ABSTRACT: **Purpose:** Speech-language pathology (SLP) clinical self-efficacy is an individual's confidence in his or her ability to perform clinical tasks successfully. The primary aim of this study was to investigate SLP clinical self-efficacy beliefs among graduate SLP students.

**Method:** This study investigated the relationship between graduate students' SLP clinical self-efficacy beliefs and their clinical performance. Additionally, the relationship between SLP clinical self-efficacy beliefs and clinical experience was investigated. Graduate SLP students completed the SLP Clinical Self-Efficacy Inventory (SLP-CSEI).

**Results:** There was a strong positive relationship between graduate students’ SLP clinical self-efficacy beliefs and their clinical performance, as well as between the students’ SLP clinical self-efficacy beliefs and their clinical experience. SLP clinical self-efficacy beliefs varied across clinical task domains.

**Conclusion:** Participants with higher SLP-CSEI ratings were judged to have more confidence in their ability to conduct clinical tasks. It may be beneficial for SLP clinical educators to be aware of the social cognitive construct of SLP clinical self-efficacy and incorporate efficacy building into clinical education.

**KEY WORDS:** speech-language pathology, SLP clinical self-efficacy, graduate education, clinical experience, supervision
Researchers in various disciplines have studied self-efficacy beliefs (Schunk & Pajares, 2004). The social cognitive construct of self-efficacy has also captured the interest of health care researchers from the perspective of both the health care provider and the consumer. Examples of published research from the health care provider’s standpoint include studies of self-efficacy in the context of occupational therapists (Petzold et al., 2012; Vax, Schreuer, & Sachs, 2012), residents and nurses in pediatric medicine (Van Schaik, Plant, Diane, Tsang, & O’Sullivan, 2011), and audiologists (Smith & West, 2006). Published self-efficacy research from the consumer’s standpoint includes treatment implementation in the context of clients with Parkinson disease (Ellis et al., 2011), communication confidence of clients with aphasia (Cherney, Babbitt, Semik & Heinemann, 2011), hearing protection intervention programs (Lusk, Ronis, & Karr, 2008; Gill, White, Green, & Bird, 2011; Juenger, 2009; REDA International, 2007). Resources have been invested in the training of speech-language pathologists to prevent further shortages; therefore, it is important that trained speech-language pathologists are retained within the profession. According to REDA International’s (2007) survey of individuals who had left the profession of SLP, 35% of survey participants left the profession in the first 5 years. In order to enhance the retention rates of practicing speech-language pathologists, it is important that academic training programs focus on increasing the clinical confidence of students across a spectrum of professional skills critical to becoming competent clinicians.

For the purpose of this study, SLP clinical self-efficacy is defined as the confidence that an individual has in successfully performing tasks related to speech and language assessment and intervention. SLP clinical self-efficacy is an individual’s belief about his or her clinical capabilities that is generated through interaction of the social cognitive factors of cognition, emotion, behavior, and environment. SLP clinical self-efficacy should not be confused with treatment efficacy, treatment outcomes, or clinician performance.

Graduate education programs in the SLP field provide students with extensive supervised clinical training. The American Speech-Language-Hearing Association (ASHA) requires graduate SLP students to complete a minimum of 400 hr of supervised clinical experience to be eligible for certification (ASHA, 2009b). Students obtain graduate contact hours during the time period of their educational program. Additionally, formative assessments are provided by clinical supervisors in the form of feedback regarding students’ clinical competence and skill development. According to Hagstrom (2006), formative assessment is a tool that is used by educators to facilitate the self-assessment of skill development and content mastery that may potentially enhance student motivation. SLP clinical self-efficacy measures may serve to enhance formative assessments and assist in identifying areas of clinical practice that students are less
confident performing and therefore may require additional refinement and greater supervisory support.

It is important to measure students' confidence in their abilities to provide various clinical services throughout the academic program. According to Lee and Schmaman (1987), graduate SLP students experience high levels of anxiety during clinical placements. Chan, Carter, and McAllister (1994) reported that SLP students experience varying levels of anxiety throughout their graduate education program. The primary factors contributing to student anxiety included students questioning their ability to perform clinical tasks successfully, students' perception of mastery learning of clinical skills, and students' self-expectations. Chan et al. encouraged graduate education programs to reduce student anxiety by restructuring courses and the curriculum. Additionally, McCrea and Brasseur (2003) recommended that Graduate SLP programs include anxiety measures along with formative evaluations in the training of SLP students.

Programs that are aimed at increasing self-efficacy of the workforce are beneficial to the well-being of the profession because self-efficacy beliefs influence cognitive processes such as forethought, goal setting, and persistence (Bandura, 1997). Locke and Latham (2002) proposed that the strength of self-efficacy is positively related to the goal level chosen. As such, individuals with high self-efficacy tend to set higher goals as they believe that they are capable of performing the task successfully and are more likely to persevere when faced with obstacles.

At present, there is a dearth of knowledge on the factors that promote SLP clinical self-efficacy. As ASHA and academic programs in SLP work toward preparing better educated and skilled speech-language pathologists for the future, it is important to study the cognitive, behavioral, emotional, and environmental factors that contribute to the shaping of clinical confidence and performance. SLP students may benefit from programs that create awareness of, promote, and advance the SLP clinical self-efficacy of their students. Understanding SLP clinical self-efficacy may be a factor that enhances graduate education pedagogy, fosters skill mastery, and builds clinical confidence.

The purposes of this study were to investigate (a) the relationship between graduate SLP students' SLP clinical self-efficacy beliefs and their clinical performance, (b) the relationship between graduate SLP students' SLP clinical self-efficacy beliefs and their clinical experience, and (c) SLP clinical self-efficacy beliefs across task domains. We hypothesized that there would be a positive correlation between graduate SLP students' SLP clinical self-efficacy beliefs and their clinical performance and experience. We also hypothesized that SLP clinical self-efficacy beliefs would vary by clinical task domain.

METHOD

Participants

This study employed a convenience sample of a total of 63 graduate SLP students at a public research institution of higher education. Of the 63 participants, 46% \((n = 29)\) were first-year graduate students and 53% \((n = 34)\) were second-year graduate students.

Variables

The dependent variable in this study was SLP clinical self-efficacy, and the independent variables were clinical performance, clinical experience, and task domains. For the purposes of this study, SLP clinical self-efficacy was operationally defined as the participant’s SLP Clinical Self-Efficacy Inventory (SLP-CSEI) index. This inventory was developed by the authors for this study. Clinical performance was operationally defined as self-reported formative evaluation scores from clinical supervisors for the most recent clinical enrollment. Clinical experience was operationally defined by two measures: year in graduate school (first or second year) and number of direct graduate contact hours. Task domain was operationally defined as the subcategories contained within the knowledge and skills acquisition (KASA) document as prescribed by ASHA (2009a). These seven task domains included case history, evaluation, diagnosis, administrative and reporting, communication, collaboration and counseling, and intervention.

Instrumentation

SLP clinical self-efficacy measure. The SLP-CSEI was used to measure the SLP clinical self-efficacy beliefs of graduate students. The construction of the SLP-CSEI was based on the standard methodology for measuring self-efficacy beliefs as outlined by Bandura (2006). Consistent with Bandura’s guidelines for constructing self-efficacy measures, items were selected portraying different tasks and levels of task difficulty, as Bandura proposed that self-efficacy beliefs can vary across activities and circumstances. The items in the SLP-CSEI were generated based on formative evaluation domains of clinical skill development used by an academic program and the domains contained within the KASA Summary Form for Certification in Speech-Language Pathology (ASHA, 2009a).
The SLP-CSEI consists of multiple items that measure Graduate SLP students’ perceived confidence in completing assessment and intervention tasks successfully. Specifically, the SLP-CSEI consists of the following seven domain-specific SLP clinical self-efficacy measures: Case History Self-Efficacy Scale, Evaluation Self-Efficacy Scale, Diagnoses Self-Efficacy Scale, Administrative and Reporting Self-Efficacy Scale, Communication Self-Efficacy Scale, Collaboration and Counseling Self-Efficacy Scale, and Intervention Self-Efficacy Scale. These seven measures are assessed by a total of 95 items. All items in the scale begin with a carrier phrase: “How confident are you that you can…”

For each item, the participants were asked to rate the strength of their confidence in their ability to execute the clinical task successfully. They recorded the strength of their SLP clinical self-efficacy beliefs (confidence) on a unipolar continuous 100-point scale ranging from 0 (no confidence at all) to 100 (completely confident). Sample items include “select appropriate standardized instrument(s) to evaluate clients” and “develop appropriate materials/activities for clients with severe communications disorders.” To ensure face validity, the SLP-CSEI was reviewed by three expert speech-language pathologists with substantial clinical and academic experience, and their recommendations were incorporated into the final draft of the instrument.

Participants’ domain-specific indices were generated by dividing the total number of the clinical self-efficacy scores divided by the number of items within each domain. Participants with higher indices were judged to have more confidence in their ability to conduct clinical tasks within the domain. A total SLP clinical self-efficacy index was generated through the summation of all domain-specific indices. This total index served as the global measure of SLP clinical self-efficacy. Because the total index was a reflection of the number of items completed, it was calculated only for participants who completed all items in the SLP-CSEI. In the current sample, 48 of the total 63 participants completed all items in the SLP-CSEI. Among first-year graduate students, 18 of the 29 participants completed all items in the SLP-CSEI, and among second-year graduate students, 30 of the 34 participants completed all items in the SLP-CSEI.

**Background questionnaire.** In addition to the SLP-CSEI, participants completed a written background questionnaire. The background questionnaire consisted of items related to the participants’ direct graduate contact hours, year of graduate education, and self-reported formative evaluation scores from clinical supervisors for the most recent clinical enrollment. Self-reported formative evaluation scores, which were assigned through a formal assessment, were on a 5-point Likert scale where 1 represented limited clinical abilities, 2 represented emerging clinical abilities, 3 represented present clinical abilities, 4 represented developed clinical abilities, and 5 represented skilled clinical abilities. Each participant reported his or her formative evaluation score, which represented the average measure of clinical ability across multiple clinical domains, including planning evaluation and intervention, executing evaluation and intervention, synthesizing clinical information, completing clinical documentation, collaborating with other professionals, and counseling.

**Procedure**

Following approval from the Texas Tech Institutional Review Board, we administered the survey instruments in a classroom setting to first- and second-year graduate SLP students who were enrolled in an accredited program. The participants were given both oral and written instructions related to the survey instrument. Participants were informed that participation was voluntary and would not affect any class grades. Neither the instructors of the classes nor the investigators were present in the classroom when the students completed the survey. Surveys were de-identified and separated from informed consent forms. All participants received a monetary compensation of a $5.00 gift card for participation, which was defined as submission of the informed consent form.

**RESULTS**

The participants who completed the full SLP-CSEI consisted of 18 first-year graduate students and 30 second-year graduate students (Table 1). Direct graduate contact hours for the first-year graduate students ranged from 38 to 260 ($M = 128.50, SD = 75.75$), and self-reported formative evaluation scores from clinical supervisors for the first-year graduate students ranged from 2.50 to 4.30 ($M = 3.21, SD = 0.50$). Direct graduate contact hours for the second-year graduate students ranged from 300 to 510 ($M = 422.03, SD = 41.74$), and self-reported formative evaluation scores from clinical supervisors for second-year graduate students ranged from 3.50 to 5.00 ($M = 4.09, SD = 0.35$).

Total SLP-CSEIs ranged from 37.47 to 87.77 across all participants. SLP CSEI indices for first-year graduate students ranged from 37.47 to 81.29 ($M = 64.46, SD = 12.42$). SLP CSEI indices for second-year graduate students ranged from 55.79 to 87.77 ($M = 76.97, SD = 8.31$).
Relationship Between SLP Clinical Self-Efficacy Beliefs and Clinical Performance

The Pearson product–moment correlation coefficient was determined to assess the relationship between the students’ SLP clinical self-efficacy beliefs and their clinical performance. Clinical performance was operationally defined by the students’ self-reported formative evaluation scores for the most recent enrollment. There was a significant positive correlation ($r = .51$, $p < .01$) between the students’ total SLP-CSEI indices and their self-reported formative evaluation scores. Graduate students who had higher self-reported formative evaluation scores had higher SLP-CSEI indices and were more confident about their ability to complete clinical tasks successfully.

Relationship Between SLP Clinical Self-Efficacy Beliefs and Clinical Experience

For the purpose of this study, clinical experience was measured by both the year of graduate education and the number of direct contact hours. Clinical experience was delineated into these two measures as a high degree of variability in the accrual of direct contact hours within each year of graduate education was expected.

**SLP clinical self-efficacy beliefs and year of graduate education.** An independent sample $t$ test was conducted to compare the SLP clinical self-efficacy beliefs of first- and second-year graduate students. There was a significant difference ($t(46) = -4.184, p < .05$, in the total SLP-CSEI indices between first-year ($M = 64.46, SD = 12.42$) and second-year graduate SLP students ($M = 76.97, SD = 8.31$). Overall, first-year students had lower SLP-CSEI indices, indicating that they were less confident about successfully completing SLP clinical tasks than were second-year graduate students.

**SLP clinical self-efficacy beliefs and direct contact hours.** The Pearson product–moment correlation coefficient was calculated to assess the relationship between the students’ SLP clinical self-efficacy beliefs and their direct contact hours. There was a significant positive correlation between total SLP-CSEI indices and direct contact hours ($r = .57$, $p < .01$). Graduate students with a greater number of direct clinical hours had higher SLP-CSEI indices, indicating that they were more confident about their ability to complete clinical tasks successfully than students with fewer hours.

SLP Clinical Self-Efficacy Beliefs Across Task Domains

There was wide variability in SLP clinical self-efficacy beliefs by clinical task domain for all students (Figure 1). As shown in Table 2, the graduate students were most confident about successfully completing clinical tasks that were related to communication ($M = 85.86, SD = 12.00$) and intervention ($M = 81.96, SD = 12.87$). The graduate students were least confident about successfully completing tasks related to evaluation ($M = 40.74, SD = 6.38$).

A one-way analysis of variance was performed to evaluate the effect of task domain on SLP clinical self-efficacy beliefs for all students. Results indicated that there was a significant main effect for task domain, $F(6, 398) = 62.31, p < .01$. A post hoc Tukey HSD test ($p < .05$) with a Bonferroni correction was used to determine significance among mean scores across the seven domains. Results revealed that the SLP-CSEI index for evaluation tasks was significantly lower in comparison to the SLP-CSEI indices of the remaining six domains. Further, the index for the communication domain was significantly higher than all of the other domains’ indices except for the indices of collaboration and intervention. Additionally, there were no significant differences between the administrative and reporting domain index and the case history domain index. The collaboration domain index was not significantly different from any other domain except for the evaluation domain.

A multivariate test (Wilk’s lambda) was conducted to examine the SLP-CSEI indices across task domains for first- and second-year graduate students. Results indicated that the year of graduate study had a significant effect, $F(7, 40) = 4.16, p < .01$, on all of the clinical task domains. Among the task domains, the greatest difference between the first- and

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Table 1. Speech-language pathology (SLP) clinical self-efficacy by clinical experience, clinical performance, and SLP clinical self-efficacy index.

<table>
<thead>
<tr>
<th>Number of participants</th>
<th>Clinical experience</th>
<th>Clinical performance</th>
<th>SLP clinical self-efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean direct contact hours</td>
<td>Mean self-reported formative evaluation</td>
<td>Mean SLP clinical self-efficacy index</td>
</tr>
<tr>
<td>18</td>
<td>128.50</td>
<td>3.21</td>
<td>64.46</td>
</tr>
<tr>
<td>30</td>
<td>422.03</td>
<td>4.09</td>
<td>76.97</td>
</tr>
</tbody>
</table>

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second-year graduate students was seen in the domains related to administrative and reporting functions, $F(1, 54) = 22.11, p < .001,$ and to communication, $F(1, 54) = 18.43, p < .001.$

**DISCUSSION**

The results of this study revealed a strong relationship between SLP clinical self-efficacy and clinical performance. These findings are supported by previous research in SLP that also indicated that measures of self-efficacy were a predictor of clinical performance (Lee & Schmaman, 1987). These results suggest that it is important to identify and provide additional academic support to students who report low SLP clinical self-efficacy beliefs in order to enhance their confidence in completing clinical skills successfully.

Further, this study revealed that SLP clinical self-efficacy varied by clinical experience. There was a strong positive relationship between SLP clinical self-efficacy beliefs and the number of direct contact hours. There was also a significant difference between the SLP clinical self-efficacy beliefs of first- and second-year graduate students. According to Bandura (1977), mastery and vicarious experience are powerful sources of self-efficacy information. Therefore, through observation and practical experience, second-year students may have gained confidence in completing clinical tasks successfully. Second-year graduate students may have had a wider variety of clinical experiences in a number of different clinical settings than first-year graduate students, who typically have more uniform or controlled experiences in a university clinic. As graduate students progress through a university training program, they learn and gain confidence by observing how their peers manage

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**Table 2.** Descriptive statistics for domain means for first- and second-year graduate students.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Year</th>
<th>Mean</th>
<th>95% confidence interval</th>
<th>Year</th>
<th>Mean</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower bound</td>
<td>Upper bound</td>
<td></td>
<td>Lower bound</td>
<td>Upper bound</td>
</tr>
<tr>
<td>Case history</td>
<td>1</td>
<td>70.70</td>
<td>65.83</td>
<td>75.58</td>
<td>2</td>
<td>80.28</td>
</tr>
<tr>
<td>Evaluation</td>
<td>1</td>
<td>36.89</td>
<td>34.19</td>
<td>39.59</td>
<td>2</td>
<td>43.05</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1</td>
<td>67.94</td>
<td>61.41</td>
<td>74.47</td>
<td>2</td>
<td>83.89</td>
</tr>
<tr>
<td>Administrative and reporting</td>
<td>1</td>
<td>60.55</td>
<td>53.51</td>
<td>67.59</td>
<td>2</td>
<td>82.19</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td>78.38</td>
<td>73.36</td>
<td>83.41</td>
<td>2</td>
<td>90.34</td>
</tr>
<tr>
<td>Collaboration and counseling</td>
<td>1</td>
<td>68.95</td>
<td>61.66</td>
<td>76.25</td>
<td>2</td>
<td>86.82</td>
</tr>
<tr>
<td>Intervention</td>
<td>1</td>
<td>73.08</td>
<td>67.88</td>
<td>78.28</td>
<td>2</td>
<td>87.29</td>
</tr>
</tbody>
</table>
various difficult cases in a variety of clinical settings. Students also gain confidence by encountering and successfully managing challenging cases. Further, Bandura (1997) stated that the successful repetition of easy tasks does not add to the efficacy beliefs of an individual. Reappraisal of efficacy occurs with the mastery of difficult tasks. This finding reaffirms the presence of a gradient of task difficulty between first-year and second-year clinical experiences.

Finally, the results of this study revealed that SLP clinical self-efficacy beliefs varied by task domain. In this study, SLP clinical self-efficacy was measured for seven task domains that mirrored the certification standards for the practice of SLP contained within the KASA document as prescribed by ASHA (2009a). These seven task domains included case history, evaluation, diagnosis, administrative and reporting, communication, collaboration and counseling, and intervention. Although ASHA requires that graduating students document evidence of basic entry-level skills for each of these task domains, this study indicated that students are not equally confident in performing the various tasks successfully. Graduate SLP students were confident about completing most of the tasks within the seven domains, especially tasks that were related to communication and intervention. However, they were least confident about completing evaluations tasks successfully. Both first- and second-year graduate students reported lower confidence in completing tasks within the evaluation domain. These findings suggest that, in our sample, students perceived clinical tasks related to evaluations to be more challenging than other SLP clinical tasks.

Clinical Implications

The results of this study have implications for the training of speech-language pathologists. Previous findings, as well as the results of the current study, indicate that graduate students’ SLP clinical self-efficacy is related to their clinical performance and experience (Rudolf et al., 1983; Lee & Schmaman, 1987). Therefore, it may be important to integrate SLP clinical self-efficacy building into academic programs. The following methods can be used by academic programs to foster SLP clinical self-efficacy based on the four primary sources of self-efficacy as postulated by Bandura (1997).

The primary purpose of clinical practicum is to provide knowledge and skills through enactive experiences. Enactive experiences are the most influential contributors to the development of self-efficacy (Gist, 1987), as enactive experiences contain the most authentic evidence of capabilities (Bandura, 1997; Usher & Pajares, 2008). Self-efficacy beliefs are most influenced as an individual is first introduced to a task and begins skill development (Bandura, 1982; Usher & Pajares). Clinical educators should be cognizant of current theoretical training and the skill level of an entry-level Graduate SLP student and assign initial clinical tasks that match the student’s knowledge and skills. Due to scheduling restrictions and the availability of clinical supervisors, entry-level students may be required to manage cases that are above their knowledge and skill level. Assigning clinical cases that are above a student’s knowledge and skill set increases the risk of clinical failure. According to Bandura (1997), successfully completing a task establishes a strong belief in one’s personal efficacy; however, failure undermines personal efficacy, especially if failure is experienced early in skill development. As such, it is important that graduate educators and clinical supervisors be aware and conscious of SLP clinical self-efficacy beliefs and the influence of enactive experiences on these beliefs at the beginning stages of skill acquisition.

According to Locke (2000), enactive mastery occurs through a progression of three phases. The first phase includes the introduction and exhibition of skills to master a task. In the case of SLP clinical self-efficacy, the 25 hr of clinical observation required for ASHA certification would meet this first phase of introduction and exhibition of clinical skills. The second phase incorporates opportunities for individuals to master the skills, through guided practice and simulated conditions. Before the first SLP clinical experience, students should be provided with opportunities to practice clinical skills and complete simulated case studies that are closely related to cases they will be exposed to in their first clinical experience. The third and final phase of enactive mastery involves the provision of progressive opportunities to conduct the task at various difficulty levels. Bandura (1997) stated that competent skill development is enhanced when complex skills are broken down into progressive subskills that are easily mastered. For example, a clinical supervisor should break down the complex skill of diagnostic evaluation into the progressive subskills of case history, nonstandard measures, standardized measures, interpretation, reporting, and counseling. This would allow the SLP student to successfully master each of the subskills without being overwhelmed by the complexity of the full diagnostic task.

Vicarious experiences or modeled performances are the second most influential variable in the development of self-efficacy beliefs (Bandura, 1997). According to Carroll and Bandura (1987), individuals observe, compare, and make judgments about their skills and capabilities by comparing their skills with
those of successful models (Gist & Mitchell, 1992). Models that exemplify coping strategies have a strong effect on individuals’ self-efficacy beliefs (Bandura). According to Bandura (1997), clinical models in which setbacks and coping strategies are exhibited convey the message that obstacles can be overcome with perseverance. The demonstration of perseverance encourages confidence-building beliefs. For example, it would be advantageous to pair a less confident student at the beginning stages of skill mastery with a more confident student who has greater skill mastery and has developed coping mechanisms across a variety of clinical task domains.

The third contributor to the development of self-efficacy is verbal persuasion. The overt and covert messages that an individual receives from clinical supervisors and peers may influence the perceptions of his or her performance capabilities (Gist, 1987). Evaluative feedback on clinical task performance is an example of verbal persuasion. Positive verbal persuasion encourages individuals to attempt, persist, and succeed, which in turn promotes skill development and builds confidence in successful task completion (Bandura, 1997). According to Bandura (1997), performance feedback can be expressed in a manner that either enhances or damages self-efficacy beliefs, especially in the early stages of skill development. Effective formative evaluation feedback in SLP clinical education should be specific and should include strategies and coping mechanisms to improve clinical performance. For example, formative feedback following a completed clinical task, such as an evaluation, should begin with highlighting the subskills that were performed skillfully followed by specific strategies to improve the subskills that were performed less successfully. One example would be suggesting use of a checklist of evaluation tasks to a student who had neglected to complete a portion of an evaluation.

The fourth contributor to the development of self-efficacy is emotional arousal. Bandura (1997) stated that when judging their capabilities, individuals consider somatic information. People may interpret stress or anxiety as a sign of poor skill capabilities. When an individual is less confident about performing a task successfully, stress reactions are further exaggerated by anticipatory self-arousal. According to Bandura, it is not the arousal state that reduces confidence per se, but the meaning attributed to it by the individual. Therefore, it is important that SLP students are taught to interpret their somatic arousal as a challenge to boost perceived efficacy instead of interpreting it as a lack of capabilities. For example, in preparation of clinical experience, clinical educators should acknowledge students’ anxiety and discuss the human body’s fight-or-flight response to stress. Clinical educators should counsel SLP students on being conscious of physiological states and to self-monitor these conditions. Educators should explain to the SLP students that stress and anxiety are often expressed in a variety of symptoms. Further explain that these physiological expressions of emotions should not be interpreted as indicators of a lack of clinical skill, but are just the body’s way of dealing with stress. Further, students should be encouraged to channel the somatic arousal into a positive energy that improves their performance.

By incorporating SLP clinical self-efficacy-enhancing strategies into SLP education, clinical educators can improve SLP education and student performance. In fact, clinical SLP self-efficacy building should be an important element of graduate education due to the relationship between SLP clinical self-efficacy, clinical performance, and clinical experience. Therefore, it is important that graduate educators be aware of the construct of SLP clinical self-efficacy and take action to integrate efficacy building into clinical education.

**Future Research**

Although there is an extensive literature base on self-efficacy beliefs, there is a dearth of knowledge on SLP clinical self-efficacy. This study serves as a preliminary investigation of graduate student SLP clinical self-efficacy. Additional research is warranted to further explore the variables that affect the development of SLP clinical self-efficacy. In particular, the development of SLP clinical self-efficacy across task domains and the influence of social cognitive factors within educational programs on SLP clinical self-efficacy should be examined.

**ACKNOWLEDGMENT**

This research was supported in part by a research grant award from the Texas Society of Allied Health Professionals.

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