The Development of Speech-Language Pathologists' Counseling Self-Efficacy

by

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Abstract

The purpose of this investigation was to understand, from the perspective of speech-language pathologists (SLPs), what factors contribute to the essential structure of the experience of SLPs with low perceived counseling self-efficacy (CSE), the factors that contribute to the essential structure of the experience of SLPs with high perceived CSE, and how SLPs can transition from lower to higher perceived CSE. Ten female speech-language pathologists participated in interviews to discuss their counseling experiences and the development of their personal SLP CSE. The interviews were divided into 982 meaning units. The meaning units were categorized to determine the recurring themes contributing to the essential structure of low and high SLP CSE and to determine how the transition from low to high CSE occurs. Four recurring themes associated with low CSE were identified, including: (1) lack of knowledge, (2) lack of experience, (3) lack of feedback from others, and (4) personal attributes. Seven recurring themes associated with high CSE were identified, including: (1) experience, (2) situation-specific confidence, (3) experiences of success, (4) life experiences, (5) observation of others, (6) feedback from others, and (7) personal attributes. Four themes associated with perceived needs and resources for continued CSE growth were identified, including: (1) further counseling training, (2) feedback from others, (3) experience, and (4) self-reflection. Further, it was found that internal locus of control was associated with higher levels of CSE.

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ASD	Autism Spectrum Disorder
ASHA	American Speech-Language Hearing Association
CASES	Counselor Activity Self-Efficacy Scales
CCC	Certificate of Clinical Competence
CSE	Counseling Self-Efficacy
CF	Clinical fellowship
CSD	Communication Sciences and Disorders
IRB	Institutional Review Board
NICU	Neonatal Intensive Care Unit
PI	Principal Investigator
SLP	Speech-Language Pathologist

Chapter 1

Introduction

Counseling as a Part of the SLP Scope of Practice

The American Speech Language Hearing Association (ASHA) provides a Scope of Practice for speech-language pathologists (SLPs) including relevant procedures, actions, and processes necessary for appropriate practice. Counseling is included within the scope of practice as an important component of clinical responsibility in the field of speech-language pathology. Specifically, ASHA (2016a) delineates eight domains of service delivery for SLPs within the Scope of Practice: collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems. Diagnosis of a communication disorder is known to have the potential to cause emotional and psychological distress, which accounts for why counseling plays an integral role in the treatment of individuals with communication disorders. According to Luterman (2006), individuals with communication disorders along with their families/caregivers present with a variety of complex emotional reactions to their diagnoses. SLPs are called to provide support and assistance in an interactive manner to their patients who face these challenging emotions and difficult life situations in order to form realistic goals to pursue an overall more fulfilling quality of life (Flasher & Fogle, 2012; Tellis & Barone, 2018). For SLPs, counseling is not an optional aspect of service delivery to be provided on occasion. It is a necessary provision for individuals of all ages and disorder types seen by the SLP.

It is vital for SLPs to understand counseling and how it fits into the scope of practice. ASHA (2016a) defines the role of SLPs in the counseling process as having to do strictly with the emotions caused by a communication, feeding, or swallowing disorder. Flasher and Fogle

(2012) categorize counseling within the purview of SLPs as being either informational or personal adjustment counseling. Informational counseling refers to discussing the nature of a disorder or situation, intervention techniques, and prognosis and resources. Personal adjustment counseling involves addressing the deep effects of a communication disorder on everyday life by addressing feelings, thoughts, and emotions that come about as a result of a disorder/difference (Flasher & Fogle, 2012). Families and caregivers are included in these definitions alongside the patients themselves, emphasizing that the role SLPs play in counseling extends to everyone involved in the care of patients, in addition to the patients themselves. It is important to note that counseling in speech-language pathology involves more than dispensing information or advice to patients. According to ASHA (2016a), SLPs should integrate guidance, provide education, prevent further complications, and offer support in the counseling process with their patients, a process much more complex and involved than simply offering advice.

The role of the SLP in counseling may look very similar or even identical to that of a professional counselor in some situations. Luterman (2006) described how in some situations where patient affect is particularly high, thus inhibiting the progression of treatment for the communication disorder, intervention should center around counseling the individual through their struggles. In most cases, counseling is built into the treatment plan for patients receiving services. Corey (2019) emphasized the importance of an effective interpersonal relationship between patient and clinician. Within this relationship, counseling clinicians collaborate with their patients and significant others to work to bring about positive change. This interpersonal relationship, along with the goals and tasks of therapy, form the therapeutic alliance between client and clinician. According to Bachelor and Horvath (1999), this therapeutic alliance is of primary importance to the outcome of therapy.

There are instances where the counseling needs of patients exceed the scope of practice for SLPs. The ASHA Code of Ethics (2016b) states that “Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate, to ensure that quality service is provided." It is not ethical for the SLP to assume the responsibility for the counseling needs of an individual when they go beyond the realm of communication disorders. Tellis and Barone (2018) indicated that psychological or behavioral therapy in treatment for mental or emotional disorders should be left to licensed mental health professionals. Additional situations warranting the need for the expertise of another professional include drug or alcohol addiction, mental health disorders, psychosocial disorders, suicidal thoughts, physical abuse, or deterioration in relationships (ASHA, 2016a). Currently in the field of speech-language pathology, little is known about what makes one SLP a better or more competent counselor than the next. The degree to which a clinician feels prepared to provide counseling could be dependent upon several constructs: training, experience, counselor self-efficacy, and locus of control.

Counseling Skill Acquisition

Given that counseling is a domain of service delivery for SLPs, it is important to discuss how counseling skills are acquired. Counseling training for SLPs usually comes in the form of graduate coursework, clinical practicum experience, continuing education, and self-study. ASHA’s *Preferred Practice patterns for the Profession of Speech Language Pathology* (2004) states that counseling should be “conducted by appropriately credentialed and trained speech-language pathologists.” It is the ethical responsibility of SLPs to pursue sufficient education that is required to provide the highest quality of services to clients. Scheuerle (1992) established that adequate education and training allows clinicians to view counseling as more than simply

instructing and giving advice. Having sufficient training and experience also contributes to the competence and confidence one feels when performing counseling.

Formal Counseling Training

Formal counseling training is an area that is believed to increase counseling confidence for SLPs. Despite this, there is a definite lack of adequate formal counseling training for members of the field. Much of the insufficient training is likely due to the absence of available counseling coursework within SLP training programs. A study conducted by McCarthy, Culpepper, and Lucks (1986) indicated that only 40% of accredited communication sciences and disorders (CSD) programs offered counseling courses in the department, 36% had available counseling classes only outside the department, and 24% did not offer any counseling courses at all. Further, only 12% of the respondents felt that the majority of communication sciences and disorders programs offer adequate coursework and practicum to sufficiently prepare students for counseling. More recently, Doud et al. (2020) performed an updated systematic survey on CSD programs to determine if counseling courses were more widely available than in the years prior. They discovered that the number of programs offering a dedicated counseling course (within or outside the department) had dropped from 76% to 59% over the 34-year period. Luterman (2020) corroborated this when he found that slightly over half of CSD graduate programs offered a course in counseling and that only 25% of those offering a course required one. Northcott et al. (2017) provided more evidence to this end in their focus group study including twenty-three SLPs who each revealed that they had received a ‘token nod’ in the way of formal counseling training courses, or no training at all. This data serves to highlight the longstanding lack of emphasis placed on counseling training in the field of speech-language pathology.

Currently, there is no requirement for counseling coursework for SLP training programs in place. Although it is widely accepted that counseling is inherent to the field of speech-language pathology, it has long been recognized that SLPs feel they are unprepared for or lack sufficient training in this area. Luterman (2001) found that 82% of graduate students feel they lack sufficient counseling training and experiences in counseling. DiLollo and Neimeyer (2022) describe the "disconnect" that can be seen between guiding principles that suggest counseling should be utilized and what actually occurs in clinical practice, meaning that clinicians are not utilizing counseling to the extent that they should (p. 8). Overall, despite the clear directive for counseling provided in the ASHA Scope of Practice and Preferred Practice Patterns, many clinicians have been reluctant to provide such services, and a factor that is thought to contribute to this reluctance is the lack of explicit training (Holland, 2007). For many SLPs, this reluctance leads to the avoidance of providing counseling altogether.

This obvious lack of widespread, quality training has implications for the field. Sekhon et al. (2019) conducted a systematic review on counseling training for SLPs working with patients with post-stroke aphasia. They found evidence that although SLPs were required to engage in a significant amount of counseling using a range of approaches, the SLPs reported a sense of low knowledge, skills, and confidence, as well as feelings of psychological burden after engaging in counseling with this population. Research indicates that there is a definite relationship between the amount of training SLPs receive in the area of counseling and their feelings of preparedness when counseling patients. Phillips and Mendel (2008) demonstrated this when they found positive correlations between a.) hours of counseling within a work week and feelings of preparedness when providing counseling to clients and their caregivers (0.620), and b.) hours of coursework completed and feelings of being prepared to conduct counseling (0.653). Although

most SLPs would agree that counseling is an important aspect of treating the whole person, few feel adequately prepared in the area of counseling upon graduation.

Further, Rose et al. (2014) reported that although counseling is integral to the treatment of aphasia, clinicians do not feel that they are fully trained in this area. Many clinicians in the field are dissatisfied or concerned with their level of competence relating to counseling; lack of training and experience in this area is likely responsible for these feelings of concern and/or dissatisfaction (Culpepper et al., 1994). Significantly, SLPs' beliefs about and confidence with using counseling methods can influence how clients perceive their sessions. Clients report higher levels of satisfaction when counselors show greater confidence (Lent et al., 2009). Lucker (2005, p.19) further solidifies this notion with the statement, "Having greater knowledge and experiences in counseling can lead to greater success."

Experience

Counseling experience comes in many forms for SLPs and can be obtained within graduate training programs through clinical practicum, post-graduate experience within the clinical fellowship (CF) year, and post-licensure. Experience, like training, is thought to be a key factor in the development of clinician counseling confidence. Just as there is a need for the increased availability of counseling training in the field of speech-language pathology, there is a need for more widespread counseling practicum experience within graduate training programs (Rosenberg, 1997). Although SLP graduate training programs include extensive supervised clinical practicum experience, there is great variation in the amount of counseling-specific practicum experience received from person to person, and many clinicians feel a lack of experience directly related to counseling within their education. Specifically, Luterman (2001) reported that 82% of SLP graduate students indicated a need for more counseling practicum

experiences in their training programs. The 2020 Standards and Implementation Procedures for the Certificate of Clinical Competence in Speech-Language Pathology state in Standard V-B.3.c that applicants are required to have completed a program of study that included experiences sufficient to achieve a variety of skills, including counseling clients/families/caregivers regarding communication and swallowing disorders (CFCC, 2018). Thus, to receive credentialing to become a speech pathologist, it is necessary to have experience counseling in order to be sufficiently trained.

In an investigation on communication disorders students' ability to identify the boundaries of counseling, Atkins (2007) performed two surveys in which 54 graduate students were asked to rate their feelings of agreement/disagreement regarding their counseling skills and respond to whether certain topics are or are not within the scope of practice for communication disorders. Based on the results of the surveys, it was recommended that training in communication disorders programs should include counseling experiences so that students can feel more confident in counseling theories, techniques, and knowledge of appropriate topics. With such a wide array of communication disorder types addressed by SLPs, it stands to reason that there are many psychological factors that should be addressed by counseling; thus, proper counseling preparation for SLP students is absolutely essential.

Counseling experience can also be obtained following graduate education within the clinical fellowship (CF) year and post-licensure. The CF year is completed by SLPs after graduating with a master's degree. In a study of SLPs in their CF year, Zipoli and Kennedy (2005) found that clinicians more frequently used clinical experience to inform their practice than opinions of colleagues, research articles, or clinical practice guidelines. Following the CF year, SLPs receive their Certificate of Clinical Competence (CCC), indicating that they meet the

academic and professional standards for providing high-quality service to clients. The necessity of adequate experience prior to obtaining the CCC is detailed by the ASHA Code of Ethics, which states that "individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the profession that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience" (ASHA, 2016b). Further experience following the CCC and licensure can be obtained by engaging in continuing education courses specific to counseling, through work experience, or self-study.

Due to the wide variety of disorder types treated by SLPs, there is often a greater level of experience required for working with more specific populations, such as tracheostomy patients. Manley et al. (1999) evaluated how 228 practicing SLPs responded to a questionnaire on clinician experience and knowledge regarding patients with a tracheostomy tube. It was observed that SLPs who experience both academic and clinical exposure to tracheostomized patients have higher levels of confidence. Similar results can be observed for clinicians working with the specific population of children with autism spectrum disorder (ASD). In a 2013 study by Plumb and Plexico, the graduate training experiences of SLPs working with children with ASD were assessed using a web-based survey in which experiences of pre-2006 and more recent graduates were compared. It was found that the pre-2006 graduates exhibited greater confidence levels in several areas, including counseling parents of children with red flags of ASD, than the more recent graduates. These results emphasize the importance of clinical experience in conjunction with continuing education for SLPs.

The level of experience SLPs have can impact the extent to which they choose to engage in counseling within the realm of speech pathology. Parkinson and Rae (1996) found that less experienced therapists practiced fewer counseling behaviors than those with more experience.

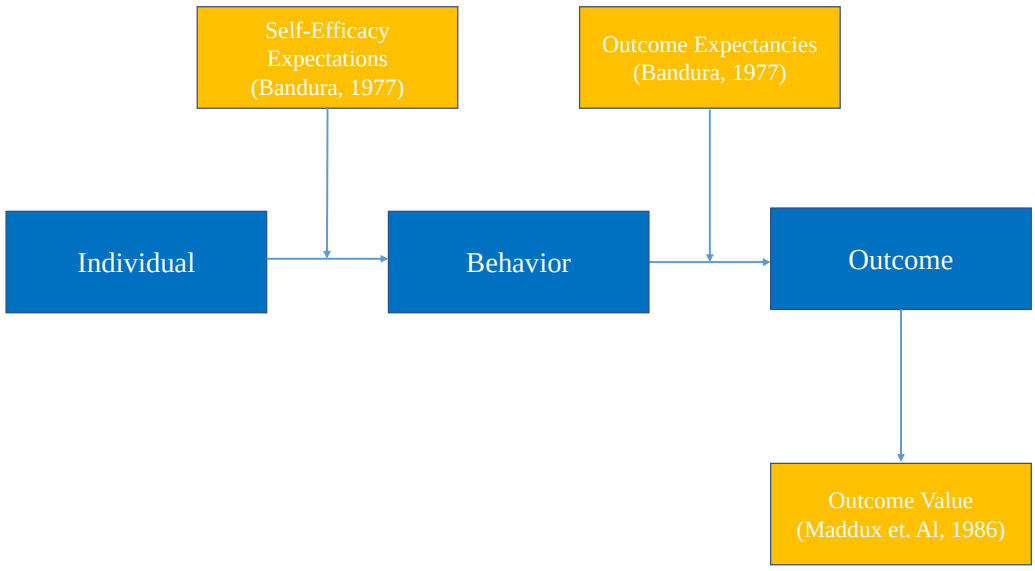
There are also implications for clinician effectiveness when a clinician has more experience. According to Schum (1986) the ability to be a truly impressive clinician, distinguish between patients' thoughts and feelings, have the knowledge on how to educate clients about their disorder, and facilitate client independence is more often seen with more experienced clinicians. These findings suggest that clinicians are more effective at counseling when they have more experience with it. The effect of increased experience is known to increase competence at a given task; this holds true for counseling experience in speech-language pathology as well.

Self-Efficacy

Self-efficacy is a construct that is believed to influence clinician confidence and competence when performing counseling. Albert Bandura (1977) originally defined self-efficacy as an individual's belief in his or her capability to successfully execute the behaviors necessary to produce specific performance achievements. According to Bandura's (1977) self-efficacy theory, a person has self-efficacy expectations and outcome expectancies. Self-efficacy expectations are the convictions that one can produce outcomes with success, and these expectations have the most influence on whether a person chooses to engage in a given behavior (Bandura, 1977). Outcome expectancies are a person's estimates that a certain behavior will lead to specific outcomes and are dependent primarily on self-efficacy expectations (Bandura, 1986). Outcome value, which refers to the potential reinforcement or stimulation an individual receives as part of the outcome of their behavior, was later proposed by Maddux et. al (1986) as a third component to the self-efficacy model. These three components, as shown below in Figure 1, interact to influence an individual's behavior.

Figure 1

The Components of Self-Efficacy.



For example, a SLP who is confident in their ability to perform a particular therapy method for a patient (self-efficacy) will expect a successful result of the therapy they provided (outcome expectancy) due to the quality of their work. The outcome value in this situation could be the increased communicative abilities of the patient or the monetary incentive they receive for their work. It is also possible to have high self-efficacy for some tasks and low self-efficacy for others within the same job, such as a SLP who has higher self-efficacy related to treating articulation disorders but lower self-efficacy for treating swallowing disorders (Heslin & Klehe, 2006). Efficacy expectations are differentiated from outcome expectations. Efficacy expectations refer to a person's confidence in their ability to successfully perform a behavior to achieve a specific outcome, while outcome expectancies refer to a person's belief that the behavior will lead to the desired outcome (Bandura, 1977). Further, efficacy expectations influence outcome

expectations to a degree, in that individuals who expect success in a particular enterprise also expect successful overall outcomes (Bandura, 1986).

Maddux (2012) describes how people have a tendency to engage in behaviors they believe will get them the things they are striving for and for which they have higher perceived self-efficacy. For example, if a person fears a certain task and has great apprehension about participating in it, they are less likely to initiate that task (Bandura, 1977). This works the other way around as well, such as when a person feels more capable of the task at hand, even if it is intimidating, they are more likely to engage in it. In this way, perceived self-efficacy influences a person's choice of activities and settings through their expectation of the level of success they will experience (Bandura, 1977). If a SLP is faced with the task of treating a fluency client, the SLP would be more likely to engage in treatment of the client if they felt capable of handling the situation, and less likely to engage if they felt apprehensive or fearful regarding the situation and its eventual outcome. Self-efficacy levels are not fixed. A study by Cervone (2000) suggests that feelings of self-efficacy can generalize across situations, and this occurs when individuals focus on a specific personal attribute as they are assessing their ability to perform in different situations.

Self-efficacy can also impact the way an individual copes once they are engaged in a given activity (Bandura, 1977). Efficacy expectations impact the level of effort an individual expends once engaged in an activity and the amount of persistence they have when faced with adversity (Bandura, 1977). That increased effort and persistence for those with higher self-efficacy often leads to increased positive outcomes, perpetuating and reinforcing their sense of efficacy, while those with lower efficacy expectations who choose not to engage preserve their lower levels of efficacy expectations (Bandura, 1977). Lu et al. (2016) performed a study on 164

employee-supervisor pairs in which the relationship between job stressors, job performance and self-efficacy were measured. The results of the study indicated that people who persist through occupation-related stress and hardships have higher self-efficacy related to their job as a result (Lu et al., 2016). Therefore, individuals with higher self-efficacy are more likely to persist in the face of difficulty. SLPs with high self-efficacy may see more success in clinical situations because they are more willing to engage and persist in those activities than those with lower self-efficacy.

Sources of Influence

According to Bandura's (1977) self-efficacy theory, feelings of self-efficacy are developed based on four sources of influence, including: performance accomplishments, vicarious experience, verbal persuasion, and physiological states. The SLP graduate training program is well-equipped to provide these experiences (Victorino & Hinkle, 2019). Performance accomplishments come in the form of mastery experiences (Bandura, 1986). Mastery experiences result from experiences of successful performance and are influenced by one's cumulative efforts at a task (Bandura, 1977). When a person experiences success, their mastery experience is raised; when they experience failure, their mastery experience is lowered (Bandura, 1977). These mastery experiences have the power to produce changes in behavior that generalize and persist over time. According to Lee and Schmaman (1987) SLP grad students' clinical self-efficacy increased after their first year of clinical practicum experience as a result of gaining mastery experiences. These mastery experiences are the most effective way of building self-efficacy (Bandura & Wessels, 1994).

The next source of self-efficacy is vicarious experience. Bandura (1977) holds that seeing another person similar to oneself succeed at a task increases observers' beliefs that they too are

capable of the efforts necessary to succeed at that task. Observation of others, such as seeing another clinician successfully counsel a client, can be extremely beneficial in building clinical self-efficacy for individuals in the field of speech-language pathology (Pasupathy et al., 2017). Verbal feedback influences self-efficacy when one receives encouragement or discouragement regarding their ability to perform (Zimmerman, 2000). Verbal persuasion is a less significant source of self-efficacy because outcomes are described but not actually experienced (Zimmerman, 2000). An example of verbal persuasion occurs when SLP students receive feedback from a clinical supervisor. Lastly, physiological states refer to a person's emotional, physical, and psychological wellbeing which affects self-efficacy at a given time (Bandura, 1977). Bandura (1977) stated that it is not only the physiological state of a person that influences self-efficacy, but how that state is perceived and responded to. He went on to explain how persons who experience higher self-efficacy are likely to view their state of emotional arousal as facilitating and motivating for their performance, while persons with lower self-efficacy are troubled and off-set by the aroused state (Bandura, 1977). Maddux and Meier (1995) later proposed a fifth route to building self-efficacy, termed imaginal experiences/visualization. This involves visualizing yourself in a favorable position in the mind, leading to increased belief in oneself and, subsequently, greater experiences of success (Maddux & Meier, 1995).

Self-efficacy is of great importance in the realm of helping professions, not only for patients, but for clinicians as well. Maddux (2012) described self-efficacy as a theory of therapeutic behavioral and emotional change that is of great value in practice for clinical researchers and practitioners. Mackenzie and Peragine (2003) performed a study on nurses involved in the care of dementia patients in which training aimed to increase self-efficacy was provided for the nurses. This self-efficacy training resulted in higher levels of confidence for

managing issues related to the patients and their families, as well as decreased levels of work-related burnout over time. Self-efficacy, along with academic performance, was also a significant predictor of physician's assistants' clinical performance (Opacic, 2003). Pasupathy and Bogschutz (2013) discovered a positive relationship ($r = 0.51$, $p < 0.01$) between SLP grad students' feelings of clinical self-efficacy and their overall clinical performance as determined by their clinical supervisors. This research indicated that there is a key relationship between SLP clinical self-efficacy and clinical performance. There is a definite lack of research pertaining specifically to SLP clinical self-efficacy currently available. Based on available literature pertaining to clinicians in related health professions, however, it is clear that clinician self-efficacy has an influence on clinical performance, thus influencing clinical outcomes for patients.

Counseling Self-Efficacy

Counseling self-efficacy (CSE) is a discipline-specific form of self-efficacy that was first described by Larson et al. (1992) as the belief counselors hold about their capability to carry out behaviors that lead to positive clinical outcomes. This measure of self-efficacy has impacts on clinical outcomes and experiences for both the patient and clinician. Clinicians with high CSE have been shown to provide more effective counseling instruction and show greater persistence when faced with adversity or difficult cases (Lent et al., 2006, 2009). Lent et al. (2009) also described how the CSE of clinicians has the potential to lead patients to feel more pleased with their sessions and the quality of those sessions. This corollary of self-efficacy has been studied as it relates to the field of speech-language pathology.

Although there is currently a lack of research on the impact of SLP CSE, a measure entitled the Counselor Activity Self-Efficacy Scales (CASES) was developed by Lent et al. (2003) as a means to that end, providing a way to gauge the level of self-efficacy a person

experiences related to counseling. This scale was originally created to assess students' CSE but was recently adapted into the CASES for SLPs by Victorino and Hinkle (2019) to assess SLP CSE. This was accomplished by adapting the original CASES scale to measure only the counseling skills and procedures directly related to the field of speech-language pathology (Victorino & Hinkle, 2019). In order to validate the CASES for SLPs in the realm of speech-language pathology, Victorino and Hinkle (2019) recruited 294 SLP graduate students and recent graduates of no more than five years post-graduation to test the scale. The adapted subscales of the CASES for SLPs included Emotional Support Skills, Session Management Skills, and three categories of Helping Skills (Insight, Exploration, and Action), all of which are relevant to SLP counseling practice (Victorino & Hinkle, 2019). The adapted subscales and the overall CASES scale identified strong internal consistency and significant statistical intercorrelations, indicating good reliability. The construct validity of the scale was also determined to be strong. Therefore, it was determined in this study that the CASES for SLPs was effective for the use of gauging SLP CSE. This measure has the ability to provide valuable information on counseling in the field of speech language pathology and its impact for clinicians.

Locus of Control

Locus of control is a construct that is believed to affect clinicians by influencing feelings of control over behaviors and outcomes. Locus of control was first defined by Rotter (1966) as "the degree to which the individual perceives that a reward follows from, or is contingent upon, his own behavior or attributes versus the degree to which he feels the reward is controlled by forces outside of himself and may occur independently of his own actions" (p. 1). This psychological construct can influence a person's functioning, depending on whether their locus of control is internal or external. When a person has internal locus of control, they believe that an

outcome occurred as a result of their effort or capability; when a person has external locus of control, they believe that the outcome occurred by chance, luck, or the control of others (Beretvas et al., 2008). A person with internal locus of control might attribute their recent promotion to their own effort and proficiency at the job, while someone with external locus of control will think that the promotion occurred because they had a great mentor at their job whose actions led them to obtain the promotion.

According to Wallston and Wallston (1982) internal and external locus of control do not have to be exclusive; one can simultaneously have internal and external beliefs about events. In one of the earliest studies on locus of control, Seeman and Evans (1962) discovered that hospitalized tuberculosis patients with internal locus of control had more knowledge about their affliction, asked their doctors and nurses more questions, and were more discontent with the amount of information conveyed to them from hospital staff than those with more external locus of control. Those with higher levels of internal locus of control often act with more confidence, assuredness, and are intentional in commanding their environment (Rotter, 1966). People with more external locus of control tend to be more passive when it comes to responding and manipulating their external circumstances (Rotter, 1966).

Rotter (1966) developed a validated 29-item scale to determine degrees of internality and externality that has since been used on a wide variety of populations, including Black civil rights activists of the 1960s (Strickland, 1965), women going through divorce (Morgan, 1988), and therapy clients (Foon, 1986). This scale, entitled the Locus of Control Scale, measures the degree to which a person believes that events result from their own actions or from factors beyond their control (Rotter, 1966). Estimates of internal consistency ranged from 0.69 to 0.73 with test-retest reliability estimated to be 0.72. Good construct validity for the scale was demonstrated based on

its effectiveness at predicting individuals' behavioral attempts to control their environment, their motivation to achieve success, and their resistance to subtle hostility. Out of the 29 total items, six items are neutral and have no effect on the resulting final score. A total score of 9 or above indicates external locus of control and a score of less than nine indicates internal locus of control.

There is an extensive body of research indicating that locus of control of fluency clients has an influence on the achievement and maintenance of goals in the therapy setting (Riper, 1973; Andrews & Craig, 1988; Luc & Kroll, 1995). There is less available research, however, pertaining to clinician locus of control specifically and its effect on the therapy process in the field of speech-language pathology. In the related field of counseling and psychotherapy, research demonstrating the influence of clinician locus of control on patient outcomes has been performed. Koeske and Kirk (1995) studied groups of clinical social workers and mental health professionals and found that the clinicians with more internal locus of control reported less job burnout due to emotional fatigue and more positive attitudes towards patients. External locus of control for the clinician can also influence patient outcomes. Evidence to support this idea has been provided in a systematic review conducted by De Vries et al. (2014) which examined the attributes of clinicians that influence communication between the patient and clinician and the patient outcomes in the field of oncology. Locus of control was one attribute investigated by the researchers in this study, and it was found that external locus of control influences a clinician's method of communicating with clients. Specifically, clinician external locus of control was associated with more timely and relevant information provided to patients, a greater occurrence of utterances directed to the family of the patients, and was associated with increased use of evaluating, examining, and summarizing communicative abilities (De Vries et al., 2014). A

positive impact on the nature of communication between the patient and clinician and the patient outcomes was reported as a result of clinicians' external locus of control within this review.

An important consideration is the interaction between the orientation of the locus of control of the patient and that of the clinician. Foon (1986) performed a study on psychotherapeutic outcomes in which 67 participants presenting with psychosomatic or neurotic struggles were asked to complete a questionnaire providing insight into their locus of control orientation, social class, and several demographic factors. The participants were then asked to view eight five-minute videos of clinicians role-playing based on a script provided by the researchers which portrayed the therapists as being oriented towards either more internal or more external locus of control. Participants then rated their feelings of comfort with the therapists and how helpful they felt the therapist would be if they were to engage in therapy with them based on the role play scenarios. The results of the study showed that similar locus of control styles of the therapist and client indicated more favorable expectations on the part of the client (Foon, 1986). Although it can be determined from research on clinicians from related disciplines that clinician locus of control has an impact on the therapeutic process, further research on its effects on clinician locus of control in the field of communication disorders is still needed.

Interaction Between Self-Efficacy and Locus of Control

It has been demonstrated that self-efficacy and locus of control each individually have an influence on confidence levels when performing tasks and engaging in therapy. There is also a relationship between self-efficacy and locus of control that has been observed to impact behavior. In a systematic review on the relationship between self-efficacy, locus of control, and medication adherence, Nafradi et al. (2017) provided evidence that high self-efficacy and more internal locus of control consistently predicted medication adherence. It was established that

building patients' higher levels of self-efficacy and encouraging more internal locus of control was associated with patient empowerment, which then leads to unbiased clinician-client relationships (Nafradi et al., 2017). Further research examining the effect of clinician self-efficacy and locus of control on the therapeutic alliance is still needed.

There is evidence showing the influence of the interaction of self-efficacy and locus of control on clinicians working as a part of the therapeutic process. Severino et al. (2011) demonstrated this in a survey-based study on interaction between self-efficacy and locus of control on health professionals. In this study the interaction of the constructs was examined in order to determine their effects on learning achievement in the context of distance education for health professionals. It was discovered based on participant reports that locus of control and self-efficacy have a significant relationship with each other (Severino et al., 2011). This interaction between self-efficacy and locus of control has many functional implications. Skinner and Greene (2008) hold that control beliefs, namely, self-efficacy and locus of control, have two primary functions in molding control processes: (1) in preparation for an activity, control expectations have a regulatory function of framing how people approach and take part in a task, and (2) they have an interpretative function, in that they help interpret the meaning of the experience for future control following an outcome resulting from a given action. For example, in the clinical setting, the way a SLP approaches and chooses to take part in the interaction, along with the way they process the interaction once it has ended, both depend on that clinician's self-efficacy and locus of control.

In the realm of counseling, Harper (2008) found a positive relationship between high CSE and internal locus of control, as well as between toleration of ambiguity and higher CSE. A positive relationship between external locus of control and low CSE, as well as low toleration of

ambiguity and lower CSE was also found. In his dissertation analyzing the presence of a relationship between dogmatism, locus of control, and CSE as experienced by 45 graduate students, Benesh (2017) found a positive relationship between locus of control and perceived CSE. Further research on the effects of locus of control and perceived self-efficacy specifically related to counseling in the speech pathology setting is warranted, but research from related fields implies the relevance of these constructs in the counseling setting for SLPs.

Justification

ASHA recognizes counseling as a fundamental aspect of service delivery and an ethical responsibility for SLPs. It is therefore important for SLPs to determine how to become effective, competent counselors. CSE is a construct that has been shown to influence clinicians. Lent et al. (2006) demonstrated that clinicians with high CSE have been shown to provide more effective counseling instruction and show greater persistence when faced with adversity or difficult cases. Although there has been research on the effect of self-efficacy and the influence of locus of control on clinicians in the related fields of psychotherapy and healthcare, there is a lack of research pertaining specifically to SLP CSE in the field of communication disorders. This study provided valuable information on the contributing factors that influence SLPs' CSE. The information provided by this study will serve to identify ways that SLPs can go about increasing their counseling confidence to become overall more competent counselors, able to provide sufficient counseling services for patients experiencing the difficulties and life struggles that often accompany communication disorders.

This phenomenological study aimed to address the gaps in the research pertaining to this area by describing in detail the underlying factors that contribute to a SLP's experience of perceived CSE.

The present study aimed to answer the following questions:

1. What is the essential structure of the experience of a SLP with greater perceived CSE?
2. What is the essential structure of the experience of a SLP with lower perceived CSE?
3. How can a SLP transition from lower perceived CSE to greater perceived CSE?

Chapter II

Methods

The goal of the current study was to develop insight into the clinician characteristics of SLPs that align with feelings of perceived CSE. Specifically, the purpose of this investigation was to explore themes that help explain why some SLPs are perceived to be more confident in their counseling ability than other SLPs. Rather than measuring the overt characteristics of clinicians, a qualitative methodology was performed in the form of phenomenological analysis of interviews of adults who had practiced counseling techniques in the speech-language pathology setting. A qualitative research model was selected because of its ability to provide a naturalistic representation of clinicians' counseling experiences (Patton, 2015).

Research Participants

To participate in the study, participants had to be individuals who had graduated from a graduate-level speech-language pathology program, were over the age of 19, and not currently receiving any treatment for a mental health disorder. Anyone receiving current treatment for a mental health disorder was excluded from the study because their current personal experiences with treatment might influence their perception of counseling. The participants were diverse in their age, primary clinical setting, and therapy experiences to represent a broader range of experiences (Patton, 2015).

Recruitment

Initial approval from the Auburn University Institutional Review Board (IRB) was received before the study began (see Appendix 1). The participants were recruited for this study through several methods. Flyers that included a description of the study and an invitation to scan a QR code leading to the project participation website were posted to investigators' Facebook

pages and relevant SLP Facebook groups (see Appendix 2). Investigators posted the flyer and a corresponding social media script to the following Facebook groups: Early Intervention SLPs - Birth to 3, Pediatric Medical SLPs, SLP Medical Research Group, SLPs for Evidence Based Practice, School-Based SLPs, Introvert SLPs, Speech Pathologists at Large, Stuttering and Fluency Disorders for SLPs, Clinical Research for SLPs, AAC for the SLP, SLP Private Practice Beginners, and Medical SLP Forum. Additionally, a post including the flyer, social media script, and an invitation to participate were made on the ASHA Community website. The investigators posted to the following ASHA Communities: SLP Schools, SLP Private Practice, SLP Health Care, Research, Early Intervention, SLP Technology, and Autism. The invitation to participate was also spread by word of mouth.

Following their initial contact with the principal investigator (PI), participants were sent the information letter (see Appendix 3), a Code ID form (see Appendix 4), and a link to a Qualtrics survey including a copy of the information letter, details of the study, a brief demographic questionnaire, and the CASES for SLPs (see Appendix 5) via email. Participants were also provided with the opportunity to provide a pseudonym for the purposes of the study within the survey. A second survey including the Locus of Control Scale and a question inquiring on the participants' ethnicity was also sent out (see Appendix 6).

Once the CASES Qualtrics survey and Code ID form were completed, a Zoom interview time was established within two weeks of the survey completion, at the convenience of the participant. It was made clear to participants within the information letter that the risks involved with participation in the study could include emotional discomfort or feelings of uneasiness associated with recalling past counseling experiences, and that there was also a possibility of a confidentiality breach, although extensive measures would be taken to prevent that possibility.

Participants were informed that the benefits involved with participating in the study included increased exposure to counseling terminology and counseling skills. Further, the information letter also provided the information that participation was voluntary and could be discontinued at any time without penalty.

Interview

All the interviews for this study were conducted by either a graduate researcher or an undergraduate researcher. Each interview took place over Zoom in a private location where participant responses could not be overheard. The Zoom interview waiting room feature was enabled to ensure that there were no interruptions or others joining the meeting by accident. Additionally, each participant was sent a personalized link to each Zoom meeting which was associated with that meeting time only and not with any of the researchers' private Zoom rooms or recurrent meetings. Participants were asked to complete the interview in a private space to protect their privacy and ensure conversations were not overheard. They were also encouraged to disable "cookies" and close their device browser. During the interview, participants were asked to answer the questions to the best of their ability. The participants were all given the same series of open-ended interview questions predetermined by the researchers (see Appendix 7). These interview questions were based on Bandura's (1977) "Self-efficacy: Toward a unifying theory of behavioral change" article. The questions were designed to elicit the participants' perceptions of their perceived CSE and what factors contributed to their perception. The interviews were semi-structured, meaning that the format was flexible and allowed for probing and follow-up questions. The participants were also asked at the end of each interview whether there was anything they wanted to add to contribute to the discussion that was not addressed in the series of questions. Each interview was around one hour in length. The narrative responses of the

participants were collected for subsequent analysis by recording the audio and video of the interviews over Zoom. The recordings were immediately uploaded to the Box drive and then deleted from the researcher's computer following the interview. The participants' identifiable information was only accessible by the key personnel and was kept on password protected computers.

Analyses

The first survey completed by participants was the CASES for SLPs (Victorino & Hinkle, 2019). This survey is an adapted version of the original CASES designed by Lent et al. (2003) which examines SLP students' and practicing clinicians' levels of CSE. The survey includes a total of 35 questions and is divided into five subscales: Emotional Support Skills, Session Management Skills, Helping Skills- Insight, Helping Skills- Exploration, and Helping Skills-Action. Respondents are asked to rate their feelings of confidence for each question on a 5-point scale ranging from 1-5, with higher numbers indicating higher confidence levels. Scores of 1-5 can be interpreted as follows: (1) the participant is not at all confident (2) a little confident, (3) somewhat confident, (4) very confident, (5) totally confident (Victorino & Hinkle, 2019). If a respondent is not familiar with the concept addressed by a question, they are instructed to select a zero on the scale. For the purpose of this study, if a participant selected a zero indicating unfamiliarity with a certain counseling construct, this question was omitted in the calculation of their final score. To obtain the final score, the selected numbers for each question are added and then divided by the total number of questions to obtain an average. Thus, if an individual is familiar with all counseling constructs, the minimum score to be obtained is 1. The maximum possible score is a 5. This holds true for both the overall CASES for SLPs score and the subscale scores.

The second survey sent to participants was the Rotter's (1966) 29-item Locus of Control Scale to measure the participants' degrees of internal/external locus of control. This measure requires individuals to select the statement they agree with most with from a field of two choices for all 29 items. For example, a.) Many of the unhappy things in people's lives are partly due to bad luck, or b.) People's misfortunes result from the mistakes they make. Participants are awarded one point for each answer choice they select that aligns with a more external viewpoint. Six of the questions are fillers only and are not included in the final score. Scores can therefore rage from 0-23, with higher scores indicating more external locus of control and lower scores indicating more internal locus of control.

A phenomenological research method was used for data analysis of the interviews. Phenomenological research seeks to explain phenomena, which are manifested in lived experiences (Polkinghorne et al., 1989). These phenomena can be tangible, such as programs and organizations, or more intangible things such as feelings and relationships. The most effective way to go about conducting phenomenological research is to conduct in-depth interviews with people who have personally experienced the phenomenon being studied. The goal is to explain the essence of the lived experience by describing how people feel, perceive, recall, talk about, and make sense of it (Polkinghorne et al., 1989). By comparing different people's feelings on the particular phenomenon, researchers are able to capture the essence of the phenomenon, seeking to encourage shared experiences. As researchers delve deeper into aspects of the experience, they seek to explain the world around them in a more effective way. Phenomenological research puts people's unconscious awareness, observations, and conceptions into words, describing how they have been integrated into conscious experience, and then seeks to explain the meaning (Polkinghorne et al., 1989). Using this method, the data is clustered into meaning units which are

then grouped together into topics of significance. By meticulously examining the meaning units, the researcher attempts to extract the essence of meaning of units within the holistic context of the phenomenon (Groenwald, 2004).

The spoken responses of the participants were transcribed verbatim and were used as the main source of data for this study. Participants' responses were included if the participant (a) had been able to provide rich descriptions of the phenomenon, (b) had been able to adequately communicate their experiences with the phenomenon, (c) had been willing to fully share their experiences about the phenomenon, and (d) had a history of employing counseling methods in the speech-language pathology setting. Each interview was coded with the pseudonym chosen by the participant. Using the Microsoft Word platform, the researchers independently broke each utterance into units of meaning. After performing this task separately, the two researchers came together to compare the number of agreements/disagreements contained in their division of the interviews and derived a percent reliability based on areas of agreement. A consensus was met for all areas of disagreement, so that the final set of meaning units were agreed upon by all members of the research team. The meaning units were then entered into the NVivo 11 Pro software (QSR International, 2015) in order to further organize the data into a hierarchy of categories.

Credibility

It was the aim of this qualitative study to perform the research in as unbiased a manner as is possible. However, the nature of qualitative research does not allow the researcher to completely remove their biases from a study. At the start of the study, the PI, a SLP graduate student, and a SLP undergraduate student were involved in participant recruitment and data collection. The undergraduate student then took over the process under the direction of the PI

upon beginning graduate school. This student has an undergraduate degree in Speech, Language, and Hearing Sciences and a minor in Counseling. Both students were trained in the process of coding the meaning units by the PI. In the present study, credibility was addressed by integrating the following procedures:

1. Each interview was recorded with high quality audio and video over the Zoom platform and transcribed verbatim prior to analysis.
2. Investigator triangulation was incorporated in order to integrate multiple viewpoints, establishing themes from more than one point of view. This was accomplished when the two student investigators coded the meaning units separately, and then met together to compare. The PI's perception was sought out when the meaning units could not be agreed upon, as the PI attended many of the interviews and interacted with the participants, indicating an understanding of the participants' experiences.

Chapter III

Manuscript

Counseling as a Part of the SLP Scope of Practice

The American Speech Language Hearing Association (ASHA) provides a Scope of Practice for speech-language pathologists (SLPs) including relevant procedures, actions, and processes necessary for appropriate practice. Counseling is included within the scope of practice as an important component of clinical responsibility in the field of speech-language pathology. Specifically, ASHA (2016a) delineates eight domains of service delivery for SLPs within the Scope of Practice: collaboration; counseling; prevention and wellness; screening; assessment; treatment; modalities, technology, and instrumentation; and population and systems. According to Luterman (2006), individuals with communication disorders along with their families/caregivers present with a variety of complex emotional reactions to their diagnoses. SLPs are called to provide support and assistance in an interactive manner to their patients who face these challenging emotions and difficult life situations in order to form realistic goals to pursue an overall more fulfilling quality of life (Flasher & Fogle, 2012; Tellis & Barone, 2018). For SLPs, counseling is not an optional aspect of service delivery to be provided on occasion. It is a necessary provision for individuals of all ages and disorder types seen by the SLP. Currently in the field of speech-language pathology, little is known about what makes one SLP a better or more competent counselor than the next. The degree to which a clinician feels prepared to provide counseling could be dependent upon several constructs: training, experience, counselor self-efficacy, and locus of control.

Counseling Skill Acquisition

Given that counseling is a domain of service delivery for SLPs, it is important to discuss how counseling skills are acquired. Counseling training for SLPs usually comes in the form of graduate coursework, clinical practicum, continuing education, and self-study. ASHA's *Preferred Practice patterns for the Profession of Speech Language Pathology* (2004) states that counseling should be "conducted by appropriately credentialed and trained speech-language pathologists." It is the ethical responsibility of SLPs to pursue sufficient education necessary to provide the highest quality of services to clients. Scheuerle (1992) established that adequate education and training allows clinicians to view counseling as more than simply instructing and giving advice. Having sufficient training and experience also contributes to the competence and confidence one feels when performing counseling.

Formal Counseling Training

Formal counseling training is an area that is believed to increase counseling confidence for SLPs. Despite this, there is a definite lack of adequate formal counseling training for members of the field. Much of the insufficient training is likely due to the absence of available counseling coursework within SLP training programs. Doud et el. (2020) performed an updated systematic survey on communication sciences and disorders programs to determine the current availability of counseling courses. They discovered that the number of programs offering a dedicated counseling course (within or outside the department) had dropped from 76% to 59% since 1984. There is currently no requirement for counseling coursework for SLP training programs in place. Due to this lack of sufficient counseling training and experience provided for students, SLPs can have lower levels of confidence related to their counseling abilities as a result (Millar et al., 2010). Many clinicians in the field are dissatisfied or concerned with their level of

competence related to counseling; lack of training and experience in this area is likely responsible for these feelings of concern and/or dissatisfaction (Culpepper et al., 1994).

Experience

Counseling experience comes in many forms for SLPs and can be obtained within graduate training programs in the form of clinical practicum experience, post-graduate experience within the clinical fellowship (CF) year, and post-licensure. Experience, like training, is thought to be a key factor in the development of clinician counseling confidence. Just as there is a need for the increased availability of counseling training in the field of speech-language pathology, there is a need for more widespread counseling practicum experience within graduate training programs (Rosenberg, 1997). In a study on SLPs in their CF year, Zipoli and Kennedy (2005) found that clinicians more frequently used clinical experience to inform their practice than opinions of colleagues, research articles, or clinical practice guidelines. The level of experience SLPs have can impact the extent to which they choose to engage in counseling within the realm of speech pathology. There are also implications for clinician effectiveness when a clinician has more experience. According to Schum (1986) the ability to be a truly impressive clinician, distinguish between patients' thoughts and feelings, have the knowledge on how to educate clients about their disorder, and facilitate client independence is more often seen with more experienced clinicians. These findings suggest that clinicians are more effective at counseling when they have more experience with it.

Self-Efficacy

Self-efficacy is a construct that is believed to influence clinician confidence and competence when performing counseling. Albert Bandura (1977) originally defined self-efficacy as an individual's belief in his or her capability to successfully execute the behaviors necessary

to produce specific performance achievements. According to Bandura's (1977) self-efficacy theory, a person has self-efficacy expectations and outcome expectancies. Self-efficacy expectations are the convictions that one can produce outcomes with success, and these expectations have the most influence on whether a person chooses to engage in a given behavior (Bandura, 1977). Outcome expectancies are a person's estimates that a certain behavior will lead to specific outcomes and are dependent primarily on self-efficacy expectations (Bandura, 1986). Outcome value, which refers to the potential reinforcement or stimulation an individual receives as part of the outcome of their behavior, was later proposed by Maddux et. al (1986) as a third component to the self-efficacy model. These three components interact to influence an individual's behavior.

Sources of Influence

According to Bandura's (1977) self-efficacy theory, feelings of self-efficacy are developed based on four sources of influence, including: performance accomplishments, vicarious experience, verbal persuasion, and physiological states. Performance accomplishments come in the form of mastery experiences (Bandura, 1986). Mastery experiences result from experiences of successful performance and are influenced by one's cumulative efforts at a task (Bandura, 1977). The next source of self-efficacy is vicarious experience. Bandura (1977) found that seeing another person similar to oneself succeed at a task increases observers' beliefs that they too are capable of the efforts necessary to succeed at that task. Verbal feedback influences self-efficacy when one receives encouragement or discouragement regarding their ability to perform (Zimmerman, 2000). Lastly, physiological states refer to a person's emotional, physical, and psychological wellbeing which affects self-efficacy at a given time (Bandura, 1977).

Counseling Self-Efficacy

A corollary of self-efficacy that has been studied in the field of speech-language pathology is counseling self-efficacy (CSE); (Victorino & Hinkle, 2019). CSE is a discipline-specific form of self-efficacy that was first described by Larson et al. (1992) as the belief counselors hold about their capability to carry out behaviors that lead to positive clinical outcomes. This measure of self-efficacy has impacts on clinical outcomes and experiences for both the patient and clinician. Clinicians with high CSE have been shown to provide more effective counseling instruction and show greater persistence when faced with adversity or difficult cases (Lent et al., 2006, 2009). Although there is currently a lack of research on the impact of SLP CSE, a measure entitled the Counselor Activity Self-Efficacy Scales (CASES) was developed by Lent et al. (2003) as a means to that end, providing a way to gauge the level of self-efficacy a clinician experiences related to counseling. This scale was originally created to assess students' CSE but was recently adapted into the CASES for SLPs by Victorino and Hinkle (2019) to assess SLP CSE.

Locus of Control

Locus of control is a construct that is believed to affect clinicians by influencing feelings of control over behaviors and outcomes. Locus of control was first defined by Rotter (1966) as "the degree to which the individual perceives that a reward follows from, or is contingent upon, his own behavior or attributes versus the degree to which he feels the reward is controlled by forces outside of himself and may occur independently of his own actions" (p. 1). When a person has internal locus of control, they believe that an outcome occurred as a result of their effort or capability; when a person has external locus of control, they believe that the outcome occurred by chance, luck, or the control of others (Beretvas et al., 2008). Rotter (1966) developed a

validated 29-item scale which is commonly used to determine degrees of internality and externality. This scale, entitled the Locus of Control Scale, measures the degree to which a person believes that events result from their own actions or from factors beyond their control (Rotter, 1966).

Interaction Between Self-Efficacy and Locus of Control

There is evidence showing the influence of the interaction of self-efficacy and locus of control on clinicians working as a part of the therapeutic process. In the realm of counseling, Harper (2008) found a positive relationship between high CSE and internal locus of control, as well as between toleration of ambiguity and higher CSE. A positive relationship between external locus of control and low CSE, as well as low toleration of ambiguity and lower CSE was also found. In his dissertation analyzing the presence of a relationship between dogmatism, locus of control, and CSE as experienced by 45 graduate students, Benesh (2017) found a positive relationship between locus of control and perceived CSE. Further research on the effects of locus of control and perceived self-efficacy specifically related to counseling in the speech pathology setting is warranted, but research from related fields implies the relevance of these constructs in the counseling setting for SLPs.

Purpose

ASHA recognizes counseling as a fundamental aspect of service delivery and an ethical responsibility for SLPs. It is therefore important for SLPs to determine how to become effective, competent counselors. CSE is a construct that has been shown to influence clinicians. Lent et al. (2006) demonstrated that clinicians with high CSE have been shown to provide more effective counseling instruction and show greater persistence when faced with adversity or difficult cases. Although there has been research on the effect of self-efficacy and the influence of locus of

control on clinicians in the related fields of psychotherapy and healthcare, there is a lack of research pertaining specifically to SLP CSE in the field of communication disorders. This study provided valuable information on the contributing factors that influence SLPs' CSE. The information provided by this study will serve to identify ways that SLPs can go about increasing their counseling confidence to become overall more competent counselors, able to provide sufficient counseling services for patients experiencing the difficulties and life struggles that often come alongside communication disorders.

This phenomenological study aimed to address the gaps in the research pertaining to this area by describing in detail the underlying factors that contribute to a SLP's experience of perceived CSE.

The present study aimed to answer the following questions:

4. What is the essential structure of the experience of a SLP with greater perceived CSE?
5. What is the essential structure of the experience of a SLP with lower perceived CSE?
6. How can a SLP transition from lower perceived CSE to greater perceived CSE?

Methods

Research Participants

To participate in the study, participants had to be individuals who had graduated from a graduate-level speech-language pathology program, were over the age of 19, and not currently receiving any treatment for a mental health disorder. Anyone receiving current treatment for a mental health disorder was excluded from the study because their current personal experiences with treatment might influence their perception of counseling. The participants were diverse in

their age, primary clinical setting, and therapy experiences to represent a broader range of experiences (Patton, 2015).

Recruitment

Initial approval from the Auburn University Institutional Review Board (IRB) was received before the study began. The participants were recruited for this study through several methods. Flyers that included a description of the study and an invitation to scan a QR code leading to the project participation website were posted to investigators' Facebook pages and relevant SLP Facebook groups. Additionally, a post including the flyer, social media script, and an invitation to participate were made on the ASHA Communities website. The invitation to participate was also spread by word of mouth.

Following their initial contact with the principal investigator (PI), participants were sent the information letter, a Code ID form, and a link to a Qualtrics survey including a copy of the information letter, details of the study, a brief demographic questionnaire, and the Counselor Activity Self-Efficacy Scale for Speech-Language Pathologists (CASES for SLPs) via email. Participants were also asked to complete a survey containing the Locus of Control Scale and provide their ethnicity following the completion of the interviews. They were given the opportunity to provide a pseudonym for the purposes of the study within the survey. Once the Qualtrics survey and Code ID form were completed, a Zoom interview time was established within two weeks of the survey completion, at the convenience of the participant.

Interview

All the interviews for this study were conducted by either a graduate researcher or an undergraduate researcher. Each interview took place over Zoom in a private location where participant responses could not be overheard. The Zoom interview waiting room feature was

enabled to ensure that there were no interruptions or others joining the meeting by accident. Additionally, each participant was sent a personalized link to each Zoom meeting which was associated with that meeting time only and not with any of the researchers' private Zoom rooms or recurrent meetings. Participants were asked to complete the interview in a private space to protect their privacy and ensure conversations were not overheard. The participants were all given the same series of open-ended interview questions predetermined by the researchers. Participants were asked at the beginning of each interview how they would rate their counseling confidence on a 100-point counseling confidence scale. A self-rating of 50 or above identified them as a high CSE participant, while a self-rating of below 50 identified them as a low CSE participant. Each interview was around one hour in length. The narrative responses of the participants were collected for subsequent analysis by recording the audio and video of the interviews over Zoom.

Analyses

The first survey completed by participants was the CASES for SLPs. This survey is an adapted version of the original CASES designed by Lent et al. (2003) which examines SLP students' and practicing clinicians' levels of CSE. The survey includes a total of 35 questions and is divided into five subscales: Emotional Support Skills, Session Management Skills, Helping Skills- Insight, Helping Skills- Exploration, and Helping Skills- Action. Respondents are asked to rate their feelings of confidence for each question on a 5-point scale ranging from 1-5. Scores of 1-5 can be interpreted as follows: (1) the participant is not at all confident (2) a little confident, (3) somewhat confident, (4) very confident, (5) totally confident (Victorino & Hinkle, 2019). If a respondent is not familiar with the concept addressed by a question, they are instructed to select a zero on the scale. For the purpose of this study, if a participant selected a

zero indicating unfamiliarity with a certain counseling construct, this question was omitted in the calculation of their final score. To obtain the final score, the selected numbers for each question are added and then divided by the total number of questions to obtain an average. Thus, if an individual is familiar with all counseling constructs, the minimum score to be obtained is 1. The maximum possible score is a 5. The adapted subscales and the overall CASES scale identified strong internal consistency and significant statistical intercorrelations, indicating good reliability. The construct validity of the scale was also determined to be strong. Therefore, it was determined in this study that the CASES for SLPs was effective for the use of gauging SLP CSE.

The second survey sent to participants was the Rotter's (1966) 29-item Locus of Control Scale to measure the participants' levels of internal/external locus of control. This scale, entitled the Locus of Control Scale, measures the degree to which a person believes that events result from their own actions or from factors beyond their control (Rotter, 1966). Estimates of internal consistency for the scale ranged from 0.69 to 0.73 with test-retest reliability estimated to be 0.72. Good construct validity for the scale was demonstrated based on its effectiveness at predicting individuals' behavioral attempts to control their environment, their motivation to achieve success, and their resistance to subtle hostility. Out of the 29 total items, six items are neutral and have no effect on the resulting final score. A total score of nine or above indicates external locus of control and a score of less than nine indicates internal locus of control.

The spoken responses of the participants were transcribed verbatim and were used as the main source of data for this study. Participants' responses were included if the participant (a) had been able to provide rich descriptions of the phenomenon, (b) had been able to adequately communicate their experiences with the phenomenon, (c) had been willing to fully share their experiences about the phenomenon, and (d) had a history of employing counseling methods in

the speech-language pathology setting. Each interview was coded with the pseudonym chosen by the participant. Using the Microsoft Word platform, the researchers independently broke each utterance into units of meaning. After performing this task separately, the two researchers came together to compare the number of agreements/disagreements contained in their division of the interviews and derived a percent reliability based on areas of agreement. A consensus was met for all areas of disagreement, so that the final set of meaning units were agreed upon by all members of the research team. The meaning units were then entered into the NVivo 11 Pro software (QSR International, 2015) in order to further organize the data into a hierarchy of categories.

Credibility

It was the aim of this qualitative study to perform the research in as unbiased a manner as is possible. However, the nature of qualitative research does not allow the researcher to completely remove their biases from a study. At the start of the study, the PI, a SLP graduate student, and a SLP undergraduate student were involved in participant recruitment and data collection. The undergraduate student then took over the process under the direction of the PI upon beginning graduate school. This student has an undergraduate degree in Speech, Language, and Hearing Sciences and a minor in Counseling. Both students were trained in the process of coding the meaning units by the PI. In the present study, credibility was addressed by integrating the following procedures:

1. Each interview was recorded with high quality audio and video over the Zoom platform and transcribed verbatim prior to analysis.
2. Investigator triangulation was incorporated in order to integrate multiple viewpoints. This was accomplished when the two student investigators coded the meaning units separately,

and then met together to compare. The PI's perception was sought out when the meaning units could not be agreed upon.

Results

Participants

Ten SLPs were included as participants in the study, all of whom were female and had obtained, at minimum, a master's degree from a graduate-level speech-language pathology program. The participants had varying degrees of experience in a variety of settings. They ranged in age from 26 to 63 years of age (M = 41.5, SD = 37) and had an average of 12.35 years of experience (SD = 9.160). Table 1 provides a summary of the demographic data of each participant. Following Table 1, a brief description of each participant is provided.

Overall, the individuals who agreed to participate in the study were diverse in age, clinical background, and years of clinical experience. Every participant had experience treating patients with comorbidities. The majority of the participants (n=8) were White, one was Asian, and one was of Aruban descent and therefore had no assigned race or ethnicity. All the participants were female. Four of the ten total participants presented with low CSE at the time of the interviews, and the remaining six reported experiencing high CSE, based on their verbal report of their level of counseling confidence on a 100-point counseling confidence scale. Therefore, both high and low CSE participants were represented as participants in this study. All the participants had obtained, at minimum, a master's degree, with the highest level of education for one participant being a doctoral degree.

Table 1

Demographic Information

Pseudonym	Gender	Race	Ethnicity	Age	Years of Experience	Primary Clinical Setting
Genevieve	F	White	Not Hispanic or Latino	43	18	Day Rehabilitation*
Chiara	F	White	Not Hispanic or Latino	31	2	Skilled Nursing Facility*
Clara Praat	F	Other	Other	35	10	Skilled Nursing Facility
Riley Taylor	F	White	Not Hispanic or Latino	29	6	School*
Uma Lake	F	White	Not Hispanic or Latino	63	32	University*
TKLM	F	Asian	Not Hispanic or Latino	58	21	Inpatient Hospital*
Lucille	F	White	Not Hispanic or Latino	32	8	School*
Evelyn Rose	F	White	Not Hispanic or Latino	40	8	School
Rebecca	F	White	Not Hispanic or Latino	58	17.5	University*
Ellen	F	White	Not Hispanic or Latino	26	<1	Early Intervention

*Note. * Indicates participants worked in more than one clinical setting.*

Quantitative Data Analysis

All ten participants completed the CASES for SLPs through the initial online survey. Total scores on the scale ranged from 2.34 to 4.29 with a mean score of 3.27 (SD = .575). Total scores for both the overall score and for each subscale on this measure can range from 1 (lowest level of CSE) to 5 (highest level of CSE). On the subscales, the group mean score was 2.8 (SD = .749) for the Emotional Support Skills subscale, 3.63 (SD = .632) for Helping Skills- Action, 3.72 (SD = .601) for Helping Skills- Exploration, 3.17 (SD = 1.085) for Helping Skills- Insight, and 3.57 (SD = .402) for Session Management Skills. These scores indicated that the SLPs who took part in the study had greater CSE regarding their helping action skills, helping exploration skills, and session management skills. They had lower CSE for their emotional support skills and

helping insight skills. Participants who verbally reported low counseling confidence on the 100-point counseling confidence scale in their interview received a total score of 3.31 or below, indicating that they ranged from somewhat confident to a little confident in their counseling skills. Participants who reported high counseling confidence on the 100-point counseling confidence scale received a total score of 3.63 or above, indicating that they ranged from somewhat to totally confident in their counseling skills. In general, the scores on the measure aligned with participants' verbal report of their level of CSE when asked to rate themselves on the 100-point counseling confidence scale. Table 2 provides a summary of the participants' verbal self-report of CSE and locus of control level, their CASES for SLPs total scores and subscale scores, and their Locus of Control Scale scores. The participants were listed from lowest to highest level of CSE based on their verbal self-rating within the table.

Table 2

Participants' CSE self-rating, CASES for SLPs Total Scores and Subscores, and Locus of Control Scale Total Scores

Participant	CSE Self-Rating	CASES for SLPs Total Score	Emotional Support Skills	Helping Skills: Action	Helping Skills: Exploration	Helping Skills: Insight	Session Management Skills	LOC Self-Rating	LOC Scale Score
Genevieve	30/100	2.34	1.63	3.25	3.0	1.5	3.17	Internal	17
Chiara	30/100	2.6	2.0	2.75	3.4	2.0	3.5	Internal	18
Clara Praat	30/100	3.31	2.83	4.25	3.4	3.0	3.67	Internal/External	15
Riley Taylor	40/100	2.76	2.43	3.25	2.8	2.0	3.33	Internal	19
Uma Lake	75/100	3.85	3.5	4.75	3.8	4.4	3.5	Internal/External	NR
TKLM	75/100	4.29	3.63	4.5	5.0	4.33	4.5	Internal	11
Lucille	75/100	2.97	2.0	3.0	4.0	3.17	3.17	External	9
Evelyn Rose	80/100	3.34	2.63	3.5	3.6	3.17	4.0	Internal	7
Rebecca	85/100	3.63	3.5	3.75	4.0	3.17	3.67	External	12
Ellen	87/100	3.63	3.86	3.3	4.2	5.0	3.17	External	7

Nine participants agreed to complete the Locus of Control of Behavior Scale survey. One participant expressed that she did not feel comfortable completing the survey due to the wording of the questions. Scores on this measure ranged from 7 to 19, with a mean of 12.8 (SD = 4.39). These scores indicated that participants primarily had more external locus of control. Based on visual inspection of the scores, all participants with lower perceived CSE presented with higher scores on the scale (n=4), indicating more external locus of control. Half of the high confidence participants (n=3) were observed to have external control based on the results of the scale, while the remaining participants with high confidence who provided a response to the locus of control scale (n=2) were observed to have internal control based on score visualization. These results indicated that external locus of control was an indicator of low CSE, while a pattern of control for high CSE participants could not be visualized. A summary of scores on the Locus of Control Scale for the participants can be found in Table 2.

Qualitative Data Analysis

All the participants who took part in the present study described having either higher or lower CSE, which was determined by their self-rating on a 100-point counseling confidence scale. Participants who rated themselves at a 50 or above were considered to have high CSE, while those who rated themselves below 50 were considered to have low CSE. Six of the ten participants indicated that they had high perceived CSE while the remaining four indicated low perceived CSE. The interviews of these ten participants were broken down into 982 meaning units by two researchers, with the assistance of the PI when a disagreement occurred and a solution could not be decided upon. The overall reliability established between the investigators over the course of triangulation was 83.17%, indicating good reliability. Reliability ranged between 73.39% and 92.63%, with greater consensus achieved over time. In three instances, the

reliability fell below 80%. Following the determination of meaning units, themes contributing to both high CSE, low CSE, and perceived needs and resources for continued CSE growth were then identified. These themes were considered significant if at least three participants contributed to them. Each theme will be discussed by overall category in the following sections.

Low Confidence

The four participants with low reported CSE shared the factors they believed had contributed to their lower levels of confidence. These participants most often discussed lacking certain constructs that they thought would lead to higher levels of CSE if they were to obtain them. The themes identified throughout the interviews of low confidence participants which were associated with having an influence over their lower levels of CSE were as follows: lack of knowledge on how to counsel, lack of experience, lack of support, lack of feedback from others, and personal attributes. The low confidence participants also identified strategies they utilized to compensate for their low levels of CSE in their careers.

Lack of Knowledge

All participants with low perceived CSE associated a lack of knowledge on the topic of counseling with their low confidence level (n=4). Having more information on counseling was reported to lead directly to having more confidence, and vice versa (n=4). This lack of knowledge was described as a gap in terms of knowledge and skills related to counseling that was often attributed to the absence of adequate training pre-certification. Clara Praat shared her personal experience of feeling that her counseling knowledge was inadequate in many situations post-graduate school: “There were many sessions where I left thinking, ‘That could have gone 100% better if I had a counseling degree.’” The realm of counseling within the field of speech-language pathology proved to be more significant and intertwined with the role of the SLP than

several participants realized when they first entered the field. When asked what the biggest contributing factor to her level of counseling confidence was, Chiara responded, “The lack of education that I have about what counseling is and what it looks like is probably the biggest contributing factor.”

Lack of Experience

Participants with low CSE identified experience as a factor contributing to their CSE (n=4). Half of the participants (n=2) with low CSE even singled out experience as the most impactful variable on their level of counseling confidence. Genevieve provided insight on how experience influenced her personally when she stated:

> [Experience] would be the driving factor. Do I have experience to pull from, what happened in those experiences, and is there more information I need to know, is there anything I would do differently? I would say it’s the driving factor.

Participants discussed the topic of situation-specific confidence and how, often, they felt greater confidence in some situations than others. Participants reported that the more experience they had with a situation, the more confident they felt in it. With more practice in a given situation, such as giving parents news of a difficult diagnosis, they tended to feel more confident and competent. Riley Taylor articulated how experience in a certain situation provided her with tools to use when she was placed in a similar situation in the future. She stated:

> If I have more experience and I have more tools at my disposal of how to do it, then it’s like an emotional scene in a play or something and if I’ve rehearsed this a lot, then I know I can get through it. But if it’s kind of an improv situation and an emotional situation comes up, then [my confidence] definitely will be heavily impacted.

Experience also brought some participants an awareness of deficits in counseling ability and areas they needed to improve on. This awareness provided fuel for self-reflection that participants could use to improve their performance. Life experiences, such as the experience of raising a child who participated in counseling, were also identified as areas that helped

participants develop counseling confidence and identify a need for further development in their counseling skills (n=2).

Lack of Feedback from Others

For participants with low confidence, feedback from others, including other professionals, clients, and caregivers, was endorsed as a theme contributing to their level of counseling confidence (n=3). The participants described how they depended on observing other professionals in order to maintain confidence, and without the other professionals they felt less confident. Clara Praat described how feedback from other professionals impacted her confidence:

> We do a lot more joint sessions now with other OTs, PTs, and special instructors. And I think we do kind of grab a little bit of each person's kind of questions or how they deal with situations, and we put it in a basket and use it for our own sessions. I do use some of the questions that my colleagues ask, or I can see how some of my colleagues would ask a parent a question the way I would ask them.

Chiara described how her confidence had dropped after graduate school because she no longer received feedback from a supervisor. "Maybe this is just a matter of experience, but I felt a lot more confident in these situations during grad school than I do now because I was getting the feedback and able to change it." Not receiving feedback in their current setting was seen as contributing to lower confidence. It was shared that in an ideal situation, feedback would be provided following grad school in order to help heighten confidence in performing not only counseling, but the overall role of a SLP. Two participants with low CSE reported that being the sole SLP in their workplace took a toll on their confidence level because they did not have other SLPs to rely on in times of uncertainty.

Personal Attributes

Participants with low CSE most often reported being deterred by emotionally arousing cases (n=3). Several participants shared that although they felt the urge to avoid stressful situations, they had no choice but to respond and take action in them. The feeling of the need to help clients despite the intimidating nature of a given situation was described as a motivator despite the experience of uneasiness. Clara Praat described how emotional situations in which counseling was required were more difficult than those in which she was required to treat strictly speech-related issues. She stated:

> I don't want to go into the lion's cage, but it happens. I can't say I'm not going to see this family because they have a lot of issues. You know, like I can't say that. I prefer situations where I didn't have to do a lot of counseling, it's just more speech stuff. Those are my happy, easy families. But that's not real life.

The topic of anxiety was often discussed by participants in the low confidence category as a contributor to feelings of low confidence (n=3). Anxiety was identified as a personal attribute which often interfered with participants' ability to counsel to the best of their ability. Chiara described the nature of the breakdowns she experienced in moments of stress:

> I feel like anxiety for me feels like my heart rate goes up and I want to run away from the situation. I think that my ability to explain things well goes down in those moments because of the anxiety, so I'm not really able to articulate myself very well, which isn't helpful. And then that makes more anxiety so it's kind of cyclical.

Overall, the SLPs with low CSE tended to experience feelings of avoidance and anxiety when faced with stressful or anxiety-inducing situations which impacted their performance and their overall belief in their ability to perform well.

Strategies for Coping with Low Confidence Level

Three participants with low perceived CSE endorsed strategies that they utilized in their jobs to deal with their lower confidence levels (n=3). One strategy reported to be effective was

being fully prepared, even to the extent of being overprepared for a session or counseling situation. Clara Praat spoke on her experience with preparation when she stated, “It is easier when I come into a situation knowing, ‘Okay, this might happen so I need to prepare myself on what I can tell these people or these family members,’ but when things happen right then and there, I never know what to say.” Seeking research articles, EBP, and asking questions were the specific tools cited by participants that provided them with knowledge to support their counseling skills. Genevieve illustrated how asking questions helped her in counseling situations when she stated:

> I think asking questions, like getting at the heart of something is difficult. I feel like oftentimes families or patients talk about surface issues but not really the topic, so for instance, I worked with a family, their daughter had Down Syndrome and the mom was really concerned. Every session it was like, “I want her to be able to answer questions,” and, “I want her to be able to start conversations,” and stuff like that. But the more I worked with the family and the more the mom shared, I feel like she was really more concerned about like her daughter’s safety, so things like that came out more once I knew them a little bit better. I feel like in retrospect if I had been able to ask better questions, or maybe it’s a listening component, maybe I could’ve gotten at that faster instead of spending time focused on a topic. I feel like there was a bigger issue at play.

Observation of other professionals experiencing success in counseling clients and then modeling their methods after those professionals’ was a final strategy participants used to cope with their low confidence. Having a model for how to deliver difficult news or even how to deal with failures in counseling boosted the participants’ confidence when dealing with the same issues themselves.

High Confidence

Participants with low CSE often reported a lack of certain constructs. This was in contrast with participants with high CSE who reported having obtained many of the constructs the low confidence group lacked, leading to an increase in their overall confidence level. For example, while the low CSE group identified a lack of general and situation-specific experience, the high

confidence group indicated that their possession of those types of experiences had led to the increase from low to high confidence in their lives. Additionally, the groups differed in their personal attributes: those with low CSE most often reported being deterred by emotionally arousing or stressful cases, and those with high CSE indicated that the clinical responsibility to serve patients was more powerful for them than any feelings of deterrence. The following sections delve deeper into the themes identified as contributing to the confidence level of high CSE participants, which include experience (situation-specific, successes, failures, and life experiences), counseling training, and observation of other professionals.

Experience

Individuals with high CSE often endorsed a form of experience as contributing to their current level of CSE (n=6). Experience was reported to impact participants' feelings of familiarity, comfort, and confidence with counseling. This factor was identified as both a high confidence attribute and a transitional attribute causing the increase of CSE. Evelyn Rose, a participant with high CSE, identified past experience with performing counseling as being the most influential variable on her current level of CSE. She stated: "…if I have experienced whatever they are needing counseling about or have had some experience with it that helps." With acquired experience, confidence was found to increase over time for each participant. Lucille described how her confidence increased with experience over the course of her career: "I think it's gotten better the longer I've been doing it."

Several subcategories of experience were discussed, including situation-specific confidence, experiences of success, experiences of failure, and life experiences. Three participants described how the experience of performing counseling impacted their CSE, and three identified subcategories of experience as having more influence.

Situation-Specific Confidence. Confidence does not appear to transcend all situations; a single therapist can feel very confident in one situation and have lower confidence in others. Individuals with higher CSE indicated that increased experience with people of a certain population or in a certain setting led to greater confidence in similar future situations (n=6). Even participants with the highest reported levels of CSE reported lowered levels of confidence in situations in which they had less experience. For example, TKLM reported experiencing high confidence in all types of clinical settings except for the neonatal intensive care unit (NICU). She attributed this lower level of confidence to a lack of experience in this area. Although she reported that her confidence would be lower, she described how she would have to find her way.

> I've never worked in the NICU so I wouldn't feel so confident about NICU because I didn't have a good a sizeable experience. I worked in a special care nursery once, that's about it so if somebody throws me into a NICU then I would feel totally lost. Not lost but- like I would have to find my way.

Experiences of Success. Having successful experiences was credited by many participants as being an important way to increase their counseling confidence. Successes served as positive reinforcement and bolstered the confidence of participants. Each participant indicated that success either contributed to higher confidence (n=5) or had a neutral effect on confidence (n=1). Success with the added reinforcement of positive feedback from others and seeing progress with clients were two influential factors of success specified.

Uma Lake described how confidence and success often go hand in hand, with each serving to increase the other: "When I am feeling more confidence I think both I'm more successful and more confident when I feel like they're working hand-in-hand." Evelyn Rose described how success increased her resolve and encouraged her to continue to provide the best quality of care for clients:

> It both just kind of strengthens my own personal resolve of caring for people both personally and professionally and my own personal belief that people are very valuable and that life is valuable. I want to practice that in my profession too by treating people of all cognitive abilities and all abilities, period, the same.

Experiences of Failure. Participants with high CSE most often indicated that experiencing failures had a neutral effect on their confidence. They saw failures as an opportunity to explore areas they could improve clinically, reach out to other professionals for assistance, or attributed the failures to the fact that some clients will be easier to get along with than others. TKLM described her feelings of failure when she said: "…sometimes there are patients that you don't feel like you know you did well with. There's always a handful of them that made me explore deeper where I need to improve, but not lose confidence." Evelyn Rose described how she takes lessons from clinical failures to use for the next time she is in a similar situation in order to improve her performance at the next available opportunity:

> There have been times when I've said something or not said something in a counseling situation and later I've thought, 'Oh man I should have said it that way.' I mean for sure I always keep a firm professional hat on as far as how I'm talking with my students and counseling them, but [there were] just things I could have put in a better phrase or something, so I just tuck it away for the next time.

Life Experiences. Participants' personal life experiences were reported to be one of the most significant contributors to their level of CSE. Life experiences were discussed by every participant with high CSE (n=6) as having provided them with a high level of confidence. In many cases, participants had the prior personal experience of receiving counseling, which impacted their views on and approach to performing counseling. Several participants provided insight on how their experience dealing with difficult life situations, such as abuse, death of a loved one, or divorce, shaped their perspective on how to effectively counsel others. Lucille described the impact of her life experience and how it shaped her perspective.

> I was physically and emotionally abused as a child and so that has always been something I carry with me everywhere I go. That lens is how I see kids and I guess that's why I don't find what others describe as challenging cases as challenging. I see it as a way someone can really see you and that's what I love about speech you know, giving someone a voice when there's a lot going on that probably makes them feel pretty powerless.

Life experiences were more often identified as being involved in increasing CSE than formal training for participants with high CSE. Life experiences served as a well to draw from when providing counseling to others and worked to help participants become better and more confident counselors. Going through these difficult life situations often gave the participants perspective on what their clients might be going through. When working with the pediatric population, several participants reported that having the experience of being a parent themselves was highly impactful on how they counseled other parents. Rebecca described how life experiences provided a certain perspective on clients' life circumstances which formal training was incapable of providing in her situation: "I think a counseling course could provide some basic tools, but I really do believe just with some time and dealing with life in general is what's going to be as beneficial for a counseling scenario."

Observation of Others

Another theme that emerged throughout the interviews was observation of other professionals (n=4). Observing other professionals when counseling, whether other SLPs or professionals from another discipline, was often identified as a factor influencing participants' high levels of counseling confidence. Participants often took it upon themselves to seek out opportunities to observe individuals with different perspectives on counseling than their own. A participant described how the firsthand experience of seeing how people counseled her directly impacted her approach to counseling others. Several participants detailed their experience with interprofessional team meetings and how the learning provided through this experience increased

their confidence in their own counseling practice. Uma Lake described how learning from others is not optional; in order to achieve the goal of being a high-quality counselor, SLPs should look to others:

> That's essential, it's wonderful, and I go to every conference I can to see videos of other people doing things and learn from that. And as I said, [receiving] counseling has helped me be a better counselor by seeing somebody else in action.

Interdisciplinary team meetings provided an opportunity for Lucille to learn by watching other professionals while also taking part in treatment alongside them. She described this as having a positive impact on her counseling confidence:

> …three days a week we do our interdisciplinary assessment teams, IDATs, and we have a behavioral pediatrician, psychologist, a behavioral health worker, social worker, OT, and me, there's always six people either watching you or participating. So it's anxiety-producing, but it's also nice that what I observe and what I say is either supported, acknowledged, or not.

Feedback from Others

Feedback from others was another theme endorsed by all the participants with high CSE as being a key factor in the development of their confidence level (n=6), with one participant reporting that feedback was the most influential variable in her experience. Feedback from patients, supervisors, other professionals, or from significant others in participants' lives were all identified as significant in helping them to identify areas of strength and weakness. Participants described how feedback made them aware of their strengths in areas they had not been aware of before. Positive feedback from patients was most often discussed. Feedback was also identified as a way to increase CSE. TKLM shared how feedback from a previous client revealed her counseling competence to herself. She stated: "…and [it's] interesting last year I had a patient who just retired from social work, and she wrote me an appreciation letter and she wrote that I'm a natural counselor, so I think that tells it." Rebecca described how she realized, based on the

feedback from a professional from another discipline, that her counseling method was successful and that she had made a positive impact on the client:

> There was an OT student doing a practicum and we all worked together so I was explaining some things to the OT student and just the OT clinician said, "You have a really good way of explaining things," so that I guess would be some feedback that let me know, 'Okay you're doing this, you have related and you are positively impacting your students and then maybe some of your families.'

Personal Attributes

When the participants with high CSE were asked whether they were motivated or deterred by emotionally arousing cases, they indicated that they felt the clinical responsibility to serve the client regardless of their feelings of motivation or deterrence (n=3). TKLM described how, despite her feelings, she felt the responsibility to do everything in her power to help the patient and their family in emotionally arousing circumstances:

> I'm not motivated but then I'm not deterred. If this is what the patient has then I have the responsibility to help this patient or the family out. I think it's my responsibility to seek guidance or find resources on how I can best guide or help the patient and the family.

One participant described how, as her career progressed, she learned not to let the emotional cases affect her to a substantial degree because it is impossible to solve every client's problems. She found that setting boundaries was a necessary step in maintaining the capacity within herself to serve her clients well. Rebecca stated:

> When I was a bit younger, I took more stuff home so to speak from an emotional standpoint. I'm probably better now at somewhat compartmentalizing. And I do think I love my clients and I do think I am empathetic and provide services, but I have learned to set somewhat of a boundary and that I can't solve all their problems, I can't fix everything, and I can't change some decisions and choices they've made.

Transitioning from Lower to Higher Counseling Confidence

The participants with high reported levels of perceived CSE shared that they possessed experience, situation-specific confidence, experiences of success, life experiences, observation of

others, feedback from others, personal attributes of acting on responsibility to the client despite stressful or challenging circumstances, and were neither negatively nor positively impacted by experiences of failure. Following the analysis of the interviews of these participants, it appears that these constructs were necessary for the high confidence participants to transition from low to high confidence; they contribute to the makeup of a clinician with high CSE. Therefore, in order to increase levels of CSE, one can consider these themes on which in-depth information has been provided in this study. Several, such as counseling experience and its subcategories, come with time in the field participating in counseling others. Others are available for clinicians to ascertain no matter their experience level, such as feedback and observation of others. It can be argued that in the way of personal attributes, participants with high CSE simply chose to perform counseling for the best interest of the client *despite* inherent feelings of anxiety or aversion.

Perceived Needs and Resources for Continued CSE Growth

Although several participants rated themselves highly on the 100-point counseling confidence scale, every participant indicated that they saw room for improvement in their level of counseling confidence. Within each interview, participants were asked what they believed could bridge the gap between their self-rating and a perfect score of 100 on the scale. The topics discussed by participants parallel the previously discussed themes that contribute to the makeup of an individual with high CSE. The following were themes endorsed by participants as having the potential to raise their level of CSE: further counseling training (n=9), feedback from others (n=3), more experience (n=6), and self-reflection (n=3).

Further Counseling Training

Nearly every participant identified a need for further counseling training in order to increase their level of perceived CSE (n=9). When asked whether they thought pre- or post-

qualification training would be more effective in bolstering their confidence, post-qualification was most often selected as potentially having the most impact. Ellen described how, although she had received a good foundation of counseling training in college, undergoing further training post-qualification would be impactful when she stated:

> I think I would probably just prefer it post-graduation because then maybe I could find some specialized counseling. I don't know the kinds of counseling situations that you have in different work areas, but I'd just be able to specialize and hone in more on like things that are applicable for my situations. I feel like the experience I had in college [provided] really good foundation information.

Several participants also noted that pre-qualification counseling training would have influenced their counseling confidence, or a combination of both pre- and post-qualification training. They spoke on how it would have led them to feel more prepared and better-equipped to face the challenges accompanying their jobs. Riley Taylor expressed how she felt it would have been ideal to receive both pre- and post-qualification counseling training to facilitate the development of counseling confidence and skills as she progressed through her career.

> I feel like the sooner the better that it would have been available to me, then that would have really impacted my confidence and it would have been really nice to have that starting out in undergrad. And then possibly grad school just kind of at the beginning so it's like, 'Okay, I'm beginning this career, now I know more what to do at the start of it and then that can develop as I gain experience.'

Feedback from Others

Another perceived need for continued CSE growth which was recognized as a recurring theme was feedback from others (n=3). These participants expressed their desire to gain insight from another person on their clinical performance in order to know where and how they could best improve. When investigators asked Genevieve what would need to happen for her to feel more confident in counseling, she replied:

> … getting feedback... just approaching it as an area to learn about. I tend to think about learning as like that feedback part is critical and important- I think in my job right now we're not set up for that, so I've just had to take it upon myself to start instituting some of that kind of stuff. So I guess ideally it would already be part of the job.

Lucille shared a similar answer when asked the same question by the interviewers: "I do better with feedback, like it's something that I actively ask my supervisor for directly about counseling." Feedback was identified as a level of support that participants did not necessarily have in their current positions, but which they realized they needed in order to improve their counseling confidence and thus, their overall performance in counseling.

Experience

Just as experience was a recurring theme participants discussed often as being a significant contributor to their current confidence levels, many (n=6) also shared a need for more experience in order to develop their confidence further. Clara Praat shared how although she did not initially realize a need to develop her counseling confidence, as her career progressed, she realized a need for practice in conjunction with training to boost her CSE levels:

> Both. When I was working with adults, maybe I was naïve and thought I had no issues with counseling. And now that I'm taking more counseling courses, I think I'm more aware of people's behaviors and the counseling world that I'm like, "Oh okay I need to get better." So I do need to practice more and I do need to be trained more in what to say and how to avoid certain situations or how to de-escalate certain situations.

Experience was most often discussed throughout interviews with the participants as having a considerable influence over CSE. The overall theme was that if given more experience, higher confidence levels would result. When participants possessed experience with a given counseling situation, they possessed a commensurate level of counseling confidence.

Self-Reflection

A final construct that was endorsed as a perceived need or resource for continued CSE growth was self-reflection (n=3). Self-reflection was a starting point from which participants

identified ways to move forward and improve their future performance. The continuation of utilizing this skill was found to be important for the development of CSE. TKLM described the role of self-reflection in her life. She stated:

> I kind of just reflect at the end of the day you know, 'How could I have done better with this patient or that patient,' and then I try it out the next time and usually it works most of the time. So it's the listening and the compassion, but if you don't have the listening skills- I think they go hand in hand.

When asked what she would need in order to heighten her level of counseling confidence, Genevieve shared: "I think, continuing ed could be a part of it so reading, reflecting, practicing, getting feedback... just approaching it as an area to learn about."

The construct of self-reflection offered participants a way to process event that had already occurred and helped them to identify ways to move forward. In order to experience continued increases in CSE levels, self-reflection was thought to be important for participants moving forward. A summary of the overall themes endorsed as having an impact on CSE is provided in Table 3.

Table 3

Recurring themes identified as contributing to low and high confidence levels

Low Confidence (n=4)	High Confidence (n=6)	Perceived Needs and Resources for Continued Growth
Lack of Knowledge (n=4)	Experience (n=6)	Further Counseling Training (n=9)
Lack of Experience (n=4)	Situation-Specific Confidence (n=6)	Feedback from Others (n=3)
Lack of Feedback from Others (n=3)	Experiences of Success (n=5)	Experience (n=6)
Personal Attributes (n=3)	Life Experience (n=6)	Self-Reflection (n=3)
	Observation of Others (n=6)	
	Feedback from Others (n=6)	
	Personal Attributes (n=3)	

Essential Structure of the Experience of CSE

SLPs attributed their experience of high CSE largely to counseling experiences. More counseling-specific experience was invaluable, and served to increase feelings of familiarity, comfort and preparedness to counsel. Experiencing successes in counseling situations was a source of reinforcement and positive feedback that contributed to CSE. CSE can be built through experience counseling people through difficult situations, such as providing a diagnosis. Alongside counseling-specific experiences, life experience impacted CSE by providing SLPs with perspective on difficult life circumstances that clients may have experienced as well. Similarly, personal counseling experience was influential to SLPs in building their counseling skills and CSE. Gaining feedback from others on counseling skills, whether from other counselors or significant others was also a key component of building confidence by helping them build awareness of areas of strength and weakness. Having experience observing other counselors in the act of counseling was also a tool that serves to make SLPs feel more prepared and confident when they perform counseling themselves.

The essential structure of the experience of a SLP with low CSE was characterized by a lack of experience, knowledge, and feedback, and a different response to personal attributes when compared to SLPs with high CSE. SLPs with low CSE simply did not have sufficient counseling experiences to possess high CSE. They felt unprepared and had low confidence in counseling as a result of insufficient counseling training causing the lack of a firm knowledge base on how to counsel. These SLPs also did not have the opportunity to receive feedback from others on their counseling abilities in their position. While SLPs with high CSE more often acted in stressful situations despite their feelings of uneasiness, those with low CSE tended to act on their feelings of deterrence to avoid stressful counseling situations. Transitioning from lower to

higher levels of CSE involved obtaining the constructs identified as composing factors of high CSE. SLPs can make their way to higher levels of CSE by obtaining counseling-specific experiences, having success in counseling situations, experiencing difficult life circumstances and the personal experience of being counseled, receiving counseling training, feedback from and observation of others, and choosing to counsel in the face of feelings of deterrence due to anxiety-inducing circumstances.

Discussion

The purpose of this study was to discover, from the perspective of practicing SLPs, themes that contribute to the development of perceived CSE. The levels of internal/external locus of control of the participants were also investigated in order to determine the interaction between the two constructs and their impact on clinician counseling confidence. Analysis of the ten interview transcripts resulted in four themes contributing to low CSE, seven themes contributing to high CSE, and four themes identified as constructs that would likely increase CSE.

Comparing High vs. Low CSE

For participants with both high and low CSE, counseling experience, and lack thereof, was identified as a contributing theme. This aligns with Bandura's (1977) self-efficacy theory which identifies mastery experiences as the most effective route to building self-efficacy. While participants with high CSE often endorsed years of counseling practice through their role as a SLP as increasing their CSE, those with low confidence identified the lack of counseling experience as having a key role in their similar lack of confidence. Participants with high CSE also endorsed several subcategories of experience as recurring themes having a great impact on their CSE levels. These included situation-specific confidence, experiences of success, and life experiences, and further solidify the notion that more practice at a given skill serves to increase

feelings of competence, confidence, and preparedness for the task. Although these themes were not identified by participants with low CSE, this could be attributed to the fact that they did not possess these specific types of experiences. In the case of life experiences, it can be observed that experience in a related task has a generalizing effect. For example, participants who received counseling themselves tended to feel more confident counseling within the profession. Overall years of experience in the field did not appear to directly influence CSE levels; increasing CSE appeared to be influenced more by counseling-specific tasks. Participants with eight or more years of experience tended to have higher levels of CSE based on visualization of CSE self-ratings and years of experience data, but even the participant with the lowest level of experience had one of the highest reported self-ratings of CSE level.

Feedback from others was another theme which emerged as a contributor to CSE for high CSE participants, while the lack of feedback from others emerged as a theme for participants with low CSE. The participants with low CSE often worked in settings where they were the sole SLP or simply did not receive a great deal of feedback from others in their workplace; participants often brought up the way that they missed the feedback they had received in graduate school and how they knew their confidence suffered as a result of not having anyone to critique their performance. All participants with high CSE reported that feedback contributed to their confidence. This again parallel's Bandura's (1977) self-efficacy theory which holds that verbal persuasion is a route to building self-efficacy. The significance of feedback identified in the present study also aligns with results by Zimmerman (2000) who found that verbal feedback influences self-efficacy when one receives encouragement or discouragement regarding their ability to perform but is a less significant source of self-efficacy because outcomes are described but not actually experienced.

Personal attributes was another recurring theme discussed by both high and low confidence participants. Low confidence participants more often reported feeling deterred by emotionally arousing situations and the anxiety they felt as a result. This contrasted with the high confidence participants who more often felt motivated to help despite the emotionally arousing nature of a situation. These findings indicate that high confidence participants felt more empowered to exercise more control over their emotions than those with low CSE. Therefore, the ability to feel confident in pressured and high stakes situations may not be an inborn skill, but rather that increased self-efficacy leads to a greater ability to manage feelings of anxiety and arousal. This finding is once again in alignment with Bandura (1977) who provided evidence that persons who experience higher self-efficacy are likely to view their state of emotional arousal as facilitating and motivating for their performance, while persons with lower self-efficacy are troubled and off-set by the aroused state.

Although the theme of lack of knowledge was endorsed by all participants with low CSE, those with high CSE did not report that their prior training had an impact on their current level of confidence. It is worth noting that only half of the participants with high CSE (n=3) had received counseling coursework within their education, and SLPs are unlikely to attribute their perceived CSE to counseling training if they never received it. Additionally, the majority (n=3) of those with low CSE had not received any counseling coursework within their education. Even so, almost all participants (n=9) shared that they believed their level of counseling confidence would increase with continuing education and self-reflection on counseling skills. These findings suggest that SLPs are aware of the importance of counseling to their practice, but they recognize a gap in their counseling knowledge as a result of a lack of coursework or preparation. These results align with those of Rose et. al (2014) who found that despite SLPs' realization that

counseling is integral to clinical practice, clinicians recognize that they are not fully trained in this area. Additionally, the importance of continuing education and self-reflection is emphasized and should not be underestimated. Due to the lack of required counseling coursework in SLP training programs, it is important that SLPs be given the opportunity to pursue the development of their knowledge in the area of counseling after graduation.

A final recurring theme for high CSE participants that was not brought up by participants with low CSE was observation of others. This theme provides additional support for Bandura's (1977) finding that obtaining vicarious experience in the form of seeing another person similar to oneself succeed at a task increases observers' beliefs that they too are capable of the efforts necessary to succeed at that task, thus building self-efficacy. This finding further emphasizes the importance of continuing education for SLPs, as several participants described how observing other clinicians' success with counseling methods served as a catalyst for increasing their counseling confidence even years post-graduation. Pasupathy et al. (2017) found that observation of others, such as seeing another clinician successfully counsel a client, can be extremely beneficial in building CSE for individuals in the field of speech-language pathology. Our findings support this route to building CSE for SLPs.

Interaction between CSE and Locus of Control

Visualization of the results of the CASES for SLPs and the Locus of Control Scale indicated a pattern of low CSE participants possessing external locus of control. A pattern of internal/external control for participants with high CSE was not observed based on visualization of the scores. An influencing factor over this lack of a definitive pattern of control for high CSE participants could have been impacted by the fact that one participant chose not to respond to the survey containing the locus of control scale. Our results also align with Harper (2008) who found

a positive relationship between external locus of control and low CSE. This suggests that clinicians who feel that they have more less control over outcomes of a situation tend to feel less confident and prepared for them as a result.

Proposed Route to Higher Levels of Perceived CSE

A goal of the present study was to identify how SLPs can transition from lower to higher levels of CSE. The themes identified as contributors to counseling confidence provide insight into action steps that can be taken by clinicians to build counseling confidence. The first of these action steps we recommend that was frequently brought up in the interviews is to actively seek experience.

Research by Holland (2007) suggests that feelings of inadequacy in the area of counseling lead some SLPs to choose not to engage in counseling. However, the results of the present study indicate that the most effective way to build clinician counseling confidence is to engage in counseling in order to build counseling experience. An encouraging aspect of the study results is that, according to the participants with high CSE, experiences of success serve to increase self-efficacy, while experiences of failure only serve to help clinicians identify areas where they need to improve or have a neutral effect. Therefore, when SLPs actively seek counseling experience and their CSE is heightened, failures have less of a negative effect and can further increase CSE. If SLPs desire to increase their self-efficacy in a particular area of counseling, results show that this is attainable by gaining experience in that specific situation. Another parallel to counseling experience is life experience. Clinicians who receive personal counseling or are going through difficult life circumstances that are similar to those of clients' are better able to relate to clients' experiences and guide them through them as a result.

Although experience can only be collected over time, there are several themes contributing to the development of CSE that all clinicians regardless of experience level can ascertain. One of these themes that was most often endorsed by all participants was training. The majority of participants identified a lack of counseling training. This parallels the results of Luterman (2001) who found that 82% of graduate students feel they lack sufficient counseling training and experiences in counseling. Our findings indicate that SLPs believe that formal counseling training is necessary, but for the most part have not actually received it themselves. It is imperative that SLPs receive foundational knowledge of counseling within their education. For this to happen, more graduate training programs should require counseling education, or at the very least offer more guided experiences.

Continuing education courses is one route to obtaining training post-graduation that the results indicate increases CSE. This continuing education can come in several forms, including formal continuing education units, or observation of and feedback from others who are skilled counselors. The role of other people in the route to building CSE should not be underestimated. We encourage clinicians to seek opportunities to receive mentorship and feedback from others on their counseling skills whenever possible. Based on our results, this feedback on counseling skills was found to be impactful when received from other professionals, patients, supervisors, or from significant others in the clinicians' lives. While feedback can come from many sources, the more specific feedback in the form of mentorship from a skilled counselor was also suggested as a route to higher CSE. Additionally, participants identified self-reflection as a form of continuing education related to counseling.

Our results indicate that clinicians with high CSE tend to choose to engage in counseling in the face of anxiety and emotionally arousing cases despite their inherent reaction to the

situation. This occurs in contrast with low confidence participants, who reported feeling more deterred by emotionally arousing cases, leading to avoidance of counseling. These results suggest that although high and low CSE experience similar feelings of deterrence in the face of arousing cases, high CSE leads clinicians to choose to engage despite these feelings. This parallels Bandura's (1977) study results which suggested that it is not only the physiological state of a person that influences self-efficacy, but how that state is perceived and responded to. According to this study, persons with higher self-efficacy are likely to view their state of emotional arousal as facilitating and motivating for their performance, while persons with lower self-efficacy are troubled and off-set by the aroused state (Bandura, 1977). Therefore, CSE has the potential to be influenced by conscious choice of the individual clinician. Individuals with high CSE included in this study were more likely to engage in the emotionally arousing cases. This likely led to increased experience for the high CSE participants, which increased their CSE all the more.

Benefits and Setbacks Associated with Clinicians' Perspective for Low CSE

The reports of participants with low CSE indicate several setbacks associated with their low confidence. These setbacks include increased feelings of anxiety, a decreased willingness to engage in counseling situations, and overall feelings of lack of sufficiency to counsel. These setbacks emphasize the importance of CSE not only for the practice of individual clinicians, but also for the field of speech-language pathology as a whole. We know based on Bandura's (1977) seminal work on self-efficacy that if a person does not possess the expectation that they have what it takes to succeed at a task in the form of self-efficacy expectations, they are much less likely to attempt the activity. Contrastingly, when an individual has high self-efficacy expectations and believes in their own ability to perform, they have more positive outcome

expectations (Bandura, 1986). When SLPs choose not to counsel because of these low expectations regarding their abilities, clinicians miss out on developing a collaborative partnership with their clients that has great importance in tackling life struggles related to communication disorders. ASHA (2016a) emphasizes the importance of counseling for the field as a whole; in order for counseling to truly be utilized as it is encouraged, it is important for SLPs to obtain sufficiently high levels of CSE.

The CSE self-rating of the SLPs tended to align relatively well with their scores on the CASES for SLPs measure. This ability for low confidence participants to identify their lower self-efficacy level is viewed as a relative strength. Not only were these participants able to identify their lack of confidence, they were also able to pinpoint the specific counseling constructs they lacked. Several of those constructs aligned quite well with what high confidence participants attributed their high CSE to. An important first step in building self-efficacy is identifying low levels of CSE. An interesting observation gained from the results is the indication that often the participants with low CSE were being held back by their low confidence levels from the most influential builder of CSE: counseling experience. We encourage SLPs to actively seek and engage in counseling experiences despite low efficacy expectations in order to gain experience to most effectively build their CSE.

Strengths, Limitations, and Future Directions

A strength of this study was the practical nature of the results. The information provided in this study gave insight into particular action steps SLPs can take to increase their CSE. Another strength was that the responses obtained for the study which served as a rich source of data coming directly from SLPs with the firsthand experience of counseling in the field of speech-language pathology. The essential structure of the experience of perceived high and low

CSE was examined in depth based on 982 meaning units. Additionally, the interviews were not restricted, as participants were encouraged to provide information on what they believed to be relevant regarding the development of their counseling confidence. Finally, when separating the interview into meaning units, the examiners achieved high reliability using the investigator triangulation method.

Several limitations of the present study must be considered. It is important to note that the development of CSE is an individualized process that will vary from individual to individual. The qualitative nature of the ten interviews yielded results that were highly specific to the participants studied; however, the essential structure of the experience of a SLP with high CSE is likely composed of common factors. The aim of this study was to identify these common factors in order to learn from their lived experience as clinicians with varying levels of CSE. The method of social media recruitment was limited in that the investigators only posted to Facebook and not to any other popular social media sites. Further, a limitation to this study is that it is likely that SLPs with a propensity towards counseling responded to the invitation to participate. This could mean that the SLPs involved in the study had higher engagement in counseling than the average SLP. The homogeneity of the participants in the area of race, ethnicity, and gender could also be considered limiting; however, this homogeneity was consistent with the demographics of the profession. The majority of participants were White, non-Hispanic or Latino females. This study relied primarily on participants' self-reports. Although it is doubtful that any participant would inaccurately recall their experiences on purpose, several of them reported on events that had taken place many years prior, therefore, it is possible that their recollection was inaccurate or incomplete.

Future research should investigate therapeutic outcomes of patients receiving therapy from a clinician with high CSE versus low. The growth of CSE over the course of their career would also be worth investigating in future studies in order to provide a deeper understanding of the effectiveness of the CSE-building constructs identified in this study over time. Future study could also focus on the influence of clinician CSE on the therapeutic alliance. Additionally, since feedback was identified as a contributor to building levels of CSE, future studies could examine whether the type of feedback, such as high or low, has any impact on its contribution to CSE. Lastly, the impact of self-reflection on CSE should be examined, as this construct was identified as having the potential to raise CSE levels if received by participants hypothetically, but it was not endorsed as a recurring theme in this study.

Conclusions

Clinician CSE is integral to the SLP profession, and yet, many SLPs continue to report low levels. These low levels of CSE can lead SLPs to feel that they are not equipped to counsel, keeping clients from obtaining maximum results from SLP services. It is important for SLPs to have an understanding of ways to build CSE, which is what this study sought to provide. The results of the phenomenological analysis of the ten interviews analyzed in the study indicated a hierarchy of themes contributing to the development of perceived CSE. The construct that was reported to have the most impact on the development of CSE was experience, with training, observation of others, and feedback from others also endorsed as important contributors. Internal locus of control was also identified as an indicator of high CSE. These constructs illuminate particular action steps which can be taken for SLPs to take initiative in building their counseling confidence.

Although counseling experience is emphasized and encouraged, the importance of counseling training beginning early in graduate training for SLPs should not be underestimated. By obtaining counseling training early, SLPs can begin their career with a foundation of knowledge which they can then choose to cultivate throughout their careers through continuing education. Increasing CSE often is not an individual journey; SLPs should pursue opportunities to gain mentorship and feedback from others in their personal lives and occupation who can offer insight on their performance. Feedback from others such as patients, other SLPs, counselors, and even pastors, spouses, and friends are effective means of gaining confidence. Similarly, life experience in the form of receiving counseling, parenting, and living through difficult life circumstances were all cited as supplementary confidence-builders that can be pursued along with specialized counseling experiences directly related to speech pathology. Although personal attributes can influence CSE levels, SLPs have the choice regarding whether they allow inherent anxiety or apprehension to dictate their actions. SLPs play an important role in collaborating with clients to counsel them through challenges related to communication disorders, leading to an overall more fulfilling quality of life (Flasher & Fogle, 2012). With the development of CSE, SLPs will only become better equipped to guide clients to overall more successful outcomes.

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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

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

1. PROJECT IDENTIFICATION **Today's Date** June 8, 2020

a. Project Title Speech-Language Pathologist Counseling Self-Efficacy

b. Principal Investigator Dr. Laura Plexico Degree(s) B.S., M.A., Ph.D.
Rank/Title Professor and Department Chair Department/School Speech Language and Hearing Sciences
Phone Number 844-9620 AU Email lwp0002@auburn.edu

Faculty Principal Investigator (required if PI is a student) _____
Title _____ Department/School _____
Phone Number _____ AU Email _____

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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 Fiona Mand Degree (s) B.S.
Rank/Title Student Department/School Speech Language and Hearing Sciences
Role Participant recruitment, data acquisition, and data analysis
AU affiliated? ■ YES ☐ NO If no, name of home institution _____
Plan for IRB approval for non-AU affiliated personnel? _____

Personnel Name Audrey Scott Degree (s) _____
Rank/Title Student Department/School Speech Language and Hearing Sciences
Role Participant recruitment, data acquisition, and data analysis
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 05/27/2020 to ----------
Protocol # 20-258 EX 2005

Appendix 2

Flyer

Speech-Language Pathologist Counseling Experiences Research Study

The Department of Speech Language and Hearing Sciences at Auburn University

Are you 19 years of age or older?

Did you graduate from a graduate-level speech-language pathology program?

If you answered YES to these questions, you may be eligible to participate in research!

The purpose of this research study is to examine the essential structure of speech-language pathologists who experience different levels of perceived counseling self-efficacy. In addition, it is our aim to examine how a speech-language pathologist can transition from lower to higher perceived counseling self-efficacy. Participants will be asked to complete a brief survey and a Zoom interview lasting approximately one hour.

Please contact Dr. Laura Plexico at lwp0002@auburn.edu or at (334) 844-9620 if you have any questions. Scan the QR code below for more information.

Appendix 3:

Information Letter for Study Participants

INFORMATION LETTER
For a Research Study entitled
"Speech-Language Pathologist Counseling Self-Efficacy"

You are invited to participate in a research study that investigates the experience of perceived counseling self-efficacy for speech-language pathologists. The study is being conducted by Dr. Laura Plexico in the Auburn University Department of Speech, Language and Hearing Sciences. We hope to develop an understanding of the essential structure of a speech-language pathologist who experiences greater perceived counselor self-efficacy. We also hope to develop some perspective on the essential structure of a speech-language pathologist who experiences lower perceived counselor self-efficacy. Lastly, it is our hope to gain insight on how a speech-language pathologist can transition from lower perceived counselor self-efficacy to greater perceived counselor self-efficacy. You are invited to participate because you are able to adequately communicate your experiences, you have graduated from a graduate- level speech-language pathology program, and you are age 19 or older. In addition, you are not receiving any treatment for a mental health disorder. Through the use of an interview format, you will be asked to describe your experiences in as much detail as possible.

What will be involved if you participate? If you decide to participate, we will send you a brief survey to collect your basic background information. Through email correspondence, you will then be scheduled a time to take part in a locked Zoom interview that will last approximately one hour. This meeting will be scheduled at your convenience within two weeks of the completion of the survey. Once the meeting has been scheduled, you will be sent a Zoom link to participate in the interview. The audio and video of the interview will be digitally recorded over Zoom for the purpose of analysis for this research project. We ask that you describe your experience as honestly as possible so as to ensure our interpretation of your information is accurate. We as the researchers wish to be certain that we fully understand your experience. We will send you a copy of the results and a feedback form within six months to the address that you will provide on the form below. We will ask that you return the feedback form in the addressed and stamped envelope that will be provided for you. It will be very important for the study that you let us know if our analysis is accurate or not. For that reason, we strongly urge you to return the feedback form that will be sent to you with the study description; even if just to confirm that the findings are correct.

Are there any risks or discomforts? The risks involved with participation in this study could include emotional discomfort or feelings of uneasiness associated with recalling past counseling experiences. There is also a possibility of a confidentiality breach, though extensive measures will be taken to prevent that possibility. Your participation in the study is completely voluntary, and you will not be penalized for withdrawing at any time.

Are there any benefits to yourself or others? The benefits involved with participating in this study include increased exposure to counseling terminology and counseling skills.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be

withdrawn as long as it is identifiable. If you change your mind about participating during the Qualtrics survey, you can withdraw at any time by closing your browser window. Data collected will be withdrawn and deleted. If you change your mind about participating during the Zoom interview, you may withdraw from the study by informing the interviewer you would like to withdraw at any point in time. Data will be withdrawn and

deleted. 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. Your identity, and that of any individuals whom you discuss, will be known only to Laura Plexico. We ask that you complete the interview in a private space to ensure conversations are not overheard. You are also

encouraged to disable "cookies" and close your device browser during the interview. When transcribing the recorded interview, the pseudonym (i.e., false name) that you indicate will be used in place of your actual name. The pseudonym will also be used in preparing a written report of the study. Any details in the interview recording that might identify you or any individuals whom you discuss will also be altered during the transcription process. The waiting room feature will be enabled to lock the meeting when conducting the interview over Zoom to protect your privacy and prevent others from joining the meeting. The recorded interview will not be saved to the cloud, but will be uploaded onto a password protected computer. Laura Plexico and her research assistants will be the only individuals with access to the recorded interview and the interview transcript, and these will be stored in a secure place under lock and key. When Laura Plexico has completed the study, she will discuss the research findings with you and provide you with a written report of the findings. Information collected through your participation during this study may be used by Laura Plexico for other research purposes or for developing a paper for presentation or publication in a professional journal. If so, none of your identifiable information will be included.

If you have questions about this study, please ask them now by contacting Laura Plexico by phone at (334) 844-9620 or email lwp0002@auburn.edu. She will be happy to answer any questions you might have. If you should have any questions about your rights as a research participant, you can contact the Office of Human Subjects Research or the Institutional Review Board by phone at (334) 844-5966 or email at hsubjec@auburn.edu or IRBChair@auburn.edu. 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.

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.

Appendix 4:

Document Request and Code ID Form

Document Request & Code ID Form

In order to make sure that I am really understanding your experience correctly, I would like to ask you to read our findings and correct us if I misunderstand anything. After the interview is transcribed and analyzed (probably in about 6-12 months - it takes a while!) I will ask you to give me feedback on whether we have adequately captured your experience. I will send to you a copy of the analysis and a sheet requesting feedback with an addressed, stamped envelope. I will look forward to your feedback. It is very important to us as it is the only way we know if we are on track or not. It allows you the opportunity to make sure we get it right and lets us know if we did get it right!

Name:_____

Age:_____

Race:_____

I,_____, would be willing to give you feedback on the analysis of my interview.

_____

Yes No

I,_____, am interested in receiving a copy of my interview transcript as well.

_____

Yes No

You can send these documents to me at the following addresses or can contact me at the number below to seek feedback on your findings:

Mail Address: _____

_____

_____

Email Address: _____

Phone Number: _____

Code ID#: _____

Appendix 5:

CASES Qualtrics Survey

SLP Counselor Experiences

Q1 **INFORMATION LETTER**
For a Research Study entitled
Speech-Language Pathologist Counseling Experiences **You are invited to participate in a research study** that investigates the experience of perceived counseling self-efficacy for speech-language pathologists. This study is being conducted by Dr. Laura Plexico in the Auburn University Department of Speech Language and Hearing Sciences. We hope to develop an understanding of the essential structure of a speech-language pathologist who experiences greater perceived counselor self-efficacy. We also hope to develop some perspective on the essential structure of a speech-language pathologist who experiences lower perceived counselor self-efficacy. Lastly, it is our hope to gain insight on how a speech-language pathologist can transition from lower perceived counselor self-efficacy to greater perceived counselor self-efficacy. You were selected as a possible participant because you are able to adequately communicate your experiences, you have graduated from a graduate-level speech-language pathology program, and you are over 19 years of age. In addition, you are not receiving any treatment for a mental health disorder. Through the use of an interview format, you will be asked to describe your experiences in as much detail as possible.
What will be involved if you participate? If you decide to participate, we will send you a brief survey to collect your basic background information. Through email correspondence, you will then be scheduled a time to take part in a locked Zoom interview that will last approximately one hour. This meeting will be scheduled at your convenience within two weeks of the completion of the survey. Once the meeting has been scheduled, you will be sent a Zoom link to participate in the interview. The audio and video of the interview will be digitally recorded over Zoom for the purpose of analysis for this research project. We ask that you describe your experience as honestly as possible so as to ensure our interpretation of your information is accurate. We as the researchers wish to be certain that we fully understand your experience. We will send you a copy of the results and a feedback form within six months to the address that you will provide on the form below. We will ask that you return the feedback form in the addressed and stamped envelope that will be provided for you. It will be very important for the study that you let us know if our analysis is accurate or not. For that reason, we strongly urge you to return the feedback form that will be sent to you with the study description; even if just to confirm that the findings are correct.
Are there any risks or discomforts? The risks involved with participation in this study could include emotional discomfort or feelings of uneasiness associated with recalling past counseling experiences. There is also a possibility of a confidentiality breach, though extensive measures will be taken to prevent that possibility. Your participation in the study is completely voluntary, and you will not be penalized for withdrawing at any time.

Are there any benefits to yourself or others? The benefits involved with participating in this study include increased exposure to counseling terminology and counseling skills.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. If you change your mind about participating during the Qualtrics survey, you can withdraw at any time by closing your browser window. Data collected will be withdrawn and deleted. If you change your mind about participating during the Zoom interview, you may withdraw from the

study by informing the interviewer you would like to withdraw at any point in time. Data will be withdrawn and deleted. 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.

Your privacy will be protected. Any information obtained in connection with this study and that can be identified with you will remain anonymous. Your identity, and that of any individuals whom you discuss, will be known only to Laura Plexico. We ask that you complete the interview in a private space to ensure conversations are not overheard. You are also encouraged to disable "cookies" and close your device browser during the interview. When transcribing the recorded interview, the pseudonym (i.e., false name) that you indicate will be used in place of your actual name. The pseudonym will also be used in preparing a written report of the study. Any details in the interview recording that might identify you or any individuals whom you discuss will also be altered during the transcription process. The waiting room feature will be enabled to lock the meeting when conducting the interview over Zoom to protect your privacy and prevent others from joining the meeting. The recorded interview will not be saved to the cloud, but will be uploaded onto a password protected computer. Laura Plexico and her research assistants will be the only individuals with access to the recorded interview and the interview transcript, and these will be stored in a secure place under lock and key. When Laura Plexico has completed the study, she will discuss the research findings with you and provide you with a written report of the findings. The data collected from your participation during this study may be used by Laura Plexico for other research purposes or for developing a paper for presentation or publication in a professional journal. If so, none of your identifiable information will be included.

If you have questions about this study, please ask them now by contacting Laura Plexico by phone at (334) 844-9620 or email lwp0002@auburn.edu. She will be happy to answer any questions you might have. If you should have any questions about your rights as a research participant, you can contact the Office of Human Subjects Research or the Institutional Review Board by phone at (334) 844-5966 or email at hsubjec@auburn.edu or IRBChair@auburn.edu. You may print a copy of this information letter to keep.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU WISH TO PARTICIPATE IN THIS RESEARCH STUDY. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP.

The Auburn University Institutional Review Board has approved this document for use from May 27, 2020. Protocol #20-258 EX 2005

- ○ YES, I have read the information provided and wish to participate in this research study.
- ○ NO, I do not with to particpate in this research study.

Q2 What pseudonym have you selected?

_____

Q3 How did you hear about this project?

- ○ Facebook
- ○ ASHA Special Interest Group
- ○ ASHA Community Website
- ○ Flyer

Q4 What is your gender?

- ○ Male
- ○ Female
- ○ Non-binary

Q5 What is your education level?

- ○ Master's Degree
- ○ Ph.D
- ○ Ed.D

Q6 How many undergraduate-level credit hours of counseling coursework have you taken as a part of your bachelor's degree?

Q7 How many graduate-level credit hours of counseling coursework have you taken as a part of your master's degree?

Q8 Was the graduate-level counseling coursework a dedicated course, or was it infused throughout curriculum?

- ○ Dedicated course
- ○ Infused throughout curriculum

Q9 Was the graduate-level counseling coursework elective or required?

- ○ Elective
- ○ Required

Q10 How many years of SLP experience do you have?

- ○ Less than 1 year
- ○ 1-2 years
- ○ 2-5 years
- ○ 5-10 years
- ○ 10-15 years
- ○ 16+ years

Q11 What clinical population/setting do you currently work with? Choose all that apply.

- ☐ Pediatric/school
- ☐ Pediatric/outpatient
- ☐ Pediatric/inpatient
- ☐ Adult/outpatient
- ☐ Adult/inpatient
- ☐ Adult/skilled nursing facility

Q12 How many hours of Continuing Education Units (CEUs) in counseling have you taken?

- ○ 0 hours
- ○ 1-3 hours
- ○ 3-6 hours
- ○ 6-12 hours
- ○ 13+ hours

Q13 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 (1)	(1) Not at all confident (2)	(2) A little confident (3)	(3) Somewhat confident (4)	(4) Very confident (5)	(5) Completely confident (6)
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)	○	○	○	○	○	○

Q14 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 (1)	(1) Not at all confident (2)	(2) A little confident (3)	(3) Somewhat confident (4)	(4) Very confident (5)	(5) Completely confident (6)
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 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)	○	○	○	○	○	○

Appendix 6:

Locus of Control Scale Qualtrics Survey

Locus of Control

Q Please provide your first and last name.

_____

Q For each question, please select the statement that you agree with the most.

Q1

- Children get into trouble because their parents punish them too much.
- The trouble with most children nowadays is that their parents are too easy with them.

Q2

- Many of the unhappy things in people's lives are partly due to bad luck.
- People's misfortunes result from the mistakes they make.

Q3

- One of the major reasons why we have wars is because people don't take enough interest in politics.
- There will always be wars, no matter how hard people try to prevent them.

Q4

- In the long run people get the respect they deserve in this world.
- Unfortunately, an individual's worth often passes unrecognised no matter how hard they try.

Q5

- The idea that teachers are unfair to students is nonsense.
- Most students don't realize the extent to which their grades are influenced by accidental happenings.

Q6

- Without the right breaks one cannot be an effective leader.
- Capable people who fail to become leaders have not taken advantage of their opportunities.

Q7

- No matter how hard you try some people just don't like you.
- People who can't get others to like them don't understand how to get along with others.

Q8

- Heredity plays the major role in determining one's personality.
- It is one's experiences in life which determine what they're like.

Q9

- I have often found that what is going to happen will happen.
- Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

Q10

- In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
- Many times exam questions tend to be so unrelated to course work that studying is really useless.

Q11

- Becoming a success is a matter of hard work, luck has little or nothing to do with it.
- Getting a good job depends mainly on being in the right place at the right time.

Q12

- The average citizen can have an influence in government decisions.
- This world is run by the few people in power, and there is not much the little guy can do about it.

Q13

- When I make plans, I am almost certain that I can make them work.
- It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

Q14

- There are certain people who are just no good.
- There is some good in everybody.

Q15

- In my case getting what I want has little or nothing to do with luck.
- Many times we might just as well decide what to do by flipping a coin.

Q16

- Who gets to be the boss often depends on who was lucky enough to be in the right place first.
- Getting people to do the right thing depends upon ability. Luck has little or nothing to do with it.

Q17

- As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
- By taking an active part in political and social affairs the people can control world events.

Q18

- Most people don't realize the extent to which their lives are controlled by accidental happenings.
- There really is no such thing as "luck."

Q19

- One should always be willing to admit mistakes.
- It is usually best to cover up one's mistakes.

Q20

- It is hard to know whether or not a person really likes you.
- How many friends you have depends upon how nice a person you are.

Q21

- In the long run the bad things that happen to us are balanced by the good ones.
- Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

Q22

- With enough effort we can wipe out political corruption.
- It is difficult for people to have much control over the things politicians do in office.

Q23

- Sometimes I can't understand how teachers arrive at the grades they give.
- There is a direct connection between how hard I study and the grades I get.

Q24

- A good leader expects people to decide for themselves what they should do.
- A good leader makes it clear to everybody what their jobs are.

Q25

- Many times I feel that I have little influence over the things that happen to me.
- It is impossible for me to believe that chance or luck plays an important role in my life.

Q26

- People are lonely because they don't try to be friendly.
- There's not much use in trying too hard to please people, if they like you, they like you.

Q27

- There is too much emphasis on athletics in high school.
- Team sports are an excellent way to build character.

Q28 28)

- What happens to me is my own doing.
- Sometimes I feel that I don't have enough control over the direction my life is taking.

Q29

- Most of the time I can't understand why politicians behave the way they do.
- In the long run the people are responsible for bad government on a national as well as on a local level.

Q30 What is your ethnicity? (Aboriginal, African American or Black, Asian, European American or White, Native American, Native Hawaiian or Pacific Islander, Māori, or some other race. If other, please specify.)

- ○ Aboriginal
- ○ African American or Black
- ○ Asian
- ○ European American or White
- ○ Native American
- ○ Māori
- ○ Native Hawaiian or Pacific Islander
- ○ Other (please specify) _____

Appendix 7:

Interview Questions

1. How many years of experience do you have in the field?
    a. What settings have you worked in?
    b. How much time have you spent in each of those places?
    c. What was your overall experience in each setting?
    d. What different patient populations have you worked with?
    e. To what degree have you/do you work with clients with comorbidities?
2. Did you receive counseling training prior to your graduate education?
    a. No – stop.
    b. Yes – can you describe what the training was like and what it included?
3. Did you receive counseling training in your graduate education?
    a. No – stop.
    b. Yes – can you describe what the training was like and what it included?
4. Did you receive counseling training after your graduate education?
    a. No – stop.
    b. Yes – can you describe what the training was like and what it included?
    c. Can you describe the impact that the training had on your practice?
5. If yes - Do you feel that the counseling (pre or post certification) training in any way influenced your confidence in your career?
6. Have you received any specific mentorship or feedback in regards to counseling?
7. Do you judge yourself as competent in the area of counseling?
    a. No – in what areas do you lack?
    b. Yes – specific description of areas they feel competent in.
8. On a 100 point scale, how would you rate your feelings of perceived confidence as it relates to counseling?
    a. < 100 = What would need to happen for you to feel more confident as a SLP in counseling? What factors would contribute to increasing your counseling confidence?
9. If given further counseling training, do you expect that it would impact your confidence?
    a. During pre or post qualification?
10. Do you believe there is any relationship between your confidence as a counselor and your performance as a SLP?
    a. If no – why not? What factors do you feel influence your performance as a SLP?
    b. If yes – can you describe that relationship?
11. Describe any relationship you see with your experiences as a SLP and your counseling confidence?
    a. How do you feel your personal successes have contributed to your sense of confidence?
        i. Do other people influence the way you perform counseling services in the speech-pathology setting?
        ii. Has observing other counselors' success when using certain methods influenced your use of those same methods? How?
    b. How do you feel your failures have contributed to your sense of confidence?

        i. To what degree do you think you can overcome those failures?
12. To what degree do you engage in active discussion with others about your counseling performance? Either prior to or after an experience? Do you feel that those discussions have an impact on your performance? What about on the way you perceive your confidence as a counselor?
13. Do you feel that your level of counseling confidence is situation specific? How?
14. Are you generally motivated or deterred by emotionally arousing cases? Explain...
    a. For example, when put in a stressful or anxiety-inducing situation, do you feel your counseling confidence level is affected?
    b. Do you avoid or gravitate towards potentially stressful/challenging cases? Explain...
15. Do you believe that you perform well or not under emotionally arousing circumstances?
16. Our counseling ability is likely influenced by a variety of different things. What would you describe as having the most impact on your counseling achievements?
    a. To what degree do you credit your achievements to personal capability versus external factors? Effort?
    b. To what extent are your feelings of confidence influenced by external forces or reinforcement beyond your control?
17. Do you believe your perceived confidence in counseling influences your performance as a SLP?
    a. How?