Speech-Language Pathologists' Counselor Self-Efficacy

by

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Abstract

The purpose of this study was to measure and determine the factors that influence counseling self-efficacy in speech-language pathologists. Data was collected through an anonymous 95-question web-based survey. Five hundred and twenty-seven completed responses were received. The results indicated that participants in the study were confident in their counseling abilities and skills; however, lesser confidence in skills related to personal adjustment counseling were observed. Further, it was found that emotional intelligence, internal locus of control, counseling training and years of experience all had a significant positive relationship with counseling self-efficacy. From this, it can be concluded that speech-language pathologists can increase their counseling self-efficacy through increased training opportunities and experiences, development of greater emotional intelligence, and by having an internal locus of control.

Table of Contents

List of Tables

List of Abbreviations

ASHA   American Speech-Language and Hearing Association

ANOVA   One-way Analysis of Variance

CASES   Counselor Activity Self-Efficacy Scales

CASESslp The Counselor Activity Self-Efficacy Scales for SLPs

CEU   Continuing Education Unit

COSE   Counselor Self-Estimate Inventory

CSES   Counselor Self-Efficacy Scale

CSE   Counselor Self-Efficacy

EI   Emotional Intelligence

EJI   Emotional Judgment Inventory

LoC-C   Chance Locus of Control

LoC-I   Internal Locus of Control

LoC-P   Powerful Others Locus of Control

SLP   Speech-Language Pathologist

STAI   State-Trait Anxiety Inventory

TEIQue   The Trait Emotional Intelligence Questionnaire

TEIQue-SF The Trait Emotional Intelligence Questionnaire Short Form

WLCS   Work Locus of Control Scale

Chapter I

Introduction

Counseling in the Field of Communication Disorders

The American Speech-Language-Hearing Association (ASHA) has long recognized counseling as a necessary component of speech-language pathology. Counseling was originally included in ASHA's Scope of Practice for speech-language pathologists (SLPs) in 1997 and continues to be incorporated in the most recent versions (ASHA, 2016). According to ASHA (2016), there are eight domains of speech-language pathology service delivery: collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology and instrumentation; and population and systems. For SLPs, counseling takes form through helping individuals manage, adjust to, and cope with their disorder (DiLollo & Neimeyer, 2014). It is vital that an SLP is aware of their role in counseling, understanding that it involves more than simply giving advice. Individuals with communication disorders often experience diverse and complex emotional reactions to their diagnoses and the experiences that accompany them (Victorino & Hinkle, 2019). "To have a communication disorder is also to have strong feelings; this is true for both the client and his or her family" (Luterman, 2017, p. 47).

It is important to note that counseling in the field of speech-language pathology does not refer to the treatment of mental health disorders. Instead, counseling in the field of speech-language pathology refers to counseling families, caregivers, and persons with communication and swallowing disorders by providing support, education, and guidance. Barone (2016) details example situations that are within and outside of an SLP's counseling scope of practice. Examples of issues outside an SLP's counseling scope of practice include diagnosed mental health disorders, issues not related to the communication disorder, suicidal thoughts, and drug or

alcohol dependencies (Barone, 2016). When clients experience something outside of the SLP's scope of practice, it is required that an appropriate referral to a trained counseling professional be made (Barone, 2016). Ultimately, ASHA (2016) specifies that SLPs are responsible for counseling clients during interactions related to thoughts, feelings, emotions, and behaviors resulting from their communication disorder. This includes counseling both clients and their families on acceptance, adaptation and decision making regarding their diagnosis. Two main types of counseling often discussed in literature are informational and personal adjustment counseling, both of these fall under the purview of SLPs (Flasher & Fogle, 2012). Informational counseling involves education and discussion about the nature of the communication disorder, options for treatment interventions, prognosis and providing resources or materials to the client and their families/caregivers. Personal adjustment counseling acknowledges and addresses the thoughts, feelings, emotions and beliefs of the client and their families/caregivers regarding the communication disorder.

The emotional and psychological impact of communication disorders have been identified for many years, dating back to as early as the 1930's (Orton, 1937). According to Phillips and Mendel (2008), clinicians must not only be aware of the anatomical and physiological effects of communication disorders on a client, but also of how the disorder affects the client both psychosocially and emotionally. To conduct effective counseling, the SLP should be able to identify the emotional state and coping mechanisms of the client or their family members (Gold & Gold, 2018). Speech-language pathology is considered a helping profession, where treatment is provided with the goal of promoting positive outcomes (Lieberman, 2018). The same is true for the field of counseling, it too is considered a helping profession with the goal of treatment for positive change. Although training, techniques, and scope of practice differ

8

for these fields, there is overlap between the professions and they are unified through the basis of a helping relationship. During counseling, thoughts, feelings and behaviors are collaboratively explored between the clinician and client. This is a time where empathy, trust, and rapport are built, strengthening what is known as the therapeutic alliance. The therapeutic alliance is considered the basis of trust and a bond between the clinician and client (Freckmann, Hines, & Lincoln, 2017). In a study on therapeutic alliances between SLPs and individuals who stutter, Plexico, Manning, and DiLollo (2010) found the therapeutic alliance to be a key factor in successful intervention.

Counseling Training for SLPs

As stated in the 2016 ASHA Code of Ethics, SLPs should be properly educated and trained to provide the services offered within their scope of practice. Additionally, they should only engage in areas within their scope of practice and competence. For SLPs, counseling training typically occurs through graduate coursework, clinical practicum experience, and continuing education. There is extensive supervised clinical training in SLP graduate education programs. However, previous research has shown that there has been a significant lack of dedicated counseling training in the field of communication disorders. McCarthy, Culpepper, and Lucks (1986) reported that within accredited communication disorder programs only 40% offered counseling courses within the department and 23% offered no courses at all. A repeat of this survey was conducted eight years later and reported little notable change in the number of counseling courses offered (Culpepper, Mendel, & McCarthy, 1994). These findings indicate that there was not only a severe lack of counseling specific course training within accredited programs but also counseling training and experience within these programs were not advancing. In 2008, Phillips and Mendel surveyed clinical fellows regarding counseling training and

feelings of preparedness in conducting counseling activities. Eighty percent of respondents reported receiving no counseling training during graduate school. Of the participants surveyed, 93% agreed or strongly agreed that it was within the SLPs role to provide counseling services.

Sekhon et al. (2019) conducted a systematic review on counseling training for SLPs working with post-stroke aphasic patients. When comparing pre- and post-qualification counseling training, Sekhon et al. (2019) found that pre-qualification counseling training covered a range of clinical areas and more general counseling approaches. They found that the amount of pre-qualification counseling training speech-language pathology students received to counsel patients with aphasia was unclear. They also found that clinical areas in communication disorders outside of post-stroke aphasia had similar results, unclear or unreported amounts of training (Culpepper et al., 1994; McCarthy, Culpepper, & Lucks, 1986; Sekhon, Oates, Kneebone, & Rose, 2019). In post-qualification counseling training the training became more domain specific, targeting certain clinical areas (Sekhon et al., 2019). However, in one study they reviewed, the majority of SLPs reported receiving no additional training in counseling or psychology following their degree (Sekhon, Douglas, & Rose, 2015). Current research suggests counseling training is still insufficient in the field of communication disorders (Luterman, 2020). A recent unpublished survey examined 72 master's programs in speech-language pathology and results of the survey indicated approximately half of the programs offered a counseling course and only 25% of those courses were required (Luterman, 2020). These findings are unfortunately consistent with surveys conducted over two decades ago. Although it is clear that counseling is an essential component of the evaluation and treatment process, research has shown that counseling training in SLP graduate programs is severely underrepresented.

As noted by Atkins (2007), lack of adequate clinical practicum experiences and academic instruction for counseling can lead to decreased positive outcomes when treating communication disorders. In their study investigating recent speech-language pathology and audiology graduates, Phillips and Mendel (2008) determined that when clinical fellows were asked about their feelings of preparedness and comfort in providing counseling services, only 33.3% of participants surveyed felt ready to conduct counseling after graduation. Millar et al. (2010) stated that an absence of formal counseling training in graduate-level programs leads to SLPs having limited learning and skill development opportunities prior to work experiences. Due to lack of experience and training in counseling, SLPs can lack confidence in their counseling abilities (Millar et al. 2010). Currently, the inherent characteristics that contribute to an SLPs counseling self-efficacy are unknown and have yet to be investigated.

Self-Efficacy

Self-efficacy is an integral component of Albert Bandura's social cognitive theory. Self-efficacy refers to an individual's belief about his or her ability to perform a particular behavior and the confidence to perform that behavior with success (Bandura, 1977). Social cognitive theory explains human actions through the interaction of behavior, personal traits, and the environment (Bandura, 1989). Bandura (1977) asserted that successful execution of a behavior requires not only skills and knowledge but also efficacy expectations and outcome expectations. Efficacy expectations refer to one's belief in their ability to successfully execute the behavior necessary for the particular outcome (i.e., self-efficacy). For example, an SLP may have the efficacy expectation that they can treat a client with an expressive language delay. Outcome expectations refer to an estimate that a certain behavior will lead to a particular outcome (e.g., success). For example, an SLP may have the outcome expectation that to treat an expressive

language delay client successfully, you must have experience in that area. These two concepts are differentiated from each other because one can believe certain actions will produce a particular outcome, but if they have any doubts in their own abilities to perform, then their outcome beliefs do not positively influence their behavior to engage in the actions (Bandura, 1977). An individual can know that a given behavior (e.g., interviewing) can result in a given outcome (e.g., getting a job). However, having the knowledge that interviewing for a job can result in getting a job is not sufficient in and of itself. This is because if there are any doubts in the ability to execute the specific behavior (i.e., effectively interviewing) then the doubts will inhibit the individual's ability to make progress towards the desired outcome (i.e., getting a job). That is, knowledge of the behavior/outcome interaction is necessary, but not sufficient. One must also have beliefs in their own ability to produce such actions before the outcome can be achieved.

One's perceived self-efficacy takes part in determining their choice of settings and activities. Efficacy expectations affect both initial engagement and perseverance of behaviors. There is a tendency for individuals to avoid situations in which they believe are threatening and exceed their coping skills, whereas individuals typically engage in activities where they deem themselves capable (Bandura, 1977). Once a behavior is initiated, efficacy expectations of predicted success can affect coping efforts and persistence. Perceived self-efficacy also takes part in determining the level of effort one is willing to expend and the length of time they are willing to persevere through adversity. Bandura (1977) asserted that the higher an individual's perceived self-efficacy is, the more active their efforts will be. Additionally, he stated that those who persist through aversive experiences will acquire corrective experiences that diminish defensive behaviors and reinforce feelings of high self-efficacy. However, those who do not

persist and rather cease coping efforts prematurely, will reinforce and retain feelings of low self-efficacy (Bandura, 1977).

Self-efficacy was originally evaluated by Bandura (1977) who used a microanalytic methodology to measure perceived self-efficacy. Microanalytic methodology measures perceived self-efficacy by level, strength, and generality. Magnitude refers to the level of difficulty associated with a given task. For example, it is often considered easier to speak to a small group of people versus a large group of people. Generality refers to the degree to which an experience results in more task specific self-efficacy or generalizes to a broader range of efficacy expectations across a range of experiences. For example, self-efficacy with regard to communication ability would have greater generality than self-efficacy with regard to singing ability. Strength refers to the level of certainty a person has in their abilities to perform a specific task. For example, an SLP could be extremely confident (100%) in evaluating a stroke patient yet be far less confident (10%) in evaluating a voice patient. According to Bandura (1989), individuals with a high sense of self-efficacy can visualize success which will encourage positive performance, whereas individuals with a low sense of self-efficacy may visualize failure and undermine their performance.

It is theorized that there are four sources of information that determine expectations of self-efficacy: (1) performance accomplishments, (2) vicarious experience, (3) verbal persuasion, and (4) emotional arousal (Bandura, 1977). Performance accomplishments, also known as mastery experiences, refer to performing a behavior successfully. According to Bandura (1977), performance accomplishments are the most influential information source to perceived self-efficacy, because they are authentic and tangible experiences of favorable behavior performance. Performing counseling activities with prior success will increase perceived efficacy; whereas,

recurrent failures will weaken perceived self-efficacy, especially in the early stages of counseling (Ooi, Wan Jaafar, & Baba, 2018). Vicarious experience refers to learning through observing a successful modeled behavior. Though less influential than performance accomplishments, vicarious experiences are helpful in instances where the individual has limited experience in the target behavior. An individual can use information learned from vicarious experiences to judge their own chance of success for the same or similar tasks (Britner & Pajares, 2006). Verbal persuasion refers to listening to how to perform a behavior successfully. Efficacy expectations stemming from verbal persuasion are weaker than those stemming from performance accomplishments because a tangible experimental base is not provided (Bandura, 1977). Emotional arousal refers to physiological states and emotions that impact well-being. Examples of these physiological states that may inhibit increasing perceived self-efficacy include anxiety and stress. Generally, aversive emotional arousal causes debilitated performance. Success is more likely to be observed in individuals who are not beset by feelings of anxiousness and stress (Bandura, 1977).

Counselor Self-Efficacy and Treatment

There have been a number of studies conducted relating self-efficacy theory to the counseling process (Larson & Daniels, 1998; Larson et al., 1992; Lent, Hill, & Hoffman, 2003). Counselor self-efficacy (CSE) refers to one's self-perceived ability to perform counseling-related behaviors and effectively counsel a client (Larson & Daniels, 1998). The construct of self-efficacy and specifically CSE has been evaluated in a variety of ways.

The Counselor Self-Efficacy Scale (CSES; Johnson, Baker, Kipala, Kiselica, & Thompson, 1989) is among one of the first counselor specific efficacy measures developed. Following the CSES, the Counselor Self-Estimate Inventory (COSE) was developed by Larson

et al. (1992) and included the evaluation of more advanced counseling skills. In an extensive review of the literature, Larson and Daniels (1998) determined that the COSE was the most widely used measurement for CSE of the 32 studies they examined. Following the reviews and critiques of the literature on CSE (e.g., Larson, 1998; Larson & Daniels, 1998; Lent et al., 1998) Lent, Hill, and Hoffman (2003) developed the Counselor Activity Self-Efficacy Scales (CASES) to assess student's CSE based on conceptualization of their counseling skills. The counseling skills measured in the CASES are divided into three domains: (a) Helping Skills, (b) Session Management, and (c) Counseling Challenges. Victorino and Hinkle (2019) aimed to develop a tool to assess counseling skills specific to SLPs. Their scale was developed and adapted for SLPs from the CASES (Lent et al., 2003). The scale mirrors the original CASES with modifications to language such as replacing the word counselor with speech-language pathologist. The Counseling Challenges portion of the CASES was not included in the SLP adaptation. It was deemed as irrelevant to speech-language pathology due to containing challenges specific to psychological counseling. Instead, seven replacement questions were added, focusing on clinician confidence in responding appropriately to emotions expressed by clients or family members. For the purposes of this paper the CASES will be differentiated from the CASES for SLPs using the abbreviation CASESslp.

The construct of clinical or counselor self-efficacy has not been widely studied in the field of speech-language pathology. To date, there are only three published studies investigating SLPs clinical self-efficacy (e.g. Lee and Schmaman. 1987; Pasupathy and Bogschutz, 2013; Rudolf, Manning and Sewell, 1983), and one study to date investigating CSE in practicing speech-language pathologists (Victorino & Hinkle, 2019). It is important to distinguish perceived self-efficacy from actual clinical skills and performance. Although self-efficacy is not

15

a measure of proficiency, there is mixed evidence to support the relationship between the two. Sharply and Ridgway (1993) determined no relationship to be found between CSE and performance. However, validity estimates of the COSE indicate that it is positively related to counselor performance (Larson et al., 1992). Wan Jaafar, Mohamed, Bakar, and Ahmad Tamizi (2009), found a significant linear relationship between CSE and trainee performance when using the COSE as the measure of CSE. In their review of CSE literature, Larson and Daniels (1998) concluded that CSE has been shown to relate to counselor performance.

There are a number of factors that have been found to be significant predictors of CSE. In their review of CSE literature, Larson and Daniels (1998) found CSE to be predicted by anxiety, counselor characteristics, and work or training environment. Larson and Daniels also noted that CSE correlates positively with developmental level and performance of counselors. Indicating that counselors with more experience report higher CSE than those with less experience. In addition, they indicated that practicum experiences such as role playing, modeling and feedback can encourage self-efficacy.

CSE and Anxiety

Bandura (1977) postulated that there is an inverse relationship between self-efficacy and anxiety. Other studies have concluded similar findings in the field of counseling, demonstrating that CSE has been found to correlate negatively with anxiety (Barbee, Scherer, & Combs, 2003; Friedlander, Keller, Peca-Baker, & Olk, 1986; Larson & Daniels, 1998; Larson et al., 1992). To establish convergent validity when developing the COSE, Larson et al. (1992), presented correlations between the COSE and the State-Trait Anxiety Inventory (STAI; Spielberger, et al. 1970). The STAI (1970) consists of two 20 item questionnaires, one measures State Anxiety, or how one feels in the moment, while the other measures Trait Anxiety, how one feels in general.

Larson et al. (1992) found higher scores on the COSE correlated to lower scores on the STAI, in regard to both State and Trait Anxiety. This finding is consistent with the findings of Friedlander et al. (1986) who examined the effects of role conflict on student counselor's anxiety level, performance, and self-statements. They found an inverse relationship between anxiety and strength of student counselor's CSE ($r = -.34$, $p < .007$). Their study revealed student counselor performance was also inversely related to anxiety level (Friedlander et al., 1986). Validity estimates for the COSE (Larson et al., 1992) indicated that counselor performance is significantly predicted by anxiety and perceived counseling self-efficacy (i.e., the COSE; Larson et al., 1992). Using the COSE as the measure of CSE and the STAI (Spielberger, et al., 1970) as the measure of anxiety, Al-Darmaki (2005) found moderately significant correlations between COSE scores and State Anxiety ($r = -.50$) and Trait Anxiety (-.37). Barbee et al. (2003), in a study of the impact of prepracticum service learning on CSE and anxiety, noted a significant negative correlation between CSE and State Anxiety. Bandura's (1977) fourth phenomena influencing self-efficacy, emotional arousal, claimed the higher the arousal (e.g. anxiety or fear) the lower the self-efficacy. Research in the field of counseling has further examined this relationship and the literature strongly indicates an inverse relationship between anxiety and CSE.

CSE and Experience

As stated previously, Bandura asserted the most influential source of efficacy is through performance accomplishments, also known as mastery experiences. Mastery experiences in the field of counseling are prior successes performing the counseling behavior that elevate feelings of efficacy. Research in the field of counseling indicates that CSE can be influenced by experience and learning opportunities in training, with several studies supporting the positive

relationship between CSE and counselor training and experience (Larson & Daniels, 1998; Larson et al., 1992; Lent et al., 2003; Sipps, Sugden, & Faiver, 1988). Development and validation of the COSE found that CSE was significantly higher in individuals with more years of counseling experience, more advanced degrees, and more semesters of supervision (Larson et al., 1992). Sipps et al. (1998) found that when compared to first- and second-year counselor doctoral students, CSE was higher in fourth-year students. Lent et al. (2003) discovered changes in CSE across time, noting the tendency for CSE to increase when relevant experience increased. Additionally, it was discovered that CSE increased from the beginning of a practicum experience to the end. A significant positive relationship between training, years of clinical experience, developmental level, and CSE have also been determined (Barbee et al., 2003; Leach et al., 1997; Melchert et al., 1996)

Victorino and Hinkle (2019) analyzed the effects of experience on SLP's perceptions of counselor self-efficacy (CSE) using the scale they developed, the CASESslp. Multivariate analysis of variance was conducted using the CASESslp five subscales (Emotional Support Skills, Session Management Skills, Helping Skills-Insight, Helping-Skills Exploration, and Helping Skills-Action) as the dependent variables, and Experience as the between-subjects variable. They divided experience into four levels: current graduate students with less than 30 credits, graduate students with 30 credits and above, SLPs with master's degrees granted within the past 2 years, and SLPs with master's degrees granted between 2 and 5 years ago. Results of their study found that two categories of Helping Skills (Exploration and Action) were the most sensitive to the effects of experience. They also found an increase in confidence between first- and second-year graduate students with a slight decrease in clinician confidence during the first two years after graduating. Increases in confidence were again seen with the more experienced

clinicians. Overall findings included higher self-efficacy rating for skills associated with action, exploration, and session management than for skills associated with emotional management or development of insight (Victorino & Hinkle, 2019).

Emotional Intelligence

To be emotionally intelligent one must be highly aware of their own emotional state, others emotional states, and be able to manage them. Emotional Intelligence (EI) effects how you interact with the people around you. Taylor (2005) claimed the best way to define EI is to state what it is not. He stated EI is not being kind and friendly all of the time. It is not about being highly emotional or "touchy-feely" either (Taylor, 2005). He noted that unlike biological characteristics that cannot develop and adapt, EI can change and grow over time.

There are three major models of EI that can be identified in the literature. Each define EI somewhat differently, however, they are generally convergent (Petrides, 2011). In Salovey and Mayer's (1990) ability model, EI is defined as a type of social intelligence involving the ability to recognize the meanings and relationships of emotions, monitor personal and others' emotions, and use the understanding of emotions to guide one's thoughts and actions. Goleman's (2006) mixed model of EI details five main components of EI: self-awareness, self-regulation, motivation, empathy, and social skills. Self-awareness is defined as the ability to acknowledge and comprehended emotions, moods, drives, and their impact on others. A hallmark of self-awareness is self-confidence. An SLP who is self-aware knows their strengths, weaknesses, and limits. They recognize their own emotions and their effects. A self-aware SLP has a strong sense of self-worth (Rao, 2006). Self-regulation is defined as the ability to monitor and manipulate disruptive moods. A hallmark of self-regulation is integrity. A self-regulated SLP maintains control within therapy sessions. They do not allow personal emotions to interfere with work

performance. In counseling sessions, a self-regulated SLP would avoid judgement of the client and maintain composure and emotional distancing when faced with emotionally challenging confrontations (Rao, 2006). Motivation is defined as the passion to pursue goals with pure intentions and a strong desire to achieve success. A hallmark of motivation is optimism. Rao (2006) claims a trait that all effective leaders possess is motivation, and that most SLPs are leaders. A motivated SLP is one who seeks out challenges, strives for improvement, embraces change and does not stay stagnant. SLPs must motivate their clients within the session to continue therapy, be positive, and commit to the process (Rao, 2006). Empathy is defined as the ability to comprehend the emotions of other's and treat them accordingly. A hallmark of empathy is sensitivity. An empathetic SLP is one who is socially aware. They have the ability to perceive outside perspectives while taking genuine interest in others concerns (Rao, 2006). According to Lanser, (2000) the key to developing empathy is to listen. SLPs must listen and sense others needs and emotions in the counseling setting. Social skills are defined as the ability to build rapport with others skillfully while building relationship networks. A hallmark of social skills is persuasiveness (Rao, 2006). To an SLP, social skills is often termed as pragmatics. A pragmatic SLP has the ability to mediate conflict, make difficult decisions, persuade others and manage relationships (Lanser, 2000; Rao, 2006). An SLP who has strong social skills will develop meaningful relationships with clients, colleges, and others. They may have clients who stay in touch after being discharged. Social skills are a skill that can be capitalized. Once therapeutic relationships have been built, the SLP has more credibility in their persuasiveness. Competent social skills allow SLPs to use their EI skills more efficiently. Petrides' (2009) trait model of EI views EI as an individual's emotional self-perceptions. These emotional self-perceptions in conjunction with their emotional traits make up an individual's personality

(Petrides, 2009). In this model, EI is conceptualized in terms of personality (Petrides & Furnham, 2003). Petrides' trait model subsumes the above discussed Goleman model.

A large number of psychometric tools have been developed to assess EI. Due to previous varying operationalization's, an important conceptual distinction must be made when choosing an EI measure. Measurement tools for the construct of EI can be categorized into one of the three major models of EI. However, the literature typically categorizes them into either trait EI measures or ability EI measures (Petrides & Furnham, 2003). The third model, the mixed model, was introduced by Goleman (1998) and is typically subsumed under trait EI (Livingstone & Day, 2005). There is a fundamental difference between trait and ability EI. Trait EI, also known as emotional self-efficacy, examines typical performance using self-report questionnaires. Ability EI, also known as cognitive-emotional ability, measures maximum performance using maximal-performance tests. Trait and ability EI are two separate constructs conceptually, empirically and methodologically (Petrides, 2011). Using ability measures of EI can be problematic because emotions are a subjective experience and maximum performance tests include items or tasks that are scored objectively (Matthews, Zeidner, & Roberts, 2007; Robinson & Clore, 2002). Ability measures require participants to solve emotion-related problems (e.g., what emotion might someone feel preparing for a work evaluation? (a) happiness, (b) sadness, (c) nervousness, (d) all of the above). These questions have predetermined answers that are deemed to be correct or incorrect. Petrides, Fredrickson, and Furnham (2004) further elaborated on the problematic nature of using ability measures, noting that they simply assess an individual's ability to understand emotion and do not predict their typical behavior to demonstrate characteristics of EI.

The Trait Emotional Intelligence Questionnaire (TEIQue; Petrides & Furnham, 2009) is a widely used well-supported measure for trait EI. Petrides and Furnham (2009) view EI as an

aspect of personality, rather than a function of cognitive processes. The TEIQue yields 15 facets, four factors, and a global trait score. It consists of 153 items and uses a 7-point Likert scale ranging from strongly disagree (1) to strongly agree (7). The TEIQue possesses acceptable psychometric properties (Cooper & Petrides, 2010). The four main factors are emotionality, sociability, well-being, and self-control. There are two facets, adaptability and self-motivation, that contribute directly to the global trait EI score but do not represent any specific factor. The facets trait empathy, emotional perception, emotional expression, and relationships all fall into the emotionality factor. Emotion management, assertiveness, and social awareness fall into the sociability factor. Self-esteem, trait optimism, and trait happiness fall into the well-being factor. And finally, the facets of stress management, impulsiveness, and emotion regulation all belong in the self-control factor. The TEIQue also has a corresponding short form, the TEIQue-SF is popular due to its condensed format, allowing it to be used in many survey studies (Petrides & Furnham, 2009). The TEIQue-SF is a 30-item form that includes two items from each of the 15 trait EI facets included in the full form. Items in the short form were selected based on their correlations with the corresponding total facet scores. Although the short term does not yield scores for the 15 facets found in the full form, it is possible to derive scores from the four main trait factors. However, it is primarily intended to be a measure of global trait EI.

A variety of questionnaires have been developed to measure ability EI. However, the most widely used is the Mayer-Salovey-Caruso EI Test (MSCEIT; Mayer, Salovey, & Caruso, 2002). The MSCEIT is an ability measurement based on the Mayer and Salovey model and is one of the most researched and supported measures. The MSCEIT consists of 141 total items and provides 15 main scores. The scores provided include a total EI score, two area scores, four

branch scores, and eight task scores. Internal consistency reliabilities of 0.91 for the full scale and test-retest reliability of 86 was reported (Mayer et al., 2002; 2003).

CSE and EI

Strong relationships have been identified between EI and CSE (Easton, Martin Jr, & Wilson, 2008; Martin Jr, Easton, Wilson, Takemoto, & Sullivan, 2004). Consistent with behaviors related to CSE, EI encompasses the ability to use emotion to plan, problem solve, make decisions, and understand others (Easton et al., 2008). Martin et al. (2004) investigated the association between EI and CSE and found that EI predicted CSE perceptions in both student and professional counselors. In a continuation of the Martin et al. (2004) study, Easton et al. (2008) conducted a nine month study examining the relationship between EI and CSE with 180 counselors, Easton et al. (2008) found that student and professional counselors who determined themselves to have high CSE, as rated by the COSE, also perceived themselves to have high EI as rated by the Emotional Judgment Inventory (EJI; Bedwell, 2003). Whereas counselors with perceived low efficacy were found to have low perceptions in their ability to use emotions within problem-solving tasks. Additionally, they found that when compared to the general population, counselor trainees scored higher on the EJI. The results of this two-part study suggest that EI is an attribute that competent counselors inherently have. In fact, Easton et al. (2008) demonstrated that the EJI had a statistically significant relationship with CSE, with CSE being predictive of EJI scores. A major finding of both studies was the significance of the counselor's ability to identify their own emotions and skills as it relates to their CSE. This is directly tied to self-awareness, the first of five main components of EI as stated by Goleman (1998). The ability to clearly identify personal emotions in an essential skill in any counseling environment due to the extent of emotions counselors will come across when working with clients in addition to how

these emotions will affect how the conduct themselves in response to clients. Akinlolu and Chukwudi (2019) conducted a study examining the predictive relationship between CSE and professional commitment with mediating factors of EI and gender identification. Using the CASES (Lent et al., 2003) as a measure of CSE, Akinlolu and Chukwudi (2019), found that CSE had significant relationship with counselor commitment, with EI as the mediator of that relationship. In their test for mediation, they found that EI was found to be a statistically significant predictor of the CASES.

Reick (2013) examined the relationship between EI and client outcomes in 32 student counselors and their 133 clients. Results of his study demonstrated that counselors who had higher EI had better client outcomes with greater positive client change. Comparatively, those with low EI elicited worse client outcomes. In their meta-analysis, O'Boyle, Humphrey, Pollack, Hawver, and Story (2011) concluded that EI has been shown to have a positive impact on job performance.

Locus of Control

Locus of control is a concept central to social psychologist J.B. Rotter's (1954) earlier work on social learning theory. Social learning theory proposes that an individual forms beliefs and expectancies about a particular behavior resulting in an outcome. As these beliefs and expectancies strengthen through reinforcement, a person begins to generalize beliefs about the future. The generalization of these expectancies are what affirms one's locus of control (Foon, 1987). Locus of control is the degree to which an individual believes they can control the events around them. It is an important variable of personality and it varies from person to person (Rotter, 1966). According to Rotter (1966), a person can be considered to have an internal locus of control, where they feel they have power over their own destiny, or an external locus of

control, where they feel their destiny is controlled by others. An example of having an internal locus of control would be feeling that to be successful, you must work hard. An example of having an external locus of control would be feeling that to be successful, you must have luck. Locus of control is a continuum, with many people falling somewhere between the extremes of total control (internal locus) and no control (external locus) (Luterman, 2017).

Since its development, Rotter's (1966) Locus of Control Scale has been majorly popular and widely accepted as a measurement tool. Rotter's original scale used a forced choice format for 29 items, including six filler items. Each item in Rotter's scale contained two statements, one referring to internal locus of control and one referring to external. Internal consistency estimates reported by Rotter ranged from .69 to .73 with test-retest reliability of .72. Rotter believed that locus of control was a one-dimensional construct and initially, suggested that his scale consisted of one general factor. However, this has since been challenged. In a response to criticism of Rotter's unidimensional general scale, Levenson (1974) developed a 24-item multidimensional scale using a six-point Likert-type format. Levenson's scale used Rotter's same concept of internality, however, she distinguished between two different types of externality, chance and powerful others. Levenson's scale consists of three subscales, Internal (LoC-I), Chance (LoC-C), and Powerful Others (LoC-P) that are each comprised of eight items. Internal consistency and reliability estimates for the subscales were .64, .78, and .77, respectively. Levenson suggests that for internality, individuals with high LoC-I believe that they have the ability to create their own changes and play a significant role in directing their own lives. For externality, individuals with high LoC-C believe in chance or fate while individuals with high LoC-P believe that their lives are directed by powerful individuals.

Therapeutic Constructs Related to Locus of Control

A number of factors potentially influencing locus of control have been investigated. Among these are stress, burnout, self-control, performance, and success. Many of these factors are constructs relevant to therapy. Evidence suggests that those with an internal locus of control exhibit greater self-control than those with an external locus of control (James, Woodruff, & Werner, 1965; MacDonald, 1970; Straits & Sechrest, 1963). Locus of control has also been investigated as a potential moderator of stress. External locus of control has been shown to relate to greater levels of stress, burnout and emotional exhaustion within helping professions including counselors, mental health professionals and nurses (Injeyan et al., 2011; Koeske & Kirk, 1995; Schmitz, Neumann, & Oppermann, 2000). Gray-Stanley et al. (2010) studied work stress and depression among professionals who served adults with intellectual and developmental disabilities and found that those who were stressed were also more likely to be depressed. They found that workers with an internal locus of control were less likely to be depressed.

CSE and Locus of Control

Locus of control is a concept central to all counseling techniques (Luterman, 2017). According to Luterman (2017), when counseling, an SLP must relinquish control to the client so that the client can feel enabled to make changes. Though the constructs of CSE and locus of control have been well studied separately, there has been limited research conducted on locus of control as it relates to CSE. However, of the available research on locus of control and counseling for communication disorders, much of it focuses on the orientation of the client, not the clinician. Client locus of control has been investigated within communication disorders such as people who stutter and those with hearing impairments. Harper (2008) investigated clinician locus of control in counselors. She hypothesized that a counselor with an internal locus of control

would have higher CSE, and a counselor with an external locus of control would have lower CSE. She examined the impacts of locus of control and tolerance of ambiguity on perceived CSE among doctoral student counselors. The CASES was used to measure CSE and the Work Locus of Control Scale (WLCS; Spector, 1988) was used to measure locus of control. Findings of the study supported her original hypothesis revealing a statistically significant positive relationship ($p < .01$) between internal locus of control and high CSE and external locus of control and low CSE in doctoral students.

Abundant research on counseling effects of clinician locus of control is in short supply. As Levenson suggested, those with an internal locus of control feel they have the capacity to make changes and are in control of dictating the outcomes of their life. Those with an external locus of control tend to fault others or their surroundings for the circumstances surrounding them. Discovering locus of control orientation as it pertains to perceptions and abilities of counseling skills in SLPs could provide insight to why some SLPs have greater or lesser CSE.

Justification

Counseling is a fundamental competency and an expected role of SLPs. Currently, there are limited studies investigating how practicing SLP's feel about their counseling skills or what constructs influence those perceptions (Luterman, 2020). There is a dearth of evidence pertaining to practicing SLPs' self-efficacy with few studies to date investigating clinical or counselor self-efficacy in practicing speech-language pathologists. There is; however, decades of research on CSE in related disciplines. Specifically, factors pertaining to increased CSE have been investigated heavily in helping professions similar to speech-language pathology and indicate strong relationships between CSE and EI (Easton et al., 2008; Martin Jr et al., 2004). Locus of control has also been identified as a concept cardinal to counseling skills (Luterman, 2017). However, there is little empirical evidence relating locus of control and CSE constructs directly. Due to the lack of available research on factors influencing CSE in SLPs, the present study will be conducted to evaluate the relationships among locus of control, EI, and SLPs CSE. Valuable information can be provided from the findings of this study, for future and current SLPs, to determine the factors that influence an SLPs confidence in their counseling abilities. Further, the outcomes of this investigation will provide insight into what factors require consideration and what potential training is needed to further facilitate counseling confidence in practicing SLPs.

The primary aim of the current study is to investigate the factors that contribute to an SLP's CSE. Therefore, the goal of this study is to (a) measure CSE in SLPs, (b) determine the relationship between SLP's locus of control and CSE, (c) determine the relationship between SLP's EI and CSE, (d) evaluate whether an SLPs counseling training predicts their CSE above and beyond EI and locus of control, and (e) evaluate whether an SLPs experience predicts their CSE above and beyond EI and locus of control. For this study, it is hypothesized that the

CASESslp will have a positive relationship with EI and internal locus of control. Further, it is anticipated that CSE will have a positive relationship with counselor training and years of experience. That is, SLPs with more counseling training and years of experience will have greater CSE.

<center>**Chapter II**</center>

<center>**Manuscript**</center>

Counseling in the Field of Communication Disorders

The American Speech-Language-Hearing Association (ASHA) has long recognized counseling as a necessary component of speech-language pathology. Counseling was originally included in ASHA's Scope of Practice for speech-language pathologists (SLPs) in 1997 and continues to be incorporated in the most recent versions (ASHA, 2016). For SLPs, counseling takes form through helping individuals manage, adjust to, and cope with their disorder (DiLollo & Neimeyer, 2014). It is important to note that counseling in the field of speech-language pathology does not refer to the treatment of mental health disorders. Instead, counseling in the field of speech-language pathology refers to counseling families, caregivers, and persons with communication and swallowing disorders by providing support, education, and guidance. Individuals with communication disorders often experience diverse and complex emotional reactions to their diagnoses and the experiences that accompany them (Victorino & Hinkle, 2019). As Luterman (2017) states, "To have a communication disorder is also to have strong feelings; this is true for both the client and his or her family" (p. 47). ASHA (2016) specifies that SLPs are responsible for counseling clients during interactions related to thoughts, feelings, emotions, and behaviors resulting from their communication disorder. This includes counseling both clients and their families on acceptance, adaptation and decision making regarding their diagnoses. Two main types of counseling discussed in the literature are informational and personal adjustment counseling, both of these fall under the purview of SLPs. Informational counseling involves education and discussion about the nature of the communication disorder, options for treatment interventions, prognosis and providing resources or materials to the client

<center>30</center>

and their families/caregivers. Personal adjustment counseling acknowledges and addresses the thoughts, feelings, emotions and beliefs of the client and their families/caregivers regarding the communication disorder (Flasher & Fogle, 2012).

Counseling Training for SLPs

As stated in the 2016 ASHA Code of Ethics, SLPs should be properly educated and trained to provide the services offered within their scope of practice. Additionally, they should only engage in areas within their scope of practice and competence. For SLPs, counseling training typically occurs through graduate coursework, clinical practicum experience, and continuing education. There is extensive supervised clinical training in SLP graduate education programs. However, research has shown that there has been a significant lack of dedicated counseling training in the field of communication disorders. McCarthy, Culpepper, and Lucks-Mendel (1986) reported that within accredited communication disorder programs only 40% offered counseling courses within the department and 23% offered no courses at all. In 2008, Phillips and Lucks-Mendel surveyed clinical fellows regarding counseling training and feelings of preparedness in conducting counseling activities. Eighty percent of respondents reported receiving no counseling training during graduate school. Current research suggests counseling training is still insufficient in the field of communication disorders (Luterman, 2020).

Although it is clear that counseling is an essential component of the evaluation and treatment process, research has shown that counseling training in SLP graduate programs is severely underrepresented. Due to lack of experience and training in counseling, SLPs can lack confidence in their counseling abilities. An absence of formal counseling training in graduate-level programs leads to SLPs having limited learning and skill development opportunities prior

to work experiences (Millar et al., 2010). Currently, the inherent characteristics that contribute to an SLPs counseling self-efficacy are unknown and have yet to be investigated.

Self-Efficacy

Self-efficacy refers to an individual's belief about his or her ability to perform a particular behavior and the confidence to perform that behavior with success (Bandura, 1977). One's perceived self-efficacy takes part in determining their choice of settings and activities. There is a tendency for individuals to avoid situations perceived as threatening and exceed their coping skills, whereas individuals typically engage in activities where they deem themselves capable (Bandura, 1977). Those who persist through aversive experiences will acquire corrective experiences that diminish defensive behaviors and reinforce feelings of high self-efficacy. However, those who do not persist and rather cease coping efforts prematurely, will reinforce and retain feelings of low self-efficacy (Bandura, 1977). According to Bandura (1989), individuals with a high sense of self-efficacy can visualize success which will encourage positive performance, whereas individuals with a low sense of self-efficacy may visualize failure and undermine their performance.

It is theorized that there are four sources of information that determine expectations of self-efficacy: (1) performance accomplishments, (2) vicarious experience, (3) verbal persuasion, and (4) emotional arousal (Bandura, 1977). Performance accomplishments, also known as mastery experiences, refers to performing a behavior successfully. According to Bandura (1977), performance accomplishments are the most influential information source to perceived self-efficacy because they are authentic and tangible experiences of favorable behavior performance. Vicarious experience refers to learning through observing a successful modeled behavior. Though less influential than performance accomplishments, vicarious experiences are helpful in

instances where the individual has limited experience in the target behavior. An individual can use information learned from vicarious experiences to judge their own chance of success for the same or similar tasks (Britner & Pajares, 2006). Verbal persuasion refers to listening to how to perform a behavior successfully. Efficacy expectations stemming from verbal persuasion are weaker than those stemming from performance accomplishments because a tangible experimental base is not provided (Bandura, 1977). Emotional arousal refers to physiological states and emotions that impact well-being. Generally, aversive emotional arousal causes debilitated performance. Success is more likely to be observed in individuals who are not beset by feelings of anxiousness or stress (Bandura, 1977).

Counselor Self-Efficacy and Treatment

Counselor self-efficacy (CSE) refers to one's self-perceived ability to perform counseling-related behaviors and effectively counsel a client (Larson & Daniels, 1998). The construct of self-efficacy and specifically CSE has been evaluated in a variety of ways. Lent, Hill, and Hoffman (2003) developed the Counselor Activity Self-Efficacy Scales (CASES) to assess student's CSE based on conceptualization of their counseling skills. The counseling skills measured in the CASES are divided into three domains: (a) Helping Skills, (b) Session Management, and (c) Counseling Challenges. Victorino and Hinkle (2019) adapted the CASES to assess counseling skills specific to SLPs. Their scale mirrors the original CASES with modifications to language such as replacing the word counselor with speech-language pathologist. For the purposes of this paper the CASES will be differentiated from the modified version of the CASES for SLPs using the abbreviation CASESslp. The construct of counselor or clinical self-efficacy has not been widely studied in the field of speech-language pathology. To date, there are only three published studies investigating SLPs clinical self-efficacy (e.g. Lee and

Schmaman. 1987; Pasupathy and Bogschutz, 2013; Rudolf, Manning and Sewell, 1983), and one study to date investigating CSE in practicing speech-language pathologists (Victorino & Hinkle, 2019).

There are a number of factors that have been found to be significant predictors of CSE. In their review of CSE literature, Larson and Daniels (1998) found CSE to be predicted by anxiety, counselor characteristics, and work or training environment. Larson and Daniels also noted that CSE correlates positively with developmental level and performance of counselors. Indicating that counselors with more experience report higher CSE than those with less experience. In addition, they indicated that practicum experiences such as role playing, modeling and feedback can encourage self-efficacy.

Counselor Self-Efficacy and Experience

Research in the field of counseling indicates that CSE can be influenced by experience and learning opportunities in training, with several studies supporting the positive relationship between CSE and counselor training and experience (Larson & Daniels, 1998; Larson et al., 1992; Lent et al., 2003; Sipps, Sugden, & Faiver, 1988). A significant positive relationship between training, years of clinical experience, developmental level, and CSE has also been determined (Barbee et al., 2003; Leach et al., 1997; Melchert et al., 1996) Victorino and Hinkle (2019) analyzed the effects of experience on SLP's perceptions of CSE. Results of their study found an increase in confidence between first- and second-year graduate students with a slight decrease in clinician confidence during the first two years after graduating. Overall, they found that following graduation, more experienced clinicians had greater counseling confidence.

Emotional Intelligence

Emotional Intelligence (EI) effects how you interact with the people around you. Unlike biological characteristics that cannot develop and adapt, EI can change and grow over time (Taylor, 2005). To be emotionally intelligent one must be highly aware of their own emotional state, others emotional states, and be able to manage emotions. There are three major models of EI that can be identified in the literature: trait, ability, and mixed. Each model defines EI somewhat differently; however, they are generally convergent (Petrides, 2011). Petrides' (2009) trait EI model describes EI as an individual's emotional self-perceptions. Emotional self-perceptions in conjunction with emotional traits make up an individual's personality (Petrides, 2009). Therefore, in the trait EI model, EI is conceptualized in terms of personality, rather than a function of cognitive processes (Petrides & Furnham, 2003). In the ability model, EI is defined as a type of social intelligence involving the ability to recognize the meanings and relationships of emotions, monitor personal and others' emotions, and use the understanding of emotions to guide one's thoughts and actions (Salovey and Mayer, 1990). Measurement tools for the construct of EI can be categorized into one of the three major models of EI. However, the literature typically categorizes them into either trait EI measures or ability EI measures (Petrides & Furnham, 2003). The third model, the mixed model, was introduced by Goleman (1998) and is typically subsumed under trait EI (Livingstone & Day, 2005). Trait EI examines typical performance using self-report questionnaires while ability EI measures maximum performance using maximal-performance tests. Using ability measures of EI can be problematic because emotions are a subjective experience and maximum performance tests include items or tasks that are scored objectively (Matthews, Zeidner, & Roberts, 2007; Robinson & Clore, 2002) A widely used and well supported measure for trait EI is the The Trait Emotional Intelligence

Questionnaire (TEIQue; Petrides & Furnham, 2009) which has a corresponding short form, the TEIQue-SF that is popular due to its condensed format, allowing it to be used in many survey studies.

Counselor Self-Efficacy and Emotional Intelligence

Strong relationships have been identified between EI and CSE (Easton, Martin Jr, & Wilson, 2008; Martin Jr, Easton, Wilson, Takemoto, & Sullivan, 2004). Consistent with behaviors related to CSE, EI encompasses the ability to use emotions to plan, problem solve, make decisions, and understand others (Easton et al., 2008). Martin et al. (2004) investigated the association between EI and CSE and found that EI predicted CSE perceptions in both student and professional counselors. In a continuation of the Martin et al. (2004) study, Easton et al. (2008) conducted a nine month study examining the relationship between EI and CSE with 180 counselors, Easton et al. (2008) found that student and professional counselors who determined themselves to have high CSE, also perceived themselves to have high EI. Whereas counselors with perceived low CSE were found to have low perceptions in their ability to use emotions within problem-solving tasks. Additionally, they found that when compared to the general population, counselor trainees had greater EI. The results of this two-part study suggest that EI is an attribute that competent counselors inherently have. The ability to clearly identify personal emotions is an essential skill in any counseling environment due to the extent of emotions counselors will come across when working with clients in addition to how these emotions will affect how they conduct themselves in response to clients.

Locus of Control

Locus of control is the degree to which an individual believes they can control the events around them. It is an important variable of personality and it varies from person to person

(Rotter, 1966). According to Rotter (1966), a person can be considered to have an internal locus of control if they believe they have power over their own destiny, or an external locus of control if they believe their destiny is controlled by others. An example of having an internal locus of control would include believing that to be successful, you must work hard. An example of having an external locus of control would include believing that to be successful, you must have luck. Locus of control is a continuum, with many people falling somewhere between the extremes of total control (i.e., internal locus) and no control (i.e., external locus) (Luterman, 2017). One scale frequently used to measure locus of control is the Levenson (1974) Locus of Control scale. The multidimensional scale consists of one internal scale (LoC-I) and two external scales (LoC-Chance and LoC-Powerful Others). Levenson suggested that individuals with high LoC-I believe that they have the ability to create their own changes and play a significant role in directing their own lives.

Counselor Self-Efficacy and Locus of Control

Locus of control is a concept central to all counseling techniques (Luterman, 2017). Though the constructs of CSE and locus of control have been well studied separately, there has been limited research conducted on locus of control as it relates to CSE. Harper (2008) investigated clinician locus of control in counselors. She hypothesized that a counselor with an internal locus of control would have higher CSE, and a counselor with an external locus of control would have lower CSE. Findings of the study supported her original hypothesis revealing a statistically significant positive relationship ($p < .01$) between internal locus of control and high CSE and external locus of control and low CSE in doctoral students.

Research on clinician locus and its relationship to CSE is scarce. As Levenson suggested, those with an internal locus of control feel they have the capacity to make changes and are in

control of dictating the outcomes of their life. Those with an external locus of control tend to

fault others or their environment for the circumstances surrounding them. Discovering locus of

control orientation as it pertains to perceptions and abilities of counseling skills in SLPs could

provide insight to why some SLPs have greater or lesser CSE.

Justification

Counseling is a fundamental competency and an expected role of SLPs. Currently, there are no studies investigating how practicing SLP's feel about their counseling skills or what constructs influence those perceptions (Luterman, 2020). There is a dearth of evidence pertaining to practicing SLPs' self-efficacy with a limited number of studies to date investigating clinical or counselor self-efficacy in practicing speech-language pathologists. Due to the lack of available research on factors influencing CSE in SLPs, the present study will be conducted to evaluate the relationships among locus of control, EI, and SLPs CSE. Valuable information can be provided from the findings of this study, for future and current SLPs, to determine the factors that influence an SLPs confidence in their counseling abilities. Further, the outcomes of this investigation will provide insight into what factors require consideration and what potential training is needed to further facilitate counseling confidence in practicing SLPs.

The primary aim of the current study is to investigate the factors that contribute to an SLPs CSE. Therefore, the goal of this study is to (a) measure CSE in SLPs, (b) determine the relationship between SLP's locus of control and CSE, (c) determine the relationship between SLP's EI and CSE, (d) evaluate whether an SLPs counseling training predicts their CSE above and beyond EI and locus of control, and (e) evaluate whether an SLPs experience predicts their CSE above and beyond EI and locus of control. For this study, it is hypothesized that the CASESslp will have a positive relationship with EI and internal locus of control. Further, it is anticipated that CSE will have a positive relationship with counselor training and years of experience. That is, SLPs with more counseling training and years of experience will have greater CSE.

Chapter III

Methods

Participants

A total of 527 respondents completed the survey. To meet inclusion criteria, respondents were graduates of a graduate-level speech-language pathology program who were currently practicing in the field. Individuals who did not meet inclusion criteria were taken to the end of the survey and their responses were not used for data analysis.

Materials

To answer the questions of the study, a 95-item survey was created using Qualtrics software, an electronic, internet-based, survey tool. The survey was developed to address questions in four main areas: (I) Demographic and Background Information, (II) The Counselor Activity Self-Efficacy Scales for SLPs (CASESslp; Victorino & Hinkle, 2019), (III) Levenson's Internal Locus of Control Scale (LoC-I; Levenson, 1974), and (IV) The Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF; Petrides, 2009). All survey questions are included in Appendix A.

Demographic Questionnaire

A demographic questionnaire was developed for this study and was administered to collect the following information from all participants: gender; demographic region; education level; years and degree of experience; primary work setting; employment status; degree of counseling training, continuing education, supervision and feedback.

The Counselor Activity Self-Efficacy Scales for SLPs (CASESslp)

The CASESslp (Victorino & Hinkle, 2019) was adapted from the Counselor Activity Self-Efficacy Scales (CASES), developed by Lent et al. (2003). The adapted scale includes 35

items that assess counseling skills specific to communication disorders. The scale is divided into two sections: skills and tasks. The instructions for the first section state: "Please indicate how confident you are in your ability to use each of the following counseling skills effectively, over the next week, with most clients with communication disorders." Skills targeted in this section include listening, attending, self-disclosure, open-ended questions, and immediacy. Instructions for the second section state: "Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling most clients with communication disorders." Tasks targeted in this section include providing structure to sessions, addressing topics related to culture, helping the client to decide what actions to take and providing responses to various feelings expressed by clients or caregivers. Respondents rate their confidence on a 6-point scale, ranging from not at all confident (1) to extremely confident (5). If the respondent is not familiar with the counseling concept, a score of zero (0) can be indicated. For the purposes of data analysis in this study, a score of zero (0) is treated as a missing data point. Total scores can range from a minimum score of zero to a maximum score of 175. However, if the respondent is familiar with all the counseling concepts, the minimum possible total score is 35. Higher scores reflect greater CSE.

Items in the CASESslp (Victorino & Hinkle, 2019) are grouped into the following five subscales, listed with sample items and Cronbach's alpha internal reliability values: *Emotional Support Skills* (e.g., Help your client/caregiver to understand his or her thoughts, feelings, and actions as they relate to the communication disorder; 8 items, $\alpha = .91$), *Session Management Skills* (e.g., Provide structure to sessions and maintain focus on treatment goals; 6 items, $\alpha = .85$), *Helping Skills-Insight* (e.g., Self-disclosures for insight, discloses past experiences in which you gained some personal insight; 6 items, $\alpha = .85$), *Helping Skills-Exploration* (e.g., Attending,

orienting yourself physically toward the client; 5 items, α = 0.83), and *Helping Skills-Action* (e.g., Help your client to decide what actions to take regarding his or her problems; 4 items α = .91). Strong internal consistency for each subscale was demonstrated with internal reliability (Victorino & Hinkle, 2019). Internal reliability for the entire scale was .95, demonstrating overall internal consistency (Victorino & Hinkle, 2019). In this study the Cronbach's alpha for the entire CASESslp scale was .97. This study's Cronbach's alpha for the subscales of Emotional Support, Session Management, Helping Insight, Helping Exploration, and Helping Action was .94, .83, .88, .84 and .84, respectively. Each of the subscales was found to be significantly interrelated (p < .01) and strongly correlated with the overall scale score (.743 - .844). Higher subscale scores are indicative of higher CSE in that area. Victorino and Hinkle (2019) reported that there are no similar measures comparable for SLPs to examine the scales convergent and discriminant validity. Evidence of construct validity was considered with reference to the ASHA Scope of Practice Statement. Victorino and Hinkle (2019) concluded the scale presents strong construct validity because it measures the broad competencies outlined in the ASHA Scope of Practice Statement.

Levenson's Internal Locus of Control Scale (LoC-I; Levenson, 1974)

Levenson Internal Locus of Control (LoC-I) scale is one subscale from the 24-item self-report questionnaire designed to measure an individual's perceived causation of life events. The full scale contains three subscales designed to assess locus of control orientation. The LoC-I is comprised of eight items and responses are on a 6-point Likert scale ranging from strongly disagree (-3) to strongly agree (3). A higher score indicates a greater internal locus of control. To avoid negative scores, 24 is added to the internality score with scores ranging from 0 – 48. Good

test-retest reliability has been shown LoC-I ($\alpha = .64$), LoC-C ($\alpha = .78$) LoC-P ($\alpha = .77$) (Levenson, 1974). In this study the Cronbach's alpha for the LoC-I scale was .71.

The Trait Emotional Intelligence Questionnaire Short Form (TEIQue-SF; Petrides, 2009).

Derived from the full TEIQue form, the TEIQue-SF contains 30 items that are designed to measure global trait EI. The full form identifies 15 distinct facets and the TEIQue-SF uses two items from each of the facets. Responses on the TEIQue-SF are formatted in a 7-point Likert scale ranging from completely disagree (1) to completely agree (7). A minimum total score of 30 indicates low trait EI and a maximum total score of 210 indicates high trait EI. The global trait score can be calculated by summing the scores from each item after reverse scoring for negative items. Higher scores on the TEIQue-SF indicate higher trait EI. In this study the Cronbach's alpha for the TEIQue-SF was found to be relatively low at .31.

Procedure

Prior to distribution of the survey, an initial draft was piloted to refine survey questions, receive feedback, and eliminate any potential survey bias. Following the piolet, the survey was edited to include minor formatting changes.

Approval from the Auburn University Institutional Review Board (IRB) was received before commencement of the study. Participants in the current study were recruited through two methods. Initially, an announcement detailing the purpose and description of the survey was posted to the primary investigator's Facebook page. The post contained an embedded link for direct access to the survey and was made public and shareable to anyone on Facebook. Participants who elected to click on the embedded link were directed to the survey where an information letter was displayed and opportunity for informed consent was provided by participants selecting "yes" or "no" to participate. The announcement was also posted on speech-

language pathology Facebook group pages where the primary investigator was a member of. Additionally, the same announcement was posted to the ASHA Community website with a description of the survey and an invitation to participate. Two weeks after the initial posting on the Facebook pages and ASHA Community website, a reminder announcement was be posted, once again containing the weblink and a description of the survey. The survey was administered through Qualtrics. All data collection through Qualtrics was deidentified and kept anonymous. Participants were ensured that all responses will remain confidential. Participation was completely voluntary and no incentive to participate was provided.

Survey Development and Distribution

The ever-growing presence of a technology driven world has allowed for the frequent use of electronic surveys. Though evolving technology has provided additional opportunities to recruit participants through electronic avenues, these advances have also enabled potential participants to avoid or ignore surveys. Amongst the primary reason for low response rates is the overall reluctance to respond to surveys (Dillman, Smyth, & Christian, 2014). According to Dillman, Smyth, and Christian (2014) participants are more reluctant to respond if contacted amidst traditional work hours. Therefore, recruitment posts were made before or after traditional work hours during the time frames of 7:00 a.m. – 9:00 a.m. and 7:00 p.m. – 9:00 p.m. Additional guidelines suggested by Dillman and colleagues (2014) were included to permit for optimal survey development and distribution and to increase the chance of obtaining a response. This survey was developed to allow for multimedia accessibility, including compatibility for both computers and phones. Additionally, confidentiality will be emphasized throughout the recruitment process. Dillman et al. (2014) state potential participants must trust that the risks outweigh the benefits of participating. Therefore, the investigators were transparent about the

potential benefits and risk to participating, in addition to providing a time commitment

estimation. Social exchange theory was applied to distribution of the survey by posting during

intentional time frames with follow up posts occurring two weeks after the initial postings.

Chapter IV

Results

Data Analysis

Survey responses were filtered for completion. Data was analyzed for outliers. Data points greater than three standard deviations above the mean were considered outliers and were winsorized to be representative of the data set. Following results collected from the online survey, data were analyzed via Qualtrics software and IBM Statistical Program for the Social Sciences (SPSS) Version 23. Descriptive statistics were used to evaluate the means and standard deviations for all demographic information and scales used. Pearson correlation coefficients were calculated to determine the relationships amongst the variables. Linear regression analysis, one-way analysis of variances (ANOVAs) and a one-way analysis of covariance (ANCOVA) were conducted to evaluate the relationship of CSE from training and experience.

Demographics

The online survey was initiated by 867 participants. Thirty-three respondents were excluded from the study due to their lack of a graduate degree in speech-language pathology. When filtered for completion, 307 participants initiated but did not fully complete the survey. Thus, the results were drawn from a total of 527 participants who met the inclusion criteria and completed the survey. Participants were invited through Facebook postings (81%; $n = 427$), ASHA Community Group postings (18%; $n = 91$), and other unspecified avenues (e.g., word of mouth, 2%; $n = 9$).

Respondents were queried about general background information. They were asked to select the gender they identify with, the race(s) they identify with, the ethnicity they identify with, their highest level of education, and the demographic region in which they currently

practice (See Table 1). The majority of participants identified their gender as female (98%; $n =$ 515), race as White (92%; $n = 487$), ethnicity as Non-Hispanic (93%; $n = 491$), and highest level of education as master's degree (95%; $n = 499$). Additionally, the largest percentage of participants identified their demographic region as South (36%; $n = 189$).

Table 1
Participant Demographics

Demographic (N = 527)	Frequency n	Percentage %
Gender		
Female	515	98
Male	6	1
Non-binary	6	1
Race*		
White	487	91
Black and/or African American	17	3
Other	16	3
Asian	5	1
Biracial	4	1
American Indian/Alaska Native	2	0.5
Native Hawaiian/Pacific Islander	2	0.5
Ethnicity		
Hispanic	491	93
Non-Hispanic	32	6
No Response	4	1
Education Level		
Master's Degree	499	9
Ph.D.	25	5
Ed.D	3	1
Demographic Region		
South	189	36
Midwest	139	26
Northeast	112	21
West	85	16
No Response	2	0.5

Note. N = total number of respondents; n = number of respondents per choice; % = percentage of respondents based on 527 respondents; * = choose all that apply

Experience

Respondents were asked to provide information regarding their experience as an SLP. With regard to years in clinical practice, a third of participants ($n = 175$) reported a total of 16 years of experience or greater. Additionally, participants reported experience with working in a variety of settings and with various populations. When asked to choose all of the current clinical populations and settings they work in, the largest percentage of participants reported working in a pediatric school setting (30%; $n = 222$). When asked to choose all of the ASHA "Big 9" areas of practice that the participant had the most experience with, the most commonly selected answer was receptive and expressive language (24%; $n = 473$). A breakdown of SLP experience is provided in Table 2.

When asked to what extent the participant works with clients with comorbidities, nearly three fourths (73%; $n = 386$) reported "often," approximately one fourth (26%; $n = 138$) indicated "sometimes" and less than 1% ($n = 3$) indicated "never." When asked to estimate the percentage of clients served that are their same race and ethnicity the average was 61% (SD = 27.52). Percent's ranged from 0 to 100.

When asked to choose between the individuals they counsel most often, 60% ($n = 316$) of respondents indicated they counsel the caregiver (i.e., family members, caretakers, spouses, parents) most often in comparison to 39% ($n = 208$) of respondents who indicated they counsel the client most often. Three participants did not respond (1%). Respondents also shared the percentage of time with clients that involved counseling. On average, SLPs reported spending 35% (SD = 22.62) of their time on counseling. Percent's ranged from 2 to 100.

Table 2

SLP Experience

Experience	Frequency	Percentage
	n	%
Years of Experience (N = 527)		
Less than 1 year	48	9
1-2 years	83	16
3-5 years	86	16
6-10 years	84	16
11-15 years	51	10
More than 16 years	175	33
Population/Setting*		
Pediatric/school	222	30
Pediatric/outpatient	160	22
Pediatric/inpatient	12	2
Adult/outpatient	123	17
Adult/inpatient	94	13
Adult/skilled nursing facility	124	17
ASHA "Big 9"*		
Receptive and Expressive Language	473	24
Articulation	314	16
Cognition	297	15
Swallowing	256	13
Social	232	11
Communication Modalities	146	7
Fluency	114	6
Voice/Resonance	87	4
Hearing	45	2

Note. N = total number of respondents; *n* = number of respondents per choice; % = percentage of respondents based on 527 respondents; * = choose all that apply

Training

Participants were asked to indicate the degree to which they acquired counseling knowledge and skills in the following settings: on the job training, clinical practicum, graduate level education, continuing education, and self-study (see Table 3). Participants reported acquiring "most" of their counseling skills and knowledge through on the job training and "some" of their counseling skills and knowledge through their clinical practicum, graduate level education, continuing education, and self-study.

Table 3
Counseling Knowledge and Skills

	None	Some	Most	All	No Response
Setting (N = 527)	n(%)	n(%)	n(%)	n(%)	n(%)
On the job training	46(9%)	151(29%)	279(53%)	47(9%)	4(1%)
Clinical practicum	72(14%)	336(64%)	85(16%)	10(2%)	24(5%)
Graduate level education	109(21%)	306(58%)	78(15%)	15(3%)	19 (4%)
Continuing education	147(28%)	276(52%)	88(17%)	7(1%)	9(2%)
Self-study	77(15%)	260(49%)	152(29%)	21(4%)	17(3%)

Note. N = total number of respondents; *n* = number of respondents per choice; % = percentage of respondents based on 527 respondents

Academic training. Participants were asked to provide the number of credit hours of counseling coursework taken. Seven outliers for undergraduate credit hours and six outliers for graduate credit hours were identified within the data set as determined by being more than three standard deviations above the mean. Outliers above 18 credit hours were winsorized to 18 credit hours. Following this, the mean number of undergraduate-level counseling credit hours taken was 1.32 (SD = 3.246). The number of undergraduate-level credit hours taken ranged from 0 to 18. A large majority of participants reported taking zero credit hours as a part of their bachelor's degree (74%; *n* = 363). The mean number of graduate-level counseling credit hours taken was 1.87 (SD = 2.972). The number of graduate-level credit hours taken ranged from 0 to 18. Again,

the largest percentage of respondents reported taking no counseling credit hours during their master's degree (49%; *n* = 244). A breakdown of undergraduate and graduate-level credit hours in counseling coursework can be found in Table 4.

Table 4
Number of Credit Hours in Counseling Coursework

Credit Hours (N = 527)	Undergraduate	Graduate
	n(%)	n(%)
0	363(69%)	244(46%)
.5-3	83(16%)	199(38%)
3.5-6	19(4%)	41(8%)
6.5-12	10(2%)	8(2%)
12.5-18+	13(2%)	11(2%)
No Response	39(7%)	24(4%)

Note. N = total number of respondents; *n* = number of respondents per choice; % = percentage of respondents based on 527 respondents

Supervision. Participants were then asked how often they received supervision dedicated to their counseling skills during their graduate school training and post-graduate clinical fellowship. Nearly two thirds (64%; *n* = 336) indicated that they "sometimes" received dedicated supervision to their counseling skills, while 26% (*n* = 139) indicated they "never" received dedicated supervision and the rest indicated they received it "about half of the time" (6%; *n* = 33), "most of the time" (3%; *n* = 17) or "always" (0.4%; *n* = 2). Similar results were reported when queried on counseling supervision that was infused within supervisor feedback. When asked to choose between "graduate school" and "post-graduate" regarding the place they received the majority of their counseling supervision, responses were approximately 50/50 with 265 (50%) respondents indicated they received their supervision in graduate school and 249 (47%) indicated they received it after graduating. Thirteen participants did not respond (3%).

Continuing Education Units (CEUs). Just over a third ($n = 184$) of respondents said they have taken 0 hours of CEUs in counseling, 26% ($n = 136$) said they have taken 1-2 hours of counseling CEUs, 21% ($n = 112$) said they have taken 3-6 counseling CEU hours, 11% ($n = 58$) said they have taken 7-12 counseling CEU hours and 7% ($n = 36$) said they have taken more than 13 hours of CEUs in counseling. One participant did not respond.

Counselor Self-Efficacy in SLPs

For the CASESslp, 527 SLP participants completed the survey measure. The mean total scale score for the group on the CASESslp was 3.47 (SD = .698). Scores on the measure ranged from 1.5 to 5.0. The mean and standard deviation total scale scores for the group indicate that SLP's are "somewhat" to "very" confident in their counseling abilities. For the CASESslp subscale scores, the group had a mean score of 3.17 (SD = .884) on the Emotional Support Skills Scale 3.70 (SD = .683) on the Session Management Skills Scale 3.09 (SD = .914) on the Helping Skills Insight Scale, 3.89 (SD = .685) on the Helping Skills Exploration Scale, and 3.66 (SD = .755) on the Helping Skills Action Scale. Comparitively, the means and standard deviations for the subscores indicate that SLPs have higher CSE in session management, helping exploration, and helping action skills than in emotional support and helping insight skills.

Relationship between Counselor Self-Efficacy, Locus of Control and Emotional Intelligence

Correlation coefficients were computed for the CASESslp, TEIQue-SF and the LoC-I scales. Using the Bonferroni correction to reduce the likelihood of a Type 1 error across the 3 correlations, a p value of less than .017 (.05/3 = .017) was required for significance. The results of correlational analysis is presented in Table 5 and shows that all three statistically significant correlations were greater than or equal to .219. The strength of the correlation between the CASESslp and TEIQue-SF was moderate and suggests that that those with greater overall CSE

also tend to have greater EI. A weaker relationship between the CASESslp and LoC-I was observed, indicating that internal locus of control also influences CSE but to a lesser degree than EI.

Table 5
CSE EI LOC Correlation

Variable (N = 527)	1	2	3	M	SD
1. Emotional Intelligence	-			158.27	19.469
2. Internal Locus of Control	.357**	-		30.66	7.097
3. Counselor Self-Efficacy	.440**	.219**	-	3.47	.698

Note. N = total number of respondents; M = Mean; SD = Standard Deviation; ** = Correlation is significant at the 0.01 level

Experience, Counselor Self-Efficacy, Locus of Control and Emotional Intelligence

An ANOVA was conducted to evaluate the relationship between the CASESslp, each of it's subscales and years of SLP experience. To control for Type 1 errors across the 5 correlations, the Bonferroni correction was applied and a *p* value of less than .01 (.05/5 = .01) was required for significance. The independent variable was experience and included six levels: less than one year, 1-2 years, 3-5 years, 6-10 years, 11-15 years and 16+ years. The dependent variable was the CASESslp and each of the subscales, Emotional Support Skills, Session Management Skills, Insight Helping Skills, Exporation Helping Skills, and Action Helping Skills. The ANOVA was significant for the CASESslp and all of the subscales as seen in Table 6. Follow-up tests were conducted to evaluate pairwise comparisons among the years of experience for each of the CASESslp subscales (Table 7). Results of the pairwise comparisons for Insight Helping Skills (*p* = .000), Exploration Helping Skills (*p* = .000), and Emotional Support Skills (*p* = .000), show that the CSE in those areas is greater with 16+ years of experience and that changes in CSE for those skills are not significant early in an SLPs career. Earlier detected changes in CSE, starting

at around 11 years of expereince were seen in overall CSE (p = .000), Session Management

Skills (p = .007) and Action Helping Skills (p = .000). Results of the analysis revealed that all

factors were sensitive to the effects of experience and the total scale was the most sensitive.

Evaluation of the group means revealed an increase in CSE with increased experience with the

expection of Helping Insight skills, Helping Exploration skills, and overall CSE between 3-5

years and 6-10 years where a very slight decrease in confidence was observed (Table 8).

Table 6
CSE with Years of Experience

Subscale	df	F	p	η^2	Mean Square
Emotional Support					
Years of Experience	5	12.72	.000	.11	8.95
Error	521				.70
Intercept					4183.19
Session Management					
Years of Experience	5	15.49	.000	.13	6.36
Error	521				.41
Intercept					5783.18
Helping/Insight					
Years of Experience	5	14.39	.000	.12	10.65
Error	521				.74
Intercept					3996.94
Helping/Exploration					
Years of Experience	5	8.94	.000	.08	3.90
Error	521				.44
Intercept					6513.53
Helping/Action					
Years of Experience	5	14.92	.000	.13	7.52
Error	521				.50
Intercept					5624.30
Total Scale					
Years of Experience	5	17.38	.000	.14	7.33
Error	521				.42
Intercept					5077.35

Table 7

Significance for Pairwise Comparison for Relationship between Experience and CSE

Years of Experience	1	2	3	4	5	6
Total Scale						
1. 16+ Years	-					
2. 11-15 Years	.051	-				
3. 6-10 Years	.000	.023	-			
4. 3-5 Years	.000	.016	.884	-		
5. 1-2 Years	.000	.000	.106	.139	-	
6. Less than 1 Year	.000	.000	.060	.084	.771	-
Emotional Support						
1. 16+ Years	-					
2. 11-15 Years	.039	-				
3. 6-10 Years	.000	.152	-			
4. 3-5 Years	.000	.038	.464	-		
5. 1-2 Years	.000	.005	.118	.398	-	
6. Less than 1 Year	.000	.006	.097	.298	.750	-
Session Management						
1. 16+ Years	-					
2. 11-15 Years	.014	-				
3. 6-10 Years	.000	.259	-			
4. 3-5 Years	.000	.116	.614	-		
5. 1-2 Years	.000	.006	.059	.161	-	
6. Less than 1 Year	.000	.000	.005	.016	.231	-
Helping/Insight						
1. 16+ Years	-					
2. 11-15 Years	.085	-				
3. 6-10 Years	.000	.007	-			
4. 3-5 Years	.000	.021	.630	-		
5. 1-2 Years	.000	.000	.360	.161	-	
6. Less than 1 Year	.000	.011	.861	.558	.543	-
Helping/Exploration						
1. 16+ Years	-					
2. 11-15 Years	.720	-				
3. 6-10 Years	.000	.008	-			
4. 3-5 Years	.004	.063	.357	-		
5. 1-2 Years	.000	.000	.295	.049	-	
6. Less than 1 Year	.000	.001	.270	.059	.835	-
Helping/Action						
1. 16+ Years	-					
2. 11-15 Years	.140	-				
3. 6-10 Years	.000	.115	-			
4. 3-5 Years	.000	.054	.693	-		
5. 1-2 Years	.000	.001	.038	.090	-	
6. Less than 1 Year	.000	.000	.001	.002	.098	-

Table 8

Group mean CSE ratings as a function of Experience, reported as M (SD)

	Emotional Support	Session Management	Helping/ Insight	Helping/ Exploration	Helping/ Action	Total Scale
Less than 1 year	2.80 (.73)	3.31 (.53)	2.82 (.66)	3.63 (.61)	3.16 (.71)	3.12 (.57)
1-2 years	2.85 (.74)	3.45 (.69)	2.73 (.80)	3.65 (.59)	3.37 (.68)	3.18 (.59)
3-5 years	2.96 (.87)	3.58 (.68)	2.91 (.90)	3.85 (.64)	3.56 (.73)	3.33 (.67)
6-10 years	3.06 (.84)	3.63 (.64)	2.85 (.87)	3.76 (.67)	3.60 (.75)	3.34 (.63)
11-15 years	3.27 (.82)	3.76 (.61)	3.27 (.89)	4.07 (.65)	3.80 (.65)	3.60 (.63)
16+ years	3.55 (.90)	4.01 (.63)	3.50 (.90)	4.11 (.71)	3.96 (.71)	3.80 (.70)

Note. M = Mean; SD = Standard Deviation

An ANOVA was conducted to evaluate the relationship between EI and years of SLP experience. The independent variable was experience and the dependent variable was EI. The ANOVA was significant $F(5, 521) = 5.312$, $p = .000$. The relationship between experience and EI as assessed by the η^2 accounted for 5% of the variance observed in EI. Follow-up tests were conducted to evaluate pairwise differences among the EI means. Tukey HSD was used to conduct the post hoc comparisons. There was a significant difference in the EI means between the group with less than 1 year and 16+ years of experience ($p = .007$), 1-2 years and 16+ years of experience ($p = .000$), and 3-5 years and 16+ years ($p = .016$). This finding indicates that EI is greater with 16+ years of experience and that the changes in EI are not significant early in ones SLP career.

An ANOVA was conducted to evaluate the relationship between LoC-I and years of SLP experience. The independent variable was experience and the dependent variable was LOC. The ANOVA was significant $F(5, 521) = 4.398$, $p = .001$. The relationship between experience and LoC-I as assessed by the η^2 accounted for 4% of the variance observed in LOC. Follow-up tests were conducted to evaluate pairwise differnces among the LOC means. Tukey HSD was used to conduct the post hoc comparisons. There was a significant difference in the LOC means between

the group with 1-2 years and 16+ years of experience ($p = .001$) as well as the group with 3-5

years and 16+ years of experience ($p = .02$). This finding indicates that LOC increases with 16+

years of experience; however, the changes in LOC are not significant and more variable early in

ones SLP career.

An ANCOVA was conducted to evaluate whether years of SLP experience has a

relationship with CSE above and beyond LOC and EI. The independent variable was years of

SLP experience. The dependent variable was CSE and the two covariates were LOC and EI. The

ANCOVA was significant, $F(5, 519) = 11.584$, MSE $= .357$, $p = .000$. The variance accounted

for by the relationship between SLP experience and CSE as assessed by the η^2 was 10% holding

LOC and EI constant. The means for CSE adjusted for LOC and EI were ordered as expected

across the 6 different levels of experience. Follow-up test were conducted to evaluate the

pairwise differences among the adjusted means. Based on the LSD procedure, the adjusted

means for CSE differed between the SLP's with less than 10 years of experience and greater than

10 years of experience (see Table 9).

Table 9
Significance for Pairwise Comparison for Relationship between Experience and
CSE above and beyond LOC and EI

Years of Experience	1	2	3	4	5	6
1. 16+ Years	-					
2. 11-15 Years	.151	-				
3. 6-10 Years	.000	.026	-			
4. 3-5 Years	.000	.034	.899	-		
5. 1-2 Years	.000	.002	.285	.227	-	
6. Less than 1 Year	.000	.001	.136	.108	.567	-

Training and Counselor Self-Efficacy

Correlation coefficients were computed for overall CSE and training variables. The number of graduate level credit hours in counselling coursework taken was evaluated. Results show there is a small significant relationship (Cohen, 1988) between the number of graduate-level credit hours taken in counseling coursework and reported CSE ($r = .123$, $p = .006$). Analyses were also conducted to evaluate the relationships between where the participants reported acquiring knowledge and skills in counseling and their CSE. Results of the correlation show that on on the job training ($r = .104$), continuing education ($r = .223$), and self study ($r = .257$) all had a significant positive relationship with CSE. All other settings where counseling skills and knoweldged were acquired were not significant.

Multiple regression analyses were conducted to evaluate whether credit hours of graduate training in counseling predicted CSE above and beyond LOC and EI (Table 10). The results of this analysis indicated that LOC and EI accounts for a significant amount of the CSE variability, $R^2 = .196$, adjusted $R^2 = .192$, $F(2,500) = 90.223$, $p = .000$, indicating that SLPs with greater EI and LOC tended to have higher scores on the CASESslp measure. A second analysis was conducted to evaluate whether a measure of graduate training predicted CSE over and above LOC and EI. The graduate training measure accounted for a significant proportion of the CSE variance after controlling for LOC and EI, $R^2 = .206$, adjusted $R^2 = .201$, $F(3,499) = 6.676$, $p = .010$ These results suggest that SLPs who have similar LOC and EI are more likely to have greater CSE with increased graduate hours of counseling coursework.

Table 10

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
1 (Constant)	2.77	.136		20.368	.000	2.506	3.041
Locus of Control Internal	.022	.004	.224	5.156	.000	.014	.031
2 (Constant)	.877	.236		3.722	.000	.414	1.341
Locus of Control Internal	.009	.004	.087	2.035	.042	.000	.017
Emotional Intelligence	.015	.002	.405	9.499	.000	.012	.018
3 (Constant)	.859	.235		3.663	.000	.398	1.320
Locus of Control Internal	.010	.004	.096	2.264	.024	.001	.018
Emotional Intelligence	.014	.002	.395	9.283	.000	.011	.017
Counseling Credits	.024	.009	.104	2.584	.010	.006	.043

Population and Setting Analysis

An ANOVA was conducted to evaluate the relationship between overall CSE and the primary clinical population worked in. Clinical population was broken into six populations and settings: pediatric/school, pediatric/outpatient, pediatric/inpatient, adult/outpatient, adult/inpatient, and adult/skilled nursing facility. The dependent variable for each analysis was CSE. The ANOVAs were significant for pediatric/school $F(1, 525) = 9.042$, $p = .003$ and adult/outpaitent $F(1, 525) = 16.772$, $p = .000$. These results suggest that SLP's who work in adult outpatient settings have higher CSE, while those who work in pediatric schools have lower CSE. All other populations and settings were not significant. Table 11 shows CSE means and standard deviations for all clinical populations and settings assessed.

Table 11

Population/Setting CSE means, reported as M (SD)

Pediatric/School	3.37 (.67)
Pediatric/Outpatient	3.45 (.72)
Pediatric/Inpatient	3.40 (.64)
Adult/Outpatient	3.69 (.68)
Adult/Inpatient	3.51 (.74)
Adult/Skilled Nursing Facility	3.50 (.69)

Note. M = Mean; SD = Standard Deviation

Chapter V

Discussion

The purpose of this study was to explore SLPs' locus of control, EI, training and experience, and the relationship between these findings and respondents' CSE. The findings indicate that the constructs of internal locus of control, EI, years of experience, and training individually have a significant positive relationship with CSE. Results highlight the importance of training and experience on SLP CSE, in addition to the positive impact of internal locus of control and high EI on counseling confidence.

Counselor Self-Efficacy

Overall, SLP's have average confidence in their counseling abilities. CSE in SLP's was slightly higher than that was found in Victorino and Hinkle's (2019) study. Additionally, CSE subscale scores were slightly higher for Emotional Support Skills, Session Management Skills, Helping Insight Skills, and Helping Action Skills when compared to Victorino and Hinkle's findings. However, the mean score for Helping Exploration Skills was found to be slightly lower than the mean reported in Victorino and Hinkle's study. Respondents indicated they were, on average, "somewhat confident" in the areas of Emotional Support and Helping Insight Skills. In the areas of Session Management, Helping Exploration, and Helping Action Skills, respondents were on average closer to "very confident". This provides additional support Victorino and Hinkle's findings, demonstrating that SLPs have lower CSE in skills related to Emotional Support and Insight, while they have higher CSE for skills pertaining to Session Management, Exploration, and Action. This finding indicates a possible mismatch between SLP's confidence in personal adjustment counseling versus informational counseling. Our findings and the literature show that counseling training is scarce within SLP graduate programs even though the

61

number of programs that offer a counseling course has continued to rise. Yet, for those programs that do offer coursework, studies have yet to be conducted on the type of counseling education that students are receiving within their programs. For counseling to be effective, an SLP must be confident in both their informational and personal adjustment counseling skills. Information based counseling is not effective if you do not consider the clients emotions. When a client's emotions are heightened, they are less likely to retain information provided (Kessels, 2003; Krueger & Bernstein, 1990; Margolis, 2005). Therefore, an SLP must be cognizant of and comfortable with addressing how a client feels and their emotional needs in order to be an effective clinician (Luterman, 2020). Importantly, those with high EI are highly comfortable with their own emotions and others' emotions, a skill imperative to personal adjustment counseling.

Emotional Intelligence

Our findings are consistent with the literature and demonstrate that there is a relationship between CSE and EI (Easton et al., 2008; Martin et al., 2004). Those with greater EI were observed to have greater CSE. This relationship was stronger than the relationship between CSE and internal locus of control, suggesting that EI plays a larger role in predicting CSE than locus of control. Additionally, EI increased as years of experience as an SLP increased, demonstrating that EI can become greater the longer you are a practicing SLP. However, these increases in EI are not detected early on in one's career as an SLP, rather it takes many years to develop. Although some individuals will be inherently more emotionally intelligent than others, our findings show that EI can be developed over time. Clarke (2007) found that the ability to use emotions to facilitate decision making/thinking and the ability to manage emotions were significant elements of EI that develop within the workplace for healthcare workers.

Measures of EI, such as the TEIQue-SF (Petrides & Furnham, 2009) could be useful to help future and current SLPs evaluate how emotionally intelligent they are and in what areas could they improve in to increase their EI and therefore, increase their CSE. Assessing EI early on in an SLPs career, such as during their graduate education, may identify areas of strength and weakness and how that may be impacting their CSE. Research indicates that EI can increase with training (Schutte, Malouff, & Thorsteinsson, 2013; Slaski & Cartwright, 2003). Increasing EI could help SLPs communicate more effectively with their clients, connect to their clients on a deeper emotional level, and become more confident in their abilities to unpack the emotions related to their clients' communication disorders. Without effective communication skills, all other clinical skills are ineffective when working with clients (Luterman, 2020). The skills that make up EI such as managing own and others' emotions, using emotions in problem solving, and being aware of emotions, all play a crucial role in fostering the skills needed for effective personal adjustment counseling.

Locus of Control

A relationship between locus of control and CSE was observed. Though a weaker relationship than the one between CSE and EI, our results suggest that having an internal locus of control does impact CSE. Many SLPs were found to have an internal locus of control and those SLPs were found to have greater CSE. This finding demonstrates that SLPs who believe they have more control over their own destiny also have greater confidence in their ability to counsel their clients and caregivers. This aligns with the findings of Harper (2008), who discovered that counselors with an internal locus of control also had higher CSE. Research on locus of control has shown that those with a greater internal locus also report greater

performance and satisfaction with their job and life and also anticipated more favorable

outcomes with their clients (Koeske & Kirk, 1995; Renn & Vandenberg, 1991).

Our findings also showed that individuals were more likely to have greater internal locus

of control when they had more years of experience. Although locus of control has the potential to

be influenced by very strong life changes, longitudinal studies show that locus of control

typically remains stable throughout adulthood with very slight increases toward internality with

age (Doherty 1983; Hovenkamp-Hermelink et al., 2019) However, literature in nursing suggests

that in students, locus of control can shift from external to internal when engaged in a mentorship

program (Bulut, Hisar & Demir, 2010; Demir, Bulut & Hisar, 2014). Including a mentorship

program for SLP graduate students has the potential to foster an internal locus of control, thus

potentially fostering greater CSE in future SLPs.

Experience

CSE was found to increase in SLPs as their years of experience increased. This finding

adds further support to the work of Larson and Daniels (1998) and Victorino and Hinkle (2019)

who found that counselors and SLPs with more experience also report higher CSE. Analysis of

clinical population and settings demonstrated that SLPs who primarily work with adults in an

outpatient facility have high CSE; whereas, SLPs who work with children in a school setting

have lower CSE. Although counseling can and should occur in every setting, certain settings and

clinical populations may provide more opportunities for the SLP to counsel, practice their

counseling skills, and increase their CSE. SLPs who work in adult outpatient facilities likely

have frequent interactions with their client's family members and loved ones who may bring the

client to therapy sessions. However, school-based SLPs who work with children likely do not

have as many opportunities to involve or interact with their client's family members as often.

This aligns with our finding that SLPs reported counseling family members more frequently than counseling clients. According to Pappas et al. (2008), SLPs who work in educational settings involved parents significantly less than those who work in other settings. School-based SLPs have reported that they do not have the time, often fail, and would benefit from training on how to collaborate with family members (Kent-Walsh, Stark, & Binger, 2008). Providing more experience and training opportunities for SLPs to counsel their clients and family members effectively is important in all clinical populations and settings.

Training

Many speech-language pathology graduates have received no formal training in counseling and due to this have a lack of understanding of how to counsel and the boundaries between counseling, guidance, and psychotherapy (Doud, Hoepner, & Holland, 2020; Shipley & Roseberry-McKibbin, 2006). A large number of respondents (46%) in the present study indicated that they had not taken any credit hours in counseling coursework. Though this finding demonstrates a decrease in the number of SLP graduates who have not taken any hours in counseling coursework, down from 80% reported in 2008 by Phillips and Lucks-Mendel, a large percent of SLPs are still graduating without any formal counseling training. Our results also indicate that graduate-level credit hours in counseling coursework predicted CSE above and beyond emotional intelligence and locus of control. These findings emphasize the importance of counseling coursework and the need for required coursework dedicated to counseling to be included in speech-language pathology graduate programs. Additionally, counseling infused throughout academic coursework would increase opportunities for training and discussion on counseling related topics in graduate programs.

Similar to counseling coursework, a large number of respondents indicated engaging in no continuing education opportunities. This result is consistent with the findings of a 2015 study where a majority of SLPs reported receiving no additional training in counseling or psychology following their degree (Sekhon, Douglas, & Rose, 2015). However, our findings indicate that those who take CEUs in counseling have greater CSE. Additionally, those who indicated they acquired most of their knowledge and skills in counseling through CEU's had greater CSE when compared to those who did not. This result is similar to that reported in Sekhon et al. (2015) which found that SLPs with additional counseling training had 4 times the odds of feeling knowledgeable of, confident in, and satisfied with their ability to counsel. Additionally, those who engage in self-study were found to have greater CSE. This indicates the need for greater CEU opportunities and more resources for SLPs to have in order to continue their training in counseling.

Currently, the ASHA website offers continuing education courses by topic. There are 12 main topics for the CEU opportunities they offer, these are: Autism and Developmental Disorders, Augmentative and Alternative Communication, Cochlear Implants, Coding and Payment, Fluency, Language and Literacy, Multicultural Issues, Neurogenic Speech and Language, School-Based Issues, Service Delivery and Practice Management, Speech and Voice Disorders, and Swallowing Disorders. Counseling is not a CEU topic offered. ASHA does state that each of the CEUs they offer fall within one or more subject codes and that counseling approaches may be included within the subject codes content. However, upon investigating the webpage for Speech and Language Pathology Subject Codes, counseling is not listed under any of the subjects. Additionally, out of the 19 available Special Interest Groups (SIGs), there is not currently an ASHA SIG available for counseling. ASHA describes SIGs as a way to be engaged,

collaborate, learn, and conduct self-study. Ample CEUs and an ASHA SIG dedicated to counseling would provide additional opportunities for SLPs to seek out new information, stay up to date on the literature, and engage in further self-study and training to increase their CSE.

Proposed Training Model

Our results indicate that on the job training is the way most SLPs acquire the majority of their counseling knowledge and skills. This finding is important to consider when discussing how to foster greater CSE in SLPs. It is important to note that there is a significant lack of graduate level training offered and therefore SLPs cannot receive their counseling knowledge and skills through their graduate education if it was never offered.

The ASHA Scope of Practice defines two aspects of counseling, an educational or information component, and a personal adjustment component (ASHA, 2016). Currently, SLPs are not receiving sufficient training in counseling. Specifically, a gap in personal adjustment counseling has been identified. According to Luterman (2020), information-based counseling can be quite easy to teach and is a necessary skill that is foundational for personal adjustment counseling. Personal adjustment counseling, however, appears to be more difficult to teach and involves teaching, recognizing, and addressing emotions in clients. This could explain why, even when counseling coursework is provided, there is still a missing component to the course. In personal adjustment counseling, the SLP must listen to and acknowledge the client feelings. There is a need for graduate-level counseling coursework and further, guidelines are needed for counseling curricula to ensure personal adjustment counseling is being taught and developed in addition to informational counseling.

Limitations and Future Directions

A potential limitation to this investigation is that SLPs with particular interest in, or exposure to, counseling may have responded to this survey. For example, although the SLPs in this study reported spending an average of 35% of their time counseling clients, these results could be inflated. SLPs who have a stronger interest in counseling may be more likely to respond to a survey on counseling, value counseling, and conduct more counseling than an SLP who does not have a strong interest in this subject. Additionally, SLPs who have exposure to counseling training may have been more inclined to take the survey. This could explain why our results show a sizeable increase in the number of SLPs who reported receiving formal counseling training during their graduate education. It would be of interest to re-administer the survey to randomized controlled groups to further assess CSE in SLPs.

Another limitation is the reliability of self-reported measures such as participants reporting the number of credit hours they took in counseling coursework during their graduate school education. The majority of participants reported having more than 16 years of experience, meaning they graduated from their master's program over 16 years ago. It may have been difficult for these participants to accurately recall the specific number of credit hours in counseling coursework they took during their graduate education. Therefore, these results should be interpreted with caution. However, while the exact number may not be completely accurate, it is likely that it is a good estimate of the extent of coursework taken. It is unlikely that an individual who took coursework in counseling would falsely report taking none.

Future research should investigate additional factors that may influence CSE in SLPs. We know that the counseling literature indicates those with anxiety and stress may have lower CSE (Bandura, 1977; Barbee, Scherer, & Combs, 2003; Friedlander, Keller, Peca-Baker, & Olk,

1986; Larson & Daniels, 1998; Larson et al., 1992). However, the impact of mental health and personal experience with counseling on CSE has yet to be investigated in SLPs. It would be of interest to include questions assessing SLPs personal experiences with counseling and mental health as it relates to CSE. In future research it may also be beneficial to assess the other dimensions of locus of control, such as the external dimensions to determine their role in CSE. Our study focused on the impact internal locus of control has on CSE; however, according to Levenson (1981), a person may associate with more than one dimension. Finally, it may also be beneficial for future research to evaluate the growth of EI over graduate training. This could help determine the factors that need to be included in graduate programs to increase EI. Of note, the internal consistency scores for the EI measure used in this study were found to be relatively low and it may be of benefit to select an EI measure that warrants higher alphas.

Conclusion and Clinical Implications

This study reported CSE ratings and the factors that influence CSE in 527 SLPs. This study provided perspective on areas of strength and weakness in counseling for SLPs. Across the participants, most judged themselves to be "somewhat" confident in their ability to counsel their clients and family members across a variety of skills. It was found that of the factors examined, the ones that had the most significant impact in fostering greater CSE were EI and experience. However, results also demonstrate that having internal locus of control and more training also increase CSE. Importantly, training predicted CSE over EI and internal locus of control. We know that years of experience can only increase with time; however, training can and should occur early on in an SLPs career. While ASHA makes it clear that counseling is a part of the required areas of practice for an SLP, many participants still report receiving no formal training in counseling, yet most of their knowledge and skills in counseling comes from their graduate

education. It is imperative that SLP graduate programs include a required course dedicated to counseling. A particular focus on personal adjustment counseling would provide the most beneficial training as our results show that SLPs are less confident in this aspect of counseling when compared to informational counseling.

The importance of continuing education and self-study was also a highlighted result from this survey, with SLPS who took more CEUs and/or reported gaining most of their counseling knowledge and skills from CEU's and self-study had greater CSE. SLPs should continue to seek out CEU opportunities and resources for self-study. Additionally, these opportunities should become more abundant and accessible to the SLP.

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Appendix 1:

Institutional Review Board Research Approval

Auburn University Human Research Protection Program

EXEMPTION REVIEW APPLICATION

For information or help completing this form, contact: **THE OFFICE OF RESEARCH COMPLIANCE,**
Location: 115 Ramsay Hall   **Phone:** 334-844-5966   **Email:** IRBAdmin@auburn.edu

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Submit completed application and supporting material as one attachment to **IRBsubmit@auburn.edu**.

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1. PROJECT IDENTIFICATION   **Today's Date** _____

a. Project Title Factors influencing Speech-Language Pathologist's Counseling Self-efficacy: An Electronic Survey

b. Principal Investigator Fiona Mand _____ **Degree(s)** B.S.
Rank/Title Graduate Research Assistant _____ Department/School Speech, Language, and Hearing Sciences
Phone Number 352-860-3122 _____ AU Email fjm0007@auburn.edu

Faculty Principal Investigator (required if PI is a student) Dr. Laura Plexico
Title Professor and Department Chair _____ Department/School Speech, Language, and Hearing Sciences
Phone Number 344-844-2182 _____ AU Email lwp0002@auburn.edu

Associate Dean of Research
Dept Head Dr. Cynthia Bowling _____ Department/School CLA Department of Political Science
Phone Number 334-844-2182 _____ AU Email bowlicj@auburn.edu

c. Project Personnel (other PI) – Identify all individuals who will be involved with the conduct of the research and include their role on the project. Role may include design, recruitment, consent process, data collection, data analysis, and reporting. Attach a table if needed for additional personnel.

Personnel Name Dr. Stephen Erath _____ **Degree (s)** Ph.D
Rank/Title Professor and Director of Graduate Programs **Department/School** Human Development and Family Studies
Role Design, Recruitment, Data Analysis, Reporting
AU affiliated? ■ YES   ☐ NO   If no, name of home institution _____
Plan for IRB approval for non-AU affiliated personnel? _____

Personnel Name Dr. Megan-Brette Hamilton _____ **Degree (s)** Ph.D
Rank/Title Assistant Professor _____ Department/School Speech, Language, and Hearing Sciences
Role Design, Recruitment, Reporting
AU affiliated? ■ YES   ☐ NO   If no, name of home institution _____
Plan for IRB approval for non-AU affiliated personnel? _____

Personnel Name_____ **Degree (s)** _____
Rank/Title_____ Department/School_____
Role_____
AU affiliated? ☐ YES   ☐ NO   If no, name of home institution _____
Plan for IRB approval for non-AU affiliated personnel? _____

d. Training – Have all Key Personnel completed CITI human subjects training (including elective modules related to this research) within the last 3 years?   YES ✔   NO ☐

> The Auburn University Institutional Review Board has approved this Document for use from
> __08/05/2020__ to __-----------__
> Protocol # ___20-374 EX 2008___

Appendix 2:

Information Letter for Survey Participants

INFORMATION LETTER
For a Research Study entitled
"Factors influencing Speech-Language Pathologist's Counseling Self-efficacy:
An Electronic Survey"

You are invited to participate in a research study to determine the factors that contribute to a speech-language pathologist's counselor self-efficacy (CSE). The study is being conducted by Fiona Mand, Master's student in the Department of Speech, Language, and Hearing Sciences and Auburn University, under the direction of Dr. Laura W. Plexico, Professor and Department Chair in the Auburn University Department of Speech, Language, and Hearing Sciences. You are invited to participate because you have graduated from a graduate-level speech-language pathology program and are age 19 or older.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete an online survey that includes 95 questions. Your total time commitment will be approximately 13 minutes.

Are there any risks or discomforts? The risks associated with participating in this study are the potential for breach of confidentiality. To minimize these risks, we will not ask any identifying information, keep all responses anonymous, and use all reasonable security measures. Responses will be stored within Qualtrics software and will not be linked to any IP addresses.

Are there any benefits to yourself or others? If you participate in this study, you can expect to gain exposure to counseling terminology and skills. We cannot promise you that you will receive any or all of the benefits described.

Will you receive compensation for participating? No compensation will be provided.

Are there any costs? There are no costs associated with this survey.

If you change your mind about participating, you can withdraw at any time by closing your browser window. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Once you've submitted anonymous data, it cannot be withdrawn since it will be unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University or the Department of Speech, Language and Hearing Science.

Any data obtained in connection with this study will remain anonymous.

We will protect your privacy and the data you provide by not asking for any identifiable information and storing all data behind the secure system of Qualtrics and password protected Auburn University computers. Information collected through your participation may be published in a professional journal, and/or presented at a professional meeting.

If you have questions about this study, please ask them now by contacting Fiona Mand by email at fjm0007@auburn.edu or Dr. Laura Plexico by phone at (334) 844-9620 or email lwp0002@auburn.edu. We will be happy to answer any questions you might have. You may print a copy of this information letter to keep.

If you have any questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334)-844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

> The Auburn University Institutional
> Review Board has approved this
> Document for use from
> __08/05/2020__ to __-----------__
> Protocol # ____20-374 EX 2008____

Page 1/2

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO
PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA
YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO
KEEP.

Fiona J. Mand, B.S.

_____
Investigator   Date

Laura W. Plexico, Ph.D., CCC-SLP

_____
Co-Investigator   Date

The Auburn University Institutional Review Board has approved this document for use from _____
to _____. Protocol #_____

https://auburn.qualtrics.com/jfe/form/SV_9Yvwel1ZBstkaGx

The Auburn University Institutional
Review Board has approved this
Document for use from
__08/05/2020__ to __------------__
Protocol # ___20-374 EX 2008___

Appendix 3:

Survey Questions

HAVING READ THE INFORMATION LETTER, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE CLICK ON THE LINK BELOW.
YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

○ YES, I wish to participate (1)

○ NO, I do not wish to participate (2)

Skip To: End of Survey If Q1 = NO, I do not wish to participate
End of Block: Information Letter

Start of Block: Demographics

Q2 Have you graduated from a graduate-level speech-language pathology program?

○ Yes (1)

○ No (2)

Skip To: End of Survey If Q2 = No

Q3 How did you hear about this project?

○ Facebook (1)

○ ASHA Special Interest Group (2)

○ ASHA Community Website (3)

○ Other (5)

Q4 What is your gender?

○ Male (1)

○ Female (2)

○ Non-binary (3)

Q5 With which race(s) do you identify?

- ☐ American Indian/Alaska Native (1)

- ☐ Asian (2)

- ☐ Black and/or African American (3)

- ☐ Biracial (7)

- ☐ Native Hawaiian/Pacific Islander (8)

- ☐ White (4)

- ☐ Other (6) _____

Q6 With which ethnicity do you identify?

- ○ Hispanic (1)

- ○ Non-Hispanic (2)

Q7 What demographic region do you practice in?

- ○ Northeast (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, or Pennsylvania) (1)

- ○ Midwest (Ohio, Michigan, Indiana, Wisconsin, Illinois, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, or Kansas) (2)

- ○ South (Delaware, Maryland, Virginia, West Virginia, District of Columbia, Kentucky, North Carolina, South Carolina, Tennessee, Georgia, Florida, Alabama, Mississippi, Arkansas, Louisiana, Texas, or Oklahoma) (3)

- ○ West (Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, California, Oregon, Washington, Alaska, or Hawaii) (4)

Q8 What is your highest level of education?

○ Bachelor's Degree (1)

○ Master's Degree (2)

○ Ph.D (3)

○ Ed.D (4)

Skip To: End of Survey If Q8 = Bachelor's Degree

Q9 How many years of SLP experience do you have?

○ Less than 1 year (6)

○ 1-2 years (1)

○ 3-5 years (2)

○ 6-10 years (3)

○ 11-15 years (4)

○ 16+ years (5)

Q10 What clinical population/setting do you currently work with? Choose all that apply.

☐ Pediatric/school (1)

☐ Pediatric/outpatient (2)

☐ Pediatric/inpatient (3)

☐ Adult/outpatient (4)

☐ Adult/inpatient (5)

☐ Adult/skilled nursing facility (6)

Q11 Which of ASHA's "Big 9" areas do you have the most experience working with? Choose all that apply.

☐　　　Articulation (1)

☐　　　Fluency (2)

☐　　　Voice/Resonance (9)

☐　　　Receptive and Expressive Language (3)

☐　　　Hearing (4)

☐　　　Swallowing (5)

☐　　　Cognition (6)

☐　　　Social (7)

☐　　　Communication Modalities (8)

Q12 When considering the clients that you work with on a daily basis, approximately what percentage of the clients are of the same race/ethnicity as you?

_____

Q13 To what extent do you work with clients with comorbidities?

○ Never (1)

○ Sometimes (2)

○ Often (3)

Q14 On average, what percentage of your time with clients involves counseling?

ASHA (2004) defines counseling as: "providing timely information and guidance to clients,

families/caregivers, and other relevant persons about the nature of the disorder(s), the course of intervention, ways to enhance outcomes, coping with disorder(s), and prognosis"

_____

Q15 Who do you counsel most often?

○ Client (1)

○ Caregiver (family members, caretakers, spouses, parents) (2)

Q16 Please indicate the degree to which you acquired counseling skills and knowledge in the following settings:

	None (1)	Some (2)	Most (3)	All (4)
On the job training (1)	○	○	○	○
Clinical practicum (2)	○	○	○	○
Graduate level education (3)	○	○	○	○
Continuing education (4)	○	○	○	○
Self-study (5)	○	○	○	○

Q17 How many undergraduate-level credit hours of counseling coursework have you taken as a part of your bachelor's degree?

_____

Q18 How many graduate-level credit hours of counseling coursework have you taken as a part of your master's degree?

_____

Skip To: Q20 If Condition: How many graduate-level cre... Is Equal to 0. Skip To: How would you rate the supervision, m....

Q19 Please estimate the number of graduate-level counseling credit hours received in the following categories:

	Credit Hours Dedicated to Counseling (1)	Credit Hours in Courses with Counseling Infused throughout Curriculum (2)
Required Credit Hours (1)		
Elective Credit Hours (2)		

Q20 During graduate school and post-graduate clinical fellowship experiences, how often did you receive supervision that was dedicated to your skills in counseling?

○ Never (1)

○ Sometimes (5)

○ About half the time (2)

○ Most of the time (3)

○ Always (4)

Q21 During graduate school and post-graduate clinical fellowship experiences, how often did you receive supervision where counseling was infused in your supervisor feedback?

○ Never (1)

○ Sometimes (2)

○ About half the time (3)

○ Most of the time (4)

○ Always (5)

Q22 When did you receive the majority of your counseling supervision?

○ Graduate school (1)

○ Post-graduate (2)

Q23 How many hours of Continuing Education Units (CEUs) in counseling have you taken?

○ 0 hours (5)

○ 1-2 hours (1)

○ 3-6 hours (2)

○ 7-12 hours (3)

○ 13+ (4)

End of Block: Demographics

Start of Block: CASES for SLPs Part 1

X→

Q24 Part I Instructions: Please indicate how confident you are in your ability to use each of the following counseling skills effectively, over the next week, with most clients with communication disorders.

	(0) I'm not familiar with that concept (0)	(1) Not at all confident (1)	(2) A little confident (2)	(3) Somewhat confident (3)	(4) Very confident (4)	(5) Completely confident (5)
1. Attending (orient yourself physically toward the client). (1)	○	○	○	○	○	○
2. Listening (capture and understand the messages that clients communicate). (2)	○	○	○	○	○	○
3. Restatements (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear). (3)	○	○	○	○	○	○
4. Open questions (ask questions that help clients to clarify or explore their thoughts or feelings). (4)	○	○	○	○	○	○

5. Reflection of feelings (repeat or rephrase the client's statements with an emphasis on his or her feelings). (5)	○	○	○	○	○	○
6. Self-disclosure for exploration (reveal personal information about your history, credentials, or feelings). (6)	○	○	○	○	○	○
7. Intentional silence (use silence to allow clients to get in touch with their thoughts or feelings). (7)	○	○	○	○	○	○
8. Challenges (point out discrepancies, contradictions, defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change). (8)	○	○	○	○	○	○

9. Interpretations (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behaviors, thoughts, or feelings). (9)	○	○	○	○	○	○
10. Self-disclosures for insight (disclose past experiences in which you gained some personal insight). (10)	○	○	○	○	○	○
11. Immediacy (disclose immediate feelings you have about the client, the therapeutic relationship, or yourself in relation to the client). (11)	○	○	○	○	○	○

12. Information giving (teach or provide the client with data, opinions, facts, resources, or answers to questions). (12)	○	○	○	○	○	○
13. Direct guidance (give the client suggestions, directives, or advice that imply actions for the client to take). (13)	○	○	○	○	○	○

X→

Q25 Part II Instructions: Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling most clients with communication disorders.

	(0) I'm not familiar with that concept (0)	(1) Not at all confident (1)	(2) A little confident (2)	(3) Somewhat confident (3)	(4) Very confident (4)	(5) Completely confident (5)
1. Provide the best response, depending on what your client/caregiver needs at a given moment. (1)	○	○	○	○	○	○
2. Help your client/caregiver to explore his or her thoughts, feelings, and actions related to the communication disorder. (2)	○	○	○	○	○	○
3. Know what to do or say next after your client expresses feelings or concerns. (3)	○	○	○	○	○	○
4. Help your client/caregiver to understand his or her thoughts, feelings, and actions as they relate to the communication disorder. (4)	○	○	○	○	○	○
5. Help your client to decide what actions to take regarding his or her problems. (5)	○	○	○	○	○	○

6. Provide an appropriate response to clients or family members expressing feelings of grief regarding their/their family member's communication disorder. (6)	○	○	○	○	○	○
7. Provide an appropriate response to clients or family members expressing feelings of anger regarding their/their family member's communication disorder. (7)	○	○	○	○	○	○
8. Provide an appropriate response to clients or family members expressing feelings of guilt regarding their/their family member's communication disorder. (8)	○	○	○	○	○	○
9. Provide an appropriate response to clients or family members expressing feelings of denial regarding their/their family member's communication disorder. (9)	○	○	○	○	○	○

10. Provide an appropriate response to clients or family members expressing feelings of resistance regarding their/their family member's communication disorder. (10)	○	○	○	○	○	○
11. Counsel a client/family member regarding their locus of control and how it relates to their feelings/attitudes about their communication disorder. (11)	○	○	○	○	○	○
12. Engage families as co-diagnosticians in the diagnostic process, (12)	○	○	○	○	○	○
13. Answer questions the client or family members/caregivers have regarding diagnosis and treatment in an effective and clear manner. (13)	○	○	○	○	○	○
14. Ask open questions to obtain information regarding how the communication disorder has impacted the client's life and relationships. (14)	○	○	○	○	○	○

15. Ask open questions to obtain information regarding how the communication disorder has impacted the family system. (15)	○	○	○	○	○	○
16. Provide empathic responses to concerns caretakers/family members have regarding the client's communication disorder. (16)	○	○	○	○	○	○
17. Provide structure to sessions and maintain focus on treatment goals. (17)	○	○	○	○	○	○
18. Ask questions to evaluate client progress on treatment goals. (18)	○	○	○	○	○	○
19. Provide the client/caregivers with appropriate referrals (e.g., audiologist, medical doctor, counselor) when necessary. (19)	○	○	○	○	○	○
20. Maintain appropriate professional boundaries with your client and his or her family members/caregivers. (20)	○	○	○	○	○	○

21. Know how to address sensitive topics related to culture that may arise during diagnosis or treatment. (21)	○	○	○	○	○	○
22. Engage the client in a discussion related to his or her culture and how it may impact the thoughts, feelings, or actions related to the communication disorder. (22)	○	○	○	○	○	○

X→

Q26 For each of the following statements, please indicate the extent to which you agree or disagree by selecting the appropriate response.

	Strongly disagree (-3) (-3)	Disagree somewhat (-2) (-2)	Slightly disagree (-1) (-1)	Slightly agree (+1) (1)	Agree somewhat (+2) (2)	Strongly agree (+3) (3)
1. Whether or not I get to be a leader depends mostly on my ability (1)	○	○	○	○	○	○
2. Whether or not I get into a car accident depends mostly on how good a driver I am. (4)	○	○	○	○	○	○
3. When I make plans, I am almost certain to make them work. (5)	○	○	○	○	○	○
4. How many friends I have depends on how nice a person I am. (9)	○	○	○	○	○	○
5. I can pretty much determine what will happen in my life. (18)	○	○	○	○	○	○

6. I am usually able to protect my personal interests. (19)	○	○	○	○	○	○
7. When I get what I want, it's usually because I worked hard for it. (21)	○	○	○	○	○	○
8. My life is determined by my own actions (23)	○	○	○	○	○	○

Q27 Please answer each statement below by selecting the number that best reflects your degree of agreement or disagreement with that statement. Do not think too long about the exact meaning of the statements. Work quickly and try to answer as accurately as possible. There are no right or

rong answers. There are seven possible responses to each statement ranging from 'Completely Disagree' (number 1) to 'Completely Agree' (number 7).

	1 - Completely Disagree (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 - Completely Agree (7)
1. Expressing my emotions with words is not a problem for me. (1)	○	○	○	○	○	○	○
2. I often find it difficult to see things from another person's viewpoint. (2)	○	○	○	○	○	○	○
3. On the whole, I'm a highly motivated person (3)	○	○	○	○	○	○	○
4. I usually find it difficult to regulate my emotions. (4)	○	○	○	○	○	○	○
5. I generally don't find life enjoyable. (5)	○	○	○	○	○	○	○
6. I can deal effectively with people. (6)	○	○	○	○	○	○	○
7. I tend to change my mind frequently. (7)	○	○	○	○	○	○	○
8. Many times, I can't figure out what emotion I'm feeling. (8)	○	○	○	○	○	○	○

9. I feel that I have a number of good qualities. (9)	○	○	○	○	○	○	○
10. I often find it difficult to stand up for my rights. (10)	○	○	○	○	○	○	○
11. I'm usually able to influence the way other people feel. (11)	○	○	○	○	○	○	○
12. On the whole, I have a gloomy perspective on most things. (12)	○	○	○	○	○	○	○
13. Those close to me often complain that I don't treat them right. (13)	○	○	○	○	○	○	○
14. I often find it difficult to adjust my life according to the circumstances. (14)	○	○	○	○	○	○	○
15. On the whole, I'm able to deal with stress. (15)	○	○	○	○	○	○	○

16. I often find it difficult to show my affection to those close to me. (16) ○ ○ ○ ○ ○ ○ ○

17. I'm normally able to "get into someone's shoes" and experience their emotions. (17) ○ ○ ○ ○ ○ ○ ○

18. I normally find it difficult to keep myself motivated. (18) ○ ○ ○ ○ ○ ○ ○

19. I'm usually able to find ways to control my emotions when I want to. (19) ○ ○ ○ ○ ○ ○ ○

20. On the whole, I'm pleased with my life. (20) ○ ○ ○ ○ ○ ○ ○

21. I would describe myself as a good negotiator. (21) ○ ○ ○ ○ ○ ○ ○

22. I tend to get involved in things I later wish I could get out of. (22) ○ ○ ○ ○ ○ ○ ○

23. I often pause and think about my feelings. (23)	○	○	○	○	○	○	○
24. I believe I'm full of personal strengths. (24)	○	○	○	○	○	○	○
25. I tend to "back down" even if I know I'm right. (25)	○	○	○	○	○	○	○
26. I don't seem to have any power at all over other people's feelings. (26)	○	○	○	○	○	○	○
27. I generally believe that things will work out fine in my life. (27)	○	○	○	○	○	○	○
28. I find it difficult to bond well even with those close to me. (28)	○	○	○	○	○	○	○
29. Generally, I'm able to adapt to new environments. (29)	○	○	○	○	○	○	○
30. Others admire me for being relaxed. (30)	○	○	○	○	○	○	○