

Research Paper

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

Rea Shejith^{1*}, Anushka Negi², Dr. Surender Kumar Dhalwal³

ABSTRACT

Background: This study investigates the relationship between therapist beliefs, goal orientation, counselor self-efficacy among clinical psychologists. Given the increasing demand for mental health services, understanding the factors that enhance or hinder therapist effectiveness is crucial. Counselor self-efficacy, defined as the belief in one's ability to execute behaviors necessary for successful outcomes, is influenced by various beliefs and goal orientations. **Materials and method:** Thirty-two clinical psychologists from all throughout India made up the sample. A semi-structured questionnaire for socio-demographic details was administered. Therapist Beliefs Scale-R, Counselor Self-Efficacy Scale (CASES), and Goal Orientation Scale were used. This correlational research incorporates quantitative questionnaires to examine how mastery and performance goal orientations affect therapist beliefs and counselor self-efficacy. To examine the relationship between the variables, Pearson's Correlational Coefficient was employed. **Results:** The result indicates that mastery goal orientation positively correlates with counselor self-efficacy fostering resilience and persistence. **Conclusion:** Qualitative insights emphasize the importance of supportive environments and continuous professional development in enhancing therapist confidence. The findings underscore the need for training programs that promote healthy beliefs and mastery orientations to improve therapeutic practice and client care. This research contributes to a deeper understanding of the dynamics between therapist beliefs, counsellor self-efficacy, and goal orientation, providing valuable implications for training and practice in the field of psychotherapy.

Keywords: *Therapist Beliefs, Goal Orientation, Counselor Self-Efficacy, Clinical Psychologists*

In this world of constant development, the need for mental health services is rising day by day and with that being said, the need for an efficient, self-confident therapist is also rising the same. There are different learning styles that a therapist adapts to learn and

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Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

increase their knowledge in the field and he/she goes through many difficulties that make them question their abilities and life choices. However, after seeing the results from the therapy, they regain their confidence.

Therapist beliefs are unhealthy thoughts that contribute to feelings of burnout from vicarious trauma, which are categorized by low tolerance of distress, rigid adherence to a therapeutic model, belief of responsibility, and need for control (Emery et al., 2009; McLean et al., 2003).

Unique stressors related to the therapist-client relationship and therapy itself are also present in psychotherapy for the therapist. Particularly, it has been discovered that certain factors related to beliefs about therapy or the therapeutic relationship can lead to therapist stress. These factors include the need to operate at maximum efficiency in all situations with all clients; rigid, inflexible, and dogmatic attitudes toward the application of therapeutic models and process; the need to appear knowledgeable; a low threshold for ambiguity; the need for emotional and therapeutic control; and intolerance for the emotionality of the client (Deutsch, 1984; Forney, Wallace-Schutzman, & Wiggers, 1982; Hellman, Morrison, & Abramowitz, 1987; Rodolfa et al., 1988; Murtagh & Wollersheim, 1997).

A social-cognitive explanation of achievement motivation is called goal orientation theory. Although goal theory dates back to the early 20th century, it wasn't until 1985 that it gained significant traction as a theoretical framework for the investigation of academic motivation. Goal orientation theory looks at why students do their academic work, while other motivational theories (such as attribution theory) look at how students see their triumphs and failures.

Edwin Locke and Gary Latham offer a comprehensive theory of motivation based on goal-setting. The theory highlights the significance of the connection between performances and goals.

Two types of goal orientations to achievement-related activities have been identified: mastery (or learning) orientation and performance orientation (Dweck, 1986). Mastery and performance orientations to learning represent different ideas of success and different reasons for engaging in learning (Ames, 1992). The ideas that ability is malleable and that effort produces better results are components of a mastery perspective. Mastery-oriented people put a lot of effort into learning new abilities, trying to comprehend what they are doing, and effectively meeting self-referenced mastery standards. On the other hand, those who approach learning with a performance orientation think that one can demonstrate aptitude by outperforming others, going above and beyond normatively based expectations, or achieving with minimal effort (Ames, 1992; Dweck, 1986). Performance-oriented people aspire to outwardly surpass others in their level of accomplishment.

Albert Bandura, a Canadian-American psychologist and Stanford University professor, originally used the term "self-efficacy" in 1977. As a personal assessment of "how well one can execute courses of action required to deal with prospective situations," he first put forth the idea. According to Bandura (1977), self-efficacy is a person's unique set of beliefs that influence how successfully they can carry out a plan of action in potential scenarios.

A counselor's beliefs or judgments about his or her capacities to effectively counsel a client in the near future" is the definition of counselor self-efficacy (L. M. Larson & Daniels, 1998,

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

p. 180). Since the majority of counseling programs include all four sources of self-efficacy—performance accomplishments, vicarious experiences, verbal persuasion, and emotional arousal—Bandura's theory would imply that as counselors receive training and experience—such as coursework and counseling role plays—they will grow more confident in their abilities as professionals.

Regarding stable counselor attributes (such as age, gender, personality, skill, accomplishment, and ethnicity), the majority of research has discovered weak, non-significant associations with counselor self-efficacy. Nonetheless, two consistent counselor attributes have surfaced as noteworthy and affirmative correlates of counselor self-efficacy: degree of expertise (Harris, 2007; L. M. Larson et al., 1992; Martin, Easton, Wilson, Takemoto, & Sullivan, 2004; Melchert, Hays, Wiljanen, & Kolocek, 1996; Tang et al., 2004) and degree of instruction (Friedlander & Snyder, 1983; L. M. Larson et al., 1992; Melchert et al., 1996).

Therapist beliefs: Research underscores the critical role of therapist beliefs in shaping professional development and therapeutic effectiveness. Beverly et al. (2015) demonstrated that therapists' engagement with self-practice and self-reflection, influenced by their beliefs, is pivotal for continuous professional growth. Curtis (2013) highlighted the prevalence of inaccurate beliefs about client deception among therapists, which can impact therapeutic relationships and outcomes. These studies suggest that while therapists generally perceive self-reflective practices as beneficial, there are gaps in accurate belief systems regarding client interactions that need addressing to improve therapeutic efficacy.

Goal orientation: Goal orientation significantly impacts learning processes and performance outcomes in therapeutic settings. Studies by Dweck and Leggett (1988) and Breland IV (2001) emphasized the importance of distinguishing between learning and performance goal orientations. Learning goal orientation, in particular, has been shown to foster greater self-efficacy and adaptability in therapeutic practices. This orientation promotes a mindset that values skill acquisition and resilience, which are crucial for effective therapy.

Counselor self-efficacy: Counselor self-efficacy, a central tenet of Bandura's social cognitive theory, is influenced by various factors including training, experience, and personal attributes. Research by Larson and Daniels (1998) and others consistently shows that higher levels of training and experience correlate with increased self-efficacy among counselors. Furthermore, anxiety and perceptions of the work environment significantly affect self-efficacy, highlighting the importance of supportive supervision and professional development environments.

Overall, the reviewed literature highlights the complex interrelationships between therapist beliefs, goal orientation, and counselor self-efficacy. Effective therapeutic practice is influenced by accurate self-reflective beliefs, a learning-oriented goal approach, and robust self-efficacy fostered through comprehensive training and supportive professional environments.

MATERIALS AND METHOD

Aim of the study

The purpose of the study is to understand the relationship between the therapist beliefs, goal orientation, counselor self-efficacy among the clinical psychologists.

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

Objectives

To study the relationship between goal orientation with therapist belief, counselor self-efficacy and work experience

Hypotheses

- **H0₁:** There is no significant relationship between therapist beliefs and goal orientation among clinical psychologists.
- **H0₂:** There is no significant relationship between therapist beliefs and counselor self-efficacy.
- **H0₃:** There is no significant relationship between goal orientation and counsellor self-efficacy among clinical psychologists.

Participants

A correlational research design was used, combining quantitative surveys to gather comprehensive data on therapist beliefs, goal orientation, and counselor self-efficacy. Licensed clinical psychologists who are currently practicing as clinical psychologists and have a minimum of one year of service experience were included in the study. The sample size was 32.

Materials and Scoring

Socio-Demographic Data Sheet

This sheet collects essential socio-demographic information from participants, including age, gender, education level, occupation, marital status, work experience, and whether the participant has a history of undergoing therapy in the past/thinking of seeking it in the future.

It provides a comprehensive overview of the sample's characteristics, which aids in contextualizing the results and identifying any demographic patterns or confounding variables. The purpose was to gather relevant background information that might influence the study's findings and ensure a diverse and representative sample.

The Therapist Belief Scale - Revised (TBS-R) (McLean, Wade, & Encel, 2003): The Therapist Belief Scale (TBS-R) is a questionnaire assessing therapists' thoughts about their roles and work as therapists. It has primarily been utilized to measure beliefs in therapists who are working with survivors of trauma; its psychometric properties are currently unknown. The original version contained 58 items that were rated on a 6 point Likert Scale with 1 being "strongly disagree" and 6 being "strongly agree." An example of some items from this measure include: "I must not make mistakes in therapy, if I do then I've failed" and "I am responsible if therapy is not successful" (McLean et al., 2003). A factor analysis was conducted with a criterion of 0.32 for the correlation between the item and the primary factor, and the results indicated that 69% of the items (48 out of 58) were loaded onto this factor (McLean et al., 2003). Subsequent factor analyses were conducted with a criterion of > 0.60 for the correlation between the item and the primary factor. The end result was 29 items loading onto one of three factors related to distress, inflexibility, and control, which compose the revised version. These analyses provide support for the validity of utilizing a total score as a basis of measurement, with higher scores indicating lower levels of irrational beliefs in regards to therapy (Emery et al., 2009).

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

The scale consists 4 subsets which are (1) low tolerance of distress, (2) rigid adherence to therapeutic model, (3) beliefs of responsibility and (4) need for control and understanding. Scoring: (1) low tolerance of distress – 10 items (1, 2, 8, 12, 14, 16, 17, 18, 19, 20); (2) beliefs of responsibility – 7 items (3, 4, 7, 11, 15, 21, 23); (3) need for control and understanding – 6 items (5, 6, 9, 10, 13, 22).

Counselor self-efficacy (CASES): The CASES (Lent et al., 2003) was developed to assess one's self-efficacy for performing helping skills, managing the counseling process, and handling challenging counseling situations. The CASES is composed of 41 items, divided into 3 subscales, i.e., Part I are the Helping Skills self-efficacy scales; Part II = Session Management self-efficacy; and Part III = is Counseling Challenges self-efficacy. Item All items are arranged on a 10-point Likert-type scale ranging from no confidence at all (0) to complete confidence (9). Higher subscale and total scores indicate higher self-efficacy. Thus, possible scores range from 0 to 369.

Internal consistency, test-retest reliability, convergent validity, and discriminant validity values were computed by Lent and colleagues (2003). In this investigation, the Cronbach alpha coefficient for the whole CASES score was .98. There was evidence of social desirability, indicating strong discriminant validity. The two-week test-retest reliability estimates in the study by Lent and colleagues varied from .59 to .76. The overall score of the CASES and the COSE in the same study showed a strong correlation ($r = .76$), indicating strong convergent validity. Additionally, a weak association was discovered between the total score of the CASES and a social desirability measure, indicating strong discriminant validity.

Deriving the score: For every kind of instrument, scale scores are traditionally calculated by adding up all of the item responses on a particular scale and dividing the result by the total number of scale items. In essence, this establishes the metric as equal to the scaling interval (e.g., 0-9, 1-7), and generates an average score over the set of items. For example, if a student answers all 10 self-efficacy items with a total of 50, they will obtain a score of 5 (50 divided by 10), which is slightly higher than the midpoint of a 0–9 point scale. Larger scores in this method typically indicate more favorable perceptions (such as stronger self-efficacy, more contextual supports, and firmer decision goals); larger scores would, of course, reflect more negative perceptions in the case of contextual barriers or negative outcome expectancies.

Goal orientation scale By Button et al. (1996): Performance goal orientation was initially assessed with 10 items. Responses were based on a 7-point scale that ranged from (1) “Strong Disagree” to (7) “Strongly Agree.” High agreement with these items indicates a strong desire to obtain favorable judgments of one’s competencies or, conversely, a desire to avoid negative judgments of one’s competence (that is a strong performance goal orientation). A low agreement suggests little concern for performing better than others or making errors (that is a weak performance goal orientation). The 10-item scale exhibited a Cronbach’s alpha of .76.

Learning goal orientation was initially assessed with 10 items. These items were also rated on a 7-point scale that ranged from (1) “Strongly Disagree” to (7) “Strongly Agree.” Strong agreement with these items indicates a strong desire to perform challenging work, learn new skills, and develop alternative strategies when working on a difficult task (that is a strong learning goal orientation). A low agreement suggests little concern for mastering tasks or

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

gaining competency (that is a weak learning goal orientation). The alpha for these 10-items was .79.

Data Collection

To conduct the study, the tools were administered individually on the sample. A Google Form was distributed by the test administrator to a few clinical psychologists around India via social media such as LinkedIn, WhatsApp, and Instagram in order to gather data utilizing the snowball method. The participants then were asked to share the Google form with other clinical psychologists who are working in the clinical setup. After that, it was requested that each new participant to share the Google form with additional participants. A Google Form including all the instructions and questions was distributed by the administrator. Before starting the test, the participants were assured of the confidentiality of their results. The participants were individually approached and all the required details pertaining to filling out the questionnaires were given. The participants' voluntary consent was taken before starting to attempt the questionnaires. The Google form was in different sections to collect the demographic details, consent, and the questionnaire responses.

Statistical Analysis

Quantitative data was analyzed using the Statistical Package for Social Sciences (SPSS) Version 25. Descriptive statistical methods were employed to calculate the sociodemographic and clinical characteristics of patients. This included the creation of pie charts or graphs that displayed the percentage-wise distribution of participants across various sociodemographic variables. The study also computed the frequency and percentage, along with the mean and standard deviation (SD), of therapist beliefs, goal orientation, and counselor self-efficacy among the sample. Additionally, Pearson's correlation was used to examine the relationships between therapist beliefs, goal orientation, and counselor self-efficacy. Scatter plots were generated to visually represent these relationships.

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Initially, 33 adults consented to participate. These participants were screened based on inclusion and exclusion criteria. One participant, a psychologist with an M.A. qualification, was excluded from the study. The remaining 32 participants proceeded to the administration phase, where they were given scales to complete, including the Therapist Belief Scale-Revised (TBS-R), Counselor Activity Self-Efficacy Scales (CASES), and the Goal Orientation Scale. Following the administration of these scales, data analysis was conducted. Finally, the results and discussions were derived from the analyzed data.

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

Variables

- Independent Variable: Goal Orientation
- Dependent Variable: Therapist Beliefs and Counselor Self-Efficacy.

RESULTS AND DISCUSSION

Table 1: Socio-Demographic Details of the Participants

Demographic Variables		Total	Percentage
Age	25-35	29	90.6%
	36-45	1	3.1%
	46-55	2	6.2%
Marital status	Married	7	21.8%
	Unmarried	25	78.1%
Work experience	1-2 years	14	43.8%
	3-more than 5 years	18	56.2%
Educational Qualification	M.Phil	30	93.7%
	P.hd	2	6.3%
Currently undergoing therapy/have gone through in the past/ thinking of seeking in the future	Yes	12	37.5%
	No	19	59.3%
	Thinking of seeking in the future	1	3.1%

The study reveals significant insights into the demographic details, therapist belief, goal orientation, and counselor self-efficacy profiles of clinical psychologists. Predominantly young (25-35 years old) and unmarried, the participants are highly educated, with a majority holding M.Phil degrees and possessing considerable professional experience (3+ years). A notable finding is that more than half have never undergone therapy, which might influence their therapeutic beliefs and self-efficacy.

Therapists exhibit varying levels of beliefs, with a high mean score in low tolerance of distress, suggesting that many find it challenging to handle distressing situations. Conversely, the need for control and understanding scores the lowest, indicating less concern with maintaining control or fully understanding all therapy aspects.

Goal orientation analysis shows a stronger inclination towards learning over performance, highlighting a preference for development and improvement in professional competencies. This is further supported by the lower variability in learning goal orientation scores, suggesting consistency in the participants' desire to learn.

Counselor self-efficacy is highest in handling counseling challenges, reflecting confidence in dealing with complex cases, whereas session management is seen as less certain. This disparity indicates areas for potential training and support to balance self-efficacy across different professional tasks.

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

Table 2: Pearson’s correlation between therapist belief and counsellor Self-efficacy

	Helping skills self-efficacy	Session management self-efficacy	Counseling challenges self-efficacy
Low tolerance of distress	.314	.281	.251
Rigid adherence to therapeutic model	-.080	-.011	.046
Beliefs of responsibility	.328	.332	.251
Need for control and understanding	.421*	.485**	.341

*Correlation is significant at 0.05 level

**Correlation is significant at 0.01 level

Crucially, the study uncovers significant positive correlations between the need for control and understanding and both helping skills and session management self-efficacy. This relationship suggests that therapists who feel a stronger need for control and understanding also feel more efficacious in their skills and session management.

Table 3: Pearson’s Correlation between Counselor Self-Efficacy and Goal Orientation

	Helping skills self-efficacy	Session management self-efficacy	Counseling challenges self-efficacy
Learning goal orientation	.533**	.553**	.514**
Performance goal orientation	.296	.307	.333

*Correlation is significant at 0.05 level

**Correlation is significant at 0.01 level

Additionally, a robust positive correlation exists between learning goal orientation and all facets of counselor self-efficacy, underscoring the importance of fostering a learning-oriented mindset to enhance professional confidence and competence.

These findings provide valuable directions for developing targeted training programs that emphasize learning goal orientation and address specific belief systems to bolster overall self-efficacy among clinical psychologists. By understanding and supporting these dynamics, professional development initiatives can be more effectively tailored to meet the needs and enhance the capabilities of practitioners in the field.

DISCUSSION

The study aimed to explore the relationships between therapist beliefs, goal orientation, and counselor self-efficacy among clinical psychologists. The findings revealed significant insights into these relationships, leading to the acceptance of one null hypothesis and rejection of two.

Therapist Beliefs and Goal Orientation: The lack of significant correlation between therapist beliefs and goal orientation suggests that these constructs operate independently. Factors such as personality traits, coping strategies, and environmental influences may mediate these

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

relationships. Distress tolerance, adherence to therapeutic models, and beliefs of responsibility and control seem to develop through different pathways compared to goal orientations.

Therapist Beliefs and Counselor Self-Efficacy: A significant positive correlation was found, indicating that therapists with strong beliefs about their roles and adherence to therapeutic models tend to have higher self-efficacy. This suggests that self-efficacy and therapist beliefs are mutually reinforcing, contributing to a structured and confident approach to therapy. High self-efficacy helps therapists feel capable of managing therapy sessions effectively, which in turn strengthens their adherence to models and professional responsibilities.

Goal Orientation and Counselor Self-Efficacy: The positive correlation between learning goal orientation and counselor self-efficacy highlights the importance of a growth mindset in enhancing professional confidence. Learning-oriented counselors are more resilient, view challenges as growth opportunities, and engage in continuous professional development. In contrast, performance goal orientation, which focuses on external validation, did not correlate with self-efficacy. This indicates that intrinsic motivation and a focus on skill mastery are more crucial for developing self-efficacy in counselors.

Overall, the study emphasizes the significance of fostering learning goal orientations and reinforcing therapist beliefs to enhance counselor self-efficacy. These findings have important implications for training and professional development programs for clinical psychologists, suggesting that an emphasis on growth, learning, and strong professional beliefs can lead to more effective and confident practitioners.

CONCLUSION

This study illuminates the intricate relationships between therapist beliefs, goal orientation, and counselor self-efficacy among clinical psychologists. The findings reveal that while therapist beliefs do not significantly influence goal orientation, they positively correlate with counselor self-efficacy. This suggests that therapists' confidence in their abilities enhances their adherence to therapeutic models and sense of responsibility. Furthermore, learning goal orientation significantly boosts counselor self-efficacy, highlighting the importance of a growth mindset and continuous skill development for effective therapy outcomes. In contrast, performance goal orientation does not impact self-efficacy, indicating that intrinsic motivation and a focus on learning are more crucial for counselors' professional development and confidence. These insights contribute to the broader understanding of how individual differences and learning strategies influence therapy practices and outcomes, emphasizing the value of fostering learning-oriented environments for clinical psychologists.

Implications for theory and practice

This study highlights the importance of therapist beliefs and learning goal orientation in enhancing counselor self-efficacy. Therapists with strong beliefs in their professional roles and those who focus on learning goals tend to have higher self-efficacy. This relationship suggests that fostering a learning-oriented mindset and reinforcing professional beliefs can improve therapeutic outcomes. Further research with larger and more diverse samples is recommended to validate these findings and explore potential gender differences and cultural influences.

Strengths and limitations

Strengths: The study provides a comprehensive analysis of the relationship between therapist beliefs, goal orientation, and counselor self-efficacy among clinical psychologists. It highlights the importance of measuring goal orientation and understanding its connection to clinical psychologists' practices. The use of validated instruments such as the Goal Orientation Scale, CASES, and TBS-R ensures the validity and reliability of the results. Additionally, the diverse sample, which includes clinical psychologists from various regions of India and a range of demographic backgrounds, enhances the generalizability of the findings.

Limitations

Despite the strengths, the study has several limitations. The sample size of 32 individuals, while sufficient, may limit the applicability of the findings to larger populations. The cross-sectional design of the study restricts the ability to infer causal relationships between the variables. Moreover, the reliance on self-reported measures introduces the possibility of social desirability bias or inaccuracies in self-assessment. These limitations suggest the need for further research with larger and more diverse samples, as well as longitudinal studies to better understand the causal relationships between these variables.

Future Directions

To improve the generalizability of the results, more extensive and varied sample sizes should be used in future research attempts to duplicate this study. Longitudinal studies are required to investigate the directionality of the links between therapist beliefs, goal orientation, and counselor self-efficacy in order to establish causal relationships. It would be beneficial for future research to investigate additional psychological variables, such as job burnout, quality of life, etc., in order to obtain a more thorough understanding of the factors impacting the variables.

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Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

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Conflict of Interest

The author declared no conflict of interests.

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Fig 1: Flow Chart for the Study Procedure

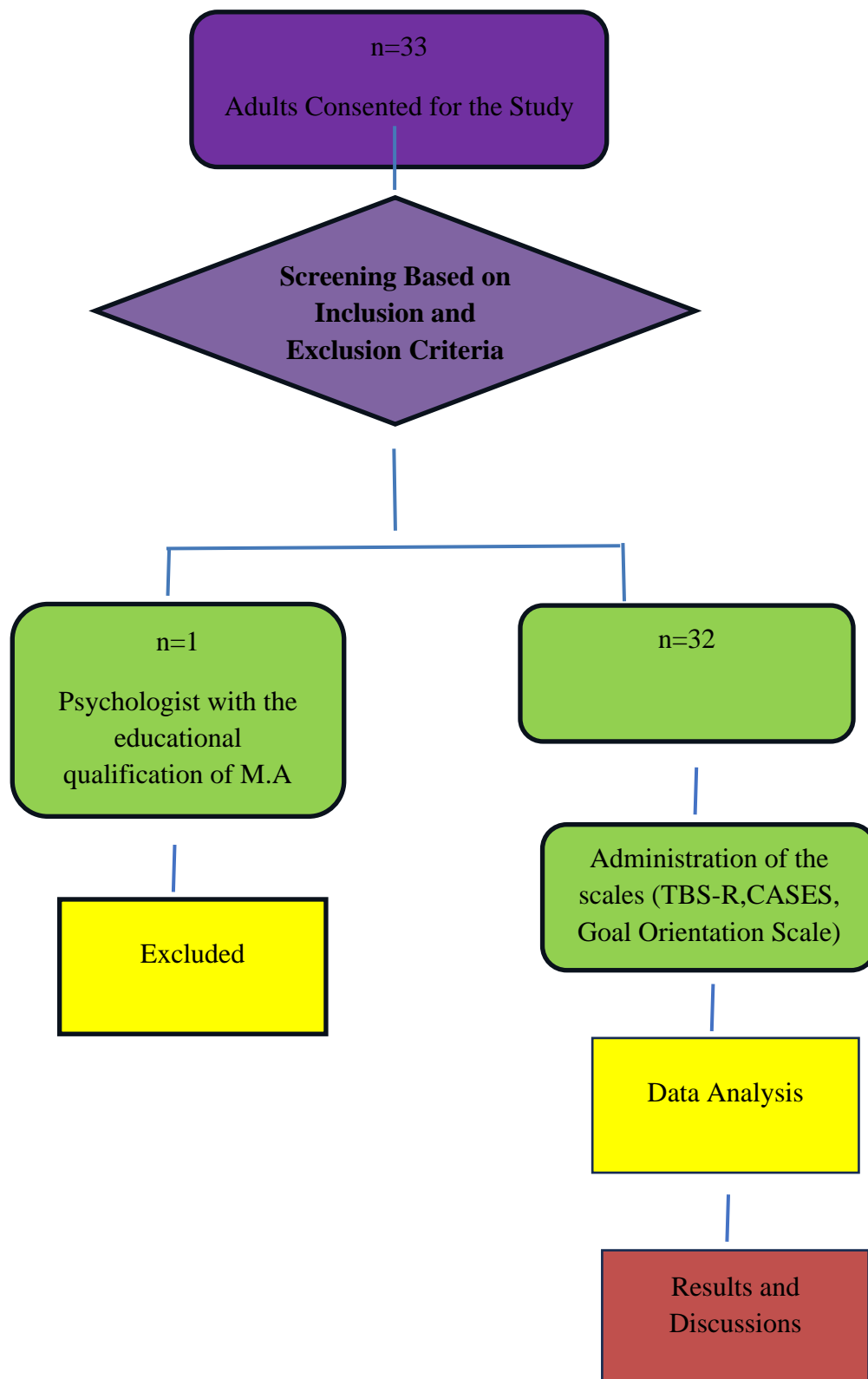


Fig 2: Demographic Age Distribution of the Participants

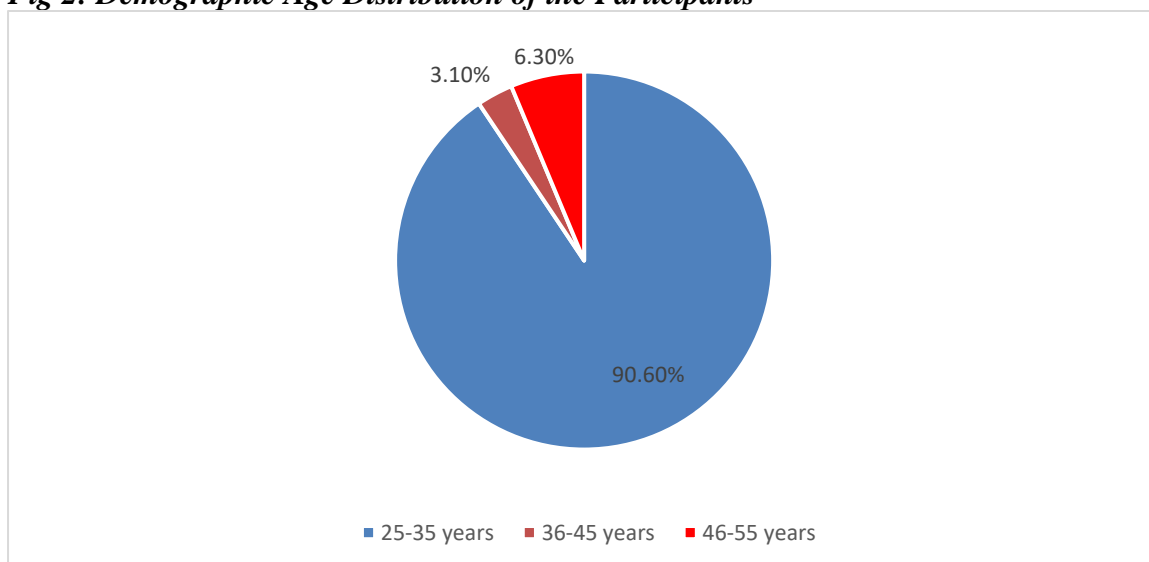


Fig 3: Demographic Marital Status of the Participants

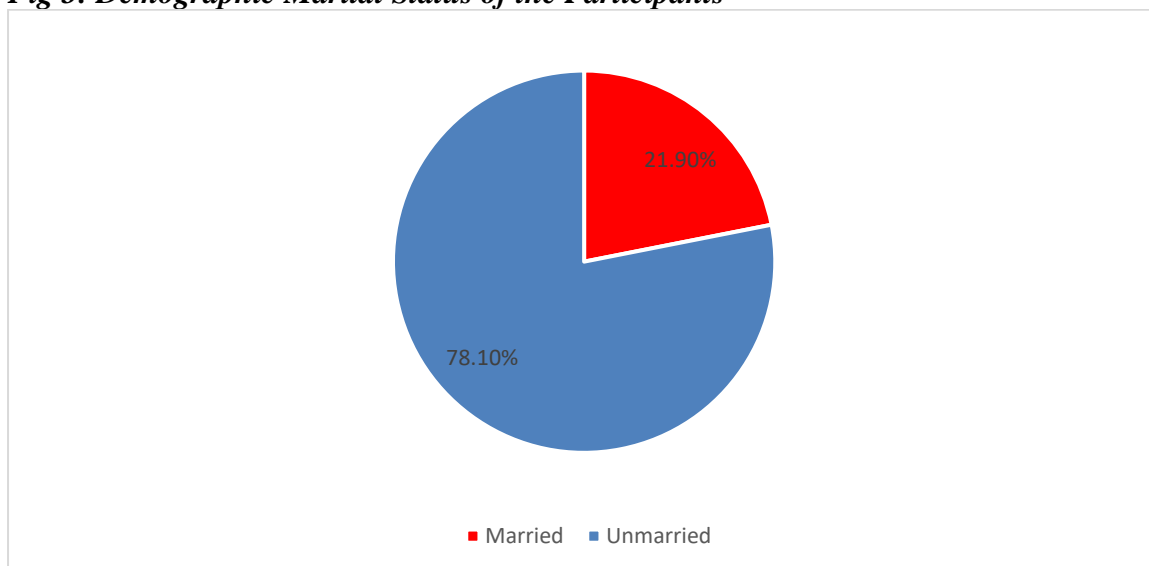


Fig 4: Demographic Work Experience Distribution of Participants

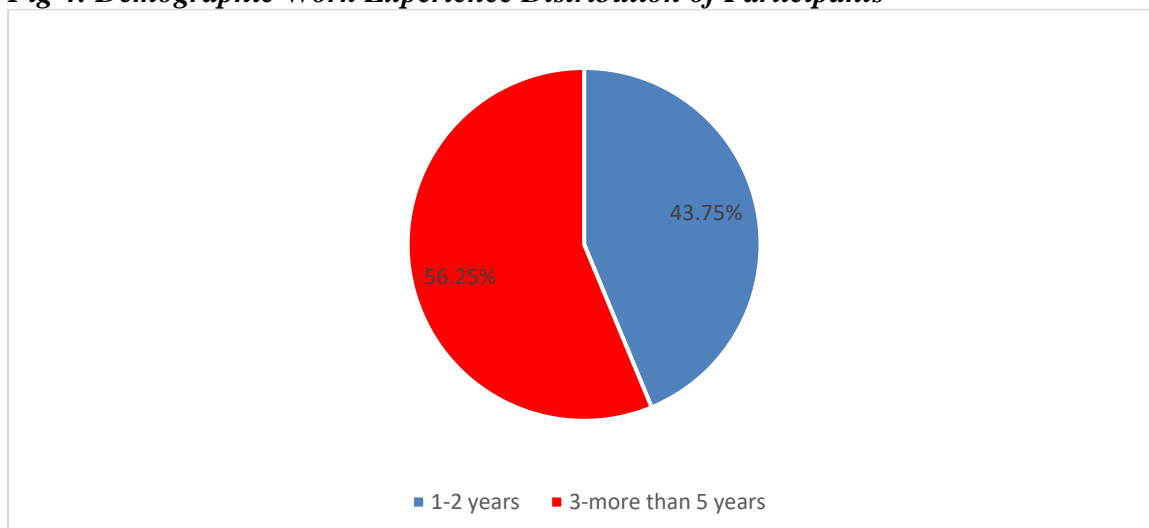


Fig 5: Demographic Educational Qualification Distribution of the participants

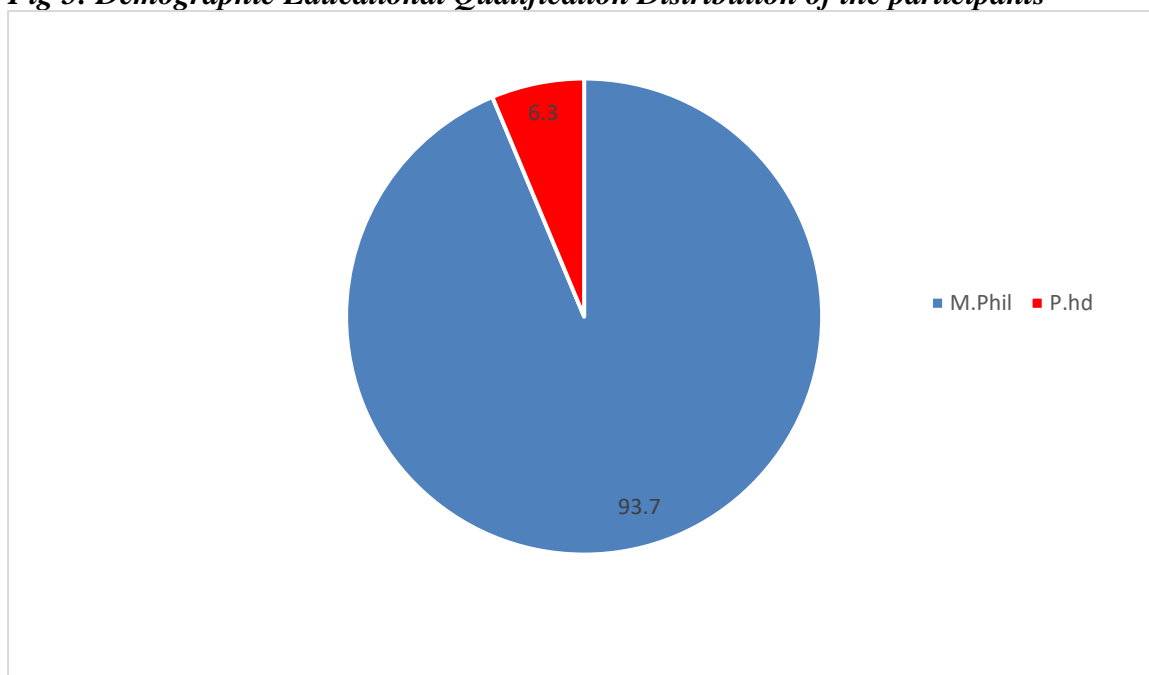
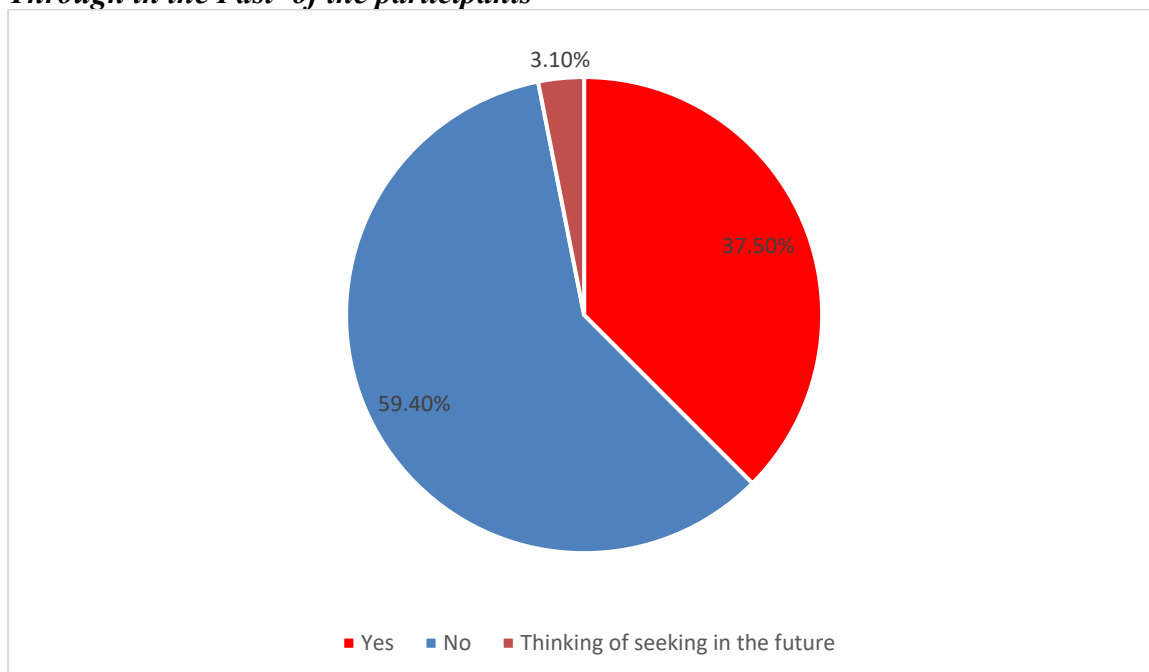


Fig 6: Demographic Distribution of 'Currently Undergoing Therapy or Have Gone Through in the Past' of the participants



Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

Fig 7: Scatter plot of correlation between Helping skills self-efficacy and Need for control and understanding

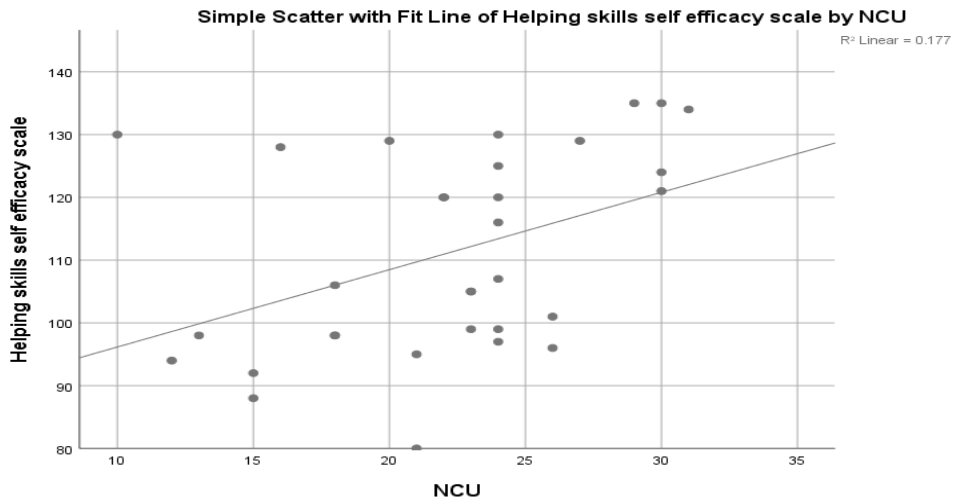


Fig 8: Scatter plot of correlation between Session management Self-Efficacy and Need for control and understanding

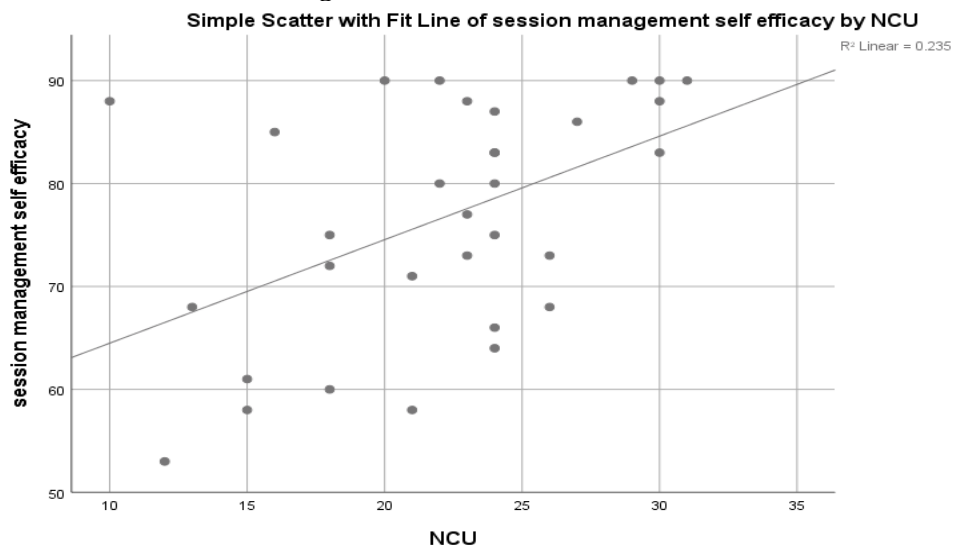
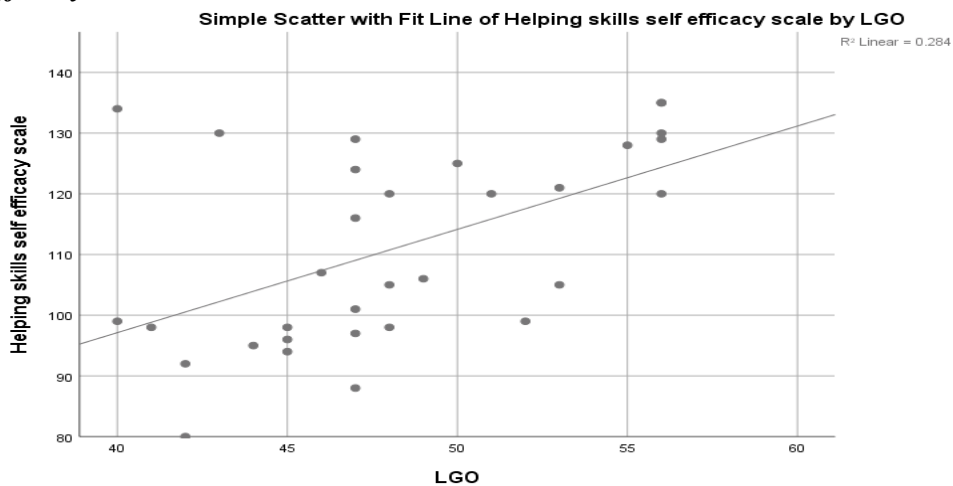


Fig 9: Scatter plot of correlation between learning goal orientation and helping skills self-efficacy



Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

Fig 10: Scatter Plot of Correlation between Learning Goal Orientation and Session Management Self-Efficacy

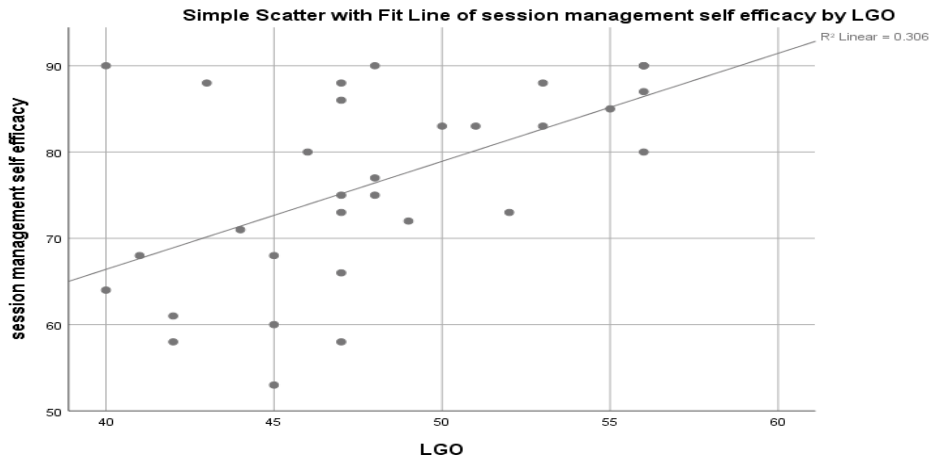


Fig 11: Scatter Plot of Correlation between Learning Goal Orientation and Counseling Challenges Self-Efficacy

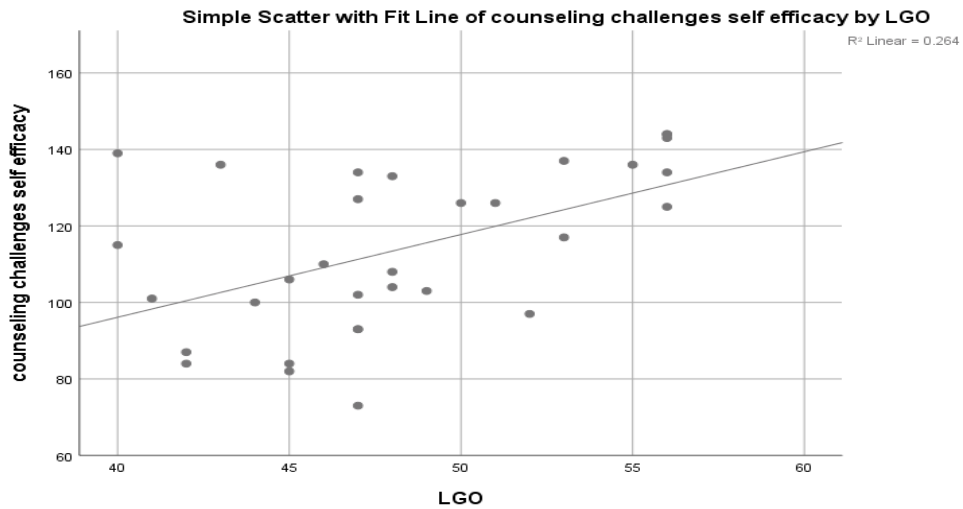
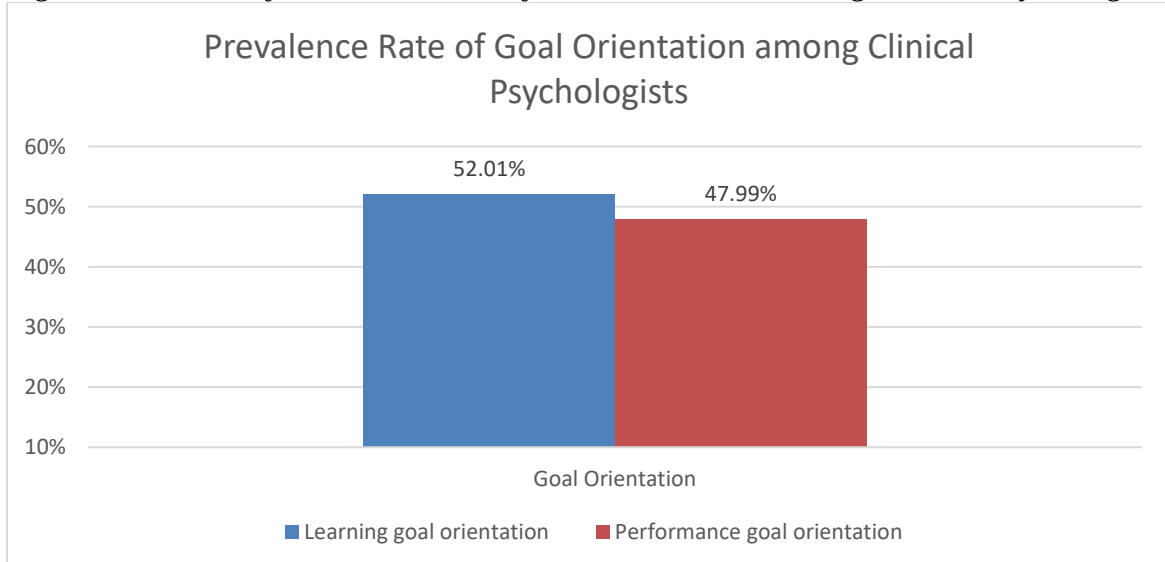


Fig 12: Bar Chart of Prevalence Rate of Goal Orientation among Clinical Psychologists



Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

Fig 13: Bar Chart of Prevalence Rate of Counselor Self-Efficacy among Clinical Psychologists

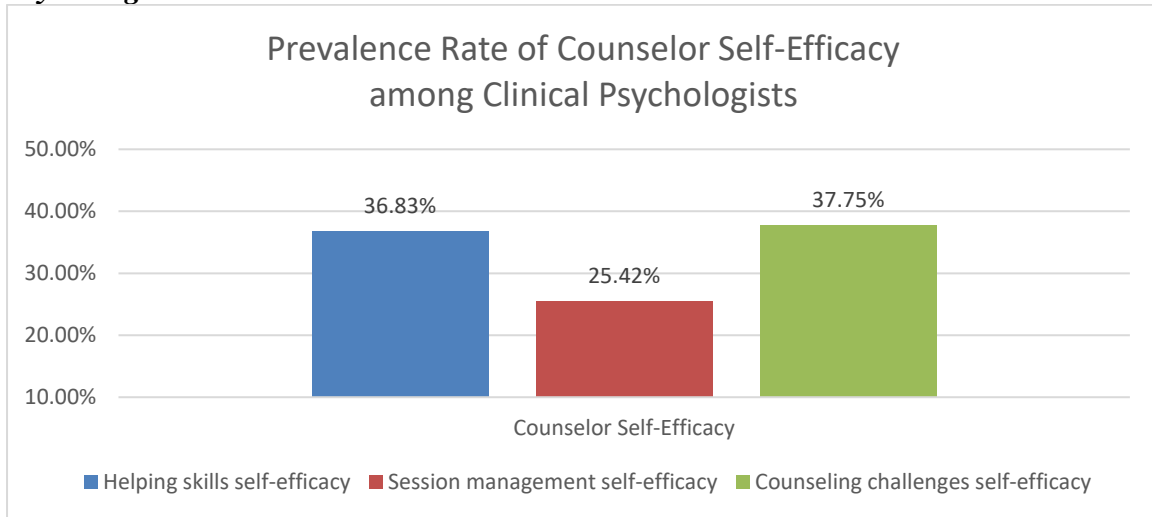


Fig 14: Bar Chart of Prevalence Rate of Therapist Beliefs among Clinical Psychologists

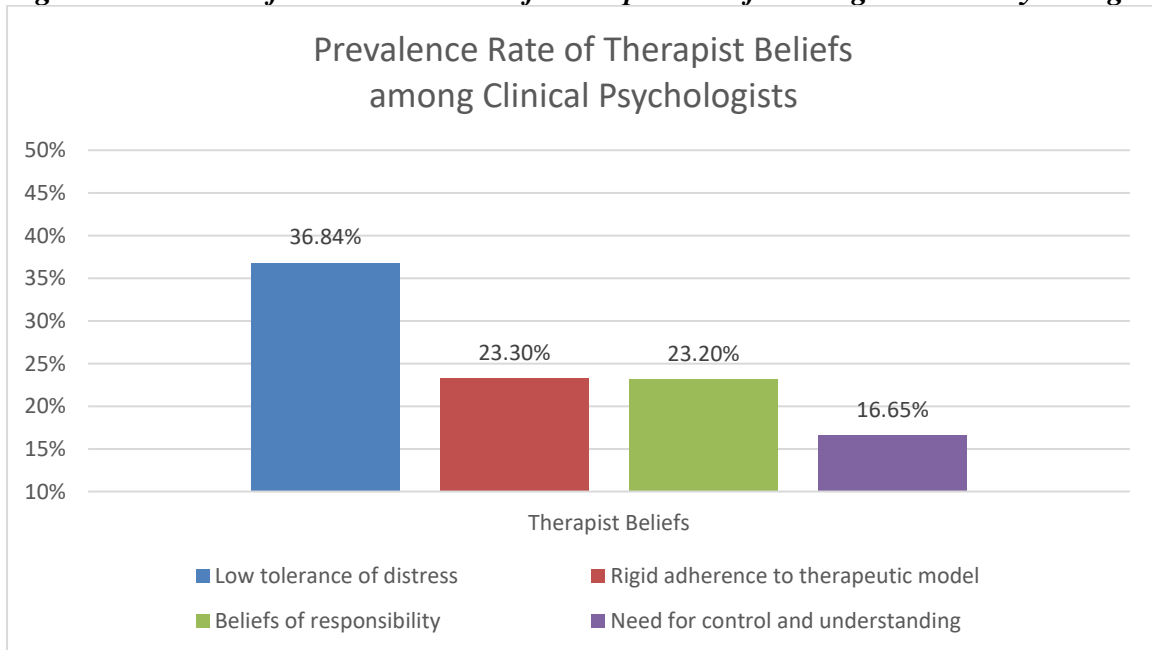


Table 1: Mean and Standard Deviations of scores on Therapist belief among the participants

	Mean scores	Standard Deviation (SD)	N
Low tolerance of distress	48.88	6.089	32
Rigid adherence to therapeutic model	30.91	4.291	32
Beliefs of responsibility	30.78	5.229	32
Need for control and understanding	22	5.456	32

Therapist Beliefs, Goal Orientation, And Self-Efficacy Among Clinical Psychologists

Table 2: Mean and Standard Deviations Score on Goal Orientation among the Participants

	Mean	Standard Deviation (SD)	N
Learning goal orientation	48.19	5.000	32
Performance goal orientation	44.47	7.144	32

Table 3: Mean and Standard Deviations Score on Self-efficacy among the Participants

	Mean	Standard Deviation (SD)	N
Helping skills self-efficacy scale	111.06	15.962	32
Session management self-efficacy	76.66	11.318	32
Counseling challenges self-efficacy	113.84	21.070	32

Table 4: Pearson's Correlation between Therapist Beliefs and Goal Orientation

	Low tolerance of distress	Rigid adherence to therapeutic model	Beliefs of responsibility	Need for control and understanding
Learning goal orientation	.279	-.157	.158	.274
Performance goal orientation	.308	-.113	.003	.255