic, religious, or geographic area. Instead torture is found to be more common in countries that are economically disadvantaged and struggling to develop, and in any country undergoing social unrest and stress (Vesti & Katsrup, 1995).

Estimates of the number of survivors of torture are often based on refugee and asylee populations, which cannot account for survivors who are displaced within their own countries or who never manage to leave the country. Based on estimates that torture survivors make up 35-50% of the refugee global population (Chester, 1990), it is estimated that seven to ten million of the 20 million refugees in the world (Whiteford, 2005) are torture survivors. Torture survivors in the United States are estimated at 500,000 (Campbell, 2007) though this number almost certainly underestimates the actual population. It is important to note that torture survivors have been coming to the United

States for a long time and are not only living in metro areas in select states (Engstrom & Okamura, 2004). Rather, it is increasingly common for torture survivors to be found in any community where there is work. These statistics underscore the need for professionals to receive clinical training related to working with refugee torture survivors.

The Impact of Torture and Migration

Torture results in the total assault of an individual's body, mind, and entire personality to systematically destroy a person's personality, identity, and ability to trust or have hope in order to create a sense of hopelessness, isolation, and vulnerability (Bustos, 1990; Fabri, 2001; Gorman, 2001). Torture impacts every dimension of an individual, including physical (e.g. traumatic brain injury, back injury, dental decay, infections), psychological, social (e.g. stigmatization, loss of social status, interpersonal mistrust), economic, vocational (e.g. education and credentials not recognized in new country), sexual, and spiritual aspects. Survivors are likely to develop difficulties in any one of the areas stated above, and most frequently in several areas simultaneously (Pachaly, 2000). Pronounced patterns of extreme anxiety, depression, irritability, paranoia, guilt, suspiciousness, confusion, impaired memory, intrusive thoughts and impaired concentration, insomnia and nightmares, emotional disturbances, sexual dysfunction, occupational and social impairment, somatic symptoms, substance abuse, learned helplessness, depersonalization and dissociation, fear of intimacy, and changes in identity are common among torture survivors (Pachaly, 2000; Somier et al., 1992).

Symptoms related to having survived torture are compounded by acculturative stress when survivors settle in their host country (Fischman & Ross, 1990; Gonsalves,

1990; Gorman, 2001; Pope & Garcia-Peltoniemi, 1991). Everyday tasks such as: dressing, meal preparation, laundry, shopping, housekeeping, childcare, timing of meals, eating customs, profuse use of electricity and technology, fast pace of life, and occupational change present some challenges for many refugees, and for many torture survivors these everyday tasks often prove too difficult to master (Whiteford, 2005). Language barriers and discrimination add to the mistrust refugee torture survivors have for authority and have a combined impact on help-seeking behavior (Behnia, 1997).

Responses to torture vary by individual and contexts. Although little empirical research is available regarding risk and resiliency factors of those who are tortured, Vesti and Kastrup (1995) outlined possible factors based on clinical observations and research relevant to other forms of trauma. Environmental factors contributing to resiliency may include greater predictability of attacks; less repetition, shorter duration, and lower severity of attacks; better prison conditions; less isolation; knowing the "rules"; no forced self-betrayal (i.e. signing statements of being well-treated); less stigma faced upon release; ability to connect with other survivors after release; debriefing immediately after an event; receiving news from the outside; and the ability to find employment after release. Individual factors contributing to resiliency may include not having previously experienced trauma, connection to loved ones, ability to make meaning out of torture, strong social support, not experiencing discrimination after resettlement, having coping skills, and previous knowledge of motivation for torture.

Treatment of Refugee Torture Survivors

Although services and awareness about torture survivors have increased in recent years, much more is needed (Engstrom & Okamura, 2004; Piwowarczyk, 2007; Vesti & Kastrup, 1995) as there is a stark shortage of psychologists who are prepared to work with refugee torture survivors (Gorman, 2001; Singh, 2005). When specialized services are not available, survivors may turn to general trauma centers, untrained psychologists, or not receive services at all. General trauma treatment centers, however, may not be able to deal with the specific experiences and needs of refugee torture survivors (Sansani, 2004), and untrained psychologists are at risk of providing inadequate, even harmful services, if they agree to provide services at all (Elsass, 1997a; Patel & Mahtani, 2007). Specialized training is necessary to work with refugee torture survivors, though few psychologists receive such training (Bouhoutsos, 1990).

Psychologists who work with refugee torture survivors must possess awareness, understanding, and skills that are uniquely combined in treatment (Bouhoutsos, 1990; Campbell, 2007; Elsass, 1997a; Fabri, 2001; Gorman, 2001; Sansani, 2004). The literature discussing the various dimensions of treatment has been conceptualized as three general areas of competence: multicultural counseling competency with refugees, torture counseling competency, and competency related to working with interpreters. A multicultural approach to treatment is especially important because there are cultural differences in the meaning of torture, manifestations of torture, and in social responses to torture and survivors of torture (Campbell, 2007). I describe in the following sections the multicultural counseling competency framework, which is the theoretical framework for

this study and the design of the proposed assessment (Arredondo, 1999; Sue et al., 1982; Sue et al., 1998; Vera & Speight, 2003).

Multicultural Counseling Competency Theoretical Framework

The Multicultural Counseling Competency (MCC) framework was first described in 1982 by Sue and colleagues to capture the inadequacy of traditional techniques of therapy when working cross-culturally and the necessity of specific counselor competencies when working cross-culturally. There were three primary tenets of the MCC framework. First, MCC purports that counselors must first be aware of themselves as cultural beings, their own biases, values, attitudes, privileges, and power (Arredondo 1999; Arredondo et al., 1996; Sue et al., 1982) to work competently with people from diverse cultural backgrounds and experiences. Second, culturally inclusive counseling requires counselors to understand the cultural and individual values, beliefs, and practices associated with healing and health (APA, 2003; Sue et al., 1982). Third, counselor cultural knowledge and awareness must be demonstrated through skills. Multicultural competence involves being a change agent, challenging the status quo, and working towards social justice and equality (Vera & Speight, 2003). Multicultural competence is a way of conceptualizing the therapeutic encounter and attending to the interaction of client, therapist, and context.

The term Multicultural Counseling Competency was first described as culture-specific knowledge, awareness, and skills (Sue et al., 1982). 'Awareness' was described as having awareness of one's self as a cultural being while also being aware of differences that exist between one's self and others. 'Knowledge' referred to having

specific information about different groups, sociocultural factors, and worldviews. 'Skills' were defined as abilities to develop and implement interventions, techniques, and strategies that are culturally appropriate. Since the original conception of multicultural counseling competence, emphasis has been added on the inclusion of awareness of issues related to power and privilege (Arredondo 1999, Arredondo et al., 1996) and social justice (Sue et al., 1998; Vera & Speight, 2003). Empirical and clinical knowledge relevant to working with refugee torture survivors was integrated with the MCC framework and theory to create a more specific and targeted Refugee Torture Survivor Counseling Competency measure. The competencies involved in counseling refugee torture survivors are described in the next section.

Operationalizing Refugee Torture Survivor Counseling Competency

For the purpose of this study, counseling competency with refugee torture survivors is based on the MCC framework and comprises knowledge, awareness, and skills related to (a) multicultural counseling competency with refugees, (b) torture, and (c) working with language interpreters, as described above.

*Multicultural Counseling Competency with Refugees - Awareness***.** A counselor's ability to critically reflect on the self and how his/her sense of self impacts and interacts with refugee clients' sense of self is critical to service provision (Patel & Mahtani, 2007). Without this awareness clinicians are more likely to commit microaggressions (Sue et al., 2007), or other forms of more overt discrimination, which in turn may negatively impact trust building and the therapeutic relationship at best, and lead to additional trauma at worst. Psychologists are encouraged to not only be aware of their own identities and development, but also of the contexts in which they practice and live as well. Societal

views regarding refugees in general, refugees from specific areas or nations, xenophobia, and discrimination impact psychologists' attitudes toward refugees, and consequently, refugees' experiences and attitudes toward clinicians and mental health treatment.

An ecological model of human development (Bronfenbrenner, 1992) and critical consciousness literature (Freire, 1970) are useful in helping clinicians increase their awareness and attention to their own cultural, political, and historical contexts that influence how they work with refugee torture survivors, and enhance clinicians' awareness and attention to the contexts that influence refugees' development in ways that are effective and not traumatizing. A refugee's experiences of power imbalance, and the importance of the political context that creates that power imbalance, make sensitivity to and inclusion of those issues in therapy especially important. Moreover, psychologists are encouraged to be aware of the Western paradigmatic assumptions that influence our approach to clients and that present barriers to refugees operating from different paradigms. Three commonly cited examples of Western assumptions are individualism, mind-body duality, and the belief that our models for psychology and medicine are "better" or "more true" compared to models from other cultures (Elsass, 1997b). When these and other assumptions are left unaddressed, or practitioners are unaware of them, miscommunication and misunderstanding in therapy may occur and lead to ineffective or harmful treatment.

Multicultural Counseling Competency with Refugees - Knowledge. Literature on best practice with refugees suggests that clinicians must understand the cultural and individual values, beliefs, and practices associated with healing and health for each client (CVT, 2005b; Short et al., 2010). A basic understanding of how individual refugee

clients view their own health and approach to treatment is fundamental to rapport building and treatment planning (Campbell, 2007). Specifically, understanding how an individual refugee conceptualizes help-seeking and therapy will give the counselor valuable insight into how to most effectively and competently to work with the client. Therapy, as we understand it, is largely a Western phenomenon and may feel strange and uncomfortable to refugees from different cultures and different parts of the world (Behnia, 1997; Campbell, 2007; Elsass, 1997b; Fabri, 2001; Gorman, 2001). Practice literature suggests that counselors must understand the cultural manifestations and communication of stressors/problems in order to work collaboratively with refugees (Elsass, 1997b). For example, Iranian culture uses the term "heart problems" to apply to experiences of difficult life situations (Elsass, 1997b). An Iranian refugee who talks about having "heart problems" in the United States, however, is likely to be examined for heart disease and/or labeled a 'somatizer' by the medical community if his/her doctors are not knowledgeable about Iranian culture and the possibly different ways in which health-related difficulties are described. Literature also suggests that understanding cultural differences in terms of family structure, gender role expectations, and relevant social roles is also critical to working competently with refugees (CVT, 2005b). Changes in family structure are common as families are broken apart by migration, and gender and social roles often change because of the difficulty with finding adequate employment. Knowledge about how such family structure changes may impact refugee health outcomes is an essential part of multicultural counseling competence.

Another unique part of a refugee's experience is the migration and resettlement process. Migration experiences for refugees may be conceptualized as three distinct time

periods: pre-flight, flight, and post-flight (CVT, 2005b). The pre-flight period includes the escalation of violence or threat, sociopolitical context, and individual experiences in the refugee's home country. Throughout the flight period, refugees are likely to experience ongoing uncertainty and fear because of the insecurities associated with flight and the often increased vulnerability to additional violence, threats, or other trauma (CVT, 2005b). During the post-flight or settlement period refugees experience different acculturative processes and related stress. Knowledge about acculturation is critical for counselors who work with refugees (Behnia, 1997; Prendes-Lintel, 2001), although mental health treatment and healing is often complicated by ongoing trauma and the marginalization that refugees face in their new home (CVT, 2005a). Through the resettlement process, it is helpful for counselors to have knowledge regarding the legal systems relevant to various migrant statuses as it can impact access to services, employment, as well as how trusting and honest a refugee feels that s/he can be in counseling (Behnia, 1997; Piwowarczyk, 2007; Vesti & Kastrup, 1995).

Multicultural Counseling Competency with Refugees - Skills. Translating multicultural counseling knowledge and awareness into skill implementation effectively is essential to demonstrating multicultural counseling competence with refugees. Counseling skills necessary for working with refugees include: attending to issues of power and control in the therapeutic relationship (Arredondo, 1999; Fabri, 2001), consulting and collaborating with other mental health professionals to facilitate treatment (APA, 2003), gaining knowledge about specific cultural groups (Sue et al., 1982), accurately assessing mental health needs, providing information about available community health and cultural resources, and using diagnostic categories and assessment

tools in culturally competent ways (APA, 2003; Campbell, 2007). The issue of diagnosis and assessment is critical to providing competent services to refugee torture survivors. To date, most of our clinical assessment tools are culturally biased (Patel & Mahtani, 2007) and clinicians must interpret clients' assessment results with caution and in consideration of the multiple contexts that influence clients' mental health symptoms and assessment responses (Gorman, 2001).

Torture Counseling Competency - Awareness. Torture is a reality that many people and clinicians would rather remain unaware of; however, it is only by increasing our awareness of torture that we can begin to work toward effective treatment and prevention (Vasti & Kastrup, 1995). Torture has received greater attention on a national level and in political circles. More awareness about the prevalence and impact of torture is needed, especially in mental health training programs where discussions of torture are absent.

Lack of awareness of torture and its impact is likely to influence clinicians' attitudes about torture. A study conducted among 336 medical students showed that, despite strong condemnation of torture by the American Medical Association, the World Medical Association, and the Geneva Convention, 35% of participants believed that torture could be condoned under some circumstances, and 24% disagreed that torture should be prohibited or that it is intrinsically wrong to torture (Bean et al., 2008). It was also found that 94.2% of participants received less than one hour of instruction regarding the nature and ethics of torture. This study shows that trainees' awareness of and attitudes about torture do not necessarily correspond with professional policies.

Our own policies in psychology have been arguably less clear in condemning torture (see Bauer, 2008 for a discussion on this topic) and it is likely that clinicians' attitudes about torture vary accordingly. Awareness of our attitudes about torture is an important part of providing services to torture survivors. Unlike traditional counseling that embraces therapist neutrality, literature suggests that it is critical that counselors are able to recognize and communicate their beliefs and values about torture to the survivors they work with (Elsass, 1997a; Fabri, 2001; Vesti & Kastrup, 1995) in order to build trust and safety in the therapeutic relationship. The communication of our beliefs about torture to torture survivor clients is also indicated because of the power differential between therapist and client, and the fact that psychologists may have been involved in the architecture of the survivor's torture (Behnia, 1997; Gorman, 2001).

Torture Counseling Competency - Knowledge. Torture is critically understudied (Campbell, 2007) which limits our knowledge of its impact on survivors and best treatment practices to facilitate rehabilitation and healing. There is, however, much fundamental and general knowledge that has accumulated through descriptive studies and clinical practice (see Campbell, 2007; CVT 2005a; Engstrom & Okamura, 2004; Fabri, 2001; Gorman, 2001; Prendes-Lintel, 2001). Best practice literature suggests that clinicians' knowledge of the impact of torture (described in previous section) on the physical and mental health of individual survivors as well as their families is necessary in order to provide treatment that is of adequate scope. The experience of torture is a unique trauma that does not lend itself to being captured by a single diagnosis (Campbell, 2007). Clinicians, therefore, are not encouraged to merely apply previously established treatments for a given diagnosis (i.e. Post-traumatic stress disorder, depression) even if

the survivor meets the diagnostic criteria for that disorder because the treatment would be too narrow in scope (Gorman, 2001).

The scope of treatment for survivors of torture is broad, often including medical care, social work, community resources, legal aid, spirituality, employment, and more. Literature on best practice suggests that clinician knowledge of the resources available in their communities and how to collaborate with other providers is critical in providing the broad-based, holistic care that is recommended. Knowledge of common symptoms, presentations, and comorbidities of torture is also helpful in recognizing and accurately assessing survivors who are unlikely to state, "I am a survivor of torture." Literature on regarding the impact and effect of torture on survivors points out that it is normal and expected that survivors' stories and memories may change over time and vary with their level of comfort and trust in counseling and cognitive abilities for recall, and therefore it is recommended that clinicians interpret inconsistencies with survivors in this context (Bouhoutsos, 1990; Campbell, 2007; CVT, 2005b). In addition, clinician knowledge about the healing process for survivors is likely to be critical to successful treatment (Herman, 1992).

Torture Counseling Competency - Skills. The literature on best practice suggests that counselors working with survivors of torture expand and adjust traditional counseling methods to fit unique individual needs, use various modalities of service (i.e. body therapy, art therapy), and work in a holistic and multi-disciplinary manner (Center for Victims of Torture; CVT, 2005a; Engstrom & Okamura, 2004, Prendes-Lintel, 2001; Sansani, 2004; Short et al., 2010). The collaborative and holistic nature of therapy with survivors of torture also makes it important for clinicians to be able to work with the

survivor in various roles (i.e. therapist, advocate). Literature has argued that the most effective practice with this population involves clinicians who have skills to work with the family as needed, address power and control in the relationship, provide safety, maintain an active working alliance (balancing directive and supportive techniques; Elsass, 1997a), and provide psycho-education regarding the impact and healing of torture (Fabri, 2001; Prendes-Lintel, 2001; Singh, 2005). Practice literature also supports that clinician skills in negotiating diagnosis and assessment are critical, so as to not depoliticize the experience of the survivor by placing the pathology within the individual and thereby invalidating the experience of torture and the pathology of the system (Gorman, 2001). Finally, clinicians will need to be able to seek supervision and appropriate self-care.

Competency Related to Working with Interpreters - Awareness. Language barriers discourage many refugee survivors from seeking help (Vesti & Kastrup, 1995) and the use of interpreters in counseling is one way that clinicians can work to address that barrier. According to the U.S. Census (2003), there are more than 300 languages spoken in the United States. By competently working with interpreters in clinical settings, clinicians will be able to provide the best services to the most people. Further, the federal government requires that offices receiving funding through the U.S. Department of Health and Human Services (see website at http://www.hhs.gov/ocr/civilrights/resources/index.html for more information) be in compliance with laws protecting against discrimination due to language differences. Clinicians need to be aware of how language barriers limit refugees' access to services,

clinicians' ethical and/or legal obligation to make services available in various languages, and issues surrounding who may be used as an interpreter in therapy.

Competency Related to Working with Interpreters - Knowledge. The role of an interpreter in clinical settings is more complex than simply providing a translation service. Interpreters act as cultural brokers and become part of the therapeutic triangle (CVT, 2005b). It is therefore critical that the interpreters who are used in clinical settings are trained and supervised about the specific skills and responsibilities that they have in the clinical setting and therapeutic context (CVT, 2005b; Prendes-Lintel & Peterson, 2008). It is also critical that clinicians have knowledge about the interpreter's role and responsibilities and the necessity of interpreter training (for more information regarding interpreter training, see Prendes-Lintel & Peterson, 2008). When working with interpreters, there exist several relationships in addition to the traditional client-therapist relationship that clinicians must navigate. Clinicians' knowledge of how to navigate these complex relationships is important.

Competency Related to Working with Interpreters - Skills. Practice has shown that working with interpreters in therapeutic settings involves a specific set of skills (CVT, 2005b). In addition to monitoring and building a strong therapeutic triangle in session, there are several skills clinicians use before, during, and after therapy sessions. This section provides a summary of guidelines for working with interpreters (see CVT, 2005b).

Prior to the first session it is suggested that clinicians be able to identify and screen possible interpreters, work collaboratively with interpreters to determine which cultural and language groups they may best work with, and provide some basic training including information about the agency's mission and goals as well as role expectations.

During a therapy session, time spent discussing the role of the interpreter with the client and establishing expectations about eye contact and patterns of communication will likely be helpful. Non-verbal communication may become more important because it may be the only direct communication between the therapist and client; consequently, clinicians are reminded to be especially aware of their body language and use non-verbal language intentionally. Also during session, clinicians have a responsibility to be alert to what is happening in each of the relationships that are part of the therapeutic triangle. After a therapy session, clinicians should spend time debriefing with interpreters to discuss communication and/or emotional issues that occurred during the session.

Summary and Training Implications

A summary of Counseling Competency with Refugee Torture Survivors is provided in Table 1. The impact of being a refugee torture survivor is present in every domain of functioning. Treatment practices with refugee survivors must be equally wide in scope and address multiple domains of functioning (CVT, 2005a; Prendes-Lintel, 2001). Competency related to working with refugee torture survivors is critical to providing clinical services that are sensitive to the unique ways that power, control, trust, politics, and context are present in therapy (Fabri, 2001; Gorman 2001). Inherent in the competent treatment of refugee survivors is that clinicians tailor treatments to the individual needs of clients and work for their empowerment (Fabri, 2001). There are many challenges associated with providing competent clinical services to this population, including the variance in survivors' presentation, the amount of cultural and contextual knowledge needed, the distrust many survivors have of clinicians and the therapy process, language barriers, and the need for clinicians to work outside of traditional counseling

Table 1

Counseling Competency with Refugee Torture Survivors

	Multicultural Counseling Competency with Refugees	Torture Counseling Competency	Competency in Working with Interpreters
Awareness	• Critical self-awareness • Ecological awareness • Refugee's context • Western paradigm assumptions	• Existence and prevalence of torture • Ethics and attitudes towards torture	• Language barriers • Obligation to provide services • Need for trained interpreters
Knowledge	• Values, beliefs, and practices around healing and health • Cultural communication styles • Family structure, gender roles, and other social norms and expectations • Migration experience • Legal status issues	• Impact of torture • Sequelae of torture • Comorbidities • Common presentations • Community resources • Healing process • Limits and availability of established treatments	• Interpreter skills • Interpreter role and responsibilities • Therapeutic Triangle
Skills	• Facilitating critical consciousness • Addressing issues around power and control • Consultation • Finding needed cultural information • Culturally appropriate assessment and diagnosis • Provision of resources	• Adjusting traditional models • Work holistically and multi-disciplinarily • Provide family therapy as needed • Address issues of power and control • Provide safety • Maintain active working alliance • Provide torture psychoeducation • Engage in effective self-care • Consultation • Implement and interpret assessments and interventions appropriately	• Screening and selection of appropriate interpreters • Training of interpreters • Collaboration with interpreter • Monitoring non-verbal communication • Navigating relationships in the therapeutic triangle • Debriefing with interpreter

models and roles (CVT, 2005a; Elsass, 1997; Fabri, 2001). Specific and in-depth training is needed to prepare clinicians to address the challenges of working with refugee torture survivors and to foster the competencies required to be successful. Researchers and clinicians interested in training human service professionals to work with refugee torture survivors have begun to identify training activities that trainees rate as most interesting (see Singh, 2005), and to emphasize the need for training to include the "hands-on" component of field placement (Fabri, 2001).

To date, however, there are no empirical studies documenting the type of training that clinicians receive related to the mental health treatment of refugee torture survivors, clinicians' self-reported multicultural counseling competencies with this population, or the relationship between training activities and counseling competency development with refugee torture survivors. The primary purpose of this study is to use a multicultural counseling competency framework to assess the training experiences that clinicians' have received related to working with refugee torture survivors, and to assess clinicians' self-reported multicultural counseling competencies with this population. The next section, therefore, provides a review of multicultural counseling competency assessment literature and research.

Multicultural Counseling Competency Assessment with Refugee Torture Survivors

Assessment is a critical component to competent training and practice with refugee torture survivors. First, assessment allows us to identify gaps in clinicians' knowledge, awareness and skills, which in turn can help us identify gaps in existing training and areas where the development of new training is needed. Second, assessment

allows us to identify which pieces of multicultural competency practice are linked to client outcomes, thereby identifying which pieces of multicultural competency may be most important to focus on during training. Third, competency assessments will provide a way for educators and researchers to measure the effectiveness of their training on increasing trainee competency as well as how competency related to working with refugee torture survivors may be associated with other developmental processes (e.g. identity formation, critical consciousness development) and competencies (e.g. general counseling, general multicultural counseling). Fourth, an assessment of competency related to working with refugee torture survivors would also allow for an examination of strengths and weaknesses related to both individual counseling abilities and programmatic training effectiveness. Fifth, formal assessments regarding "what works" for training practitioners to be competent in working with refugee torture survivors will provide valuable information to educators and researchers working to implement effective training programs. Although assessments of multicultural competency have much to offer, the changing and vague nature of the definition of multicultural counseling competence makes it a difficult construct to measure and area of skill development to target for training.

Researchers have identified several limitations of the most commonly used assessments of multicultural counseling competency. A primary critique is that the definition of multicultural counseling competency is too vague (Ponterotto et al., 1994) and that assessments of competency fail to measure the intended construct. The fact that considerable overlap has been found between multicultural counseling competency and general counseling competency is evidence that more precise measures are needed

(Coleman, 1998; Dunn et al., 2006). A second critique is that the most widely used measures are not population specific, implying that the required set of awareness, knowledge, and skills for one cultural group is the same as any other cultural group. Further, when respondents answer an item it is unclear whether they are thinking about a specific population or general multiculturalism (Kitaoka, 2005). The assumption that competency generalizes across groups has been called into question and many are suggesting that the general measures currently in use should be adapted or traded for measures that are culturally specific (Constantine et al., 2002; Hays, 2008). A third limitation of current multicultural counseling competency assessment is that items measuring knowledge, awareness, or skills associated with power, privilege, and social justice are nearly absent from current measures. Issues of power, privilege, and social justice are central for counselors not only to understand clients' reality and perspective but their own Selves as well, and therefore must be measured as part of multicultural counseling competency (Arredondo, 1999; Hays, 2008). A fourth critique of current assessment of multicultural counseling competency is reliance on participant self-report. Many assessments that use self-report methods are likely measuring multicultural counseling self-efficacy and not competence (Cartwright et al., 2008, Constantine et al., 2002; Constantine & Ladany, 2000). Other methods of assessment (i.e. observation) may be required to better assess competency (Cartwright et al., 2008; Kocarek et al., 2001). Finally, self-report measures are also subject to social desirability demands (Constantine et al., 2002; Dunn et al., 2006), which may need to be taken into account by the researcher. Table 2 provides a summary of how this study will address some of these current gaps in the literature associated with multicultural counseling competency

assessment with refugee torture survivors. This study will not address the critique of assessments using self-report methods alone to assess counseling competency. To address this critique, researchers would need access to confidential client information either through direct observation or client-report. Asking for access to client information, especially for refugee torture survivors, is likely to greatly reduce participation in the study, thus greatly limiting power in analyses.

Table 2

Addressing the Critiques of Multicultural Counseling Competency Assessment

Critiques of Assessments of Multicultural Counseling Competency	Assessment of Refugee Survivor of Torture Counseling Competency in this Study
Multicultural Counseling Competency is too vaguely defined	Knowledge, Skills, and Awareness of Refugee Survivor of Torture Counseling Competency are clearly defined in the literature review and methods section
Assessments are not population specific	This assessment targets a narrower sample
Issues related to power, privilege, and social justice are not represented	Items reflecting issues of power, privilege, and social justice will be included
Subject to social desirability demands	A separate measure of participant likelihood to provide socially desirable responses will be included
Rely on self-report only	Will not addressed in this study

Despite the measurement difficulties associated with assessing multicultural counseling competency, even critics agree that it is an essential component of counseling

(Constantine et al., 2002; Fuertes et al., 2006; Pope-Davis et al., 2002). There is also evidence that multicultural counseling competency impacts treatment, the client-therapist relationship, and client satisfaction (Constantine et al, 2002; Pope-Davis et al., 2002). Although there are many limitations to our current measures, they do have merit and researchers do not need to wait for more developed measures to conduct studies of multicultural counseling competency (Dunn et al., 2006; Ponterotto et al., 1994). Moreover, if multicultural counseling competency measures are actually capturing counseling self-efficacy rather than competency, such measures are still important given the numerous empirical studies that have linked self-efficacy expectations to training effectiveness, practice competency, and persistence in learning new skills (Lent, Brown, & Hackett, 1994, 2000).

Study Purpose

The purpose of this study is to expand the limited extant empirical research related to assessment of clinician training and self-reported multicultural counseling competency assessment with refugee torture survivors. Working from a multicultural counseling competency framework, this study includes the construction and testing of a new instrument designed to measure multicultural counseling competency with refugee torture survivors. Additionally, in this study I assessed: (a) trainee and clinician training experiences working with refugee torture survivors, (b) trainee and clinician attitudes towards torture, and (c) trainee and clinician multicultural counseling competency with refugee torture survivors. Finally, I examined the relationship between clinician training experiences related to working with refugee torture survivors with both (1) clinicians'

attitudes about torture, and (2) multicultural counseling competency with refugee torture survivors.

This study contributes to the literature in the following ways: (a) by developing and collecting psychometric data for an original measure of refugee torture survivor counseling competency, (b) by providing empirical information regarding the type and amount of training that trainees and clinicians have received related to working with refugee torture survivors, (c) by providing empirical information about how clinicians are currently thinking about torture, and (d) by examining the relationship between clinicians' training experiences and self-reported multicultural counseling competency with refugee torture survivors.

Research Questions

Provided the dearth of literature published on counseling refugee torture survivors and related counseling competency assessment, the following research questions are exploratory with no directional hypotheses identified. Further, research questions were organized into three groups based on question type: factor analysis, descriptive, and group comparison.

Part I – Factor Analysis

Research Question One. What are the psychometric properties and factor structure of the Refugee Torture Counseling Competency Assessment, a measure modified for this study?

Part II – Descriptive Research Questions

Research Question Two. What training experiences have trainees and practicing clinicians received relevant to working with refugee torture survivors?

Research Question Three. What are trainees' and clinicians' attitudes toward torture?

Research Question Four. What levels of competencies do trainees and practicing clinicians report with regard to providing clinical services for refugee torture survivors?

Part III – Group Comparisons

Research Question Five. What is the relationship between field and classroom training experiences with (a) practitioner attitudes toward torture, and (b) their competency in providing services for refugee torture survivors?

CHAPTER III

METHODS

Research Design

This study is passive-observational (Cook & Campbell, 1979) and used a non-experimental, single administration comparison group design. Participants' total scores and subscale scores will be compared based on type of training experienced as well as training level. There are five primary study variables: (a) attitudes about torture (continuous), (b) refugee survivor of torture counseling competency (continuous), (c) social desirability (continuous), (d) training experiences working with refugee torture survivors (categorical) with two levels: those whose training included field work, and those whose training was only classroom/lecture based, and (e) training level with two levels: current trainee and professional. All measures used in this study are self-report and will be described in greater detail in the measures section.

Participants

Participants included part- and full-time practicing clinicians and counseling and clinical psychology student trainees who are enrolled in Masters and Doctoral level graduate study (heretofore referred to as *trainees).* Eligible pilot study participants (a) held or were pursuant of a Masters or Doctoral degree in clinical or counseling psychology (including M.A., M.S., Ph.D., and Psy.D.), (b) are over the age of 18, and (c) provide direct client services to adults, children, groups, and/or families in any agency or private practice context. Participants may or may not be licensed. No exclusion criteria

will be applied; that is, all participants meeting the above criteria will be eligible to participate in the study. Participants include graduate students (trainees) enrolled in clinical or counseling psychology programs across the United States, and practicing clinicians (professionals) working in private practice or with social service agencies across the United States.

Measures

Table 3 provides a summary of study variables and the corresponding measures. See Appendices A-D for full measures.

Table 3

Study Variables and Measures

Variable	Measure
Training experiences with refugee torture survivors	Demographics and Training Questionnaire (DEMO-TRAIN; Furr & Chronister, 2009)
Attitude towards torture	Attitude Towards Torture Questionnaire (ATTITUDES; Bean et al., 2008)
Competency related to providing clinical services to refugee torture survivors	Refugee Torture Counseling Competency Assessment (REFTOR; Furr & Chronister, 2009)
Social Desirability	Social Desirability Scale (SOC DESIRE MC2(10); Strahan & Gerbasi, 1972)

Demographics & Training Questionnaire (DEMO-TRAIN; Furr & Chronister, 2009)

The demographics and training questionnaire is an original 23-item self-report questionnaire designed for this study. With regard to demographics, the DEMO-TRAIN

asks participants to identify a variety of demographics including their age, gender, and ethnicity; highest level of formal education completed; estimates of the total number of clients for whom they have provided direct individual or group services; the number of months spent working with clients in various contexts; and the number of years they have been engaged in clinical practice and/or clinically relevant training. Specifically related to training with refugee torture survivors, the DEMO-TRAIN asks participants to report continuing education credits and workshops completed that were related specifically to refugee torture survivors; conference presentations attended and presented that related to refugee torture survivors; courses taken that specifically address refugee torture survivor issues; the number of empirical and non-empirical readings addressing issues related to refugee torture survivors; direct clinical services provided to clients whose family member(s) identified as a refugee torture survivor; and the total number of clients for whom they have provided direct clinical services who have identified as refugee torture survivors.

Refugee Torture Counseling Competency Assessment (REFTOR; Furr & Chronister, 2009)

The REFTOR is an original self-report measure created for this study and includes 42-items in the original item-pool. Please see Procedures for a detailed review of how the REFTOR was created. To date, there are no existing measures to assess refugee torture survivor-related counseling competencies. REFTOR items were created by adapting items from the well-established Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised (MAKSS-CE-R; Kim et al., 2003) and using information from extant research, published practice literature, and clinical knowledge

from practitioners who work with refugee torture survivors. REFTOR items measure participants' self-reported knowledge, skills, and awareness in three domains of competency with refugee torture survivors: (1) multicultural counseling competency with refugees, (2) torture counseling competency, and (3) competency working with interpreters. Sample items include, "Talking about politics in counseling with refugee torture survivors is a good idea", "At this point in your life, how would you rate your understanding of how refugee torture survivors commonly present in clinical settings?" and "How well would you rate your ability to use current models of therapy, or adapt models of therapy, to meet the needs of refugee torture survivors?" Participants rate their competency level using a 5-point (1=strongly disagree to 4=strongly agree, 5=don't know) or 4-point (1=very limited to 4=very good) Likert-type response scale. Total scores are calculated by summing the value or reversed value for each item answered, with higher scores on the REFTOR indicating more competence. The three subscale scores may also be calculated by summing the values of the responses, with higher scores indicating more competence on that subscale.

In terms of the reliability of the MAKSS-CE-R, internal consistency coefficient alphas of .80 for the Awareness factor, .87 for the Knowledge factor, and .85 for the skill factor were reported for the scores across two separate samples. An internal consistency coefficient alpha of .81 was reported for the entire 33-item scale (Kim et al., 2003). In terms of the reliability of the REFTOR with the present sample, internal consistency coefficient alphas were .96 for the Efficacy factor, .71 for the Awareness factor, and .94 for the entire REFTOR measure.

Attitudes Towards Torture Questionnaire (ATTITUDES; Bean et al., 2008)

The ATTITUDES questionnaire (adapted from Bean et al., 2008) is a 9-item self-report Likert-type scale that assesses participants' beliefs and attitudes about torture, with response options ranging from 1 = strongly agree to 5 = strongly disagree. Sample items include, "Rare exceptions for the use of torture can be condoned under extreme circumstances by legitimate state agents" and "If there is the 'slightest belief' that life-saving information can be obtained, it is permissible to use torture." One question was adapted from the original measure (developed for medical students) to be used for this study. The original ATTITUDES item, "It is permissible for physicians to treat individuals to verify their health so that torture could begin or continue" was changed to "It is permissible for psychologists to treat individuals and assess their mental health so as to inform torturous interrogation procedures." Three additional items were added to the questionnaire for the purposes of this study: "Information obtained using torture techniques is reliable", "Torture is sometimes necessary for the greater good", and "Having strict oversight by authority when using torture in interrogations decreases the long-term physical and psychological impact on detainees." Items 1 and 3 are reversed scored. Overall scores are calculated by summing the total of all items, with higher scores on the ATTITUDES indicating a more negative attitude towards torture. This measure has been used previously in one study with medical students and no reliability and validity data were reported (Bean et al., 2008). An internal consistency coefficient alpha of .90 was obtained for this measure with the present sample.

Social Desirability Scale (SOC DESIRE MC2(10); Strahan & Gerbasi, 1972)

The Marlowe-Crowne 2(10) Social Desirability Scale [MC 2(10)] is a 10-item self-report, true-false inventory of personal and interpersonal behaviors that assesses participants' tendency to give socially desirable responses. With a recent increase in attention to multicultural competencies in counselor training programs, as well as to issues about torture, it is possible that counseling trainee participants might attach high social desirability to their self-reports of competence related to working with refugee survivors and attitudes towards torture. The SOC DESIRE MC 2(10) is a short form of the original 33-item instrument (Crowne & Marlowe, 1960). In studies conducted with university undergraduate samples, scores on the short form were highly correlated with scores on the longer version (r = .80 to .90) (Strahan & Gerbasi, 1972). The 10-item version also had equal Kuder-Richardson formula reliability to the original scale (Strahan & Gerbasi, 1972). Overall scores are calculated by adding the number of responses that "match" the socially desirable response, with higher scores indicating more socially desirable responding. The SOC DESIRE MC 2(10) was used to examine the validity of participants' responses on other study measures. An internal consistency coefficient alpha of .68 was obtained for this measure with the present sample.

Procedures

Measurement Construction: Refugee Torture Counseling Competency Assessment (REFTOR) Scale

The following recommended steps in scale construction given by DeVellis (2003) were followed to create the REFTOR: (1) clearly determine the construct intended for

measurement, (2) generate an item pool, (3) determine the format of the measure, (4) enlist experts to review the initial item pool, (5) consider inclusion of validation items, (6) administer items to a development sample, (7) evaluate items, and (8) optimize scale length.

Step 1: Determine the Construct Measured. The construct that is being measured is competency related to providing mental health services to refugee torture survivors. Based on a comprehensive review of the literature "counseling competency with refugee torture survivors" is defined as having the necessary knowledge, awareness, and skills in the dimensions of (a) multicultural counseling with refugees, (b) counseling with torture survivors, and (c) working with interpreters. Further description of the construct is outlined in the literature review.

Step 2: Generate an Item Pool. I used existing multicultural competency development theory, measures of multicultural competence, and published practice and research scholarship with refugee torture survivors to create the REFTOR item pool. Items were generated using the framework established with the MAKSS-CE-R (Kim et al., 2003), a recent revision of the popular MAKSS-CE (D'Andrea et al., 1991) measure in counseling. Research with the MAKSS-CE has been completed with diverse samples and shown the measure to have adequate reliability and validity data (e.g. Constantine & Ladany, 2000; Neville et al., 1996). The MAKSS-CE-R also has evidence of adequate reliability and validity (Dunn et al., 2006; Kim et al., 2003).

Step 3: Determine Measure Format. Likert scales are widely used to measure opinions, beliefs, and attitudes (DeVellis, 2003) and are also commonly used on other counseling competency instruments. Thus, a Likert response format was chosen for the

REFTOR measure and items were generated as declarative statements that require respondents to report their agreement and disagreement with measure items.

Step 4: Expert Review of Items. Experts in the field of working with refugee torture survivors were asked to review and provide feedback regarding the REFTOR items and scale format. See Table 4 for a list of the expert review panel and their credentials. Expert feedback was used to construct the REFTOR prior to administering it to the study sample. In addition to feedback provided by the panel of experts, colleagues in my counseling psychology doctoral research seminar were be asked to complete the REFTOR and provide feedback about (a) the survey length, (b) clarity of directions, questions, and formatting, and (c) their overall experience completing the measures.

Step 5: Validation Items. A minimum of three validation items are included on the REFTOR measure; one item for each theoretical subscale (knowledge, skills, and awareness). It is hypothesized that these single validation items will be directly correlated with the corresponding subscale total scores. Social desirability effects are also a factor in instrument validity (DeVellis, 2003) and will be measured with a separate instrument, the SocDesire MC2(10) (Strahan & Gerbasi, 1972).

Step 6: Development Sample. The REFTOR scale was administered to the sample for this study to gather psychometric data for the REFTOR.

Steps 7 and 8: Evaluate Items and Optimize Scale Length. After collecting psychometric data for the REFTOR, correlations, reliability, and exploratory factor analyses will be conducted to evaluate REFTOR items, to identify the factor structure of the measure, and to optimize scale length.

Table 4

Expert Review Panel Members

Expert	Credentials/Experiences
Krista Chronister, Ph.D.	Associate Professor, Counseling Psychology, University of Oregon. Primary research includes domestic violence intervention and immigrant mental health. Primary teaching interests include cross-cultural counseling skills development.
Ruth Forman, M.A., Q.M.H.P.	Clinical Supervisor and Counselor at Siempre Amigos in Eugene, OR
Mark Kinzie, M.D., Ph.D.	Director, Torture Treatment Center of Oregon and Intercultural Psychiatric Program Staff Psychiatrist at OHSU in Portland, OR
Francisca Peterson, M.S., N.C.S.P., L.M.H.P.	Therapist and Interpreter Trainer, For Immigrants and Refugees Surviving Torture (FIRST) Project in Lincoln, NE.
Maria Prendes-Lintel, Ph.D.	Director and Therapist, FIRST Project in Lincoln, NE.

Participant Recruitment

Participants were recruited via email to complete the web-based surveys through email listserves and snow-ball sampling techniques. Snowball sampling is a non-probability sampling method that relies on members of the investigated population to identify and recommend the study to other people who may qualify as potential participants (Gay & Airasian, 2003). Advantages of these recruitment techniques compared to traditional recruitment techniques are that they provide greater access to participants, are more efficient and practical, and are less costly (Gosling et al., 2004). In

order to increase variability in training experiences, purposeful sampling techniques were used to target trainees and practitioners who have training and experience in providing mental health services for refugee torture survivors for inclusion in this study.

Participants accessed the questionnaires by clicking on a web-based link provided in the recruitment emails. The link directed participants to a website hosting the statement of informed consent and online questionnaires. The statement of informed consent (see Appendix E) included the purpose of the pilot study, nature of participation, potential risks and benefits, voluntary nature of the study, protection of participant confidentiality, resources for support, and contact information for the primary investigator and the Office for the Protection of Human Subjects. Participants indicated consent to participate by completing and submitting the measures.

Participants were recruited in three ways: (1) through local and national email listserves targeting training directors of counseling and clinical psychology graduate programs, (2) communication with colleagues, mentors, faculty members, and campus organizations who recommended email listserves and/or individuals who could connect me with such listserves from universities and professional networks across the nation, and (3) use of member directory available through APA's website to contact practitioners. Monetary incentives via a drawing were used to increase recruitment success by providing each participant with an opportunity to win one of six $75 gift certificates from Amazon.com.

Participants must identify as counselors or psychologists in practice or training. I recruited trainees affiliated with (a) graduate programs in counseling and clinical psychology, (b) major mental health professional organization list serves (e.g. APA

Division 45), and (c) departmental majors to which I have access via personal connections (e.g., word of mouth, recommendations, personal communication). I recruited practitioners affiliated with (a) major email organization list serves, and (b) agencies or private practices to which I have access via personal connections. On a national level, I attempted to recruit a diverse population of counselor trainees and practitioners who are affiliated with, or connected with someone who is affiliated with, organizations such as the following: the American Psychological Association (APA), the American Psychological Association of Graduate Students (APAGS), the American Counseling Association (ACA), and the National Consortium of Torture Treatment Programs (NCTTP).

Data Collection and Management

Data collection begun in Fall 2009. Data collection had been planned to continue until the minimum number of participants (N = 210) had completed the web-based survey in order to meet sample size recommendations for power and reliability. At the end of the Spring 2010 academic term 222 participants had completed the measure and data collection was stopped due to non-response. Recruitment messages were sent to local, regional, and national listserves that included trainees and practitioners, as well as torture treatment specialists and general practitioners (see Participant Recruitment List in Appendix F). Some months after the initial request and second request was made and in the cases where a listserv administrator recommended sending a request at a different time, a third request was made. Along with each request was the IRB approved informed consent page and also an introductory message briefly explaining the purpose of the study and who was eligible to participate. An additional statement clearly stating that no

experience working with refugee torture survivors was needed to participate was also included. After the second, and in some cases third, recruitment request there seemed to be a negligible response rate and after consultation with my committee chair it was decided to stop data collection at that point. All data were collected in compliance with the University of Oregon Office for the Protection of Human Subjects policies. I initially established contact with potential participants through an informational email requesting their participation. This email included (a) a brief description of my study, including the population that I was seeking and the length of time it should take to complete the surveys, (b) a statement of participants' chances to win one of six $75 gift certificates from Amazon.com, and (c) a web-based link connecting them to the survey.

I used PsychData (www.PsychData.com) to create and maintain my questionnaires. PsychData is an online data collection service that is often used by the social science community to conduct secure Internet-based research. After I created my account with PsychData, access to an online Research Manager allowed me to control all aspects of my data collection including editing surveys, changing survey response options, tracking numbers of participants, and downloading data at anytime during the data collection process. I used Psych Data's Survey Editor to build online surveys from my personal computer. Each survey that I created through PsychData was hosted by a secure environment that is designed to protect participants' privacy. Throughout the data collection process, I was able to log on to the PsychData website and view data and download a copy for analysis. I also was able to import data into standard statistical analysis or spreadsheet programs such as SPSS and Microsoft Excel.

PsychData stored confidential survey data on a secure computer server, protected by a login ID and password available only to me. In addition, this service stored signed informed consent forms or any other identifying participant information on a separate, secure server. This information was then provided to me in randomized order so that it was not possible to connect the participant identifying information with the completed questionnaire battery. I also gathered contact information for those who wanted to participate in the drawing to win a gift certificate by creating two separate, linked surveys. The first link was for the survey battery and the second link was to collect contact information, which I used to randomly select names for the drawing so that participants would not be linked to their survey responses and remain anonymous. Finally, all downloaded data were stored on a password-protected computer and/or in a locked file cabinet to further ensure confidentiality. Incomplete surveys were saved and kept secure as well.

Data Analyses

Preliminary Analyses

Descriptive statistics and Pearson correlations were used to examine the central tendency, variance and distributions of all study variables, and to verify that statistical assumptions were met. In the case that there was more than 5% missing data, I planned to use the SPSS MVA module to complete Expectation-Maximization (EM) imputation. EM imputation uses an Expectation-Maximization algorithm to predict and substitute the missing values (Scheffer, 2002). Using Pearson's *r*, the correlations between social

desirability, attitudes towards torture, and competence related to providing mental health services to refugee torture survivors were examined as evidence of measurement validity.

Part I – Factor Analysis

Research Question One. An exploratory factor analysis (EFA) was used to examine the first research question: what are the psychometric properties and factor structure of the Refugee Survivor of Torture Counseling Competency Assessment? Factors were identified based on examination of scree plots, Eigenvalues, minimum number of items to load for a definable factor, and explained variance. As Comrey and Lee (1992) suggest, items with factor loadings less than .30 on any particular factor were not retained. This guideline for item retention was also used for the MAKSS-CE-R on which the REFTOR was based. Internal consistency reliabilities were then assessed on each resulting factor to further assess the properties of each subscale identified in the EFA. Cronbach's alpha coefficients and inter-item correlations were used as measure of the overall reliability of each subscale. Items that substantially decreased the internal consistency of any resulting subscale was dropped and resulting subscales were used as constructs for the research questions in Part II of this study.

Part II – Descriptive Research Questions

Research Question Two. Descriptive statistics from the DEMO-TRAIN measure were used to answer the second research question: What training experiences have trainees and professionals received relevant to working with refugee torture survivors? Frequencies were obtained for items 13-17 and means for items 18-20 to determine the types and amount of training that participants report.

Research Question Three. Descriptive statistics including the mean, variance, and distribution of scores on the ATTITUDES measure were used to answer the third research question: What are trainees' and professionals' attitudes toward torture?

Research Question Four. Descriptive statistics including the means, variances, and distributions of scores on the REFTOR measure were used to answer the fourth research question: What competencies do trainees and professionals report with regard to providing clinical services for refugee torture survivors? Statistics were obtained for the global REFTOR score as well as REFTOR subscales.

Part III – Group Comparisons

Research Question Five. Independent-Samples *t* – test was used to investigate the fifth research question: What is the relationship between field and classroom training experiences with attitudes toward torture, and counseling competency relevant to providing services for refugee torture survivors among trainees and professionals? In addition to conducting the t-test comparing group means, effect sizes for each significant different was also be calculated using Cohen's formula for unequal group size where $d = (m_1-m_2)/SD_{pooled}$, and where $SD_{pooled} = \text{sqrt}[((n_1-1)v_1 + (n_2-1)v_2)/(n_1+n_2-2)]$.

Planned Post-Hoc Analyses

Group differences between trainees and practitioners on the ATTITUDES and REFTOR measure were investigated and group means and standard deviations were obtained. Independent-Samples *t* – tests were used to identify significant differences and the effect sizes of significant differences was obtained using the same formula given above.

Statistical Power Analyses

A priori power analyses indicated that 210 participants would be necessary to detect a medium effect size of $d = .5$ (Cohen, 1988) with alpha at .05 for group comparisons using *t*-tests. Additionally, sample size recommendations for factor analysis has ranged from a subject:item ratio of 5:1 to 20:1, though research is now indicating that recommended sample size is better determined by component saturation, absolute sample size, and variables per component (Stevens, 2002). A subject: item ratio of 5:1 for the 42-item REFTOR would also require 210 participants for the exploratory factor analysis. Thus, to help ensure reliability and power for our analyses, we intended to collect data from at least 210 participants.

CHAPTER IV

RESULTS

Preliminary Analyses

A total of 222 participants originally took the web survey. Of the 222 original participants, 14 (6%) chose to discontinue the survey before completing all the items. There was no apparent pattern in which the 14 participants chose to discontinue the survey. An additional 29 participants (13%) did not meet the inclusion criteria of holding or pursuing a degree in clinical or counseling psychology, reporting qualifications in Marriage and Family Therapy, Rehabilitation Counseling, and other areas. Thus, participants who chose to discontinue the survey and those who did not meet eligibility criteria were excluded from analyses. All data were complete for the 179 participants, and these participants were included in all subsequent analyses.

Participants included clinical and counseling psychology trainees and practitioners (M.A., M.S., Ph.D., & Psy.D) who currently provide direct services. Participants included 148 (82.7%) females, 118 (65.9%) trainees, and 85 (47.5%) in the area of counseling psychology. Trainees reported a mean age of 30.70 (SD = 8.27), while professionals reported a mean age of 46.56 (SD = 13.26). Overall mean age for the sample was 36.11 (SD = 12.69). The majority of participants were European American (n = 139, 77.7%), with 10 (5.6%) Asian or Asian American, 9 (5.1%) Hispanic/Latino/Chicano, 6 (3.4%) multi-ethnic, and 7 (3.9%) other ethnic identities also making up part of the sample; 8 (4.5%) of the participants did not endorse an ethnicity.

Regional information about participants was not collected, but as an internet survey available in the U.S., respondents could have replied from all across the U.S.

Prior to analysis, data were tested to ensure that all assumptions were met for each analysis used in the study. Visual inspection of scatterplots indicated normal distribution among study variables and did not indicate outliers in the data. Excluding demographic variables that collected ordinal data (e.g. gender, ethnicity, area of specialization), all variables were measured with interval data.

The results of this study are presented in three parts. The first part presents the results of the factor analysis, addressing Research Question 1. The second part presents descriptive statistics relevant to training experiences, attitudes towards torture, and counseling competency with refugee torture survivors, addressing Research Questions 2 – 4. The third part presents group comparison data based on the factor solution derived through the first part, addressing Research Question 5 and post-hoc analyses.

Part I – Factor Analysis

This section is devoted to the factor analysis of the REFTOR Counseling Competency Assessment. It covers the process of exploring and stabilizing factors as well as preliminary examination of the reliability and validity of the factors. This section is primarily concentrated on addressing the first research question of this study.

Research Question One

Exploratory Factor Analysis. An exploratory factor analysis (EFA) with principal axis factoring and oblimin (oblique) rotation was used to answer the first research question: What are the psychometric properties and factor structure of the Refugee

Torture Counseling Competency Assessment (REFTOR)? To examine the factor structure and identify possible subscales within the original 42 items of the REFTOR, an exploratory factor analysis was conducted. This sample represents a subject to item ratio of approximately 5:1 which is less than the commonly adopted 10:1 ratio though within the range of ratios suggested by Stevens (1996). Additionally, the sample size in this study fits Comrey and Lee's (1992) description of a "fair" sample size. In a review of EFA best practices Costello and Osborne (2005) stated that there are no longer strict rules about sample size. Further, the sample size needed changes with the strength of the data, with stronger data requiring smaller sample sizes. Therefore, the adequacy of the sample size will at least in part be determined by the outcome of the analysis.

Kaiser-Meyer-Olkin measure of sampling adequacy was .92 while Bartlett's test of sphericity yielded an approximate chi-square of 4671.90, $df = 861$, $p < .000$. Examination of the residuals between observed and reproduced correlations of the items indicated 8% with absolute values greater than .05. These results are evidence supporting the use of an EFA procedure with this data.

The original 42 items were first submitted for an exploratory factor analysis with principal axis factoring and direct oblimin (oblique) rotation without specifying a factor solution. Results revealed nine factors with Eigenvalues greater than 1.0 and accounting for 55.59% of the total variance. Inspection of the pattern matrix for the nine factors revealed several factors loading with 3 to 4 items and was therefore determined to be an untenable solution. Inspection of the scree plot indicated that Eigenvalues visibly tapered off in the range of two to four factors. As a result, I again conducted a principal axis factor analysis, but given the results above the analysis was conducted with a restriction

on the number factors sought, set at four (4) factors. This analysis procedure revealed four factors, as predetermined in the input, with Eigenvalues greater than 1.0. Three of these factors emerged as tenable and strong factors, but a fourth factor loaded with only two items. This four factor solution accounted for 46.03% of the total variance.

Subsequently, I conducted another analysis, limiting the factor solution to only three factors. When doing this, three factors emerged with Eigenvalues greater than 1.0, and with a total variance explained of 43.13%. But, again, this analysis revealed two strong factors and a third factor that loaded with only two items. As such, this third factor was not sustainable and likely did not reflect enough distinct and unique variance to be considered a viable factor.

Finally, I conducted a principal axis factor analysis, limiting the extraction to only two factors, and this final solution revealed the strongest and most interpretable factor solution. This two factor solution, with each factor having an Eigenvalue greater than 1.0, was determined to be the most tenable, and accounted for 39.78% of the total variance. Next, the items pattern coefficients were examined in order to determine which, if any, items needed to be excluded from further analyses. No items loaded above .35 on more than one factor, although 5 items loaded below .30 on a single factor. These 5 items were eliminated. The two factor solution was then run again with 5 fewer items (n = 37 total items), and the structure appeared to be stable.

As a result of item elimination, 37 items were retained with 29 items on the first factor, and 8 items on the second factors. The 29 items on the first factor contained all of the items originally designed in line with both the "Knowledge" and "Skills" subscales of the MAKSS-CE-R (Kim et al., 2003) as well as the item "I am aware of the issues

relevant to providing competent counseling service for refugee torture survivors," which was originally written as a validation item for items designed in line with the MAKSS-CE-R Awareness subscale. This first factor was interpreted to represent general "Efficacy" in counseling refugee torture survivors. The 8 items on the second factor exclusively contained items originally designed in line with the "Awareness" subscale of the MAKSS-CE-R and inspection of these items was interpreted to represent ecological "Awareness" of the various ecological levels of issues relevant to counseling refugee torture survivors. The 29-item factor was labeled "Efficacy" and accounted for 38.90% of the variance. The 8-item factor was labeled "Awareness" and accounted for 4.74% of the variance. The combined factors accounted for 43.64% of the total variance. See Table 5 for a summary of the factor analysis solution.

The correlation between the two factors was .37. See Table 6 for a summary of structure matrix coefficients. These initial results suggest that the two factors of Efficacy and Awareness are measuring distinct dimensions of counseling competency when working with refugee torture survivors.

Reliability. The internal reliability for the scores of the two factors and the entire 37-item scale were examined. The results indicated internal consistency coefficient alphas of .96 for the Efficacy factor, .71 for the Awareness factor, and .94 for the entire REFTOR measure. Guidelines provided by George and Mallery (2003), suggest these results show adequate reliability for the Awareness factor and excellent reliability for the Efficacy factor as well as the overall REFTOR measure.

In order to determine if internal consistency reliability could be improved, I next examined the corrected item-total correlations and calculated internal consistencies after

Table 5

Pattern Coefficients, Communality Estimates, Eigenvalues, and Percent Variance From Exploratory Factor Analysis and Means and Standard Deviations on the Retained Items for Refugee Torture Survivor Counseling Competency Assessment (REFTOR)

Factor/Item	Factor 1	Factor 2	h^2	*M*	*SD*
Factor 1: Efficacy					
Prompts: At this point in your life, how would you rate your understanding of… How would you rate your ability to…					
28. provide competent counseling services for refugee torture survivors?	.88	-.10	.73	2.23	.81
27. accurately assess the needs of female refugee torture survivors?	.88	-.16	.69	2.45	.79
26. accurately assess the needs of male refugee torture survivors?	.87	-.12	.69	2.33	.75
42. the necessary knowledge to provide competent counseling services for refugee torture survivors?	.86	-.04	.72	2.03	.85
37. the healing process for refugee torture survivors?	.84	-.02	.69	2.00	.79
36. how refugee torture survivors commonly present in clinical settings?	.80	.03	.66	1.91	.82
29. the term “impact of torture”?	.77	.04	.61	2.52	.84
39. non compliance issues with refugee torture survivors?	.76	.04	.59	1.85	.75

Table 5 (continued)

Factor/Item	Factor 1	Factor 2	h^2	*M*	*SD*
41. how torture impacts family dynamics?	.75	.04	.60	2.15	.80
18. adapt current models of therapy to meet the needs of refugee torture survivors?	.75	-.05	.53	2.55	.77
15. address issues around power and control in the therapeutic relationship with refugee torture survivors?	.71	-.00	.51	2.40	.87
38. the skills interpreters need to provide mental health services to refugee torture survivors?	.70	.10	.56	2.03	.82
22. co-create a treatment plan with a refugee torture survivor client?	.70	-.05	.46	2.72	.84
23. provide a diagnosis without invalidating the survivor's experience?	.70	.01	.49	2.80	.80
24. identify conditions that are commonly comorbid among refugee torture survivors?	.70	.15	.59	2.36	.90
30. the term "sequelae of torture"?	.69	.04	.50	2.15	.96
20. use mental health assessments in a way that is culturally appropriate when working with refugee torture survivors?	.68	-.05	.44	2.30	.78
34. the various experiences of migration?	.67	.09	.50	2.31	.76
16. effectively consult with other professionals as needed when providing mental health services to refugee torture survivors?	.63	.00	.40	2.98	.88

Table 5 (continued)

Factor/Item	Factor 1	Factor 2	h^2	*M*	*SD*
25. discuss the political and social history of a survivor's home country?	.63	.04	.42	2.27	.93
35. the various legal statuses of migrants in the United States?	.58	.10	.39	2.24	.80
14. How would you react to the statement: "I am aware of issues relevant to providing competent counseling services for refugee torture survivors."	.58	.04	.35	2.40	.87
17. facilitate refugee torture survivors connected with other resources in the community that they need?	.58	.03	.34	2.25	.87
31. the term "therapeutic triangle"?	.55	-.13	.26	2.09	.95
32. the values, beliefs, and practices around health and healing of various global cultures?	.53	.16	.38	2.35	.65
33. the social norms (e.g. family structure, gender roles) of various global cultures?	.45	.18	.30	2.45	.61
19. engage in effective self-care while providing mental health services to refugee torture survivors?	.45	-.07	.18	3.04	.69
40. the ethics code for interpreters?	.42	.06	.20	2.01	.87

Eigenvalue: 14.87; Variance: 38.90%

Table 5 (continued)

Factor/Item	Factor 1	Factor 2	h^2	*M*	*SD*
Factor 2: Awareness					
Prompt: How would you react to the following statement?					
12. The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of refugee torture survivors?	-.03	.59	.32	2.33	1.59
4. Refugee torture survivors have limited access to the mental health assistance they need.	.01	.56	.31	3.01	1.46
13. The effectiveness of counseling with refugee torture survivors may be impacted by a counselor's beliefs about torture.	-.03	.54	.30	3.44	.84
11. Even basic implicit concepts such as "torture" and "health" may need to be defined in counseling with refugee torture survivors.	.07	.42	.26	3.16	.99
3. It is generally important for therapists to address refugee torture survivors' experiences of power both in and out of the counseling relationship.	.08	.52	.31	3.26	1.08
7. Male and female refugee torture survivors generally experience different types of torture.	.02	.39	.20	2.32	1.49
5. It is preferred that interpretation services in therapy with refugee torture survivors be conducted by a professional who speaks the appropriate language and who is not a relative or friends of the survivor.	.02	.39	.16	3.28	1.19

Table 5 (continued)

Factor/Item	Factor 1	Factor 2	h^2	*M*	*SD*
2. Discussing political issues of the host and home countries in counseling is helpful in the mental health treatment of refugee torture survivors.	.14	.31	.15	2.51	1.42
Eigenvalue: 2.46; Variance: 4.74%					
Cumulative percent of explained variance: 43.64%					

Table 6

Structure Coefficients on the Retained Items for Refugee Torture Survivor Counseling Competency Assessment (REFTOR)

	Factor	
Factor/Item	1	2
Factor 1: Efficacy		
Prompts: At this point in your life, how would you rate your understanding of… How would you rate your ability to…		
28. provide competent counseling services for refugee torture survivors?	.85	.24
27. accurately assess the needs of female refugee torture survivors?	.82	.21
26. accurately assess the needs of male refugee torture survivors?	.82	.17
42. the necessary knowledge to provide competent counseling services for refugee torture survivors?	.85	.28
37. the healing process for refugee torture survivors?	.83	.29
36. how refugee torture survivors commonly present in clinical settings?	.81	.33
29. the term “impact of torture”?	.78	.33
39. non compliance issues with refugee torture survivors?	.77	.32
41. how torture impacts family dynamics?	.77	.33
18. adapt current models of therapy to meet the needs of refugee torture survivors?	.73	.23
15. address issues around power and control in the therapeutic relationship with refugee torture survivors?	.71	.26
38. the skills interpreters need to provide mental health services to refugee torture survivors?	.74	.36
22. co-create a treatment plan with a refugee torture survivor client?	.68	.21
23. provide a diagnosis without invalidating the survivor’s experience?	.70	.27

Table 6 (continued)

Factor/Item	Factor 1	Factor 2
24. identify conditions that are commonly comorbid among refugee torture survivors?	.75	.41
30. the term “sequelae of torture”?	.70	.30
20. use mental health assessments in a way that is culturally appropriate when working with refugee torture survivors?	.66	.21
34. the various experiences of migration?	.70	.34
16. effectively consult with other professionals as needed when providing mental health services to refugee torture survivors?	.63	.24
25. discuss the political and social history of a survivor’s home country?	.65	.28
35. the various legal statuses of migrants in the United States?	.62	.32
14. How would you react to the statement: “I am aware of issues relevant to providing competent counseling services for refugee torture survivors.”	.59	.25
17. facilitate refugee torture survivors connected with other resources in the community that they need?	.59	.24
31. the term “therapeutic triangle”?	.50	.08
32. the values, beliefs, and practices around health and healing of various global cultures?	.59	.36
33. the social norms (e.g. family structure, gender roles) of various global cultures?	.52	.35
19. engage in effective self-care while providing mental health services to refugee torture survivors?	.42	.10
40. the ethics code for interpreters?	.44	.22
Eigenvalue: 14.87; Variance: 38.90%		

Table 6 (continued)

Factor/Item	Factor 1	Factor 2
Factor 2: Awareness		
Prompt: How would you react to the following statement?		
12. The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of refugee torture survivors?	.15	.56
4. Refugee torture survivors have limited access to the mental health assistance they need.	.22	.56
13. The effectiveness of counseling with refugee torture survivors may be impacted by a counselor's beliefs about torture.	.17	.53
11. Even basic implicit concepts such as "torture" and "health" may need to be defined in counseling with refugee torture survivors.	.16	.51
3. It is generally important for therapists to address refugee torture survivors' experiences of power both in and out of the counseling relationship.	.27	.55
7. Male and female refugee torture survivors generally experience different types of torture.	.22	.44
5. It is preferred that interpretation services in therapy with refugee torture survivors be conducted by a professional who speaks the appropriate language and who is not a relative or friends of the survivor.	.16	.40
2. Discussing political issues of the host and home countries in counseling is helpful in the mental health treatment of refugee torture survivors.	.26	.36
Eigenvalue: 2.46; Variance: 4.74%		
Cumulative percent of explained variance: 43.64%		

dropping the least correlated item from each factor. For factor 1, the least correlated item was "At this point in your life, how would you rate your understanding of the ethics code for interpreters?" Dropping the item from the factor and re-running the internal consistency revealed that the coefficient alpha remained at .96 for the factor. Thus, it was decided to retain the item in the factor because removing it did not improve the internal consistency. For factor 2, the least correlated item was "Discussing political issues of the host and home countries in counseling is helpful in the mental health treatment of refugee torture survivors." Dropping the item from the factor and re-running the internal consistency revealed a new coefficient alpha of .70 for the factor. Thus, the least correlated item was retained in the factor because eliminating it decreased the overall internal consistency for the factor.

Validity. Including experts in the construction of the original items was the first step towards developing the validity for the REFTOR measure. Direct comparisons between this measure and others is difficult because no other known instruments exist that measure counseling competency with this population, thus evidence for validity was obtained as described below.

In an effort to clarify the construct validity of the measure, I conducted a correlation analysis between the REFTOR and its two subscales with theoretically similar and dissimilar constructs to determine potential examples of concurrent and discriminant validity for the measure (see Table 7 for a summary). This analysis included correlations between the REFTOR measure, including the Efficacy and Awareness subscales, with the Adapted ATTITUDES measure, the number of refugee torture survivor clients seen by a participant (an experience variable), the item "How would you react to the statement "I

am well prepared to deal with issues related to refugee torture survivor clients in a therapeutic setting" from the DEMO-TRAIN questionnaire, and the Marlowe-Crowne 2(10) Social Desirability Scale. Results of these correlations are presented in Table 7.

Table 7

Correlational Evidence of Validity for the REFTOR

	1	2	3	4	5	6	7
1. ATTITUDES	1.00						
2. REFTOR	.30*	1.00					
3. Efficacy	.27*	.96*	1.00				
4. Awareness	.22*	.60*	.35*	1.00			
5. # of clients	.18*	.48*	.49*	.21*	1.00		
6. I am well prepared to deal with issues related to refugee torture survivor clients in a therapeutic setting	.24*	.73*	.75*	.30*	.50*	1.00	
7. SOC DESIRE MC2(10)	.19*	.21*	.25*	-.02	.06	.22*	1.00

Note. ATTITUDES = Adapted Attitudes Towards Torture Questionnaire; REFTOR = Refugee Torture Counseling Competency Assessment ; Efficacy = Efficacy factor of REFTOR measure; Awareness = Awareness factor of REFTOR measure; # of clients = number of refugee torture survivor clients seen; SOC DESIRE MC2(10) = Marlowe-Crowne 2(10) Social Desirability Scale
* $p < .05$

Regarding correlations between the REFTOR full and subscales and the Adapted ATTITUDES measure, results demonstrated significant correlations between the Adapted ATTITUDES measure and the REFTOR full scale (.30), Efficacy factor (.27), and Awareness factor (.22). These results demonstrate moderate, significant correlations.

Regarding correlations between the REFTOR full and subscales and the number of refugee torture survivor clients seen by a participant (experience variable), results demonstrated significant correlations with the REFTOR full scale (.48), Efficacy factor (.49), and Awareness factor (.21). These results demonstrate moderate, significant correlations.

Regarding correlations between the REFTOR full and subscales and the item "How would you react to the statement "I am well prepared to deal with issues related to refugee torture survivor clients in a therapeutic setting," results demonstrated significant correlations with the REFTOR full scale (.73), Efficacy factor (.75), and Awareness factor (.30). These results demonstrate moderate to strong, significant correlations.

Regarding correlations between the REFTOR full and subscales and the Marlowe-Crowne 2(10) Social Desirability Scale, results demonstrated significant correlations with the REFTOR full scale (.21), and the Efficacy factor (.25). These results demonstrate moderate, significant correlations. Results also demonstrated an insignificant correlation with the Awareness factor (-.02).

Part II – Descriptive Research Questions

This section is dedicated to descriptive data analysis and addresses research questions two through five.

Research Question Two

Descriptive statistics from the DEMO-TRAIN measure were used to answer the second research question: What training experiences have trainees and professionals received relevant to working with refugee torture survivors? Training was categorized in

two groups: classroom and fieldwork. Classroom training included courses, presentations, and readings relevant to working with refugee survivors. The fieldwork training category included providing services to refugee survivors as well as discussing relevant issues in supervision. Frequency counts revealed that 49% of participants had read no empirical articles with information relevant to refugee torture survivors, 32% had read 1-3 articles, 7% had read 3-6 articles, and 12% had read 7 or more articles. Frequency counts for non-empirical articles revealed 33% of participants had read none, 46% had read 1-3 articles, 9% had read 4-6 articles, and 12% had read 7 or more articles. A summary of training experiences reported is presented in Table 8.

Table 8

Frequencies, Means, and Standard Deviations for Training Experiences Relevant to Working with Refugee Torture Survivors

Item	None % (*n*)	One % (*n*)	Two % (*n*)	Three % (*n*)	Four or More % (*n*)
Number of undergraduate courses in which you received relevant information	87.2% (156)	8.4% (15)	3.4% (6)	1.1 % (2)	0% (0)
Number of graduate courses in which you received relevant information	76.5% (137)	16.2% (29)	5.6% (10)	.6% (1)	1.1% (2)
Number of lectures or presentations you have attended in which you received relevant information	50.3% (90)	19% (34)	14% (25)	6.1% (11)	10.7% (19)

Table 8 (continued)

Item	None % (*n*)	1-3 % (*n*)	4-6 % (*n*)	6-10 % (*n*)	11 or more % (*n*)
Number of relevant EMPIRICAL articles you have read	48.6% (87)	32.4% (58)	6.7% (12)	4.5% (8)	7.8% (14)
Number of relevant NON-EMPIRICAL articles you have read	33% (59)	45.8% (82)	8.9% (16)	2.2% (4)	10.1% (18)
	Never % (*n*)	Rarely % (*n*)	Sometimes % (*n*)	Often % (*n*)	*M* (*SD*) 1 = never; 4 = often
Extent that relevant issues were discussed in a clinical supervision setting	71.5% (128)	17.9% (32)	6.1% (11)	4.5% (8)	1.44 (.80)
Classroom only training	82.7% (110)	15.8% (21)	1.5% (2)	0% (0)	1.19 (.43)
Field training	37.8% (17)	24.4% (11)	20.0% (9)	17.8% (8)	2.18 (1.13)
	Strongly Disagree % (*n*)	Disagree % (*n*)	Agree % (*n*)	Strongly Agree % (*n*)	
Reaction to the statement: I am well prepared to deal with issues related to refugee torture survivor clients in a therapeutic setting?	44.7% (80)	33% (59)	18.4% (33)	3.9% (7)	

Table 8 (continued)

Item	*M*	*SD*	None % (*n*)	One % (*n*)	Two or More % (*n*)
Number of refugee torture survivor clients	2.89	11.94	74.3% (133)	6.7% (12)	18.5% (34)
Trainees	1.43	8.03	85.6% (101)	3.4% (4)	11% (13)
Professionals	5.75	16.96	52.5% (32)	13.1% (8)	33.3% (20)

Regarding coursework, frequency counts revealed 76.5% of participants had never had a graduate class that included information relevant to working with refugee torture survivors, 16.2% had one class that included information relevant to working with refugee torture survivors, 5.6% had two classes with relevant content, .6% had three classes, and an additional 1.1% reported having four or more classes with content relevant to working with refugee torture survivors. Similarly, half of participants (50.3%) reported having not received any relevant information through a presentation or lecture, 19.0% reported receiving relevant information from one presentation, 14.0% reported attending two presentations with relevant content, 6.1% reported three presentations, and 10.7% reported four or more presentations relevant to working with refugee torture survivors.

Regarding fieldwork training, descriptive analyses showed that participants had worked with a mean of 2.89 clients (*SD* = 11.9, range 0-100) who identified as refugee survivors, although it is notable that 74% of participants reported having no experience in working with refugee survivors. Similarly, descriptive analyses showed participants had worked with a mean of 2.85 clients (*SD* = 13.45, range 0-120) who had family member

who identified as refugee survivors, although 75% of participants reported no experience in this area. Finally, in reaction to the statement "I am well prepared to deal with issues related to refugee torture survivor clients in a therapeutic setting," 44.7% of participants strongly disagreed, 33% disagreed, 18.4% agreed, 3.9% strongly agreed (see Table 8).

Regarding supervision, using a scale of "1 = never" to "4 = often" to describe participants' frequency of discussing issues relevant to refugee survivors in supervision, the mean was 1.44 (*SD* = .80), suggesting a low frequency of supervision time spent on discussing refugee torture survivors. For participants who reported no experience providing clinical services to refugee torture survivors, the mean frequency of discussing relevant issues in supervision was 1.19 (*SD* = .43), while for participants who did report experience providing clinical services to refugee torture survivors the mean frequence was 2.12 (*SD* = 1.13, $t(48.33) = -5.72$, $p < .05$).

Research Question Three

Descriptive and inferential statistics including the mean, variance, and distribution of scores on the ATTITUDES measure were used to answer the third research question: What are trainees' and clinicians' attitudes toward torture? Results are presented in Table 9.

First, measurement information includes the following: Internal consistency reliability for the Adapted ATTITUDES measure was .90. The score distribution appears to be normally distributed. The possible range of scores on the measure was 9 to 46, with higher scores indicated more negative attitudes towards torture. Participant mean score on this measure was 36.56 (*SD* = 6.64). Responses to selected items are detailed below; a complete summary is listed

Table 9

Summary of Responses on Adapted Attitudes Towards Torture Questionnaire

Item	Strongly Agree % (*n*)	Agree % (*n*)	Un-decided % (*n*)	Disagree % (*n*)	Strongly Disagree % (*n*)	*M*	*SD*
The use of torture should be prohibited as a matter of state policy – PERIOD*	58.1% (104)	19.6% (35)	16.2% (29)	5% (9)	1.1% (2)	4.28	.98
Rare exceptions for the use of torture can be condoned under extreme circumstances by legitimate state agents	2.8% (5)	16.2% (29)	13.4% (24)	23.5% (42)	44.1% (79)	3.90	1.21
The use of torture to elicit information from captives is immoral and intrinsically wrong*	53.1% (95)	29.6% (53)	11.7% (21)	4.5% (8)	1.1% (2)	4.29	.92
If there is the "slightest belief" that life-saving information can be obtained, it is permissible to use torture	.6% (1)	5% (9)	22.9% (41)	34.1% (61)	37.4% (67)	4.03	.93
Under extreme conditions, it is permissible for interrogators to yell at prisoners and to use psychological intimidation	.6% (1)	31.4% (61)	26.3% (47)	21.2% (38)	17.9% (32)	3.22	1.12
It is morally permissible for psychologists to treat individuals and assess their mental health so as to inform torturous interrogation procedures	1.1% (2)	2.8% (5)	8.4% (15)	29.6% (53)	58.1% (104)	4.41	.85
Information obtained using torture techniques is reliable	.6% (1)	2.2% (4)	15.1% (27)	33% (59)	49.2% (88)	4.28	.24

Table 9 (continued)

Item	Strongly Agree % (*n*)	Agree % (*n*)	Un-decided % (*n*)	Disagree % (*n*)	Strongly Disagree % (*n*)	*M*	*SD*
Torture is sometimes necessary for the greater good	1.7% (3)	8.9% (16)	21.2% (38)	24.6% (44)	43.6% (78)	3.99	1.08
Having strict oversight by authority when using torture techniques decreases the long-term physical and psychological impact on detainees	1.7% (3)	3.9% (7)	18.4% (33)	28.5% (51)	47.5% (84)	4.16	.97

* indicates items with reverse scoring

in Table 9. In response to the item “Exceptions for use of torture can be condoned under extreme conditions,” 19% of respondents "strongly agreed" or “agreed”, 13.4% were "undecided", and 67.6% "strongly disagreed" or “disagreed”. In response to the item “It is permissible for interrogators to psychologically intimidate captives,” 34.7% "strongly agreed" or “agreed”, 26.3% were "undecided", and 39% "strongly disagreed" or “disagreed”. In response to the item “Torture is sometimes necessary for the greater good,” 10.6% "strongly agreed" or “agreed”, 21.2% were undecided, and 68.2% (strongly) disagreed. See Table 9.

Research Question Four

Descriptive statistics including the means, variances, and distributions of scores on the REFTOR measure were used to answer the fourth question: What competencies do trainees and professionals report with regard to providing clinical services for refugee torture survivors? First, measurement information includes the following: Internal consistency reliability for the REFTOR with this sample was .94, with .96 for the Efficacy subscale, and .71 for the Awareness subscale. Scores appeared to be normally distributed. The range of possible scores on the Efficacy subscale was 29 – 116 with higher scores indicating more efficacy in counseling refugee torture survivors. The participant mean score on this subscale was 66.85 (*SD* = 16.69). The range of possible scores on the Awareness subscale was 0 – 323 with higher scores indicating more awareness relevant to counseling refugee torture survivors. The participant mean score on this subscale was 23.32 (*SD* = 5.87). The range of possible scores on the full measure was 29 – 148 with high score indicating more competence in working with refugee torture survivors. The participant mean score on the full scale was 90.17 (*SD* = 19.53).

Part III – Group Comparisons

Research Question Five

Independent-Samples *T* – test was used to investigate question: What is the relationship between field and classroom training experiences with attitudes toward torture, and counseling competency relevant to providing services for refugee torture survivors among trainees and professionals? Field training was defined as experience providing clinical services to refugee torture survivors. Classroom training was defined as any training that did not include direct service provision and included lectures, presentations, workshops, readings, etc. Of the 179 participants, 43 reported having field training, 133 reported classroom only training, and 3 did not indicate their training experiences.

Significant differences with moderate to strong effect sizes were found on both the Efficacy and Awareness factors of the REFTOR, the overall REFTOR score, as well as attitude towards torture between those whose training included field experience and those who only experienced classroom training. Results of these group comparisons are presented in Table 10.

Regarding efficacy, results of the *T*-test demonstrated that those with field training in working with refugee torture survivors ($M = 81.60$, $SD = 18.57$) rated significantly higher on the Efficacy subscale of the REFTOR in engaging in this work than those with only classroom training ($M = 61.86$, $SD = 12.71$), $t(58.55) = -6.62$, $p < .01$). This difference revealed a strong effect size, Cohen's $d = 1.37$.

Regarding awareness, results of the *T*-test demonstrated that those with field training in working with refugee torture survivors ($M = 25.82$, $SD = 5.93$) rated

Table 10

Comparing Variables Across Type of Training

	Field Training		Classroom Training				
	M	*SD*	*M*	*SD*	*t*	*df*	*d*
ATTITUDES	39.38	5.73	35.55	6.65	-3.45*	176	.60
REFTOR	107.42	21.40	84.34	15.04	-6.70*	59.38	1.37
Efficacy	81.60	18.57	61.86	12.71	-6.62*	58.55	1.37
Awareness	25.82	5.93	22.47	5.64	-3.32*	176	.59

Note. ATTITUDES = Adapted Attitudes Towards Torture Questionnaire; REFTOR = Refugee Torture Counseling Competency Assessment ; Efficacy = Efficacy factor of REFTOR measure; Awareness = Awareness factor of REFTOR measure
* $p < .05$

significantly higher on the Awareness subscale of the REFTOR in engaging in this work than those with only classroom training (M = 22.47, SD = 5.64), $t(176) = -3.32$, $p < .01$. This difference revealed a moderate to strong effect size, Cohen's d = .59.

Regarding overall self-reported counseling competency, results of the *T*-test demonstrated that those with field training in working with refugee torture survivors (M = 107.42, SD = 21.40) rated significantly higher on the REFTOR measure in engaging in this work than those with only classroom training (M = 84.34, SD = 15.04), $t(59.38) = -6.70$, $p < .01$. This difference revealed a strong effect size, Cohen's d = 1.37.

Regarding attitudes towards torture, results of the *T*-test demonstrated that those with field training in working with refugee torture survivors (M = 39.38, SD = 5.73) rated significantly higher on the ATTITUDES measure than those with only classroom training (M = 35.55, SD = 6.65), $t(176) = -3.45$, $p < .01$. This difference revealed a moderate to strong effect size, Cohen's d = .60.

To follow-up and add clarity to these findings I conducted a follow-up correlational analysis between the number of refugee torture survivor clients seen, the REFTOR measure and subscales, and the ATTITUDES measure. Results revealed a positive correlation between the number of clients seen who identified as refugee torture survivors with competency and attitude towards torture, indicating that as a service provider gains more experience in working with refugee torture survivors they also report more competency and a more negative view of torture. The correlations are summarized in Table 11.

Table 11

Correlations Between Number of Refugee Torture Survivor Clients, Attitudes Towards Torture, and Counseling Competency with Refugee Torture Survivors

	1	2	3	4	5
1. ATTITUDES	1.00				
2. REFTOR	.30*	1.00			
3. Efficacy	.27*	.96*	1.00		
4. Awareness	.22*	.60*	.35*	1.00	
5. # of clients	.18*	.48*	.49*	.21*	1.00

Note. ATTITUDES = Adapted Attitudes Towards Torture Questionnaire; REFTOR = Refugee Torture Counseling Competency Assessment ; Efficacy = Efficacy factor of REFTOR measure; Awareness = Awareness factor of REFTOR measure
* $p < .05$

Results demonstrate that both field training and number of refugee survivor of torture clients are related to higher competency levels and more negative attitudes towards torture. Additionally, comparing correlations of the ATTITUDES measure with overall REFTOR and each of the REFTOR subscales revealed that the following

correlations were greater for those who had field training experiences compared to those with classroom only training: ATTITUDES and the Efficacy subscale (r_{field} = .43, $r_{classroom}$ = .07, Z = 2.20, p < .05), the overall REFTOR and the Efficacy subscale(r_{field} = .97, $r_{classroom}$ = .93, Z = 2.44, p < .05), and the overall REFTOR and the Awareness subscale (r_{field} = .58, $r_{classroom}$ = .23, Z = 2.41, p < .05) were found to be higher for those with field training compared to those with classroom only training.

Post-Hoc Comparisons

In order to further understand how study variables are related, trainees (n = 118) were compared to professionals (n = 61) to further examine the role of training and experience on responses to the ATTITUDES and REFTOR measures. Comparisons between these groups were analyzed using a *T*-test. See table 12 for a summary.

Table 12

Comparing Variables Across Training Level

	Trainee		Professional				
	M	*SD*	*M*	*SD*	*t*	*df*	*d*
ATTITUDES	35.57	6.74	38.49	6.03	-2.85*	177	-.45
REFTOR	86.48	16.97	97.30	22.19	-3.34*	97.20	-.57
Efficacy	63.87	14.50	72.61	19.11	-3.13*	96.64	-.54
Awareness	22.61	5.63	24.69	6.11	-2.27*	177	-.34

Note. ATTITUDES = Adapted Attitudes Towards Torture Questionnaire; REFTOR = Refugee Torture Counseling Competency Assessment ; Efficacy = Efficacy factor of REFTOR measure; Awareness = Awareness factor of REFTOR measure
* p < .05

Regarding attitudes towards torture, results of the *T*-test demonstrated that trainees (M = 35.56, SD = 6.74) rated significantly more positive attitudes towards torture on the ATTITUDES measure compared to professionals (M = 38.49, SD = 6.03), $t(177)$ = -2.85, $p < .05$. The difference revealed a moderate effect size of Cohen's d = -.45.

Regarding efficacy, results of the *T*-test demonstrated that trainees (M =63.87, SD = 14.50) scored significantly lower on the Efficacy subscale of the REFTOR measure compared to professionals (M = 72.61, SD = 19.11), t (96.64) = -3.13, $p < .01$. This difference revealed a moderate effect size of Cohen's d = -.54.

Regarding awareness, results of the *T*-test demonstrated that trainees (M = 22.61, SD = 5.63) scored significantly lower on the Awareness subscale of the REFTOR measure compared to professionals (M = 24.69, SD = 6.11), t (177) = -2.27, $p < .01$. This difference revealed a moderate effect size of Cohen's d = -.34.

Regarding, over all competency with refugee torture survivors, results of the *T*-test demonstrated that trainees (M = 86.48, SD = 16.97) scored significantly lower on the REFTOR measure compared to professionals (M = 97.30, SD = 22.19), t (97.20) = -3.34, $p < .01$. This difference revealed a moderate effect size of Cohen's d = -.57.

In order to control for the effect of type of training between trainees and professionals, participants were first divided into groups based on training experiences (field vs. classroom only) and then means were again compared using *T*-tests between trainees and professionals in each of the conditions. Results show that the differences found when comparing all trainees and professionals largely disappear when controlling for type of training experience. See Table 13 for a summary.

Table 13

Comparing Variables by Training Level Controlling for Training Type

	Trainee (n = 101)		Professional (n = 32)				
Classroom Only Training	*M*	*SD*	*M*	*SD*	*t*	*df*	*d*
ATTITUDES	35.36	6.75	36.13	6.36	-.56	131	-.12
REFTOR	83.50	14.70	87.00	16.01	-1.15	131	-.23
Efficacy	61.48	12.40	63.09	13.75	-.63	131	-.13
Awareness	22.02	5.72	23.91	5.22	-1.66	131	-.34
	Trainee (n = 17)		**Professional (n = 28)**				
Field Training	*M*	*SD*	*M*	*SD*	*t*	*df*	*d*
ATTITUDES	36.76	6.74	40.96	4.43	-2.52*	43	-.78
REFTOR	104.24	19.06	109.36	22.82	-.78	43	-.24
Efficacy	78.12	18.00	83.71	18.91	-.99	43	-.30
Awareness	26.12	3.50	25.64	7.07	.26	43	.06

Note. ATTITUDES = Adapted Attitudes Towards Torture Questionnaire; REFTOR = Refugee Torture Counseling Competency Assessment ; Efficacy = Efficacy factor of REFTOR measure; Awareness = Awareness factor of REFTOR measure
* $p < .05$

Regarding attitudes towards torture, results from the *T*-test demonstrated that among those who have received classroom only training, no differences were found between trainees (M = 35.36, SD = 6.75) and professionals (M = 36.13, SD = 6.36) in their scores on the ATTITUDES measure, t (131) = -.56, $p > .05$. Among those who have field training experience with refugee torture survivors, results of the *T*-test

demonstrated there was a difference between trainees (M = 36.76, SD = 6.74) and professionals (M = 40.96, SD = 4.43) scores on the ATTITUDES measure t (43) = -2.52, $p < .01$. This difference revealed a large effect size of Cohen's d = -.78.

Regarding efficacy, results from the *T*-test demonstrated that among those who have received classroom only training, no differences were found between trainees (M = 61.48, SD = 12.40) and professionals (M = 63.09, SD = 16.01) in their scores on the Efficacy subscale of the REFTOR measure, t (131) = -1.15, $p > .05$. Similarly, among those who have field training experience with refugee torture survivors, *T*-test demonstrated there was no difference between trainees (M = 78.12, SD = 18.00) and professionals (M = 83.71, SD = 18.91) in their scores on the Efficacy subscale of the REFTOR measure, t (43) = -.99, $p > .05$.

Regarding awareness, results from the *T*-test demonstrated that among those who have received classroom only training, no differences were found between trainees (M = 22.02, SD = 5.72) and professionals (M = 23.91, SD = 5.22) in their scores of the Awareness subscale of the REFTOR measure, t (131) = -.63, $p > .05$. Similarly, among those who have clinical experience with refugee torture survivors, there was no difference between trainees (M = 26.12, SD = 3.50) and professionals (M = 25.64, SD = 7.07) in their scores on the Awareness subscale of the REFTOR measure, t (43) = .26, $p > .05$.

Regarding counseling competency, results from the *T*-test demonstrated that among those who have received classroom only training, no differences were found between trainees (M = 83.50, SD = 14.70) and professionals (M = 87.00, SD = 16.01) in their scores on the REFTOR measure, t (131) = -1.15, $p > .05$. Similarly, among those

who have clinical experience with refugee torture survivors, there was no difference between trainees (M = 104.24, SD = 19.06) and professionals (M = 109.36, SD = 22.82) in their scores on the REFTOR measure, t (43) = -.78, p > .05.

CHAPTER V

DISCUSSION

Based on a literature review conducted in October, 2009, and again in April, 2011, with PsychINFO as well as a review of the Torture Journal (http://www.irct.org/library/torture-journal.aspx) and the Center for Victims of Torture (http://www.cvt.org/) websites, this study appears to be the first empirical study to examine the combination of psychologists' and trainees' attitudes towards torture, training experiences related to working with refugee torture survivors, and an evaluation of psychologist and trainee counseling competencies related to working with this highly vulnerable population. This is the first research to construct an original measure designed to assess psychologist and trainee counseling competencies with refugee torture survivors. Findings of this study suggest that the REFTOR is an adequate and reliable measure of counseling competencies in working with refugee torture survivors, with two factors labeled "Efficacy" and "Awareness", and with clear evidence of construct validity. The creation of a new measure was the primary emphasis of this study because no known instrument exists that measures counselor competency variables related to refugee torture survivors. The REFTOR was created as an adaptation of the MAKSS-CE-R (Kim et al., 2003) while also following the steps suggested by DeVellis (2003) for scale construction. Findings of this study also demonstrated that training experiences in working with refugee torture survivors are limited, and that all participants reported having been exposed to at least one aspect of working with refugee torture survivors. Attitudes towards torture varied considerably with a sizable proportion of participants endorsing torture in some circumstances and reporting uncertainty about the morality of

psychologists' professional involvement in torture. As would be expected, counseling competency with refugee torture survivors was significantly higher among participants who had experience working clinically with refugee survivors. These results and the results using the REFTOR measure are interpreted in light of the measure's early stage of development.

Factor Analysis

The REFTOR was intended to capitalize on the strengths of the MAKSS-CE-R (Kim et al., 2003), while also addressing some of the criticisms it has received. Specifically, this measure used clearly defined constructs, targeted a more specific population, included items reflecting issues of power, privilege, and social justice, and was correlated with a social desirability measure. Additionally, items were constructed in consultation with clinicians who have extensive counseling experience with refugee torture survivors.

In contrast to the three factors identified for the MAKSS-CE-R, the results of the factor analysis for the REFTOR in this study revealed two factors. This finding was not predicted. Examination of items on each factor suggests that participants did not respond in a way that distinguished knowledge and skills, though awareness was a distinct construct. An explanation of this finding may be found in the literature on the measures on which the REFTOR was modeled. This result is reflective of some of the inconsistent findings described in the literature. For example, in a previous study, Constantine, Gloria, and Ladany (2002) examined several prominent measures of multicultural counseling competency, and their results suggested that two-factors (self-perceived skills and

attitudes/beliefs) underlie multicultural counseling competency, instead of the traditional three knowledge, awareness, and skills factors. This finding is also reflected in the factor structure of another popular multicultural counseling competency measure, the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996). The MCAS was also developed using the traditional tripartite factors. Similar to results from this study, however, factor analyses of the MCAS has demonstrated that knowledge and skills items load together, with awareness items loading in a separate factor (Ponterotto et al., 1991, 2002). So findings here are not inconsistent with previous multicultural competencies measurement literature. In contrast, an exploratory and confirmatory factor analysis of the updated MAKSS-CE-R supported the traditional three factor structure (Kim et al., 2003). More empirical studies regarding the factor structure of the recently updated MAKSS-CE-R could not be found. While different findings have emerged in the literature regarding factor structures of competencies measures, it is still unclear why the Skill and Knowledge factors loaded together on the REFTOR measure.

There may be a variety of reasons to explain the findings in this study. First, sampling effects may have impacted the factors identified in the factor analysis. Those choosing to participate in the study may have had certain traits or experiences that skewed responses in a way that does not represent the general population of clinicians. For example, all participants reported some exposure to information relevant to working with refugee torture survivors. It is unclear how their responses would relate to other psychologists' and trainees' who have had no exposure. Another possibility is that the sample size of this study was not large enough to allow difference between the theoretical factors to be detected. Research has shown that smaller communalities makes larger

sample size a more important aspect in factor analysis results for any given sample to be stable and to align with the factor solution for the population (MacCallum et al., 2001). Thus, the small communalities found for many items in this study may indicate a sampling effect where the factor solution found for the sample does not match the factor solution for the population. An additional potential influence is that findings represent a modeling error (MacCallum & Tucker, 1991) where factor loadings are not the same for all members of a population. For example, it may be that a model attempting to distinguish knowledge, awareness, and skills in counseling competency with refugee torture survivors is more appropriate for a sample that has substantial counseling experience with this population. It is unclear, however, how much the issues identified above have influenced findings in the present study. Future research with larger sample sizes is indicated as a means to determine how well the results of this study reflect other and more broad-based samples of psychologists and trainees.

Early evidence of the REFTOR construct validity was obtained through correlations with other study measures and individual items. Small-to-moderate correlations were found between social desirability in responding with the REFTOR full scale and with the Efficacy subscale. This is not unusual, as other multicultural counseling competency measures, which are generally considered reliable, have also demonstrated small-to-moderate significant correlations with social desirability (Kim et al., 2003; Sodowsky et al., 1998; Worthington et al., 2000). The relationship between social desirability and self-reported counseling competency may be due to the interpersonal process involved in counseling (Constantine & Ladany, 2000). That is, the need to be seen positively by others may be related to the interpersonal skills that are

measured in many current counseling competency instruments. Some authors have called for instruments specifically designed to measure multicultural social desirability to address this issue (e.g. Sodowsky et al. 1998). It is recommended that the REFTOR be administered with a measure of social desirability so that the socially desirable responding can be controlled for.

Correlations between the REFTOR factors and the ATTITUDES measure indicated that more negative attitudes towards torture were related with higher competency scores on the REFTOR. This supports the construct validity of the REFTOR measure. This finding also reflects best-practice literature suggesting counselors' attitudes towards torture impacts their work with refugee torture survivors (Elsass, 1997a; Fabri, 2001; Vesti & Kastrup, 1995). Based on years of clinical experience, this best-practice literature suggests that a counselor with a more conventionally neutral stance may re-traumatize the client or be seen as disbelieving to the client (Fabri, 2001), thus negatively impacting the effectiveness of treatment. Although there is no other empirical evidence linking attitudes towards torture to counseling competency with torture survivors, evidence of this link has been found with other populations. One example is that numerous studies have found a link between counselors' racial attitudes and multicultural competencies (Middleton et al., 2005; Ottavi et al., 1994; Pope-Davis et al., 1993). Thus, the correlations between the REFTOR and its factors with the ATTITUDES measure support the validity of the RETOR.

Correlations also showed that higher competency scores were related to having worked with a greater number of refugee torture survivors and with clinician and trainee self-assessment of their preparedness for clinical work with refugee torture survivors.

This correlation also supported the construct validity of the REFTOR. These findings are in line with previous research linking multicultural self-efficacy with counseling competency (Constantine, 2001). Each encounter with a refugee torture survivor client may create additional opportunities for learning through the encounter itself and also through supervision, likely raising self-efficacy as well as competency (Lent, Brown, & Hackett, 1994).

Additional evidence of the REFTOR measure construct validity can be seen in group comparisons of competency where those with field training had higher competency scores compared to those with classroom-only training. These findings are in line with current recommendations for general multicultural counseling training that emphasize direct clinical experience, and contribute to early empirical evidence of validity for the REFTOR. Specifically, research has shown that experiential and field training experiences are the most impactful on trainees (Furr & Carroll, 2003). Further, evidence has suggested that multicultural counseling skills are best acquired through direct experience with clients (D'Andrea, Daniels, & Heck, 1991) and supervision (Vereen, Hill, McNeal, 2008). Thus, the correlations of the REFTOR and its factors with the number of refugee torture survivors seen support the construct validity of the measure.

Training Experiences

Results indicated that the majority of information that participants received about working with refugee torture survivors came from non-empirical articles with then secondarily from empirical articles. The specific content of the articles reported is unclear because I did not ask this specifically, and so the information may include a wide range

of topics that only generally relate to the topic and population served. Regardless of content, research has shown that trainees report readings to be the least important part of building multicultural counseling competency (Heppner & O'Brien, 1994). So although the majority of information relevant to working with refugee torture survivors is obtained through articles, the impact on actual competency is unclear. At the same time, nearly three-fourths of participants reported not receiving information on refugee torture survivors in their graduate classes. This suggests that the majority of information received relevant to refugee torture survivors was not accessed as part of a graduate program's planned curriculum, but instead on an as-needed or as-interested basis. It is notable, however, that all participants indicated that they had had at least one kind of exposure to information related to refugee torture survivors. In regards to field training, a large majority (nearly 75%) reported having no clinical experience working with refugee torture survivors. A significant number of participants did report providing services to refugee torture survivors (15% of students, and nearly 50% of professionals [25% of the whole sample]). Research has consistently shown that opportunities for field training are critical to building counseling competencies (e.g. Furr & Carrol, 2003; Vereen, Hill, McNeal, 2008) so the number of trainees engaging in these experiences with refugee torture survivors is significant in determining the strength and quality of training in this area. Results showed that a majority of participants received little to no exposure to information and experiences to prepare them for working with refugee torture survivors. While a substantial number (25%) of participants reported providing clinical services to refugee torture survivors, they had not necessarily been exposed to training experiences that would prepare them for this work. Together, these findings support literature based

on clinical experience that has identified a need for more training and preparation for clinicians to work with refugee torture survivors (see Campbell, 2007; Engstrom & Okamura, 2004; Gorman, 2001; Singh, 2005; Vesti & Kastrup, 1995).

Attitudes Towards Torture

Although the majority of the participants indicated negative attitudes towards torture, a substantial number reported beliefs that torture may be acceptable under certain circumstances (22.5%) and that torture may be *necessary* "for the greater good" (31.8%). These responses may not be wholly surprising. For example, the recent passage of the APA petition banning psychologists from working in a setting where persons are being tortured unless they are working directly for the person detained or an independent third party to protect human rights was approved by a simple majority of 58.8% (APA, 2008), indicating that the field may be far from unified on this issue. Similarly, previous research with medical students suggests that trainees and professionals are likely to hold attitudes towards torture that conflict with those endorsed by the professional organizations in which they are involved (Bean et al., 2008). In some ways, psychologists' attitudes towards torture mirror those of the general population as captured by public opinion polls post September 11, 2001. These polls generally show that 60-70% of respondents support the use of torture at least on rare occasions (Pew Research Center for the People & the Press, 2007, 2009), compared to attitudes prior to 9/11 where Americans would have considered torture "beyond the pale" (McKeown, 2009). The phenomenon has been described as a "large group regression" whereby dichotomous and defensive thinking are intensified (Thomas, 2011). In this way, mental health

professionals and trainees in this sample may simply reflect the general public attitude, and their relative lack of exposure to torture victims contributes to the fact that their practical experience does not mediate their attitudes about torture.

Participants' attitudes towards torture were found to correlate with counseling competency with refugee torture survivors, with more negative attitudes linked to greater competency. This finding is consistent with literature which has asserted that clinicians' beliefs about torture influence the therapeutic process (Elsass, 1997a; Fabri, 2001; Vesti & Kastrup, 1995). Specifically, this literature suggests that clinicians' denouncement of torture to their clients can facilitate trust and safety in the therapeutic relationship. This finding also relates to previous research linking attitudes towards ethnicity and case conceptualization ability, another facet of counseling competency (Constantine & Gushue, 2003). As may be expected, clinicians' attitudes, beliefs, and biases impact case conceptualization and treatment process.

Impact of Training on Attitudes and Competency

Not surprisingly, results showed that participants with experience working with refugee torture survivors reported more negative attitudes towards torture and higher scores on the REFTOR Efficacy and Awareness factors than participants who had received only classroom information on refugee survivors. The moderate to strong effect size for these differences suggest that direct experience working with refugee torture survivors is a vital part of the training that is needed to work with this group. This finding also extends research with medical students which showed that those caring for refugee patients reported greater awareness and sensitivity to cultural and migrant issues

(Griswold et al., 2006). Further, results of this study showed that as clinical experience with this population increased, so did counseling competency and negative attitudes towards torture. These findings demonstrate that the REFTOR effectively distinguishes between groups in a theoretically predictable manner, and supports its continued use. At the same time, as discussed below, further research on this measure would improve its utility.

Similar to comparing attitudes and competency between field and classroom training, professionals also had significantly higher scores on Efficacy and Awareness factors and more negative attitudes towards torture than trainees. Differences between trainees and professionals largely disappeared, though, when training experiences were controlled for. After controlling for training experience, the difference remaining between these two groups was that among those with field training, professionals had more negative attitudes towards torture compared to trainees. This finding is congruent with numerous research studies on multicultural counseling training emphasizing the role that experiential and direct client experience have on the development of multicultural counseling competence (Delsignore et al., 2010; Furr & Carroll, 2003; Heppner & O'Brien, 1994). Research on the importance of various training components in the development of multicultural counseling competency suggests that readings may be the least impactful (Heppner & O'Brien, 1994) while experiential and field trainings are the most impactful (Furr & Carroll, 2003). This may be because skills related to multicultural counseling competency, compared to knowledge and awareness, are more difficult to learn through classroom-like experiences (D'Andrea, Daniels, & Heck, 1991). Furthermore, engaging in direct clinical work allows for important learning through

supervision of those activities (Fukuyama, 1994; Vereen, Hill, McNeal, 2008). The results of this study underline the importance of field training experience in supporting counseling competency, and also suggest that while attitudes towards torture are related to counseling competency, they may be impacted by different learning experiences.

Study Implications

Results from this study provide information that is important in building and refining of theory around counseling competency with refugee torture survivors. The REFTOR was created from a theory of counseling competency first articulated in this study and based on available literature and research as well as the Multicultural Counseling Competency model (Sue et al., 1982, 1998) and the MAKSS-CE-R (Kim et al., 2003). Continued research in this area will further clarify underlying constructs important in counseling competency with this population and may serve as evidence to shape the developing theory of multicultural counseling competency with refugee torture survivors used in this study.

The REFTOR also has potential for use in future training and research. Results indicate the need for an emphasis on integrating direct service training experiences with refugee torture survivors whenever possible as the most effective training needed for this work. Several authors have called for specialized training in this area (Campbell, 2007; Bouhoutsos, 1990; Elsass 1997a; Fabri, 2001; Gorman, 2001; & Sansani, 2004) and these results shed light on the current state of training, supporting claims that there is a shortage of trained professionals ready and able to work with refugee torture survivors (Gorman, 2001; Singh, 2005). Toward this end, using the REFTOR measure as a research

instrument to compare pre- and post-training competencies may provide valuable information about the effectiveness and impact of the training. More generally, using the REFTOR to assess first-year or early-career students may also be helpful in identifying specific areas of needed growth that can be further developed during training.

Results regarding attitudes towards torture were striking. The number of participants endorsing positive attitudes towards torture suggests that more attention regarding the ethics, impact, and social justice issues related to torture is needed, as called for by the Division of Social Justice of the American Psychological Association (Lott, 2007). Similarly, authors with experience working with refugee torture survivors identify a lack of knowledge and awareness of torture issues as a significant obstruction to improving services for this population (Campbell, 2007; Vesti & Kastrup, 1995), so increasing awareness is clearly warranted. While there may always be some variability in attitudes within the field regarding torture, it is remarkable that nearly one-third of participants endorsed the use of torture which is condemned by a wide community of professional and international organizations, including one of their own (APA, 2006, 2007, 2010). Study implications are that mental health professional training could be significantly improved by directly addressing the ethics, impact, and social justice issues related to torture.

Study Limitations

One limitation of the present study is the reliance of self-report measures. Assessment of counseling competency would be strengthened by adding another assessment modality (e.g. observer assessment, supervisor assessment). Literature has

shown differences in self-report versus other-report measures of multicultural counseling competency (Cartwright, Daniels, & Zhang, 2008), and some have suggested that self-report measures of counseling competency actually measure counseling self-efficacy (Constantine, Gloria, & Ladany, 2002). Although research suggests that self-efficacy may be a component of competency (Lent, Brown, & Hackett, 1994; 2000), more research is needed with the REFTOR to determine how well it measures competency versus self-efficacy. Specifically, studies including a comparison of self-reported scores on the REFTOR with observer ratings and/or client reported outcomes may be helpful.

A second limitation is that participants self-selected for the study. It is possible that participants choose to respond because of a unique interest in the population or topic. Although responses showed normalized variability, results may not generalize to other trainees and professionals.

A third limitation is the relatively small sample size. While literature suggests that the sample was adequate for an EFA if the data are of quality, a larger sample size would have provided more reliable results. Larger sample sizes may be especially helpful at determining underlying constructs of the REFTOR measure, and would also allow for a Confirmatory Factor Analysis to be conducted.

A fourth limitation of this study was that I did not gather more extensive evidence to support the criterion related and construct validity of the REFTOR. Regarding criterion related validity, assessing actual client outcomes for clinicians working with refugee torture survivors would have been one way to gather evidence for the effectiveness and validity of the REFTOR measure. Regarding construct validity, while the use of experts in the construction of the measure supports construct validity and evidence of how the

constructs behaved in subsequent analyses was obtained, there are currently no known other measures of counseling competency with refugee torture survivors with which to gather empirical evidence in this area. Additionally, this study did not obtain evidence of discriminant validity for the REFTOR.

A fifth limitation for this study was the poor reliability of the social desirability measure. The lower internal consistency of the SOC DESIRE MC 2(10) in this study makes the correlations found with the REFTOR full scale and Efficacy subscale difficult to interpret. Further, responses to the measure that the REFTOR was adapted from have been shown to not be significantly influenced by social desirability (Kim et al., 2003). Future research may benefit from including various measures of social desirability to validate the REFTOR.

As these limitations suggest, there are several opportunities for future research highlighted in this study. Many of these opportunities lie in extending this study's findings, as outlined above. Future research should focus on gathering additional evidence to further shape and understand the REFTOR measure. A larger sample may provide better information regarding the underlying constructs in the REFTOR, and utilizing multi-modal assessment methods would provide valuable information regarding the measure's validity. Future research should also evaluate the effectiveness of various types of training for mental health professionals in working with refugee torture survivors. The findings herein, despite study limitations, suggest that greater programmatic attention to training in this area is clearly warranted.

Conclusion

The REFTOR is the first instrument to measure counseling competencies regarding work with refugee torture survivors. Results suggest that the REFTOR has clinical and research potential, specifically as a measure of clinician self-efficacy and awareness in counseling refugee torture survivors. Although the measure needs to be further validated, it represents a promising tool for understanding and improving current services offered to refugee torture survivors with potential for use in research and training settings. Additionally, this study provides important information regarding current training experiences related to the mental health treatment of refugee torture survivors and clinician and trainee attitudes towards torture. Findings suggest that current training experiences are limited, and mostly consist of reading articles. This information may be useful in further shaping courses and practica to improve training in this area. Attitudes towards torture varied considerably though a considerable number of participants endorsed torture in some circumstances and reported uncertainty about the morality of psychologists' professional involvement in torture. Results further indicate that clinicians' attitudes towards torture influence the counseling process with refugee torture survivors. This information may be useful in developing and improving training in professional ethics. In summary, findings from this study increase our understanding of what is currently happening in the field in regards to training and attitudes relevant to counseling refugee torture survivors and informs future training to improve services for refugee torture survivors. This study also provides a promising new tool with clinical, research, and training applications.

APPENDIX A

DEMOGRAPHICS AND TRAINING QUESTIONNAIRE

(DEMO-TRAIN; FURR & CHRONISTER, 2009)

(Items 1-5 were created to measure **Demographics**)

1. What is your age _____

2. What is your gender? Female _____ Male_____
   Transgender/Other_____

3. Race/Ethnicity: *please mark all that apply*
   _____ Black or African-American
   _____ White or European-American
   _____ Hispanic
   _____ Latino(a)
   _____ Chicano(a)
   _____ Asian or Asian-American
   _____ Native American or Alaskan Native
   _____ Pacific Islander
   _____ Middle Eastern
   _____ Multi-ethnic (please specify)_____
   _____ Other (please specify) _____

4. Please Indicate your Highest Degree Completed To Date
   _____Master of Arts (MA)
   _____Master of Science (MS)
   _____Master of Social Work (MSW)
   _____Master of Education (MEd)
   _____Doctor of Philosophy (PhD)
   _____Doctor of Psychology (PsyD)
   _____Other: Please specify_____

5. Area of Specialization/Area of Emphasis (please select only one):
   _____Clinical psychology
   _____Counseling psychology
   _____School psychology
   _____Marriage and Family Therapy or Couples and Family Therapy
   _____School counseling
   _____Rehabilitation counseling
   _____Other: Please specify_____

(Items 6 - 12 were created to measure **Training - General Counseling**)

6. Are you currently registered as a student in a human service-related training program?
___Yes ___No

If you answered 'Yes' to question 6, please continue to question 7.
If you answered 'No' to question 6, please skip to question 10.

7. Please indicate your year in the current graduate program
_____First year
_____Second year
_____Third year
_____Fourth year
_____Fifth year
_____Sixth or more

8. Are you currently in a practicum/internship/externship placement?
___Yes ___No

9. Are you currently providing direct clinical services to clients as a program-related experience?
___Yes ___No

10. For how many total **MONTHS** have you provided services to clients in the following settings?
_____College or university counseling center
_____Veterans Administration (VA) hospital
_____Other hospital setting (please specify:)_____
_____Community college counseling center
_____Community mental health agency
_____High School
_____Middle School
_____Elementary School
_____Other (please specify:)_____

11. As of today, for approximately how many clients have you provided direct clinical services in a clinical setting?
_____None
_____1-5
_____6-10
_____11-20
_____21-30
_____31-40
_____more than 40 clients

12. How many years of direct counseling service provision experience do you have with all populations? _____

(Items 13 - 17 were created to measure **Training – Coursework**)

13. Please indicate the number of **undergraduate courses** in which you received information dealing with issues related to refugee torture survivors:

None One Two Three Four or more

14. Please indicate the number of **graduate courses** in which you received information dealing with issues related to refugee torture survivors:

None One Two Three Four or more

15a. Please indicate the number of lectures or presentations you have attended in which you received information dealing with refugee survivors of torture.

_____None
_____1
_____2
_____3
_____4
_____5
_____6 or more

15b. Please indicate the setting in which the lectures/presentations occurred (mark all that apply).

_____Undergraduate coursework
_____Required graduate coursework
_____Elective graduate coursework
_____Local conferences. Please identify_____
_____Regional conferences. Please identify_____
_____National conferences. Please identify_____
_____Community-based trainings or workshops
_____Presentations sponsored by an adoption agency
_____Other. Please specify_____

16. Please indicate the number of **EMPIRICAL** articles you have read in which you received information dealing with refugee survivors of torture.

_____None
_____1-3
_____4-6
_____6-10
_____11 or more

17. Please indicate the number of **NON-EMPIRICAL** articles you have read in which you received information dealing with refugee survivors of torture.

_____None
_____1-3
_____4-6
_____6-10
_____11 or more

(Items 18 - 20 were created to measure **Training – Field Work**)

18. How many clients have you provided direct therapy services to who identified as refugee survivors of torture? _____

19. How many clients have you provided direct therapy services who had family members who identified as refugee survivors of torture? _____

20. To what extent have your practicum or clinical supervisors discussed people's experiences of torture and mental health treatment issues relevant to refugee torture survivors?

(1) never (2) rarely (3) sometimes (4) often

(Items 21 - 23 were created to measure **Training – Other Info**)

21. At this time, how would you react to the following statement: I am well prepared to deal with issues related to refugee torture survivor clients in a therapeutic setting?

strongly disagree	disagree	agree	strongly agree

22. What additional training would you want about the experiences of refugee survivors of torture and working clinically with this population? (mark all that apply)

___formal CE or course training
___formal class content
___informal observation of service provision
___reading materials
___supervised direct service provision
___videos
___none at this time

23. What kind information or topics related to the mental health treatment of refugee torture survivors would you like to learn more about?

Thank you for your participation!

APPENDIX B

ATTITUDES TOWARDS TORTURE QUESTIONNAIRE

(ATTITUDES; ADAPTED FROM BEAN ET AL., 2008)

We want to know more about your experiences and perceptions around torture in general. There are no incorrect answers. Your honest responses will help us better understand the views of psychology practitioners and trainees. Please select the answer that is honestly true for you; not the answer you anticipate to be the "right" one. Thank you for your participation.

Directions: *Please read each of the following statements carefully and click on the answer that best reflects your agreement with the statement.*

a. strongly agree b. agree c. undecided d. disagree e. strongly disagree

1. The use of torture should be prohibited as a matter of state policy – PERIOD

2. Rare exceptions for the use of torture can be condoned under extreme circumstances by legitimate state agents

3. The use of torture to elicit information from captives is immoral and intrinsically wrong

4. If there is the "slightest belief" that life-saving information can be obtained, it is permissible to use torture

5. Under extreme conditions, it is permissible for interrogators to yell at prisoners and to use psychological intimidation

6. It is permissible for psychologists to treat individuals and assess their mental health so as to inform torturous interrogation procedures.

7. Information obtained using torture techniques is reliable.

8. Torture is sometimes necessary for the greater good.

9. Having strict oversight by authority when using torture techniques decreases the long-term physical and psychological impact on detainees.

APPENDIX C

REFUGEE TORTURE COUNSELING COMPETENCY ASSESSMENT

(REFTOR; FURR & CHRONISTER, 2009)

ORIGINAL ITEM POOL

We want to know more about your general experiences with and perceptions about refugee torture survivors, and your specific counseling experiences with refugee torture survivors. There are no incorrect answers. Your honest responses might help us better understand how to prepare mental health clinicians to work effectively with clients who are refugee torture survivors.

Please select the answer that is true for you; not the answer you anticipate to be the "right" one. Thank you for your participation.

Directions: *Please read each of the following statements carefully and choose the answer that best reflects your agreement with the statement.*

(ASSESSING AWARENESS)

How would you react to the following statements?

(1)	**(2)**	**(3)**	**(4)**
strongly disagree	*disagree*	*agree*	*strongly agree*

1. Torture is a widespread practice across the globe.

2. Discussing political issues of the host and home countries in counseling is helpful in the mental health treatment of refugee torture survivors.

3. It is generally important for therapists to address refugee torture survivors' experiences of power both in and out of the counseling relationship.

4. Refugee torture survivors have limited access to the mental health assistance they need.

5. It is preferred that interpretation services in therapy with refugee torture survivors be conducted by a professional who speaks the appropriate language and who is not a relative or friend of the survivor.

6. The impact of a torture experience is largely independent of its duration and severity.

How would you react to the following statements?

(1)	**(2)**	**(3)**	**(4)**
strongly disagree	*disagree*	*agree*	*strongly agree*

7. Male and female refugee torture survivors generally experience different types of torture.

8. The social aspects (e.g. role of relationships in torture, the impact of torture on relationships) of torture and survivorship should be a primary focus of mental health treatment with refugee torture survivors.

9. The treatment of refugee torture survivors does not need to focus primarily on the experience of torture.

10. Most refugee torture survivors will not benefit from promotion of a sense of psychological independence in counseling

11. Even basic implicit concepts such as "torture" and "health" may need to be defined in counseling with refugee torture survivors.

12. The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of refugee torture survivors.

13. The effectiveness of counseling with refugee torture survivors may be impacted by a counselor's beliefs about torture.

14. I am aware of issues relevant to providing competent counseling services for refugee torture survivors.*

(ASSESSING KNOWLEDGE)

At the present time, how would you rate your understanding of the following terms and concepts?

(1)	**(2)**	**(3)**	**(4)**
very limited	*limited*	*good*	*very good*

15. "impact of torture"

16. "sequelae of torture"

17. "therapeutic triangle"

At this point in your life, how would you rate your understanding of…

(1)	**(2)**	**(3)**	**(4)**
very limited	*limited*	*good*	*very good*

18. the values, beliefs, and practices around health and healing in various global cultures?

19. the social norms (e.g. family structure, gender roles) in various global cultures?

20. the various experiences of migration?

21. the various legal statuses of migrants in the United States?

22. how refugee torture survivors commonly present in clinical settings?

23. the healing process for refugee torture survivors?

24. the skills interpreters need to provide mental health services to refugee torture survivors?

25. noncompliance issues with refugee torture survivors?

26. the ethics code for interpreters?

27. how torture impacts family dynamics?

28. the necessary knowledge to provide competent counseling services for refugee torture survivors?*

(ASSESSING SKILLS)

How well would you rate your ability to…

(1)	**(2)**	**(3)**	**(4)**
very limited	*limited*	*good*	*very good*

29. address issues around power and control in the therapeutic relationship with refugee torture survivors?

30. effectively consult with other professionals as needed when providing mental health services to refugee torture survivors?

31. facilitate refugee torture survivors connecting with other resources that they need?

How well would you rate your ability to…

(1)	**(2)**	**(3)**	**(4)**
very limited	*limited*	*good*	*very good*

32. adapt current models of therapy to meet the needs of refugee torture survivors?

33. engage in effective self-care while providing mental health services to refugee torture survivors?

34. use mental health assessments and interventions in a way that is culturally appropriate when working with refugee torture survivors?

35. identify appropriate language interpreters to work with you in the therapy context with refugee torture survivors?

36. co-create a treatment plan with a refugee survivor of torture client?

37. provide a diagnosis without invalidating the survivor's experience?

38. identify conditions that are commonly comorbid among refugee torture survivors?

39. discuss the political and social history of a survivor's home country?

40. accurately assess the needs of female refugee torture survivors?

41. accurately assess the needs of male refugee torture survivors?

42. provide competent counseling services for refugee torture survivors? *

*** = Validation Items**

APPENDIX D

MARLOWE-CROWNE 2(10) SOCIAL DESIRABILITY SCALE

(SOC DESIRE MC2(10); STRAHAN & GERBASI, 1972)

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

1. I never hesitate to go out of my way to help someone in trouble. (T)
2. I have never intensely disliked anyone. (T)
3. There would have been times when I was quite jealous of the good fortune of others. (F)
4. I would never think of letting someone else be punished for my wrong doings. (T)
5. I sometimes feel resentful when I don't get my way. (F)
6. There have been times when I felt like rebelling against people in authority even though I knew they were right. (F)
7. I am always courteous, even to people who are disagreeable. (T)
8. When I don't know something I don't at all mind admitting it. (T)
9. I can remember "playing sick" to get out of something. (F)
10. I am sometimes irritated by people who ask favors of me. (F)

Scoring Algorithm

For each answer the respondent provides that matches the response given above (i.e., T=T or F=F) assign a value of 1. For each discordant response (i.e., the respondent provides a T in place of an F or an F in place of a T) assign a value of 0. Total score can range from 10 (when all responses "match") to 0 (when no responses "match").

APPENDIX E

INFORMED CONSENT FORM

You may print a copy of this form for your records.

You are invited to participate in a research study conducted by Gina Prendes-Lintel Furr, a doctoral candidate in the counseling psychology program at the University of Oregon. The purpose of the study is to expand current knowledge and awareness about the needs of counselor education and training.

You are eligible to participate in this study if you are 18 years or older, have or are working toward of a Masters or Doctoral degree in clinical or counseling psychology (including M.A., M.S., Ph.D., and Psy.D.), provide direct client services to adults, children, groups, and/or families in any agency or private practice context, and are able to write and speak English. You will be asked to fill out a survey which will take approximately 10-15 minutes. Participation in the study is completely voluntary, and you may discontinue participation at any time without penalty. Only the researcher will have access to survey materials.

By participating in the study, you are making a significant contribution to research that may enhance counselor training based on findings from this study. Further, responses will enable counselors and psychologists to develop and apply more effective strategies when addressing clinical practice and training. A potential benefit from participating in this study is increased awareness about counselor training issues.

As a participant in this study, you will have the opportunity to participate in a confidential raffle in which you may enter to win one of three $75 gift certificates for Amazon.com. If you choose to participate in this raffle, you will submit your contact information (phone number and email address) in addition to the answers on your survey battery. Your identifying and contact information will *not* be linked in any way to your answers in the survey battery. Upon completion of my participant recruitment process, I will randomly select three participants who will win a $75 Amazon.com gift certificate. You will have a 1 in 60 chance of winning.

If you have any questions or concerns about the survey or your participation, please feel free to contact the primary researcher or her research advisor:

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If you have questions regarding your rights as a research subject, contact the Office for Protection of Human Subjects, University of Oregon, Eugene, OR 97403, (541) 346-2510. This Office oversees the review of the research to protect your rights and is not involved with this study.

Selecting the consent box indicates that you have read and understand the information provided above, and that you willingly agree to participate with the option to withdraw your consent at any time and discontinue participation without penalty.

APPENDIX F

PARTICIPANT RECRUITMENT LIST

Requests were sent to the following organizations at least two times, in some cases three due to recommendations based on timing on requests. I do not know how many forwarded the request to the listserv. Additionally, I do not know how many people forwarded to recruitment request to other colleagues.

- Lane County Psychology Society
- Oregon Psychological Association
- ACA listservs
    - COUNSGRADS listserv
    - Multiracial/Multiethnic Counseling Concerns Interest Network
    - Traumatology Interest Network
    - AACE
    - ACCA
    - ACES
    - AMCD
    - ARCA
    - C-AHEAD
    - CSJ
    - ACA Midwest Region
    - ACA North Atlantic Region
    - ACA Western Region
- Members of the National Consortium of Torture Treatment Programs
    - Florida Center for Survivors of Torture
    - Marjorie Kovler Center
    - Boston Center for Refugee Health and Human Rights
    - HPRT (Harvard Program in Refugee Trauma)
    - International Survivors Center
    - ASTT (Advocates for the Survivors of Torture and Trauma) Center
    - ACCESS Psychosocial Rehabilitation Center
    - CVT (Center for Victims of Torture)
    - Center for Survivors of Torture and War Trauma
    - War Trauma Recovery Project
    - Cross Cultural Counseling Center
    - Bellevue/NYU Program for Survivors of Torture
    - Doctors of the World
    - International Trauma Studies
    - Torture Treatment Center of Oregon

    - Center for the Prevention and Resolution of Violence
    - Center for Survivors of Torture (AACI)
    - Survivors International of Northern California
    - Survivors of Torture, International
    - Institute for the Study of Psychosocial Trauma
    - Los Angeles-Program for Torture Victims
    - Rocky Mountain Survivor Center
    - Khmer Health Advocates
- Training listservs
    - CCPTP (Council of Counseling Psychology Training Programs)
    - CUDCP (Council Of University Directors of Clinical Psychology)
    - ADPTC (Association of Directors of Psychology Training Clinics)
- APA listservs
    - Clinical Psychology of Ethnic Minorities
    - SSCPNet listserv (Society for a Science of Clinical Psychology)
    - Div 45 (Ethnic Minority Issues)
    - Div 56 (Trauma)
    - Div 42 (Independent Practice)

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