The Relationship Between Clinical Experience, Emotional Intelligence and Counselor

Self-Efficacy with Resilience as a Moderator

by

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ABSTRACT

Emotions are essential ingredients to the human experience. How one feels influences how one thinks and behaves. The processing capacity for emotion-related information can be thought of as emotional intelligence (Salovey & Mayer, 1997). Regulating emotions and coping with emotional experiences are among the most common reasons individuals seek counseling. Counselors must be uniquely equipped in processing and managing emotional content. Counselor's skills and abilities related to emotional intelligence are vital to effective counseling. There is indication that confidence in one's counseling skills may be equally as important as competence in these skills. Counselor self-efficacy, one's belief in one's ability to perform counseling activities, has been shown to relate to counselor performance and ability and increased clinical experience has been associated with higher levels of counselor self-efficacy (Larson & Daniels, 1998). One's emotion-related information processing abilities and one's clinical experiences may contribute to one's perception of one's competencies and abilities as a counselor.

However, this relationship may not be a simple cause-and-effect association. Individuals may possess a certain aptitude (emotional intelligence) and not perceive themselves as competent as counselors. Resilience, one's ability to "bounce-back" and persevere through adversity may moderate the relation between emotional intelligence and counselor self-efficacy (Wagnild, 1990).

The current study explored the relations among clinical experience, emotional intelligence and resilience in predicting self-efficacy. In addition, whether resilience would moderate the relationship between emotional intelligence and counselor self-

efficacy was examined. Eighty counselor trainees enrolled in CACREP-accredited master's programs participated in this study online. They completed a demographics form, the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT; Mayer, et al., 2002), the Counselor Activities Self-Efficacy Scales (CASES; Lent et al., 2003), and The Resilience Scale (RS; Wagnild & Young, 1993). Multiple hierarchical regressions revealed clinical experience (specifically a completed practicum), emotional intelligence, and resilience predicted counselor self-efficacy. The moderation was not significant. These findings support the value of the exploration of clinical experience, emotional intelligence and resilience in developing counselor self-efficacy. A more comprehensive discussion of the findings, limitations, and implications of the current study as well as suggested direction for future research are discussed herein.

DEDICATION

To my mother, Elizabeth Ann Petrolle, a woman *ahead of her time* and *gone too soon*; a woman who was anything but cliché, despite my afore-related application above - for her love, her support, her generosity, her humor and her encouragement.

And, to my family.

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CHAPTER 1

PROBLEM IN PERSPECTIVE

Emotions represent the currency of counseling. The adept counselor is not only

agile in their abilities to recognize, reflect, facilitate, and manage the emotions of clients

but their own emotions as well. Emotional intelligence can be understood as "the ability

to perceive accurately, appraise and express emotion; the ability to access and/or generate

feelings when they facilitate thought; the ability to understand emotion and emotional

knowledge; and to regulate emotion to promote emotional and intellectual growth"

(Mayer & Salovey, 1997, p.10). Understanding the role emotional intelligence may play

in the developing counselor can help to inform modalities of counselor training as well as

the personal and professional growth of the counselor trainee. Aspects of emotional

intelligence, such perceiving emotions in one's self and others as well as regulating

emotions in one's self and others, may make emotionally intelligent counselors more

confident in their therapeutic work. Therefore, possessing greater emotional intelligence

may facilitate greater self-efficacy with regard to therapeutic work.

The relation between counselor ability and counseling outcome is not a simple

one. Counseling is stressful and, often times, emotionally draining work. Counselors are

required to harness internal and external coping resources in order to actualize ability in

an effective and efficacious manner. Resilience, one's adaptive capacity, one's ability to

gather internal and external resources in order to cope effectively with adverse

circumstances, may moderate the relationship between emotional intelligence as an

ability and counselor self-efficacy as an outcome. The primary purpose of the current

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study was to examine the interrelations among emotional intelligence, resilience, and counselor self-efficacy are examined. These constructs reflect the theoretical foundation of the present study.

Emotional Intelligence

Emotional Intelligence (EI) refers to a specific set of cognitive abilities associated with emotions. Emotions can be defined as states of arousal in response to perceived stimuli and as involving physiological reactions, cognitive appraisals, subjective reactions, and a pattern of overt expression (Salovey et al., 1995; Scheff, 2015). Goleman (1995) described emotion as a "feeling and its distinctive thoughts, psychological and biological states, and propensities to act" (p. 289). Emotions offer information that informs both cognition and behavior. Research highlights the manner in which emotions inform the processes of the brain and consequently shapes the structure of the brain, serving to format further how we input and output information (Damasio, 1994; Davidson, 2006; Davidson et al., 1999, Davidson & Slagter, 2000;). Emotions have been portrayed as compromising cognitive and intellectual processes; however, this perspective is myopic and generally inaccurate. Recent research indicates that emotions help to support cognitive processes and, in general, emotions serve to enhance cognitive abilities (Wolff et al., 2006). In fact, emotional intelligence is asserted as a greater predictor of future performance success than are more traditional forms of intelligence (Goleman, 1995).

In 1995, The American Dialect Society selected *emotional intelligence* and *EQ* (EQ is Goleman's shorthand for emotional intelligence or emotional intelligence

quotient) as the most useful new words or phrases of the year (Brodie, 1996). Pioneering

research in the field of psychology by Mayer and Salovey and their colleagues introduced

the notion of emotional intelligence within academia (Mayer & Salovey, 1990). The

best-selling book, *Emotional Intelligence* by Goleman (1995), popularized the concept

and electrified the zeitgeist. Emotional intelligence became a trend, a cultural

phenomenon plastered across the covers of *Time* and *USA Today Weekend* magazines

(Gibbs, 1995). Since its inception and subsequent reception, emotional intelligence has

been defined and redefined (Mayer, Salovey, & Caruso, 2000).

Research evidences cognitive intellectual ability as merely one predictor of

overall human performance, with other predictors emerging from the influence of

affective, conative abilities (or traits) collectively referred to as "emotional intelligence"

(Bar-On & Parker, 2000; Goleman, 1995, 1998, 2006; Mayer & Salovey, 1997; Mayer,

Salovey, & Caruso, 2003, 2008; Matthews, Zeidner, & Roberts, 2002; Wang, Young,

Wilhite, & Marczyk, 2011). EI has been defined as "the ability to engage in sophisticated

information processing about one's own and others' emotions and the ability to use this

information as a guide to thinking and behavior" (Mayer et al., 2008, p. 503). In other

words, EI is composed of a set of mental processes "involved in the recognition, use,

understanding, and management of one's own and other's emotional states to solve

problems and regulate behavior" (Brackett & Salovey, 2006, p. 34). Recent research has

found that greater EI is associated with generally positive life outcomes, such as greater

life satisfaction (Law, Wong, & Song, 2004; Palmer, Donaldson, Stough, 2002),

professional success (Bar-On, Handley, & Fund, 2006; Jordan & Ashkanasy, 2006),

stress tolerance and mood management (Ciarrochi, Chan, & Bajgar, 2001; Lopes, Cote, & Salovey, 2006), increased group productivity and team effectiveness (Boyatzis, 2006; Cheniss, 2000; Lopes, Cote, & Salovey, 2006), greater leadership skills (Bar-On, Handley, & Fund, 2006), larger social network size (Ciarrochi, Chan, & Bajgar, 2001), greater social network quality (Brackett, Mayer, & Warner, 2004; Ciarrochi, Chan, & Bajgar, 2001;), less illicit drug use (Rivers et al., 2013; Saklofske, Austin, & Minski, 2003), greater cognitive ability (Brackett et al., 2011, Saklofske, Austin, & Minski, 2003; Van Rooy & Viswesvaran, 2004), greater academic performance (Brackett et al., 2011; David, 2005), better interpersonal relationships and interpersonal sensitivity (Brackett et al., 2011), greater mental health and enhanced overall well-being (Brackett, Mayer, & Warner, 2004; David, 2005; Palmer, Donaldson, Stough, 2002; Saklofske, Austin, & Minski, 2003).

Theoretical Conceptualization of Emotional Intelligence. There has been much discussion and debate within the field of psychology regarding the nature of emotional intelligence, with researchers and theorists struggling to classify emotional intelligence distinctly as a portion of the personality or a set of information processing abilities or capacities (Bracket & Salovey, 2006; Brackett & Mayer, 2003; Mayer et al., 2000). Currently, there are two main approaches to conceptualizing and measuring emotional intelligence (EI): trait EI and ability EI (Bar-On, 2000; Mayer et al., 2008; Mayer & Salovey, 1997; Mayer, et al., 2000; Petrides, 2010; Petrides & Furnham, 2001; Petrides, Pita, & Kokkinaki, 2007; Salovey & Mayer 1990, 1997). Trait EI is conceptualized as a set of emotion-related self-perceptions and personality-like

dispositions (Bar-On, 2000; Petrides, 2010; Petrides, Furnham, & Mavroveli, 2007; Petrides et al., 2007), whereas ability EI is conceptualized as a set of cognitive abilities involving information processing abilities of emotion-related information (Mayer & Salovey, 1997; Mayer et al., 2000; Mayer et al., 2008). Typically, trait EI is assessed through self-report questionnaires (Petrides & Furnham, 2001; Petrides et al., 2007), whereas ability EI is assessed via performance based tests (Brackett & Salovey, 2006; Mayer et al., 2000; Mayer et al., 2008). Trait EI and ability EI represent two distinct concepts with regard to their theoretical underpinnings as well as methodological assessment and empirical evidence; however, research supports trait and ability EI as complementary rather than conflictual constructs (Petrides & Furnham, 2001; Petrides, 2010). Some theorists attempt to combine trait and ability EI in what is termed a mixed model approach to EI (Goleman, 2001). Often times mixed models of EI and trait EI are lumped together as they are both measured through self-report and represent an individual's perceived emotional competencies, personality-like dispositions, and abilities. These models and their associated measures fail to tap actual ability as they rely solely on self-report measures of ability, thus foregoing any true prospect of actually assessing ability and persisting in again merely assessing trait EI (Bar-On, 1997; Goleman, 1995). In the present study, EI was conceptualized as an ability and, as such, an ability-based measure was employed to assess EI.

Pioneers of the concept of emotional intelligence, Mayer and Salovey (1990; 1995) were among the first to operationalize the EI construct. According to their framework of EI as a true form of intelligence, EI can be defined as a set of interrelated

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mental abilities. In accord with this framework, EI can be viewed as a capacity to reason about and with emotions (Mayer & Salovey, 1997; Salovey et al, 2000; Salovey et al., 2003). In general, theories of intelligence vary; however, there is considerable consensus with regard to central tenets of intelligence systems.

Thorndike (1920), a pioneer of modern conceptualizations of intelligence, was among the first to delineate a form of intelligence referred to as social intelligence. Thorndike conceptualized true intelligence as transcending mere academic ability and incorporating social and emotional factors. Thorndike's division of intelligence into three facets--(1) the ability to understand and manage ideas (abstract intelligence), (2) the ability to manage and understand concrete objects (mechanical intelligence), and (3) the ability to manage and understand people (social intelligence)--provides the basis for modern multi-faceted conceptualization of intelligence. Thorndike described social intelligence as "the ability to understand and manage men and women, boys and girls -- to act wisely in human relations" (p. 228). Therefore, central to this understanding of intelligence, social intelligence can be understood as encompassing the abilities to understand others and utilize this understanding to manage others and relationships. Thorndike hypothesized social intelligence as malleable, explaining this form of intelligence as an innate ability that could be cultivated or corrupted by environmental factors.

Intelligence has continued to be viewed as multidimensional in nature. Guilford (1959) conceptualized intelligence as a complex construct comprised of over 120 distinct abilities and classified these abilities into four categories, with one category as social

intelligence. Guillford's social intelligence, like Thorndike's (1920) social intelligence, involved understanding emotions of the self and others. Similarly, Gardener's (1983) conceptualization of multiple intelligences further highlighted the multifaceted understanding intelligence as well as the complex nature of intellectual abilities inclusive of social-emotional information processing abilities. Gardener identified both intrapersonal intelligence (the abilities to understand and manage the self-inclusiveness of emotions) and interpersonal intelligence (the abilities to understand and manage others emotions) as viable and meaningful "modalities" of intelligence.

The architect of the most empirically tested and most frequently utilized measures of intelligence (e.g. WAIS & WISC), David Wechsler (1950) acknowledged that traditional intelligence tests and conceptualizations of intelligence fail to assess and account for the entirety of intelligence. Wechsler identified personality and emotional factors as playing an influential role in the expression of intelligence. Ascribing to an information processing model of intelligence and cognition, Wechsler (1975) described intelligence as "the capacity of an individual to understand the world around him [her] and the resourcefulness to cope with its challenges" (p. 139). The ability-based model of emotional intelligence compliments this perspective.

In accord with information processing models of cognition, generally speaking, an intelligence system can be viewed as a capacity to sense and input information, process, and output information. The processing of this information can be viewed as the manipulation of the incoming data while referencing established information or knowledge. Integral to this systems approach to understanding intelligence is the

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implication that the express primary purpose of these abilities is problem solving. For the system of emotional intelligence, this information processing and problem solving expressly deals with the content domain of emotion. Mayer and Salovey (1997) detailed a four-branch model of emotion-related information processing.

Branches of Emotional Intelligence. The four-branch emotion information processing model proposed by Mayer and Salovey included "[1] the ability to perceive accurately, appraise, and express emotions; [2] the ability to access and/or generate feelings when they facilitate thought; [3] the ability to understand emotion and emotional knowledge; [4] the ability to regulate emotions to promote emotional and intellectual growth" (p. 10). These four branches of EI develop in complexity across mental processes, from more simplistic to more complex emotional and intellectual abilities. These four inter-related abilities are organized in hierarchy with more rudimentary psychological processes, such as perceiving emotions at the base or foundation of the model and more advanced or sophisticated psychological processes such as reflective regulation of emotion, at the top (Brackett et al., 2011). In accord with this developmental understanding of this model, these processes develop and evolve with maturity, with more emotionally mature and developed individuals manifesting greater ability.

Consistent with the information processing model of intelligence, the first dimension of EI, *emotion perception*, involves recognizing and classifying emotional information in one's self and others as well as stimuli such as people's voices or works of art (Brackett & Salovey, 2006; Mayer & Salovey, 1997). This dimension can be thought

of as the first step in this information processing system's process: information cannot be processed unless one first attends to the information. Emotional perception entails "registering, attending to and deciphering emotional messages as they are expressed in facial expressions, voice tone, objects of art, and other cultural artifacts" (Mayer et al., 2000, p. 109). This dimension of EI has been shown to relate to enhanced emotional awareness, diminished alexithymia, and enhanced emotional expressivity (Bracket & Salovey, 2006).

The second branch or dimension of EI, *emotion facilitation*, concerns the use of emotion to guide or facilitate thinking. Emotions inform thinking through the manner in which emotional content is encoded and processed. The way this content is encoded and manipulated influences how this information is used to inform and facilitate problem-solving, reasoning, and interpersonal communication. Accordingly, this branch can be viewed as a sort of next step in the emotion information processing process, as this branch focuses on "how" the information enters the system and affects cognition impacting thought. Developmentally, as people mature, they are better able to employ emotions in informing decisions and directing attention to important internal and external changes (Salovey et al., 2000). Simply put emotion can influence cognition. This may happen consciously or unconsciously. People may become anxious, and this anxiety may cloud thinking and/or people may become anxious and this anxiety may motivate them to address an arising issue. One's mood state can further inform how one processes information. For example, when a person is happy a cognition may be regarded as positive; whereas, when a person is feeling sad, that very same cognition may be

regarded as negative (Forgas, 1995; Salovey & Birnbaum, 1989). These alterations in cognition afford greater cognitive flexibility and encourage greater perspective taking behaviors as well as enhanced creativity in problem-solving (Mayer & Hanson, 1995; Mayer & Salovey, 1997).

The third branch or dimension of this model addresses *understanding emotion*. This dimension involves understanding emotional content and employing this understanding in reasoning and analysis. This third step in the information processing involves higher level to more complex manipulation of and comprehension of the information. As children grow and mature, they are better equipped to comprehend the relations among emotions as well as between emotions and situations (Mayer & Salovey, 2002). For example, as children develop they begin to recognize and understand the connection between emotions, such as the relation between liking and loving, as well as the connection between emotions and experiences such as sadness resulting from loss (Brackett et al., 2011; Mayer & Salovey, 1997; Salovey et al., 2003). Emotional understanding involves comprehending the meaning of emotions, grasping the emotional lexicon as well as the unique ways in which emotions blend together and progress over time and across feeling states (Brackett & Salovey, 2006).

The fourth and final branch or dimension of EI encompasses *emotion regulation*, one's abilities to manage moods and feeling states in one's self as well as others. The reflective regulation of emotion involves higher level information processing and utilizing this processed information in output consciously to affect the self and/or others. When applied to the self, emotion management involves the abilities to perceive, label,

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understand, monitor, and adjust moods and feeling states accurately to promote a desired outcome. When applied to others, emotion management involves helping others to regulate their moods, feeling states, and general reactions to these entities (Brackett & Salovey, 2006). Developmentally, as children age mature, they learn to manage better their emotions, at first externally and then internally. When angry, children may act out by hitting or screaming, and they may receive input from their environment to aid in the productive regulation of this emotional state such as a parent suggesting an alternative prosocial behavior (i.e., taking a time-out and reflecting on a more appropriate behavioral choice). Eventually, children internalize this outside regulation by developing self-regulation and learn that every emotional state does not need to be acted upon, and, if acted upon there may be more appropriate and more productive alternatives for action than that initial reaction described above. Moreover, children grow, evolve, and learn to reflect on emotional states, making choices around how best to or whether to respond to emotional information. As they mature, people are equipped to reflect on emotional processes consciously to use this reflection to determine the extent to which emotional information may be affecting cognitive processes and to select behaviors based on this reflected upon information (Mayer & Salovey, 1997).

Counselor Emotional Intelligence. From a developmental perspective, the lowest branch consists of relatively simple abilities of perceiving, appraising, and expressing emotion, whereas, the highest branch involves relatively complex abilities of conscious, reflective regulation and management of emotions and responses (Mayer & Salovey, 1997). The abilities to perceive and express emotion are integral to the

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counseling process (e.g., establishing rapport, accurately reflecting feelings). As human beings mature, they are better able to use emotions to inform decisions and manage internal (thoughts) and external (behaviors) responses to stimuli. As counselors develop, they utilize emotions to facilitate thinking within the counseling session. The ability to utilize emotion content to inform decision-making is integral to the counseling process (i.e. interpreting, restating, etc.). The abilities to understand, analyze, and employ emotion develop over the lifespan. As people mature from children to adults, they grow better equipped and able to understand the connection between emotion and behavior in themselves and others (Mayer & Salovey, 1997). Emotional knowledge increases with experience, and the understanding of more complex emotional ideas as well as their connections to behavior develops with time and experience. For counselors, the ability to recognize complex emotions in others as well as in the self and to apply understanding to this emotional content are hallmarks of one of the most salient therapeutic constructs, empathy. Counselors must be aware of their own complex blending of emotions, as well as the emotional content and processes of the client, and manage the potential transference and countertransference that may be linked to these experiences.

As human beings evolve, they become better-equipped in the regulation of emotion and the promotion of emotional and intellectual growth. The emotion regulation branch, the most complex of emotional abilities in accord with this model (Mayer & Salovey, 1997), suggests that emotionally intelligent individuals are better able to regulate their own emotions as well as the emotions of others. This branch of EI involves allowing emotional reactions to occur regardless of the valence, tolerating these feelings,

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and attending to them in order to learn from them (Mayer & Salovey, 1997). These abilities are central to effectiveness as a counselor. Counselors work to manage anxieties and other emotional responses in a therapeutic manner within and between sessions and utilize this content within themselves as well as within their clients to attend to and to address better the needs of the client and the goals of treatment. Counselor behaviors such as self-disclosure, offering insight, and managing personal reactions to clients are informed by higher level EI abilities. Thus EI can be viewed as intrinsic to counseling, with higher levels of EI affording abilities party to effective counseling skills and competencies.

Research supports the connection between emotional intelligence abilities and counseling skills. Counselor trainees develop competence by practicing and exhibiting skills such as attending behaviors, observing and reflecting feelings, and summarization (Easton, Martin, & Wilson, 2008; Ivey, Packard, & Ivey, 2006). The development of competence and a congruent counseling self is contingent on self-understanding and emotional intelligence (Easton et al., 2008; Ivey & Ivey, 2003). According to a study conducted by Martin and colleagues (2004), counselor trainees and counseling professionals indicated higher levels of perceived EI than normative sample utilized in the generation of the EI instrument utilized (The Emotional Judgment Inventory (EJI); Bedwell, 2002). The normative sample of the EJI was comprised 1,283 people who were predominantly Caucasian, female, college students with (Bedwell, 2002). The findings of Martin and colleagues' study (2004) suggests EI as an integral component in the professional pursuit of counseling. These findings contributed information in support of

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previous research highlighting higher EI among psychotherapists (Schutte et al., 1998) and elevated emotional self-regulation among care professionals with respect to other comparison groups (Salovey, Hsee, & Mayer, 2001).

In a follow-up study, Easton, Martin, and Wilson (2008) explored the relation between emotional intelligence and counseling self-efficacy with a sample of 118 professional counselors and counselor trainees utilizing the Counseling Self-Estimate Inventory (COSE) and the EJI. Significant correlations between EI and counselor self-efficacy domains were found. More specifically, the abilities related to accurately identifying one's own emotions as well as the emotions of others were found to be significantly related to counselor self-efficacy beliefs. The perceived ability to identify one's own emotions clearly is vital within the counseling context secondary to the range and assortment of emotions one experiences when counseling clients (Easton et al., 2008). Identifying one's emotions, a significant aspect of EI, may be integral to the recognition and management of transference and countertransference in the therapeutic relationship (Jackson, 2002). In order to provide effective services, counselors must be able to recognize and regulate their own emotions in response to both transference and countertransference (Jackson, 2002).

In general, research indicates that counselors and counselor trainees who perceive themselves as emotionally intelligent are more likely to perceive themselves as competent with regard to attending skills and skills related to managing difficult client behavior (Easton et al., 2008; Martin et al., 2005). Although these studies highlighted the importance of EI in counseling, they failed to assess actual EI ability. The current study

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extends this literature by exploring EI *ability*, or EI performance, in relation to counselor self-perceptions of competence.

Self-Efficacy

Social cognitive theory endeavors to explain human behavior through the elucidation of processes of learning and motivation. Bandura (1989) posited that though environmental factors influence behaviors and thought processes, individuals possess the agency to act as causal agents and influence their thoughts, actions, and environments. Bandura's model of triadic reciprocal determinism asserts that environmental events, personal factors (biological events, cognition, emotion), and human behavior serve as interacting influences that impact the individual (Bandura, 1977). In accord with this model of triadic reciprocal determinism, individuals do not merely react to their environments, they determine the manner in which they will interpret and act upon their environments (Bandura, 1977). These interactions inform the manner in which an individual operates affectively, behaviorally, and cognitively. Self-efficacy serves to mediate these operations. Self-efficacy can be defined as the extent to which one considers one's self capable of performing a particular activity (Bandura, 1977).

Within this understanding of human behavior, self-efficacy operates to influence the way people think about their environments as well as how they choose to act upon our environments. In accord with social cognitive theory, an individual's actions and reactions, including social behaviors and cognitive processes, are greatly influenced by and greatly influence self-efficacy beliefs (Bandura, 1989). This theory asserts

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psychological procedures, in their various forms, as altering the level and strength of *self-efficacy* (Bandura, 1977).

Self-efficacy, as an element of self-perception, is highly influential in the determination of the outcome of an event and operates to influence outcome and achievement factors such as task persistence and skill acquisition (Driscoll, 2005). According to social cognitive theory, self-efficacy beliefs represent beliefs about one's abilities to exercise control over events impacting one's life. Self-efficacy beliefs in one's abilities to exercise control over events in one's life as well as the beliefs in one's abilities to motivate behavior, access resources, and manage demands, function such that one can meet the demand of a specific task or situation (Maddux, 1995). Therefore, self-efficacy beliefs can vary with regard to specific tasks, situations, and abilities.

As a primary vehicle of human agency, self-efficacy can account for the discrepancy between ability and action. Self-efficacy provides the causal link between the content of what people know how to do and the behavior that people actually do. Self-efficacy beliefs provide motivation and regulation to both cognitive processes and social behaviors (Bandura, 1989). In accord with his model of reciprocal determinism, Bandura (1977; 1978) suggested that through self-observation, personal assessment, and self-responsiveness, people can regulate/manage not only their personal factors but also environmental factors and behavioral factors as well. Accordingly, self-efficacy beliefs can be built and bolstered as well as torn down and corrupted. Self-efficacy is contingent on self-observation and self-evaluation, as well as on responsiveness to environmental feedback (such as the feedback of a client or supervisor, perceived successes and

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failures). Therefore, self-efficacy beliefs are not solely contingent upon one's level of

skill but also on personal perception and appraisal of what one can do with those skills

(Bandura, 1986). One's responses to successes and failures can influence the quality of

self-efficacy (Driscoll, 2005), and, in turn, people who hold lower levels of self-efficacy

may be less likely to persist in the face of challenges and expend less energy in task

pursuit (Driscoll, 2005). Self-efficacy influences behavior, goal-orientation, outcome

expectations of behavior, and appraisal of environmental factors in both direct and

indirect manners (Benight & Bandura, 2004). Individuals with a diminished sense of

self-efficacy tend to focus and perseverate on perceived personal inadequacies, anticipate

problematic circumstances, and over-estimate perceived challenges (Bandura, 1977;

1989). Evidence suggests that elevated levels of task motivation, task investment, and

task achievement are often contingent on an optimistic sense of personal self-efficacy

(Bandura, 1977; 1989; 1997); therefore, self-efficacy can influence how likely one is to

engage and persist in a task. Notably, self-efficacy is not a fixed trait but rather is a

generative ability influenced by one's perceptions of one's experiences (Driscoll, 2005).

In accord with Bandura's model, ability is not conceptualized as a stagnant entity

fixed within an individual but rather as a fluid, cumulative capacity or set of capacities.

The expressions of these capacities and the organization of the cognitive, behavioral,

motivational, and social skills affiliated with these capacities are greatly influenced by

efficacy beliefs. As Bandura (1993) suggested "efficacy beliefs influence how people,

feel, think, motivate themselves and behave" (p. 118). Self-efficacy influences behavior,

and behavior, in turn, influences self-efficacy beliefs. Self-efficacy influences the

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selection of activities, initiation of activities, and skills acquired as well as the effort put forth, regulation of and persistence in these endeavors (Larson et al., 1992).

Self-efficacy beliefs are dynamic entities informed by a variety of information sources. Self-efficacy beliefs are informed by four primary sources, (a) performance accomplishments, (b) vicarious experience, (c) verbal/social persuasion, and (d) physiological/affective states (Bandura, 1977).

Performance accomplishments, or mastery experiences, represent the most influential sources of self-efficacy information (Bandura, 1977; 1982). These performance accomplishments are mastery experiences that result from either actual or symbolic practice. An individual may enhance their self-efficacy when they encounter a task, cope successfully with challenges affiliated with the task, avoid potential adverse circumstances associated with the task, and overall successfully control for and meet the demands of the task. Overall, successes enhance mastery expectations; recurring failures bring them down, particularly if the misfortunes early in the progression of events (Bandura, 1977). Accordingly, successes enhance perceived efficacy, whereas failures, in particular repeated failures, diminish perceived efficacy (Bandura, 1977; 1986). Notably, after sturdy self-efficacy expectations are solidified through repeated success experiences, the negative influence of occasional failures is diminished (Bandura, 1977).

Another route to enhancing or strengthening self-efficacy beliefs is through vicarious experience. Many expectations are derived from observations of others. Although vicarious experience is less effective than performance accomplishment in influencing self-efficacy beliefs, vicarious experience remains influential, especially

when the model executes a clear outcome perceived as positive by the observer (Bandura, 1977) and the model is perceived by the observer as similar to the observer (Bandura, 1995; Kazdin, 1974). In short, when an individual sees someone completing a task and that someone is perceived as similar to the himself/herself, the individual's beliefs about his/her abilities to complete the task are enhanced. Both outcome expectations and goals influence the likelihood of engaging and mastering an observed behavior (Bandura, 1986).

Another source of information influencing self-efficacy is verbal or social persuasion. Verbal persuasion or feedback from others concerning the likelihood that one will succeed is influential in the development and maintenance of self-efficacy beliefs. Efficacy expectations generated in this manner are likely to be weaker than efficacy expectations resulting from one's own mastery experiences as these expectations fail to emerge from an authentic experiential base (Bandura, 1977). Verbal persuasion is most effective when people are socially persuaded that they hold the abilities to master challenging situations and are provided supports and conditions that facilitate effective performance (Bandura, 1977). Therefore, people who are verbally persuaded that they have the resources necessary to succeed in a task are more likely to put forth effort, sustain effort, and persist in the task (Bandura, 1995).

The final source of information affecting self-efficacy beliefs is emotional arousal or physiological/affective states. Emotional arousal influences self-efficacy beliefs when individuals interpret their capabilities in reference to past emotional or physiological responses to the task. Bandura (1977) suggested that emotional arousal can be

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motivating or debilitating to self-efficacy beliefs contingent upon the individual's interpretation of the arousal. Additionally, Bandura identified that mood can provide a context for our cognitive appraisal of information influencing self-efficacy beliefs, such that mood may affect an individual's judgment of self-efficacy. For example, a positive mood may enhance perception of self-efficacy. Accordingly, emotional intelligence, the manners in which people perceive, interpret, process and manage emotional information, may inform the manner in which people process information affecting self-efficacy beliefs.

Bandura (1977) suggested that self-efficacy serves to motivate and guide cognition and behavior. Therefore, in accord with this supposition, self-efficacy beliefs can motivate individuals to make certain choices (careers, relationships, learning environments, etc.) based upon the degree to which particular factors enhance or diminish self-efficacy (Bandura, 1977). Individuals may gravitate toward settings in which they perceive an enhanced likelihood of success relative to failure and avoid settings that provide the opposite opportunities.

Self-efficacy can be influenced by practicing skills, observing skilled models, receiving effectively targeted feedback, and receiving support in managing physiological and emotional arousal. Moreover, persistence in pursuits that are subjectively threatening but in fact are relatively safe, such as challenging clinical experiences, can serve to enhance of self-efficacy through experiences of mastery (Bandura, 1977). Furthermore, the more reliable the experiential sources, the greater the alterations in perceived self-efficacy (Bandura, 1977).

Self-efficacy plays a significant role in the ways in which individuals approach new environments, respond to environmental stimuli, cope with potential challenges, and persist in the face of these challenges. Therefore, the magnitude of one's self-efficacy (one's belief in one's abilities to succeed as informed by performance accomplishments), one's emotional intelligence (one's abilities to process emotion-related accurately information), and one's resilience (one's ability to persist in the face of adversity) can determine various life outcomes and motivate successful behaviors.

Counselor Self-Efficacy. As a dynamic set of cognitive performance appraisals attached to specific behaviors, self-efficacy beliefs can be domain specific. One such domain is counseling. Counseling psychology researchers and practitioners, alike, have long been devoted to the understanding the development of counselor competency (Lent et al., 2006; Russell, Crimmings, & Lent, 1984). Bandura's (1977) social cognitive model of human behavior provides a meaningful framework within which to conceptualize counselor development with attention to a particularly meaningful construct, self-efficacy.

Counselor self-efficacy (CSE) pertains to the counselor's perception or judgment of their own abilities to counsel a client successfully and perform role-related behaviors (Larson & Daniels, 1998; Larson et al., 1992; Larson et al., 1999; Lent et al., 2006). Therefore, effective counselors are expected to adapt to and exercise multiple skills sets such as attending to, interpreting, and reflecting feelings while managing the continuous fluctuations of the counseling setting (Easton, Martin, & Wilson, 2008; Larson & Daniels, 1998). In accord with Bandura's (1977) description of self-efficacy, counselor

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self-efficacy serves as the causal determinant in the relationship between possessing the knowledge of how to act and the actual acting. Additionally, counselor self-efficacy beliefs are domain specific as they pertain to the perception of one's abilities in a specific domain, counseling. Lent and colleagues (2006) suggested that CSE can be understood in terms of (a) task and content self-efficacy, perceived capabilities related to helping skills and session management skills and (b) coping self-efficacy, perceived capabilities related to managing complex clinical challenges.

Research provides evidence in support of the relevance of CSE to counseling. Investigation of CSE has generated a flourishing domain of research, with researchers investigating counselor trainees' perceived abilities in both general counseling (Larson et al., 1992) and specific forms of counseling such as career counseling (Lent et al., 2006; O'Brien, Heppner, Flores, & Bikos, 1997; Tang, 2004).

Counselor Self-Efficacy and Emotional Intelligence. Integral to training is the development of both competency and confidence in one's counseling skills (Larson & Daniels, 1998). Emotion management is an integral aspect of counseling competency and consequently self-efficacy within this domain. The Rogerian concepts empathy, warmth, congruence/genuineness, and self-disclosure as empirically supported aspects of the counseling relationship that significantly influence effective counseling outcomes (Norcross, 2002; Rogers, 1957). A strong therapeutic alliance is integral to the efficacy of the counseling process, and these factors inform the quality of this relationship (Norcross, 2002). Emotion is imbedded in each of the facets of the therapeutic alliance identified above, and the manners in which counselors perceive themselves as efficacious

in these therapeutic entities may be somewhat contingent on EI abilities. Research evidences the manner in which beliefs about one's own abilities to counsel effectively influences the amount of anxiety counselor trainees experience and how this anxiety is interpreted. Anxiety may be interpreted as motivating or handicapping contingent upon the level of CSE (Larson & Daniels, 1998). The management and regulation of anxiety and other emotional experiences are abilities emerging from capacities comprising the EI construct.

Larson and colleagues (1992) suggested that there are five factors that impact a counselor trainee's competence and confidence: (a) executing microskills, (b) attending to process, (c) dealing with difficult client behaviors, (d) behaving in a culturally competent way, and (e) being aware of one's own values. These five factors comprise CSE and comprise the foundation for the Counseling Self-Estimate Inventory (COSE, Larson et al., 1992). Micro-skills assessed, in this measure, identify factors mediated by EI (e.g., "I will not reflect and react to a client's feelings, and the interview will remain on an intellectual level"). Therefore, researchers suggest that, in part, factors related to perceived counseling competency and express CSE are related to abilities associated with EI.

Research supports the connection between emotional intelligence abilities and counselor self-efficacy. Counselor trainees develop confidence and competence by practicing and exhibiting skills (Easton, Martin, & Wilson, 2008; Ivey, Packard, & Ivey, 2006). The development of confidence in one's counseling abilities is impacted by self-understanding and EI (Easton et al., 2008; Ivey & Ivey, 2003). A study conducted by

Martin and colleagues (2004) found that EI as measured by the EJI predicted counselor self-efficacy in practicing counselors and counselor trainees. One's perceptions of one's skills related to identifying emotions, using emotions adaptively, and employing emotions in problem-solving emerged as significantly predictive of one's counselor self-efficacy. The EI factors--Identifying Own Emotions, Expressing Emotions Adaptively, and Using Emotions in Problem Solving--predicted counselor self-efficacy of both practicing counselors and counseling students, accounting for approximately 53.7% of the variance in counselor self-efficacy. Comprehending and appraising emotions and emotional states, generating mood states that facilitate task performance, adaptively communicating how one feels to facilitate a desired outcome, and assisting clients work through emotion-related problems are essential to effective counseling (Bedwell, 2002; Martin et al., 2004).

In a follow-up to this study, Easton, Martin, and Wilson (2008) examined the relations between EI and counselor self-efficacy in counselors and counselor trainees. The purpose of this second phase of the study described above was to determine whether perceived EI and counselor self-efficacy increased with counselor training and experience over time. The counselor self-efficacy of both counselors and counselors-in-training increased over time, with counselor trainees experiencing the most significant gains. Significant correlations between EI and counselor self-efficacy domains were found. In particular, the abilities related to accurately identifying one's own emotions as well as the emotions of others were found to be significantly related to counselor self-efficacy beliefs. The perceived ability to identify one's own emotions clearly is vital within the

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counseling environment due to the variety of emotions counselors experience when counseling clients (Easton et al., 2008). Identifying one's emotions, a significant aspect of EI, may be integral to the recognition and management of transference and countertransference in the therapeutic relationship (Jackson, 2002). Results further indicated that individuals with perceived low self-efficacy in managing and addressing challenging client behaviors also evidenced low ability in using emotional information in problem solving. Effective use of emotion-information in problem-solving is integral to effectual counseling. Emotional intelligence-related abilities, such as understanding emotions, integrating emotional information into problem-solving, and using this in formation in interpersonal interaction are essential for a counselor. Counselors need to be well-equipped emotionally to manage session challenges ranging from connecting with a noncommittal client to appropriately intervening in a client crisis situation (Easton et al., 2008).

Research highlights the relations between EI and counselor self-efficacy. Counselors and counselor trainees who perceive themselves as emotionally intelligent are more likely to perceive themselves as competent in their counseling skills and abilities (Easton et al., 2008; Martin et al., 2004). However, this prior research failed to explore EI as a true ability by incorporating a performance-based measure of emotional intelligence that requires the use of emotional information to solve emotion-related problems. The current study extends this literature by exploring EI *ability*, as measured by the MSCEIT (Mayer et al., 2002), in relation to counselor self-efficacy, as measured by Counselor Activity Self-Efficacy Scales (Lent et al., 2003)

Measurement of Counselor Self-Efficacy. Several measurement concerns have been reported with regard to the assessment of CSE. Lent, Hackett, and Brown (1998) identified several factors that are problematic in the identification and measurement of CSE. Lent, Hill, and Hoffman (2003) noted that counselor self-efficacy scales often presume a level of knowledge of counseling skills that may allude beginning counselor trainees, contain content and/or formats that suggest that the measure may be assessing constructs such as values outside of self-efficacy, fail to sample adequately self-efficacy relative to advanced counseling skills or role requirements such as the ability to counsel complex clients, and often are not explicitly grounded in theories related to helping skills and counselor development (Lent et al., 2003). In response to these concerns, Lent and colleagues (2003) created the Counselor Activity Self-Efficacy Scales (CASES).

The CASES was developed from Lent and colleagues' (2003) conceptual fusion of the Hill and O'Brien (1999) helping skills model and related research (Hill et al., 1999), critiques and reviews of the literature on counselor self-efficacy (e.g., Larson, 1998; Larson & Daniels, 1998; Lent et al., 1998), as well as the researchers' clinical experiences in educating and supervising counselor trainees and professionals. In particular, Lent and colleagues (2003) conceptualized counselor self-efficacy as composed of three broad subdomains of self- perceived ability to (a) perform basic helping skills, (b) manage session tasks, and (c) negotiate challenging counseling situations and presenting issues. In their 2003 psychometric study, Lent and colleagues examined CASES scores during the first week and 15th week of participants' second semester of master's practica. They found that CSE scores increased with relevant

helping skills and counseling experience. CASES is described in more detail in the Method chapter as this instrument was utilized in the assessment of CSE in the current study. Again, as in the case of previously discussed measures of CSE, EI informs many of the skills and content areas assessed by these measures.

Clinical Experience and Counselor Self-Efficacy. Prior experience is foundational to one's belief in one's abilities to be successful within a particular domain. This belief in personal ability to succeed can be thought of as self-efficacy. Mastery experience, which can be thought of as performance accomplishment, is an influential source in the development of self-efficacy. The experience of success can serve to enhance one's sense of personal efficacy by "providing authentic evidence that one can muster whatever it takes to succeed" (Bandura, 1986, p. 82). Prior counseling experience can be conceptualized as informing performance expectations, the most influential determinant of self-efficacy beliefs (Bandura, 1977).

In the context of counseling practice, counselor self-efficacy has been indicated as a significant predictor of counselor performance (Larson, 1998; Larson & Daniels, 1998). In their major literature review of counselor self-efficacy literature, Larson and Daniels (1998) found that existing measures of CSE correlate positively with counselor developmental level and counselor performance, with more experienced counselors reporting higher levels of CSE than less experienced counterparts. Additionally, higher levels of CSE were shown to correlate with stronger performance of counseling skills within the counseling session as well as greater client satisfaction. In general, CSE was shown to be one of the strongest predictors of overall counselor performance (Larson &

Daniels, 1998). Tang and colleagues (2004), in their study of 116 counselor trainees students found that clinical experiences, more specifically, the length of internship hours and previous counseling-related work experience were positively correlated with counseling self-efficacy. Larson and colleagues (2006) found that both anxiety and self-efficacy beliefs were significantly related to counselor performance, with lower anxiety correlating with higher CSE. Examining counselor education students enrolled in practicum, Bradley and Fiorini (1999) found that a counselor's confidence in his/her ability to execute counseling-related skills such as critical thinking and empathy directly influenced the quality of services rendered, as indicated by counselor educator reports. These findings evidence clinical experience as contributing meaningfully to counselor self-efficacy.

Evidence also suggests that counselor trainees in latter stages of training exhibit higher levels of CSE (Larson & Daniels, 1998) and that CSE increases with both time and experience. Johnson and colleagues (1989) found that CSE increased over the first eight weeks of the course on pre-practicum counselor training among master's level trainees. Larson and colleagues (1992) found that both master's and doctoral level practitioners had higher levels of CSE than did beginning practicum counselor trainees. Larson and Daniels (1998) indicated, in particular, that role-playing, modeling, and receiving positive feedback appear to promote CSE in counselor trainees beginning their practicum experience. Daniels and Larson (2001) also found that performance feedback influenced perceptions of CSE, with positive feedback promoting participant CSE and negative feedback diminishing participant CSE.

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Though research addressing the relationship between CSE and counseling performance has been somewhat variable; in general, research has elucidated moderate positive correlations between CSE and counselor performance (Johnson et al., 1989; Larson et al., 1992). Additionally, with regard to predictive potential, researchers (Bradley & Fiorini, 1999; Larson, et al., 1999) reported CSE as predicting counselor performance. In accord with Social Cognitive Theory (SCT) reciprocal determinism, these performance experiences further inform counselor self-efficacy.

One's development of counselor self-efficacy has been viewed as grounded in one's cognitive appraisal of one's experiences in counseling clients (Larson & Daniels, 1998). Prior counseling experience can be thought of as fundamental to the development of counselor self-efficacy. In a thorough review of extant literature, Larson and Daniels (1998) evidenced measures of counselor self-efficacy as significantly correlating with indexes of counselor performance and counselor developmental level. In general, the data evidenced experienced counselors as reporting higher counseling-related self-efficacy than did less experienced counselors. The research explains past counseling experiences as significantly contributing to counselor self-efficacy and, in turn, indicates counselor self-efficacy as contributing positively to future counseling performance (Easton et al., 2008; Larson et al. 1992; Lent et al., 2003). The role of counseling experience on CSE was investigated in the current study.

Resilience

The term resilience is derived from the Latin word *resilio* (from *re + salire*) that means to leap or spring back, to rebound. Modern psychological conceptualizations are

as varied as the construct's applications, and definitions of this construct seem contingent upon the construct's application in the specific purpose of a particular line of research. Despite the multitude of definitions, however, there are common themes across definitions, including adaptability, competence, determination, and acceptance (Wagnild, 2009).

It has been noted that the construct of resilience first received attention in the developmental literature in investigations of children's adaptation to chronic adversity (Bonnano, 2012; Masten, 2001; Wagnild, 2009). Relevant across the lifespan, resilience may be approached from a developmental perspective. Developmentally, one's capacity for resilience can be seen as increasing over the lifespan and well into adulthood, often as a consequence of coping with adverse experiences (Wagnild & Collins, 2009). Accordingly, research suggests the contribution of both genetic and environmental factors in the development and expression of resilience (Cicchetti & Blender, 2006; Feder, Nestler, & Charney, 2009; Haglund et al., 2007). Therefore, one may be born with a genetic predisposition or capacity for a certain level of resilience, and environmental factors may determine the extent of the expression of this capacity.

Resilience reflects the ability to "bounce back" from unfavorable experiences and "connotes inner strength, competence, optimism, flexibility, and the ability to cope effectively when faced with adversity" (Wagnild & Collins, 2009, p. 29). Resilience is neither simply a personality variable nor simply the absence of pathology (Bonnano, 2012). It is not regarded as a fixed trait or characteristic but as a quality of a person's adaptive trajectory (Luthar & Zelazo, 2003). It is a malleable process and may operate in

different ways contingent on context (Gilligan, 2007). Resilience can be described as a

motivational force imbued with the ability to drive pursuits of wisdom and self-

actualization; life's stressors and changes can provide growth (Richardson, 2002).

Resilience is an adaptive ability. For the purpose of this study, resilience was

conceptualized as an adaptive capacity, the ability to harness internal and external

resources to cope effectively with adverse circumstances (Wagnild & Young, 1993;

Wagnild & Collins, 2009).

Resilience has been shown to be associated with a variety of positive physical

(Black & Ford-Gilboe, 2004; Humphreys, 2003; Monteith & Ford-Gilboe, 2002;

Wagnild, 2009) and mental health outcomes (Bonanno et al., 2006; Broyles, 2005;

Humphreys, 2003; Nygren et al., 2005; Rew, Taylor-Seehafer, Thomas, & Yockey,

2001). It has also been found to correlate negatively with depression (Wagnild, 2009;

Wagnild & Collins, 2009; Wagnild & Young, 1993) and anxiety (Humphreys, 2003) and

to correlate positively with possessing a sense of purpose in life, one's belief that one's

life has meaning (Nygren et al., 2005), and with self-efficacy, one's belief that one can be

successful in life (Caltabiano & Caltabiano, 2006).

Through grounded-theory research based on a qualitative study of 24 older

women who had experienced significant loss (e.g. loss of a spouse, health, or

employment) and had successfully coped with this loss (Wagnild & Young, 1988) and a

qualitative study (Wagnild & Young, 1990) of 39 caregivers of spouses diagnosed with

Alzheimer's disease, Wagnild and Young identified a theory and measure of resilience.

The five theoretical underpinnings emerging from their qualitative work comprise the

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conceptual foundation for the construct of resilience and the instrument, *The Resilience Scale*. Wagnild and Young (1990; 1993) delineated and defined these resiliency characteristics as purpose, perseverance, equanimity, self-reliance, and existential aloneness. The first characteristic, *purpose,* can be understood as the belief that life has meaning and valuing one's own contribution to this meaning (Wagnild, 2009). The second characteristic, *perseverance,* can be defined as the act of persistence despite adversity or discouragement, indicating a willingness to continue the struggle to reconstruct one's life and remain committed to this construction in spite of adversity (Wagnild, 2009). Quite simply, perseverance is the ability to stick it out in the face of obstacles and setbacks. The third characteristic, *equanimity,* can be understood as one's ability to maintain a balanced perspective of life and may be thought of as "taking what comes", thus modulating one's response to adversity (Beardlee, 1989; Kadner, 1989; May, 1986; Wagnild, 2009). The fourth characteristic, *self-reliance* can be defined as believing in one's self and one's abilities and involves recognizing personal strengths and limitations. Lastly, *existential aloneness* (authenticity) can be explained as the realization that each person has a unique path in life, and, though some life experiences may be shared, many experiences will be faced alone. Existential aloneness connotes both a sense of uniqueness as well as a sense of lightness or freedom (Wagnild, 2009; Wagnild & Young, 1990, 1993). The *Resilience Scale* assesses resilience in accord with this 5-chracteristic model.

In a recent review of studies (Wagnild, 2009) employing *The Resilience Scale* (RS), a meta-analysis supported the psychometric utility of the scale for use across

diverse populations of varying age groups including, yet not limited, to undergraduate students, graduate students, at risk adolescents, caregivers of spouses with Alzheimer's disease, patients struggling with heart disease, mothers or pre-school aged children, army chaplains, military wives, older gay men, and older adults (Wagnild, 2009). Results across studies suggest sound reliability (with internal consistency scores ranging from .85 to .94) and validity (Wagnild, 2009). The scale has shown statistically significant associations with morale, self-esteem, life satisfaction, depression, self-reported health status, and perceived stress (Wagnild, 2009).

Counselor Trainee Resilience. To date few studies have investigated the resilience of counseling students or counseling professionals. Although no published peer-reviewed studies were found that explicitly, quantitatively explored the manner in which resilience contributes to the experiences of post-graduate level counseling students, several studies have examined resilience in counselor trainees qualitatively as well as other graduate level students and helping professionals quantitatively and qualitatively. For example, using narrative analysis, Dayal, Weaver and Domene (2015) qualitatively explored the experiences of shame and resilience in counselor trainees ($n = 7$) coping with eating issues. They found that trainee's motivation to help others and benefit society appeared to boost personal growth and serve as a protective factor in the face of stressors and adversity. In their five-year longitudinal qualitative study, Edwards, Ngcobo, and Edwards (2014) investigated resilience and coping experiences in master's level South African professional psychology students. Their sample was comprised of 12 men and 31 women with an age range of 21 to 51 years and a mean age of 26 years.

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Results indicated that resilience fell within the four broad themes of struggle experiences, personal bounce back experiences, life management experiences, and study experiences. Coping mechanisms fell within the eight broad themes of social support, management of personal/professional life balance, personal and study skills, recreation activities, personal therapy, spiritual activities, and relaxation practices. The results of this study suggested that resilience characteristics and coping mechanisms are interrelated. The findings also indicated that resilience characteristics related to positive adaptation from challenges and adversity involved coping, health, and performance.

Focusing on supervision, Pyhältöa, Vekkailaa and Keskinen (2015) investigated the fit between doctoral students' and supervisors' perceptions of experiences in supervision and explored how the perceived fit contributed to students' satisfaction and resilience. Their participants included 1184 doctoral students (770 females and 338 males), and 431 supervisors (166 female and 252 male) recruited from the University of Helsinki in the areas of agriculture and forestry, arts, behavioral sciences, social sciences, biological science, environmental sciences, law, medicine, pharmacy, theology and veterinary medicine. Resilience was explored in a qualitative manner. The researchers reported that their results indicated that it was important for students and supervisors to have similar views about supervision as this joint understanding about the supervisory relationship promoted students' resilience and aspects of academic satisfaction. The research supports the relation between clinical experiences, such as clinical supervision, and resilience.

Several studies have quantitatively examined resilience among graduate students. In their longitudinal study (2006-2007), Dyrbye and colleagues (2010) examined the relations among burn-out, recovery, resilience burnout, quality of life, stress, fatigue, social support, learning environment, life events, employment status, and demographics of 1321 medical students. Based on their performances on the measures, participants were identified as either resilient or vulnerable. No significant demographic differences were noted between the groups; however, resilient students experienced less depression, higher quality of life, less unemployment, fewer stressful life events, higher levels of social support, and less stress and fatigue, and generally perceived learning climate more positively than did vulnerable students.

Also examining the role of resilience in the experiences of graduate level students, Wang (2009) explored the relationship between adjustment and resiliency characteristics in 207 international graduate students in the United States. Resilience characteristics were highly negatively correlated with adjustment problem areas and moderately associated with background variables. More specifically, a positive view of the world and flexibility with regard to ways of thinking about the self and the world were negatively correlated with all 11 areas of adjustment problems assessed, suggesting that individuals with higher resilience cope more effectively with adjustment-related challenges. Moreover, the findings indicated that resilience characteristics do not dramatically change with modest alterations of background variables. This finding suggested that, though related to background variables, resilience is not solely contingent on background variables (e.g. age, gender, length of stay in the United States, marital

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status, TOEFL score). The findings demonstrated the significant relation between resilience and student adjustment as well as the role of resilience in predicting adjustment difficulties; it was indicated that resilience characteristics serve to mediate one's abilities to cope and change. Adjusting to life changes is not only a significant aspect of the graduate school experience but also the counseling experience as well. Resilience serves to inform coping and supports adjustment across life circumstances and perhaps counseling experiences.

Collectively, these studies indicated resilience as contributing positively to the life experiences of post-college students. Resilience has been shown to relate positively with common themes including perceived support from family and faculty, positive learning environments, cognitive flexibility, prosocial adjustment, and optimism about the world. Other studies have examined the role of resilience in care professions.

Resilience and Clinical Experience. Although there has been limited research specifically targeting the interplay between resilience and clinical experience in counseling professionals, several studies have explored the relations between resilience characteristics and clinical experience in care professionals. Lambert and Lawson (2013) explored relations among mental health, self-care, burn-out, resilience, and vicarious traumatization in professional counselors who provided services to those affected by Hurricanes Katrina and Rita. They measured professional resilience and conceptualized professional resilience for mental health providers as a commitment to achieve balance between professional stressors and personal life challenges while maintaining and cultivating professional values as well as career stability (Fink-Smanick, 2005 as cited in

Lambert & Lawson, 2013).   Resilience was measured across three dimensions: compassion satisfaction; burn-out; and compassion fatigue. The findings indicated that survivor-volunteer counselors (counselors who survived the hurricanes) had higher levels of posttraumatic growth than did the volunteer counselors. Results further indicated that both volunteer and survivor-volunteer counselors experienced compassion fatigue. Moreover, counselors who engaged in self-care strategies affiliated with positive professional resilience were found to experience less burnout, compassion fatigue, and vicarious traumatization than did their less resilient counterparts, suggesting that resiliency may serve to buffer the negative effects of adverse life experiences.

Utilizing a grounded-theory method, Clark (2009) conducted a qualitative exploration of resilience in marriage and family practitioners. The sample was comprised of eight licensed marriage and family therapists: five female and three male, all self-reported as Caucasian, ranging in age from 50 to 73, with an average age of 58.9 and an average of 22.6 years of experience. Four participants possessed master's degrees, one had an educational specialist degree, and three had a doctoral degree. All described their orientation/approach to therapy as systemic and eclectic. With the exception of one clinician, all were either employed by an agency or in private practice and reported feeling energized by their work. Resilience was related to an integration of ''self'' within therapeutic practice, and the research emphasized the importance of therapist self-care in establishing resilience. Specifically, resilience was related to generating supportive practice environments, finding strategies to manage risk, imparting purpose and meaning in work, and deriving enjoyment from client contact. Moreover, resilience was found to

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be affiliated with a career path marked by positive clinical experiences, supportive work environments, mentorship, collegial support, and sound clinical training. Finally, Clark suggested that clinicians' abilities to tune into their emotional responses and to separate self from other were central to practitioner resilience.

Edward (2005) explored resilience in crisis-care, community mental health workers in Australia. In this qualitative study, Edward conducted extensive individual interviews of six crisis-care clinicians. Resilience was explained as the ability to bounce back from adversity and to persevere through adversity, returning to a state of internal balance, a healthy state of being. The study findings suggested that resilience in crisis-care roles in mental health is consistent with having a sense of self including the clinician's level of experience and clinical expertise. The findings further indicated that resilience is allied with having a sense of faith, one's insight into one's clinical role, including professional self-introspection and appropriate self-management of feedback. Furthermore, the findings explained resilience as related to one's personal self-care including embeddedness in social support networks of exercise, getting adequate sleep, and having relaxation activities and hobbies.

Exploring the relation between self-care and burn-out prevention strategies in career counselors, Skovholt, Grier and Hanson (2001) proposed a developmental model to the promotion of counselor resilience. They explained that caring professions, and counseling, in particular, revolve around a continuous sequence of empathic attachments, committed involvements, and eventual felt separations. They proposed this "the caring cycle" as integral to counseling success and suggested that continual pressure to create

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and re-create the cycle of caring can cause fatigue and burnout. In order to promote resilience, caring professionals are encouraged to recognize the risks of "high touch" work, such as continuous one-way caring and limited resources, and to maximize professional and personal sustenance through self-reflection, nurturing support networks, and maximizing professional experiences of success while attending to personal wellness.

In a 2007 study investigating resilience in caring professionals, Gillespie, Chaboyer, Wallis, and Grimbeek explored characteristics associated with resilience among a sample of 1430 operational room (OR) nurses. Five variables (hope, self-efficacy, coping, control and competence) were found to relate to resilience. Of note, age, experience, education, and years of employment were not shown to contribute to resilience. In a follow-up study utilizing the same sample, Gillespie, Chaboyer, and Wallis (2009) supported the previous findings that resilience in the workplace is predicted by attributes other than demographic characteristics. Regression analyses investigated the hypothesis that age, years of experience, and education would contribute to resilience in the sample ($n = 735$).   However, only years of experience predicted resilience, accounting for 3.1% of the variance in resilience. Clinical experience was found to relate positively to resilience, however, not in a manner that would suggest collinearity.

Research further indicates a relation between resilience and job satisfaction in care professionals. For example, when Zheng and colleagues (2017) explored the relation between resilience and job satisfaction in 748 mental health nurses in Singapore, they found a positive relation between resilience and job satisfaction and between

resilience and years of clinical work experience. In a 2010 study studying resilience and

job satisfaction in 36 psychiatric nurses, Matos, Neushotz, Griffin, and Fitzpatrick found

that the professional status aspect of job satisfaction was positively correlated with

resilience; however, this was at the $p < .10$ level and accounted for just over 10% of the

variance in job satisfaction was explained by resilience. Professional status was

comprised of recognition, importance, significance, pride, and skill in the nursing

profession. Approximately 20% of the nurses' satisfaction with professional status was

explained by the resilience scores. This finding as consistent with two previous studies on

work satisfaction in psychiatric hospitals (Stamps, 1997). The research suggests a

positive relation between resilience and professional status, specifically taking pride in

and being recognized for professional achievement and skill.

Resilience and Emotional Intelligence. Li, Cao, Cao, and Liu (2015)

investigated the relations among post-traumatic growth, trait-based emotional intelligence

and resilience in 202 Chinese nursing students. Post-traumatic growth was associated

with EI and resilience in a curvilinear relation, with moderate-level EI and resilience

most associated with positive post-traumatic growth. Li et al. suggested that their finding

implied that moderate resilience and EI may support nursing students' coping with

adversity in clinical work.

A 2011 study explored the relation between trait-based emotional intelligence and

resilience in helping professional trainees in clinical social work (Kinman & Grant,

2011). The researchers investigated social and emotional competencies, including

emotional intelligence, as predictors of resilience in 240 social work trainees with a mean

age of 33.7 (*SD* = 9.04).   Emotional and social competencies accounted for 47% of the variance in resilience. There was a significant negative relation between psychological distress and resilience; however, when resilience was held constant, the previously significant relation between EI and psychological distress emerged as non-significant, thus evidencing a full mediation effect. Accordingly, resilience was found to mediate the negative relation between EI and psychological distress, highlighting the relation between resilience and EI in the generation of protective factors associated with well-being. Kinman and Grant (2011) suggested that this finding indicates that EI enhances resilience that, in turn, fosters psychological well-being. These findings support the relation between resilience and EI in the generation of positive outcomes.

Schneider, Lyons, and Khazon, (2013) also examined the relationship between ability-based emotional intelligence, resilience and stress reactions among 126 undergraduate psychology students. The students' mean age was 20 (*SD* = 4.6), 60% were female, 67% were freshman, and 70% were Caucasian. Ability-based EI facilitated stress resilience. The researchers demonstrated that facets of EI (in particular, perceiving emotions and understanding emotions) inform resilient psychological and physiological responses in the face of stress.

The roles emotional intelligence and resilience in German mental health professionals caring for patients with serious mental illness (SMI) was investigated by Frajo-Apor, Pardeller, Kemmler and Hofer (2015). This cross-sectional study assessed ability-based EI and resilience and as well as the interrelations between these variables in 61 mental healthcare professionals working for an outreach team as compared with 61

control participants with non-healthcare related professions. EI was examined employing

the German version of the Mayer-Salovey-Caruso-Emotional-Intelligence Test

(MSCEIT), and resilience was examined utilizing the German version of the Resilience

Scale (RS). Both groups showed an average level of EI in all categories of the MSCEIT

and indicated high levels of resilience. Correlation analysis revealed a positive

association between the RS total score and the MSCEIT total score. The experimental

and control groups did not differ in their EI and resilience scores. Researchers suggested

that their results implied that mental healthcare professionals may not be more resilient

than the general population and, therefore, may not be more 'protected' from stressors

and adversity. They acknowledged that selection bias may have contributed to their

findings, noting that less emotionally intelligent and resilient practitioners may have

opted out of the study secondary to privacy concerns and less resilient or emotionally

intelligent practitioners may theoretically have stopped working within the clinic due to

the emotional weight of the work. They further suggested that the positive correlation

between EI and resilience indicated that EI may be a potential focus for education and

training efforts to enhance resilience.

Research suggests relations among resilience, EI, professional experience, and

perceived self-competencies. Specifically, as counselor trainees and/or counseling

professionals accumulate clinical experience, their counselor self-efficacy increases

(Daniels & Larson, 2001; Larson & Daniels, 1998; Larson et al., 1992; Lent et al., 2003;

Lent et al., 2006). The literature also indicates that EI abilities inform counseling

abilities and counselor perceived competencies (Easton et al., 2008; Jackson, 2002;

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Martin et al., 2004). Moreover, the research evidences a relation between resilience and EI for students and other care professionals (Frajo-Apor et al., 2015; Kinman & Grant, 2011; Schnedier et al., 2013) and indicates the potential benefit of further exploration into the interplay among these variables with specific attention to the measurement of EI as an ability (Frajo-Apor, 2015; Mayer et al., 2002; Mayer et al., 2003).

The Current Study, Research Question and Hypotheses

The current study extends the existent literature addressing the relations between emotional intelligence, resilience, clinical experience, and counselor self-efficacy. Unlike much of the previous research exploring the relations between EI and CSE, this study employed a performance-based measure to assess EI abilities. Moreover, it explored the role of resilience in the moderation of the established relationships between CEx and CSE as well as EI and CSE. The current study endeavored to address the questions, do clinical experience and emotional intelligence contribute to counselor self-efficacy and does resilience moderate these contributions? Based on the literature reviewed, it was hypothesized that:

H1: Clinical experience (CEx) would predict counselor self-efficacy (CSE) such that as counselor experience increases so does CSE. This hypothesis was based on the literature indicating positive relations between clinical experience and counselor self-efficacy (Daniels & Larson, 2001; Larson & Daniels, 1998; Larson et al., 1992; Lent et al., 2003; Lent et al., 2006; Tang et al., 2004).

$$CEx \Rightarrow CSE$$

H2: Above and beyond the predictive contribution of CEx, it was expected that emotional

intelligence (EI) would be directly related to CSE such that as EI increases, so would

CSE. This hypothesis was based on the literature indicating positive relations between

emotional intelligence and counselor self-efficacy (Easton et al., 2008; Jackson, 2002;

Martin et al., 2004).

$$CEx + EI => CSE$$

H3: Resilience (RS) would moderate the relationship between EI and CSE, such that as

RS increases, so would the strength of the relationship between EI and CSE. This

hypothesis was based on the literature indicating positive relations among emotional

intelligence and resilience in contributing to well-being (Edward, 2005; Frajo-Apor et al,

2015; Kinman & Grant, 2011; Lambert & Lawson, 2013; Li et al., 2015; Schneider et al.,

2013; Dayal et al., 2015).

$$CEx + EI \text{ (moderated by RS)} => CSE$$

CHAPTER 2

METHOD

Recruitment Procedure

The current research study was conducted with prior authorization from the Institutional Review Board of Arizona State University (see Appendix A). To be eligible to participate in this study, participants had to be enrolled in a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited master's degree counseling program. A national sample of counseling trainees was solicited through the list of CACREP liaisons for master's level accredited counseling programs. The 100 randomly selected liaisons were asked to distribute the invitation to participate in the study to their program student listserv.

Participants

A priori power analysis was conducted using G*Power Statistical Computing Version 3.1 (Faul et al., 2007; Faul et al., 2009) software to determine the number of participants needed to conduct quantitative hierarchical regression and moderation analyses congruent with the research hypotheses. The power analysis $(1 - \beta = .80, \alpha = .05, f^2 = .15)$ revealed that a minimum sample size of 77 participants was needed to detect the effect of the proposed model. A total of 80 completed surveys was obtained. Finally, participation was voluntary. Participants were informed that they would be provided a $15 Amazon gift card upon confirmed completion of the study.

Table 1 provides demographic information on the study's sample. The mean age for the sample was 30.41 years ($SD = 9.16$; range = 22 - 58); 66 (82.5%) participants

were female and 14 (17.5%) were male. Race/ethnic identity was reported as White/Caucasian (n = 55, 68.8%), Black/African American (n = 7, 8.8%), Bicultural/Multicultural (n = 6, 7.5%), Asian/Pacific Islander American (n = 5, 6.3%), Hispanic/Latino/Chicano (n = 5, 6.3%), Native American/Alaskan Native (n = 1, 1.3%), and Other (n = 1, 1.3%).   Participants identified their counseling track/specialization as clinical counseling (n = 33, 41.3%), student affairs counseling (n = 13, 16.3%), marriage/couples/family counseling (n = 12, 15%), community/mental health counseling (n = 11, 13.8%), college counseling (n = 1, 1.3%), school counseling (n = 4, 5.0%), career counseling (n = 1, 1.3%), and 'other' counseling program (n = 5, 6.3%). With regard to clinical experience, 46.3% (n = 37) of participants had completed practicum, 21.3% (n = 17) of participants had completed internship and 11.3% (n = 9) of the participants had been employed in a counseling role in the past.

Instrumentation

The Mayer-Salovey-Caruso Emotional Intelligence Test (MCSEIT; Mayer, Salovey, & Caruso, 2002), the Resilience Scale (RS; Wagnild & Young, 1990; 1993), and the Counselor Activities Self-Efficacy Scale (CASES; Lent, Hill, & Hoffman, 2003) were used to assess the study variables. Additionally, a demographic form was utilized to collect descriptive data on the sample and information related to their counseling experience. These measures were tested in a pilot study, and results suggested that they were appropriate for the intended population. The included instruments were selected based on their consistency with the theoretical foundations described above.

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Demographic Form. A researcher-generated demographic form was used to collect general demographic information about the participants. Counselor trainees (participants) were asked to provide their age, sex, ethnicity, type of counseling program in which they were enrolled, enrollment status (yes or no) in counseling skills, pre-practicum, practicum and internship courses, and completion status (yes or no) in counseling skills, pre-practicum, practicum and internship courses (see Appendix B). Participants were also asked to identify whether or not they had been employed professionally as a counselor (yes or no). The responses to the completed practicum, internship, and employment questions assessed clinical experience (CEx).

Table 1
Demographic Characteristics of Participants (N = 80)

Characteristics	N	%
Sex		
Female	66	82.5
Male	14	17.5
Race/Ethnic Identity		
American Indian/Alaskan Native	1	1.3
Asian American/Pacific Islander	5	6.3
Black/African American	7	8.8
Bicultural/Multicultural	6	7.5
Hispanic/Latino/Chicano	5	6.3
Other	1	1.3
White/Caucasian	55	68.8
Clinical Experience		
Completed Clinical Practicum	37	46.3
Completed Clinical Internship	17	21.3
Former Clinical Employment in Counseling	9	11.3
Counseling Track/ Specialization		
Career counseling	1	1.3
College counseling	1	1.3

(Table 1 continued)

Community/Mental Health counseling	11	13.8
Marriage/Couples/Family counseling	12	15
Other	5	6.3
School counseling	4	5
Student Affairs counseling	13	16.3

Mayer Salovey Caruso Emotional Intelligence Test V2.0 (MSCEIT). The MSCEIT (Mayer et al., 2002) is a performance-based measure of emotional intelligence (EI) abilities. The precursor to the MSCEIT, the multifactor Emotional Intelligence Scale (MEIS; Mayer, Caruso, & Salovey, 1999) was the first test to measure the four branches of EI ability (emotion perception, emotion facilitation, understanding emotion, and emotion management). The MSCEIT evolved from this initial measure and assesses EI in accord with the 4-branch model.

The MCSEIT (Mayer et al., 2002), a 141-item ability-based measure of EI, is comprised of four subscales: perceiving emotions; facilitating thought; understanding emotions; and managing emotions. Each theoretical branch of EI has a corresponding subscale. Scale items are divided across eight tasks, with two tasks for each of the four EI branches (emotion perception, emotion facilitation, understanding emotion, and emotion regulation; Mayer & Salovey, 1997). Each of the four subscales of EI provides an individual subscale score. The first two subscale scores can be aggregated to produce the Experiential EI area score, and the final two subscale scores can be scored to provide

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a Strategic EI score. All four branch scores, taken together, provide an overall EI ability index score (Brackett & Salovey, 2006; Mayer et al., 2002; Mayer et al., 2003).

The MSCEIT was designed to yield total scores equivalent to standard IQ tests with a mean of 100 and *SD* of 15 (Mayer et al., 2002). EI as measured by the MSCEIT meets classic criteria for a standard intelligence measures. The factor structure of the MSCEIT is consistent with the theoretical ability-based model of EI. The abilities that comprise EI can be objectively, reliably, and validly measured (Brackett & Salovey, 2006; Mayer et al., 2002; 2003). The tasks that measure the four abilities that comprise EI are related to one another but also evidence unique variance (Mayer et al., 2002). The branches of EI are related to other measures of cognitive ability such as verbal reasoning but again show unique variance. Consistent with standard models of intelligence, EI develops with age and experience (Brackett & Salovey, 2006). The MSCEIT (Mayer et al., 2002) is appropriate for individuals aged 17 and older and is often completed in 30-45 minutes.

Tasks comprising the MSCEIT vary with regard to format as well as number of questions that comprise the task. As proposed by Mayer et al. (2002), the perceiving emotions subscale assesses an individual's ability to perceive emotions in the self, others, and other stimuli such as art. Perceiving Emotions is examined by asking participants to identify specific emotions expressed in images of people's faces (Faces) as well as the feelings implied by artistic designs and landscapes (Pictures). The Faces task has four groups of questions with five possible responses each. For example, in the Faces task, participants are presented with an image of a person conveying a basic emotion and

below the image is a list of five emotions (Bracket & Salovey, 2006). The participant is

asked to rate on a five-point Likert-type scale (e.g., ranging from 1 = "No Happiness" to

5 = "Extreme Happiness") the degree to which a particular emotion is conveyed in the

image of a face (Brackett & Salovey, 2006). The Pictures task consists of six groups of

questions with five responses each, and participants rate the degree to which a specific

emotion is expressed in the abstract design or landscape in the same manner explained

above in the description of the Faces.

The second branch of EI, using emotions to facilitate thought, is assessed across

two tasks. The facilitating thought subscale examines an individual's ability to generate,

employ, and feel emotion in order to convey feelings or utilize feelings in support of

cognition and information processing (Mayer et al., 2002). The first task (Sensations)

measures one's ability to describe emotions and match them to non-emotion sensations.

For example, a Sensations task provides participants with a statement requesting them to

imagine feeling an emotion such as shame. Participants are then provided a list of

adjectives more commonly affiliated with other sensory processes or modalities (e.g.,

cold, blue, and sweet) and are asked to rate on a five-point scale from "Not Alike" to

"Very Much Alike" the extent to which the feeling of shame is similar to the adjectives

(Brackett & Salovey, 2006). There are five groups of three questions each that comprise

this task. In the second task (Facilitation) affiliated with this branch, respondents identify

the feelings that might facilitate or interfere with the successful performance of various

cognitive and behavioral tasks. This task is comprised of five groups of questions with

three responses each. For example, a participant is asked to rate the utility of three

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moods (tension, surprise, and joy) across a five point Likert-type scale ranging from "not useful" to "useful" in response to questions such as "what mood(s) might be useful to feel when meeting in-laws for the very first time?" (Brackett & Salovey, 2006).

The third branch of EI, Understanding Emotion, is measured by two tasks. The understanding emotions subscale assesses one's ability to comprehend emotional information, appreciate how this information may combine in relationship transitions, and understand emotional meanings (Mayer et al., 2002). The first task (Blends) assesses the ability to analyze blended or complex emotions. This task consists of 12 questions for which participants identify emotions that can be combined. For example, "Optimism is a combination of . . . " and participants are then presented with a list of response alternatives (e.g., "a) happiness and anticipation; b) fear and sadness; c) happiness and joy; d) sadness and happiness") and asked to select the most appropriate response alternative. The second task (Changes) measures the ability to understand how emotional reactions change over time. In this 20-item task, participants are asked to identify the emotion that is the intensification of a given emotion. An example of an item for this task is "When anger intensifies, it turns into: a) rage; b) frustration; c) sadness; d) joy" (Mayer et al., 2003).

The fourth branch of EI, Managing Emotions, is composed of two tasks. The managing emotions subscale examines one's ability to be open to feelings and to adjust these feelings in oneself and others in support of personal understanding and growth (Mayer et al., 2002). The first task (Social Management/Emotional Relationships) assesses management of the emotions of others. For example, the Social

Management/Emotional Relationships task, which is comprised of three item groups with three responses each, directs participants to read a short story about another person and then to evaluate how effective several different optional courses of action would be in coping with the person's feelings. Participants rate a number of possible actions on a five-point Likert-type scale ranging from "Very ineffective" to "Very effective". The second task (Emotion Management) assesses ability to regulate one's own emotions. This task is comprised of five groups of questions with four responses each and requires participants to a read a short story about another person and then judge the action that is required to obtain a certain desired outcome for that person (Brackett & Salovey, 2006; Mayer et al., 2003).

The MSCEIT (Mayer et al., 2002) provides a reliable and valid measure of EI, with internal consistencies comparable to those of tests of standard intelligence. Factor analysis supports the four-branch structure of the test. A variety of validity studies has provided evidence for the construct validity of the MSCEIT (Mayer et al., 2000; 2003). Scale norms are based on a sample of 2,112 adults aged 18 or older. Mayer and colleagues (2003) reported full scale reliabilities of .93 and .91 for consensus and expert scoring, respectively. The two Experiential and Strategic Area score reliabilities were .90 and .90 and were .88 and .86 for general and expert scoring, respectively (Mayer et al., 2003). Reliabilities for the four branch scores ranged from .76 to .91 (Mayer et al., 2003). A three-week test-retest of the full MSCEIT yielded a reliability coefficient of .86 (Mayer et al., 2003). Additionally, two-week test-retest reliability was also .86, which indicates that MSCEIT scores are stable over time. In terms of validity, factor analysis

supported one factor, two factor, and four factor models that are representative of EI but indicated that the four-factor model fits the data in a markedly superior manner to other models. For the purpose of this study, total scores on the MSCEIT measure were used to analyze the hypotheses. The authors, who reported individual task reliabilities ranging from .55 to .88, do not recommend utilizing individual task scores (Mayer et al., 2003). In a recent study, Rossen and colleagues (2008) conducted a factor analysis that suggested that the Overall EI score renders the most useful information. Spector (2005) identified the MSCEIT as the preferred measure of EI due its acceptable validity, and Stratton, Saunders, and Elam (2008) explained that future studies examining EI should utilize the MSCEIT (Mayer et al., 2002) as its ability-based method of assessment may assist in delineating EI from other cognitive processing abilities.

As indicated above, the MSCEIT may be scored with regard to either consensus or general scoring. Matthews, Zeidner, and Roberts (2012) discussed the complexity of the MSCEIT scoring system, identifying concern that the MSCEIT does not rely on conclusively true answers. EI is a more nebulous construct than is general intelligence, and emotion-problem solving can be more complex than linear mathematics problem-solving. In an effort to address these potential issues, the MSCEIT has two scoring methods: expert scoring and consensus scoring. These are extremely similar in that one is based on a consensus among 21 experts and the other is based on a consensus among 5,000 test-takers (Mayer et al., 2002). Notably, the experts employed in generating the MSCEIT's expert scoring were 21 members of the International Society for Research on Emotions (ISRE). These scoring methods generated highly similar scoring keys: "The

correlation between the weights of alternatives calculated based on the experts versus those calculated using the test-taker sample varied from .88 to .91 depending upon the subsample studied (all Ns > 2,000)" (Mayer et al., 2012, p. 404). Furthermore, the two scoring methods produced branch, area, and total scores with rs = .96 to .98— "so high as to be nearly indistinguishable from one another" (Mayer et al., 2012, p. 404). Notably, these high correlations resulted whether employing 2,000 study participants or the full normative sample of 5,000 individuals (Mayer et al., 2002; Mayer et al., 2003, Mayer et al., 2012). In the MSCEIT user manual, Mayer et al. (2002) identify that scoring methods provide similar results.

Mayer et al. (2003), however, supported an expert panel scoring system rather than a general consensus system. As previously discussed, the expert scoring method was normed on emotion researchers, and the consensus scoring method was normed on a typical normative sample. In both methods, the "best" (the most selected response) was identified and is regarded as the "correct" response when scoring the test. There is some argument that experts, especially in more specialized areas, provide better "best" answers. This is often the norm for measures of some aspects of intelligence. For example, for the Wechsler scales of intelligence, some Wechsler subtests (e.g., Comprehension) employ an expert scoring method (Mayer et al., 2012). Caruso explained a preference for the use of "expert scoring with no corrections. It's clean and straightforward" (Caruso, n.d.). For the purpose of the present study, the expert scoring method was used. On the whole, experts typically agree more with one another as well as

depart from the general consensus, particularly in parts of EI where there is more well-developed domain-specific knowledge (i.e., emotion perception).

For interpretation purposes, consistent with the scoring model employed, raw scores were converted to standard scores ($M = 100$, $SD = 15$) following the traditional standardized test model common to most intelligence assessments. Scores of 70 or below are considered well below average at two standard deviations below the mean and are labeled "Improve", scores above 70 and below 90 are scored as "Developing", scores between 90 and 110 are considered "Competent", scores below 130 and above 110 are considered "Skilled", and scores above 130 (two standard deviations above the mean) are labeled "Expert" (Mayer et al., 2003).

Mayer and colleagues' review (2003) of the reliability of the MSCEIT V2.0 indicated that interpretations of the score outcomes should be based on the total scale (overall EI) and at the branch levels, with little or no interpretation being implemented at the task level. Notably, in this review conducted by the scale architects, they supported an expert panel scoring system over a general consensus system. This test was selected for use in this study, given the excellent psychometric properties of the instrument, the thorough theoretical conceptualization and construction of the scales, and the demonstrated research utility of the instrument. In the current study, only the total EI scores were used in the data analyses.

Counselor Activity Self-Efficacy Scales (CASES). This scale was based on the Lent et al. (2003) integration of the Hill and O'Brien (1999) helping skills model and related research, reviews and critiques of the literature on counselor self-efficacy (e.g.,

Larson, 1998; Larson & Daniels, 1998; Lent et al., 1998), and the researchers' clinical experiences as counselor trainers and supervisors. The CASES measures counselor self-efficacy from a social cognitive perspective. The 41-item self-report instrument is comprised of three subdomains: 1) Helping Skills Self-Efficacy--perceived ability to perform helping skills; 2) Session Management Self-Efficacy--perceived ability to employ basic helping skills in the management of common counseling session related tasks; and 3) Counseling Challenges Self-Efficacy—perceived ability to work effectively with challenging presenting issues in counseling. Items are rated along a 10-point Likert-type scale ranging from "No Confidence" to "Complete Confidence". A CASES total scale score is derived by summing responses across the 41 items. Higher scores indicate greater counselor self-efficacy (CSE).

Informed by Hill and O'Brien's (1999) counselor training model and related research (Hill & O'Brien 1999), the 15-item Helping Skills Self-Efficacy subdomain assesses helping across the three stages of exploration, insight, and action, with five items assessing exploration, six assessing insight, and four assessing action skills. In addition to the general instructions, the instructions for this section request that participants indicate "How confident are you that you could use these general skills effectively with most clients over the next week?" Example items include: "Attending (orient yourself physically toward the client)"-an exploration skill, "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 behavior, thoughts, or feelings)"- an insight skill, and "Direct guidance (give

the client suggestions, directives, or advice that imply actions for the client to take)"-an action skill.

The second subdomain, Session Management Self-Efficacy, was designed to assess counselors' perceptions of their abilities to incorporate basic counseling skills in managing a variety of specified, somewhat typically occurring counseling situations. Conceptually, the primary distinction between this subdomain and the previous subdomain is that the Session Management Self- Efficacy subdomain involves the ability to produce responses to session scenarios, rather than merely to enact basic helping skills. In this subdomain, participants are assessed on their abilities to blend and assemble the basic helping skills in response to relatively typical session requirements. This subdomain consists of 10 items assessing self-efficacy pertaining to session management. The instructions for this section request that participants indicate "How confident are you that you could do these specific tasks effectively with most clients over the next week?" Sample items pertaining to this section include "Keep sessions "on track" and focused" and "Help your client to talk about his or her concerns at a "deep" level".

The final subdomain, Counseling Challenges Self-Efficacy, assesses perceived ability to tackle difficult counseling situations. Instructions for this section request that participants "Please indicate how confident you are in your ability to work effectively, over the next week with each of the following client types, issues, or scenarios". The instructions specifically state: "By 'work effectively,' I am referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain your poise during difficult interactions, and, ultimately, to help the client

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resolve his or her issues". The 16 items that comprise the Counseling Challenges Self-Efficacy subdomain are further divided into two sub-categories (Client Distress and Relationship Conflict) and are modeled after Bandura's theory of coping self-efficacy (Bandura, 1997; Hill & O'Brien 1999). Sample items assess perceived competency with regard to working with a client who is "clinically depressed" (Client Distress sub-category) and/or "is sexually attracted to you" (Relationship Conflict sub-category).

The three-subdomain scale (the ability to perform basic helping skills; management of therapy sessions; and management of challenging therapy) was normed utilizing a sample of 345 students (266 women, 76 men, 3 individuals who did not report their sex) enrolled either in a helping skills training class for advanced undergraduates (n = 159), master's level counseling practica (n = 118), or assorted levels of doctoral training, largely in counseling psychology (n = 68). Participants, who ranged in age from 20 to 57 (M = 26.32, SD = 7.46), self-reported race/ethnicity as 66% European American, 17% African American, 6% Hispanic American, 9% Asian American, and 3% multiracial or other racial/ethnic status.

Factor analysis supported the three-factor model proposed by the scale architects (Lent et al., 2003). Internal consistency estimates were all found to be adequate ranging from .79 to .94 for the individual subdomains, and .97 for the total scale, suggesting strong reliability. Intercorrelations among the subscales ranged from medium (.44) to large (.77) supporting the assumption that the subdomains (subscales) represent distinct yet overlapping aspects of CSE. Test-retest reliabilities were assessed over a two-week period, and results indicated relatively stable consistency with test-retest scores ranging

from .59 to .76, and a CASES total score reliability of .75. (Lent et al., 2003). Moreover, criterion-related validity was also established (Lent et al., 2003) utilizing the COSE (Larson et al., 1992), and findings indicated strong correlations ranging from .61 to .76 between subscales/subdomains that measured theoretical similar content.

Lent and colleagues (2003) conducted a MANOVA to explore the extent to which CASES may be employed to assess differences in self-efficacy as a function of clinical experience. Notably, analyses communicated significant differences ($p < .05$) between therapists of different experience levels, indicating that CASES (Lent et al., 2003) may be employed to assess increases in therapy self-efficacy that are acquired through psychotherapy experience. Notably, the most experienced group had significantly higher self-efficacy than the intermediary group on most subscales.

The CASES scale was selected for use in this study given its excellent psychometric properties, sound theoretical underpinnings, and demonstrated research utility. For the purposes of this study, the CASES showed strong reliability with subscale Cronbach's alphas of .91 (Helping Skills Self-Efficacy), .93 (The Session Management Self-Efficacy), and .96 (Counseling Challenges Self-Efficacy. Total scale yielded an alpha coefficient of .97. The total score was used to test the study hypotheses.

The Resilience Scale (RS). The RS was developed by Wagnild and Young (1990; 1993). They explained five theoretical underpinnings that comprise the conceptual foundation for the construct of resilience as well as the measurement of this construct. Through qualitative interviews of a sample of women who had successfully adapted to adverse life events and through an exhaustive review of extant literature,

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Wagnild and Young identified and defined five characteristics of resilience: purpose; perseverance; equanimity; self-reliance; and existential aloneness. These five characteristics are assessed across the 25 items of the RS. The 25 items are rated on a 7-point Likert-type scale ranging from "Strongly Disagree" to "Strongly Agree". For example, participants are asked to indicate the extent to which they agree with statements such as "I am determined" and "I am friends with myself". Total scores range from 25 to 175, with scores below 125 indicating low resilience, scores between 125 and 145 indicating moderate resilience, and scores above 145 indicating moderately high to high resilience.

A meta-analysis of studies (Wagnild, 2009) employing the Resilience Scale (RS) supported its psychometric utility in terms of validity and reliability for use with diverse populations of varying age groups including undergraduate students, graduate students, at risk adolescents, caregivers of partners diagnosed with Alzheimer's disease, mothers returning to the workforce, public housing residents, military wives, adult Irish immigrants to the United States, and middle-aged and older adults. Results across studies provided Cronbach's alpha coefficients that were consistently acceptable and moderately high (.73 to .91). Convergent evidence for validity was further supported by findings of significant relations with morale, self-esteem, life satisfaction, depression, and perceived stress (Wagnild, 2009). Additionally, Wagnild (2009) found that RS scores were inversely related to stress, depression, anxiety, loneliness, and hopelessness, further strengthening support for the construct validity of the RS.

This Resilience Scale was selected for use in this study given the demonstrated research utility of the scale, the efficacious application of this scale across varied populations, and the sound psychometric properties of the scale. The internal consistency of the RS was investigated for the study sample. Reliability analysis found good internal consistency with a Cronbach's alpha of .86.

Procedure

Prior to study implementation, permission to conduct the current study was attained from the university's Institutional Review Board (Appendix A). Data collection was executed through an online survey system, "QuestionPro." QuestionPro was employed to create and disseminate the surveys and to manage the completed survey data. Additionally, in accord with copyright law procedures, after completing the first portion of the survey on QuestionPro, participants were directed to an external website housing the MSCEIT (Mayer et al., 2002). In order to recruit participants and attain data, an email containing the link to the online study was sent to 100 randomly selected training director/liaisons of CACREP accredited master's programs. The email requested that they distribute the survey to students in their respective counseling program. In order to increase the likelihood of participation, participants were provided a $15.00 eGift card to Amazon upon confirmed completion of all portions of the study. Participants were instructed to email one of the researchers upon completion of all aspects of the study in order to obtain the eGift card.

Participants were informed that the purpose of the study was to investigate the relations among emotional intelligence, resilience, and counselor self-efficacy. During

the first portion of the study, participants generated a unique code in accord with parameters outlined by the researchers. Upon completion of the entire study, participants contacted the researchers with their self-generated code to confirm study completion. Data completion took place over a 7-day period during the spring semester.

CHAPTER 3

RESULTS

Preliminary Analyses

Prior to conducting the analyses to test the current study's hypotheses, descriptive

statistics were derived for the Counselor Activities Self-Efficacy Scale (CASES; Lent,

Hill, & Hoffman, 2003), the Mayer- Salovey-Caruso Emotional Intelligence Test

(MSCEIT; Salovey, Caruso, & Mayer, 2002), Resilience Scale (Wagnild & Young,

1993), and clinical experience (completed practicum, completed internship, and prior

work experience in a counseling role). These results are presented in Table 2. Reliability

analyses were conducted for CASES and RS measures, and were reviewed in the

instrumentation section.

Skewness and kurtosis were calculated to evaluate whether assumptions of

normality were met, that is values should fall between +2.0 and $-$ 2.0 to show normal

distribution of the data (Field, 2000 & 2009; George & Mallery, 2010; Gravetter &

Wallnau, 2014; Trochim & Donnelly, 2006). Examination of the data indicated that all

variables with the exception of the EI met the assumptions for normality (Table 3). The

kurtosis for EI was 2.059. A review of the data also indicated that an extreme outlier on

the EI scale accounted for this deviation in normality as when the participant was

eliminated the assumptions of normality were adequately met. However, given the

sample size as well as the fact that this individual did not present as an outlier on the

other measures, the outlier was not eliminated in the analyses. Given that the variables

met the vast majority of assumptions for normality, the data for EI were not modified.

Table 2

Correlations among study variables

Variable	*M* (*SD*)	1.	2.	3.	4.	5.	6.
1. C_Prac	.46 (.50)		-	-	.11	.38**	.46**
2. C_Intern	.21 (.41)			-	-.05	-.14	.12
3. P_Employ	.11 (.32)				.11	.18	.18
4. EI	102.13 (17.51)					.16	.29**
5. RS	163.61 (17.57)						.30**
6. CSE	301.70 (48.45)						

**Correlation is significant at the .01 level (1-tailed)
*Correlation is significant at the .05 level (1-tailed)
C_Prac = completed practicum; C_Intern = completed internship;
P_Employ = Previous employment in a counseling role;
EI = emotional intelligence; RS = resilience; CSE = counseling self-efficacy

Prior to examining the proposed hypotheses, the correlations between measured variables were assessed for multicollinearity. A review of the correlations among the variables did not reveal problems of singularity. Some predictor variables were significantly correlated, and no issues of multicollinearity were detected as their relatedness did not exceed $r = .70$ (Tabachnick & Fidell, 2007). Furthermore, a review of tolerance scores (ranged from .911 to .966) indicated that assumptions of multicollinearity were not violated. The data were assessed for missing data (Tabachnick & Fidell 2007). Seven participants were missing one response each on either of the RS or CASES measures, and one participant was missing two responses on one scale; the mean was imputed for these cases (Tabachnick & Fidell, 2007). Specifically, data missingness was addressed by taking the mean score for the individual on the respective scale and substituting the missing data with the mean score. There were no missing data on the EI scale.

Prior to conducting the hierarchical regression analyses to test whether resilience (RS) moderated the relation between emotional intelligence (EI) and counselor self-efficacy (CSE), the scores for the EI and for RS were centered to reduce multicollinearity (Frazier et al., 2004). To center EI and RS scores, the sample mean score for each variable was subtracted from each participant's score for that variable (i.e., EI or RS). The cross-product interaction scores were calculated by multiplying the centered EI scores and the centered RS scores. The cross-produce scores were used to test for a moderation effect.

Hypotheses Testing

Hierarchical multiple regressions were used to test the study hypotheses. For each regression, counselor experience (CEx) was entered in step one, EI and RS in step two, and the cross-product interaction (centered RS x centered EI) in step three. The probability level was set at .05 for each regression.

It was hypothesized that clinical experience (CEx) would predict counselor self-efficacy (CSE) such that as counselor experience increased so would CSE (H1). A hierarchical multiple regression analysis was performed to examine the strength of the relation between CEx and CSE. The three clinical experience variables (completed practicum, completed internship, and past counseling employment) were entered in step one. The regression analysis revealed that CEx significantly explained 22.1%, $F(3, 76) = 7.17$, $p < .001$, of the variance in CSE. After reviewing the effect that each predictor had on the criterion variable, only completed practicum experience was a significant predictor of CSE ($\beta = .465$, $p < .01$), while completed internship experience and past employment in a counseling role did not significantly predict CSE ($\beta = -.090$, $p > .05$ and $\beta = .105$, $p > .05$, respectively). Notably, the three clinical experience predictor variables were significantly correlated; however, no issues of multicollinearity were detected (see Table 2) as correlations did not exceed $r = .70$ (Tabachnick & Fidell, 2007). The data supported H1, CEx, specifically a completed practicum experience, was positively related to CSE.

Hypothesis 2 posed that emotional intelligence (EI) would be directly related to CSE above and beyond the predictive contribution of CEx. It was expected that as EI increased, so would CSE. In step one, the clinical experience variables were entered into

the equation. In step two, the EI variable was entered into the equation. Results of the regression analysis revealed that EI explained 5.3% additional variance in CSE above and beyond CEx, $\Delta F(1, 75) = 5.52$, $p = .021$). Together CEx and EI significantly explained 27.4%, $\Delta F(4, 75) = 7.08$, $p < .001$, of the variance in CSE. After reviewing the effect that each predictor had on the criterion variable, completed practicum experience ($\beta = .434$, $p < .01$) and emotional intelligence ($\beta = .235$, $p < .05$) significantly predicted CSE. Completed internship experience and past employment in a counseling role did not significantly predict CSE. Notably, the EI was not correlated with the three clinical experience predictor variables (see Table 2) but was positively correlated with the CSE outcome variable, which suggests multicollinearity ($r = .29$, $p < .01$) was not a problem. The data supported H2.

It was hypothesized that resilience (RS) would moderate the relation between EI and CSE, such that as RS increased so would the strength of the relation between EI and CSE (H3). To test this hypothesis, the clinical experience variables were entered first into the equation. Then, the centered EI variable and centered RS variable were entered into the equation. In step three, the cross-product term (centered RS x centered EI) was added. The hierarchical multiple regression analysis revealed that the cross-product interaction term did not significantly contribute to additional variance in CSE, $\Delta F(1, 73) = 1.10$, $p = .297$. Therefore, the data did not support H3.

However, RS and EI, as well as CEx, were significant predictors of CSE, accounting for 37.2% of the variance in CSE, $F(2, 74) = 8.92$, $p < .001$. The beta weights revealed that completed practicum experience ($\beta = .485$, $p < .01$), resilience ($\beta = .332$, $p <$

.05), and emotional intelligence (β = .188, p = .05) each significantly predicted CSE.

Again, completed internship experience and past employment in a counseling role were

not significant predictors of CSE.

Table 3

Summary of Hierarchical Regression Analysis for Variables Predicting Counselor Self-Efficacy (N = 80)

Variable	Model 1			Model 2			Model 3			Model 4		
	B	SE B	β	B	SE B	β	B	SE B	β	B	SE(B)	β
C_Prac	44.94	10.64	.47**	41.91	10.42	.43**	46.89	9.86	.49**	49.47	10.16	.51**
C_Intern	-10.54	13.24	-.09	-6.77	12.96	-.06	-1.13	12.25	-.01	.57	12.35	.01
P_Employ	16.01	16.30	.10	11.80	15.94	.08	-.63	15.37	-.004	-5.10	15.93	-.03
EI				66.45	28.29	.23*	53.03	26.78	.33**	-196.71	239.27	-.17
RS							149.72	44.04	.18*	-74.36	217.83	-.70
RS x EI										241.07	229.52	1.09
R^2	.22			.27			.37			.38		
F change in R^2	7.17**			5.52*			8.92**			1.10		

Note: EI (emotional intelligence) and RS (resilience) were centered at their means.

*p ≤ .05. **p < .01.

CHAPTER 4

DISCUSSION

Discussion of Findings

The present study assessed whether clinical experiences, which included completed practicum, completed internship, prior work experience in a counseling role, and performance-based emotional intelligence would predict counselor self-efficacy and also assessed whether resilience would moderate relations between emotional intelligence and counselor self-efficacy. In this chapter the findings of the study as well as the limitations, clinical applications, and ideas for future research are presented.

The data analysis revealed that CEx and EI predicted CSE. Although RS did not moderate the relation between EI and CSE, RS itself was a significant predictor of CSE. While the data supported the hypothesis that CEx would predict CSE, of the three variables that comprised CEx, only completed counseling practicum was a significant predictor. This finding partially supports previous research evidencing past counseling experiences as significantly contributing to CSE (Larson et al. 1992; Larson & Daniels, 1998; Lent et al., 2003; Tang, 2004). Counseling practicum is typically the first-time trainees work with "real" clients. Their initial discomfort or anxiety dissipates as they discover they actually can do clinical work. It is only natural that these positive experiences lead to greater self-efficacy. Furthermore, many counseling practicums are housed within the counseling program. The embeddedness of these clinical experiences within the overall academic environment may provide nurturance of trainee self-efficacy. Trainees may have greater comfort with and greater faith in the experiences that are

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closely monitored. Therefore, one's performance experiences, mastery accomplishments, vicarious learnings, and verbal persuasions or feedback from peers and supervisors during the initial practicum may be more meaningful and more bolstering of one's CSE.

It is noteworthy that although completed practicum had a statistically significant effect on CSE, completed internship and prior work in a counseling role did not. There are several potential reasons for why these clinical experiences were not found to contribute significantly to CSE in this study. First, it is possible that not enough participants had completed internship or had worked as a counselor for these to emerge as significant predictors of CSE. Indeed, only 17 participants had completed internship and only nine participants had been employed as a counselor. Perhaps, there was insufficient power and variance for these experience variables to emerge as predictors. Second, participant's year of study was not assessed, and the study did not ask participants to provide information about when they began their practica and internship experiences. The data for this study were gathered at the end of January 2017, and many trainees may have been enrolled in their internship experience. Moreover, having completed clinical internship typically represents the culmination of one's training experience within these programs. For students to who had completed internship and were still enrolled in their counseling program, suggests that these trainees may look systematically different than typical trainees who complete their internship and graduate within the same semester. Third, in the current study, the valence, whether positive or negative, of prior counseling experiences was not assessed. Not all clinical experiences contribute positively to one's personal sense of one's own counseling abilities (Larson & Daniels, 1998; Lent et al.,

1998; Lent et al., 2003). Therefore, it is possible that past clinical experiences were not positive and that as one accumulates more "experiences" in the work of counseling, one may experience increased threats to one's self-efficacy. The findings from this study suggest that there is something more important than simply "experience" that contributes to an enhanced personal sense of competency as a counselor. It is also possible that as counselor trainees have more real world clinical experiences typically affiliated with internships in community settings, they may have met with more stressors and challenges that impact their CSE.

It was hypothesized that EI would be directly related to CSE above and beyond the predictive contribution of CEx. It was expected that as EI increased, so would CSE. The data confirmed this hypothesis. Both CEx and EI contributed to CSE among the counselor trainees in the study sample. The finding that EI was positively related to CSE supports prior research findings (Easton et al., 2008; Ivey & Ivey, 2003; Ivey et al., 2006; Martin et al., 2004). EI, the ability to understand, perceive, and use emotional information to facilitate thought as well as to manage one's own and others' feelings and mood states, is essential to effective counseling. As noted by Ivey and Ivey (2003), the ability to observe and accurately interpret one's own and others' feelings and mood states is essential to effective counseling. Research has indicated that CSE is a significant contributor to effective counseling as well (Larson & Daniels, 1998; Lent et al., 2006). Prior research has evidenced EI as significantly contributing to CSE; however, this prior research investigated EI via self-report, and counselors and counselor trainees who perceived themselves as more emotionally intelligent may have been more likely to

perceive themselves as more competent with regard to counseling related skills and abilities (Easton et al., 2008; Martin et al., 2004).

The current study assessed EI as an ability by asking participants to process emotion-related information and complete emotion-related tasks (MSCEIT; Mayer et al, 2003). To date, no study in a peer-reviewed journal was found that explored CSE and ability-based EI as measured by the MSCEIT (Mayer et al., 2003) or any other ability-based measure of EI. The current research went beyond assessing counselors' personal appraisals and perceptions of their own EI and investigated EI as a valid information processing ability in the classic manner of requiring participants to perform actual tasks evaluating their abilities. Counselor trainees who scored higher on the performance-based measure of EI also reported greater CSE thus suggesting that emotionally intelligent counselors may feel more efficacious in their counseling abilities.

This finding is meaningful within counseling as the literature suggests that EI is not a stagnant entity but rather a fluid ability or capacity (Brackett et al., 2006); therefore, counseling programs that prioritize the development and nurturance of emotion-related skills and capacities, such as reflecting feelings, processing emotional content and managing transference as well as countertransference, may see greater CSE in their trainees. Moreover, the literature suggests a significant relation between CSE and actual counseling performance (Bradley & Fiorini, 1999; Larson & Daniels, 1998). Perhaps, cultivating and nurturing EI in counselor trainees will serve to nurture and support their counseling abilities and thereby encourage trainees to work with more challenging

counseling situations that, in turn, can help expand their confidence in meeting the needs of a broader array of clients.

Finally, it was hypothesized that resilience would moderate the relation between emotional intelligence and counselor self-efficacy, such that as RS increased so would the strength of the relationship between EI and CSE. Although the data did not support the hypothesis, the data did indicate that RS and EI, as well as CEx, were significant predictors of CSE. This finding is particularly noteworthy as there is a dearth of research exploring the relation between RS and CSE.

RS, one's ability to bounce back from life's challenges, persevering through challenges to return to a healthy life balance, has been linked to adaptive life experiences. Prior research has suggested that greater RS is positively related to adapting to personal and professional life challenges and stressors in graduate students enrolled in a professional psychology training program (Edwards et al., 2014). The current study further supports prior research that highlighted a relation between CEx and RS in caring professionals, as CEx increases so does RS and vice versa (Matos et al., 2010, Zheng et al., 2017). Furthermore, prior research investigating the role of RS in mental health care professionals has found that higher levels of RS were affiliated with a number of positive personal and professional circumstances such as buffering the negative effects of adverse life events, feeling energized by clinical work, being able to manage feedback effectively, embedding in support networks, engaging in self-care activities (Clark et al., 2008 Lambert & Lawson), experiencing positive work place experiences, and increasing job satisfaction (Clark et al., 2008, Edward, 2005, Zheng et al., 2017). Moreover, the results

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of this study support the literature that addresses the role of self-efficacy in resilience (Wagnild, 2009), as well as prior research reporting a relation between measures of RS and measures of general self-efficacy (Gillespie et al., 2007; 2009).

The present study compliments the findings of past research and contributes to the literature by elucidating the significant contributions of ability-based EI, CEx, and RS in predicting CSE. The constructs of CSE, EI, and RS are conceptualized as generative capacities or abilities; therefore, they are developmental as well as malleable. This information is particularly relevant for counselor training programs given the significant contribution of the clinical experience of practicum. Practicum is both a clinical and academic experience. Practicum supervisors are uniquely equipped to educate and guide counselor trainees in supportive, educational, familiar, and personally meaningful environments. These initial practicum-related counseling experiences as well as the competencies and confidences derived from these experiences typically set the foundation for how trainees process future clinical experiences. For example, if trainees have positive experiences in supervision, trainees will be more likely to continue to openly seek guidance from future supervisors. Practicum supervisors and counseling programs, in general, may wish to consider the benefit of developing EI abilities and RS by fostering supportive and edifying clinical experiences. Nurturing these emotional capacities and abilities in the developing counselor leads to positive personal and professional growth for trainees and positively impact the health and wellness of their clients and communities at large.

Limitations of the Current Study

There are limitations to the current study that need to be noted. First the design was descriptive and correlational; therefore, there can be no assertion of causality. The study used a cross-sectional design with data that were only collected from participants at one point in time. This potentially limits the internal and external validity of the study. Cross-sectional designs do not allow measuring of change or the impact of time. Consequently, as the factors were largely generative in nature, future studies may benefit from a longitudinal design that affords an investigation of the manner in which both the predictor and criterion variables as well as the relations among these variables is affected by time and experience across individual participants as well as the general sample.

Second, in facilitation of data collection, the survey was emailed to liaisons/training directors at CACREP-accredited counseling programs, and it is not clear that each person contacted disseminated the survey. Therefore, all potential counselor trainee participants nationally are not represented in the present study. Notably, only 80 participants completed the full study. These participants comprise a volunteer sample who self-selected into the study. Since participation in the study was voluntary and participants were compensated with a $15.00 eGift card, the sample may be limited by a self-selection bias – participants electing to participate in this study may be systematically different than non-participants. For example, it may be the case that trainees who felt less efficacious in their counseling skills were less likely to elect to participate in a study asking them to reflect on their perceptions of these skills, thus compromising the overall generalizability of the sample.

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Third, although the sample size was deemed sufficient to meet the criteria of the power analysis, perhaps the sample was not large enough and diverse enough to detect significant relations in the data, particularly the moderation effect and the components of CEx. The sample was predominantly female (82.5%) and Caucasian/White (68.8%). Review of CACREP's 2015 annual report revealed the sample composition appeared to estimate closely the national composition of the CACREP-accredited programs that are reported as 82.54% female and 60.22% Caucasian/White (CACREP, 2016). Though the study sample appears to reflect the CACREP-accredited student population in the United States. the findings of the current study can only be generalized to similar demographic groups. As indicated above, the sample size may have limited the ability of the study to detect significant relations. Future studies should attempt to acquire a sample that is much larger in order to test whether RS moderates the relation between CEx, EI, and CSE.

Finally, instrumentation is another potential limitation. This study employed self-report measures that inherently include limitations due to response bias and reliance on self-appraisal. Although the self-report instruments selected had excellent psychometric properties, given the nature of the assessment of the CSE and RS variables, it is possible that participants under or over-reported on survey items. Accordingly, the subjective method of evaluation of these variables may have positively or negatively influenced the findings in the current study. The MSCEIT (Mayer et al., 2002) was selected for its objective assessment of ability. Although the instrument is shown to have acceptable to excellent internal consistency in the literature, there exist potential weaknesses. EI is a nebulous construct, and measurement of this construct may not be precise, as there may

not be one clear "correct" answer for an emotional task. In order to attend to this, authors

of the MSCEIT normed the measure on a group of "experts" in emotion and a normative

sample, thereby obtaining "correct" answers. For the purposes of this study, the expert

scoring system was selected as experts tend to have greater and more nuanced

understanding of domain-specific knowledge. Given the instrument's "objective" scoring

method, it is possible that participants may have responded with appropriate or

acceptable answers that could have been scored as incorrect as the responses may not

have matched the "correct" responses derived from the experts or normative sample.

Moreover, correctness of emotional responses may be contingent on the framework used

in assessing a response as correct (Fiori et al., 2014). For example, suppressing anxiety

when sitting with a supervisor may be a useful strategy to manage anxiety if the objective

is to present as competent; however, if the goal is to learn from the anxiety and process

the experience, the suppression of the anxiety may not be an appropriate way to manage

the emotion.

Implications and Future Research

The findings of the present study provide support for the importance of clinical

training experiences, emotional intelligence, and resilience in developing counselor self-

efficacy that has been linked to counseling performance (Bradley & Fiorini, 1999; Larson

& Daniels, 1998). The study findings suggest that it is important for counselor trainees to

acquire experience working with clients that bolsters their perceived competencies in

counseling. The findings evidenced a completed clinical practicum as significantly

predictive of CSE, whereas completed internship and prior work employment in

counseling role were not found to be significant contributors. This study may not have fully captured the impact of CEx on CSE. The study results indicating that completed internship and past counseling employment did not significantly contribute to CSE may be explained by limitations of the study secondary to sample size and composition; there were a limited number of participants who had completed internship or who had engaged in prior work in employment in a counseling role. However, these findings may all speak to the significance and importance of academic supervision in nurturing budding counselors' competencies and abilities, as well as their self-efficacy about their competences and abilities. Moreover, of further note, this study did not examine the participants' perceived quality of clinical training experiences. Future research may wish to consider the role of counselor trainees' perceptions of their clinical experiences in contributing to their perceived self-efficacy in counseling.

The significance of EI and RS in the promotion of CSE is also of importance to counselor training programs. EI, RS, and self-efficacy are all generative capacities. Counseling programs may wish to consider engaging in practices that nurture trainees' EI and RS throughout their training program, fostering CSE and, likely, consequently counselor trainees' counseling abilities and performance. Accordingly, future research may wish to explore the roles of CEx, EI, and RS in predicting CSE using a larger sample to capture more fully the potential contributions of these factors in predicting CSE as well as elucidating the potential moderation of RS in the relations between EI and CSE. Future research could benefit from examining the impact of one's actual measured emotional abilities on perceptions of one's counseling abilities and from exploring what

factors influence this relation such as supervision experiences, types of clinical experiences, and personality factors.

The findings of the current study offer a significant contribution to the field by further elucidating the significant contributions of clinical experience, emotional intelligence, and resilience to counselor self-efficacy. These findings are particularly important because of the empirically established relation between CSE and effective counseling performance. The findings of the present study indicate that the nurturance of trainee EI abilities, academic clinical experiences, and RS in counselor trainees fosters greater self-efficacy that, in turn, can lead to more efficacious and effective counseling, thus better serving clients and communities.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

ASU Knowledge Enterprise Development

Office of Research Integrity and Assurance

To:	Sharon Kurpius
	EDB
From:	Mark Roosa, Chair
	Soc Beh IRB
Date:	08/15/2013
Committee Action:	**Exemption Granted**
IRB Action Date:	08/15/2013
IRB Protocol #:	1308009518
Study Title:	Relations Among Resilience, Emotional Intelligence, and Self-Efficacy Related to Counselor to Counselor Trainee Competence

The above-referenced protocol is considered exempt after review by the Institutional Review Board pursuant to Federal regulations, 45 CFR Part 46.101(b)(2) .

This part of the federal regulations requires that the information be recorded by investigators in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It is necessary that the information obtained not be such that if disclosed outside the research, it could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

You should retain a copy of this letter for your records.

APPENDIX B

RECRUITMENT LETTER/INFORMED CONSENT FORM

My name is Laura Petrolle Clemons, and I am a doctoral student under the direction of Dr. Sharon Kurpius, professor of counseling at Arizona State University. I am recruiting 100 counseling students to participate in a study exploring the relations among resilience, emotional intelligence, and counselor self-efficacy. The study results will help training programs better prepare students to become counselors. To be eligible to participate you must be over the age of 18 and currently enrolled in a counseling master's program that includes clinical work as part of your program requirements. If you decide to participate, you will be asked to respond to an electronically administered survey, accessed by clicking on the link to the survey in your email. There are two portions to this study. First, a series of questions are provided within the QuestionPro platform, which you can complete in approximately 10-12 minutes. At the end of the first portion, you will be provided a link to the MSCEIT, the emotional intelligence measure, which will take approximately 20-25 minutes to complete.

Your participation in this study is completely voluntary and you have the right to withdraw at any time. There are no foreseeable risks associated with this study other than some emotions that could be experienced in everyday life. There is no known personal benefit from taking part in this study. However, your willingness to participate may help graduate programs training counselors.

Your survey responses will be strictly confidential, and the data will be reported only in the aggregate. Your information will be coded and will remain confidential.

We appreciate your time and participation and understand that your time is valuable. Therefore, you will receive a $15.00 Amazon gift card for participating. Upon completion of both parts of the study, you may email Laura.Petrolle@asu.edu to collect your gift card.

If you have questions concerning this study, please contact Laura.Petrolle@asu.edu or the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

By clicking on the link below, you are agreeing to participate in this study.

http://counseloreei.questionpro.com

Thank you,

APPENDIX C

DEMOGRAPHICS FORM

1. Participant ID, Generate code: Mother's maiden name and 2-digit birth month. For example, Jones04 or Smith12. ENTER CODE HERE:

2.Age_____

3. Gender

[] Female

[ ]Male

[] Transgender/Transsexual

[] Other

4. Ethnicity (Please select one)
[] White/European American/Caucasian

[] Black/African American

[] Hispanic/Latino/Chicano American

[] American Indian/Alaskan Native

[] Asian/Pacific Islander American

[] Biracial/Multi-racial

[] Other

5. Courses completed (Select all that apply):
[] Counseling Skills

[] Pre-practicum

[] Practicum

[] Internship/Second practicum

6. Courses currently enrolled in (Select all that apply):
[] Counseling Skills

[] Pre-practicum

[] Practicum

[] Internship/Second practicum

7. Counseling Track/Specialization (please select one):
[] Clinical Counseling

[] Community Mental Health Counseling

[] Rehabilitation Counseling

[] School Counseling

[] Student Affairs Counseling

[] College Counseling

[] Career Counseling

[] Addiction Counseling

[] Marriage, Couple and Family Counseling/Therapy

[] Gerontological Counseling

[] Other

8. Have you been employed as a counselor? If no, please write "No" in the text box provided, if yes, please write "Yes" in the text box provided and briefly state your role:

APPENDIX D

MSCEIT SAMPLE ITEMS

The MSCEIT has eight sub-tests and 141 individual items. Permission was granted from MHS to use these sample items to illustrate the type of items utilized in this instrument.

A feeling of concern most closely combines the emotions of _____.
a. love, anxiety, surprise, anger
b. surprise, pride, anger, fear
c. acceptance, anxiety, fear, anticipation
d. fear, joy, surprise, embarrassment
e. anxiety, caring, anticipation

---

3. Imagine you are feeling cold, slow, and sharp. How much is that feeling like each of the following?

	Not Alike				Very Much Alike
a. challenged	1	2	3	4	5
b. isolated	1	2	3	4	5
c. surprised	1	2	3	4	5

What mood(s) might be helpful to feel when figuring out what caused a fight among three young children? Each of the three young children is telling a different story about how the fight started. Figuring out what happened requires attending to the details of the stories and weighing many facts.

	Not Useful				Useful
a. happiness	1	2	3	4	5
b. surprise	1	2	3	4	5
c. sadness	1	2	3	4	5

John developed a close friend at work over the last year. Today, that friend completely surprised him by saying he had taken a job at another company and would be moving out of the area. He had not mentioned he was looking for other jobs. How effective would John be in maintaining a good relationship, if he chose to respond in each of the following ways?

Response 1: John felt good for him and told his friend that he was glad he got the new job. Over the next few weeks, John made arrangements to ensure they stayed in touch.
a. Very ineffective   b. Somewhat ineffective   c. Neutral   d. Somewhat effective   e. Very effective

Response 2: John felt sad that his friend was leaving, but he considered what happened as an indication that the friend did not much care for him. After all, the friend said nothing about his job search. Given that his friend was leaving anyway, John did not mention it, but instead went looking for other friends at work.
a. Very ineffective   b. Somewhat ineffective   c. Neutral   d. Somewhat effective   e. Very effective

Response 3: John was very angry that his friend hadn't said anything. John showed his disapproval by deciding to ignore his friend until the friend said something about what he had done. John thought that if his friend didn't say anything, it would confirm John's opinion that the friend was not worth talking to.
a. Very ineffective   b. Somewhat ineffective   c. Neutral   d. Somewhat effective   e. Very effective

APPENDIX E

THE RESILIENCE SCALE

Please read each statement and select the response that best indicates your feelings about the statement. Respond to all statements.

	Strongly Disagree							Strongly Agree
1. When I make plans, I follow through with them.	○	○	○	○	○	○	○	○
2. I usually manage one way or another.	○	○	○	○	○	○	○	○
3. I am able to depend on myself more than anyone else.	○	○	○	○	○	○	○	○
4. Keeping interested in things is important to me.	○	○	○	○	○	○	○	○
5. I can be on my own if I have to.	○	○	○	○	○	○	○	○
6. I feel proud that I have accomplished things in life.	○	○	○	○	○	○	○	○
7. I usually take things in stride.	○	○	○	○	○	○	○	○
8. I am friends with myself.	○	○	○	○	○	○	○	○
9. I feel that I can handle many things at a time.	○	○	○	○	○	○	○	○
10. I am determined.	○	○	○	○	○	○	○	○
11. I seldom wonder what the point of it all is.	○	○	○	○	○	○	○	○
12. I take things one day at a time.	○	○	○	○	○	○	○	○

14. I have self-discipline.	○	○	○	○	○	○	○	○
15. I keep interested in things.	○	○	○	○	○	○	○	○
16. I can usually find something to laugh about.	○	○	○	○	○	○	○	○
17. My belief in myself gets me through hard times.	○	○	○	○	○	○	○	○
18. In an emergency, I'm someone people can generally rely on.	○	○	○	○	○	○	○	○
19. I can usually look at situation in a number of ways.	○	○	○	○	○	○	○	○
20. Sometimes I make myself do things whether I want to or not.	○	○	○	○	○	○	○	○
21. My life has meaning.	○	○	○	○	○	○	○	○
22. I do not dwell on things I can't do anything about.	○	○	○	○	○	○	○	○
23. When I'm in a difficult situation, I can usually find my way out of it.	○	○	○	○	○	○	○	○
24. I have enough energy to do what I have to do.	○	○	○	○	○	○	○	○
25. It's okay if there are people who don't like me.	○	○	○	○	○	○	○	○

APPENDIX F

COUNSELOR ACTIVITIES SELF-EFFICACY SCALES

General Instructions: The following questionnaire consists of three parts. Each part asks about your beliefs about your ability to perform various counselor behaviors or to deal with particular issues in counseling. We are looking for your honest, candid responses that reflect your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There are no right or wrong answers to the following questions. Please indicate the response that best reflects your response to each question.

Part 1. Instructions: Please indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counseling **most** clients.

	No Confidence at all			Some Confidence			Complete Confidence		
	0	1	2	3	4	5	6	7	8	9

How confident are you that you could use these general Skills effectively with <u>most</u> clients over the next week?

1. **Attending** (orient yourself physically toward the client). — 0 1 2 3 4 5 6 7 8 9

2. **Listening** (capture and understand the messages that clients communicate). — 0 1 2 3 4 5 6 7 8 9

3. **Restatements** (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear). — 0 1 2 3 4 5 6 7 8 9

4. **Open questions** (ask questions that help clients to clarify or explore their thoughts or feelings). — 0 1 2 3 4 5 6 7 8 9

5. **Reflection of feelings** (repeat or rephrase the client's statements with an emphasis on his or her feelings). — 0 1 2 3 4 5 6 7 8 9

6. **Self-disclosure for exploration** (reveal personal information about your history, credentials, or feelings). — 0 1 2 3 4 5 6 7 8 9

7. **Intentional silence** (use silence to allow clients to get in touch with their thoughts or feelings). — 0 1 2 3 4 5 6 7 8 9

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). — 0 1 2 3 4 5 6 7 8 9

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 behavior, thoughts, or feelings). — 0 1 2 3 4 5 6 7 8 9

10. **Self-disclosures for insight** (disclose *past* experiences in which you gained some personal insight). — 0 1 2 3 4 5 6 7 8 9

11. **Immediacy** (disclose *immediate* feelings you have about the client, the therapeutic relationship, or yourself in relation to the client). — 0 1 2 3 4 5 6 7 8 9

12. **Information-giving** (teach or provide the client with data, opinions, facts, resources, or answers to questions). — 0 1 2 3 4 5 6 7 8 9

13. **Direct guidance** (give the client suggestions, directives, or advice that imply actions for the client to take). — 0 1 2 3 4 5 6 7 8 9

14. **Role play and behavior rehearsal** (assist the client to role-play or rehearse behaviors in-session). — 0 1 2 3 4 5 6 7 8 9

15. **Homework** (develop and prescribe therapeutic assignments for clients to try out between sessions). — 0 1 2 3 4 5 6 7 8 9

Part 2. Instructions: Please indicate how confident you are in your ability to do each of the following tasks <u>effectively</u>, over the next week, in counseling **most** clients.

	No Confidence at all				Some Confidence			Complete Confidence		
	0	1	2	3	4	5	6	7	8	9

How confident are you that you could do these specific Tasks effectively with <u>most</u> clients over the next week?

1. Keep sessions "on track" and focused.	0	1	2	3	4	5	6	7	8	9
2. Respond with the best helping skill, depending on what your client needs at a given moment.	0	1	2	3	4	5	6	7	8	9
3. Help your client to explore his or her thoughts, feelings, and actions.	0	1	2	3	4	5	6	7	8	9
4. Help your client to talk about his or her concerns at a "deep" level.	0	1	2	3	4	5	6	7	8	9
5. Know what to do or say next after your client talks.	0	1	2	3	4	5	6	7	8	9
6. Help your client to set realistic counseling goals.	0	1	2	3	4	5	6	7	8	9
7. Help your client to understand his or her thoughts, feelings, and actions.	0	1	2	3	4	5	6	7	8	9
8. Build a clear conceptualization of your client and his or her counseling issues.	0	1	2	3	4	5	6	7	8	9
9. Remain aware of your intentions (i.e., the purposes of your interventions) during sessions.	0	1	2	3	4	5	6	7	8	9
10. Help your client to decide what actions to take regarding his or her problems.	0	1	2	3	4	5	6	7	8	9

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Part 3. Instructions: Please indicate how confident you are in your ability to work effectively, over the next week, with each of the following client types, issues, or scenarios. (By "work effectively," we are referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain your poise during difficult interactions and, ultimately, to help the client to resolve his or her issues.)

	No Confidence at all				Some Confidence				Complete Confidence	
	0	1	2	3	4	5	6	7	8	9

How confident are you that you could work effectively
Over the next week with a client who ...

	0	1	2	3	4	5	6	7	8	9
1. ... is clinically depressed.	0	1	2	3	4	5	6	7	8	9
2. ... has been sexually abused.	0	1	2	3	4	5	6	7	8	9
3. ... is suicidal.	0	1	2	3	4	5	6	7	8	9
4. ... has experienced a recent traumatic life event (e.g., physical or psychological injury or abuse).	0	1	2	3	4	5	6	7	8	9
5. ... is extremely anxious.	0	1	2	3	4	5	6	7	8	9
6. ... shows signs of severely disturbed thinking.	0	1	2	3	4	5	6	7	8	9
7. ... you find sexually attractive.	0	1	2	3	4	5	6	7	8	9
8. ... is dealing with issues that you personally find difficult to handle.	0	1	2	3	4	5	6	7	8	9
9. ... has core values or beliefs that conflict with your own (e.g., regarding religion, gender roles)	0	1	2	3	4	5	6	7	8	9
10. ... differs from you in a major way or ways (e.g., race, ethnicity, gender, age, social class).	0	1	2	3	4	5	6	7	8	9
11. ... is not "psychologically-minded" or introspective.	0	1	2	3	4	5	6	7	8	9
12. ... is sexually attracted to you.	0	1	2	3	4	5	6	7	8	9
13. ... you have negative reactions toward (e.g., boredom, annoyance).	0	1	2	3	4	5	6	7	8	9
14. ... is at an impasse in therapy	0	1	2	3	4	5	6	7	8	9
15. ... wants more from you than you are willing to give (e.g., in terms of frequency of contacts or problem-solving prescriptions).	0	1	2	3	4	5	6	7	8	9
16. ... demonstrates manipulative behaviors in-session.	0	1	2	3	4	5	6	7	8	9