A Mixed Methods Study Exploring Trainee Counsellors' Phenomenological Hindering Self-Focused Attention

Submitted by

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Acknowledgements

If I have seen further than others, it is by standing on the shoulders of giants.
Issac Newton

In my twenties, I could never have imagined pursuing a doctorate, so I want to thank myself for having the defiance to dream for I was taught "*Don't Dream"*.

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Statement of Sources Declaration

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published work of others has been acknowledged in the text and a list of references is given.

18 March 2024

Signature Date

Abstract

Background: Novice stress is an intense stress faced by trainee counsellors during training. Trainee counsellors who experience novice stress may feel anxious and distracted. Studies have reported that trainee counsellors who have higher self-efficacy beliefs and are more self-aware tend to manage novice stress better. In counselling literature, self-awareness is described as an inner resource that trainee counsellors utilise to cultivate a therapeutic alliance with clients, guide decision-making, build empathy, effect positive client outcomes and even prevent counsellors' burnout. However, when trainee counsellors experience momentary anxiety or other internal distractions such as hindering self-focused attention (HSA), HSA can become a barrier to trainee counsellors learning to become efficacious. HSA moments and their impact on trainee counsellors have been understudied, and the relationships between HSA, supervisory working alliance (SWA), and counselling self-efficacy (CSE) were not clear.

Aim: This thesis aims to explore the interpretations trainee counsellors make of their HSA moments. It is pertinent to investigate how HSA as a specific type of anxiety in the context of novice stress changes and affects the dynamics between SWA and CSE over the course of training.

Methods: The current study adopted the longitudinal interpretative phenomenological analysis (LIPA) and the single-case design to comprehensively look for the meanings trainee counsellors made out of their HSA moments. Ten participants signed up for the 18-month study. One participant withdrew from the study halfway through the training. Nine participants completed the study. Data were collected from three sources: semi-structured interviews conducted at two time-

points, one at the beginning and another at the advanced stage of training, monthly surveys, and journals.

Data Analysis: Qualitative data were analysed using the five-step IPA process to delve deep into participants' interviews and journals to gather themes from their HSA moments. Quantitative data were calculated using an online Tau-U calculator to analyse the trends, levels, and variability of HSA, SWA, and CSE for each participant. Visual graphs for each participant were displayed showing their mean scores over the 18 time-points. Both qualitative and quantitative findings were integrated to thoroughly comprehend each participant's HSA moment and presented as a single-case study for each participant.

Qualitative Findings: Beginning stage analysis generated three group experiential themes (GET) and eight subthemes: GET (1) Putting on different lenses to view HSA: (a) Exploring HSA through unpleasant childhood memories, and (b) Exploring HSA through culture and upbringing, GET (2) It is so uncomfortable yet familiar: (a) HSA as manifestations of critical thoughts, unpleasant feelings, bodily sensations and gestures, (b) HSA as covert desires, (c) HSA as learned childhood behaviours, (d) HSA as opportunities for growth, and GET (3) Building strengths, accepting vulnerabilities: (a) Engaging in HSA reflections, (b) Learning to be kind and patient with themselves. Advanced stage findings expanded on beginning stage findings: the beginning stage IPA subthemes "Exploring HSA through unpleasant childhood memories" and "HSA as learned childhood behaviours" were found to be less pervasive and therefore excluded from the advanced stage findings. Two new subthemes, "Exploring HSA through a counselling theory", and "Exploring HSA through a counsellor's perspective" were generated from the advanced stage IPA findings to reflect the participants' growth and development as counsellors with a

more defined professional identity. The other advanced stage subthemes remained similar to those in the beginning stage.

Quantitative Results: Survey data reported that most trainee counsellors experienced less frequent HSA moments across the three training contexts (in-session, supervision and coursework). Participants also reported improved working relationships with their supervisors and had higher self-efficacy beliefs at the end of their training. The results were statistically significant with very small effect sizes for in-session HSA ($\tau_{(time.score)}$ =-.19, p<.001) and also coursework setting HSA ($\tau_{(time.score)}$ =-.16, p=.01), and small effect size for supervision HSA ($\tau_{(time.score)}$ =-.36, p<.001). The results were also significant with small effect sizes for SWA ($\tau_{(time.score)}$ =.25, p<.001) and CSE ($\tau_{(time.score)}$ =.29, p<.001).

Combined Findings: Participants with higher self-efficacy beliefs and who reported a significant change in CSE over the course of training were found to be motivated, interpreted HSA moments as opportunities for growth, and perceived their supervisors as models. IPA narratives gathered that their supervisors provided them with mastery opportunities, modelling experiences and constructive feedback. Participants with higher self-efficacy beliefs and who reported non-significant CSE change over the course of training were found to be motivated and interpreted HSA moments as covert desires. IPA narratives gathered that they chose not to disclose their HSA moments with their supervisors, had limited learning opportunities, and seemed to have exaggerated CSE beliefs to manage feelings of inadequacy which affected the working alliances further. Participants with lower self-efficacy beliefs were found to be motivated, perceived HSA moments as related to their unpleasant childhood experiences and upbringing and had strong working alliances. IPA narratives gathered that they depended on their supervisors for support and the strong

working alliances mediated between HSA and their self-efficacy beliefs. Overall, the study found that trainee counsellors' stable counsellor characteristics and the presence of HSA moments increased their vulnerabilities and influenced their learning.

Discussion and Recommendations: The mixed methods research found that HSA moments as a specific type of anxiety were pervasive across various training contexts. The presence of HSA moments and the stable counsellor characteristics increased trainee counsellors' vulnerabilities during training which could become a barrier to trainee counsellors learning to be competent. These stable counsellor characteristics included culture and upbringing, socioeconomic background, and unpleasant childhood experiences. These factors could attenuate the dynamics between trainee counsellors' self-efficacy beliefs, counselling actions, and the proximal environment. Results found that strong supervisory working relationships could influence bidirectional interactions between HSA and CSE beliefs. Recommendations and strategies to manage HSA moments were included for counselling institutions and supervisors to support trainee counsellors who experience HSA and for trainee counsellors to manage HSA more effectively.

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List of Abbreviations

Counselling self-efficacy (CSE) relates to a trainee counsellor's beliefs and judgements or perception of one's level of competence in being able to effectively counsel a client (Larson et al., 1992).

Counselling competency refers to a set of counselling skills that are divided into three stages of the counselling process. These are exploring skills (such as eye contact, body language, and tone of voice), understanding skills (such as urgency, self-disclosure, and confrontation), and acting skills (such as decision-making skills, creating expectations, and reviewing goals) (Alis et al., 2018). In this study, it was established that CSE was not an indicator of trainee counsellors' counselling competence.

Hindering self-focused attention (HSA) is defined as "experiences of being troubled by an awareness of one's anxiety and other internal distractions that occur when providing counselling" (Wei et al., 2015, p. 43). In this study, HSA experiences refer to HSA during in-session, supervision and coursework training like lectures, peer role-plays and class activities.

Novice stress refers to intense stress faced by trainee counsellors during their course of training. Catalysts for novice stress included acute performance anxiety, illuminated scrutiny of professional gatekeepers, porous or rigid emotional boundaries, unrealistic expectations, fragile or incomplete counsellor-self, inadequate conceptual maps, and the need for positive mentors (Skovholt & Rønnestad, 2003).

Psychotherapy generally refers to a long-term intensive and extensive treatment in examining a person's psychological history (Corey, 2015) while counselling typically is a short-term consultation dealing with clients' present,

practical or immediate issues that are resolved on a conscious level (Singapore Association of Counselling [SAC], 2020a). In this study, both terms are used interchangeably as SAC-accredited programs prepare trainee counsellors in both areas.

Psychotherapist refers to practitioners who offers psychotherapy treatment for their clients while counsellors are practitioners who offers counselling. In this study, psychotherapist, counsellor, therapist, and practitioner are used interchangeably.

Self-awareness refers to broad synonymous terms like somatic awareness, felt information or felt sense (Coll et al., 2013; Fauth & Williams, 2005; Howard et al., 2006; Melton et al., 2005) and often a valuable resource in counselling as the counsellor uses one's emotions, thoughts, and bodily sensations in guiding their work with clients (Peace & Smith-Adcock, 2018).

Supervisory working alliance (SWA) refers to the dyadic relationship between the supervisor and supervisee. In the counselling context, this working alliance encompasses the mutual agreement on goals set by both the supervisor and trainee counsellor, bonded by feelings of trust, concern and likeness (Bordin, 1983; Efstation et al., 1990).

Social Cognitive Model of Counsellor Training (SCMCT) was developed by Larson. It was built upon Bandura's Social Cognitive Theory (Bandura, 1977, 1982). SCMCT claims humans as agentic force of their lives who can effect change in themselves and their environments through personal efforts. Adopting SCMCT positions trainee counsellors as agents of change in spite of novice stress to cope with HSA (Larson, 1998).

CHAPTER 1

Addressing the Gap in Counsellor Training: Introduction

> *One of the most distinguished characteristics of our profession is our intense focusing on highly skilled perspective taking: a combination of empathy, perceptual flexibility, tolerance for ambiguity and affective sensitivity. When successful, all of this translates into a profound ability to understand the world as other people understand it.* (Skovholt, 1988, p. 283)

1.1 Chapter Introduction

Success as a trainee counsellor is contingent upon effectively navigating the graduate experience. Trainee counsellors are typically required to take foundational modules, professional ethics, pre-practicum skills training, and multicultural studies courses during their entry transition (Harris & Flood, 2015). The counselling curriculum offers abundant opportunities for trainee counsellors to cultivate both practical skills and theoretical knowledge (Rønnestad & Skovholt, 2003). Thus, the development of trainee counsellors during the training is complex and challenging and trainee counsellors can experience intense stress from the demands of training. Novice stress which is characterised by intense stress is found to be a universal experience for trainee counsellors (Rønnestad & Skovholt, 2003).

The Social Cognitive Model of Counselor Training (SCMCT, Larson, 1998) which is translated from Bandura's social cognitive theory (Bandura, 1977) states that learning complex actions like counselling requires trainee counsellors to not only

execute the act of counselling but also possess a comprehensive understanding of how to effectively engage in it. This multifaceted process involves more than just implementing therapeutic techniques; it also requires trainee counsellors to cultivate a deep awareness of theoretical frameworks, interpersonal dynamics, and ethical principles. The model posits that trainee counsellors with higher self-efficacy beliefs (i.e., the belief in their counselling ability) are more likely to engage in self-aiding thoughts, establish more realistic expectations, and perceive anxiety as challenging rather than debilitating (Larson, 1998). Thus, the SCMCT assumes that trainee counsellors who have higher self-efficacy beliefs would be more effective in managing novice stressors such as navigating complex situations and coping with difficult emotions. Therefore, through the lens of the SCMCT, trainee counsellors who experience intense awareness of anxiety or inner state experiences such as hindering self-focused attention, even momentarily, may face obstacles in executing effective actions. Additionally, they are susceptible to novice stress, a phenomenon characterised by feelings of overwhelm and uncertainty inherent in the early stages of professional development (Rønnestad & Skovholt, 2003). Trainee counsellors may find themselves grappling with a myriad of emotions, such as self-doubt and heightened sensitivity to the emotional experiences of their clients. These overwhelming emotions can hinder trainee counsellors from fully embodying their role as human agents of change within the therapeutic relationships affecting their development as competent practitioners.

This research was undertaken to explore the experiences of nine trainee counsellors' momentary hindering self-focused attention (HSA) over the course of their training. The study wanted to examine the relationship between HSA, supervisory

working alliance (SWA), and counselling self-efficacy (CSE) over the course of training to comprehend how HSA affected trainee counsellors' self-efficacy beliefs in effecting actions. The longitudinal mixed methods study with a bigger qualitative arm (Big QUAL) and a smaller quantitative dataset (small quant) or the QUAL-Quant study was conducted to illuminate trainee counsellors' interpretation of their HSA, and how they progress with the support of a strong SWA from the beginning stage to advanced stage to become human agents; translating the SCMCT into practice.

This introductory chapter will provide context for the study by discussing the researcher's motivations related to the area of research interest, the study's background, purpose, and research questions. Additionally, the chapter will discuss the research's significance. This chapter will conclude with a summary of the remaining chapters in this thesis.

1.2 Personal Motivation

In this section, the first-person narrative will be used as part of the researcher's reflexivity. Reflexivity refers to the ongoing process where the researcher reflected on her own biases, assumptions, and presuppositions (Smith, 2019; Smith & Nizza, 2022). Throughout the process, the researcher acknowledged and examined how her personal experiences and cultural background influenced her interactions with participants, as well as the data collection and interpretation processes. The practice of reflexivity enhances the transparency and credibility of the research (Smith & Nizza, 2022). There is an overlap between reflexivity, self-awareness and reflection. While self-awareness is the conscious knowledge of one's own internal states and processes (Williams et al., 2008), reflection involves critically thinking about one's experiences, including actions

and responses (McGillivray et al., 2015). Therefore, both self-awareness and reflection are important components of reflexivity.

By the time I submitted this thesis, I would have advanced far beyond the stage of a trainee counsellor. As I reflected on the journey, I could not help but wonder what difference it would make to my training journey if I knew something like hindering self-focused attention or rather, self-awareness was nuanced (i.e. self-awareness as a state versus self-awareness as a trait). In general, the maxim "know thyself" is synonymous with true wisdom in the therapeutic setting, because when counsellors are aware of their personalities, beliefs, and weaknesses, they will genuinely know what to learn, what to change, and how to work as effective counsellors. According to Socrates, an unexamined life is unworthy of living, and presumably, a well-examined life would require continuous introspection.

I experienced a few significant moments of hindering self-focused attention (or HSA) during my time as a trainee counsellor that evoked critical thoughts and unpleasant emotions. Whilst momentary, the awareness was hindering for it affected my learning outcomes. During an in-session, I became suddenly aware of my critical thoughts and fear of failure. I overcompensated my anxiety with excessive activities for the client without considering the client’s physical health constraints. On that occasion, I received an unfavourable report about my conduct. There was another occasion when I became suddenly aware of my bodily sensations which was similar to shame with an intense desire to hide away during a particular group discussion. For that activity, I kept quiet and remained guarded throughout the group activity. In those experiences, I walked away feeling “less”; less competent, less integrated in my role, and a less sense of “self”.

In retrospect, what could have been helpful for me back then was to have known what I was experiencing, and to have a mentor to explore those experiences with me.

Over the course of training, I experienced more frequent HSA moments in the beginning stage than in the advanced stage. HSA affected how I perceived my professional self. I felt pressure to perform and was dependent on my supervisor for approval. Personal agency was a delusive idea for I did not feel that I could exercise control, especially after receiving a negative report about my supposedly counselling action. Thus, it became evident that I experienced more novice stress while undergoing training. Things became more optimistic for me when I came across the study on in-session distracting self-awareness (Fauth & Williams, 2005). I felt relieved and excited that there was an explanation for what I was experiencing back then. Naturally, the topic became my research interest. Additionally, I discovered that HSA and countertransference have similarities, but both are distinct concepts. To learn more about HSA and how it relates to self-efficacy beliefs and personal agency, I chose to devote my efforts to investigating HSA and many times, I found myself stuck in the rabbit hole of HSA. However, I am glad that it is getting clearer for me.

1.3 Background of Research

The intense stress faced by trainee counsellors during the course of their training has been defined as novice stress (Skovholt & Rønnestad, 2003, Gutierrez et al., 2017; Rønnestad et al., 2019). Skovholt and Rønnestad identified seven novice stressors: performance anxiety, scrutiny of professional gatekeepers, rigid emotional boundaries, fragile practitioner-self, inadequate conceptual maps, unrealistic expectations, and acute need for positive mentors. Studies have found that novice stress can have a significant

impact on trainee counsellors' growth and development during training (Pierce, 2016; Skovholt & McCarthy, 1988; Skovholt & Rønnestad, 2003; Thompson et al., 2011). Novice stress can potentially result in trainee counsellors experiencing compassion fatigue, burnout or even premature exit from the profession (Beaumont et al., 2016; Rønnestad & Skovholt, 2013; Skovholt & Rønnestad, 1992a; Star, 2013; Swords & Ellis, 2018; Thompson et al., 2011). Naturally, trainee counsellors who experience novice stress tend to feel more anxious and less efficacious. Studies have reported an inverse relationship between anxiety and CSE (Friedlander & Snyder, 1983; Larson et al., 1992). Applying the SCMCT to the context of novice stress in training, trainee counsellors who experience HSA of anxiety and critical self-talk are likely to have lower self-efficacy beliefs in counselling and as a result make less self-aiding decisions that can impact the training environment.

Despite the recognised benefits of self-awareness, trainee counsellors who place too much attention on their distracting thoughts and feelings (such as HSA) for a transitory moment may be impeded in their therapeutic works (Nutt-Williams & Hill, 1996; Williams, 2003; Williams, Hurley, et al., 2003). Additionally, HSA could make it harder for trainee counsellors to manage novice stressors; they may personalise HSA as incompetence, especially for those with limited support from their supervisors. According to the SCMCT, trainee counsellors who perceive anxiety (such as HSA) as debilitating may experience cognitive and affective inflexibility that can prevent them from becoming human agents in their training environment (Larson, 1998).

Numerous studies emphasise the importance of developing and maintaining supervisory alliances for trainee counsellors (e.g. Orlinsky et al., 2005; Ybrandt et al.,

2016) and as a prerequisite for basic counsellor training and learning (Ladany, 2004; Ladany et al., 2013; Orlinsky et al., 2005; Rønnestad & Skovholt, 1993). The relationship between trainee counsellors' CSE and SWA has been given much attention. Studies have confirmed that the dyadic relationship between the supervisor and the trainee counsellor is essential to promoting supervisees' counselling self-efficacy (Alaedein, 2014; Bordin, 1979, 1983; Carr, 2017). This is especially crucial for trainee counsellors who are susceptible to novice stress, such as those who hold glamorised or unrealistic expectations of themselves and rely on external validation (Skovholt, 1988; Skovholt & Rønnestad, 2003). The SCMCT underscores the importance of modelling and social persuasion in supervision in developing trainee counsellors' CSE (Caldwell et al., 2018; Lehrman-Waterman & Ladany, 2001). Results from other studies have indicated that a strong SWA has a positive association with trainee counsellors' self-disclosure (Ladany et al., 1997; Ladany & Walker, 2003) satisfaction (Ladany & Friedlander, 1995, 1995) and feedback (Hoffman et al., 2005). Numerous studies have confirmed that ineffective supervision can have an adverse effect on trainee counsellors' CSE and actual performance (e.g. Holloway & Todres, 2003; Humeidan, 2002; Larson & Daniels, 1998; Ybrandt et al., 2016). Therefore, a strong SWA holds the potential to serve as a dual facilitator, moderating both stress levels and counselling competence among trainee counsellors. When trainee counsellors perceive a strong sense of safety and trust within the supervisory relationship, they are more inclined to discuss their challenges and vulnerabilities. This fosters an environment conducive to implementing self-aiding actions aimed at promoting self-efficacy (Bandura, 1993).

1.4 Research Gap

Most concepts and theories of self-awareness hold positive connotations such as stating that self-awareness can enhance trainee counsellors' professional effectiveness and build personal growth. However, HSA has received scant research attention. The existing research uses cross-sectional quantitative designs that risk portraying HSA as a fixed phenomenon (e.g. Fauth & Williams, 2005; Nutt-Williams & Hill, 1996; Wei et al., 2015, 2017). Perceiving HSA as static can be problematic such that when trainee counsellors perceive HSA as static, their desire to address it decreases (Bandura, 2015). Additionally, trainee counsellors may interpret HSA as a personal incapacity, rather than a developmental process, as studies have revealed that trainee counsellors can be extremely critical of themselves (Skovholt & Rønnestad, 2003). To overcome the limitations of the abovementioned cross-sectional studies on HSA, there is a pertinent need to explore trainee counsellors' HSA over time. Pertaining to the current study, HSA is operationalised as a significant experience or more specifically, a moment of heightened awareness of one's anxiety and internal distraction (Wei et al., 2017) during training. Thus, exploring trainee counsellors' interpretations of HSA and how it contributes to their developmental process requires a longitudinal approach.

Akin to self-awareness, a positive SWA can be a valuable resource for trainee counsellors. The relationship between trainee counsellors' HSA and SWA, on the other hand, has not been thoroughly explored. Therefore, the current longitudinal mixed methods research on HSA was conducted to investigate how trainee counsellors made sense of their HSA, how HSA changed over the course of training and how HSA related to SWA and CSE.

1.5 Research Significance

Being the first study to explore trainee counsellors' phenomenological HSA over 18 months, this longitudinal study sought to advance knowledge in the field and build on previous research by placing an experiential focus on trainee counsellors' HSA. The study further contributed to the developmental model of the SCMCT. Findings from the current study can be applied to counsellor development; supervisors might consider using the results as a reference in thinking about the salient constructs as introduced in the SCMCT, and when individual differences as found in the current findings (i.e., trainee counsellors who experience HSA) could potentially become a barrier to personal agency. Additionally, the research design which was also the first to combine longitudinal IPA and monthly survey data, provided a critical understanding of HSA and its relationships to other variables (i.e., supervisory working alliance and counselling self-efficacy) over time.

1.6 Research Objectives

The current research aimed to meet four research objectives:

1. To explore trainee counsellors' phenomenological HSA and meaning-making of HSA over the course of training.
2. To understand how trainee counsellors reflect on and learn from these HSA and the contexts around their HSA over the course of training.
3. To investigate the patterns of change for HSA, supervisory working alliance (SWA), and counselling self-efficacy (CSE) over the course of training.
4. To understand how changing HSA relates to SWA and CSE over the course of training.

1.7 Research Questions

To meet the abovementioned objectives, the current study aimed to answer the following research questions (RQ):

RQ1. How do trainee counsellors make sense of and interpret their HSA over the course of training?

RQ2. How do trainee counsellors reflect on and learn from their HSA and the contexts around their HSA over the course of training?

RQ3. Are there observed individual changes in the level, trend, and variability of trainee counsellors' HSA, CSE, and SWA over the course of training?

RQ4. How does trainee counsellors' changing HSA relate to changes in SWA and CSE over the course of training?

1.8 Thesis Overview

This thesis comprises the remaining chapters as follows:

1.8.1 Chapter 2 Locating the Gap in Counsellor Training: Literature Review

Provides in-depth discussion of the articles reviewed for the project, as well as the philosophical and theoretical frameworks used in this study. This results in the identification of the research gap that needs to be addressed with this project.

1.8.2 Chapter 3 Addressing the Gap in Counsellor Training: Methodology

Provides context for pragmatism as a research paradigm within which the current mixed methods research is conducted. Identifies the research design used in this study

for the purpose of addressing the research problem, providing answers to a set of research questions, and adhering to research ethics and commitment.

1.8.3 Chapter 4 Findings for the Beginning Stage Training: The Phenomenology of HSA

Presents qualitative data gathered from interviews and monthly reflective journals from the beginning stage of training. Group Experiential Themes are identified from interview transcripts and monthly journals. Participants' quotes are provided to illuminate their HSA in the beginning stage. Cross-case analysis compares nine participants' HSA to provide an in-depth exploration of similarities and differences across cases.

1.8.4 Chapter 5 Findings for the Advanced Stage Training: The Phenomenology of HSA

Presents qualitative data gathered from interviews and monthly reflective journals from the advanced stage of training. Group Experiential Themes are identified from interview transcripts and monthly journals. Participants' quotes are provided to illuminate their HSA in the advanced stage. Cross-case analysis compares nine participants' HSA (after one withdrew from the study) to provide an in-depth exploration of similarities and differences across cases.

1.8.5 Chapter 6 Trajectories Across Training: The Longitudinal Phenomenology of HSA

Provides detailed accounts of two participants, Lynn and Beatrice's moments of HSA, which spanned across the beginning and advanced stages. Visual graphics and

survey results are included to strengthen their HSA narratives and to report temporal changes with numerical data.

1.8.6 Chapter 7 Addressing the Gap in Counsellor Training: Discussion and Implications

Discusses the significance of the findings gathered from the study. It focuses on what was critically evaluated in Chapter 2 in relation to the past and extant literature and makes an argument in support of the study's overall conclusion. It discusses possible explanations for discrepant findings and details the study's limitations. The chapter makes additional research recommendations to training institutions, supervisors, and aspiring counsellors based on the SCMCT.

1.8.7 References

Contains a list of all the sources that are cited in the thesis. These sources include journal articles, theses and academic textbooks on counselling and research.

1.8.8 Appendices

Contains supplemental materials utilised in the research, data analysis, and presentation of findings. These materials consist of tables, raw data extracted from transcripts for IPA analysis, sample questionnaires, interview schedules, and a compilation of poetic evocations derived from transcripts of participants.

1.9 Chapter Conclusion

The chapter provided an overview of the study and where the research was situated. It introduced the SCMCT as the developmental model that informed and contextualised the current study. It briefly discussed the impact of HSA from novice stressors that could impede training outcomes. The chapter ended with a synopsis of each chapter of the thesis. Chapter 2 will discuss and evaluate the existing literature and identify the knowledge gap for this study.

CHAPTER 2

Locating the Gap in Counsellor Training: Literature Review

> *The process of undergoing counsellor training can have a profound effect on participants. Often, people on training courses have a sense of being asked to look at who they are from a different perspective, through the framework of the therapy approach that they are learning. This can be an exciting and liberating experience, but it can also be felt as a threat to the basis of one's pre-existing sense of self.* (McLeod, 2013, p. 593)

2.1 Chapter Introduction

In the context of counsellor education, the principal aim of a literature review is to methodically examine and synthesise extant scholarly works and empirical research that are pertinent to the discipline. This comprehensive examination aims to identify gaps, trends, and theoretical frameworks within the literature, providing a foundation for evidence-based practice in counsellor education.

In light of the aforementioned propositions, this review will introduce the training model, the Social Cognitive Model of Counselor Training (SCMCT), which serves as the theoretical framework for the study. Moreover, it will expound upon the salient concepts germane to the investigation, namely, novice stress, supervisory working alliance (SWA), counselling self-efficacy (CSE), and self-awareness; specifically hindering self-focused attention (HSA). The subsequent discourse will draw

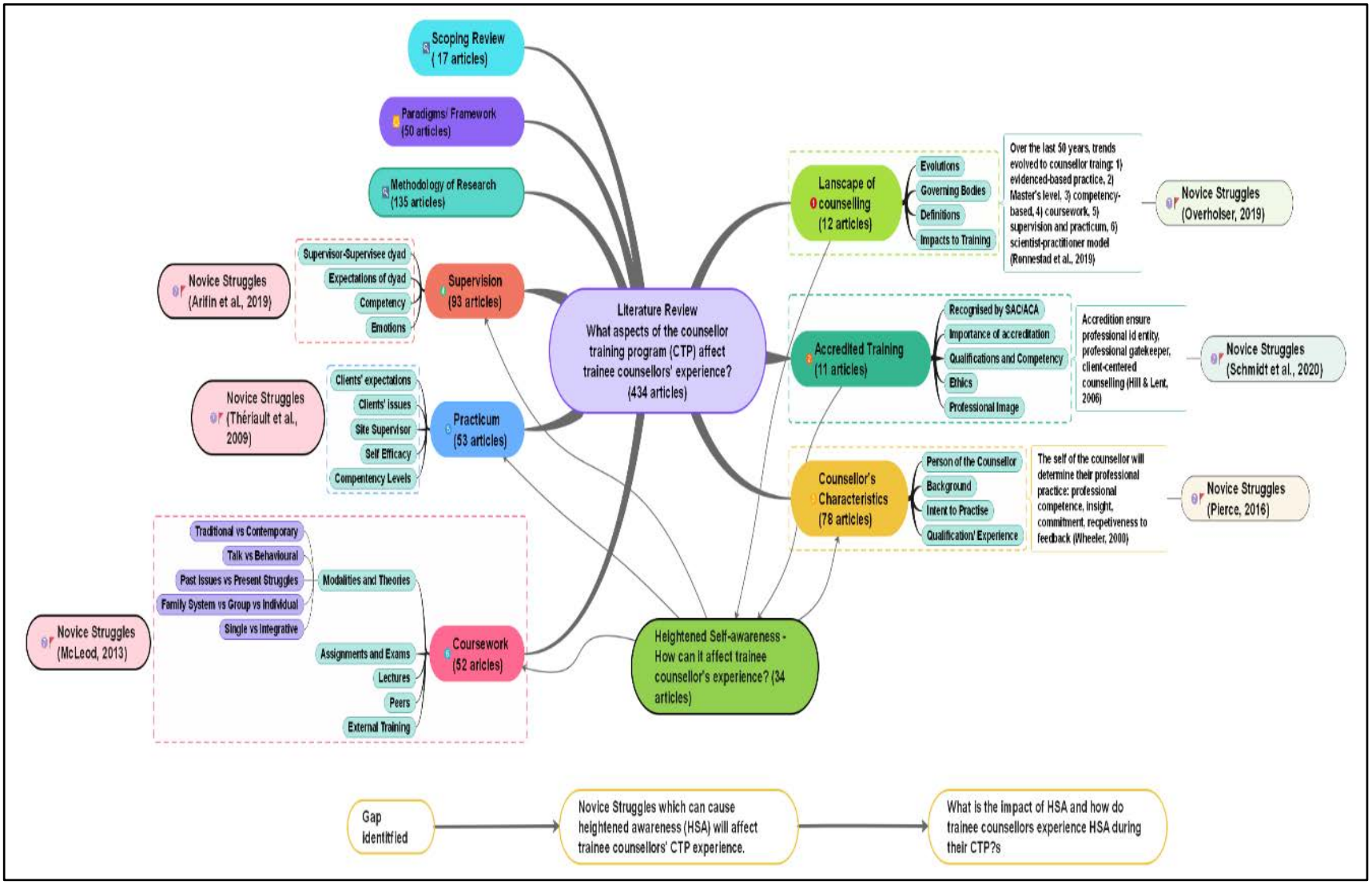
upon both empirical and conceptual literature to scrutinise and elucidate the interrelationships among the primary concepts. This analytical approach is intended to contextualise the research within the broader landscape of counsellor development and facilitate the translation of the SCMCT into practical application, particularly in understanding the role of HSA within the overarching framework. The comprehensive literature review aims to establish a foundation for the current inquiry, ensuring that the research is situated within the existing scholarly discourse and contributes meaningfully to the advancement of the field.

2.2 Review Strategy in Qualitative Research

The current study employed a qualitative design which comprised the majority of the current study and was complemented by a smaller quantitative arm. Throughout the thesis, QUAL-quant study will be used to refer to the current mixed methods study. By utilising the James Cook University library as the main search engine alongside ProQuest, Web of Science, JSTOR, Google Scholar and PsycINFO, a broad search using keywords and keyword combinations included trainee counsellors, novice, growth, development, supervision, self-awareness, perceptions. Boolean operators AND, OR, and NOT were used as they allowed the search to be broadened and narrowed. Truncation for words with multiple endings like ‘trainee’ and ‘trainees’, words with specialised spellings like ‘counsellor’ and ‘counselor’, nesting to group similar terms, and field tags like [ti], [tw] or [tiab], were used to run the different searches. A concept map was drawn up to give a clearer perspective of the review process and help identify potential gaps in the knowledge base (See Figure 1).

Figure 1

The Concept Map of Searching for Relevant Literature



In this study, Zotero was used as biographic software owing to its user-friendly, payment-free and intuitive mode of navigation and data management for any beginning researchers. The following section will discuss the main concepts and the relationships between these concepts from the counselling corpus.

2.3 Theoretical Framework

The current study adopts the Social Cognitive Model of Counselor Training (SCMCT, Larson, 1998) as its theoretical framework (See Figure 2).

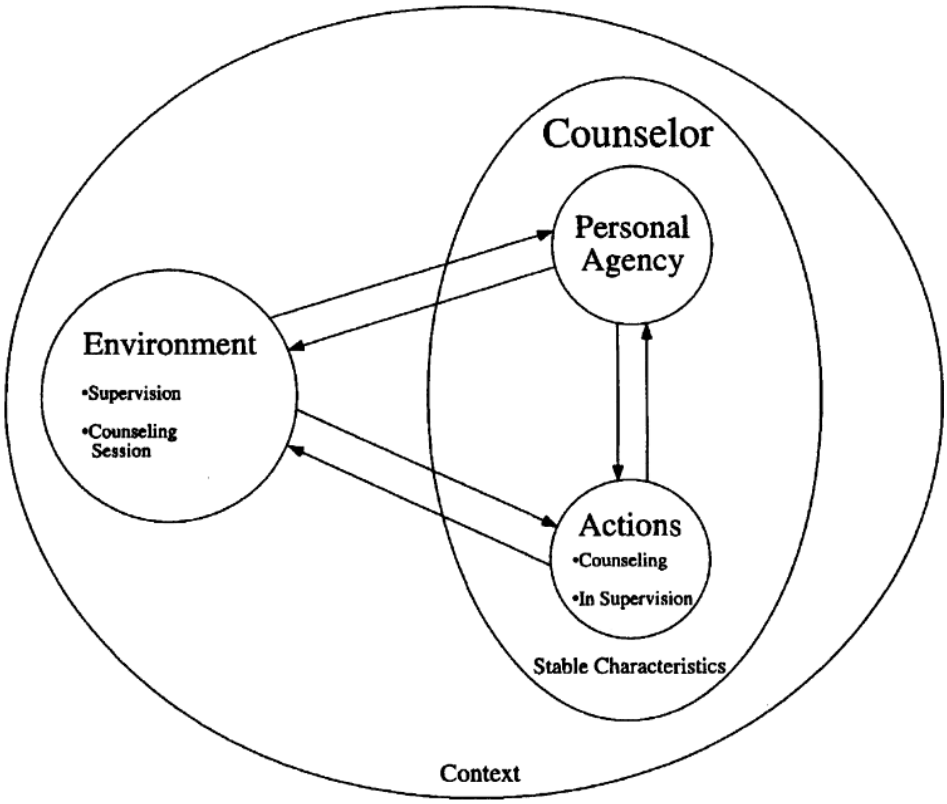
2.3.1 The Social Cognitive Model of Counsellor Training (SCMCT)

The SCMCT was built upon Bandura's Social Cognitive Theory (Larson, 1998; Larson et al., 1992; Larson & Daniels, 1998). It is a comprehensive model, typically used by supervisors and training institutions, that incorporates all aspects of counsellor training securely in a theoretical framework (Kincade, 1998). Therefore the SCMCT is a model of counsellor training (i.e., often didactic with the emphasis on the acquisition of specific skills and competencies for effective counselling practice) rather than a model of counsellor learning (i.e., broader than the acquisition of skills but extends to a comprehensive understanding of theories, ethics, and critical reflection) (Jacob et al., 2020). Considering the breadth and scope of the model, it is not within the scope of the current study to incorporate all the concepts of the SCMCT but to focus on the three primary components of the model namely, trainee counsellors' personal agency which are their self-determining influences, trainee counsellors' effective actions in counselling and supervision, and their proximal environment in which the learning of those counselling actions primarily takes place. According to the SCMCT, personal agency,

actions, and the environment operate in bidirectional reciprocity which is referred to as triadic reciprocal causation.

Figure 2

Triadic Reciprocal Causation in the Social Cognitive Model of Counselor Training



Note. Triadic reciprocal causation. From "The social cognitive model of counselor training," by L. M. Larson, 1998, *The Counseling Psychologist*: The social cognitive model of counselor training, 26(2), 219-273 (https:dor.org/10.1177/0011000098262002). Copyright 2016 by the American Psychological Association

Applying triadic reciprocal causation from the social cognitive theory to counsellor training, the SCMCT underscores the salient factors of personal agency, effective actions, and the proximal environments in which trainee counsellors learn and

carry out counselling actions (Larson, 1998). In simple terms, personal agency refers to the self-determining aspects of trainee counsellors; CSE as well as other cognitive, affective, and motivational processes that bidirectionally influence trainee counsellors' actions and their environments. Trainee counsellors' efficacious actions include observable actions that directly and indirectly result in trainee counsellors' learning to be more efficacious with clients and mastery experiences that contribute to increasing CSE. The proximal environment includes supervision and counselling sessions where trainee counsellors can select and observe appropriate models (i.e., their supervisors, peers, and recordings), and gain mastery experience in seeing clients (i.e., under optimal conditions like having a sufficient number of clients who come regularly).

The SCMCT would assume supervisors perform and provide three salient functions: modelling experiences, social persuasion, and supervisor feedback. According to the model, the provision of modelling experiences provides trainee counsellors with multiple opportunities for vicarious learning to increase CSE; supervisors model the desired counselling action and facilitate behavioural rehearsal where trainee counsellors model after their supervisors' actions. Social persuasion includes the supervisors being persuasive in influencing trainee counsellors' chances of counselling success. This would include providing trainee counsellors with realistic and supportive encouragement, and clearly identified supervision tasks. The SCMCT highlights the importance of supervisors' feedback as an impetus for mastery; trainee counsellors learn to focus on aspects that are essential to effective counselling through receiving constructive, specific, positive and changeable feedback. The SCMCT underscores the importance of trainee counsellors themselves, their supervisors, clients, and the training

environments being within acceptable ranges for them to become effective counsellors. Larson (1998) claimed that stable counsellor characteristics (such as the five factors of personality, ethnicity, sexual orientation, aptitude, social economic status, values, self-esteem, developmental stage, and health status) could increase counsellors' vulnerabilities and potentially interact with the training environment to become a barrier to counsellors learning to become effective in counselling (Larson, 1998).

In Larson's example, she described how the racial background of the counsellor, supervisor and client can impact the counselling (or learning) process. For instance, when the client (or counsellor and supervisor) has experienced racial discrimination from a major group, the presence of a counsellor from that same racial group may lead to challenges in establishing rapport and trust with the client. This dynamic may also be present between the counsellor with prior racial discrimination with the supervisor. Other stable counsellor characteristics that may attenuate the triadic reciprocal relationships include counsellors' socio-economic status, personality and beliefs from the counsellors' culture and upbringing, and childhood events (like negative childhood experiences).

The following example illustrates how the triadic reciprocity of the SCMCT works in a best-case scenario to effectively train the counsellors under the optimal condition; the trainee counsellors, their supervisors, clients, and the environment all work within the acceptable range. Ideally, the trainee counsellors with personal agency would have slightly optimistic CSE beliefs; they tend to view counselling outcomes as positive; set clear, specific, and moderately challenging goals for themselves, have manageable anxiety, report more positive self-evaluations and view their counselling

performance in a constructive way. Their supervisors would provide them with specific examples of themselves in the counselling acts, and the trainee counsellors would model after their supervisors, and receive feedback that was specific, constructive, and positive. The trainee counsellors would feel safe and trust their supervisors who would further enhance their counselling success with encouragement and opportunities for mastery. The trainee counsellors would feel motivated to practise their knowledge and skills with their clients. The trainee counsellors would be given an adequate number of cases by the site managers, and the cases would be moderately difficult. The trainee counsellors would continue to be supported by their supervisors and site managers under optimal conditions. With increasing CSE, they would become increasingly efficacious with clients and their counselling success would further reinforce their personal agency in the proximal environment.

However, counsellor training is often demanding and anxiety-provoking, especially for beginning trainee counsellors (Skovholt & Rønnestad, 2003). The nature of counselling work, the acquisition of complex counselling skills, and the emotional demands of the work contribute to the stress and anxiety of trainee counsellors. Skovholt & Rønnestad (2003) succinctly subsumed these under novice stressors which will be discussed in the next subsection. Novice stressors when unmanaged, can lead to more anxiety impeding trainee counsellors' personal agency and CSE. Studies have provided evidence of an inverse relationship between CSE and anxiety (Friedlander & Snyder, 1983; Larson et al., 1992). Based on the SCMCT, the model would assume that trainee counsellors who experience anxiety or negative self-talk such as hindering self-focused attention (HSA) may perceive and interpret their experiences inaccurately and may

become self-critical about their performance. This may in turn become a barrier to trainee counsellors taking efficacious actions. The SCMCT would hypothesise that trainee counsellors' affective and cognitive inflexibility (e.g., from HSA; suddenly being distracted by moments of anxiety or self-doubt) would interfere with triadic reciprocal causation and obstruct trainee counsellors from learning to become effective counsellors. According to the SCMCT, stable counsellor characteristics (such as adverse childhood experiences) and anxiety can become a barrier to learning. In the current study, HSA can be a specific type of anxiety that trainee counsellors experience. Theoretically, HSA might show up in different components of the SCMCT. For example, trainee counsellors might experience moments of critical thoughts about their lack of knowledge or skills affecting their personal agency and CSE (a component of trainees' personal agency). When that happens, they might feel self-conscious and anxious about their supervisors' feedback and choose not to disclose clinical concerns to the supervisors (a component of trainees' actions). Consequently, they might perceive the supervision environment as unsafe and be reluctant to take on more clients as they anticipate more counselling failures (a component of the environment). Over time, the supervisory working alliances (SWA) would deteriorate resulting in diminished CSE and reduced self-esteem. For trainee counsellors with increased vulnerability (e.g., stable counsellor characteristics like past racial discrimination), there could be a significant implication on their learning.

As the current study was conducted with the learners in mind (i.e., trainee counsellors) rather than the trainers (i.e., supervisors), the definition of the proximal environment in the SCMCT was broadened to more accurately capture the learners' experience; inclusion of coursework or classroom learning (such as unstructured

learning in peer role-play, group activities, lecture-discussion). For the purpose of this thesis, the focus will narrow down to the meanings and implications that the trainee counsellors associated with HSA in the context of novice stressors that permeated within the larger context of the SCMCT. Specifically, this study was interested in exploring interpretations of HSA and its implications on trainee counsellors' personal agency (e.g., a moment of awareness of negative self-talk affecting CSE), HSA and its impact on trainee counsellors' actions in counselling and supervision (e.g., a moment of awareness of anxiety and a related urge to mask incompetence in supervision and the impact on SWA), and HSA and its influences on the proximal environment (e.g., a moment of awareness of bodily sensations during a lecture, group supervision or counselling).

2.4 Novice Stress in the Context of SCMCT

Novice stress is defined as the intense stress experienced by trainee counsellors during training and novice stress is a universal experience for trainee counsellors (Skovholt & Rønnestad, 2003; Yalom & Leszcz, 2005, Gutierrez et al., 2017; Rønnestad et al., 2019). In the context of the SCMCT, anxiety (under which HSA is considered a specific type of anxiety) is a source of novice stress that can exist in any component of the triad; diminishing trainee counsellors' CSE in effecting efficacious counselling actions. Skovholt and Rønnestad (2003) conducted a study in which they identified seven major novice stressors that could impact trainee counsellors' performance and training outcomes (p. 45). They are 1) acute performance anxiety, 2) the fragile and incomplete counsellor-self, 3) inadequate conceptual maps, 4) scrutiny of professional gatekeepers, 5) porous or rigid emotional boundaries, 6) glamorised expectations, and 7) the acute need for positive mentors.

2.4.1 Acute Performance Anxiety

Acute performance anxiety in trainee counsellors may arise when trainee counsellors perform specific counselling tasks or navigate challenging aspects of their training (Rønnestad & Skovholt, 2003). As a result, trainee counsellors may experience a sudden and intense awareness of apprehension, fear, or critical thoughts (Fauth & Williams, 2005). The SCMCT would assume the awareness of anxiety while performing a counselling task as unhelpful as the anxiety would impact effort expenditure and persistence in the face of failures (Larson, 1998).

Skovholt and Rønnestad (2003) stated that when trainee counsellors experienced anxiety of self-consciousness, it could impede work tasks. Numerous studies have reported that trainee counsellors experience a high level of anxiety during clinical practice, supervision, and training courses (e.g., Haley et al., 2015; Kuo et al., 2016; MacFarlane et al., 2016; Tolleson et al., 2017). Anxiety has been shown to be negatively related to trainee counsellors' perceived self-efficacy (Goreczny et al., 2015; Larson, 1998; Larson & Daniels, 1998), and being aware of anxiety during a session can affect trainee counsellors' perceived competence. Tolleson et al. (2017) acknowledged that skills training was essential for trainee counsellors but recommended that trainee counsellors and institutions incorporate anxiety-reducing activities such as mindfulness; role-playing; and feedback to increase self-efficacy. Furthermore, these studies have shown that anxiety has a negative impact on trainee counsellors' counselling outcomes.

2.4.2 Fragile and Incomplete Counsellor Self

The concept of an incomplete counsellor "self" is a state where trainee counsellors may not have fully developed or integrated certain aspects of their professional identity (Adelson, 1995). This incomplete counsellor self can manifest in

various ways across different training contexts and impact the triad of the SCMCT (e.g., the stable counsellor characteristics that expose trainee counsellors' vulnerability). For example, trainee counsellors may exhibit an incomplete counsellor self when there is limited self-awareness of how their values and beliefs were influenced by their culture and background (e.g., being from low socioeconomic status, a minority group, or having low self-esteem) and how this can impede their ability to engage in reflective practice to understand how their personal experiences can impact counselling.

Skovholt and Rønnestad (2003) recommended that trainee counsellors engage in vigorous internal construction work, introspection, or self-awareness while experiencing "a series of moods: enthusiasm, insecurity, elation, fear, relief, frustration, delight, despair, pride, and shame" (p. 50). Additionally, the authors cautioned that trainee counsellors are highly reactive to negative feedback and have a high level of emotional reactivity at this stage. According to Thériault et al. (2010), the first-person perspective on feelings of incompetence, self-doubt, and insecurity is a critical component of trainee counsellors' professional identity development. This perspective is critical for developing counsellors' self-awareness because it is comparable to Socrates' introspection, or the capacity to look within oneself, akin to an insider-observer. The ability to reflect within oneself is beneficial during the therapeutic process and it is necessary for resolving countertransference, which is a state when the counsellors project feelings back to the clients due to the counsellors' unresolved personal issues. Although introspection is important, when trainee counsellors become aware of their lack of skills and knowledge, this greater awareness can lead to heightened emotions or harsh self-criticism, which can diminish trainee counsellors' competence and undermine their identity as emerging counsellors (Skovholt & McCarthy, 1988). "Therapists'

feelings of self-doubt, insecurity, and uncertainty about their effectiveness are among the most frequently reported hazards of the psychotherapeutic profession" (Thériault & Gazzola, 2010, p. 233). Whilst it is important to recognise the need for trainee counsellors to be introspective and be more aware of the "self"; understanding their own dynamics and psyches and uncovering any biases stemming from their personal experiences can be uncomfortable. The idea of bending the trainee counsellors enough to develop their counselling knowledge and competence but not breaking them in how they perceive their sense of self is worth exploring.

2.4.3 Inadequate Conceptual Maps

Conceptual maps are derived from personal formulations of helping, and for trainee counsellors, the only conceptual map available at this early stage of training is typically the conventional model of "quick problem formulation, direct advice, and a strong dose of emotional support and sympathy" (Skovholt & Rønnestad, 2003, p. 51). Owing to these inadequate conceptual maps, trainee counsellors frequently lack the clinical experience and skills necessary to deal with the cognitive, affective, and motivational processes while counselling clients. The SCMCT would assume that having no experience compared to some experience would differentiate trainee counsellors' CSE in managing challenges such as critical incidents.

Critical incidents that occur during training can result in vicarious trauma (i.e., the effects that result from being exposed to the traumatic experiences of clients) from feeling too much for their clients or compassion fatigue (DelTosta et al., 2019; Huan-Tang et al., 2017; Makadia et al., 2017). Though critical incidents can provide trainee counsellors with valuable learning opportunities to enhance their conceptual maps, the process can be emotionally challenging. Howard et al. (2006) identified five major

critical incident themes that trainee counsellors encountered: professional identity, personal issues, competence, supervision, and counselling philosophy. In order to help trainee counsellors strengthen their conceptual maps, it will be beneficial to learn how they interpret and make sense of these critical incidents. The SCMCT posits that trainee counsellors with higher CSE, a critical aspect of human agency, would likely view critical incidents as challenging but helpful and have self-generated influences to broaden their conceptual maps.

2.4.4 Scrutiny of Professional Gatekeepers

Professional gatekeepers in counsellor education play a pivotal role in evaluating and monitoring trainee counsellors' progress and readiness for professional practice (Rønnestad & Skovholt, 2001). The SCMCT highlights supervision (and supervisors) as one of its salient variables in the development of trainee counsellors through the modelling of experiences, social persuasion, and feedback. However, the nature of supervision and the dynamic between the supervisor-supervisee dyad can potentially become anxiety-provoking.

Bordin (1979) defined supervisory alliance as a mutual agreement on predetermined goals that is bonded by feelings of trust, affection, and care. Numerous studies have established the importance of supervisory alliances in determining trainee counsellors' competence (e.g., Datu & Mateo, 2016; Gonsalvez et al., 2017; Grant et al., 2012). Additionally, studies have discovered that supervision can be harmful or insufficient when supervisors are negligent, unethical or withholding from giving feedback (Ellis et al., 2014; Ladany, 2004, 2014). When professional gatekeeping becomes a threat to trainee counsellors, they tend to withdraw. Sweeney et al. (2014)

found that trainee counsellors were unlikely to disclose dissatisfaction with their supervisor or concerns about unprocessed client transference, case management difficulties, or perceived clinical errors. Other studies confirmed additional reasons for nondisclosure, including power dynamics, supervisor competence, supervisory styles, self-preservation, self-image, and feeling vulnerable to disclosure (Cook et al., 2018; Mehr et al., 2010; Singh-Pillay & Cartwright, 2019). Trainee counsellors' nondisclosure during supervision can influence the supervisory relationship and potentially lead to moments of anxiety or HSA.

In a five-year review of clinical supervision literature, the largest category of articles was concerned with harmful supervision which is defined as "supervisory practices that can result in psychological, emotional, and/or physical harm or trauma to the supervisee" (Goodyear et al., 2006, p. 435). Numerous studies have confirmed that ineffective supervision can have an adverse effect on trainee counsellors' CSE and actual performance (e.g., Holloway & Todres, 2003; Humeidan, 2002; Larson & Daniels, 1998; Ybrandt et al., 2016). When trainee counsellors perceive supervision as ineffective, the three salient supervisor functions would likely be impeded; a barrier to the supervisor to provide modelling experiences, social persuasion, and feedback to the trainee counsellors, which from the SCMCT lens, would be a feedback loop to the triad.

2.4.5 Porous or Rigid Emotional Boundaries

Boundaries are critical for the trainee counsellor's safety as well as the safety of their clients. Professional counselling entails the practice of establishing and maintaining physical and emotional boundaries within a therapeutic environment. During training, appropriate physical boundaries can be taught. However, trainee counsellors frequently

struggled with emotional boundary regulation. The SCMCT would assume trainee counsellors with emotional rigidity or porosity would have compromised cognitive and affective processing abilities with reduced flexibility in their assimilation, accommodation, and retrieval of information (Larson, 1998). Consequently, it can result in distortions of the sense of self (i.e., as stable counsellor characteristics) and become a barrier to the trainee counsellors' personal agency.

Skovholt and Rønnestad (2003) explained that trainee counsellors "need the ability to experience, understand, regulate, and express emotions at a level that facilitates counselling" (p. 48), which frequently involves the need to process large amounts of data. When trainee counsellors are confronted with intense data overload, they are likely to experience cognitive or emotional overload or both. In addition to other novice stressors, trainee counsellors frequently lack the skillset necessary to carry out the cycle of caring optimally with each client from attachment to involvement to separation (Skovholt & Rønnestad, 2003). Trainee counsellors with rigid emotional boundaries are particularly vulnerable to countertransference in such situations. Gait and Halewood (2019) acknowledged the difficulties trainee counsellors face when it comes to countertransference because these trainees lack the necessary self-awareness and reflexive skills to cope. As a result, they may experience moments of intense feelings or thoughts based on their own experiences, beliefs or unresolved issues that are often unconscious but emerge in response to their clients' reactions. Trainee counsellors may become preoccupied with the emotional pain of their clients and when clients' issues become trainee counsellors' emotional baggage, the risk of burnout or premature exit from the programme is high (Figley, 2002).

2.4.6 Glamorised Expectations

Trainee counsellors frequently have idealised views or exaggerated perceptions about counselling and their role as counsellors (Skovholt & Rønnestad, 2003). The SCMCT acknowledges that trainee counsellors with higher CSE would have more self-aiding thoughts and would set more realistic and moderately challenging goals. However, the model underscores that higher CSE does not immediately translate to better counselling performance. It would be essential to understand instances where trainee counsellors develop a false sense of competence and intervene at critical points of the triadic reciprocity.

According to the model of competence (Adams, 2011), learning of any new skills will involve the four stages: unconscious incompetence, conscious competence, conscious competence, and unconscious competence. In the unconscious incompetence stage, trainee counsellors generally lack the necessary skills or knowledge about areas where they need to improve or develop in their counselling skills. Hence, they may not be aware of their actual competence and may perceive themselves as more competent than they actually are. Trainee counsellors who are in the stage of conscious incompetence may start to learn about their knowledge gap and experience anxiety about how much they need to learn. In the stage of conscious competence, trainee counsellors have the necessary skills and are conscious when using them. With continual practice, trainee counsellors start to be comfortable when utilising the skills and become natural in application. The model posits that the stage of competence can impact trainee counsellors' perceptions of their self-efficacy beliefs and the expectations they set for themselves.

Numerous studies have indicated that trainee counsellors' expectations include the following: involving clients in the process, integrating theoretical knowledge into practice, being prepared for the session, ability to engage clients, incorporating supervision into sessions, adequacy of knowledge and skills, responding at a deeper level, responding with empathy, and possessing counsellor characteristics (Pierce, 2016; Skovholt & Rønnestad, 2003; Thériault & Gazzola, 2010). When trainee counsellors possess reasonable professional capabilities, they experience positive emotions; however, they experience negative emotions when they doubt their suitability for counselling work (Rønnestad & Skovholt, 2003, 2013; Skovholt & Rønnestad, 2003). Disillusionment frequently occurs unexpectedly, as trainee counsellors believe that the training received during training is sufficient to prepare them for all client issues in all counselling contexts (Cartwright & Gardner, 2016), despite the fact that reality frequently proves them wrong. Addressing glamorised expectations amongst trainee counsellors is essential and the process whereby trainee counsellors learn to produce efficacious counselling actions and set realistic supervision and counselling goals is highly complex and multifactorial. The SCMCT exerts the importance of the triad positively reinforcing one another for effective counsellor performance.

2.4.7 Acute Need for a Positive Mentor

According to Skovholt & Rønnestad's six-phase model of counsellor development, beginning trainee counsellors are reliant on their supervisors for validation, whereas advanced trainee counsellors are reliant on their supervisors as they struggle with independence (Rønnestad & Skovholt, 2003). In general, trainee counsellors require a safety net of mentors to assist them in navigating the state of

emotional and cognitive dissonance. They yearn for mentorship from professional elders who can show them the ropes of effective counselling. However, when trainee counsellors set such overly ambitious goals for themselves, the supervisory working relationship can suffer. According to Gnillka et al. (2016), the attachment styles of counsellor supervisees can influence the supervisory working alliance. When supervisees exhibit anxious attachment and standards, the relationship between the supervisees' discrepancies and the supervisory working alliance is negative but strong. This means that supervisees who are concerned about their performance will tend to rely more on their supervisors, which will eventually become maladaptive, resulting in a weaker supervisory working alliance (Gnilka et al., 2016). Establishing clear guidelines for supervision has the added benefit of reducing novice stress and performance anxiety. Simultaneously, supervisors should act appropriately as their mentors in guiding the trainee counsellors positively (Ladany, 1992; Ladany, Lehrman-Waterman, et al., 1999). At best, the functional outcome of the SCMCT would be for trainee counsellors to receive accurate feedback from their supervisors, who would under optimal conditions provide opportunities for mastery for trainee counsellors who would then model such actions with their clients to achieve counselling success.

The aforementioned studies examined various facets of counsellor training and addressed the seemingly unavoidable phenomenon of novice stress experienced by trainee counsellors. Anxiety and critical thoughts (such as HSA) can manifest as novice stress permeating anywhere in the SCMCT affecting the dynamic aspects of the triad. In the next section, the review will focus on the third component of the triad: environment,

specially, the elements that surround supervision such as the working alliance and its impact on trainee counsellors' CSE in effecting actions.

2.5 Supervisory Working Alliance in the Context of SCMCT

The SCMCT asserts three salient supervisor functions in assisting trainee counsellors in learning to be efficacious. These three critical functions include the provision of modelling experiences, social persuasion, and supervision feedback. In the best-case scenario, an ideal supervisor would provide a safe environment to foster a trusting relationship with the trainee counsellor, and model counselling actions for the trainee counsellor to observe and rehearse the desired skill. During the structured learning process, the ideal supervisor would provide realistic and supportive encouragement, also labelled as social persuasion, to increase the chance of the trainee's counselling success. The ideal supervisor would provide immediate feedback concerning the trainee counsellor's performance, specifically on those essential aspects that the trainee counsellor might have ignored. The feedback would be specific, positive, constructive, and changeable. Under such an optimal learning environment, the trainee counsellor would develop higher CSE to effect efficacious actions in counselling. From the lens of the SCMCT, a strong supervisory working alliance (SWA), akin to a strong therapeutic alliance between the counsellor and client, underpins the success of the supervisory process in delivering the three salient supervisor functions. Under suboptimal conditions, such as when the supervisor's stable characteristics (like values, beliefs, sexual orientation, personality, health status or personal experience) are less than optimal, for example, a supervisor from a minority racial group with prior racial discrimination experience and supporting a supervisee who represents that majority

racial group, it may become a barrier to fostering a strong SWA and prevent effective supervision from occurring, impeding the triad.

2.5.1 History of Working Alliance

During the early years of psychoanalytic psychotherapy, the relationship between a psychoanalyst and his client was referred to as a working alliance. Bordin (1979) later introduced the term “therapeutic working alliance” which has been used till the modern days of counselling. Bordin incorporated the client into the therapeutic working alliance, which entailed mutual agreement on predetermined goals that were characterised by feelings of trust, fondness, and care. This working alliance was later expanded to include the supervisory alliance. The supervisor-supervisee dyad is critical for promoting supervisees' counselling self-efficacy, and this is especially true for trainee counsellors who are vulnerable and under a great deal of novice stress (Skovholt & Rønnestad, 2003).

Bordin also indicated that an impediment to this supervisory working alliance could be the evaluative nature of supervision, resulting in a power imbalance. Despite this, Bordin maintained that the requirement for assessment would make developing supervisory alliances all the more critical and necessary. Bordin concluded by emphasising the relationship between supervisory alliance and supervisees' counselling self-efficacy (Bordin, 1979, 1983). From Bordin’s (1979) work, Efstation et al. (1990) later developed a measure, the Supervisory Working Alliance Inventory, to operationalise the supervisory working alliance which has been widely used to measure counsellors’ perceptions of the supervisory working alliance with their supervisors. This current study has chosen to use the shorter form, the Brief Supervisory Working

Alliance Inventory – Trainee (BSWAI-T, Sabella et al., 2020). The BSWAI-T was reported to be useful and practical for field application (Sabella et al., 2020). More information on the inventory will be covered in Chapter 3, Methodology.

2.5.2 The Impact of Supervisory Working Alliance on Counselling Self-Efficacy

Ladany (1992) conducted a dissertation research to predict the relationship between supervisory working alliance, trainee counsellors' counselling self-efficacy and supervisor satisfaction. Results indicated that supervisor working alliance was a significant predictor of combined counselling self-efficacy and supervision satisfaction scores but not of counselling self-efficacy alone; that counselling self-efficacy was associated with experience, and that counselling self-efficacy increased over time. Due to the fact that the participants in Ladany's study lacked prior supervisory experience, another study was conducted with two additional researchers years later.

After the initial study (Ladany, 1992), Ladany et al. (1999) discovered that supervisory working alliances contributed to greater satisfaction than the hypothesised outcome of changes in trainee counsellors' self-efficacy. The study recruited a total of 107 trainee counsellors who were under individual supervision. The study concluded that emotional bond was the most significant predictor of supervision outcome, such that as the trainee counsellors' emotional bond grew stronger over time, they also developed a more favourable perception of their supervisors' personal qualities and performance, as well as increased comfort within supervision. When supervisors form a strong working alliance, they can serve as role models (or positive mentors) for trainee counsellors in terms of skills mastery and competence development. When the bond is strong, trainee counsellors are more tolerant of affective arousal and are less likely to engage in

avoidant behaviours or nondisclosure (Ladany et al., 1999). When trainee counsellors perceive the working alliance as deteriorating over time, they have a more negative opinion of their supervisors' personal qualities and performance, and trainee counsellors also have negative opinions of their own behaviours and are less comfortable in supervision (Ladany et al., 1999). There are important implications about Ladany et al.'s findings. First, trainee counsellors will be more receptive to talking about their difficult feelings and reactions (such as HSA) when they perceive a positive working alliance with their supervisors. Second, trainee counsellors will likely be more aware of their inner experiences and potentially able to draw inferences concerning developmental issues or personal dynamics with the support of their supervisors.

Consistent with Rønnestad and Skovholt (2003), Ladany et al. (1999) stated that trainee counsellors in the advanced stage are more likely than trainee counsellors in the beginning stage to be dependent on the mode of supervisory relationship. Rønnestad and Skovholt (2013) claimed that advanced students may instead, struggle with dependency-independency issues or conditional autonomy conflict (Rønnestad & Skovholt, 2013). This is a conflictual situation because advanced trainee counsellors desire to develop their independence as counsellors while remaining completely reliant on their supervisors' professional judgment.

Carr (2017) recruited 57 participants from graduate students enrolled in psychology doctoral programmes who had completed a practicum at the university's counselling centre for their dissertation study. The findings indicated that there was a correlation between supervisory working alliance and multicultural competence in trainee counsellors. Additionally, results indicated that multicultural discussions during

supervision acted as a moderator of this relationship. Carr explained that a positive supervisory working alliance appeared to have aided trainee counsellors' multicultural counselling development, which could have an addictive effect. This means that when trainee counsellors have a weaker bond with their supervisors, sensitive topics such as culture may not be adequately explored. In another study (Ritmeester, 2016), no mediating effect of supervisory working alliance on the relationship between supervisors' multicultural competence and trainees' multicultural counselling self-efficacy was reported. However, supervisory working alliances were found to have a direct significant effect on trainees' multicultural counselling self-efficacy. These findings suggest that in the presence of a positive supervisory working alliance, trainee counsellors are more open to talking about cultural issues and tolerate discomforts around the topic. Additionally, the act of discussing sensitive topics related to culture further enhances their self-awareness and beliefs about their cultural competence.

From the abovementioned studies, it is clear that there is a positive correlation between SWA and CSE. According to the SCMCT, when working alliances are strong, trainee counsellors can maximise learning through four sources: mastery, modelling, social persuasion, and affective (and cognitive) arousal. The purpose of supervision is to provide trainee counsellors with timely feedback and both formative and summative assessments. However, what is less clear is the internal processes that go on within the trainee counsellors themselves; and how positive alliances relate to trainee counsellors' anxiety or critical self-talk (i.e., during moments of HSA). Further empirical research may be undertaken to expand the corpus.

2.6 Self-Awareness in the Context of SCMCT

From the perspective of the SCMCT, self-awareness would belong to the "counsellor" component of the triad. Bandura asserted that the self-determining aspects of a person (or trainee counsellor), which include CSE and personal agency, is a causal determinant of behavioural change (or effecting efficacious counselling actions) (Bandura, 1977). Trainee counsellors' with higher CSE beliefs are assumed to be more self-aware of their cognitive, affective and motivations that reinforce their personal agency (Larson, 1998). For example, under optimal conditions, trainee counsellors would be aware of their cognitive and affective processing in order to ascertain difficulties in a counselling session. This would involve encoding and retrieving what happens during counselling, evaluating the information that clients share while simultaneously processing and utilising their requisite subskills (e.g., listening and eliciting more information), and self-monitoring personal internal reactions. This process is highly complex and requires trainee counsellors to be aware of their own cognitive and emotional processes.

In the course of counsellors' training and development, self-awareness is often associated theoretically as an inner resource that counsellors can utilise as an effective tool to cultivate a therapeutic alliance with clients, guide decision-making, build empathy and be present, effect positive client outcomes and even prevent counsellors' burnout (Geller & Greenberg, 2012; Star, 2013; Witteman et al., 2012). Whilst Oden et al. (2009) defined self-awareness as "the capacity to allow one's feelings, thoughts, and behaviors into consciousness, especially in the context of the counsellor-client relationship" (p. 443), Williams et al. (2003) attempted to draw attention to the valence

(negative and positive) and states (global and momentary) of self-awareness. Synonymous terms with counsellors' self-awareness have emerged in the counselling literature, though each term has variations and distinctions. In this study, self-awareness is used as an umbrella term to encompass all forms of self-awareness, including its nuances.

While self-awareness concepts are similar in terms of how they can improve trainee counsellors' professional effectiveness and personal growth they can differ in terms of the subjective meanings trainee counsellors assign to their experiences. Even moments of awareness of their own anxiety and critical thoughts, like HSA, in the proximal environment can be informative. Conceptually, HSA can be a specific type of anxiety that can provide insights for trainee counsellors. However, for some trainee counsellors, their stable counsellor characteristics can increase their vulnerability and the presence of HSA can become a barrier to effecting counselling actions. The following section will first expound upon the nuances of self-awareness and HSA in the subsequent section.

2.6.1. Felt-Sense Awareness

Peace and Smith-Adcock (2018) conducted a study on the felt-sense awareness of counsellors during a preparation course. The authors quoted felt-sense experiences as being "focusing, therapeutic presence, congruence, embodied self-awareness, and mindfulness" (p. 208). Peace and Smith-Adcock claimed that when the trainee counsellors were receptive to inner-voice experiences, these felt senses could guide counsellors toward self-care thus preventing burnout or compassion fatigue. Peace and Smith-Adcock advocated for trainee counsellors to utilise their felt sense in their

therapeutic relationships with clients. The framework consisted of the following components: openness to felt experience, awareness and acceptance of the felt experience, and utilisation and confirmation of the felt experience in their clinical work with clients. Peace and Smith-Adcock strongly encouraged trainee counsellors to access and use their felt sense experience as early as the beginning training stage by practising mindfulness or mind-body connection. They recommended institutions incorporate mindfulness meditation for trainee counsellors to practise being grounded in their bodies, to "develop a curiosity toward their inner experiences, rather than avoiding or suppressing their inner thoughts, emotions, or felt sense" (p. 217). Peace and Smith-Adcock's study on felt sense emphasises the importance of the interconnectedness of the mind and body. When trainee counsellors can pay attention to their bodily sensations, they can access deeper insights and facilitate personal growth, emotional regulation and therapeutic work. Peace and Smith-Adcock saw felt sense as a positive type of self-awareness that trainee counsellors are encouraged to cultivate.

2.6.2 Mindfulness

In a collection of studies on mindfulness over a nine-year period, Christopher and Maris (2010) highlighted the importance of being in a state of awareness. The authors defined mindfulness as "being fully conscious of present-moment experience and attending to thoughts, emotions, and sensations as they arise without judgment and with equanimity" (p. 115). Christopher and Maris's qualitative study on mindfulness practices of graduate students discovered that mindfulness practices resulted in positive changes in trainee counsellors' personal and professional lives. Participants focused their attention on their breaths and experienced their bodies in the present moment during the

mindfulness practices. Participants reported increases in physical strength, flexibility, fluidity, balance, and energy (p. 117). Christopher and Maris advocated for the incorporation of mindfulness into training programmes as a strategy for trainee counsellors' self-care (Christopher et al., 2011). Simply being aware and present are the recurrent themes in mindfulness, in which practitioners become more aware of their reflexive patterns of thoughts and emotions, thereby reducing their reactivity and mindless wandering (Kabat-Zinn, 2003). Therefore, if trainee counsellors can engage in mindfulness to develop greater sensitivity and to promote a more integrated awareness of their mind-body connection, this awareness can be an important component of therapeutic work, and perhaps a buffer against novice stress. Similar to other theorists of self-awareness (e.g., Peace & Smith-Adcock, 2018), Christopher and Maris belong to the group of scholars who saw mindfulness as a positive type of self-awareness.

2.6.3 Clinical Intuition

In Witteman et al.'s (2012) study, intuition is defined as "based on automatic processes which rely on knowledge structures that are acquired by (different kinds of) learning" (p. 20). The authors argued that clinical intuition can be just as evidence-based as other studies and is not nearly as mysterious as previously believed. According to Witteman et al., there are four types of intuition: 1) associative intuition, which is acquired through reinforced associations, 2) matching intuition, which is acquired through exemplars, 3) accumulative intuition, which is the evaluation of linked memories against current information, and 4) constructive intuition, which is the use of memories and current information to construct a consistent mental representation. The participants in the study figured feelings as an important component of clinical intuition

as a participant exclaimed, “using your feelings as an instrument”. Another participant interpreted clinical intuition as, “combining factual data with how the client makes me feel” (p. 23). A few other participants also mentioned that intuitive feelings were similar to “gut feelings” that “something is wrong here” and they could feel a “physical sensation of tension” (p.23). From these participants’ experiences, before counsellors can “feel” and “observe” their clients’ behaviours, they must first tune in to their own awareness of self. Nonetheless, Witteman et al. contended that only with additional such experiences would counsellors’ clinical intuition become more astute, if not entirely accurate (Witteman et al., 2012).

Even though less explicitly stated than the other nuances of self-awareness (such as felt-sense awareness and mindfulness), clinical intuition seems more like a skill that trainee counsellors have to acquire before they can utilise it in their therapeutic work. However, as Witteman et al. clearly stated, clinical intuition is not arbitrary or based on guesswork. From the participants’ experiences, clinical intuition is grounded in a deep understanding of being attuned to their thoughts, feelings, and reactions in order to interpret their intuitive responses. Additionally, Witteman et al. stressed that the practice of self-awareness has to be repeated over and over again for the “learning” to be assimilated into trainee counsellors’ conceptual maps (Rønnestad & Skovholt, 2003). Like the abovementioned scholars of self-awareness (i.e., Christopher & Maris, 2010; Peace & Smith-Adcock, 2018), Witteman et al. saw clinical intuition as a positive type of self-awareness that is a resource for trainee counsellors in therapeutic work.

2.6.4 Inner Experiences

Melton et al. (2005) defined inner experience as “all aspects of a person’s internal processing” and “represent the different variables investigated in self-awareness” (p. 82). Melton et al. clearly stated that trainee counsellors are inundated with sensory information and develop a sense of self-awareness about their thoughts, feelings, and inner states during their training. According to the authors, these inner experiences are a critical component of counsellors' training in developing self-awareness. However, Melton et al. recognised that internal experiences such as negative self-thoughts, self-talk, and anxiety can influence trainee counsellors' counselling sessions. They asserted that by gaining an understanding of their affective states, trainee counsellors can increase their self-awareness and mitigate negative consequences associated with these affective states' inner experiences. Four major affective themes emerged from the participants’ inner experiences: 1) frustration by a sense of being directionless, 2) dissatisfaction with their inability to control emotions, 3) fear and apprehension about attempting new skills and feelings of incompetence in empathising, interpreting, or communicating, and 4) ecstasy when clients improved.

Melton et al.’s study emphasised and complemented Skovholt and Rønnestad’s (2003) assertion of trainee counsellors’ novice stress (i.e., fragile and incomplete counsellor self that contributes to an intense need for external validation from clients). When trainee counsellors are extrinsically motivated based on affirmation, they become vulnerable to their inner experiences (such as anxiety or negative self-talk). The awareness of their intense emotions and cognitions can therefore become a barrier to development. Melton et al.’s study paralleled the work of Fauth and Williams (2005) on

trainee counsellors' in-session distracting self-awareness which suggests that trainee counsellors' awareness of their inner experiences can be negative (or positive) depending on how trainee counsellors interpret their inner experiences and manage the situations.

2.6.5 Somatic and Embodiment Experiences

Athanasiadou and Halewood (2011) explored the somatic states of 12 accredited practitioners in the field of Counselling Psychology. Adopting a grounded theory approach within a reflexive framework, they came up with a developmental process that indicated how the participant's body may be a conduit of empathic and intuitive connection to the clients' internal subjective reality. According to the authors, this intersubjectivity arises from the infant's affective communication with the mother, in which "the body plays an important role in channelling of communication where somatic affective communication originating in infancy" and carries on into adulthood (p. 250). However, the researchers asserted that investigating somatic phenomena in the form of "being-in-relationship in terms of an intricate psychosomatic system is still quite rare both in literature and practice" (p.250).

Athanasiadou and Halewood's study has received considerable research attention (e.g., Hayes et al., 2018; Peabody & Gelso, 1982; Searles, 2017). The findings established that when counsellors are not overwhelmed with emotions by their clients' negative or traumatic experiences, they can rely on their somatic awareness in therapeutic work. Athanasiadou and Halewood found that therapists who admitted to having suffered from significant childhood trauma defended against their somatic experiences. These embodied messages stored "dirty pain" (p. 3) from cultural and intergenerational trauma, which could impede the healing and therapeutic work of

counsellors (Lenes et al., 2023). Applying the concept of embodied pain to the context of counsellor education, trainee counsellors who are less tolerant of negative affect may have a lower threshold for novice stressors. For example, when a trainee counsellor overidentifies himself or herself with the emotional pain of his or her client and feels an unwavering obligation to be constantly present for the client (i.e., having porous emotional boundaries), the somatic and embodiment experience thus makes him or her more vulnerable to novice stress or countertransference which specifically refers to the counsellor-client dynamics during in-session.

Considering the abovementioned findings, it is important to recognise the valence of self-awareness and to consider both positive and negative self-awareness can be informative for trainee counsellors. The discussion of the nuances of self-awareness is complex and cannot be explained in simple terms. Despite most studies finding that self-awareness has a positive connotation, self-awareness can also be unhelpful for trainee counsellors if it becomes overwhelming or has clinical implications (e.g., somatic and embodiment and countertransference). From the SCMCT perspective, trainee counsellors who have higher CSE beliefs would view difficult emotions (like anxiety) as challenging rather than debilitating and therefore would choose more efficacious counselling actions. Conversely, trainee counsellors with lower CSE would likely be hindered by anxiety and would choose less self-aiding actions. Therefore, the SCMCT would assume trainee counsellors with lower CSE would likely be hindered by their HSA and experience cognitive and emotional inflexibilities. For this group of trainee counsellors who are hindered by their HSA, it is necessary to find out whether

self-awareness would still be a resource, hence self-awareness as positive (or a barrier, hence self-awareness as negative) in the triadic reciprocal interaction.

2.7 Self-Awareness: A Resource or Barrier?

Self-awareness is a critical component of counsellor development. Trainee counsellors who are attuned to their internal processes can gain deeper insights into their inner world, regulate their emotions more effectively, and make more clinically informed decisions (Geller & Greenberg, 2012; Star, 2013; Witteman et al., 2012). The section that follows discusses the importance of counsellors' self-awareness.

2.7.1 Self-Awareness and Empathy

When counsellors have a higher level of self-awareness therapeutic effectiveness also increases (Oden et al., 2009). Oden et al. defined self-awareness as "the capacity to allow one's feelings, thoughts, and behaviors into consciousness, especially in the context of the counsellor-client relationship" (pp. 441–442). Oden et al. examined 164 master's level trainee counsellors who were enrolled in counsellor training and required to attend personal counselling. The participants reported a 56% increase in their understanding of the client perspective, a 36% increase in self-awareness, a 33% increase in their understanding of the counselling process, an 18% increase in personal growth, an 11% increase in their understanding of the counsellor's role, and a 4% increase in insight into the expectations of the preparation programme. This suggests that personal counselling can be used to help trainee counsellors develop self-awareness, self-care, and self-efficacy. When trainee counsellors are more aware of their internal processes, they tend to be more attuned to their clients and the therapeutic process.

Oden et al.'s findings are consistent with existing research indicating a positive correlation between trainee counsellors' self-awareness, empathy and counselling competence (Bandura, 1997; Greason & Cashwell, 2009; Larson, 1998; Luke & Kiweewa, 2010). When trainee counsellors are able to put themselves in clients' shoes and see the world from their perspectives, they cultivate strong therapeutic alliances with their clients. Consequently, positive relationships can become one of the therapeutic factors for change. Therefore, the study by Oden et al. underscores the significance of self-awareness as a powerful tool for trainee counsellors to ensure their well-being and therapeutic work.

2.7.2 Self-Awareness and Ethical Practice

Coll et al. (2013) asserted that self-awareness is a resource that guides professional attitude, as when counsellors are self-aware, they are cognisant of their personal values and biases. Hence, they are less likely to risk imposing their personal values on clients. In their study, Coll et al. found that when ethics were included in core courses during the training, trainee counsellors demonstrated greater professional attitude changes and self-awareness than from learning skills and theories alone. Ethical practice is all about avoiding harm, as clients are frequently in a vulnerable position. Countertransference happens when a trainee counsellor projects onto the client his or her unresolved issues; countertransference often occurs beyond the trainee counsellor's awareness. Nevertheless, countertransference can be equally harmful to both the client and the trainee counsellor, whether committed consciously or unconsciously. Coll et al. asserted that trainee counsellors can best protect their clients' interests, as well as their own, by being self-aware, acknowledging their own weaknesses and accepting their own

limitations. Additionally, Coll et al. recommended that trainee counsellors pay attention to their inner voices as part of their ethical practice. In this regard, self-awareness is considered an efficacious clinical resource.

2.7.3 Self-Awareness and the Professional "Self"

Pieterse et al. defined self-awareness as "the therapist's knowledge and understanding of himself or herself in relation to values, beliefs, life experiences and worldview" (p. 190). Pieterse et al. acknowledged a dearth of published research on trainee counsellors' self-awareness development and disagreed that self-awareness should be viewed as a by-product of counsellors' training or acquired through experience. Pieterse et al. agreed that even though trainee counsellors lack clinical experiences and have inadequate conceptual maps, adopting this restrictive approach limits trainee counsellors' potential for growth. In their study, Pieterse et al. reviewed several approaches to facilitating self-awareness during counsellors' training: self-awareness during the therapeutic process, self-awareness during training and supervision, and self-awareness in multicultural counselling. In addition, Pieterse et al. developed the Integrated Model of Self-Awareness Development (IMSAD) and encouraged trainee counsellors to first conceptualise the 'Self' in terms of both subjective and objective dimensions. The former encompasses the self's thoughts, feelings, and beliefs, while the latter encompasses the self's behaviours. At the next level, Pieterse et al. proposed the factors that contributed to the development of the individual's self, which include the seven areas: 1) relational style, 2) spiritual or religious orientation, 3) family of origin influences, 4) gender and sexual orientation, 5) racial or ethnic identity, 6) social class, and 7) personality traits.

According to Pieterse et al., the IMSAD assumes that trainee counsellors will gain control over their reactions to clients to facilitate the therapeutic relationships (i.e., more defined emotional boundaries and a reduced likelihood of countertransference) when aspects of their self-identity are brought to the conscious level. However, Pieterse et al. acknowledged that the concept of self-awareness was complex and nuanced and they referenced self-focused attention (Williams, 2008) as one of the variations of self-awareness. Despite this, Pieterse et al. clearly saw self-awareness as a resource in the development of the professional "self" of trainee counsellors.

Both models of IMSAD and the SCMCT focus on different aspects counsellor development. While IMSAD emphasises the development of the counsellor "Self" in both subjective and objective dimensions, SCMCT centers on Bandura's social cognitive theory (Bandura, 1982), which focuses on triadic reciprocity of trainee counsellors' personal agency, counselling actions, and the proximal environment. The key difference between IMSAD and the SCMCT lies in their application. IMSAD helps trainee counsellors understand how the seven factors – relational style, spiritual or religious orientation, family of origin influences, gender and sexual orientation, racial or ethnic identity, social class, and personality traits – shape their self-awareness and influence their professional practice (Pieterse et al., 2013). In contrast, the SCMCT focuses on the development of efficacious counsellors through structured training, supervision, feedback, and addressing stressors in the proximal training environment (Larson, 1998). Specifically, self-awareness permeates throughout the entire model of the SCMCT.

2.7.4 Self-Awareness and Countertransference

Countertransference is defined as “the therapist’s internal or external reactions that are shaped by the therapist’s past or present emotional conflicts and vulnerabilities” (Gelso & Hayes, 2007, p. 25). The concept of countertransference has been much debated. While some studies may report countertransference reactions as unhelpful during in-session, alternative understandings have suggested countertransference reactions (like feelings) in counsellors are unavoidable and hold valuable information about clients (Gait & Halewood, 2019). For example, if the trainee counsellor struggles to conceptualise and plan interventions because he or she lacks the conceptual maps, he or she is more likely to be influenced by his or her client’s transference reactions (i.e., the client’s reactions from the client’s own unresolved issues). Therefore, under such a situation, the trainee counsellor is less able to tolerate his or her client’s projected feelings (or behaviours) and countertransference can be a problem in counselling. Gelso and Hayes (2007) identified five counsellor characteristics as beneficial in managing countertransference: 1) self-awareness, 2) self-integration, 3) empathy, 4) anxiety management, and 5) the ability to conceptualise the client’s issues. Consistent with the numerous studies on self-awareness (e.g., Geller & Greenberg, 2012; Star, 2013; Witteman et al., 2012), trainee counsellors who possess greater self-awareness of their thoughts and feelings learn to trust and take cues from their internal processes to help them manage countertransference. In this light, self-awareness not only acts as a barrier to countertransference but also a buffer against novice stress in helping trainee counsellors manage their expectations and regulate their emotions (Skovholt & Rønnestad, 2003).

Whilst the aforementioned studies reported self-awareness as largely positive in building empathy, upholding ethical practice, developing the professional "self", and managing countertransference, a few studies highlighted that self-awareness can be negative as well. The following section will expound on HSA which has received comparatively less research attention.

2.8 Hindering Self-Focused Attention (HSA)

In the current study, HSA is defined as "experiences of being troubled by an awareness of one's anxiety and other internal distractions that occur when providing counselling" (Wei et al., 2015, p. 43). Through the lens of the SCMCT, HSA might contribute to a specific type of anxiety in trainee counsellors, and the presence of HSA and the presence of stable counsellor characteristics (i.e., those that expose trainee counsellors' vulnerability) could potentially become a barrier to trainee counsellor's learning to become effective. For example, in a worst-case scenario, trainee counsellors with past trauma history may view their momentary feelings of anger as triggered by their clients; may become defensive with the clients as a result; may set ambiguous goals in supervision; may be overwhelmed with more negative feelings and critical thoughts about their counselling performance and themselves, and their counselling actions may deteriorate.

During the early stages of training, a trainee counsellor's developing sense of self can be quite fragile (McTighe, 2011; Skovholt & Rønnestad, 2003). Some of the awareness like personal biases and beliefs can be so subtle that they are missed, while other awareness like internal self-critique and aroused emotions can become magnified

affecting the counsellors' characteristics and the triad (Fauth & Williams, 2005; Nutt-Williams & Hill, 1996; Wei et al., 2017; Williams, 2003).

2.8.1 Extant Literature on Hindering Self-Focused Attention

Prior studies (Fauth & Williams, 2005; Williams, 2003; Williams, Hurley, et al., 2003; Williams, Polster, et al., 2003) on hindering self-awareness (Anxious and Distracting) laid the groundwork for subsequent studies on in-session hindering self-focused attention (Wei et al., 2015, 2017), including the current research on HSA over the course of training. Williams (2003) found that when counsellors experienced in-session negative self-talk their ratings of own performance decreased. In addition, counsellors who experienced self-awareness of negative self-talk perceived themselves, the counselling process, and the clients' reactions negatively, regardless of how the client responded to counselling. Subsequent research by Williams and Fauth (Fauth & Williams, 2005; Williams & Fauth, 2005) on in-session self-awareness discovered contradictory findings such that counsellors' in-session self-awareness was found to be beneficial and not detrimental as compared to the earlier studies.

Williams and Fauth recruited therapists and participants with a range of counselling experiences and backgrounds for both studies. The 17-dyad study recruited student trainees as therapists and college students as volunteer clients (Fauth & Williams, 2005). In another 18-dyad study, eight therapists recruited were licensed professionals with an average of ten years of experience, while the remaining ten were advanced doctoral trainees with undergraduate students as volunteer clients (Williams & Fauth, 2005). As a result, the way therapists experienced and managed self-awareness during sessions is likely to differ between the two studies and prior research. While the

17-dyad study found that increased anxious and distracting self-awareness during sessions was beneficial, trainees also reported that increased anxious and distracting self-awareness during sessions had an effect on therapeutic alliance. On the other hand, it was discovered that the more experienced 8-dyad therapists were more effective at managing anxious and distracting self-awareness during sessions. In both studies, in-session anxious and distracting self-awareness during sessions explained 50% and 33% of the variance in therapists' involvement and challenge scores, respectively. This would indicate that experienced therapists in the 18-dyad study viewed in-session anxious and distracting self-awareness as a challenge and were enthusiastic about its affective manifestations, whereas trainee counsellors in the 17-dyad study were more affected by them.

Building upon the research on hindering self-awareness (Anxious and Distracting) (Fauth & Williams, 2005; Williams & Fauth, 2005), Wei et al. (2015) found that having fewer in-session moments of HSA mediated the associations between counselling self-efficacy and mindfulness after adjusting for age and practicum hours. The authors attributed this to trainee counsellors' “felt sense” and the capacity to be "present" with their clients' experiences, as well as to pay them more attention and observe their nonverbal behaviours (p. 54). Results found that 40% of the variance in counselling self-efficacy could be explained by fewer in-session moments of HSA while 57% of the variance in fewer in-session HSA could be explained by mindfulness and psychological flexibility. In conclusion, in-session HSA did not appear to have an effect on trainee counsellors who were more attentive, actively listening, and present. Having fewer in-session HSA also mediated the association between CSE and psychological flexibility to manage unwanted feelings and thoughts, reduce anxiety, and thus provide

ethical counselling. This parallels Coll et al.'s (2013) recommendation to include ethics in counsellor training to promote self-awareness.

Wei et al. (2017) conducted another study to investigate the moderating effects of management strategies on the relationships between in-session HSA and trainee counsellors' CSE. A total of 160 graduate-level trainees from a variety of counselling and psychology programmes were recruited. Their study discovered that when trainee counsellors used more basic counselling techniques such as reflecting clients' feelings, summarising, restating, or asking open-ended questions, counselling self-efficacy remained constant regardless of in-session HSA. However, when in-session HSA increased, trainee counsellors who used fewer basic counselling techniques reported lower CSE. Trainee counsellors who demonstrated increased self-awareness to better understand their clients, similar to Rogerian's empathic counselling, reported a similar level of CSE. Conversely, those who relied less on self-awareness to better understand their clients during sessions reported lower CSE when they encountered more instances of in-session HSA. In summary, in-session HSA can have an effect on the trainee counsellors' perceived competence. Therefore, management strategies are necessary for trainee counsellors to cope with in-session HSA. However, in-session HSA is frequently overlooked as a nuance of self-awareness in counsellor training pedagogy, which supports Williams' (2008) recommendation to conduct additional research on the valence of self-awareness.

The aforementioned studies are mostly confirmatory and unable to adequately capture the "how" and "what" of trainee counsellors' HSA. Additionally, cross-sectional studies frequently portray trainee counsellors' HSA as static. Adopting such a "fixed" perspective on HSA may not provide a full picture to comprehend trainee counsellors'

lived experiences during training. In addition, when trainee counsellors view HSA as static, adopting such a “fixed” perspective may become a barrier to effective HSA management. Trainee counsellors may become rigid or biased which can further affect their growth and development. In addition, perceiving HSA as “fixed” may compound trainee counsellors’ novice stress. Viewing through the SCMCT, trainee counsellors who are aware of their acute anxiety during a counselling session might have lower personal agency. They might experience reduced cognitive and emotional flexibility and choose less efficacious actions to avoid future similar difficult situations instead of addressing them with their supervisor.

2.8.2 Hindering Self-Focused Attention and Countertransference

The present study recognises the intricacy involved in distinguishing self-awareness and its nuances, including countertransference and HSA. Countertransference and HSA have overlaps but they also differ. In the following discussion, the terms “therapist” and “trainee counsellor” are used interchangeably.

Countertransference is conventionally defined as the unresolved conflicts of the therapist, which often stem from the therapist's early childhood and are triggered by the patient (Hayes et al., 2018). In contrast, HSA is defined as “experiences of being troubled by an awareness of one’s own anxiety and other internal distractions that occur when providing counselling” (Wei et al., 2015, p. 43). Whilst both concepts focus on trainee counsellors’ awareness of their cognitions, emotions, and physiological responses, countertransference can be either pleasant or unpleasant and often unconscious to trainee counsellors themselves (Hayes et al., 2018), whereas trainee

counsellors' awareness of HSA in the moment was either neutral or less pleasant but conscious (e.g. feeling anxious or distracted, Williams, Hurley, et al., 2003).

Hayes et al. (2018) stated that countertransference can be extremely useful when the therapists understand their reactions and use them during in-session to help understand the patient who triggers those reactions. The finding was consistent with Cartwright et al.'s (2018) study which found countertransference increased trainees' self-awareness and was a source of information to understand clients. In contrast, William et al. (2003) and Wel et al. (2017) evidenced that when trainee counsellors experienced HSA during in-session, they focused on their critical self-talk, thoughts on their personal life, or, their anxiety and as such were less focused on their clients.

Whilst the context of countertransference is often limited to clinical settings (i.e., during in-sessions), studies have cautioned against such restrictions (Cartwright et al., 2018; Hayes et al., 2018). Similarly, existing studies on HSA have been conducted primarily on in-session HSA (e.g. Fauth & Williams, 2005; Williams, 2003; Williams, Hurley, et al., 2003). The current study asserts that HSA can occur beyond in-sessions; HSA if taken as a specific type of anxiety can manifest everywhere in the novice stressors, and in the larger context of the SCMCT, affecting the dynamics of the triad. Hence, it is a gap that the current study aims to address.

2.9 The Research Gap

HSA has received scant research attention, and the existing research consists primarily of cross-sectional studies (Fauth & Williams, 2005; Nutt-Williams & Hill, 1996; Wei et al., 2015, 2017). The only available qualitative study examines the distracting self-awareness of 12 novice and experienced therapists during in-session

(Williams, Polster, et al., 2003). Hence, these studies on in-session self-focused attention may inaccurately portray HSA as "fixed". Perceiving HSA as static can be problematic, as any attempt to understand and manage HSA may reduce trainee counsellors' desire to improve (Bandura, 2015). Additionally, trainee counsellors may interpret HSA as a personal incapacity, as studies have revealed that trainee counsellors are extremely critical of themselves (Skovholt & Rønnestad, 2003). Consequently, HSA can contribute to more novice stress (as acute anxiety that might attenuate the optimal condition) that can further impede trainee counsellors from becoming human agents in the proximal environment

Empirical studies on SWA tend to demonstrate the positive outcomes of a positive SWA in enhancing trainee counsellors' CSE and self-awareness (Carr, 2017; Ritmeester, 2016). The relationship between trainee counsellors' HSA and SWA, on the other hand, has not been thoroughly explored. While prior studies have established a link between trainee counsellors' self-awareness, SWA, and CSE (McCarthy, 2012; Park et al., 2019), no longitudinal studies examining trainee counsellors' HSA, SWA, and CSE have been conducted. To fill this research gap, the current longitudinal QUAL-quant study was conducted in the larger context of the SCMCT to explore trainee counsellors' HSA and its pervasiveness in the context of the novice stressors (Skovholt & Rønnestad, 2003); the functions of supervision (such as opportunities of mastery, modelling of skills, social persuasion, and feedback) in supporting trainee counsellors with HSA; and the influence of HSA on the triadic reciprocity. For example, the trainee counsellor's momentary awareness of incompetence during a particular supervision might become a barrier to the working alliance which might further inhibit the trainee counsellor from performing under less than optimal conditions.

2.10 Chapter Conclusion

This chapter began with a general overview of the methods employed for the literature review. The review introduced the SCMCT which served as the blueprint for the current study. Additionally, the review established a positive correlation between self-awareness and the SWA; and positioned HSA as a specific type of anxiety in the context of novice stressors. The present study speculated that HSA, SWA, and CSE are inversely related. In the larger context of the SCMCT, the model would assume HSA and the presence of the stable counsellors' characteristics that increase trainee counsellors' vulnerability would attenuate the dynamic aspects of the triad. The present investigation is necessary and was conducted to fill the knowledge gap. Chapter 3 will discuss the research methodology.

CHAPTER 3

Addressing the Gap in Counsellor Training: Methodology

> *I hear the words, the thoughts, the feeling tones, the personal meaning, even the meaning that is below the conscious intent of the speaker. Sometimes too, in a message which superficially is not very important, I hear a deep human cry that lies buried and unknown far below the surface of the person, So I have learned to ask myself, can I hear the sounds and sense the shape of this other person's inner world? Can I resonate to what he is saying so deeply that I sense the meanings he is afraid of, yet would like to communicate, as well as those he knows?*
> (Rogers, 1995, p. 8)

3.1 Chapter Introduction

The primary objective of this chapter is to provide a comprehensive description of the methodological considerations relevant to this research. It will demonstrate how phenomenology can be used to provide detailed information about the lived experience of trainee counsellors who have experienced HSA. It will further detail the data collection and analysis processes. Notably, the chapter will discuss how the study was guided by sound research principles such as context sensitivity, adherence to rigour, transparency, coherence, as well as impact and significance (Yardley, 2000). It will illuminate the importance of the researcher's reflexivity which is maintained throughout the entire research process, including thesis writeup. The following section will discuss the research paradigm used in this longitudinal QUAL-Quant study.

3.2 Pragmatism as A Research Paradigm

The conduct of research is governed by a set of beliefs and theories. The researcher's philosophical assumptions will influence how a particular framework is approached. The following were points for my consideration in selecting a research paradigm: Which paradigm was sufficiently inclusive to address the research questions (on trainee counsellors' HSA during training)? Which paradigm used a flexible approach to data collection that addressed the research questions (trainee counsellors' stories combined with "hard truth" data to ensure study comprehensiveness)? Which paradigm permitted practicality to accommodate the complexities of HSA (as there would likely be uncertainties from any human phenomenal study)? After considering these criteria, pragmatism was chosen as the research framework for this study.

3.2.1 Overview of Pragmatism

Three pioneers popularised pragmatism as a philosophy: Charles Saunders Peirce (1839-1914), William James (1842-1910), and John Dewey (1859-1952). The term "pragmatic" means "practical" and derives from the Greek word "praktikos", which means to act or do (Ormerod, 2006, p. 894). Pragmatism as a philosophical approach is "about being practical, getting things done, doing things a step at a time", and "not being hung up on unattainable principles and yielding on some issues to make progress on others" (pp. 893–894). Pragmatism, as defined by Charles Saunders Peirce, is a philosophy of meaning that seeks to comprehend the real world by associating experiences with observable outcomes (Peirce, 2014). According to Pierce, pragmatism provided both objective and impersonal standards, and as a result, his proposition had a positivistic perspective (Ormerod, 2006). William James developed pragmatism further

through his book *Pragmatism: A New Name for Some Old Ways of Thinking* (James & Vescio, 2003). He gave pragmatism a more subjective definition, defining it as a method for avoiding "the first things", referring to our orientation toward things such as fixed principles or closed systems of our beliefs (Ormerod, 2006, p. 899). John Dewey, like Pierce, viewed inquiry as a process and believed that experience necessitated constant evaluation. According to Dewey, this process of reworking was a social and communal one that was rooted in people. Pierce, on the other hand, regarded pragmatism as a scientific invention, in contrast to Dewey's assertion that it was an experiential process. Dewey's theory of inquiry placed a premium on the "self-correcting method of experimentally testing hypotheses generated and refined from prior experiences", and this intelligent method of inquiry can be fostered within social structures that value continuous inquiry. There has been debate over the merits of quantitative versus qualitative methodologies and “paradigm peace” has emerged (Glogowska, 2011, p. 251). Pragmatism has been widely accepted as a research paradigm in the field of social work, as it is founded on the concepts of compatibility, alignment, and value-free research (Glogowska, 2011). Hence, a pragmatic approach allows the researchers to select the methodology that best answers their research question rather than adhering to strict methodological conventions.

3.2.2 Pragmatism versus Positivism and Constructivism

The primary objective of positivist inquiry is to discover laws that facilitate explanation and prediction via a deductive model of science. Deduction is the process of progressing from the broadest to the most specific, and in the realm of scientific research, researchers develop hypotheses and then determine whether their hypotheses are supported by observable consequences (Christensen et al., 2011). Positivism is

typically associated with quantitative methods and with claims made from objectivity, standardisation, and deductive reasoning (Creswell, 2018). On the other hand, constructivist inquiry aims to comprehend an individual's world through the creation of meanings for objects or things. Meanings are frequently diverse and multiple, prompting the constructivist researcher to delve into the richness and complexities of the data and unearth interpretations; as the name implies, the researcher and participant co-construct meaning. Constructivism is particularly pertinent to qualitative methods, in which the researcher relies entirely on the perspectives of participants to develop subjective meanings for research phenomena (Kaushik & Walsh, 2019).

Pragmatism enables a pluralistic perspective on research methods, allowing for the selection of the most appropriate quantitative or qualitative methods. Second, its inclusive framework fosters interdisciplinary and collaborative research, including work with marginalised populations, in contrast to quantitative studies, which require a large and representative sample size. Finally, pragmatism assumes that there is no ultimate truth or optimal method for knowledge generation. As Creswell stated, pragmatism is about choosing what works best in research (Creswell, 2018; Johnson & Christensen, 2008).

3.2.3 Rationale for Pragmatism

According to Patton (2002) pragmatism enables researchers to avoid metaphysical debates about truth and reality and instead focus on what is relevant and practical for real-world problems. The implication of this study's pragmatist perspective serves two purposes, as described in the following paragraphs.

First, pragmatism concerns the notion of utility or the questions “what is it for”, “who is it for” and “what works” (Creswell & Plano Clark, 2011; Feilzer, 2010). This

calls for a research methodology that is reflexive and overcomes the limitations of either positivism of absolute truth or interpretivism of multiple realities (Glogowska, 2011). In other words, the paradigm chosen must allow for abductive reasoning in order to unravel HSA. A combination of "hard truth" data (quantitative) and "in-depth" accounts (qualitative) is required to create a comprehensive picture. In the current study, HSA is both personal and subjective. It is a unique individual experience that affects trainee counsellors to varying degrees. It is critical and pertinent to listen to trainee counsellors' HSA. Additionally, training includes practicum which trainee counsellors learn to practise their role under the guidance of their supervisors. Therefore, there is a need to ascertain objectively any changes in HSA, counselling self-efficacy (CSE) and supervisory working alliance (SWA). As such, a paradigm that is inclusive of both positivist and interpretivist perspectives is critical.

Second, delving into trainee counsellors lived HSA experience would almost certainly generate lengthy but rich descriptions. However, knowledge generated in this manner is incapable of critically evaluating trainee counsellors' HSA, CSE and SWA which requires the post-positivist perspective. Adopting a pragmatic approach will not conflict with how knowledge is constructed with the interpretative phenomenological analysis (IPA) approach. Rightfully, pragmatism will likely result in a mixed methods approach to the research to comprehensively understand HSA and how HSA relates to other variables.

Third, counselling is a multidisciplinary field, and people are complex subjects of study. Human interaction, experience, and interpretation of lived experiences are complex. By adopting pragmatism as a research paradigm, we can promote multiple perspectives on "the truth" rather than opposing worldviews of objective or relative truth

in our efforts to produce knowledge (Feilzer, 2010). Counselling practice does not fall strictly into a positivist or interpretivist paradigm as the subjects of counselling involve people, and people are on the whole more complex (Glogowska, 2011). Perhaps, counselling can be a multiparadigm science (Shaw et al., 2010) where integration of paradigms will inform practice.

3.2.4 Pragmatism in A Longitudinal Mixed Methods Research

Mixed methods research has become the standard terminology used for research that have both quantitative and qualitative methods incorporated into the research design (Creswell, 2015; Creswell & Creswell, 2013; Creswell & Plano Clark, 2011). Indeed, mixed methods research has been dubbed the "third methodological movement" after quantitative research, which is the gold standard and has the longest history, and qualitative research, which is the second methodological movement (Tashakkori & Teddlie, 2003, p. 5). Mixed methods research has been gaining popularity as Johnson and group (2007) claimed:

> Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purposes of breadth and depth of understanding and corroboration. (p. 123)

Creswell (2015) cautioned researchers that mixed methods is not simply a research that has both quantitative and qualitative strands to it but most importantly, the integration of the two data sources. The term "mixed methods research" does not refer to the methodology itself but to the specific scientific techniques associated with it.

Justifications for using mixed methods research in this study include the following: establishing a comprehensive picture of trainee counsellors' HSA, increasing the trustworthiness of the study through the addition of a quantitative dataset to complement IPA; and the impracticality of using a single method when the phenomenon is not static.

The essence of this QUAL-Quant study was complementarity, where combined studies result in integration that overcomes the limitations of qualitative and quantitative studies of "complete subjectivity" and "complete objectivity", respectively (Shannon-Baker, 2016, p. 325). It was hypothesised that trainee counsellors' HSA would go through transitional changes during training. While longitudinal exploratory study generated superordinate themes (or group experiential themes) that captured these temporal changes, survey data complemented these "subjective truths". Such an abductive mode of inquiry was able to significantly produce a fuller account of the HSA.

In the next section, I will discuss the rationale for adopting the IPA approach (Smith, 1996) as compared to other research methodologies for the current study.

3.3 Interpretative Phenomenological Analysis

According to Langdridge, the "study of human experience and the way in which things are perceived as they appear to consciousness" is phenomenology (Langdridge, 2007, p. 10). Indeed, phenomenology has a long history which dates back to the 18th century.

3.3.1 Historical Development of Interpretative Phenomenological Analysis

Phenomenology was conceptualised and theorised by a German philosopher named Edmund Gustav Albrecht Husserl (1859-1938), who founded the phenomenological school. Husserl's contributions to phenomenology have aided in the

broadening of its application and viability across a variety of research disciplines. Van Manen (1990) wrote in great depth about the lived experiences of research participants and Van Manen used the term “hermeneutical phenomenology” to denote this theory of interpretation of texts of participants’ lives that they lived and experienced. Moustakas (1994) is another theorist who expanded on Husserl's phenomenology by writing about psychological phenomenology, also known as transcendental phenomenology. Phenomenological methods to generate interpretations have been widely researched by various authors (Creswell, 2013; Moustakas, 1994; Smith, 2011; Smith et al., 2009; Van Manen, 1990).

Smith, Flowers, and Larkin developed IPA as a qualitative approach that has quickly become one of the most well-known and widely used qualitative methodologies in cognate disciplines in the human, social and health sciences (Smith et al., 2009). Pertaining to the current study, IPA was chosen to explore at a deeper level, trainee counsellors’ lived experiences of HSA: understandings about HSA, contexts around HSA, and sense-making of HSA (Larkin et al., 2006, 2019). Phenomenological analysis often involves a double-hermeneutic process of interpreting meanings where the researcher who is “influenced by their contextual position in the world, is also making sense of the participant’s interpretation process” (McCoy, 2017, p. 449). In the effort to uncover trainee counsellors’ meanings associated with HSA, both the participants and the researcher engaged in the hermeneutic circle of interpretation of HSA (Smith, 2007). This cyclical and iterative process of co-construction of experiential and interpretative accounts is the essence of IPA studies (Smith et al., 2009).

Fittingly, IPA studies converge consistently on time, change and temporal context. “IPA shares the views that human beings are sense-making creatures, and therefore the accounts which participants provide will reflect their attempts to make sense of their experience” (Smith et al., 2009, p. 4). IPA is concerned with elucidating and comprehending how individuals see a specific phenomenon in their personal and social settings (Smith et al., 2009). The participant is viewed as an expert who can provide the researcher with extensive insight and comprehension of their experiences (Reid et al., 2005).

3.3.2 Rationale for Interpretative Phenomenological Analysis

The argument for using IPA in the current study stems mostly from the fact that HSA cannot be ascribed to a single conceptual model and is thus open to individual interpretation. Adopting an IPA approach would allow for the emergence of unique views on trainee counsellors' HSA. This is critical to examine because regardless of how reflexive the researcher is, to fully suspend assumptions about HSA would be difficult. IPA acknowledges that findings about trainee counsellors' HSA are ultimately an outcome of the researcher’s relationships and interactions with the data, which are based on the researcher’s experiences as a counsellor. Thus, using IPA as the main research methodology fulfils the objective of endeavouring to comprehend HSA while also complementing the hermeneutic process with the researcher’s prior life experiences. Another key reason for adopting IPA as a research methodology is that it does not test hypotheses or develop new theories, but rather can be used to stimulate conversation about current theory (Larkin et al., 2006a). The reason for doing so is to expand and explore, in a hermeneutical sense the meaning trainee counsellors associate with HSA.

In IPA, sense-making is a hermeneutic process and in the SCMCT, meaning-making is a social process.

3.3.3 Longitudinal Interpretative Phenomenological Analysis and The Theoretical Framework

This study was undergirded by the SCMCT which views trainee counsellors as agents of change in their proximal environment through their own efforts (Larson, 1998; Larson et al., 1992; Larson & Daniels, 1998). Therefore, the SCMCT was considered more appropriate for understanding trainee counsellors' phenomenological self-awareness experiences throughout their entire training period and across different contexts, compared to the Integrated Model of Self-Awareness Development (IMSAD; Pieterse et al., 2013). Conducting a LIPA study complemented the SCMCT by recognising and believing that trainee counsellors' HSA experiences would almost certainly change during training, similar to other human experiences. Adopting the SCMCT as the theoretical framework for this LIPA study reinforced the belief that trainee counsellors possess the necessary personal agency to manage HSA with support from their supervisors. In addition, adopting a LIPA approach can shed light on how trainee counsellors' CSE and SWA change with HSA throughout the training. According to the SCMCT, trainee counsellors with lower CSE would be more susceptible to novice stressors (Skovholt & Rønnestad, 2003). Through LIPA, the study can then potently capture the impact of novice stressors on trainee counsellors' CSE and HSA, and the function of SWA in developing their CSE.

3.4 Research Methodology

This section of the thesis will discuss the research design, data collection methods, pilot interviews and revisions, and data analysis. Before that, it would be helpful to provide a quick overview of counsellor education in Singapore.

3.4.1 Counsellor Education in Singapore

As stipulated by the Singapore Association of Counselling (SAC, 2020b), individuals who want to become professional counsellors in Singapore have to attend counsellor education conducted by SAC-accredited institutions. These institutions must provide at least 100 hours of practicum with a minimum of 10 hours of clinical supervision. A graduate of any SAC-recognised programme who completes at least 600 postgraduate clinical hours and 60 supervision hours is eligible to apply for SAC registered counsellor status (SAC, 2020b).

Trainee counsellors in the sample are required to complete a coursework master's degree in counselling (24 months) with an internship during the coursework period. The programme structure was split into two stages: the beginning and the advanced stage. In the beginning stage, trainee counsellors would have attended a six-month introductory phase. By the name itself, the introductory phase is a period where newly enrolled students get a sense of what counselling is about, and whether it is something that they would like to pursue as a profession. Hence, there is a possibility of them dropping out of the course for various reasons (like unsuitability of the programme, misalignment with their career goals or personal preferences, or time commitment). In addition, there are limited opportunities for face-to-face counselling other than befriending and peer role-plays. Therefore, the introductory phase is

considered a “teaser” for students to consider before committing themselves to be trained as professional counsellors. Therefore, the term “trainee counsellors” is used to refer to the group of students who have completed the beginning introductory phase and are keen to be trained as professional counsellors. Clinical supervision starts the moment students enrol into the programme. Clinical supervision aims to ensure that aspiring trainee counsellors practise ethically under the guidance and support of the counselling professionals in the field.

3.4.2 Research Questions

The design of the QUAL-quant study was influenced by the research objectives discussed in Chapter 1 of the thesis. To accomplish the research objectives, the study sought to address the following four major research questions (RQ):

RQ1. How do trainee counsellors make sense of and interpret their HSA over the course of training?

RQ2. How do trainee counsellors reflect on and learn from HSA and the contexts around their HSA over the course of training?

RQ3. Are there observed individual changes in the level, trend, and variability of trainee counsellors’ HSA, CSE, and SWA over the course of training?

RQ4. How does trainee counsellors’ changing HSA relate to changes in SWA and CSE over the course of training?

3.4.3 Research Design

This study adopted the convergent qualitative and quantitative design (Figure 2). For the qualitative study, data were collected from semi-structured interviews and monthly reflective journals; and for the quantitative study, data were collected through monthly surveys. Combined studies generated findings to comprehensively understand HSA, HSA changes, and its relationships with CSE and SWA across different training contexts such as in-session, supervision, and coursework (e.g., attending lectures, group activities, peer role-plays). The entire research process was iterative between stages of data collection, data analysis, data triangulation and design improvement.

Research questions 1 and 2 which explored deeper into trainee counsellors' HSA were the main qualitative arm of the study. Interviews at two time-points during training were able to capture trainee counsellors' temporal changes in HSA across training. Written sources (i.e., monthly journals) further provided another opportunity for trainee counsellors to describe and reflect on the unique contexts that contributed to their HSA that could otherwise be missed, forgotten at the time of the interview, or deliberately excluded from the interview as they could have caused emotional discomfort in the presence of the researcher. Findings for research questions 1 and 2 are addressed in Chapters 4 (the beginning stage) and 5 (the advanced stage).

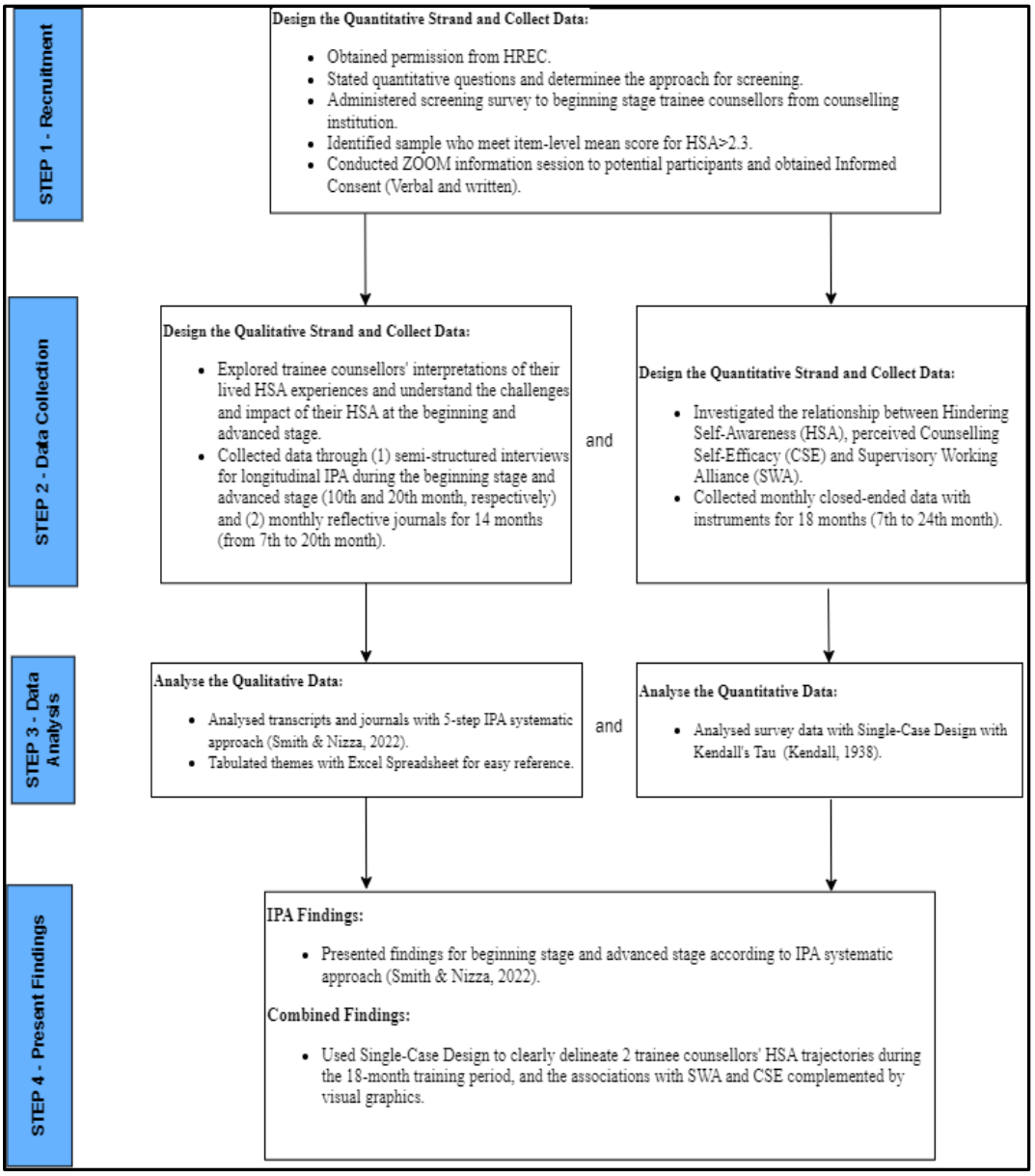
Research question 3 was addressed through a deductive mode of inquiry through monthly surveys. Data collected from surveys aimed to complement the "Big Qual" design by capturing the changes in the scores of the variables under study, which strengthened the LIPA's trustworthiness, through the triple-hermeneutic circle (Rizq & Target, 2010). The study conducted by Fauth and Williams (2005b) emphasised mainly on in-session self-awareness which was termed self-focused attention. However, the

current study argued that HSA, even though momentary, can occur during supervision, or at any point during training. As a result, the survey instrument developed by Williams et al. (2003) to assess trainee counsellors' in-session HSA was adapted to capture HSA in supervision and coursework (e.g., attending lectures and participating in class discussions and peer role-plays). Results for research questions 3 are addressed in Chapter 6.

Research question 4 was addressed through the integration of data from both studies to overcome the limitations of "complete subjectivity" and "complete objectivity" (Shannon-Baker, 2016, p. 325). Participants' narratives gathered from LIPA's findings were integrated with visual graphics as single-case analysis to abductively comprehend participants' HSA experience. Combined findings for research questions 4 are addressed in Chapter 6.

Figure 3

A Flowchart of the Convergent Mixed Methods Design Study



3.4.4 Participants

Twelve participants signed up for the study. However, two were not eligible and one dropped out of the study. The participant who dropped out of the study decided to postpone advanced stage training but consented to her data being used. The ten trainee counsellors were from three different cohorts (within the first training year) and were recruited from a counselling institution accredited by the Singapore Association of

Counselling (SAC) in Singapore. They were a homogenous sample from the same site and in the beginning stage of their counsellor training programme. Inclusion criteria were as follows: 1) trainee counsellors who were in the first year of their counsellor training at the point of recruitment and were going through practicum and clinical supervision, and 2) trainee counsellors who had met the screening criteria. The screening criteria will be elaborated upon in the Survey Instruments subsection.

IPA recommends a small sample size of between three and six (J. A. Smith et al., 2009) or six and eight participants (Pietkiewicz & Smith, 2014). Whilst there are no specific recommendations on sample size for LIPA studies, the reference list from a recent scoping review of LIPA studies (Farr & Nizza, 2019) suggested that 10-12 was an adequate sample size, which was confirmed by personal communication with the authors in June 2021. In this study the initial identified sample size was 12 after consulting past extant literature on mixed methods, IPA and LIPA studies (Kuo et al., 2020; McDonough et al., 2011; Rizq & Target, 2010; Smith, 1999), and to account for attrition. However, ten participants were recruited but nine completed the study. There were no restrictions on gender, age, or ethnicity. There were more women than men in the sample which is typical in counselling programmes. The participants had an age range of 25-49 years old and a majority of Singaporeans. All ten participants were proficient in both written and spoken English. Demographic information of the ten participants is presented in Table 1. Pseudonyms were given to all participants to preserve anonymity.

Table 1

Demographic Information for Participants

Pseudonym	Gender	Age	Ethnicity	Marital Status	Previous Occupation
Lynn	Woman	42	Chinese	Single	Sports teacher
Beatrice	Woman	26	Chinese	Single	IT manager
Mary	Woman	31	Chinese	Single	HR manager
Susie	Woman	29	Chinese	Single	Case manager
Steven	Man	47	European Australian	Married	Homemaker
Rose	Woman	36	Chinese	Single	Private tutor
Margaret	Woman	45	Indian	Married	Homemaker
Linda	Woman	36	Malay	Single	Content creator
Amanda	Woman	49	Chinese	Divorced	Student
Peter	Man	39	Chinese	Single	Freelancer

Note. Participants were from three different cohorts and in the beginning stage of counsellor training. Rose postponed her advanced stage training.

3.4.5 Recruitment

Recruitment was done by the researcher. After receiving ethics approval from the HREC, an introductory email comprising a recruitment poster and researcher's self-introduction was sent to all students of three cohorts who had enrolled for the counselling programmes through mass email by the counselling institution. A total of 12 trainee counsellors expressed interest in taking part. Following that, the researcher administered the screening survey via Qualtrics online to the interested participants. A total of 10 trainee counsellors met the screening criteria. Next, the researcher proceeded to schedule an online Zoom meeting with each interested participant on a one-on-one basis during the pandemic. This is to ensure that firstly the participants would be comfortable with the researcher and secondly, they would be willing to commit to the study owing to the longitudinal nature (i.e., 18 months in duration) of the research as

well as knowing that they reserved the right to withdraw from the study without penalties. Interested participants were also given the opportunity to have their concerns addressed. This further allowed the researcher to build rapport and trust with them. After the Zoom meeting, the researcher emailed all the participants the following: 1) Information Sheet, 2) Informed Consent Form, and 3) Timeline and Activities. Participants also provided their PayNow mobile number for monthly monetary incentives to be credited into their PayNow registered mobile bank account. During the pandemic PayNow was the safest mode of online payment as it involved no face-to-face contact and as a result, ensured participants' safety and convenience. PayNow is a secure fund transfer service adopted by the Singapore banking industry (The Association Banks in Singapore [ABS], 2017). No personal banking information was solicited from the participants and therefore the study did not violate participants' confidentiality. The participants emailed the signed Informed Consent Form to the researcher and the longitudinal study started right away. Data was collected for 18 months from three sources: interviews, journals, and surveys and the next section will discuss more about each source.

3.4.6 Data Collection

Two pilot interviews were conducted through semi-structured and in-depth interviews with two novice counsellors (within two years of graduation). Both novice counsellors recalled experiencing prior HSA. At the time of the pilot interview, both volunteers were employed in counselling-related professions working with youths. The primary objective of the pilot interview was to pre-test the interview schedule, with a focus on the language use, how the questions could have been more explorative, addition

of new questions to elicit richer data. The pilot interview was extremely helpful in providing a window into the possible data the researcher would collect, and in identifying the researcher's weaknesses as an interviewer. It was a great learning experience, and the researcher was able to engage in reflexivity as captured in the reflexivity journal:

> I'm feeling nervous and expectant at the same time. I will be conducting my second pilot interview with another ex-classmate, a male interviewee this time to scrutinise my interview questions and to hone my skills before the actual planned interview targeted in April which is two months later. In my first interview, I had a good interviewee, and she was able to offer a great deal of in-depth data just from a significant event that happened during her in-session. From her data, I was able to explore deep into her HSA and her interpretation of her HSA as related to her childhood in that particular in-session. I could also see the temporal shift from the present (with the client) to the past (with dad) to the future (future self). I feel "good enough" that the data was sufficiently rich for an IPA. However, I was too rigid in the interview; I lacked the 'flow' and came across as too mechanical. (Reflexivity journal, p. 8)

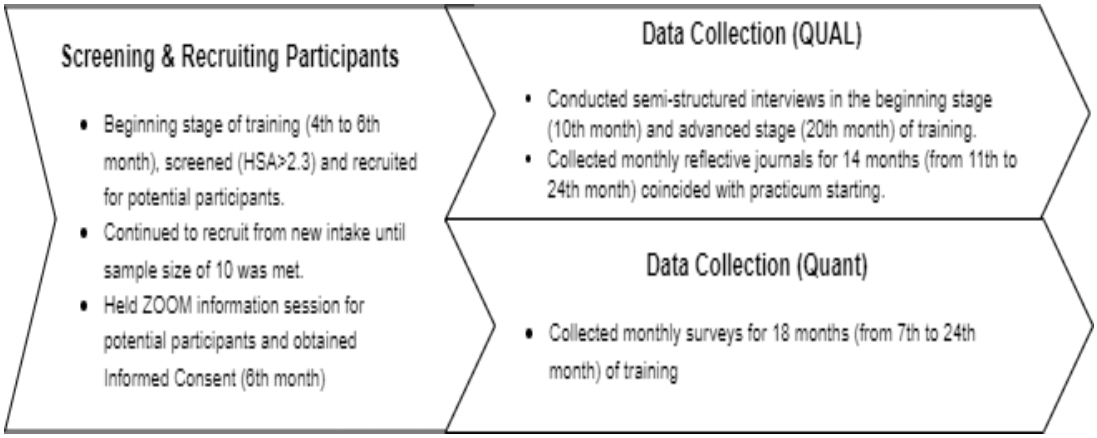
The pilot interviews went smoothly and provided the researcher with the insights necessary to identify critical areas for consideration and further exploration in the actual study. The recorded interviews were watched by the researcher's primary supervisor, and further improvements were made to the interview schedule, the interviewing style, and skills as well. Several improvements included: 1) modifying the interview structure to pursue additional questions and eliminating those that added little to the study, 2)

uncovering the researcher's assumption that participants and the researcher shared a similar understanding of counselling terminologies, 3) addressing the researcher's concern with gathering rich data, and finally 4) noting the need for reflexivity throughout the research process to bracket the researcher's assumptions. Although the sample size for the pilot interview was small, it was adequate to serve as a prototype for conducting similar interviews. However, the researcher was also cognisant of the fact that the volunteers for the pilot interview had known the researcher for a few years, and that could have aided the interview process. With newly recruited trainee counsellors, the experience would likely be different.

Data was collected over 18 time-points. Time-point 1 (TP1) was chosen after trainee counsellors completed their six-month introductory phase. Data collection typically started around the 7th month of the first training year, as trainee counsellors had gained clarity about the course, experienced a few peer role-plays and were receiving clinical supervision. Data collection ended at Time-point 18 (TP18) when trainee counsellors were near the end of their training programme. A flow chart depicting the data collection process is shown in Figure 4.

Figure 4

Recruitment and Data Collection Process During Counsellor Training



Participants were interviewed at two time-points (beginning and advanced stages of training). Almost all interviews were conducted via Zoom online due to Singapore's Safe Management Measures imposed during COVID-19. Each semi-structured interview lasted about 60-90 minutes, was audio-recorded, and transcribed with Otter.ai, a transcribing software. The interview schedule was developed from existing literature on HSA and adhered closely to IPA recommendations with open-ended questions to elicit participants' responses, for example, "Please share with me a significant experience that occurred during your time as a counsellor?", "How did you react to this significant experience?", "How did this significant experience impact your understanding of yourself as a trainee counsellor?" The purpose was not to introduce any element that might contradict the nature of an IPA study, the term "significant experience" was chosen as a more neutral term used to tease out a particular event that occurred during training (counselling session, supervision, or coursework training at the institution) that elicited momentary strong emotions, deep thoughts, or physiological responses that trainee counsellors felt were uncomfortable or troubling. Additionally, the questions remained open and flexible enough for the participants to share their HSA. In the second interview, participants were asked for another significant experience in the advanced

stage; however, the second interview maintained continuity with the first interview. This was to honour the temporal aspect of LIPA's study. The interview schedules for both stages are appended to the end of the thesis (Appendix 6 and 7).

Participants were also asked to write monthly reflective journals (from the 11th to 24th training month which coincided with the start of practicum) with a minimum word limit of 200 to ensure substantive coverage of the HSA experience. Journaling was a part of the training requirement and was generally content-based. Therefore, specific reflective prompts were provided to participants in order to collect data that focused on how and what trainee counsellors had learnt from reflecting on their HSA across different training contexts, which included supervision, in-session with clients, or coursework training such as lectures, peer role-plays or group activities that took place at the institution. Additionally, reflective prompts were broad enough to capture the scope yet specific enough for participants to reflect on experiences related to HSA. This precautionary step was helpful to avoid bias potentially introduced by artificial reporting contexts (Stone & Shiffman, 2002). Examples of reflective prompts included: Where did this significant experience occur? How would you describe this significant experience? How would you react differently now? What have you learned from this significant experience? An explanation of what constituted a significant experience was provided to all participants. The same cautionary approach adopted in the interview was used in framing the reflective prompts for the journals (Appendix 8).

Quantitative survey data were collected concurrently with journals throughout the 18 months of data collection (from the 7th to the 24th training month). However, the participants only started journaling from the 11th training month onwards which

coincided with their practicum. The journals were intended to collect participants' reflections on their HSA; therefore, it would be pragmatic to have them begin journaling during practicum. Participants were required to complete surveys every month. The surveys required approximately five minutes to complete based on pilot testing. A survey link was sent to each participant monthly and progress was monitored. Each participant was assigned a unique code (VC001, VC002, all the way to VC010). A fresh monthly survey link was a precautionary step aimed to reduce in participants the effects of "demand characteristics" or a need to play the role of "good subjects" by producing improving scores over the period (McCambridge et al., 2012). Participants were required to complete a set of online Qualtrics instruments arranged in this order: (1) Demographic questionnaire, 5 items; (2) CTPSA on participants' perceptions of the importance of self-awareness in counsellor training programme, abbreviated CTP, 3 items; (3) Adapted Self-Awareness Management Scale (SAMS), 30 items (Williams et al., 2003); (4) Brief Supervisory Working Alliance Inventory – Trainee (BSWAI-T), 5 items (Sabella et al., 2020); (5) Session Management Self-Efficacy Scale (SMSE), 10 items (Lent et al., 2003). Participants were only required to complete items (1) and (2) on the 1st and 24th month of the data collection process. The next section will provide more information on the survey instruments.

3.4.7 Survey Instruments

3.4.7.1 Demographic Survey

The survey comprised of five questions to gather information about the participants (gender, age, marital status, race, highest educational attainment).

3.4.7.2 Counsellor Training Program Self-Awareness (CTPSA)

Additional questions were included to draw out from the participants their perceptions of the importance of self-awareness and if self-awareness was included in the training pedagogy.

3.4.7.3 Self-Awareness Management Strategies Scale (SAMS)

The SAMS was used to measure trainee counsellors' in-session HSA. Williams et al. (2003) further categorised HSA as either distracting or anxious awareness. The measure was adapted for the current exploratory study to include the contexts of supervision and coursework at the institution. The adaptation of the survey consisted of a total of 30 questions over three counselling contexts: in-session, supervision, and coursework (i.e., 10 items each for each of the three contexts). As an adapted version, the survey therefore was unable to ensure the psychometric validity of the original SAMS. The SAMS was rated on a 5-point scale from "never" (1) to "always" (5). Possible composite scores range from a minimum of 30 to a maximum score of 150. Higher scores indicate a higher frequency of momentary HSA by trainee counsellors. There is no rescoring required. Sample questions for Anxious Awareness included: How often do you become aware of feeling anxious during the session? How often do you experience moments of heightened self-awareness (e.g., moments when you become increasingly aware of your thoughts, feeling overwhelmed or feeling the desire to yawn, etc.)? Sample questions for Distracting Awareness included: How often do you become aware of thinking about issues unrelated to the client or session (e.g., outside stressors, needing to return a phone call, paperwork, etc)? How often do you feel that your thoughts and reactions have interfered with your performance as a therapist during a session (e.g., you "tune out" and didn't hear what your client just said)? Research on

HSA remains scant. Wei et al. (2017) reported a Cronbach's alpha of .78 for Anxious Awareness, and .74 for Distraction Awareness, and an overall .83 for HSA. William et al.'s (2003) study reported Cronbach's alpha of .76 and it is also the only instrument available at the point of study to measure trainee counsellors' in-session HSA.

Participants for the current study were screened for eligibility. As not all interested trainee counsellors would have experienced HSA, the mean score of 2.3 was used as a reference from Williams et al.'s study (Williams, Hurley, et al., 2003). This was an additional step to ensure the suitability of candidates for the current QUAL-Quant study with a larger focus on participants' lived experiences. Therefore, recruiting participants with prior HSA experience was an essential consideration.

3.4.8.4 Brief Supervisory Working Alliance Inventory – Trainee Version (BSWAI-T).

BSWAI-T (Sabella et al., 2020) was a shorter version of the Supervisory Working Alliance Inventory – Trainee Version, SWAI-T. The BSWAI-T is a 5-item measure rated on a 7-point scale from "almost never" (1) to "almost always" (7). Possible scores range from a minimum score of 5 to a maximum score of 35 and higher scores indicate a stronger supervisory working alliance while lower scores indicate weaker supervisory working alliance. Sample questions included: My supervisor's style is to carefully and systematically consider the material I bring to supervision; I feel comfortable working with my supervisor. When compared to the full-scale SWAI-T, the BSWAI-T demonstrated a high internal consistency of .97 and a negligible reduction of only .01. The item-total correlations for all five items were greater than. 91. A retest maintained a high internal consistency of .92 which was sufficiently reliable for research purposes.

3.4.8.5 Session Management Self-Efficacy Scale (SMSE).

The Session Management Self-Efficacy Scale was used to assess counselling self-efficacy (Lent et al., 2003). The SMSE comprised of 10 items to assess the perceived ability to facilitate the counselling process. Participants were asked to rate their level of confidence in their ability to perform each of the tasks effectively over the next week during their in-session with the majority of their clients on a 9-point scale from "no confidence" (0) to "complete confidence" (9). Possible scores range from a minimum of 10 to a maximum score of 90. A higher score indicates increased self-efficacy in counselling session management. Sample questions included: Help your client to understand his or her thoughts, feelings, and actions; Know what to do or say after your client talks. Lent et al. (2003) reported coefficient alphas of .96 and .97, respectively, in their two time-point study of counsellors enrolled in a pre-practicum course. The survey instruments that were used in the study are appended to the end of the thesis (Appendix 9).

3.4.9 Data Analysis for Interpretative Phenomenological Analysis

Both transcripts and journals were analysed using the 5-step IPA systematic approach (Smith & Nizza, 2022). The five steps are: 1) Reading and exploratory notes, 2) Formulating experiential statements, 3) Finding connections and clustering experiential statements, 4) Compiling a table of personal experiential themes, and 5) Compiling group experiential themes and cross-case analysis. The process was iterative. It is worth noting that IPA has changed some of the terminology used to describe the process of analysis as the authors argued that the new parlance can reflect the process more clearly (Smith & Nizza, 2022). For example, "emergent themes" are changed to

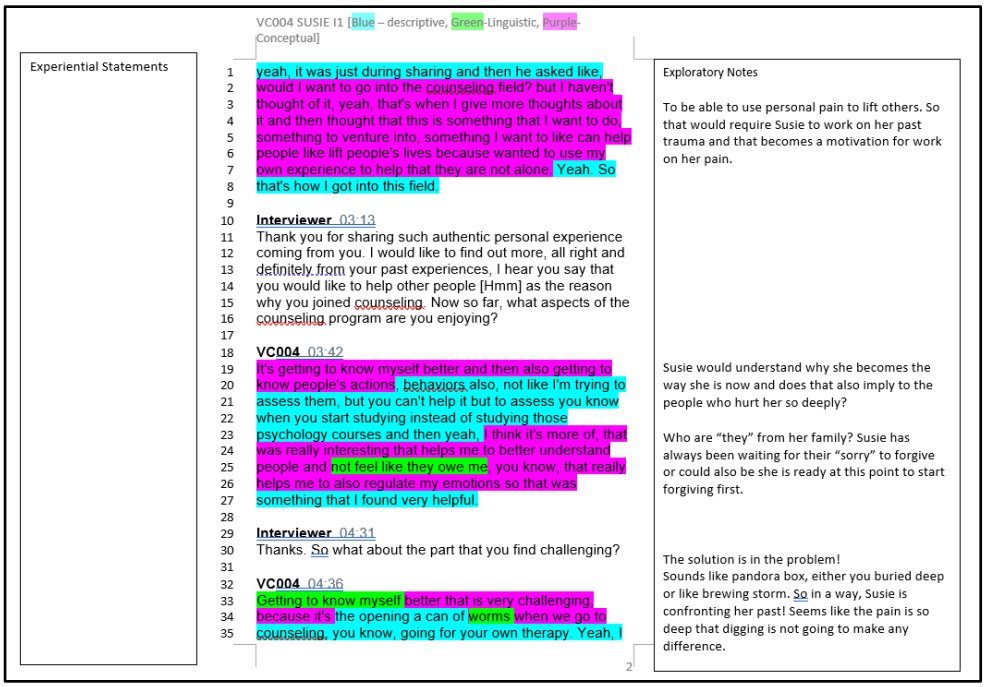
"experiential statements" to better capture the analytic process, and a collection of "emergent themes" is clustered to make up a Personal Experiential Theme, abbreviated PET (Smith & Nizza, 2022). Since this was a LIPA study, individual analysis of participants' interviews for the two training stages was integrated to identify themes that span across time, which is the hallmark of longitudinal phenomenological studies (Farr & Nizza, 2019).

Step 1: Reading and Exploratory Notes

The researcher employed Otter.ai to automate the transcription process. In the automated transcripts, however, missing words (or phrases) and misspelt words were evident. The researcher began first by listening to the audio recording to check for transcribing errors for each transcript. Following that, the researcher listened to the entire recording while reading the transcription. For the third listening, the researcher listened to the recording without the transcription; to visualise specific segments of the interview while listening to the play-back. The researcher took mental notes of her thoughts and emotions and bracketed that into the reflexive journal. For the fourth listening, the researcher zoomed into certain parts that were relevant to the study. When the researcher was able to grasp both the literal and implicit meanings of what the participants were sharing, notes were recorded in a Word Document. To honour the idiographic nature of IPA, the researcher went through Steps 1 to 5 for each transcript before working on the next transcript. A three-column table was used to capture initial notes as shown in Figure 5.

Figure 5

Recording Exploratory Notes for Susie



VC004 SUSIE I1 [Blue – descriptive, Green-Linguistic, Purple-Conceptual]

Experiential Statements

yeah, it was just during sharing and then he asked like, would I want to go into the counseling field? but I haven't thought of it, yeah, that's when I give more thoughts about it and then thought that this is something that I want to do, something to venture into, something I want to like can help people like lift people's lives because wanted to use my own experience to help that they are not alone. Yeah. So that's how I got into this field.

Interviewer 03:13
Thank you for sharing such authentic personal experience coming from you. I would like to find out more, all right and definitely from your past experiences, I hear you say that you would like to help other people [Hmm] as the reason why you joined counseling. Now so far, what aspects of the counseling program are you enjoying?

VC004 03:42
It's getting to know myself better and then also getting to know people's actions, behaviors also, not like I'm trying to assess them, but you can't help it but to assess you know when you start studying instead of studying those psychology courses and then yeah, I think it's more of, that was really interesting that helps me to better understand people and not feel like they owe me, you know, that really helps me to also regulate my emotions so that was something that I found very helpful.

Interviewer 04:31
Thanks. So what about the part that you find challenging?

VC004 04:36
Getting to know myself better that is very challenging, because it's the opening a can of worms when we go to counseling, you know, going for your own therapy. Yeah, I

2

Exploratory Notes

To be able to use personal pain to lift others. So that would require Susie to work on her past trauma and that becomes a motivation for work on her pain.

Susie would understand why she becomes the way she is now and does that also imply to the people who hurt her so deeply?

Who are "they" from her family? Susie has always been waiting for their "sorry" to forgive or could also be she is ready at this point to start forgiving first.

The solution is in the problem!
Sounds like pandora box, either you buried deep or like brewing storm. So in a way, Susie is confronting her past! Seems like the pain is so deep that digging is not going to make any difference.

The researcher divided the Word Document into three columns: the right margin for exploratory notes, the left margin for experiential statements, and the middle section for the transcript. The researcher highlighted quotes in blue, green, and purple to denote and distinguish between descriptive notes (explicit meaning of what the participant said or described, such as objects, events, and experiences), linguistic notes (actual words spoken that were considered particularly interesting, such as pronouns, pauses, repetitions, and tone), and conceptual notes (a form of questions, particularly at the start of the analytical process), respectively (Smith & Nizza, 2022).

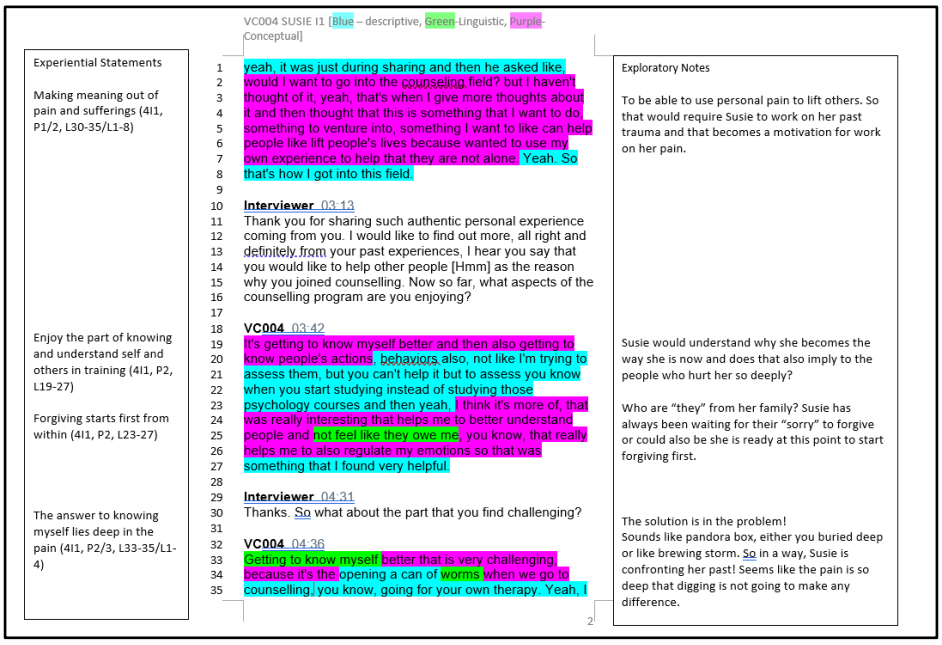
Step 2: Formulating Experiential Statements

At this point, the researcher already had a series of exploratory notes as an initial scaffold to formulate the experiential statements. According to Smith and Nizza, each experiential statement is a concise summary of what emerges from the exploratory notes

and must be grounded in the data (2022). In general, developing experiential statements necessitates a condensing effort to allow for the emergence of both significant aspects of participants' HSA experience and the researcher's understanding of their experiences. The process was formulating experiential statements is iterative. A part of the process to develop Susie's experiential statements is shown in Figure 6.

Figure 6

Developing Experiential Statements in the Left Column



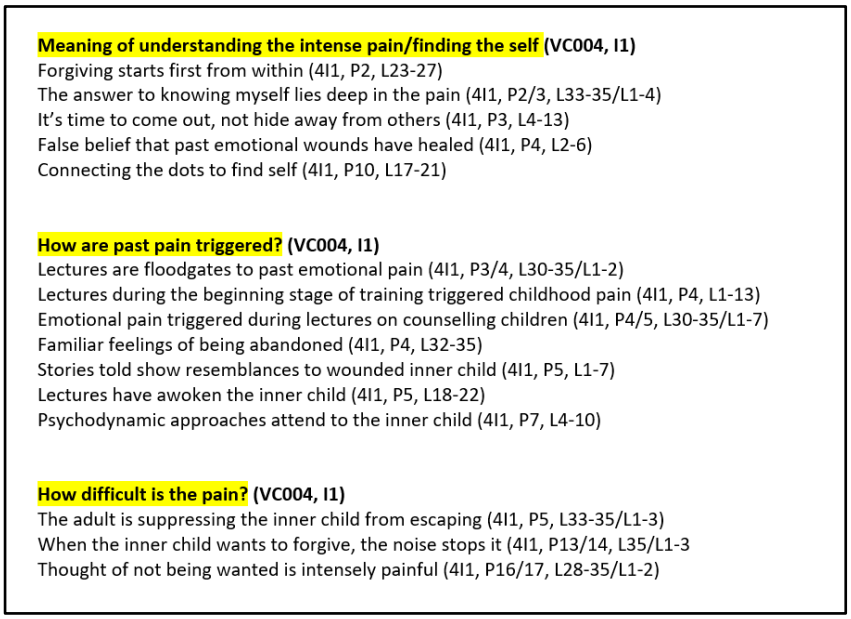
Step 3: Finding Connections and Clustering of Experiential Statements

Smith et al. (2009) defined themes as "typically expressed as phrases that speak to the piece's psychological essence and contain both enough particularity and abstraction to be conceptual" (p. 92). The researcher began abstracting and synthesising the experiential statements. For example, the analysis of Susie's entire transcript in her first interview produced over a hundred experiential statements. Smith and Nizza (2022)

recommended their preferred approach to the clustering process, which is to create a list of the experiential statements, print the list out, and cut the sheet up so that each statement is on a separate piece of paper. The paper cut-outs are then placed randomly on a large surface where they can be easily repositioned. To help illustrate the process of clustering, the researcher first formulated the experiential statements from Susie's transcript as shown in Figure 7.

Figure 7

Clustering of Experiential Statements from Susie's Transcript



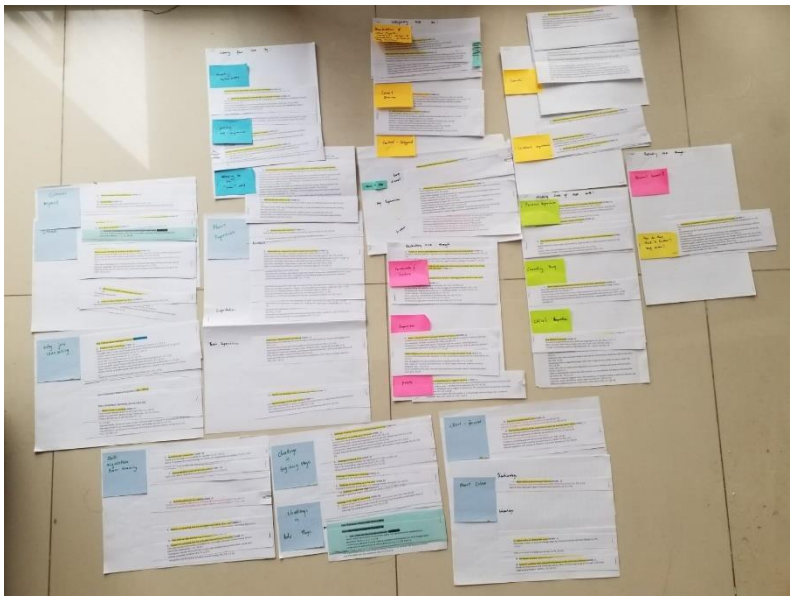
The researcher used a spreadsheet and word processor to keep track of the large amount of data which was a conscious decision made over NVivo due to the nature of the longitudinal study. The spreadsheet gave the researcher a bird's-eye view of all the experiential statements of each participant over different time-points. When the clustering and re-clustering of the experiential statements were completed the researcher proceeded to the next step.

Step 4: Compiling the Table of Personal Experiential Themes

The researcher sorted the initial clusters by shifting the paper cut-outs around on the floor to aid the process as shown in Figure 8. At this stage, the researcher also discarded some statements that were not able to best speak for the themes. The clustered experiential statements were tabulated with a spreadsheet and each cluster was given a PET with experiential statements and quotes from the transcript. At this stage, the researcher showed the PETs to her supervisor as she was able to lend an objective eye to ensure the convergence of themes. This further enhanced the trustworthiness of the analysis and that the initial interpretation was grounded in the data. For PETs that seemed questionable, they were revisited and worked through from Step 3. A snapshot of Susie's PETs is shown in Table 2.

Figure 8

Sorting Process of Cluster themes with Paper Cutouts



Step 5: Cross-Case Analysis

When all the participants' transcripts were analysed in their own entirety, the next stage involved comparing across the cases, and the results of comparisons gave rise to a table of group experiential themes (GET) that demonstrated how these themes converge and diverge. The process of convergence and divergence brought together similarities in trainee counsellors' accounts of their HSA and highlighted the high-level connectivity among their experience (hence convergence) and at the same time, also highlighted the high-level contrast that manifested among the trainee counsellors in their HSA across the passage of time (hence divergence). This rigorous screening of GET was non-linear and iterative, and I went through multiple rounds of review. A snapshot of a part of GET 3 (i.e., Building Strengths, Accepting Vulnerabilities) with direct participants' quotes (italicised) is shown in Table 3.

Table 2

Compiling the Table of Personal Experiential Themes from Susie's Analysis

Experiential Themes	**Page/line**	**Quotes**
Theme 1. Process toward understanding self		
Forgiving starts first from within	2/25	*I'm not holding on to the past.*
The answer to knowing myself lies deep in the pain	2/34	*It's the opening a can of worms when we go to counseling.*
It's time to come out, not hide from others	3/9	*I'm still trying to learn to push myself out of my comfort zone.*
False belief that past emotional wounds have healed	4/3	*I thought I got better, but it seems like I'm still moving backward.*
Theme 2. Coping with inner child		
Locking the sad inner child away with a happy face	6/18	*I am a joker you know always making people laugh.*
First attend to the inner child, next the lecture	7/10	*I know that I had that feeling of self-worth, loveless. So I just acknowledge them.*
Attending to the inner child calms intense emotions	9/28	*I kind of acknowledge it and then let's continue listening.*
When the inner child is heard, she calms down	10/8	*Is more of me acknowledging it.*

Table 3

Compiling the Table of Group Experiential Themes (GET) Across Training

GET 3: Building Strengths, Accepting vulnerabilities. (3b) Learning to be kind and patient with themself	
Susie: *Certain experiences in the past that happened made me behave this way so I'm like okay, so this is how it is, and I acknowledge it. (Beginning stage, I1)* *…one of the things that I strongly believe in is to talk about it (Susie's childhood) because if I don't talk, I think it is going to be very tough for me to be a counsellor… even though I am nervous… like I'm not hiding anything…. (Advanced stage, I2)*	Page/Line 9/26 26/6-10
Margaret: *I tap into my adult ego, and I be that person, I'm not getting intimidated. (Beginning stage, I1)* *I had always dreaded recording my session for assessment, but last week I did that with confidence... I still feel stuck and feel at a lost… but at least I am growing. (Advanced stage, J8)*	10/14 2/16-20
Amanda: *I don't carry on my script that I've carried…. (Beginning stage, I1)* *I don't think overthink as much… whether I did right or wrong, I do a bit of check in, like how could I have done differently… I think my confidence level has gone up…. (Advanced stage, I2)*	2/1-6 25/30-34
Linda: *I really do love them so much, but it came from a place of so much pain growing up. But I'm so glad I'm doing better now. (Beginning stage, I1)*	 32/18 17/28-34

GET 3: Building Strengths, Accepting vulnerabilities. (3b) Learning to be kind and patient with themself	
I finally was aware that I was so self-judgmental that because I was so judgmental of self, I thought everyone was judging me… that was like mind blowing… look at yourself more kindly, like, you know, it's still a work in progress… (Advanced stage, I2)	
Beatrice: *I can still try my best and like do whatever I need to get what I want out of my studies, but the worst can still happen and I'm ready to accept that*." (Beginning stage, I1) *…it (the current state) was helpful as it made me internally reflect on how I prioritise what are important to me and it was also a wake-up call that I don't want to be in my current situation for the rest of my life.*" (Advanced stage, J6).	29/15-18 3/2-8
Peter: *I'm aware of the areas that I need to work on and as long as I do something about it, I know that I'll be on track, so it's the process and not the result.* (Beginning stage, I1) *I think is to be aware of both ends of the stick… be relaxed and at the same time conscious of the way I speak, so is to find that balance…. (Advanced stage, I2)*	24/15-17 33/17-19
Lynn: *You don't have to start strong actually… you just have to start and keep moving, just carry on your life.* (Beginning stage, I1) *Is okay just let it go.* (Advanced stage, I2)	33/9-12 33/32

3.4.10 Data Analysis for Single-Case Design

A key assumption underlying parametric statistics concerns a normal distribution of sample data. This is to ensure unbiased sample estimates of the population parameters. However, nonparametric statistics are not founded on this assumption, so data can be collected from samples that do not adhere to the assumption. Time-series data are often auto-correlated and as such, error terms are not independent. Running conventional statistical analysis risks the validity of analyses, therefore in this study, non-parametric tests like non-overlap methods and randomisation tests were run to circumvent the problem of correlated error terms (Morley, 2018; Morley & Adams, 1989). More specifically, Kendall's tau statistic was conducted to explore the trends, levels, and variability of each participant.

Kendall's Tau ($\tau_{(time.score)}$)

Tau (τ) is introduced by Kendall (1938) as a rank correlation statistic and τ is arithmetically bound between -1 (indicates that two variables order a set of data points in exactly the opposite way) and +1 (indicates that two variables order a set of data points in the same way; Brossart et al., 2018; Parker et al., 2011).

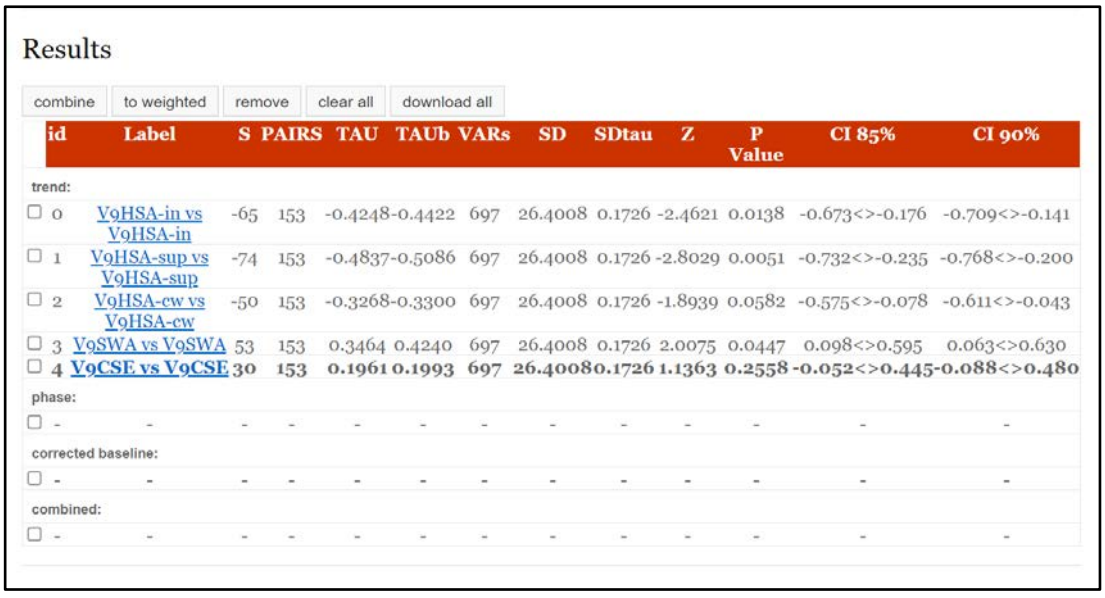
Effect Size Analysis

Effect sizes and standard errors were computed using the complimentary online utility Tau-U calculator (Vannest et al., 2016). Since the study was mainly explorative (QUAL-quant design), the calculator was used to calculate the simple non-overlap (Tau) instead of simple non-overlap controlling for positive baseline trend (Tau-U) for single-case experimental designs. Simple non-overlap (Tau) is asking, "Do time and score values order these data points in the same way?" (Brossart et al., 2018, p. 3), and this was the study's interest in simply detecting the

direct change over time, or $\tau_{(time.score)}$. Statistical significance and confidence intervals were reported to compare and evaluate between the variables. These statistics were measured by using Kendall's S in Tau which provided the degree of statistical power (Parker et al., 2011). Group Analysis was calculated to combine the contrasts into a single aggregated omnibus effect size. For example, Susie's results (HSA during in-session (HSA-I), HSA during supervision (HSA-S), HSA during coursework training (HSA-C), SWA and CSE), and weighted average of the sample from the Tau-U calculator (Vannest et al., 2016) are shown in Figure 9 and 10, respectively. In single-case studies, visual displays are essential as they provide a primary source for the analysis and interpretation of the study. Visual graphs were generated for each participant showing their HSA, SWA and CSE scores over the 18 time-points as shown in Figures 11 and 12, using Susie as an example. The results obtained will then be integrated to complement the qualitative findings and to provide explanations for any observed similarities or differences.

Figure 9

Using Tau-U Calculator to Calculate Susie's Change Over Time $\tau_{(time.score)}$



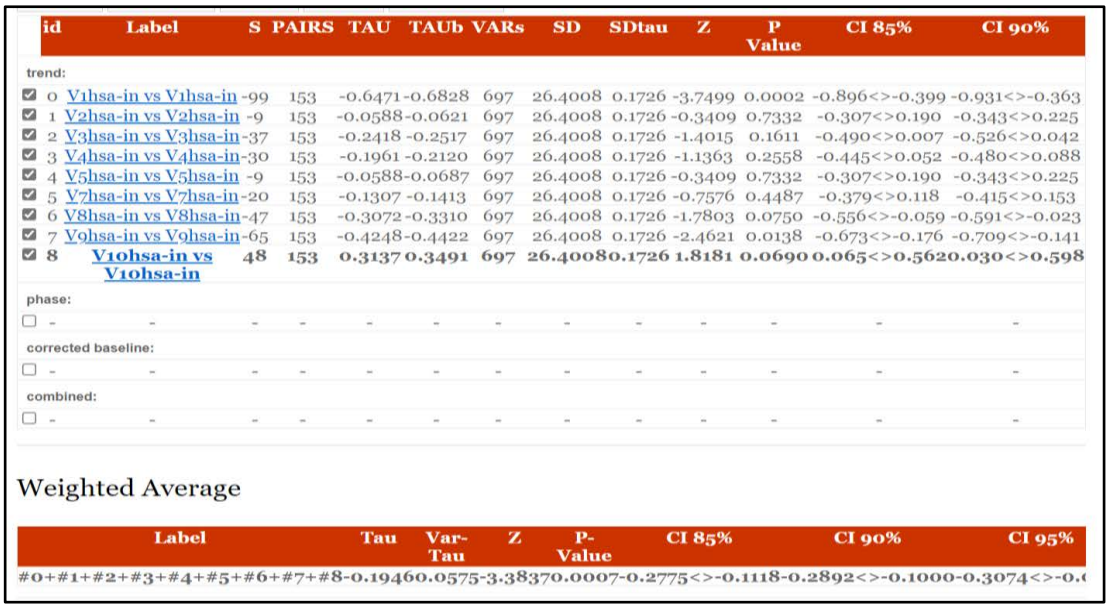
Results

combine | to weighted | remove | clear all | download all

id	Label	S	PAIRS	TAU	TAUb	VARs	SD	SDtau	Z	P Value	CI 85%	CI 90%
trend:												
0	V9HSA-in vs V9HSA-in	-65	153	-0.4248	-0.4422	697	26.4008	0.1726	-2.4621	0.0138	-0.673<>-0.176	-0.709<>-0.141
1	V9HSA-sup vs V9HSA-sup	-74	153	-0.4837	-0.5086	697	26.4008	0.1726	-2.8029	0.0051	-0.732<>-0.235	-0.768<>-0.200
2	V9HSA-cw vs V9HSA-cw	-50	153	-0.3268	-0.3300	697	26.4008	0.1726	-1.8939	0.0582	-0.575<>-0.078	-0.611<>-0.043
3	V9SWA vs V9SWA	53	153	0.3464	0.4240	697	26.4008	0.1726	2.0075	0.0447	0.098<>0.595	0.063<>0.630
4	V9CSE vs V9CSE	30	153	0.1961	0.1993	697	26.4008	0.1726	1.1363	0.2558	-0.052<>0.445	-0.088<>0.480
phase:												
-	-	-	-	-	-	-	-	-	-	-	-	-
corrected baseline:												
-	-	-	-	-	-	-	-	-	-	-	-	-
combined:												
-	-	-	-	-	-	-	-	-	-	-	-	-

Figure 10

Using Tau-U Calculator to Calculate the Change in HSA Over Time $\tau_{(time.score)}$



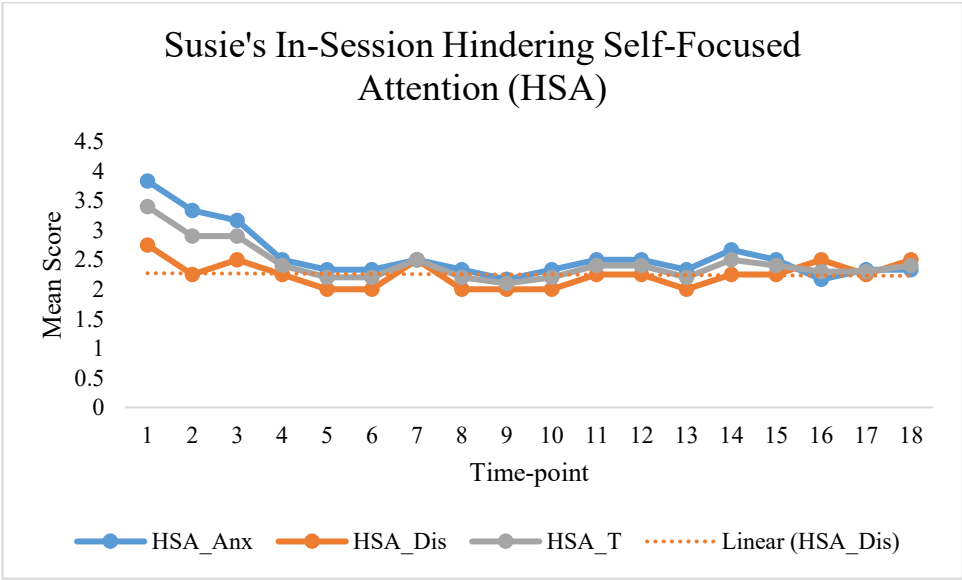
id	Label	S	PAIRS	TAU	TAUb	VARs	SD	SDtau	Z	P Value	CI 85%	CI 90%
trend:												
0	V1hsa-in vs V1hsa-in	-99	153	-0.6471	-0.6828	697	26.4008	0.1726	-3.7499	0.0002	-0.896<>-0.399	-0.931<>-0.363
1	V2hsa-in vs V2hsa-in	-9	153	-0.0588	-0.0621	697	26.4008	0.1726	-0.3409	0.7332	-0.307<>0.190	-0.343<>0.225
2	V3hsa-in vs V3hsa-in	-37	153	-0.2418	-0.2517	697	26.4008	0.1726	-1.4015	0.1611	-0.490<>0.007	-0.526<>0.042
3	V4hsa-in vs V4hsa-in	-30	153	-0.1961	-0.2120	697	26.4008	0.1726	-1.1363	0.2558	-0.445<>0.052	-0.480<>0.088
4	V5hsa-in vs V5hsa-in	-9	153	-0.0588	-0.0687	697	26.4008	0.1726	-0.3409	0.7332	-0.307<>0.190	-0.343<>0.225
5	V7hsa-in vs V7hsa-in	-20	153	-0.1307	-0.1413	697	26.4008	0.1726	-0.7576	0.4487	-0.379<>0.118	-0.415<>0.153
6	V8hsa-in vs V8hsa-in	-47	153	-0.3072	-0.3310	697	26.4008	0.1726	-1.7803	0.0750	-0.556<>-0.059	-0.591<>-0.023
7	V9hsa-in vs V9hsa-in	-65	153	-0.4248	-0.4422	697	26.4008	0.1726	-2.4621	0.0138	-0.673<>-0.176	-0.709<>-0.141
8	V10hsa-in vs V10hsa-in	48	153	0.3137	0.3491	697	26.4008	0.1726	1.8181	0.0690	0.065<>0.562	0.030<>0.598
phase:												
corrected baseline:												
combined:												

Weighted Average

Label	Tau	Var-Tau	Z	P-Value	CI 85%	CI 90%	CI 95%
#0+#1+#2+#3+#4+#5+#6+#7+#8	-0.1946	0.0575	-3.3837	0.0007	-0.2775<>-0.1118	-0.2892<>-0.1000	-0.3074<>-0.(

Figure 11

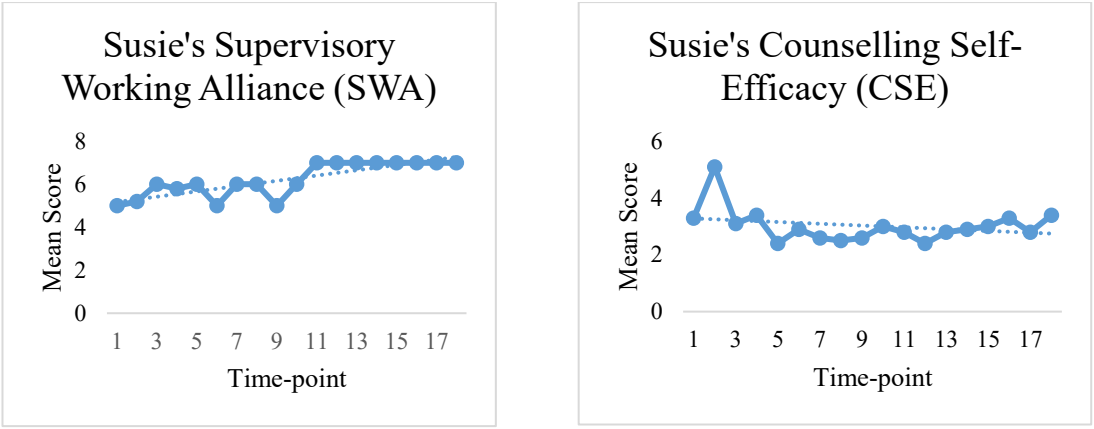
Susie's Visual Graph on HSA Across Training



Note: HSA = HSA during in-session with clients; HSA-Anx = Anxious subscale during in-session; HSA-Dis = Distracting subscale during in-session; HSA-T = Total HSA score during in-session

Figure 12

Susie's Visual Graphs on SWA and CSE Across Training



3.4.11 Integration of Findings

According to Creswell (2015) "integration is the place in the mixed methods research process where the quantitative and the qualitative phases intersect" (p. 82) and integration can exist during data collection, data analysis, and results section of the study. Pertaining to the current study, the researcher established continuity between beginning and advanced stage interviews, complemented IPA findings with survey data, and presented two of the nine participants' HSA trajectories in Chapter 6. In addition, the entire study was undergirded by the theoretical framework of the SCMCT. Therefore, integration took place throughout the entire study, and the findings were integrated into the larger context of counsellor education.

3.5 Reflexivity

Reflexivity is consistent with IPA's standard which states that effective research requires the researcher to establish rapport with the participants (Smith, 2011), and be involved in the process through "prolonged engagement and persistent observation in the field" (Creswell, 2013, p. 299). This implies that the researcher is not detached from the phenomenon, nor is the researcher adopting an etic or out-of-

the-fishbowl perspective. The researcher is not anonymous to the participants in qualitative research because the researcher is frequently the primary instrument for collecting data in the field, examining documents, observing behaviours, and interviewing participants (Creswell, 2013). Hence, reflexivity is often fundamental. Researcher reflexivity requires the researcher to convey useful information about themselves to both the participants and the audience. Information like backgrounds, how interpretations will be formed and gains from the study are necessary to build trust and improve transparency.

3.5.1 Researcher's Reflexivity

With this as a starting point, the researcher was mindful and reflective that her prior experience of HSA might affect the research undertaking. According to Willig (2013), there are two forms of researchers' reflexivity, personal and epistemological. Personal reflexivity entails the researcher being aware of the potential impact of their values, beliefs, and personal experiences on the research. When the researcher is self-aware and reflective, they can work to overcome limitations. Epistemological reflexivity entails the researcher's awareness of how their philosophical views, knowledge, and assumptions can affect not only the research process but also the findings (Willig, 2013). In the following paragraph, the researcher will provide her personal and epistemological stance and the pronoun "I" is used to personalise the reflexivity.

> My role as a counsellor has shaped both my personal and epistemological positions in this research. I hold the belief that self-awareness is a critical aspect of counsellor development. I acknowledge the complexity involved in trying to understand HSA and the way to overcome this challenge is to co-construct knowledge with my participants. I perceive multiple realities in

HSA and understanding HSA will involve a nuanced interplay between the intentional consciousness of my participants and their subjective "self" as objects of introspection. To unravel the profound nature of HSA, I strive to suspend presuppositions and cultural biases. I employ a phenomenological reductionist approach to allow for an unfiltered examination of HSA insofar as the meanings embedded are uncovered. I maintain reflexivity by keeping a research journal for personal reflections, questions, and insights. An excerpt from the researcher's journal is provided:

> I am both excited and exhausted till this point. I caught myself feeling stuck with participants' HSA…. Looking back at my own HSA to sense. I start to notice my thoughts: Is this what Susie meant? Are my interpretations grounded? Are the personal experiential themes well represented? Why am I self-doubting? Is HSA so complex and deep? (Reflexivity journal, p. 45)

3.5.2 Bracketing

Bracketing has been practised in qualitative research "to mitigate the potentially deleterious effects of preconceptions that may taint the research process" (Tufford & Newman, 2012, p. 80). Bracketing off the researcher's preconceptions also allows the participants space and freedom to express their concerns, private to their life experiences. Qualitative studies frequently elicit lengthy descriptions, and the research process can be emotionally draining and challenging. When the researcher separates or suspends their judgments and assumptions, it provides another safeguard for maintaining the research integrity. Importantly, it also enables the researcher to reach the deepest level of reflection not just during the interviewing process, but throughout the entire research study (Tufford & Newman, 2012).

Bracketing allows the researcher to remain attached (i.e., being sensitive to participants' lived experiences) and detached from the study (i.e., being mindful of emotional fuse). In the current study, the researcher bracketed off her thoughts, feelings, and doubts in the researcher's journal. In addition, random thoughts, decision-making processes, unique events or any research concerns such as contingency plans, spending, dates, and roadblocks that could affect the study were bracketed off (Birks et al., 2008). The reflexivity journals were kept in a folder secured with a password on the researcher's laptop.

3.5.3 Tensions on Bracketing

Following Husserl's introduction of the phenomenological reduction, the evolving and amorphous nature of bracketing created several tensions. These tensions include disagreements over the definitions of various bracketing elements; a lack of agreement on when bracketing should occur; who should bracket: participants, researchers, or both; and how bracketing should be conducted (Tufford & Newman, 2012). Explicit disclosure of the bracketing process should occur during the writing phase of the research process, during which the researcher describes the method and contribution of bracketing to the research undertaking. Alternatively, if a researcher takes a more Heideggerian stance and rejects the concept of reduction, it is critical to maintain transparency (Rolls & Relf, 2006; Tufford & Newman, 2012). "The lack of a uniform definition of bracketing has led many authors to speculate as to its constitutive essence" (Tufford & Newman, 2012, p. 83). Widely, bracketing may encompass the following: beliefs and values; biases; emotions; assumptions of phenomenon and researcher's suppositions (Fischer, 2009; Rolls & Relf, 2006; Tufford & Newman, 2012). The lack of unified consensus further includes the source of bracketing. Tufford and Newman (2012) suggested that bracketing can be

achieved through memos, reflexive journaling, and bracketing interviews. To uphold the methodological trustworthiness of the IPA, reflexive journaling and bracketing interviews were utilised in this study.

3.5.4 Bracketing Interview

Despite the researcher's reflexivity, the researcher was aware that it would be impossible to be free of bias from her prior HSA and that the interpretation of the HSA could be influenced by her values and culture. Rolls and Relf (2006) recommended the bracketing interview to mitigate the limit of researcher reflexivity. The researcher enlisted the assistance of her clinical supervisor, who has extensive experience in counsellor development, as the bracketer. The supervisor was briefed on the bracketer's role and responsibilities. Additionally, a downloaded copy of the literature on the bracketing interview (Rolls & Relf, 2006) was sent to the supervisor a week before the interview. Three bracketing interviews were conducted via Zoom due to the COVID-19 situation in the country. The first bracketing interview was conducted prior to the first IPA interview to discuss issues about the research and the participants. The second bracketing interview was conducted halfway through the data collection period to delve deeper into the researcher's concerns that could affect the data analysis process. The final interview was conducted after the data analysis to discuss about the findings. All the bracketing interviews were Zoom recorded and transcribed and insights were shared with the researcher's primary supervisor.

In general, the bracketing interviews revealed the researcher's concerns, worries, apprehensions, or prejudgments about the researcher's prior experience of HSA. The bracketer asked directional, awkward, and pertinent questions in an attempt to elicit information that needed to be set aside before data collection and analysis. For illustration, the researcher became aware of her preference for

particular anecdotes that she could connect with and her internal reactivity to a specific participant's response. The researcher found these insights to be beneficial as they improved her reflexivity and readiness for the second interview. The carefully spaced-out bracketing interviews provided an opportunity for reflection in between. In essence, the researcher was made known to what was not known.

3.6 Research Trustworthiness

This section delineates the measures undertaken by the researcher to ascertain that the conducted research was sufficiently rigorous and guided by a set of ethical considerations that safeguarded the study's trustworthiness.

3.6.1. Ethical Research

The study received ethical approval from James Cook University's Human Research Ethics Committee (HREC) (Approval ID: H8579), ensuring all research procedures adhered to the highest standards of ethical conduct. Prior to and throughout this research process, participants' informed consent was sought. Participants were reminded of the potential distress that they might experience during the recollection of their HSA during interviews or journaling. Participants were given the right to withdraw from the study with no explanation required. The participants were given a list of external support if they would not like to seek personal counselling at the training institution. The Information Sheet is appended to the end of the thesis (Appendix 2). Fortunately, all the participants completed the study. The researcher further ensured that no research information was withheld from the participants and that all research activities requiring their participation were clearly explained to them. Additionally, all participants were aware that the study was not sponsored. All materials and data collected were kept in a locked drawer or encrypted files. Information was deidentified to protect participants' confidentiality.

The researcher consistently updated the research process into the university's Research Data Management Plans (RDMPs) for risk management.

3.6.2 Trustworthiness

The researcher remained reflexive throughout the research process. The researcher ensured that participants' safety was not compromised and that professional boundary was maintained. Additionally, the use of IPA ensured context sensitivity. Throughout the study, quotes from participants' own words were used to substantiate the interpretations and to allow participants' accounts of their HSA to be heard. Any identification with or preconceptions about the participants' HSA was documented in the reflexivity journal and discussed during research supervision or bracketing interviews. Commitment and rigour were maintained to ensure comprehensiveness in data collection and analysis. IPA's five-step process ensured systematic analysis and findings were data-driven. The review of themes by the research supervisors provided an objective standpoint and ensured the quality of the analysis. Transparency of research was maintained throughout the study and any resources that were used to support the research were properly cited. The researcher established cogent connections between the quotes, themes, and interpretations in the analysis section to ensure research coherence and that findings remained grounded in data.

3.6.3 Member Checking

The reliability of findings is the foundation of high-quality qualitative research. Member checking, also referred to as participant or respondent validation, is a method for assessing the veracity of results (Birt et al., 2016). In the current study, participants were provided with their group experiential themes and subthemes for verification of veracity and congruence with their experiences. The findings were

emailed to the participants a few months later after all the advanced-stage interviews concluded. Eight of the nine participants reviewed the IPA findings and confirmed that the themes captured their HSA during their training. One participant did not reply. This method of knowledge synthesis allowed participants to engage with and contribute to the interpreted data and therefore, significantly improved the trustworthiness of the QUAL-Quant study.

3.7 Limitations to Research Methodology

The ten participants recruited were from the same training institution based on their prior experience with HSA. This could result in self-selection bias, which could cause the sample to be unrepresentative of the population the study was designed to examine; trainee counsellors who had HSA were included. To mitigate the issue of self-selection bias, a screening survey was employed in which participants were required to achieve a minimum score (i.e., the mean score of 2.3 from Williams et. al.'s (2003) study). In addition, the exploratory nature of the study would mean that the findings were not generalisable to a larger population of trainee counsellors, but a specific group.

Prior research on self-awareness was nuanced, and research on HSA was scarce. As a result, the current study was conducted with limited literature. As the first longitudinal QUAL-Quant research on trainee counsellors' HSA, the research design of complementing a LIPA study with time-series data could be viewed as either a methodological advancement or a limitation, given the novelty of the topic under investigation. Consequently, care was taken to ensure that the overall findings remained phenomenological and that the survey results and visual graphs from the quantitative dataset served primarily to complement and enhance the narratives of each participant.

The considerations and decisions when phrasing the interview schedule could have affected the data being collected. The term "significant experience" that was used during interviews could have been too broad and was a limitation in the data collected. When participants were requested to recount a significant experience that they encountered during training, they might recollect the most distressing moments rather than less intense experiences with HSA; being triggered by memories of childhood trauma during a particular lecture on adverse childhood events that resulted in HSA of bodily vibrations. In the second interview, the participants were requested to share another significant experience that was unrelated to the first. Doing so would safeguard participants' freedom of choice in sharing HSA in a manner that was appropriate for them. Honouring IPA's inductive mode of inquiry, the researcher's role was to remain curious while the participants made sense of their lived HSA and the personal meanings they attached to the social world. Therefore, IPA acknowledges the subjectivity of interpretation from the participants' own experiences.

There is much debate in the field regarding the best method to quantitatively examine single-case design outcomes, but there appears to be no consensus to date (Kratochwill et al., 2013). Several methods have been proposed to quantify the impact of change in single-case design studies that go beyond visual analysis and there is consensus to suggest that these methods should only be employed after determining that an intervention has at least moderate evidence based on visual analysis procedures (Kratochwill et al., 2013). However, the current study was non-experimental, so the single-case design was primarily utilised to provide a more comprehensive exploration of HSA, and hence, the concerns with Tau-u baseline correction were not the main concern in the current study.

Another potential limitation of the study relates to the claim that the IPA study lacks standardisation since it is mostly descriptive (Brocki & Wearden, 2006). However, there is a growing number of publications that describe the theoretical, methodological, and philosophical foundations of IPA (Smith et al., 2009). IPA as a research methodology has systemic steps to guide researchers through the tedious data analysis process. The current study adhered closely to IPA's systematic approach of data analysis and interpretation, up to the point of writing up the thesis. In addition, the researcher consistently received support from her research supervisors throughout the data analysis process. Actions were taken to ensure trustworthiness and rigour in the study (Creswell & Plano Clark, 2011), including member checks, data triangulation, researcher reflexivity, and bracketing interviews.

3.8 Chapter Conclusion

The chapter justified the use of a longitudinal mixed methods design to gain a comprehensive understanding of HSA. The rationale for selecting pragmatism as a paradigm for research was discussed. Additionally, the chapter discussed data collection methods deployed in this longitudinal study. Next, a detailed outline of the process of data analysis for each dataset was included. Finally, the chapter discussed the methodological limitations. The next chapter will discuss the IPA findings in the beginning stage of training.

CHAPTER 4

Findings For the Beginning Stage Training: The Phenomenology of HSA

> *The shining gem clearly makes its presence known. We don't need to be particularly attentive to see it. For the suggestive gem… we have to do more work in order to bring it out. The secret gem… it requires much more work to make sense of it… involved elision and ambiguity in agent or temporal referent.* (Smith, 2011, pp.13–14)

4.1 Chapter Introduction

This chapter presents findings from the beginning stage of counsellor training. Interviews and monthly journals were collected from 10 participants recruited from a local accredited counselling institution. The themes derived from the participants' transcripts are presented and supported by relevant quotations. The presentation of participants' quotations to support the themes is crucial because it provides validating evidence for the data interpretation (Smith & Osborn, 2008). The research questions (RQ) guiding this study are: RQ1) How do trainee counsellors make sense of and interpret their HSA over the course of training? RQ2) How do trainee counsellors reflect on and learn from their HSA over the course of training?

4.2 Phenomenology and Hindering Self-Focused Attention

The objective of phenomenological study such as the Interpretative Phenomenological Analysis (IPA) aims to examine hindering self-focused attention (HSA) in participants' subjective lived world. Therefore, the study honours multiple HSA realities that participants have pertaining to their sense-making of HSA.

Phenomenological inquiry can furnish profound, contextually embedded understandings of the complex facets of the human experience such as HSA. It is important to note that findings gathered from the beginning stage may not yield direct clinical implications, the meanings that participants subscribed to their HSA are nevertheless, personal and therefore can have indirect impacts on their counselling self-efficacy beliefs and personal agency in their proximal training environment.

4.2.1 The "Hindering" Aspects of HSA

Conceptually, if trainee counsellors are overwhelmed by self-doubt, performance anxiety, or critical thoughts of incompetence, the awareness may cause them to be distracted during counselling and as a result, reduce their counselling self-efficacy (CSE) (Wei et al., 2015, 2017; Williams, 2003a). When trainee counsellors have lower CSE, they may have less effort expenditure and less persistence in overcoming setbacks (Larson, 1998). Consequently, this may cause more intense HSA that may further impact CSE. It is not the intent of this current study to establish the causality between HSA and CSE, but it is necessary to identify the hindering aspects of the participants' self-awareness (hence HSA) that may have direct or indirect clinical implications. Additionally, the degree of being hindered by HSA is both personal and contextual; some participants felt more hindered by their HSA which affected their CSE (or supervisory working alliance, SWA) while others felt less hindered but gained more knowledge about themselves. Table 4 summarises participants' HSA; descriptions of their HSA, how HSA hindered them, and the abbreviated HSA that is used throughout Chapter 4 when presenting the IPA findings.

Table 4

Beginning Stage Hindering Self-Focused Attention (HSA)

Participant	**Context**	**Description of a moment of sudden awareness**	**HSA**
Amanda	A lecture on adverse childhood events	She became suddenly aware of her bodily vibrations and tension in her jaw. The awareness was hindering, and she started to have flashbacks of her traumatic childhood.	HSA of bodily sensations
Lynn	An online counselling session with a client from the addiction recovery centre	She became suddenly aware of a fear of being rejected by her client and a related urge to please the client. The awareness was hindering as she became preoccupied with monitoring and evaluating her nonverbal body language over Zoom.	HSA of a need to please to avoid rejection
Susie	Practicum site at the youth drop-in centre	She became suddenly aware of feeling like a frightened child and a related urge to want to leave the place. The awareness was hindering as she remained silent for most of the time at the youth drop-in centre.	HSA of desiring isolation
Rose	A peer role-play to practise Solution-Focused Brief Therapy	She became suddenly aware of her own critical thoughts and anxiety during the role-play. The awareness was hindering as she became directive and was unable to build rapport with the client.	HSA of self-criticism

Linda	A group supervision	She became suddenly aware of her own simmering thoughts about whether she could trust her feelings that the group supervisor was not conducting himself appropriately. The awareness was hindering as she became passive-aggressive, trying to use her body language to express her disapproval.	HSA of feeling conflicted
Margaret	A group supervision	She became suddenly aware of a fear that she would be judged by her classmates and self-blaming thoughts about not speaking up. The awareness was hindering as she sat through the group supervision without uttering a single word.	HSA of fearing to speak up
Steven	A lecture by a psychiatrist on Human Development	He became suddenly aware of his own argumentative behaviour in his personal life that strained relationships. The awareness was hindering as he started to lament the delay in his own personal development.	HSA of disconnectedness
Peter	A classroom discussion in which trainee counsellors participated in collective learning	He became suddenly aware of his pronunciation, sentence construction, and use of grammatically correct words and structure. The Awareness was hindering as he became more conscious of speaking in formal English and worried that Singlish (colloquial English) might just slip out.	HSA of self-consciousness

Mary	A group activity in which group members had to complete an assigned task.	She became suddenly aware of her irritation and critical thoughts about her group members' attitudes and a related urge to lead the group to achieve her learning needs. Awareness was hindering as she felt like leaving the group and she started to blame herself for being a hot-tempered person.	HSA of frustration
Beatrice	An individual supervision with her practicum supervisor	She became suddenly aware of a fear of being perceived as incompetent by her practicum supervisor and a related urge to have answers to every question during the supervision. The awareness was hindering as she avoided asking her supervisor questions and ensured that her preparation was sufficient to the extent of overpreparation.	HSA of fearing to be perceived as incompetent

4.3 Group Experiential Themes and Subthemes

The current study adopted Wei et al.'s definition of HSA which refers to "experiences of being troubled by an awareness of one's own anxiety and other internal distractions that occur when providing counselling" (Wei et al., 2015, p. 43). IPA gathered three Group Experiential Themes (GETs) and eight subthemes. They are: GET (1) Putting on different lenses to view HSA: (a) Exploring HSA through unpleasant childhood memories, and (b) Exploring HSA through culture and upbringing, GET (2) It is so uncomfortable yet familiar: (a) HSA as manifestations of critical thoughts, unpleasant feelings, bodily sensations and gestures, (b) HSA as covert desires, (c) HSA as learned childhood behaviours, and (d) HSA as opportunities for growth, and GET (3) Building strengths, accepting vulnerabilities: (a) Engaging in HSA reflections, and (b) Learning to be kind and patient with themselves. In the participants' quotations, the author's editorial elision is represented by three dots (...), and the sources of the quotes, for example, Interview One and Journal One are abbreviated to, "I1" and "J1", respectively.

4.3.1 GET (1) Putting on Different Lenses to View HSA

Humans are sense-making creatures (Larkin et al., 2006b). HSA is complex and to comprehend HSA, the participants adopted different lenses to view their HSA. Five participants viewed HSA through the lens of their unpleasant childhood memories, and five participants viewed HSA through the lens of culture and upbringing. The primary distinction between the two subthemes is participants' subjective perceptions of their childhood; participants in the first subtheme perceived their childhood experiences as negative or traumatic, whereas participants in the second subtheme acknowledged the

impact of their childhood experiences but did not perceive them as negative despite going through either tough times or harsh living conditions.

(1a) Exploring HSA through Unpleasant Childhood Memories

During a particular lecture on adverse childhood events, Amanda experienced HSA of bodily vibrations and tension in the jaw. Amanda shared that the awareness was hindering in the moment as she started to have flashbacks of her traumatic childhood and felt an intense need to share her stories and be attended to with her emotional needs. To comprehend her HSA of bodily sensations, Amanda viewed the HSA through the lens of her unpleasant childhood memories to make sense of it:

> *So as the lecturer was going through the slides, I really felt my whole body shaking… So I shared a little bit of my traumatic childhood… my dad tried to throw me down the balcony once when I was a kid… suddenly became so real to me that my body started shaking as the lecturer was saying...* (Amanda, I1, p. 5)

Amanda had likely made a connection between what the lecturer shared in the class with her own childhood experience. Although Amanda did not specifically name her emotion in the excerpt, the recollected childhood memory likely elicited fear in her and triggered a physiological response, and the vibration was sufficiently intense for Amanda to shift her attention from the lecturer to herself. Amanda described her childhood as "*traumatic*", and her father as "*abusive*"; she remembered continually having her "*antenna up*" as a child so as not to aggravate the unstable home environment (I1). From the excerpt, it was not difficult to comprehend her fear as a child, and with her limited resources, there was little she could do to protect herself besides being

"*perfect*". Therefore, viewing through the lens of her childhood memory, Amanda was able to make sense of her HSA of bodily vibrations as a natural way to cope with fear.

Lynn revealed her HSA of feeling the need to please to avoid rejection by her client during an initial counselling session. The awareness was hindering Lynn as she felt a related urge to constantly monitor and evaluate her nonverbal body language on Zoom, which she described as a deliberate effort to avoid being misunderstood by the client due to her "*assumptions and preconceptions*" of clients who were sent for mandated addiction recovery support counselling. The fear of being rejected by her client was intense enough for Lynn to feel small like a child in the moment. Lynn described herself as being "*very afraid to offend also very afraid that you will not be accepted*" (Lynn, I1, p.10). In order to make sense of her HSA of feeling the need to please to avoid rejection, Lynn viewed it through the lens of her unpleasant childhood memories of friends' rejection:

> *I think one of the things in my childhood was with my best friends. So there were three of us. Yeah, I think that was quite a major thing in my life as a child… three of us were best friends, or we hung out altogether and then, at some point, right, the two of them ganged up against me. [giggle] Yeah and so it happened once or twice, and I think that was that was quite devastating for me…* (Lynn, I1, p.27)

Lynn was emotionally distressed when she recalled her childhood memory of being rejected by her peers. She characterised the pain of rejection as "*devastating*". Since the rejection occurred twice as mentioned in the excerpt, it seemed probable that Lynn had attempted to please her friends to salvage their friendships and therefore was "*devastating*" for Lynn when the rejection happened again. During the initial

counselling session with her client, Lynn once again experienced HSA of feeling the need to please to avoid rejection, even though it occurred in a completely different context. Lynn acknowledged that her HSA affected her perceptions of her CSE and caused her to question her counselling abilities. She adopted a more cautious stance in her counselling approach, refraining from discussing topics that might elicit emotional responses from the client.

Susie shared her HSA of desiring isolation at the youth drop-in centre where she interned. Susie recalled feeling overwhelmed by the noise at the practicum site and she remembered feeling frightened like a child. The awareness was hindering Susie in the moment as she remained silent for most of the time at the youth drop-in centre. She did not feel like communicating with her clients and desired to be left alone. Susie made sense of her HSA of desiring isolation through the lens of her unpleasant childhood memories of her parents' quarrel:

> *There was huge quarrel back then. It was just crazy and that particular happening really traumatised me a lot because there were cups smashing and my mom shouting, and then she was shouting and I remember just going into the foetus position, trembling… that happened when I was in primary school. Yeah, so that incident I guess it contributed to how I hate noise and how I wish for peace.* (Susie, I1, p.14)

When Susie was at the practicum site, she described herself behaving like her "*inner child*" (J1) to draw a reference between herself and the frightened child during her childhood. In her words, she felt that her "*inner child was dominant at the youth drop-in centre*" (J1). Evidently, Susie was overwhelmed with fear and even though

Susie was physically present and "*seated in the same place*" (J1), it seemed like there was a connection between herself as a traumatised child and the overwhelmed adult at the practicum site. Susie acknowledged that her HSA affected her ability to attend to her clients' needs and felt that she was not competent in counselling. As a trainee counsellor, Susie's HSA of desiring isolation had a direct clinical implication.

Rose experienced HSA of self-criticism when she became suddenly aware of her critical thoughts and anxiety during a peer role-play to practise a new counselling modality. Rose shared that the awareness was hindering her in the moment as she became directive when the client's responses deviated from the expected script (i.e., the client wanted to talk about the past, but the new modality was forward-looking). Rose recalled becoming directive and as a result, the therapeutic alliance was affected. The client shared that she did not feel understood. For Rose to comprehend her HSA of self-criticism, she viewed it through her unpleasant childhood memories of strict parenting:

> *The perfectionistic thing in the childhood is probably that like you know you take art lessons, then you must take piano lessons, then you must take abacus, then you must take swimming, you must, you must learn everything… you must, you must do everything. I must learn so many things… probably these are all the contributing factors… you must do well.* (Rose, I1, p.22)

The frequency with which Rose used the phrase "*you must*" revealed the intense pressure and high standards she faced as a child. Under such conditions, it was natural for Rose to define herself by her accomplishments, and any failures or mistakes were intolerable. Although Rose did not talk about the origin of these expectations, she perceived that not meeting these expectations would have been dire. Rose acknowledged

that her HSA of self-criticism had a direct impact on her CSE even though the activity was simply a peer role-play. Rose remembered feeling angry with herself and perceived that as a failure on her part as a counsellor.

Linda experienced HSA of feeling conflicted during a particular group supervision when she felt offended by the group supervisor's behaviour. Linda described her HSA of feeling conflicted to include simmering thoughts and edgy body responses. The awareness was hindering Linda in the moment as she found herself unknowingly resorted to behaving "*passive-aggressively*". She recalled using nonverbal language to express her disapproval and hoped that the group supervisor would read her body cues. Linda was upset for not speaking up for herself and she viewed her HSA of feeling conflicted during the group supervision through the lens of her childhood memories:

> *My family is quite passive-aggressive, like they are all passive-aggressive and growing up, I have always been the more outspoken, rebellious one. Because I'm more outspoken, you just tend to go down that route of rebellion because everybody's so quiet and like, when I speak up, nobody listens…* (Linda, I1, p.20)

During the group supervision, Linda desired to be heard but was unsure if her concern was genuine because she had grown used to being ignored even by her family members. Therefore, it became natural for Linda to ignore her own feelings and learn "*passive-aggressiveness*" to have her needs met. In addition, she refrained from speaking out against the group supervisor for fear of being interpreted as the "*rebellious one*", as her classmates appeared unaffected and silent. Despite not having a direct clinical implication, Linda's HSA brought to her consciousness the potential novice stressors that could trigger her passive-aggressive behaviour during the training.

(1b) Exploring HSA through Culture and Upbringing

Margaret believed that culture played a significant role in her HSA of fearing to speak up in group supervision. Margaret's HSA manifested as self-doubting thoughts, feelings of nervousness, and a sensation of her body "*shaking up*" (I1). The awareness was hindering Margaret as she recalled remaining silent throughout that particular group supervision. Margaret added that the HSA affected her self-efficacy beliefs, and she doubted her ability to be a counsellor. To comprehend her HSA of fearing to speak up in group supervision, Margaret recognised a connection between her culture and upbringing:

> *I don't know how I started to be like a person with less assertiveness... So, I have always felt like a child even I am an adult because I have people whom I can cling to. My brother and my cousins, we are a very close family, extended family… who always treat me like a kid… then my mother got Alzheimer's and I was the primary caretaker as a teenager… I had to take on the role of taking care of my mother… but I had this bigger extended family members… I had more gone into a depending role… so that may have affected my confidence level.* (Margaret, I1, pp.16-17)

Margaret's excerpt illuminated the cultural values she learned regarding familial and gender roles. When viewing HSA through a cultural lens, it made sense that having to express her opinions to others was something uncommon in Margaret's culture; consequently, she experienced HSA of fearing to speak up when she was in group supervision and surrounded by people from diverse backgrounds during the beginning stage of training.

Steven attributed his momentary awareness of wanting to win arguments to his culture and upbringing. Steven explained that his pride in "*making arguments*" and "*convincing people of things*" in his previous sales profession could explain why he felt disconnected from people in his personal life. Steven acknowledged that the HSA of disconnectedness was more hindering in his personal life; he found himself alienated from empathy. To comprehend his HSA, Steven viewed his HSA of disconnectedness through the lens of his culture and upbringing:

> *I grew up in another country. It's a pretty sort of straight-talking culture… you have to defend your position...* (Steven, I1, p.28)

> *In my dad's world, the notion of being someone who helped people was weak, like, his world was destroyed and dominate… his ideal career path would have been like army general law, hotshot CEO, or one of these kinds of guys who, who valued success and power.* (Steven, I1, p.31)

Steven also shared that at the time of the interview, as he was able to relate to his peers and clients with his intellect, he was less hindered by his HSA in the training context. However, Steven agreed that he needed to be "*honest*" and "*strip away all the* layers" to build an emotional connection with clients (I1). Steven's momentary awareness of his tendency to want to win arguments in his personal life even though it did not result in any direct clinical implications, the lack of empathy could have a direct impact in his new role as a counsellor. Overall, Steven seemed to have high self-efficacy beliefs.

Peter experienced HSA of self-consciousness when speaking formal English in group settings like classroom discussions. Peter shared that he was more comfortable with Singlish. Singlish emerged in Singapore as a result of protracted language contact between speakers of numerous languages during the colonial era (Wee, 2018). Singlish arose primarily among the working classes who learned English without formal education and incorporated elements of their native tongues (Wee, 2018). According to Peter, when he experienced HSA of self-consciousness speaking in English, he became very conscious of his pronunciation and vocabulary, and tried hard not to *"let Singlish slip out*" (I1). According to Peter, the awareness was hindering as he would become more conscious and critical of the way he conversed. To comprehend the HSA, Peter viewed his HSA of self-consciousness through the lens of culture and upbringing:

> *[long pause] I guess as I'm growing up, there will always be those few who are good in their command of English. Yeah. Then also in school, academic, look. I'm not that strong in my studies. Yeah, so I think perhaps that is a seed [pause] and leads all the way to now. Yeah… in my primary school, you know, there'll be those that who are "Angmo Pia" (Dialect to mean English speakers), as their parents [laugh] speak English they're in an English-speaking environment… all the things they like … song, movie, books all very "Angmo Pia" in that sense [laugh] so I guess it's just that kind… it's not my clique*. (Peter, I1, pp.15-16)

In the excerpt, Peter's discomfort was evident from the delays he required to formulate his responses. It would be conceivable that he needed more time to consider what he wanted to say, or that he was experiencing HSA of self-consciousness during the interview. Therefore, Peter would likely be more deliberate in his expression, which

could be explained by the pauses. If Peter did experience HSA of self-consciousness during the interview, he would inevitably encounter HSA in classroom discussions.

Beatrice experienced HSA of fearing to be perceived as incompetent by her practicum supervisor during the beginning stage of training. According to Beatrice, she set high expectations for herself. The awareness was hindering Beatrice as she found herself overpreparing to feel good enough. Beatrice was cognisant of her high expectations and through the lens of her cultural upbringing she made sense of her HSA in supervision:

> *I grew up in a low-income family, and all my teachers, my family, said that education is the ticket out of poverty, so I think that stuck with me and it's also integrated into everything. I'm a strong believer in education because like, for economic, and social mobility. It is not that easy for someone who is born into a low-income family. The only way to move up the ladder, or the hierarchy is through education.* (Beatrice, I1, p.20)

Beatrice's socioeconomic background and upbringing instilled in her the desire to live a better life through diligent work. Therefore, viewing HSA through the lens of her socioeconomic background, Beatrice was able to make sense of her HSA of fearing to be perceived as incompetent by her supervisor in the beginning stage of training.

Mary experienced HSA of frustration during group discussions. Mary's HSA manifested as critical thoughts and emotions of anger and annoyance. Mary was disappointed that her learning outcomes were not met in a few group discussions. These previous unpleasant group discussions affected the way Mary perceived group

discussions, and she felt rather helpless when group discussions went poorly. Mary shared that the awareness was hindering her as she felt like either leaving the group or remaining quiet throughout the discussions, and ended up blaming herself for being "*short-fused"* (I1). To comprehend the HSA, Mary viewed her HSA of frustration through the lens of culture and upbringing:

> *I think fundamentally is because I'm the only child. So I think that that makes a big difference in a lot of things. I think being an only child, a lot of things, I just do it on my own… I tend to do a lot of things on my own. I find things out on my own. I realised I seldom ask for help. Yeah, when it comes to work, I seldom ask for help. I just get things done on my own and it works, it has worked for me and it's not something that I want to hardcore change because it has worked. [laugh] and there's evidence that it has worked because I do well.* (Mary, I1, p.22)

Being an only child has taught Mary to be independent and resourceful. Mary's excerpt showed that engaging in independent work yielded results and when her grade was pulled down by the group component, it seemed reasonable for Mary to blame others. Furthermore, in group discussions, Mary did not have full control over her learning which was different from independent work. Hence, viewing through the lens of being a single child made perfect sense in explaining her HSA in group discussions.

4.3.2 GET (2) – It Is So Uncomfortable Yet Familiar

Despite the momentary nature of HSA, participants experienced discomfort to varying degrees and interpreted their HSA differently. All participants associated HSA with manifestations of critical thoughts, unpleasant feelings, bodily sensations and gestures but to varying extents. Five participants interpreted HSA as reflecting their

covert desires, three participants associated HSA with a set of learned childhood behaviours, while the remaining two participants interpreted HSA as opportunities for growth. Adopting a phenomenological perspective, all participants' interpretations though distinct are still valid.

(2a) HSA as Manifestations of Critical Thoughts, Unpleasant Feelings, Body Sensations and Gestures

Amanda's manifestation was more of a physical nature, as according to Amanda, her mind was empty, "*My breathing is shallow, my jaw is tense. I feel it physically but what's going through my thought, nothing*!" (Amanda, I1, p.7). Amanda elaborated further on her bodily manifestation, "*I can feel my body vibrating, vibrating because, it's like, it's so real. It's like reliving a trauma…*" (Amanda, I1, p.12). Although Amanda did not elaborate on the connection between her body vibrations and her past trauma, her interpretation of her HSA of bodily sensations revealed that an unpleasant aspect of her life might have been triggered by the content that contributed to her momentary physiological reactions.

Susie's HSA of desiring isolation manifested as an intense fear at the youth drop-in centre, "*I was in a freeze mode… I was afraid and awkward... I was afraid of getting judged by the youths.*" (Susie, J1, pp.1). While Susie presumably was physically present at the practicum site, she appeared to be more aware of what was happening within her. Despite the awareness being momentary, Susie found herself having lesser self-efficacy and struggling to perform her counsellor role.

Beatrice experienced HSA of fearing to be perceived as incompetent during supervision and client sessions. She explained the implication of client sessions on supervision; ultimately it was the supervisor who would be grading her based on her counselling competence. Beatrice's HSA manifestation was a series of self-questioning thoughts that resulted in her feeling anxious, "*Am I good enough to counsel this person? What if I say something wrong? Am I documenting my case notes correctly? I feel very anxious because I feel the need to write down every single word…*" (Beatrice, I1, p.3). Beatrice acknowledged that even though the inner self-questioning was momentary, the HSA manifestations were unhelpful as these internal distractions either diverted her attention away from the client or refrained her from asking the supervisor questions. Either one, Beatrice's actual competence was compromised.

Lynn's HSA thoughts, on the other hand, were more like assumptions and in her words arose as she was "*so afraid to offend*" the client for fear of being rejected (I1). Hence, Lynn attempted to please the client by being extremely cautious of her body language and wished that her client would not see through her thoughts, "*I'm just double thinking… he is a recovering drug addict… he probably thinks that a counsellor is from the mainstream… some more is a girl… maybe she will have some bias, discriminate and not want to talk to me…*" (Lynn, I1, p.5). Even if Lynn was simply engaging in double thinking, the momentary thoughts gained her attention; she engaged in a series of actions to monitor her body language on the screen.

HSA contexts further included group discussions. While both Mary and Peter experienced HSA during group discussions, their HSA manifestations were different. During a particular group discussion, Mary felt that she had to control herself from

speaking up lest she said the wrong things, "*I'm trying to keep calm and carry on. On the other hand, like inside is like boiling, like the feeling is very uncomfortable, like boiling but cannot ventilate…*" (Mary, I1, p.11). Mary was aware of her momentary anger and self-blaming thoughts, "*What if I wasn't such hot (tempered), like what if I wasn't so short-fused, you know, maybe if I was nicer…*" (Mary, I1, p.11). Mary agreed that in the brief moment, the heightened awareness was not only uncomfortable but impeded her capacity to effectively contribute to the group discussion.

Peter's HSA of self-consciousness manifested as unpleasant feelings and self-conscious thoughts about the way he spoke, specifically speaking formal English which he described as simply, "... *I'm using very simple words…*" (Peter, I1, p.3). From the short quote, it was apparent that Peter was self-conscious of his language during the interview as well. In the training context, Peter would probably be more self-conscious and he elaborated on his self-conscious thoughts, "*[long pause] I think perhaps there's certain foundation of the grammar structure that I still need to put in a lot of effort when I'm conscientious (conscious)* (I1). From both Mary and Peter's experiences, the social aspect of group discussions appeared to trigger HSA. For Mary, she was so used to independent work that produced desirable outcomes and she found dysfunctional group dynamics slowing her down. Peter, on the other hand, was so accustomed to conversing in Singlish that the group environment in which formal English was the dominant language only served to accentuate his sense of difference.

Linda's HSA of feeling conflicted and Margaret's HSA of fearing to speak might be different, they reported having similar HSA manifestations of physiological discomforts. Both of them recalled experiencing a sense of dissonance; Linda fought

against opening her mouth to comment about the group supervisor, and Margaret struggled in opening her mouth to speak up in the group:

> *"I kept like moving in my seat. I think I had my legs crossed and I was like this [gesture of hand covering mouth, looking left and right], and like that [hand covering eyes, wishing not to see what was going on], which is a position I don't usually get into… It's almost like a "stop gasping"[gesture of hand covering her mouth] you know… I'm just keeping, keeping it in, like keeping it in, but still be in the moment and observe but very uncomfortably. Like is this real? Like is this really happening?*" (Linda, I1, p.12).

> "*I will be sitting there having an internal conflict within myself, like pushing myself "open your mouth and say something" and then I will not do that*" (Margaret, I1, p.6).

Both Linda and Margaret did not feel safe in the group supervision. According to Linda, her group supervisor appeared to have crossed a professional boundary. Margaret, on the other hand, felt more psychologically unsafe within the group. Even though the gesture was presumably a visible part of Linda's body language to express her disapproval of the group supervisor's behaviour, the group supervisor did not pick up the cues. However, what was more distressing for Linda was the hidden part; her suppressed feelings of confusion which she described as "*whether she could trust her emotions*" (I1). Margaret, on the other hand, attempted to express herself in the group but without success. The intense internal pressure might not be observable to others but according to Margaret, the intense pressure affected her ability to perform. The

emotional and physiological distractions appeared to have hindered both Linda and Margaret's personal agency.

Rose experienced HSA of self-criticism during a particular peer role-play; a component designed to equip trainee counsellors with counselling skills. Rose's HSA manifested as critical thoughts with physiological discomforts:

> *I just kept blaming myself and then I remember having some psychosomatic symptoms, like maybe I was feeling hot in the face when I, when my client told me that and also, I was sweating in my palms. I don't sweat in my palms unless I'm nervous or upset*. (Rose, I1, pp.5-6)

Despite the peer role-play being only a practice to hone her skills, Rose blamed herself critically for not listening to her intuition. If a peer role-play could trigger such an adverse reaction, it would not be inconceivable that the rest of the course would be extremely stressful, and repeated disappointments would result in lower self-efficacy beliefs and reduced tolerance to novice stressors.

Steven's HSA of disconnectedness manifested as a set of self-questioning thoughts that were divergent from the other nine participants, which he described as a slow, growing "*voice*" at the back of his mind. Steven shared that during a particular lecture on children's development, he took notice of his "*voice in his head*" that challenged his prior understanding:

> *... it starts off with this little kind of voice in the back of your head that says, "Maybe you were wrong about that." Then the voice kind of like keeps going… gets a bit louder… gets a bit louder and then you kind of slowly start to realise…*

you could have perhaps been a bit more forgiving of people you know. (Steven, I1, pp.10-11)

Steven acknowledged that his "*combativeness*" was a familiar part of himself. He perceived himself as "*argumentative*" and viewed "*winning arguments*" as a form of intelligence, a belief he internalised since childhood. In the context of his training, Steven was cognisant that combativeness could be countertherapeutic but struggled with "*removing the layers to communicate very honestly*" (I1). Consequently, the "*voice*" that Steven described in the excerpt resembled his dissonant thoughts between his past and present professional roles; establishing connections through persuasive arguments as a sales professional versus congruence and empathic understanding as a counsellor.

Participants' accounts of their HSA manifestations found their thoughts, feelings, and bodily sensations to be uncomfortable and the manifestations can have both direct and indirect clinical implications. Additionally, five participants interpreted their HSA as covert desires, three interpreted it as a set of learned childhood behaviours, and two interpreted it as opportunities for growth. The following subsections will elucidate further on participants' HSA interpretations.

(2b) HSA as Covert Desires

Five participants also interpreted HSA as underpinned by covert desires for acceptance (Lynn), assertiveness (Margaret), life success (Beatrice), admiration (Steven), and safety (Amanda).

Lynn experienced HSA of feeling the need to please to avoid rejection and the awareness was hindering her as Lynn became conscious of her body language. Lynn felt

a related urge to monitor her nonverbal cues on Zoom to avoid coming across as "*judgmental*" because of the client's background which in her perspective could result in the client's rejection. For Lynn, rejection was inconceivable, "*I really can't, I can't, I can't deal with the rejection.*" (Lynn, I1, p.13). The repetitions of "*I can't*" underscored Lynn's intense desire to be accepted and simply talking about rejection was difficult for Lynn:

> *...if it's rejection, it will be, I will, it will show on my face that, I don't think I want to, I want to completely avoid it. I want to stop this, but I can't help it and it will show my face.* (Lynn, I1, p.13)

Similarly, the repetitions of "*it will*" and "*I want*" punctuated the quote and amplified Lynn's discomfort with client's rejection albeit perceived. Lynn explained further about the impact of possibly being rejected by a client, "*When it's a person-to-person rejection is very, is very hurting… a person-rejection is quite terrible, I feel personally.*" (Lynn, I1, p.23). Lynn's intense desire to be accepted by the client underpinned her fear of rejection. Perhaps, Lynn was trying to avoid re-experiencing the pain of rejection in childhood. Lynn interpreted her HSA of a need to please to avoid rejection as her covert desire to be accepted and anyone subjected to such kind of pressure to be accepted would likely be pleasing and self-conscious.

Margaret interpreted her HSA of fearing to speak up as a strong desire for assertiveness. Margaret was aware that her lack of assertiveness to speak up in front of others could affect her self-belief and future employment prospects negatively. Margaret was cognisant of her ability and viewed herself as capable of overcoming life's

obstacles. However, she acknowledged that she felt intimidated easily and her HSA was merely a projection of her yearning for assertiveness:

> *When I feel intimidated, the normal self is, I shrink immediately inside me… so I get shaken up, I immediately go inside my shell so that affects my performance.*" (Margaret, I1, p.11).

> *I can face up to any challenge in my life... I don't break into pieces… but my confidence is lacking… when I have to be assertive or in group settings.*" (Margaret, I1, p.18).

Margaret attributed her lack of assertiveness to her cultural upbringing where she could have learnt about gender roles and family values that shaped who she is today. Margaret's top priority was always caring for others and sometimes even at the expense of her own needs:

> *With my lifestyle and the tradition (that) I came from, self-care was never a priority for me, fulfilling my responsibilities, taking care of my family, and caring for others take up my time… but for the first time, I felt so deeply about the importance of self-care... I take this as a major learning experience.* (Margaret, J2, p.3)

Margaret's excerpt captured her openness to change; to challenge some of her beliefs and values from her upbringing. Perhaps, Margaret was acculturating to life in Singapore and becoming more aware of her desires and motivation was the initial step.

Beatrice's strive for academic excellence was apparent especially when her parents struggled with financial difficulties during her childhood years. Beneath

Beatrice's desire for academic success was her yearning for life success, "*I always have to put in my best effort, like go big, or go home that kind of logic.*" (Beatrice, I1, p.18). Beatrice expected herself to excel, even as a trainee counsellor, "*I just don't want to be just a counsellor, I want to be competent enough to help… I want to acquire skills… increase my competence… my personal hopes for my education…*" (Beatrice, I1, pp.6-7). Beatrice's desire for life's success was evident in the beginning stage when she sought supervision, "*sharing or being vulnerable or telling my supervisor about things I don't know would translate to lower grades, so I won't want that… it's something that I have to avoid.*" (Beatrice, I1, p.17). In her words, Beatrice wanted to "*appear competent*" during supervision in order to achieve good grades (I1).

Beatrice's HSA of fearing to be perceived as incompetent seemed like a double-edged sword; it provided Beatrice with motivation to work hard but also hindered her learning. Beatrice wrote in her journal, "*…there are times I find that having such thoughts, beliefs, emotions have served me well as I was recently listed one of the most competent counsellors-in-training in my level.*" (Beatrice, J1, p.1). Beatrice was aware of her own expectation to have answers to all her supervisor's questions. Additionally, she was also aware of her deliberate decision to refrain from asking her supervisor any questions that could potentially be misconstrued as incompetence. Perhaps, Beatrice's tendency to overcompensate could have either direct or direct clinical implications. Due to the missed learning opportunities, Beatrice had to put in a huge amount of effort to bridge the learning gaps and the amount of hard work was synonymous with the desire for life success.

Steven experienced HSA of disconnectedness during a particular lecture when he became momentary aware of his self-questioning thoughts about his past "*argumentative conversations*" (I1) while simultaneously trying to make sense of how people connect through empathic responses. Steven prided himself in "*intellectual gymnastics*" to win arguments (I1). Even though Steven's HSA did not have any clinical impact at the point of the interview, he acknowledged the need for him to peel away his "l*ayers*" to be more "*honest*" with others in his new role as a counsellor.

> *I've just gotten a bit better at, like just being a bit more honest, to be honest… when people tell me how they feel (I) try to understand it better… like trying to strip away all the "bullshit" for "want to be a better you" word…* (Steven, I1, p.5).

Steven's excerpt revealed his desire for change to develop the qualities of a counsellor to be empathic and "*honest*" with others. This would suggest that Steven was aware of the fact that being "*combative*" and "*argumentative*" could hinder his clinical work and both traits were perhaps less desirable qualities of a counsellor. In the beginning stage of training, Steven identified more with his intellectual than his empathic side, as evidenced by "*being smarter*" and being seen as "*the big hero*":

> *I was always seen as argumentative, and I used to sort of pride myself on that because I thought it was a sign that I was smarter than other people. I could, like, do these mental gymnastics and verbal gymnastics and dance around people and be the big hero…* (Steven, I1, p.15)

Steven's transcript reflected his belief in intelligence and admiration. Steven naturally engaged in "*mental and verbal gymnastics*" to "*dance around people and be*

the big hero". Therefore, it would seem premature that Steven's desire to win arguments would not have any direct impact on his clinical outcomes and he was tentative in his claims, as he put it, "*I know that sometimes what I'll default to when I'm under stress. I'll default to a certain position.*" (Steven, I1, p.21). Unlike other participants who struggled with their HSA, Steven felt that he was less hindered by his HSA. Nevertheless, Steven interpreted his HSA of disconnectedness as his desire for admiration; an admirable counsellor who emanated competence.

Amanda believed that her "*childhood wounding*" was an integral part that she carried into her adulthood (I1). Amanda's HSA of bodily sensations during a particular lecture was associated with the lack of safety as a child, "*I witnessed my parents having fights so for me, I'm always the peacemaker when I was a kid, so I'm always the one with my antenna up…*" (Amanda, I1, p.6). Amanda revealed that as a child, she was parentified to ensure that her parents would not fight, and there was peace at home. Amanda shared that she had learned to become sensitive to her environment and her parents' needs. As a child, Amanda was able to interpret subtle cues and "*pre-empt*" things before they happened. Therefore, when Amanda experienced HSA during a particular lecture on adverse childhood events, she made sense of her HSA of her bodily vibrations as underpinned by her desire for safety which she did not have as a child.

(2c) HSA as Learned Childhood Behaviours

Three of the participants, Susie, Linda and Rose, associated their HSA experiences with a set of learned childhood behaviours.

Susie interpreted her HSA of desiring isolation as her coping behaviours to manage her "*heart cringing pain*" (I1) and therefore had to constantly wear a façade of

"*a joker*" around others to conceal her sadness from her childhood rejection by her parents (I1). Naturally, Susie would feel less safe around people and desire isolation. Susie described herself as an "*accident child*" as her parents had no intention of having another child and hence, her birth was unwelcomed. Since young, Susie felt neglected and learned to repress her emotions:

> *A lot of childhood experiences growing up, and a lot of pent-up feelings… and it stuck with me till my adult years. When things trigger me, I get really upset and would want to isolate myself.*" (Susie, I1, p.1).

In a way, Susie "*isolated*" herself from people who hurt her feelings to cope with her overwhelming emotions, "*I just ignored them. I went into that isolate, isolation state. Yeah. I hate that part of me like, I know it's wrong, I know I shouldn't treat my friends like that, but I did not know how to manage.*" (Susie, I1, p.18). Susie felt that others would judge her for being "*vulnerable*", and isolation was to her a defense mechanism to protect herself (I1). Susie revealed her difficulties in sharing her negative emotions like sadness with others and disliked conflicts that often reminded her of the quarrels at home. As a result, Susie learned to appear "*happy*" and "*joke around people*" to portray a sense of happiness:

> *I know people always think that I don't have worries. I am a joker… always making people laugh… it stops me from portraying that I'm feeling sad… lonely… like building a façade.*" (Susie, I1, p.6).

Similar to isolation, the façade of a joker that Susie wore kept her safe. Susie developed these coping mechanisms as a child to keep herself emotionally safe within

the family and around others. However, as Susie gained more knowledge about herself from her HSA, she gradually realised these childhood behaviours were maladaptive during training.

Linda talked about a particular group supervision when she experienced HSA that manifested as "*simmering thoughts*" and "*feelings of confusion*" (I1). Despite HSA being momentary, Linda described that internal conflict was uncomfortable, and Linda sought verification from her groupmates to manage her HSA, "*I also asked my two classmates… because I wanted to know whether I was too sensitive or protective of them… my classmate told me she felt uncomfortable but didn't know how to speak up for herself…*" (Linda, I1, p.17). According to Linda, her doubts about the veracity of events and inability to advocate for herself and her classmate exacerbated her distress. Linda explained that the intense conflict between her emotions and cognitions could be the reason for her passive-aggressive behaviours during the group supervision. On the one hand, Linda wanted to express her frustration to the group supervisor, but on the other hand doubted her own experience. Therefore, Linda resorted to expressing herself passive-aggressively through her body language and hoping to be seen. Linda made sense that her HSA was a set of acquired but dysfunctional childhood behaviour:

> *This is what I've learned (as a child) so I became angry [laugh], the only way people listened to me, was not when I said it nicely or when I was loving but when I showed a tantrum or when I, you know, hit something.* (Linda, I1, p.21)

When Linda used anger to communicate her needs as a child but was ignored by the trusted adults in her family, she learned that emotions, specifically negative emotions such as anger, were bad and could not be trusted. As a consequence, Linda learned

passive-aggressive behaviour to express her needs and regulate her emotions. Therefore, Linda's HSA of feeling confused and her passive-aggressive response were understandable; she was conflicted about whether her needs were valid enough to be met.

Rose experienced HSA of self-criticism during a particular peer role-play. The awareness was unhelpful as it had a direct impact on her counselling self-efficacy beliefs. Rose interpreted her HSA as a set of behaviours that she internalised as a child to "*be perfect*" and not make any mistakes, "*you must get 100 marks if you get 96 or 98 and if one time you get 91, die, 91 is very lousy, very bad…You get caned, you get scolded.*" (Rose, I1, p.22). Rose had learned as a child that only with a perfect score would she be good enough. Naturally as an adult now, she would avoid mistakes at all costs and failure would be unacceptable. As a result, Rose became fixated and had an intense desire for control; having a predictable structure to reduce failure:

> *I need to be very clear of the theory first, right, so I read the book, I watch the video, or I read the program, watch the video, and then I try to write down certain questions that I could ask the client. Then I tried to think about… I try to have some backup plan. So I have like a Word document there with questions and then in case I should say something wrong.* (Rose, I1, P.25)

Rose's excerpt illustrated the importance of predictability during the beginning stage of training. However, when Rose became overwhelmed by her fervent attempts to be in control and "*failure*" seemed inevitable, "*… like I couldn't find anywhere to take me in for practicum… I called like, 50 places.*" (Rose, I1, p.13), Rose seemed to engage in avoidant behaviour of not dealing with her intense emotion, at least for that period of

time, "*I feel that maybe I really need to defer*" (Rose, I1, p.16), and that was what she did. Rose did not continue with training in the advanced stage and could no longer participate in the study, but she consented for her data to be used up to that point. Failure or perceived failure was something Rose would avoid at all costs even if she were to make an alternative plan.

(2d) HSA as Opportunities for Growth

Mary disliked group activities in the beginning stage of training. Mary experienced momentary awareness of her "*irritation*," "*exasperation*", and "*boiling feeling*" (I1) during a group activity which hindered her as she felt like leaving the group. Mary shared that even though her HSA of frustration had no direct clinical implication, she experienced a sense of helplessness as she had no control over her learning outcomes. However, instead of leaving the group which Mary perceived as "*childish*", she learned to manage her HSA instead, "*…there's nothing else I can do to distract myself except like maybe focus on my own breathing to calm myself down…*" (Mary, I1, p.13). Within her capacity, Mary was able to regulate her intense emotion and her interpretation of her HSA of frustration was a form of "*continuous growth*" which she elaborated, "*Whenever each experience happens, what we could be different is the way we respond to it and for each difference is a form of growth.*" (Mary, I1, p.25). Mary was aware from her HSA of her attitude and expectation toward group learning and her expectations. At the same time, she also recognised how her HSA could be a barrier to impede her personal growth.

Peter interpreted his HSA of self-consciousness as an opportunity for growth, and in his words, HSA was "*a challenge and through it, I will grow.*" (Peter, I1, p.24).

Peter was cognisant that he was working on improving his English proficiency. Therefore, his HSA of self-consciousness would hinder him if he chose to avoid social interaction with fellow trainee counsellors. Additionally, he would have lower self-efficacy beliefs to perform his new role. Peter elaborated that from his HSA, he gained more self-knowledge about the origin of insecurity, "*I'm not that strong in my studies… so I think perhaps that is the seed that led all the way to now.*" (Peter, I1, p.15). As a result, Peter was able to choose more self-aiding actions by leveraging on his peers as support. Peter began to view his counselling classmates as a resource to work on his English, "*I won't use the word 'compare' but I see it more of an opportunity to practise it (formal English) as it is in a conducive environment.*" (Peter, I1, p.10). Even though experiencing HSA was unpleasant for Peter, he interpreted HSA as an opportunity for growth.

4.3.3 GET (3) – Building Strengths, Accepting Vulnerabilities

GET (3) gathered findings on the types of reflection participants engaged in and the learnings participants uncovered from their HSA. Participants' HSA reflection primarily encompassed three areas: reflection about the counselling process, reflection about personal concerns, and reflection about management strategies. Reflections allowed participants to uncover impacts and learnings from their HSA. These learnings included accepting their vulnerabilities (like unpleasant childhood events or personal limitations), appreciating their personal strengths, and extending kindness to themselves when they experienced HSA.

(3a) Reflection on the Counselling Process, Personal Concerns, and Management Strategies

Lynn reflected on the counselling process and gained insights into her pleasing behaviours as she was "*very afraid to offend*" (I1). She reflected how the HSA had come in the way, affecting the counselling process, in particular how she showed up during the in-session as a counsellor, "*he (the client) didn't want to talk about it (his ex-wife) at all… I will just totally avoid it and not talk about it at all. Now, I will not delve because I don't want the client to feel uncomfortable.*" (Lynn, I1, p8). Lynn recognised the potential clinical implication from her own fear of rejection which was compounded by her lack of clinical experience. Lynn sought help from her supervisor to discuss the clinical issue, which was how she engaged in post-HSA reflection. With the support from her supervisor, Lynn further engaged in guided reflection and came up with management strategies to approach subsequent sessions with the client, "*one of the things that came up from the supervision was not to use religion at all, like authority or rules that he (the client) is very used to living by because he has been in prison for a long time.*" (Lynn, I1, p.9). From there, instead of avoiding uncomfortable topics altogether, Lynn gained more CSE in handling similar "*uncomfortable situations*". Most importantly, Lynn seemed to gain a sense of personal agency as a trainee counsellor.

Beatrice had always desired academic excellence. She experienced HSA of fearing to be perceived as incompetent across a variety of training contexts when grades were involved. Beatrice found supervision to be the most challenging context as she would be graded and therefore experienced HSA during supervision. On the one hand, Beatrice desired competence and her supervisor was the best resource to acquire clinical

competence; on the other hand, she found it difficult to discuss her clinical concerns with her supervisor because of her desire to achieve the highest grade. Beatrice felt that she would risk being "*perceived as less competent*" and that would "*translate to a lower score*". Since obtaining academic excellence was a non-negotiable for Beatrice, she reflected on her HSA and came up with management strategies to balance her results and missed learning opportunities in supervision,

> "*I feel that I'm still depriving myself of learning opportunities by trying to appear to be perfect or competent to my supervisor. I'm still sticking to looking up information myself… the school provides this group supervision which has been very helpful, so I share my issues through that channel instead of with my individual supervisor.*" (Beatrice, I1, p.30)

Beatrice anticipated future roadblocks and came up with a strategic approach to have her professional needs met. In a way, Beatrice's plan to optimise group supervision was able to mitigate her stress and foster positive outcomes in acquiring domain-specific knowledge. Despite recognising that her HSA could impede growth, Beatrice was steadfast in her plan to succeed.

Mary reflected on her HSA of frustration during the group activity and uncovered some of her personal concerns. Mary shared that when she "*flared up*" in the past, there would be a change in her tone, loudness, and choice of words. However, in her role as a trainee counsellor, she found her past coping maladaptive. Mary had a set of self-management strategies to cope with her frustration, "*… read my notes, I read my slides, check my phone, do something else to kind of shoo them (uncomfortable feelings and thoughts) out in that sense.*" (Mary, I1, p.14). Mary's HSA reflection prompted her

that her group reaction could be her "countertransferential" response, "*whenever similar group settings came about, when there was an outcome to be achieved, then it just triggered all these unpleasant memories…what's the point of dwelling on this…*" (Mary, I1, p.23). Mary realised that her past experiences had affected her current group experiences and by appreciating the impact of her past on her present, Mary was able to take things less personally. Mary explained that as a trainee counsellor, she did not want to be misunderstood by her classmates despite the disappointment that her learning expectations had been compromised. Mary believed that she could always rely on herself when it came to acquiring knowledge. From her reflection, Mary reinforced her self-efficacy beliefs as a competent learner but also recognised the proximal learning environment as a potential stressor.

Susie experienced HSA of desiring isolation during a particular counselling session at the youth drop-in centre in which she felt a related urge to isolate herself from the "*noisy environment*". With the support from her supervisor, Susie engaged in guided reflection and identified personal concerns, "*It was during supervision that I knew that my inner child was prominent during my time at the drop-in centre. I grew up in an environment where it was noisy… I hated noise…* " (Susie, J1, p.1). According to Susie, the noise at the practicum site was a trigger for her countertransferential behaviour. Susie used the term, "*inner child*", to describe the "*traumatic childhood experiences*" she had gone through to explain her intense emotions and dysfunctional behaviours. Susie's journal further captured the management strategies to work on her personal concerns, *"…seeking help from my therapist, I am working on how I can better manage my inner child whenever such situation happens.*" (Susie, J1, p.2). Susie acknowledged

the impact of her own unresolved issues on how she showed up in the counselling space. The ability to consider this and formulate a deliberate plan was a characteristic of a reflective practitioner. Despite having a lower CSE, the support from her supervisor came as a great resource for Susie to enhance her CSE and to restore in her a sense of autonomy.

Margaret experienced HSA of fearing to speak up in group supervision which hindered her learning outcome as she reported sitting through the entire session without uttering a word. Through her mind's eye, Margaret recalled the subtle cues that she misconstrued, "*... other people's facial expressions and tones, and how they interacted… didn't have eye contact or a little gesture… affected me a lot.*" (Margaret, I1, p.7). Margaret came up with a few strategies to manage her HSA in subsequent group supervision, "*I will be at my adult ego state… I tap into my adult ego and be that person... not get intimidated by outside factors.*" (Margaret, I1, p.10). Margaret drew reference from a counselling theory that she learned from the course where she could choose to be either in her "*adult ego state*" that was confident or the "*chid ego state*" that felt intimidated. Margaret also considered leveraging her classmates as a "*safe environment*" to practise assertiveness in expressing herself. Through HSA reflection, Margaret learned to cultivate metacognitive awareness by detaching her distressing thoughts and emotions and as a result gained personal agency and increased self-efficacy beliefs.

Steven "*prided*" himself when "*taking the opposite position*" to see if he could "*win arguments*". Initially, Steven believed that he could build the skill of being "*combative and respectful*" both at the same time even in his role as a counsellor.

However, as the training progressed, Steven began to recognise that his "*combativeness*" got in the way of building empathy. Steven reflected on his HSA and identified personal concerns, "*How can I be so far behind in my own personal development?... I should have known this stuff… why am I so late? Why am I so slow to get to this process?*" (Steven, I1, p.11) Steven recalled many instances in his personal life where his "*combativeness*" had ruptured relationships and he was determined to change, "*Well, I'm going to try and catch myself talking nonsense.*" (Steven, I1, p. 14). Steven took that a step further, he practised being honest with his supervisor as the supervisory working alliance was strong. For Steven to consider there could be a better way, other than his "*combativeness*" was a huge step for him. Initially, Steven's extremely high self-efficacy beliefs seemed counterproductive in his new role as a counsellor. Even though he was less hindered by his HSA of disconnectedness (which occurred in his personal life), reflecting on his HSA prompted Steven to be more in touch with himself and his personal life.

Linda experienced HSA of feeling conflicted which she described as a combination of conflicting thoughts, emotions, and a sense of restlessness. Linda reflected critically on her HSA, "*Maybe like three days after the supervision, I sat on that uncomfortable feeling, and I kept asking myself… I also asked my two classmates… I wanted to know whether I was too sensitive…"* (Linda, I1, p.17). From the reflection, Linda came up with a set of management strategies. Linda verified her experience with her groupmates who validated and confirmed her experience. Consequently, Linda emailed the group supervisor to provide her feedback. According to Linda, the feedback was constructive and objective. Most importantly, Linda received an apology from the

group supervisor and Linda felt understood and heard. Linda's ability to choose self-aiding action instead of passive-aggressive behaviour to communicate her needs enhanced her self-efficacy beliefs and adaptive coping which further fostered personal agency.

Amanda talked about her HSA of bodily sensations during a particular lecture. The momentary awareness was hindering as Amanda started to have flashbacks about her traumatic childhood and felt a related urge to share with the class about her experience and have her emotional need attended to. Amanda's reflected on her HSA and identified personal concerns:

> *...the biggest thing in my childhood, I always felt neglected. I felt that my siblings rejected me somehow and definitely, you know, with a little trauma with my dad, I always felt a bit abandoned and stuff, you know, so there's always this need to be the perfect child.* (Amanda, I1, p.38)

Amanda could testify to the enduring impact of childhood trauma on her body and adult life. From her reflections, she gained insights that her "*childhood wounding*" (I1) was so deep that it was both helpful and unhelpful for her as a counsellor. Amanda knew that she could in her words, become a "*wounded healer*" (I1) to use her own life experiences in her work with clients. However, Amanda also recognised that her traumatic past could resurface as a countertransference when she was triggered. Amanda's HSA seemed like a precursor to countertransference, and she remained focused on working on her personal concerns. Apart from supervision and personal counselling, Amanda also gathered strength from her spiritual faith:

> *If God has given me asked me to do counselling years ago, I would be a very bad counsellor". So thank God, he didn't, you know, he knew I wasn't ready for it because I would have brought all my traits and all these things into it, my judgements and stuff. So that was my transformation* (Amanda, I1, p.32)

Amanda was cognisant that she might still be triggered, and that her HSA might still be hindering and resulting in countertransference. However, her resolve to work on healing herself reflected her personal agency and illuminated her self-efficacy beliefs despite her past experiences.

Peter experienced HSA of self-consciousness in using formal English to converse. Peter acknowledged that the awareness was hindering because he would doubt his ability and lower his self-efficacy beliefs. Peter's reflection prompted him to work out a few management strategies to address his personal concerns, "*It made me realise that I can't rely on others and it's time for me to catch up… I can't just don't bother…*" (Peter, I1, p.11). Through reflection, Peter was able to cultivate metacognitive awareness to look at his problem in the larger context, "*Is a different environment from what I have been exposed to, whether it is in my workplace or my friends… somehow, I just have doubts.*" (Peter, I1, p.7). Peter was able to appreciate that the nature of counselling was very different from his past coaching environment and his group of classmates were receptive to him. Hence, Peter decided to leverage his classmates as a learning resource, "*when there's a partner… there's someone that I can listen to and also get to practise as well, then that will be the chance when I will switch my mode.*" (Peter, I1, p.13). Though HSA might recur, Peter reassured himself that his concerns about his English

proficiency were only temporary. In addition, he was able to differentiate self-evaluation from others' evaluation which is a sign of cognitive flexibility.

Rose experienced HSA of self-criticism during a particular peer role-play which she ended up blaming herself harshly. Rose reflected on the process of peer-counselling when she "*freaked out*" and went into a "*panic*" mode (I1). She attributed her "*failure*" in part to being poorly taught by the lecturer, "…*because the lecture was very bad… nobody learned anything… it was very lousy like I didn't know how to use it (counselling modality).*" (Rose, I1, p.9). Rose further received supervision support where she had the opportunity to practise guided reflection. However, Rose seemed to struggle with reflection, "*I thought reflection just points out all your mistakes and then let's see how we can avoid them in future… even until now, I'm finding it very hard to do a proper reflection as what my supervisor wants me to do.*" (Rose, I1, p.20). Rose's supervisor had probably identified her intense anxiety as a barrier to Rose's CSE and cognitive flexibility. Rose's inability to tolerate uncertainty made her susceptible to acute performance anxiety. In her best effort to regain control, Rose planned to defer the course, and she did. However, it remained a concern whether Rose would have a greater capacity to tolerate novice stress when she resumed advanced stage training.

According to the findings, all participants engaged in reflection on HSA. Most of the participants' reflections were related to personal concerns and had related management strategies to manage HSA and its implications. However, participants also recognised that HSA could recur and for a few participants, HSA could precede countertransference. These insights were helpful for they provided all participants with a

greater understanding of themselves. All participants also learned to practise kindness and patience with themselves, and the following subsection will elucidate further.

(3b) Learning to Be Kind and Patient with Themselves

During training, participants who experienced HSA learned to be kind and patient with themselves. This intentional practice was characterised by a desire for their own health and well-being as a counsellor.

The focus of Lynn's HSA was on the theme of rejection. When she experienced HSA of feeling the need to please, she did everything in her power to avoid "*offending the client*" in the beginning stage (I1). Lynn compared herself to a weed sprouting from a crack in the asphalt, "*You don't have to start strong actually… you just have to start and keep moving, just carry on your life.*" (Lynn, I1, p.33). Lynn's metaphorical expression reflected her knowledge of her fear of rejection and the significant impact it could have on her in the beginning stage. However, she recognised that vulnerability and growth were not mutually exclusive, and she needed to be kind to herself to carry on.

Beatrice's pursuit of academic excellence contributed in part to her HSA of fearing to be perceived as incompetent. Beatrice wished to be competent in her practice, but her fear of receiving a less-than-competent evaluation from her supervisor prevented her from discussing clinical issues with her supervisor. Beatrice was aware of her high expectations for herself, but she also knew that achieving good grades was a non-negotiable for her, despite the trade-off of missed learning opportunities. Beatrice knew very well that hard work might not guarantee results and she was willing to consider the odds, "*I can still try my best and like do whatever I need to get what I want out of my*

studies, but the worst can still happen and I'm ready to accept that." (Beatrice, I1, p.29). It might be difficult for Beatrice to re-evaluate her pursuit of competence but her willingness to consider the possibility of accepting "*the worst*" (i.e. not achieving excellent grade) was a tiny step forward in being kind to herself.

Similar to Beatrice, Mary took her learning seriously. During group activities, Mary experienced HSA of frustration when learning outcomes were compromised. However, Mary was able to take a step back to reflect on her learning experience, including her HSA. Mary described that she engaged in "*a lot of continuous self-reflection*", "*...reflecting like our own personal triggers, our own challenges… at the same time take care of ourselves…*" (Mary, I1, p.25). Mary recognised that triggers that could elicit HSA responses were part of training. However, her receptivity to new experiences and practice of self-care were crucial throughout her challenges during training.

Susie's HSA experiences centred on the theme of rejection (such as isolation and withdrawal). Susie disclosed that these HSA experiences were extremely unpleasant for her, not only the physiological sensations she felt, but also the meaning she associated with her HSA (such as neglected childhood). However, Susie affirmed her growth:

> *…no longer the child… if I were to think of isolation, I would think of the child back then when I was in a foetal position, trembling, just want to be alone so growing up from that foetal position to just facing what is coming towards me, I think that there is really hard work for me.* (Susie, I1, p.21)

As evidenced by her excerpt, it took Susie a great deal of fortitude to "*not hide*" and "*face what is coming*". By acknowledging the fact that "*is really hard work*", Susie was learning to affirm herself, which was a significant step for her considering her childhood experiences.

Margaret experienced HSA of fearing to speak up during training, which resulted in a range of negative emotions (such as nervousness, internal pressure, and feeling like withdrawal). Initially, Margaret was easily intimidated by her peers whom she perceived to be better than her. Margaret was conscious of her fear of being judged by others and acknowledged that her lack of assertiveness and confidence in social situations contributed to her susceptibility to intimidation. Therefore, despite Margaret's awareness that she possessed certain abilities, she described how they "*would not come out*" and negatively impacted her performance in group activities. Furthermore, Margaret was cognisant that her cultural beliefs made it hard for her to practise self-care even though caring for others was easier for her. However, she was open to consider practising some form of self-care when her physical health took a toll which she wrote:

> *I couldn't stop my negative thoughts. It was then I realised how difficult it was in reality to tackle negative thoughts… I realised how important it is to keep our mind in peace and to do that how important self-care is!!!* (Margaret, J2, pp2-3)

Margaret was familiar with the role of a caregiver based on her culture and upbringing. Consequently, it was understandable that Margaret had difficulty considering her own needs. Margaret probably had to adjust her belief, which was not easy for her. However, by acknowledging her need for self-care was a positive first step.

Steven did not feel that he experienced HSA in the beginning stage apart from the new awareness of himself that was associative to his "*combativeness*" and "*winning arguments*" which he viewed as "*intellectual gymnastics*" in his personal life (I1). Steven recognised that his upbringing contributed to his desire for respect and admiration. However, Steven was aware that his combativeness hindered his ability to develop "*honesty*" because he had become "*too mechanistic*" and "*prescriptive*" (I1). Steven was aware that he had to be mindful in training context to "*not default*" to cause any damage to relationships but he knew he had to change. In addition, he started to believe that being honest about his feelings might not be a bad thing after all, which was a significant first step for him in respecting his feelings.

Linda experienced HSA of feeling conflicted during a particular group supervision, which she described as conflictual thoughts and emotions, accompanied by physiology of restlessness. Linda refrained from "*lashing out*" which contributed to her passive-aggressiveness of gestures and "*simmering in anger and critical thoughts*" (I1). Linda was conflicted between her passive-aggressiveness and overt frustration (by lashing out) and the latter was a consequence she did not wish to have in the counselling setting. Linda was aware of her vulnerability and was working towards effectively communicating her needs to others in difficult situation such as the one like the group supervision. Linda metaphorically described her desire to be authentic as her "*loud vulnerability*" (I1); that is, putting her authentic self out there and being heard. Linda's "*loud vulnerability*" reflected her mindful awareness of her pain and desire, while simultaneously embracing her weakness with kindness.

Amanda interpreted her HSA of perceived rejection as learned a childhood behaviour. However, Amanda was constantly monitoring the progress of her healing throughout the course of training. She recognised that her "*transformation*" was a continuous process requiring ongoing introspection, self-improvement, and personal therapy. Hence, when Amanda experienced HSA of bodily sensations (like vibration) during a lecture and a class discussion, despite feeling shocked that she could still be triggered despite intensive personal therapy, Amanda did not blame herself, "*I've to tell myself, of course, it (HSA) will sometime*s *surface but I have to keep telling myself, "You've grown up now, it's okay, just let it go.*" (Amanda, I1, p. 35). Evidently, the excerpt captured Amanda's acceptance of the past and desire to move on. Amanda embraced the journey despite her knowledge that HSA could still be triggered, and learning to "*let it go*" was an ongoing process.

As the training progressed, it became clear that Peter's HSA, while present, did not affect his motivation to be a counsellor. Instead, Peter chose to accept and acknowledge that he needed to improve his level of English proficiency. Seemingly, HSA served as a reminder for Peter that a gap still existed between his current and expected level of mastery, and to continue building his English proficiency. Looking back at his training, Peter shared his learning from HSA, "*I'm aware of the areas that I need to work on and as long as I do something about it, I know that I'll be on track, so it's the process and not the result.*" (Peter, I1, p.24). Peter's patience towards himself was evident, given his growth mindset, and expressed that he had "*peace*" despite the discomfort.

Rose seemed to experience the most difficulties in practising self-kindness. Her persistently high expectations appeared to have set her up for vicious cycles of negative self-talk of which Rose was aware:

> *I was a very neurotic person, like with a lot of perfectionistic tendencies. So I was very unhappy and stressed all the time, because I was not able to reach that perfection… it got me to a point where, you know, it affected my sleep, my mind digestion, my health, like in general…* (Rose, I1, p.3)

Rose found it hard to express kindness to herself owing to her high expectations. Perhaps in Rose's perception, applying for course deferment was a better option for her in showing care for herself while she continued with personal therapy.

4.4 Summary of Chapter Findings

In the beginning stage of this 18-month QUAL-Quant study, participants identified a variety of training contexts such as lectures, group discussions, peer role-plays, client sessions, and individual and group supervision in which HSA occurred. All participants viewed HSA through the lens of their unpleasant childhood memories or cultural upbringing. To varying degrees, all ten participants described HSA as manifestations of unpleasant emotions, critical thoughts, and bodily sensations and gestures. Even though HSA seemed similar, participants had unique interpretations of their HSA; interpretations of HSA as covert desires, a set of learned childhood behaviours, and opportunities for growth. Participants engaged in independent HSA reflections or guided reflection with their supervisors. Through HSA reflection, participants acknowledged the hindering aspects of HSA and built strengths by accepting their vulnerabilities and practising kindness with themselves.

GET (1) – Putting on Different Lenses to View HSA

GET (1) illuminated the various perspectives participants used to view their HSA experiences. Five individuals perceived their HSA through the lens of their unpleasant childhood memories. Amanda and Susie felt neglected and rejected by their families, Rose felt the pressure to be perfect and do well as a child, Linda discussed her passive-aggressive family and the impact on her behaviour as an adult, and Lynn recalled the intense emotional pain from the rejection by her childhood best friends.

Five participants viewed HSA through the lens of their culture and upbringing. They did not view their childhood experiences as negative unlike the first group but acknowledged their childhood circumstances as the source of their HSA. Steven and Margaret felt that their foreign culture and upbringing could explain their difficulties in building authentic connections and speaking up in a group setting, respectively. Peter attributed the Singaporean culture to his HSA and the perceptions he had about formal English and Singlish. Beatrice believed that her family's socioeconomic status had influenced her beliefs and values regarding educational achievement which was associated with her HSA, while Mary believed that her upbringing as an only child explained her desire for independence and expectations in group learning.

GET (2) – It Is So Uncomfortable Yet Familiar

GET (2) discussed the various interpretations participants associated with their HSA. All participants interpreted their HSA as manifestations of critical thoughts, negative emotions, and unpleasant bodily sensations and gestures. Margaret characterised her manifestations as physiological discomfort akin to internal pressure, whereas Amanda experienced body vibrations. Linda experienced conflicted emotions

and physiological restlessness. Susie, Lynn, and Peter experienced different unpleasant emotions: feelings of desiring isolation, feeling the need to please, and feeling self-conscious, respectively. While Steven, Mary, and Rose experienced more cognitive dissonant thoughts like self-questioning, self-blaming, and self-criticising. Beatrice on the contrary experienced self-doubts and performance anxiety of being perceived as incompetent by her clinical supervisor. A few of the participants such as Amanda, Susie, and Mary also saw a connection between HSA and countertransference, HSA preceded countertransference and that could result in clinical implications.

Participants also interpreted their HSA as covert desires. While Steven hoped for admiration and Beatrice desired success in life, Margaret yearned for assertiveness and Amanda desired safety. Participants also interpreted their HSA as a set of learned childhood behaviours. Lynn learned to please others to avoid rejection and Linda reacted passive-aggressively when she perceived that her need was not met. Rose became critical of herself and others when she perceived failure and a lack of personal control. Participants agreed that these learned childhood behaviours were dysfunctional in adulthood. Rose, on the other hand, seemed to be overwhelmed with acute anxiety and had to eventually defer advanced stage training. Two participants, Mary and Peter, viewed HSA as less hindering and perceived HSA as opportunities for growth. Peter felt that his struggle with speaking formal English was only transient and once he became accustomed to speaking in formal English, he would likely feel less self-conscious. Similarly, Mary felt that she had to moderate her expectations for group activities but that there was no pressing issue to address. A few participants like Beatrice, Steven, Peter and Mary recognised that HSA could be hindering, but HSA did not have direct

clinical implications. Overall, HSA provided the participants with more knowledge about themselves.

GET (3) – Building Strengths, Accepting Vulnerabilities

All participants engaged in reflections about their HSA and their reflections primarily focused on the counselling process, personal concerns, and management strategies. A few participants uncovered deeper meanings of HSA with their personal concerns. For example, through guided reflection with her supervisor, Susie was able to draw a connection between her HSA of desiring isolation and her inner child. She recognised the impact it could have on her CSE and personal agency and took accountability to work on her personal issues. Similarly, Amanda became more determined to work on her personal healing from her adverse childhood experiences. Amanda's HSA manifestations prompted her to reflect and gather support from various sources like supervision, personal counselling, and religious faith to manage HSA and its origin. A few participants reflected on the impact of HSA and the counselling process. For instance, Lynn was concerned about her lack of clinical knowledge and HSA compounded her anxiety further. With her supervisor's support, Lynn was able to receive timely feedback and modelling which helped build Lynn's CSE. When participants reflected on their HSA, they acknowledged the hindering aspects of HSA on their clinical work either directly or indirectly and came up with management strategies to manage foreseeable HSA recurrence or as a measure to prevent future countertransference. For example, Mary, Susie and Amanda's HSA seemed to precede countertransference (e.g., Mary's adverse reactions in a group discussion, Susie's disengagement from the youths by remaining silent at the youth drop-in-centre, and

Amanda's flashbacks and intense distress during lecture). These management strategies included consultation with their supervisor, personal counselling, peer support, personal adjustments to bridge learning gaps, and religious faith.

When participants reflected on their HSA, they were found to engage in some form of positive self-talk that elicited hope and courage for them to press on. For example, Linda described her HSA as "*loud vulnerability*" for her to practise expressing herself while Lynn described her HSA experience as "*weed sprouting from an asphalt crack*" to signify her growth (I1). Margaret and Susie simply affirmed themselves for their growth. Rose, unlike the other participants, struggled to affirm herself which could possibly perpetuate her performance anxiety that contributed to her HSA. To varying degrees, participants accepted their vulnerabilities and gathered strengths from HSA learnings.

4.5 Chapter Conclusion

This chapter presented the IPA findings on trainee counsellors' phenomenological HSA in the beginning stage of training. IPA's strength of providing contextually embedded insights into participants' narratives found participants' HSA to be similar but with unique HSA interpretations that were both personal and idiosyncratic. The next chapter will discuss findings for the advanced stage of training.

CHAPTER 5

Findings For the Advanced Stage Training: The Phenomenology of HSA

> *As every utterance has a dual relationship, to the totality of language and to the whole thought of its originator, then all understanding also consists of the two moments, of understanding the utterance as derived from language, and as a fact in the thinker ... Every person is on the one hand a location in which a given language forms itself in an individual manner, on the other their discourse can only be understood via the totality of language. But then the person is also a spirit which continually develops, and their discourse is only one act of this spirit of connection with the other acts.* (Schleiermacher & Bowie, 1998, pp. 8-9)

5.1 Chapter Introduction

This chapter presents the Interpretative Phenomenological Analysis (IPA) findings in the advanced stage of training which ideally would provide trainee counsellors with more practical and experiential learning opportunities. The research questions (RQ) guiding this study are: RQ1) How do trainee counsellors make sense of and interpret their HSA over the course of training? RQ2) How do trainee counsellors reflect on and learn from their HSA over the course of training? A second interview with each of the remaining nine participants allowed for further exploration of their moments of hindering self-focused attention (HSA) in the advanced stage of training to identify convergent and divergent findings from the beginning stage. Comparisons between the

two stages provided insights into participants' HSA interpretations and learning, and whether their HSA descriptions changed over time with counselling self-efficacy (CSE) and supervisory working alliance (SWA) (i.e. if the hindering aspect of HSA increased or attenuated with CSE and SWA). While participants might have recalled a few HSA moments, it is beyond the scope of this thesis to include all HSA but to focus on one for each participant. For clarity, Table 5 presents an overview of participants' HSA descriptions and abbreviated HSA that will be used in the throughout the discussion. Similar to Chapter 4, the presentation of IPA themes will be supported by participants' quotations and the chapter will end with a summary of each participant's HSA trajectory across training.

5.2 Group Experiential Themes and Subthemes

IPA findings gathered three Group Experiential Themes (GETs) and eight subthemes. They are: GET (1) Putting on different lenses to view HSA: (a) Exploring HSA through culture and upbringing, (b) Exploring HSA through a counselling theory, and (c) Exploring HSA through a counsellor's perspective, GET (2) It is so uncomfortable yet familiar: (a) HSA as manifestations of critical thoughts, unpleasant feelings, bodily sensations and gestures, (b) HSA as covert desires, and (c) HSA as opportunities for growth, and GET (3) Building strengths, accepting vulnerabilities: (a) Engaging in HSA reflections, and (b) Learning to be kind and patient with themselves. The author's editorial elision is indicated by three dots (...), and the sources of the quotes, for example, Interview One and Journal One are abbreviated to, "I1" and "J1", respectively.

Table 5

Advanced Stage Hindering Self-Focused Attention (HSA)

Participant	**Context**	**Description of a moment of sudden awareness**	**HSA**
Amanda	A class demonstration on Exposure Therapy in which she was chosen to be the client working on her fear of lizards	She became suddenly aware of her bodily vibrations and elevated heart rate. The awareness was hindering as she could not focus on the activity and recalled having similar bodily sensations during the beginning stage of training.	HSA of bodily sensations
Lynn	A lecture about automatic thoughts from Cognitive Behavioural Therapy	She became suddenly aware of her critical thoughts and emotions about her withdrawal from the practicum site. The awareness was hindering as she became distracted from the lecture and began to focus on her automatic self-critical thoughts.	HSA of a need to please to avoid rejection
Susie	A peer role-play on grief	She became suddenly aware of her annoyance about the activity and critical thoughts of having to ask the client repeatedly how the client was feeling. The awareness was hindering as she took the role-play less seriously and began to joke during the process.	HSA of annoyance

Linda	A group supervision in which she volunteered as a client working on an actual issue of the lack of sleep	She became suddenly aware of her intense resistance and sadness with accompanying bodily trembles when the lecturer continued to challenge her actions which contributed to her lack of sleep. The awareness was hindering as she tried to mask her emotions with humour in front of her group members	HSA of feeling resistant
Margaret	A class discussion in which trainee counsellors participated in unstructured learning	She became suddenly aware of her urge to want to perform in front of others. The awareness was hindering as she felt anxious and tried to distract herself.	HSA of fearing to speak up
Steven	A class discussion in which trainee counsellors participated in unstructured learning	He became suddenly aware of his argumentative trait during a heated conversation with his classmate and felt a related urge to back off from the argument. The awareness was hindering as it reminded him of his argumentative behaviour in his twenties and felt guilty.	HSA of disconnectedness
Peter	A counselling session with a group of youths from a specific culture	He became suddenly aware of his choice of words, pacing, and bodily sensations. The awareness was hindering as he became more conscious of his counselling performance.	HSA of self-consciousness

Mary	A peer group role-play.	She became suddenly aware of her critical thoughts and negative feelings towards a group member's behaviour that compromised her learning. The awareness was hindering as she deliberated whether to leave the group and she did to attend to her own emotional need.	HSA of frustration
Beatrice	A lecture	She became suddenly aware of her feeling of dread and thoughts of having to switch on her laptop and sit at her desk for hours. The awareness was hindering as she became distracted and entertained the idea of calling in sick just to rest.	HSA of dread

5.2.1 GET (1) – Putting on Different Lenses to View HSA

GET (1) has three subthemes: a) Exploring HSA through culture and upbringing, b) Exploring HSA through a counselling theory, and c) Exploring HSA through a counsellor's perspective. In the beginning stage, IPA findings gathered that participants viewed HSA through the lens of their unpleasant childhood memories and culture and upbringing. IPA findings in the advanced stage expanded to include participants' exploration of their HSA through a counselling theory and the perspective of a counsellor. The subtheme of viewing HSA through the lens of participants' unpleasant childhood memories was less pervasive in the advanced stage as compared to the beginning stage and hence removed which characterised participants' shift in their perceptions of HSA. Participants' ability to depersonalise HSA with their unpleasant childhood memories could be a sign of their development as they became more integrated as counsellors and gained more conceptual maps.

(1a) Exploring HSA through Culture and Upbringing

In the beginning stage of training, Susie viewed her HSA of desiring isolation through the lens of her unpleasant childhood memories. In the advanced stage of training, Susie experienced HSA of annoyance during a peer role-play on grief. Susie was hindered by her HSA of annoyance as she found herself inundated with critical thoughts about the activity and as a result struggled to take the counsellor role seriously. Susie began to joke during the role-play on grief and the activity was abruptly terminated by her peer who was emotionally invested in the client's role. She told Susie off and according to Susie had maintained a distance from her up to the point of the

interview. Susie tried to make sense of her HSA of annoyance by viewing it through the lens of her culture and upbringing:

> *I don't know like a part of me knows that losing people like people dying is a part and parcel of life. I guess another part of me is I don't want to think about it. I don't want to think about people dying... I guess I think is also because my family itself, we don't talk about emotion… like grief is not easy especially if you're coming from a traditional Chinese family where death is like a taboo thing...* (Susie, I2, p. 16)

Susie's HSA of annoyance with the role-play, particularly the repetition of a specific question designed to elicit the pseudo-client's feelings, might appear ridiculous to her. However, what could be more distressing for Susie was not the pseudo-client's emotional expression, but rather her limited tolerance for negative affect like grief which could be evoked during the role-play. Additionally, emotions like sadness and anxiety surrounding mortality might have been deemed unacceptable in her family of origin. Consequently, Susie would likely lack the emotional capacity to manage these distressful emotions. Therefore, she might instinctively choose to avoid engaging with such emotions altogether.

Beatrice experienced HSA of fearing to be perceived as incompetent in the beginning stage of training. She made sense of her HSA and her desire for success through the lens of her culture and upbringing which was characterised by financial hardships. In the advanced stage of training, Beatrice experienced HSA of dread during a particular lecture on Zoom. Beatrice shared that the awareness was hindering her as she found herself distracted by the wandering thoughts of her calling in sick so that she

could rest and not have to switch on her laptop. Using the lens of her culture and upbringing, Beatrice made sense of her HSA of dread in the advanced stage of training:

> *…prior to the passing of my dad, like I felt that I could explore a lot of different paths, I could do whatever I wanted because I was kind of backed by my family… but after the incident, I felt like I was limited to, you know, options, I have to sacrifice my interests to pursue practicality. I guess that's where my need for excellence comes from. I feel like I have to be the best at what I do because if I'm not the best it's wasted effort. It's a waste of time and resources.* (Beatrice, I2, p. 24)

Achieving academic excellence remained a consistent theme throughout training for Beatrice. However, Beatrice acknowledged the strive for competence had taken a toll on her health in the advanced stage which she described as "*feelings of burnout*" (I2), and it began to show up during the coursework training when she experienced HSA of dread. Beatrice recognised that her HSA of fearing to be perceived as incompetent and HSA of dread were two sides of the same achievement coin; she simply could not keep up with her own demands and expectations, which became so overbearing that she felt dread when studying. Beatrice's values and beliefs about hard work and success supported her through the demands of the training, but the constant pursuit of excellence posed a risk of exhaustion in the advanced stage of training. Beatrice was cognisant of the clinical implications of not prioritising rest, but her intense fear of incompetence made it equally challenging for her to take rest.

(1b) Exploring HSA through A Counselling Theory

In the beginning stage of training, Lynn described her HSA of a need to please to avoid rejection in a particular online counselling session with a client who was mandated to receive counselling under a drug recovery programme. Lynn remembered her related urge to monitor her online nonverbal behaviours which she was concerned would be misconstrued by the client and resulted in the client's rejection. Lynn interpreted the HSA through the lens of her unpleasant childhood memories of her childhood friends' rejection in the beginning stage. In the advanced stage, Lynn experienced a similar moment of HSA of a need to please but with a reinterpretation. According to Lynn, the awareness was hindering as she became fixated on her critical thoughts of her withdrawal from the practicum site while the lecture was ongoing. Lynn viewed the HSA through the lens of a counselling theory specifically Transactional Analysis (Berne, 1973) to make sense of it. Transactional Analysis theorised that people have three ego states, namely Parent-Adult-Child and that these ego states engage in "transactions" both internally and externally with other people (Berne, 1973):

> *...identifying when the Child ego state made the (dysfunctional) decision with respect to the Parent (ego state) and even now as a grown adult, how the Child ego state acts out the "do nots" or statements that are being played that sort of restricts or does not allow the individual to live a fulfilling life…* (Lynn, I2, p. 1)
>
> *I am often either a "Critical Parent" (ego state) or a "Rebellious Child" (ego state) in terms of relationships and communications with people and I've not changed my ways…* " (Lynn, I2, p. 3)

Lynn perceived herself to be critical and judgmental from her "*Critical Parent*" ego state and as a result, would constantly criticise herself when something went wrong. She illustrated with an example that when the "*Child*" ego state, which was dominant in the beginning stage of training, perceived rejection, it continued to "*try very hard to be accepted*" (I2). However, in the advanced stage, her "*Rebellious Child*" ego state decided to retaliate to stop getting hurt, hence she withdrew from the practicum site totally, but her action was ridiculed by her "*Critical Parent*" ego state as being immature. Whilst her child state was happy with her decision to withdraw, she felt conflicted by this decision, as the counsellor part of her thought she should stay. On the one hand, the theory helped Lynn understand why she felt the way she did, while on the other, she was presented with a clinical perspective that she struggled to alter behaviourally. Nevertheless, Lynn was able to gain insight into her emotional vulnerability.

Amanda, like Lynn, utilised Transactional Analysis to view and compare her beginning and advanced stage HSA. In the beginning stage of her training, Amanda made sense of her HSA of bodily sensations during a particular lecture on adverse childhood events through the lens of her unpleasant childhood memories. In the advanced stage of training, Amanda experienced a similar moment of HSA of bodily sensations when the lecturer demonstrated exposure therapy with Amanda on her fear of lizards by constantly repeating the word "lizard". However, Amanda claimed that the lecturer had likely mistaken her silence for consent to participate and she regretted not clarifying herself. Amanda disclosed that she has always been afraid of lizards and the sight of a live lizard would make her jump. But it came as a shock to Amanda when the repetition of the word "lizard" could momentarily elevate her heart rate and trigger

bodily vibrations. The bodily awareness hindered Amanda and she recalled similar trauma-induced physiological responses in the beginning stage. However, Amanda made sense of both her HSA of bodily sensations using Transactional Analysis:

> *Adverse childhood event is a lot about how I look (at the situation)because I was depressed basically blaming because of the way I perceived the situation… like going through Transactional Analysis, I understand all this stuff about injunctions and drivers. So I got a lot of moments like, okay, that's why dad is like that, that's why my mom is like that, that's why I have all these injunctions and what can I do to rewrite my script. So what kind of script do I want, okay, this is so I can change… Fear (of lizards) is different, is something I always found that is deep in my subconscious. I don't even know where it came from… I know lizards basically eat mosquitoes. I know that cognitive stuff that lizards are fine. I got all the perspectives… I just don't want to deal with that feeling, the other one is in my mind.* (Amanda, I2, pp. 9-10)

Amanda's excerpt revealed her intellectual ability to analyse things and therefore, viewing her HSA through the lens of a counselling theory seemed appropriate. In the beginning stage, Amanda viewed her HSA of bodily sensations through the perspectives of her unpleasant childhood memories, which was the "*script*" she told herself. Amanda utilised the counselling theory of Transactional Analysis to define her script as "*the story I tell myself*", which was the need to "*be perfect to be loved*" (I1). Amanda was able to challenge and alter that dysfunctional script, which from the Transactional Analysis lens was to make a decision from the Child ego state to come up with a new script (Berne, 1973) because the adult part of her knew that it was impossible

to be perfect. However, the lack of a probable cause or vivid memory (i.e. scriptless) of her fear of lizards made it difficult for Amanda to intellectualise it using any counselling theories. Amanda described her fear of lizards as a subconscious and instinctual reaction that she had no intention of changing even though it caused her some inconveniences; she did not think of it as dysfunctional in adulthood apart from some habitual adjustments. Amanda elaborated that even though she had learnt about the Jungian archetype of the "*shadows*" (Moonchild, 2016) to understand that her unconscious mind was composed of repressed thoughts, weaknesses, and desires, her fear of lizards was not something she perceived the need to work on. In that vein, Amanda's awareness of her felt sense in the advanced stage allowed her to expand and dive deeper into her bodily sensations than in the beginning stage.

(1c) Exploring HSA through A Counsellor's Perspective

During the beginning stage of training, Margaret experienced HSA of fearing to speak up in a particular group supervision. Margaret acknowledged that group contexts made her feel intimidated and lowered her self-efficacy beliefs. To make sense of her HSA, Margaret viewed it through her culture and upbringing which contributed to her "*outsider*" perspective (I1). Margaret experienced a similar moment of HSA during the advanced stage of her training but this time, her HSA took place in the classroom where fellow trainee counsellors contributed to an unstructured learning class discussion. Margaret's awareness of her HSA was hindering her in the moment as she found a related urge to want to perform in front of others. To make sense of the HSA, Margaret took a more balanced perspective of an emerging counsellor in the advanced stage:

> *I sense that inside I have this urge to perform. I need to perform to satisfy the client and I feel that urge to perform is artificial, I shouldn't have it. It is actually working against what I want to achieve… I think once I'm able to come out of it, I will be able to be more real and that's what I want to achieve… the approval-seeking urge is what is working against me.* (Margaret, I2, p. 5)

Whilst Margaret continued to experience HSA of fearing to speak up her perception of her HSA shifted from an external to an internal locus of control. This gave her more impetus to take action and exercise personal agency. Margaret was aware that a part of her was afraid to speak up, but the other part of her was craving to voice out and be affirmed by others. When Margaret viewed her HSA through the lens of a counsellor simply by being non-judging, she was able to observe her thoughts and garner strength in managing her HSA.

Similar to Margaret, Steven viewed his HSA of disconnectedness in the beginning stage through the lens of his culture and upbringing. He understood the implication of his "*intellectual gymnastics*" (I1) in bonding with people in his personal life. In the beginning stage, Steven had thought that he could marry combativeness with honesty in the beginning stage, but his advanced stage HSA of disconnectedness showed him otherwise. Steven experienced a similar moment of HSA of disconnectedness during a particular unstructured learning class discussion. The awareness was hindering for Steven as it reminded him of his argumentative behaviour in his younger days and his struggle to "*peel away the layers*" (I1) in his new role as a counsellor. Steven adopted the perspective of an emerging counsellor to make sense of the HSA:

> *That was a complete default… the lecture started talking about Freud… It was almost a snapback because that was like me 20 years ago… I remember getting*

> *into a pretty heated conversation with somebody (a classmate) about it, and regretting it immediately, like, why am I doing this? ... It just doesn't make any sense, right? Thankfully, I regretted it immediately.* (Steven, I2, p. 28)

Steven's rapid response upon realising the implications of his HSA was evident in the excerpt. When Steven sensed that his classmate was becoming "*extremely emotional about the topic*", he paused in his actions to observe the impact of his overly combative and disconnecting behaviour and backed away. Steven was evidently more settled into his role as a counsellor in the advanced stage. He was aware of the potential to default, and that integrating combativeness with connectedness was not as simple as he first perceived in the beginning stage. With a refreshed counsellor's perspective, Steven seemed to demonstrate cognitive flexibility despite knowing that his HSA could still recur.

Mary viewed her HSA of frustration through the lens of her culture and upbringing as an only child in the beginning stage of training. Mary had always enjoyed independent work which according to her, produced results. Therefore, when her learning outcomes were not achieved or her grades were pulled down in group work, she became resentful. In the advanced stage of training, Mary recalled a particular group role-play when she experienced a similar moment of HSA of frustration. Mary felt hindered by the HSA in the moment as she struggled with distracting thoughts about leaving the group. Mary eventually left the group to attend to her emotional needs. Mary claimed that her frustration stemmed from her unmet expectations for learning. To make sense of her HSA in the advanced stage, Mary adopted a counsellor's perspective to discern the differences and the implications of her response across the two stages:

> *I suppose to a certain extent the frustration, or the exasperation comes from the importance that I place in learning… I think the first time I felt like the lack of effort from everyone was an obstacle to learning. In this scenario, to some extent, similar as well, I guess, somebody in my group got really emotional… I felt like it wasn't appropriate because it was putting us in a very awkward position… role-play is meant for all of us to practise and apply our learning.* (Mary, I2, pp. 24-25)

> *The only time when I actually experienced such negative attitudes because of countertransference is actually that related case that I shared in that group role-play session where I walked out.*" (Mary, I2, p. 31).

Through the counsellor's point of view, Mary could objectively identify her response to leave the group role-play as a countertransference from her past unpleasant group discussions. It was essential for Mary to learn about her countertransference reactions toward group processes even though it might not have a direct clinical impact at that juncture. For Mary, the momentary HSA seemed to occur before her countertransference, and this could provide insight into her unresolved issues which could both be a challenge and therapeutic growth. Additionally, Mary became more aware of her values and beliefs which were crucial in ensuring they would not compromise the integrity of future therapeutic relationships.

Linda experienced HSA of feeling conflicted during a particular group supervision in the beginning stage of training. Linda viewed her HSA through the lens of her unpleasant childhood memory to make sense of her passive-aggressive behaviours toward the group supervisor. However, in the advanced stage, Linda described that her

"*passive-aggressiveness died*" (I2) to imply that she no longer noticed herself reacting passive-aggressively. Linda contributed another moment of HSA during a particular group supervision in the advanced stage of training. In that group supervision, Linda volunteered to be the client who was struggling with a persistent lack of sleep. During the role-play, Linda became suddenly aware of her resistance and the awareness was hindering as Linda felt a related urge to deny her responsibility for perpetuating her sleep problem and mask her emotions. Linda adopted the perspective of an emerging counsellor to make sense of her HSA of feeling resistant:

> *I've been focusing on self-compassion… the concept was difficult to grasp at first… I wish somebody would have told me about kindness… the keywords are to be kind to yourself… It was a huge thing, because like, I can be kind to others no problem… but when it comes to being kind to me, it's like a foreign concept… and I kept thinking like, "Oh, that's not kind… like that's not kind.* (Linda, I2, p. 16)
>
> *Sometimes, I wished I would fall sick so that I could take sick leave and then I could finally sleep.* (Linda, I2, p. 23).

The phrase "*that's not kind*" was used to describe the way Linda had expected of herself; to work till she would fall sick in order to sleep. In a way, Linda would likely feel guilty if she were to permit herself to rest more. Therefore, Linda's resistance as a client made sense to her as she struggled with cognitive and emotional dissonance as a client and her response (as a client) was hard for her to ignore (as a counsellor). Linda felt conflicted as on the one hand she desired self-compassion but on the other hand, her lack of self-care to have adequate sleep was diametrically opposite. In the advanced stage, Linda found self-compassion to be an integral part of counsellors' development in

order to do the work that counsellors do. Hence, when Linda experienced HSA of feeling resistant as a client, she gained insight into her lack of self-compassion from a counsellor's perspective which she acknowledged as the "*biggest change*" in her self-development.

Peter experienced HSA of self-consciousness in using formal English when he was around his classmates in the beginning stage of training. Peter felt that Singlish was part of his identity. Singlish is a colloquial form of English spoken by a specific demographic group of Singaporeans. Peter provided another moment in the advanced stage of training when he experienced HSA of self-consciousness with additional bodily sensations. Peter shared that the awareness was less hindering as compared to the beginning stage but still contributed to his anxiety as he would tune in to his felt sense more. Peter described the additional bodily awareness as a "*cue*", and he adopted the perspective of an emerging counsellor to make sense of the HSA:

> *I think now, I have more bodily awareness… the attention to sensation is amplified. In the earliest stage, I would just pay attention to the way I talked but now much more conscious of the overall… I think it gave me the cue… It gives me a cue of the state of mind or the emotion that I'm currently present because I'm neutral. So example if I'm in a situation where I'm panicky, my tone will be speaking fast, and my body will be sweating so I guess now having this baseline I know should there be instances where my physiology has gone away from the baseline, I can take it as a cue to slow down or to regulate myself.* (Peter, I2, pp. 15-16)

Peter was able to maintain awareness of his bodily cues when he chose to use Singlish or formal English on purpose. Peter's overall attitude towards his English proficiency shifted significantly when he viewed his HSA of self-consciousness through the lens of a counsellor in the advanced stage as compared to his culture and upbringing in the beginning stage. The essence of the shift was an overall acceptance of himself and his Singlish identity. According to Peter, he was able to code-switch between formal and colloquial English. In addition, Singlish was more culturally appropriate for the group of youths he was counselling. Peter's cultural sensitivity and versatility had in a way contributed to his increase in CSE. Peter was on the one hand self-conscious about using Singlish and to some extent his Singlish identity but on the other hand, the HSA had provided him with a layer of cultural and clinical sensitivity.

5.2.2 GET (2) – It Is So Uncomfortable Yet Familiar

GET (2) has three subthemes: a) HSA as manifestations of critical thoughts, unpleasant feelings, bodily sensations and gestures, b) HSA as covert desires, and c) HSA as opportunities for growth. In-depth exploration of participants' HSA in the advanced stage expanded on findings from the beginning stage. Participants' interpretations of their HSA (as manifestations, desires, and growth opportunities) remained consistent across the two stages. However, IPA found participants' interpretation of their HSA as a set of learned childhood behaviours to be less pervasive in the advanced stage and consequently removed. The elision of this subtheme could be explained by the participants' overall perception of their improvement in the advanced stage; and their ability to better manage HSA with improved CSE and personal agency that might have contributed to a reduction in maladaptive coping.

(2a) HSA as Manifestations of Critical Thoughts, Unpleasant Feelings, Bodily Sensations and Gestures

Participants' interpretations of their HSA as manifestations of cognitions, emotions, and bodily sensations and gestures were found to be convergent and divergent at both the individual and group levels and across the two stages of training.

Role-play is often utilised as a pedagogical approach to provide trainee counsellors with practice and hone their counselling skills in a simulated environment. Hence, trainee counsellors are encouraged to capitalise on experiential learning to apply theoretical knowledge in a controlled and peer-supported setting. Despite the benefits of role-play in training, Susie and Mary convergently reported unpleasant HSA moments. Susie interpreted her HSA of annoyance as manifestations of critical thoughts specifically to the role-play on grief itself:

> *I think what went through my head was, "This exercise is ridiculous!" I don't know why anyone would want to do it like keep repeating the same question to the person who is grieving… I think the repeating of the question… I always find it annoying… this is ridiculous, this is annoying…*" (Susie, I2, pp. 5-6)

Susie was evidently irritated by the role-play activity, and as a result, she became less sensitive towards her classmate who was emotionally vested in the pseudo-client's role as she had prior grief experience. As Susie became increasingly aware of her annoyance, it automatically elicited in her a behavioural response of joking to manage her intense annoyance. Even though the act of joking was inappropriate at that moment and therefore dysfunctional, Susie was unable to recognise its implication. Susie's

classmate reacted negatively toward her attitude and terminated the role-play prematurely. Despite being a role-play practice, both Susie and her peer did not feel safe enough to be vulnerable in a role-play setting and their reactions had impeded their learning which might have a clinical implication.

Mary experienced HSA of frustration when her expectation for learning was compromised in a particular trio role-play. Mary's HSA manifestation was more of a psychological experience which she described as:

> *I notice myself disengaging mentally. I kind of go into a state of, like blankness or numbness. It's a very weird state, like a state where you know, I'm not feeling or thinking much except that I feel that I want to get out of the situation… I'm still sitting there. I'm still listening but inside, you know, I feel like I am kind of shutting down, zoning out*. (Mary, I2, p. 22-23)

Mary's HSA manifestation was uncomfortable for her, and she described her peer's "*emotionally charged*" behaviour as too intense for her (I2). Mary understood that the momentary physiological "*numbness*" was her body's way of coping with intense emotions; Mary had probably been overwhelmed by her peer's sadness and lacked the emotional capacity to tolerate it. Mary eventually left the session in mid-session to tend to her own emotional needs. In a way, Mary's struggle with rigid emotional boundaries had likely contributed to her not feeling safe in that specific role-play.

Beatrice experienced HSA of fearing to be perceived as incompetent in the beginning stage of training which was significantly different to that of the advanced stage; she experienced HSA of dread. Beatrice's advanced stage HSA manifestation on

the surface looked relatively different from her HSA in the beginning stage, however, deeper exploration found associations between both:

> *During the lecture, I felt that internally there were feelings of stress and burnout… I remember thinking that if only I could meditate enough, exercise enough, vacation enough, love enough, and relax enough, then I would feel alright… when I took some time off for myself or took a break, I felt that I always needed one more day.* (Beatrice, J4, p. 1)

> *The negative feelings I associated with my laptop were probably a transference effect on my coursework and therapy sessions with my clients. I was distracted by the questions I had… whether it is worth continuing to pursue this journey in academia. There were also thoughts of quitting the workforce altogether.* (Beatrice, J5, p. 1)

Beatrice had always been a diligent student who pursued academic excellence. She expected herself to be competent in order to thrive and advance in her professional career. At the advanced stage, the constant pursuit of competence in all areas of her life appeared to become so overwhelming that she became momentary aware of her dread during that particular lecture. Beatrice made a significant connection between the pursuit of competence and the risk of burnout and premature exit from the course. Beatrice believed that her HSA of dread, despite being unpleasant, was the opposite side of her drive for competence which she was very familiar with; to keep pushing herself to the limit which perpetuated her all-or-nothing thinking such that when she perceived incompetence, she should quit. It seemed understandable why she felt the dread as the

incessant chase for success had likely exacerbated Beatrice's fear and feeling out of control.

Lynn's HSA of a need to please to avoid rejection occurred in both stages of training. Lynn perceived rejections as "*devastating*" (I1) and would avoid being rejected at all costs. Unlike the beginning stage where Lynn viewed her momentary critical thoughts as assumptions; Lynn interpreted her advanced stage HSA as automatic thoughts between her "*Critical Parent*" and "*Rebellious Child*" ego state:

> *I became aware… of these automatic thoughts and statements I play in my mind, it's irrational. I mean, it was significant because there was just sort of an awareness, like a moment of enlightenment… talking to myself, "Why do you think like that? [laugh] Why have you been thinking like that? Why have you been responding or reacting like that?" … some of these statements that played in my mind they are related to what I've mentioned earlier about being critical of myself, my Critical Parent or Rebellious child.* (Lynn, I2, p. 4)

Lynn's laughter appeared to serve the purpose of diffusing her negative emotion which was also present in the first interview. During that particular Cognitive Behavioural Therapy lecture on automatic thoughts, Lynn became suddenly aware of her inner dialogue between the two ego states and made a connection between her "*enlightenment*" and her withdrawal from the practicum site which she characterised as "*a child's defense mechanism*". Lynn had perceived rejection from a staff at the practicum site and despite knowing that she should not have "*walked away*" in her role (I2), she still did. Lynn justified that the Child ego state had probably perceived the "*wrong cues*" and the only way to stop the "*Child*" from the pain of (perceived) rejection

was to withdraw. Lynn had not mentioned in the transcripts the ethical implications of her decision to withdraw from the same practicum site that she was posted to since the beginning stage. However, Lynn's HSA seemed to shed light on the interplay between her momentary thoughts (i.e. automatic critical thoughts about perceived rejection) and her withdrawal from the practicum site, and the association between the two (such as the possibility of countertransference).

Unstructured learning plays a significant role in training, complementing formal didactic instruction. In the context of counsellor training, trainee counsellors may engage in discussion to apply theoretical knowledge, receive feedback from peers, or enhance critical thinking. However, trainee counsellors at different developmental stages are reported to progress through these stages at different rates (Stoltenberg, 1981).

Steven's moment of HSA of disconnectedness in the advanced stage was quite different from the beginning stage; a growing "voice" at the back of his mind that he could just bookmark away unlike the advanced stage which seemed louder. During a particular class discussion in the advanced stage of training, Steven became suddenly conscious of his thoughts about his combativeness and the undesirable impact on his classmate:

> *Am I really going to change somebody's views on Freud? Like, I'm really gonna sit here with another master student, and in the course of 10 minutes, convince him that I'm right, and he is wrong… it was very fast, it was very fast. I kind of got into the conversation and almost straight away, I was like need to figure a way out of this, because you're not (the classmate) in the right place here and it's just unnecessary… it's overly combative.* (Steven, I2, pp. 28-29)

Steven's excerpt did not elucidate the extent of his "*combativeness*", but it was clear from the reaction of his classmate that the argument was heated. For Steven, engaging in "*intellectual gymnastics*" might have been familiar, but the "*overly combative*" discussion revealed Steven's discomfort. Despite the momentary nature of HSA, Steven was able to recognise the association between combativeness and disconnectedness, which he emphasised heavily during the advanced stage of training. Even though Steven was swift in backing down from a combative exchange, his HSA seemed to bring to the surface how easy it was for him to default to "*dance around people and be that big hero*" (I1) if he were less aware. In a way, Steven's HSA seemed like an anticipatory sign of his past combative self.

Margaret looked back into her training and reported an overall improvement in managing her HSA of fearing to speak up in front of others. Margaret's HSA included critical thoughts and physiological discomfort. In the advanced stage, Margaret's HSA manifested as a momentary feeling of tension:

> *I don't get a lot of disturbing thoughts that make me freeze or paralysed in the session… maybe more mental sensation… momentary sensation…. Maybe I could have asked that question… or that question has blocked the flow of the conversation that kind of thoughts… those thoughts are not about evaluating my performance.* (Margaret, I2, p. 7)

> *I will feel that a little tightened feeling, tense feeling… if the mic is coming to me… that tension builds up… until it comes to me my only focus… I will use that time for preparation.* (Margaret, I2, p. 10)

Margaret felt that in the advanced stage, her HSA was less hindering for her as compared to the beginning stage. Margaret shared that she felt intimidated easily when she was around her classmates whom she perceived as more capable than she was. Margaret acknowledged that her emotional discomforts were more palpable during experiential learning like supervised practice or discussion. Unlike Steven who was inherently more articulate and intellectual, Margaret perceived herself as introverted and less confident. Perhaps in the advanced stage of training, Margaret was better able to push her hindering thoughts aside and focus on what she wanted to share, and whether that self-management was translated to increased self-efficacy beliefs remained unclear.

Linda provided two different moments of HSA across the two stages; HSA of feeling conflicted in the beginning stage and HSA of feeling resistant in the advanced stage. According to Linda, she did not see her beginning stage HSA as hindering but retrospectively, felt that her CSE had improved in the advanced stage and that HSA was no longer a concern. However, Linda's advanced stage HSA brought to her attention her lack of self-compassion and she recalled the manifestations from her momentary HSA of feeling resistant when she was in the client's hot seat:

> *I felt like, oh my God, this is hot, like it was so challenging, and I've never felt this way before... I was shaking or sweating. I still played it cool… you know breaking humour… wiping off sweat… I could feel my face quivering, like trembling, you know, and I was hoping I was like telling myself, "Oh my God, I hope they don't hear it in my voice how much I'm feeling." I can't explain it like everything was trembling.* (Linda, I2, p. 4)

Linda's excerpt showed her apparent discomfort from the intense emotion and bodily sensations she was experiencing at that moment but was struggling to suppress in front of the class. Linda acknowledged that she felt guilty for the way she treated herself right after she heard her own spoken words of wishing she could fall sick to "*finally sleep*" (I2). Linda agreed that she would burst out crying if she did not "*play cool*" to humour the class. In contrast to the concept of self-compassion that Linda was learning to cultivate, her physical reactions revealed the intense struggle she faced in reconciling between the critical and compassionate parts of herself. Even though Linda had not explicitly mentioned it in the interview, she probably expected a lot from herself, perhaps in order not to let the people in her life down. Linda had probably prioritised their needs over hers to the extent that she had to sleep less to accomplish more. However, Linda's HSA provided her with critical information about herself and her behaviour might have an indirect clinical impact despite her perceived increase in CSE.

Amanda had always been afraid of lizards which was the source of her HSA moment. Amanda shared that the lecturer could have misinterpreted her silence for consent to be the client in the role-play for the lecturer to demonstrate exposure therapy to the class as part of experiential learning. Amanda had thought that she would not be triggered but was shocked when she became suddenly aware of her body going into a "*freeze mode*" when the lecturer repeatedly mentioned the word "lizard":

> *My heart rate was very fast. My usual resting heart rate is usually about 60 plus. At the moment, because I had my Apple Watch it was 90 over just sitting down. It rammed up very fast, very fast heart rate, I felt my body vibrating my*

> *breathing became very shallow, so very tensed or the whole body was just tensed.* (Amanda, I2, p. 7)

Overall, Amanda had a negative experience that contributed to her HSA of bodily sensations during the demonstration. Amanda's excerpt revealed her momentary heightened awareness of her unpleasant bodily sensations which according to her was a new understanding of herself. Amanda learned that she could still be triggered by repeated exposure to a feared word but instead of perceiving the experience as entirely unpleasant, Amanda gained a piece of clinical insight. She reminded herself to be cautious in her therapeutic work with clients with phobias. Amanda's HSA of bodily sensations seemed to highlight her sensitivity to her somatic reactions, and she perceived her bodily awareness as having positive clinical implications. Overall, Amanda felt less hindered by her bodily sensations in the advanced stage and perceived an increase in her CSE.

Similar to other participants' moments of HSA, Peter's HSA manifestation was unique and personal; his self-consciousness in the way he used formal and colloquial English. Peter had identified Singlish with his culture and upbringing. For Peter, Singlish allowed him to convey familiarity with an identified group of youth clients. In the advanced stage of training, Peter shared that the HSA manifestations included momentary consciousness of the way he pronounced certain words, the pace at which he spoke and bodily sensations:

> *I will speak slower. Then, I also watch the way I pronounce certain words, their mispronunciation… I will be conscious about it… focus on the small details… like the pronunciation of "d", and "s", which most of the time, are missing when*

> *we speak Singlish or when we are speaking too fast… I'm aware of my bodily feeling, that I'm conscious that I'm talking, how the intonation is coming out, hearing back what I'm saying… till I'm aware that my fingers are touching… all the way to my legs and I'm able to feel my toes.* (Peter, I2, p. 13-14)

The detailed descriptions of his momentary awareness seemed to suggest that Peter might have drawn too much attention to himself. If that were the case, Peter's counselling efficacy might have been compromised. However, Peter's transcripts reflected his perceived increase in his CSE and that he appeared less perturbed by the self-consciousness. Additionally, Peter also shared that he was able to use his HSA strategically to gauge his level of presence and guide him in making efficacious counselling decisions (such as when to code-switch between formal English and Singlish). Similar to many other participants, Peter's ability to better manage HSA in the advanced stage demonstrated his development as an emerging counsellor.

(2b) HSA as Covert Desires

Six participants interpreted their advanced stage HSA as underpinned by covert desires for acceptance (Lynn), life success (Beatrice), harmonious relationships (Susie), admiration (Steven), assertiveness (Margaret), and self-compassion (Linda).

Lynn viewed rejection as "*devastating*" and would seek to avoid it at all costs (I1). Lynn's HSA of a need to please belied her desire to be accepted. She made sense of her withdrawal from the practicum site as a "*Child's*" response to avoid the pain of being rejected as she reflected in her advanced stage journal:

> *I was triggered by the social worker who was coordinating my sessions with my counselee. However, her voice and interactions with her often felt like the "Critical Parent" speaking and on one occasion, it triggered a dysfunctional response from my "Child", and I withdrew from the site…* (Lynn, J9, p. 2)

Lynn acknowledged that she tried to "*please*" the social worker on multiple occasions in the advanced stage (I2). However, in a particular setting, Lynn perceived rejection by the social worker; the social worker's tone of voice triggered the "Rebellious *Child's*" thought of "*they don't like me*" and Lynn decided to withdraw from the practicum site to restore in her "*the state of equilibrium*" (J9). Lynn felt that it was a "*rational decision*" to leave the practicum site rather than to keep subjecting the Child ego state through persistent pleasing acts. Lynn acknowledged her desire for acceptance but to constantly please others to gain acceptance was too emotionally draining. Lynn felt that it would be more sustainable to manage her critical thoughts and negative emotions than to keep pleasing the social worker. In a way, withdrawal from the practicum was a more proactive decision as it restored a sense of control in Lynn. Nevertheless, it did not negate Lynn's desire to be accepted and the clinical implications remained a concern. Overall, Lynn became more empathic with clients who struggled to change and appreciated their resistance to change as multifactorial and nuanced.

Beatrice aspired to be a competent counsellor and strove for academic excellence. Beatrice interpreted her advanced stage HSA as a covert desire to achieve life success. Beatrice talked about her internal conflict in her pursuit of academic excellence; she had wanted to achieve "*High Commendation*" (I1) for her practicum component but struggled to discuss with her supervisor about the assessment criteria. In

addition, the lack of clear distinctions between formative and summative assessments, and constructive feedback for Beatrice compounded her performance anxiety. Consequently, Beatrice made an important decision to portray an impression of competence in front of her supervisor. To mask her incompetency, Beatrice deliberately restrained herself from asking her supervisor questions, even those that were clinically based. Beatrice admitted that she had many "*missed learning opportunities*" for not asking pertinent questions, and her action might have clinical implications:

> *I always seek to present my best and most competent self as a counsellor during most or all of my supervision sessions ... In my final evaluation, I received "High Commendation" for my practicum… However, I felt a lingering sense of irony as my positive grades were due to my intentional masking of any hint of incompetence… which further affirmed this belief that I must not appear vulnerable…* (Beatrice, J14, pp. 1-2)

Beatrice's performance on her practicum component was commendable, and the desired outcome strengthened her resolve to continue pursuing competence. Despite Beatrice's belief that she had intentionally concealed her "*incompetence*" she was aware that she needed to work even harder to bridge her learning gaps to the extent of her experiencing "*signs of burnout*" (I2). Despite achieving a stellar grade for the practicum component, Beatrice's HSA and her overcompensatory behaviour were a concern; the supervisory environment and the lack of a strong working alliance became a barrier that seemed to impede Beatrice's learning effective counselling actions and possibly developing a false sense of competence.

Susie interpreted her HSA of desiring isolation as a learned childhood behaviour to cope with emotional pain in the beginning stage of her training. In the advanced stage, her HSA of annoyance was reinterpreted as a desire for harmonious relationships. Susie recalled a momentary heightened awareness of her annoyance during a particular grief role-play with one of her classmates. She found the activity, specifically the repetition of a question to be "*ridiculous*". As a result, Susie recalled making jokes during the role-play. Beyond Susie's expectations, her attitude triggered an aversive reaction from her peer who became emotionally upset and told her off. Susie attempted to make sense of her underlying need to "*joke around with people*" and interpreted the HSA as an intense desire for harmonious relationships in her life:

> *It also makes me think about why I joke around a lot… I guess to compensate for what I lost… compensate the young me, the child who has to live through parents quarrelling, have to live through not being able to see what's harmony…* (Susie, I2, p. 7)

The "*joker façade*" which was the most familiar to Susie made her feel safe around people which in Susie's words, "*this joker has protected me*" (I2). However, the behaviour became problematic in the context of that specific role-play on grief. Susie only made sense of the "*joker façade*" after realising the impact on her peer; the peer's grief in losing her mother further compounded the effects. Despite the momentary nature of HSA, Susie's intense desire for harmonious relationships in her life had a longstanding history. In addition, Susie acknowledged that she might not have the capacity to deal with intense emotions like grief as she had learned as a child to avoid expressing any emotion and to always appear happy.

Steven shared a similar HSA moment in the advanced stage where he became suddenly aware of his thoughts about his disconnectedness. Steven acknowledged the challenge in his new role as a counsellor; to "*peel away the layers*" and be "*honest*" (I1) around people. In the beginning stage, Steven expressed a desire to be seen as smart and the ability to win arguments was to Steven a sign of intelligence. However, Steven also lamented the impact of his combativeness on personal relationships which he described as "*for no reason other than malice*" (I1). In the advanced stage, Steven's perspective shifted; to be as connected and credible as a counsellor. Steven described himself as "*genuinely interested*" in finding out how he could establish more "*credibility*" as a counsellor in the advanced stage. In the beginning stage, Steven had thought about integrating combativeness with honesty to achieve admiration. However, in the advanced stage, Steven might have realised the polarity of the two traits:

> *I can still be combative, and I can still disagree with people. I think you can be combative, and respectful at the same time, it's a skill to disagree with people and for people to still kind of be happy to listen to you… it's a skill that I would like to master.* (Steven, I1, p. 26)

> *Some people do it (talk about credibility) too much… I find that a really fascinating piece about how to gain trust and credibility without trying too hard or wasting too much time. I think there's maybe an art to that that I'm genuinely interested in.* (Steven, I2, p. 11)

Steven's interview excerpts from the two stages reflected his covert desire for admiration in his professional role. In the beginning stage, Steven hoped to be admired for his intellect and "*to dance around people*" (I1) which was a remnant of his previous

corporate role. In the advanced stage, Steven was more identified in his counsellor role and "*credibility*" naturally became a more appropriate quality to "*make a good impression*" (J3) and be admired than his ability to win arguments. Overall, Steven felt a perceived increase in his CSE; whether his desire for admiration was more serving his or his clients' needs remained unclear.

Margaret interpreted her HSA of fearing to speak up in the beginning stage of her training as a desire for assertiveness. Margaret felt intimidated to articulate her opinions in a professional group setting and she attributed that to her cultural background and status as a homemaker. When she was required to speak in front of a group, she experienced an uncomfortable "*internal pressure*" within her body (I1). Compared to the beginning stage, Margaret reported feeling less hindered by her HSA in group settings and counselling sessions with her clients in the advanced stage. Consequently, she began to feel more confident and self-acceptant, and in her words, "*not a must that I have to change myself*" (I2). Despite her perceived improvement, Margaret interpreted her HSA as underpinned by the desire to be assertive which to her was a cornerstone that significantly could enhance various aspects of the job search process and contribute to her success in employment:

> *I am also fearing about how easy for me… to find a job in this field… I feel guilty for making my husband spend all that money on me at this age… and I won't be able to contribute financially to my family.* (Margaret, I1, p. 21)

> *I still have my worries… about securing a job and being a foreigner and a homemaker for the past 14 years. How will I find a job is a big question for me.* (Margaret, I2, p. 22)

Despite the progress and overall improved self-esteem, Margaret's concerns about finding a job in the local community were evident. Her worries about not being able to gain employment revealed her desire for personal and financial independence to be a resource for her family. Margaret felt that she struggled to communicate her needs and as a result, was unable to establish clear boundaries. Hence, from her HSA, Margaret gained more knowledge about herself and hoped that being more assertive could eventually contribute to finding employment, and perhaps redefining her identity.

During an experiential learning in class, Linda volunteered to role-play the client who struggled with lack of sleep. During the demonstration, Linda became suddenly aware of her resistance when the counsellor (role-played by the lecturer) challenged her role in maintaining the symptoms. To make sense of the momentary resistance (apart from its manifestations), Linda interpreted the HSA of feeling resistant as a covert desire for self-compassion. Perhaps it was difficult for Linda to acknowledge her high self-expectations of not disappointing others in her life to the extent of sacrificing her sleep to accomplish more. However, when she experienced HSA during the role play, she caught herself not prioritising her own basic needs. In addition, the recent death of her grandmother who was the most important person in her life exacerbated her symptoms and the loss of an attachment figure confronted Linda to question her relationship with herself:

> *My grandma passed away… I'm going to be alone, going to shift into my new home by myself… I really have to be kinder to myself if I want to survive… I have to learn how to be like my own best friend… because if I'm not nice to myself, I'm going to have to live with myself for the next forty years and that's not a nice way*

> *to live… words are spells in manifestation, so I kept saying, I'll be kind of myself, I want to be less judgmental of myself.* (Linda, I2, p. 18)

The fact that Linda intended to practise being kind and accepting of herself was a significant milestone in both her personal and professional development. According to Linda, when she began viewing everything through the self-compassion lens of a counsellor, she began to let go of the need to be "*passive-aggressive*" which was a defense mechanism she interpreted from her beginning stage HSA of feeling conflicted. In Linda's words, passive-aggressiveness stemmed from "*a bitter and unhappy place filled with self-doubt*" (I2) and from the vantage point of the advanced stage it offered Linda a unique perspective to gain further insights and reinterpret the beginning stage HSA. In addition, the HSA brought to Linda's attention a more pertinent issue to deal with; her relationship with herself. Even though the lack of self-compassion might not have a direct clinical impact (yet), lack of sleep could.

(2c) HSA as Opportunities for Growth

Mary revealed that overall she had more favourable group experiences in the advanced stage. However, in a particular group role-play, Mary described feeling "*numb*", and in her words, she was emotionally overcharged and disengaged from the activity during which she experienced HSA of frustration (I2). Mary deliberated whether to remain with the group or excuse herself physically which she did to attend to her emotional needs. Mary interpreted that particular HSA in the advanced stage as an opportunity for her personal growth:

> *…instances, where it (HSA) was not so helpful, is when I know that certain behaviours or people remind me of certain other people… like… countertransference that's where it's not so helpful… where I walked out.* (Mary, I2, p. 31)

Mary rationalised her behaviour of leaving the group role-play as a countertransference reaction. Mary viewed her HSA as a part of her personal growth, "…i*s always a work in progress so even then and now, we're still work in progress, so it's an ongoing thing.*" (Mary, I2, p. 35). Mary's knowledge of her countertransference helped her to continue working on self-exploration, and she associated her HSA with providing her with the opportunities to do so. In a way, Mary's HSA preceded her countertransference; the heightened emotional arousal paired with past unresolved personal issues impeded cognitive processing. For Mary, both the HSA and her countertransference expanded her self-awareness. Even though it stirred a part which Mary disliked and, in her words, "*I only learned what I don't like about myself*" (I1), it was still useful knowledge for self-exploration. Hence, Mary was right that HSA despite momentary and unpleasant, could promote growth.

Similar to the beginning stage of training, Peter interpreted his advanced stage HSA of self-consciousness as an opportunity for growth. In the beginning stage, Peter's perception of Singlish was more of a limitation in a professional context, and he was conscious of preventing Singlish from "*slipping out*" during his conversations with his classmates (I1). Peter's perspective on Singlish changed when he was in the advanced stage. He disclosed that he was able to establish rapport with clients from a specific

cultural context by utilising Singlish. Peter interpreted his advanced stage HSA as an opportunity to increase his multicultural counselling competence:

> *Also, it depends on the audience and the expression itself whether English has the word for me to express or whether the choice of words will resonate with the client better… if I have a male who has completed his national service [in armed forces] and that's where I'll know in that context he has been exposed to Singlish, then I could use Singlish at the right moment. But if I am with someone who has not lived in Singapore or spent much time in Singapore then that's when I'll use formal English… language is just a tool of expression… if I'm using formal English then that will be a particular hat and that particular hat will come with that bodily awareness, and when I'm using Singlish then my bodily awareness will be much lesser, and I can speak very fluently.* (Peter, I2, pp. 26-27)

Peter's account reflected his more integrated counsellor identity. He adopted a more balanced viewpoint regarding Singlish and formal English. Peter's clinical work may have increased his self-esteem; he gained the ability to distinguish between context and clientele due to his multicultural competence. His capacity and adaptability to select and code-switch between Singlish and formal English demonstrated his expanded self-awareness, growth, and competence as a counsellor in the advanced stage. Even though the discomfort associated with HSA still existed, Peter felt less hindered by his HSA. Perhaps, Peter had gained more CSE to tolerate anxiety better in the advanced stage.

In the advanced stage, Amanda gained a deeper level of self-awareness about her fear of lizards from her HSA of bodily sensations. She learnt that her fear could be

triggered by hearing the word "*lizard*" (I2) repeated multiple times; not just seeing a live lizard. Furthermore, her fear could manifest as bodily vibrations that were similar to that of her "*childhood wounding*" (I1) in the beginning stage. Amanda gained clinical insight from that particular HSA and intended to use it to guide her work with clients with phobias. Additionally, Amanda commented that being able to trust "*her gut*" by listening to her bodily sensations was very helpful for her to know what was "*going on inside*" of her. Amanda attributed those bodily sensations or "*intuition*" to a spiritual gift in her clinical work:

> *It's a gift. I think. Okay, one of the things I learned, I found out during the whole Master is that my intuition is very strong. I have a very strong intuition with people.* (Amanda, I2, p. 20)

> *I will go with my gut… I just let the spirit guide me in how I interact with the person… a bit weird. I mean, it's, it's very spiritual, I'm sorry. But then I do believe in the work of the Holy Spirit, like because we do have spirit in us, and I'm very much guided by that so some people would just call it your gut feeling or your instinct.* (Amanda, I2, p. 36)

Amanda interpreted her momentary inner awareness or "*intuition*" as a "*gift*" that enhanced her qualities as a counsellor in the advanced stage. In the beginning stage, she found these bodily sensations distressing; however, in the advanced stage, she was able to tune inward to her bodily sensations and use them to guide her therapeutic work (e.g., in the client's assessment, case conceptualisation, and therapeutic process). In addition to sensing her bodily sensations, Amanda's excerpt indicated that she was able to sense those around her too, and that was a valuable clinical skill for counsellors. Amanda's

excerpt revealed that momentary heightened awareness of her bodily sensations could be a counselling resource for her when she paid attention to what was going on inside of her or in her words, her "*gut feelings*". For Amanda, her association of HSA as a "*spiritual gift*" was her unique way of interpreting HSA as an opportunity for growth.

Despite HSA being unpleasant, all the participants seemed to have gained more self-awareness through their HSA over the course of their training. For a few participants, their HSA preceded countertransference and that was a piece of clinical insight that warranted further research. This study, however, cautions against inferring that participants with increased self-awareness or CSE would directly translate to higher counselling performance.

5.2.3 GET (3) – Building Strengths, Accepting Vulnerabilities

GET (3) has two subthemes: a) Reflecting on the counselling process, personal concerns, and management strategies, and b) Learning to be kind and patient with themselves. Throughout the advanced stage of training, all the participants continued to reflect on their HSA moments and learn to be kind to themselves. Similar to the beginning stage, participants' HSA reflection in the advanced stage primarily focused on three aspects: reflection about the counselling process, reflection about personal concerns, and reflection about management strategies. Reflections, either self-evaluative or guided, involved trainee counsellors contemplating personal growth, challenges, lessons learned from HSA and mitigation plans along the way.

(3a) Reflecting on the Counselling Process, Personal Concerns, and Management Strategies

In the advanced stage, Lynn experienced HSA of a need to please at the practicum site. Lynn acknowledged that it was a perceived rejection from a social worker on her part but could not help feeling hurt despite her attempts to please the social worker. In Lynn's words, she decided to stop "*trying*" to please (I2). Lynn's HSA reflection revealed her knowledge of her avoidance behaviour:

> *The feeling is that of 'rejection', and although with awareness i.e. through the Adult, I have identified this automatic thought as 'faulty', I would continue to react or respond in this way i.e. to withdraw and to avoid, which I would perceive as dysfunctional because it does not help me in developing deeper…* (Lynn, J9, p. 1)

In the beginning stage, Lynn felt that she had to "*keep pleasing*" others in order to gain acceptance and that was emotionally demanding for her (I2). In the advanced stage, Lynn's reflection uncovered a countertransference reaction which had a direct clinical implication as Lynn was partly responsible for the clients under her. In addition, it was also a personal concern as Lynn agreed that her withdrawal was a dysfunctional response from her "*Child*" ego state that had misread the cues as rejection. Even though the withdrawal provided Lynn with more certainty which she described as being a more "*stable state*", Lynn felt that she had responded in a manner that was "*authentic and genuine*" to herself. Further HSA reflection reinforced Lynn's decision to remain in her "*state of equilibrium*" which is to live with the "*Critical Parent*". Lynn's mitigation plan

was to remain mindful of her own vulnerability and extend that privilege to her clients who might not be ready for change:

> *I have learnt that it is possible to live in a state of 'dysfunctionality' or 'less than ideal' state of being… the decision for change lies with the counselee because growth and process of change might be more uncomfortable and difficult than living with our less-than-ideal state/condition.* (Lynn, J9, p. 3)

Lynn's reflection appeared to capture the sentiment of both her and the clients who were in recovery from substance abuse. Through her HSA, Lynn perceived herself to be better at empathising with her clients who struggle to change. However, it remained unclear whether Lynn had brought her HSA up for supervision or received constructive feedback from the supervisor on her decision to withdraw. Despite acquiring greater self-awareness, Lynn acknowledged her ongoing vulnerability around rejection and the need for consistent supervision.

In the advanced stage, Beatrice recalled on multiple occasions that she experienced reduced motivation and increased exhaustion in her studies. Beatrice believed that academic achievements were a pathway to life success. However, she also started to question how sustainable her pursuit of competence would be for her. Beatrice shared that her HSA of dread which she interpreted as a transference in the advanced stage prompted her to reflect on the pursuit of competence:

> *I have slowly learned to let go… I recognise that I don't have the capacity to always aim for the highest score… I will say gradually opening up to the idea of*

being open of what I do in counselling sessions or questions that come up…" (Beatrice, I2, p. 8)

…now that we are moving towards the end of the programme, I feel like, I have quite several missed learning opportunities… because of my insecurity, like, I didn't want to appear bad, because it affected my grades… I missed a lot of learning opportunities there." (Beatrice, I2, p. 12)

Even though it was not explicitly stated, Beatrice's excerpt reflected her more realistic expectations of herself. Beatrice could not deny the impact of prolonged exposure to the stressors inherent in training. Beatrice's reflection identified possible clinical repercussions if she continued to work under an undue amount of stress without adequate self-care. For her management strategies, Beatrice eventually took a short break to recharge herself which she described as akin to "*start over with a new pair of lens*" (I2). Additionally, Beatrice learned to gradually open up to her supervisor for clinical support. Beatrice regarded the supervisory alliance as "*professional and cordial*" (I1) in the beginning stage as she was intentional in maintaining that distance owing to the power differential. In the advanced stage though, Beatrice reconciled that her supervisor could provide her with constructive feedback to improve her counselling performance. However, she did wonder if she had not deliberately masked her incompetence, would she have received the stellar grade which she strove for?

Mary reported an overall improved group experience in the advanced stage, except for one particular peer role-play in which she experienced HSA of frustration. She recalled deliberating whether to stay or leave the group to attend to her own emotional needs. Mary eventually left the group to regulate her "*highly charged*"

emotions before returning (I2). Mary's post-HSA reflection revealed a countertransference reaction from the unpleasant group experiences in the past. Even though the countertransference had no direct clinical implication, Mary learned that her past could still be triggered and manifested as HSA. Mary did not specifically mention how she was supported by her supervisor, and she did not see that as a clinical issue to be addressed during supervision; to her it was more about group dynamics. However, Mary did share that she felt "*somewhat alone*" (I2) during her counselling session with her clients. It remained unclear whether Mary felt stuck during in-sessions or a lack of supervisory support. However, it would be assumed that if Mary were to be adequately supported by the supervisor's mastery of skills or constructive feedback, she would feel less alone. From her HSA reflection, Mary perceived her countertransference as a personal concern and felt efficacious enough to work on it independently.

During the advanced stage of her training, Susie continued to engage in self-reflection and guided reflection through journaling and supervision, respectively. Susie's HSA centred on rejection and isolation. When she experienced HSA of annoyance during a peer role-play on grief, Susie recalled being flooded with critical thoughts about the activity and began to joke during the role-play. Consequently, Susie's attitude upset her peer who told her off. Despite Susie's apology, she felt that the peer relationship had since then been affected. From that HSA, Susie reflected on her momentary annoyance and "*joker façade*" (I2). Through reflections, Susie made sense of her unmet childhood desire for harmonious relationships and her own discomfort with intense emotions like grief. Susie recognised a need to work on healing herself from her unpleasant childhood experiences, "*I want to talk about it, I don't want to hide. I want to heal…I know it's not*

going to be easy, but I just wanted to heal from the trauma experience." (Susie, I2, p.25). Susie further recognised the significant impact her childhood trauma could have on the counselling process. For example, Susie recalled in the beginning stage, it was through guided reflection with her supervisor that Susie realised her desire to isolate at the youth drop-in centre was countertransference. Susie's HSA preceded countertransference which was a piece of clinical insight for her in the advanced stage; Susie's annoyance during the peer role-play was in response to her trauma narratives. From her HSAs, Susie discerned the gravity of her childhood experiences could be a barrier to her CSE beliefs and overall self-esteem. Fortunately, Susie had a strong working alliance with her supervisor who fostered an environment of safety and trust. Susie was able to process her HSA during supervision to understand how her past unresolved issues could manifest in difficulties in forming secure therapeutic alliances with clients and hinder clinical effectiveness. Additionally, Susie planned to work on personal healing and decided to resume personal therapy. Overall, Susie gained more self-knowledge from her HSA and HSA reflections.

Margaret shared that she was less hindered by her HSA in the advanced stage and felt more confident in expressing herself. In one of her advanced stage journals, Margaret wrote about her HSA of fearing to speak up which included feelings of self-doubt and critical thoughts around others. Margaret reflected on her HSA and identified personal concerns to work on; her desire to seek affirmation from others impeded her self-efficacy beliefs about herself. For example, Margaret recalled "*feeling demotivated*" (J6) when her client did not return for counselling and attributed that to a lack of counselling competence. In another HSA reflection, Margaret noticed that she was

rejecting herself and saw her "*introverted personality*" (I2) as a personal weakness that she had to change. Margaret came up with a few strategies to manage her HSA in the advanced stage; to seek inner strength and focus on the task at hand instead of critical thoughts; and to identify models (like her lecturers) to learn from. However, in the advanced stage, Margaret did not explicitly mention her supervisor as her model, but she described her supervisor as "*very supportive*" (I2). Margaret recalled once when her supervisor attempted to refer a client to her. Even though the referral did not go as planned, Margaret was grateful for her supervisor's acceptance of her. Margaret had on a few occasions experienced clients who were either inconsistent or failed to attend (no-shows) scheduled counselling sessions with her. Margaret struggled to find "good enough" clients for her to build her competence; clients who were moderately challenging to increase her CSE. It remained unclear from Margaret's reflection whether her supervisor had supported her through her HSA moments. Margaret's transcripts seemed to focus a lot more on what she could work on independently on her own which could imply that Margaret would become more efficacious in effecting counselling actions or she would develop a false sense of competence to conceal her intense anxiety.

Steven's advanced stage journals captured the difficulty he faced to refrain from defaulting to his intellectual side, which contributed to his HSA of feeling disconnected:

> *I felt quite strongly about my views but regretted expressing them so forcefully… looking back… I'm not quite sure why I feel so strongly… but it is a bias… I think in future when an opportunity comes up to comment on a topic that I have a very strong view on unless I have time to think and reflect… I'll pass.* (Steven, J3, p. 2)

> *…but it became clear pretty quickly that my philosophical point was drowned out by the emotional response of the class cohort… I wish I had not contributed to what appears to be a very sensitive topic.* (Steven, J4, p. 1)

Steven's HSA prompted him to pause and reflect on the implications of his combativeness in winning arguments. In the advanced stage, Steven was quick to notice the impact of his behaviour in evoking intense responses from his classmates. However, he was concerned that his strong emotional reactions like combativeness (or anger) could impede the counselling process. He gave a few examples when he caught himself "*being prescriptive*" (J6), "*in denial about frustration*" (J7), and becoming "*emotionally involved*" (J8) when he experienced similar HSA moments. Even though these moments of HSA might not have contributed to countertransference, Steven was cognisant that he could still default. To mitigate undesirable outcomes, Steven found it helpful to gather feedback from his classmates and his supervisor. Steven generally felt that he could practise honesty with his supervisor, and their relationship was positive. Steven reported positive supervision satisfaction; he felt engaged at the intellectual level with his supervisor who treated him like a colleague. However, Steven did not mention explicitly whether he felt engaged at the emotional level to feel a sense of connectedness.

In the advanced stage, Linda experienced HSA of feeling resistant during a particular demonstration where she volunteered to be the client. In the role-play, Linda used her lack of sleep as a counselling issue. She reflected on her HSA and identified critical issues that she wanted to work on, specifically her relationship with herself:

> *I have all these expectations of self and this means not having self-compassion. It is the reason for so many of my problems, like not being able to go to the gym,*

> *you know, my social anxiety the past year, and not being able to form good relationships with some of my family members. The reason why I suffer every time there's a breakup… my lack of compassion was the problem... I finally am aware that I am so self-judgmental that because I am so judgmental of myself, I think everyone is judging me, you know, and that was mind-blowing, because I'm like, oh, my God, I'm doing this to myself.* (Linda, I2, p. 17)

Linda's HSA prompted her to reflect on her self-expectations and self-judgments. From the excerpt, Linda recognised that she was projecting her own judgments onto others, and she did that as a form of psychological defense of not having to feel hurt. However, the process of projection further impacted her interpersonal relationships. In light of Linda's passive-aggressiveness in the beginning stage, Linda's advanced stage reflection seemed to make sense that when she felt that her needs were not met and struggled to trust her emotions (hence HSA of feeling conflicted), in order not to feel hurt, she projected her own critical thoughts and feelings onto another person unconsciously. In a way, Linda's HSA brought to the surface her unacceptable aspects (her critical self) that warrant attention. In addition, the grief and loss in the advanced stage further confronted Linda to question her life purpose. Linda planned to give herself a break to recharge and gain clarity about her future direction. Linda did not mention whether she sought support from her supervisor for her difficult moments. However, Linda shared that she perceived an overall increase in her CSE in the advanced stage.

In both the beginning and advanced stages of training, Amanda experienced HSA of bodily sensations. Amanda expressed interest in paying attention to her bodily sensations and perceived herself as having a strong intuition that had clinical

implications. Amanda shared that by attending to her bodily cues, she was able to access deeper layers of experience beyond her cognitive process. In two of her advanced stage journals, Amanda reflected on her HSA moments of tuning into her "felt" bodily awareness:

> *During the session, I noticed at one point, I started to swirl my chair and I had my arm around it. This happened when I was starting to have a good conversation with the client. I was aware of my bodily movements, but I didn't think too much about it at that moment. After the session, while driving back, I reflected on it and… made me aware that I had become so comfortable in my interactions and relationship with the client that I unconsciously let loose myself. However, I am aware that that is unprofessional… there is a professional image to maintain.* (Amanda, J6, p. 1)

> *She (the client) thanked me for being so present and sensitive to her needs even though she did not know it herself. In this case, my awareness of my own senses and responses and the client's, have served me and the client well. If I had continued to go along with her, she would have been under even more stress.* (Amanda, J8, p. 1)

Amanda's first excerpt revealed her momentary awareness of her bodily movements which caught her attention during the in-session with her client. The insight she gained from the HSA reflection served as a future template to conduct herself during the counselling process. In the second excerpt, Amanda's awareness of her own senses or "*gut feeling*" guided her to make clinical decisions. It seemed like Amanda's momentary awareness of her felt sense when utilised appropriately, could be a valuable

resource during the counselling sessions. Amanda reported being less hindered by HSA but more using it as a clinical tool. Unlike other participants, Amanda felt strongly supported by her supervisor in the advanced stage. Amanda shared that she and her supervisor matched in ideology and the supervisor accepted her “cowboy” personality (to speak her mind) and treated her like a peer. Additionally, Amanda also received modelling and constructive feedback in supervision. Overall, Amanda felt an increase in her CSE and was able to effect efficacious counselling actions.

Peter's HSA reflections became more nuanced as he progressed through the training stages. In the beginning stage of his training, his reflections primarily focused on plans to prevent "*slipping into Singlish*" (I1) in the training context. In the beginning stage, Peter had perceived Singlish as less professional and as a result, others might judge him as less competent. In the advanced stage, Peter’s self-consciousness served more as a cue to guide his intentional use of Singlish. Peter did not refrain from using Singlish in the advanced stage. According to him, he did so strategically and with a purpose; such as building rapport or challenging a client from a specific culture. Peter was still very conscious of the way he used Singlish with clients during in-sessions. From his HSA reflections, Peter identified a specific counselling process where he could skilfully inject humour into Singlish to make clinical confrontation less judgmental:

> *I'll say that happened when I combined Singlish in the session and after the rapport had been built, I might use it with confrontation, but the way I confront is more of a sarcastically joking manner, I amplify the negative situation with more of a joke rather than a firm tone.* (Peter, I2, p. 18)

Perhaps for non-Singlish English speakers, Peter's excerpt was difficult to comprehend. In a way, Peter's utilisation of Singlish aimed to foster a sense of shared identity and inclusivity. Hence, Peter was intentional in using Singlish to his advantage; the need for mutual understanding between him and his specific clients. According to Peter, even though Singlish was more natural for him, he could end up saying something he described as "*unmindful*" when he used Singlish, which could be a barrier to the counselling process. Peter was evidently more at ease with his use of Singlish in the advanced stage than in the beginning stage. In addition, Peter revealed an increase in his CSE, specifically in the aspects of cultural awareness and sensitivity, which could have a direct impact on his identity. Similar to Amanda, Peter felt supported by his supervisor in the advanced stage. He described the relationship as "*very good*", "*open*" and "*very helpful*" (I2). According to Peter, his supervisor provided him with opportunities for mastery, modelling of skills, and constructive and specific feedback which contributed to his overall increase in perceived CSE.

(3b) Learning to Be Kind and Patient with Themselves

Findings from participant transcripts indicated that although HSA was challenging, it also supported their development when they practised self-kindness. Rather than blaming and evaluating themselves critically throughout the entire HSA experience, participants eventually acknowledged their limitations and made peace with their critical thoughts and emotions. Consequently, they reported HSA-related insights.

Even though Lynn could have continued her practicum at the same location, she recognised the need to address her emotional needs first before she could attend to any clients. Lynn's acknowledgement of her pain (of rejection) was a prerequisite for self-

kindness, and she did that by telling the Child ego state, "*Is okay just let it go.*" (Lynn, I2, p.33), which was her way of comforting the fearful "*Child*" from her Parent ego state.

As Beatrice reflected in her advanced stage journal, the demands she placed on herself had a negative impact on her overall mental health, "*I dread that every time I must switch on my laptop and sit at my desk for long hours…*" (Beatrice, J5, p. 1). Gradually, Beatrice realised the risk of burnout and delved deeper into her pursuit of life's success, which she reflected on in her subsequent journal, "*…it (the current state) was helpful as it made me internally reflect on how I prioritise what is important to me, and it was also a wake-up call that I don't want to be in my current situation for the rest of my life.*" (Beatrice, J6, p.3). Beatrice adjusted her approach to achieving competence in the advanced stage of training by recognising her basic needs for self-care and personal limitations.

Mary acknowledged that she had high expectations of herself regarding learning and consequently experienced HSA of frustration when her expectations were not met during group activities. Mary recognised, on the one hand, that her response of walking away from the peer group role-play was a countertransference from previous negative group experiences, but on the other, she needed space to regulate her own emotions. Mary had always believed that self-discovery and self-acceptance were an ongoing process, which she described as a "*work in progress*" (I1). Even though Mary acknowledged she could have done certain things differently, she also affirmed her growth in the advanced stage, "*Oh, you've grown up! Well done!"* (Mary, I2, p.32).

Susie's advanced stage journals captured multiple HSA moments which provided her with insights into the need to heal her "*inner child*" (I1); she needed to process her unpleasant childhood experiences. In a way, Susie was learning to be kind and self-accepting, "*…one of the things that I strongly believe in is to talk about it (Susie's childhood) because if I don't talk, I think it is going to be very tough for me to be a counsellor… even though I am nervous… like I'm not hiding anything…*" (Susie, I2, p. 26). As evidenced by her HSA, it took Susie a great deal of courage to "*not hide*", and the foremost person to attend to her "*inner child*" was not others but herself.

Margaret was able to use what she learned as a counsellor to practise being kind and patient with herself in the advanced stage in order to not feel intimidated but more assertive, "*I had always dreaded recording my session for assessment, but last week I did that with confidence... I still feel stuck and feel at a loss… but at least I am growing.* (Margaret, J8, p. 2). In the excerpt, Margaret affirmed her success and acknowledged her vulnerability. Margaret anticipated that the journey ahead would be difficult. However, her willingness to continue improving herself was her affirmation of her positive attitude and self-acceptance.

Steven recorded more instances of HSA of feeling disconnected in his advanced stage journals across different contexts, "*I think part of it (apologising for being insensitive to client) is just me holding myself to a high standard, better to apologise briefly and then move on with the session I think.*" (Steven, J3, p. 1). Steven's excerpt revealed his inability to empathise adequately with his client, but his willingness to accept responsibility and not "*win arguments*" (I1). In the beginning stage of training, it was difficult for Steven to take that position which he perceived as "*less intelligent*". It

also overshadowed Steven's struggle to be kind to himself. In another journal, Steven wrote about a particular counselling session when he experienced HSA of feeling disconnected which he attributed to his "*prescriptiveness*" (I1), "*I suspect the client sensed my frustration a bit… My main learning here is that when things aren't going your way in therapy, just slow it down… take the time to explain without becoming frustrated.*" (Steven, J6, p. 2). Steven recognised that he was being prescriptive and that his "*combative*" side merely desired to fix the situation. However, the ability to reflect objectively allowed Steven to practise slowing himself down first, followed by reflection to build on his empathy for others and himself.

Linda's advanced stage interview captured her intentional focus on self-compassion which she found important in both her personal and professional development. Linda expressed excitement that the training was coming to an end and aspired to be the "*best counsellor*" while working through her "*flaws*" (I2). Linda candidly shared how looking through the lens of a self-compassionate counsellor shifted the way she perceived her "*flaws*": "*… look at yourself more kindly, like, you know, it's still a work in progress… the self-judgment… I think without that a lot of my problems are non-existent."* (Linda, I2, p. 18). In the advanced stage, Linda attempted to be less critical of herself. Despite recognising that self-compassion was a foreign concept for her, Linda was able to respond promptly to her internal dialogue, "*You're just thinking like the past and that's not a good thing so let's not do that today.*" (Linda, I2, p.20). Linda was cognisant that she needed to be self-compassionate as it was a work in progress.

In the advanced stage of training, Amanda revealed attending more to her bodily cues not just in her counselling but even for self-care:

> *I was feeling a bit burnout… I wasn't very grounded… this unsteadiness came out in the way I speak, you know, the pace… So lately, I've been doing some self-care… I decided to just watch videos instead and skip classes so that I get enough rest to be at my best for the client.* (Amanda, I2, p. 36)

Apart from ensuring that she had adequate rest, Amanda also reported more confidence in her clinical work. Amanda felt that she also needed to affirm herself and give herself the credits when due:

> *I don't overthink as much as I did in the beginning stage. I do a bit of check-in, like, could I have done this differently after a session, but not as much as I did before. So in a way, I think the confidence comes from I trust myself a lot.* (Amanda, I2, p. 25)

In the beginning stage, Amanda perceived herself to be a perfectionist and frequently self-critical. In the advanced stage, she learned to be kind and more patient with herself. While it was evident that HSA could be unpleasant, it also expanded Amanda's knowledge about herself, her clients, and the qualities of an effective counsellor.

Peter, like the other participants, learned to be patient with himself as he worked to improve his English proficiency during the training. Peter characterised himself as "*too self-conscious*" when attempting to speak formal English specifically in the

beginning stage. In the advanced stage, Peter viewed himself with more a balanced and less critical perspective:

> *I think is to be aware of both ends of the stick… be relaxed and at the same time conscious of the way I speak, so is to find that balance… So the balance will be to speak slower, at the same time, be conscious about the way I'm going to express the message, and just know that should I slip or make any mistake is fine and just embrace the process.* (Peter, I2, p. 33)

Peter described Singlish as a "*metaphor*" for his clinical ability to relate certain information to a specific clientele that formal English could not. In this sense, Peter also reflected his overall enhanced counselling competence at the advanced level of training:

> *Singlish has become a metaphor that I can relate things to the clients who grow up in the same context. The client also realises that I'm understanding them better… so I find my skills as a counsellor have improved, I'm flexible and able to adapt to situations.* (Peter, I2, p. 35)

Peter was able to "embrace" all aspects of himself as a result of his increased self-awareness and CSE. Even though HSA was factually reported as being uncomfortable, Peter and all other participants learned to be kind to themselves, through adopting self-care activities and learning better HSA coping strategies. The next section will summarise the IPA themes that spanned across the training.

5.3 Overview of Themes That Spanned Across Training

The current longitudinal IPA study explored trainee counsellors' lived HSA over a training period of 18 months; from the beginning stage to the advanced stage in order to

understand the meaning and essence of participants' HSA as they unfolded over time. Findings in the advanced stage expanded on those in the beginning stage as discussed in Chapter 4, capturing the evolving nature of participants' subjective HSA moments. Table 6 presents the overview of all subthemes that spanned across time. In the case summary write-up that follows, "BS" denotes the beginning stage, and "AS" denotes the advanced stage.

Lynn

Throughout Lynn's training, all but one subtheme remained; from exploring HSA through unpleasant childhood memories (BS) to exploring HSA through a counselling theory (AS). Lynn experienced HSA of a need to please in both stages of training. In the beginning stage, Lynn viewed her HSA through the lens of her unpleasant childhood memories of being rejected by her childhood friends. Lynn remembered the significant impact their rejection had on her in adulthood. Lynn described the pain of rejection as "devastating" and felt compelled to gain acceptance by pleasing others in her adulthood. Even though the fear of rejection remained a central theme in Lynn's decision to withdraw from the practicum site in the advanced stage, she made sense of the similar HSA of a need to please through Transactional Analysis, a counselling modality taught in training. Even though her decision to withdraw was interpreted as dysfunctional and originated from her "Child" ego state, Lynn felt that it restored her a sense of control and personal agency. In addition, Lynn experienced an increase in her CSE; she was more confident in effecting efficacious actions in counselling.

Table 6

Summary of Participants' Subthemes that Spanned Across Training

Participant	Lynn		Beatrice		Mary		Susie		Steven		Rose		Margaret		Linda		Amanda		Peter	
Stage	**BS**	**AS**	**BS**	**AS**	**BS**	**AS**	**BS**	**AS**	**BS**	**AS**	**BS**	**AS**	**BS**	**AS**	**BS**	**AS**	**BS**	**AS**	**BS**	**AS**
Exploring HSA through unpleasant childhood memories	✔						✔				✔				✔		✔			
Exploring HSA through culture and upbringing			✔	✔	✔			✔	✔				✔						✔	
Exploring HSA through a counselling theory		✔																✔		
Exploring HSA through a counsellor's perspective						✔				✔				✔		✔				✔
HSA as manifestations	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔
HSA as covert desires	✔	✔	✔	✔				✔	✔	✔			✔	✔		✔				
HSA as learned childhood behaviours							✔				✔				✔					
HSA as opportunities for growth					✔	✔												✔	✔	✔
Reflecting on counselling process, personal concerns, and management strategies	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔
Learning to be kind and patient with themselves	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔

Note: "BS" denotes the Beginning Stage and "AS" the Advanced Stage. Rose postponed her advanced stage training.

Lynn also reported a positive supervisory working alliance in the advanced stage and received constructive feedback from her supervisor regarding her counselling performance. However, it remained unclear whether Lynn brought her HSA up for supervision. Overall, Lynn's identity as a counsellor seemed more defined in the advanced stage.

Mary

For Mary, all but one subtheme remained; exploring HSA through culture and upbringing (BS) to exploring HSA through a counsellor's perspective (AS). In the beginning stage, Mary experienced HSA of frustration during one group discussion as she felt that her learning needs were not met. She made sense of the beginning stage HSA through the lens of culture and upbringing as an only child where she learned to be independent. However, in a group context, she lost this sense of agency due to factors beyond her control. In the advanced stage, Mary experienced a similar HSA and she decided to leave the group role-play to attend to her emotional needs. Mary adopted a counsellor's perspective to look at the HSA of frustration during that particular peer role-play and made sense that she needed to be first congruent with herself; she needed to calm herself down before she could have the capacity for others. However, upon reflection, Mary realised it was a countertransference and that was a piece of clinical insight for her; that her unresolved past could still be triggered and unstructured learning seemed to make her more susceptible to HSA. Mary did not bring her HSA up for supervision as she perceived that as a personal issue which seemed to suggest that the relationship between Mary and her supervisor might not be strong enough for Mary to openly discuss barriers that impeded her learning.

Susie

For Susie, there was a temporal shift in two subthemes: exploring HSA through unpleasant childhood memories (BS) to exploring HSA through culture and upbringing, and interpreting HSA as learned childhood behaviours (BS) to interpreting HSA as covert desires (AS). In the beginning stage, Susie experienced HSA of desiring isolation at her practicum site which she viewed through the lens of her unpleasant childhood memories of her parents fighting to make sense if it. Susie interpreted her HSA of desiring isolation as a learned childhood behaviour for safety. In the advanced stage, Susie experienced HSA of annoyance during a particular peer role-play on grief and this time, Susie looked at the HSA through the lens of her culture and upbringing where only anger was allowed, while other emotions like sadness and death anxiety were taboos. Susie interpreted her HSA as a covert desire for harmonious relationships which she did not have as a child. Across training, Susie continued to struggle with familial issues, both in her childhood and adulthood. Remarkably, Susie's resilience was evidenced in her willingness to reflect on her HSA, to bring it up for supervision, and also to work with her personal counsellor on her unresolved childhood issues to be more effective in her therapeutic work. Through guided reflection with her supervisor, Susie gained knowledge of her countertransference and with HSA preceding it. Susie perceived a lack of counselling competence and struggled with aroused affect. Fortunately, she felt safe enough to self-disclose with her supervisor. Overall, Susie still experienced performance anxiety and her past experiences seemed to make her more susceptible to novice stressors (such as rigid emotional boundaries); moving her personal issues (lower

tolerance for negative affect) from distal to proximal (e.g., avoidant of role-play on grief).

Beatrice

Beatrice's subthemes remained as status quo over the course of training. Beatrice viewed her HSA of fearing to be perceived as incompetent through the lens of her culture and upbringing in both the beginning and advanced stages and interpreted her HSA as her covert desire for success in life. In addition, Beatrice experienced HSA of dread in the advanced stage, which she interpreted as a result of the intense amount of work she had to put in to maintain her level of competence, simultaneously masking her incompetence in front of her supervisor. Ironically, when Beatrice eventually received the grade that she desired, she felt that it reinforced her belief that she must continue to conceal her incompetence to achieve success. Beatrice perceived an overall increase in her CSE. However, she felt that she had many missed learning opportunities and had not benefited from supervision as much as she would like. She was concerned that if she did address her clinical concerns in supervision, her supervisor might misconceive her competence. Consequently, Beatrice might not have received constructive feedback about her actual counselling performance and mastery of skills and modelling from her supervisor. Therefore, it would be assumed that Beatrice did not feel safe with her supervisor to openly discuss how she would be assessed, and Beatrice might have been intentional in maintaining a "*professional and cordial*" working alliance with her supervisor.

Margaret

Similar to Mary, Margaret had all but one subtheme remained; exploring HSA through culture and upbringing (BS) to exploring HSA through a counsellor's perspective (AS). In both stages of her training, Margaret experienced similar moments of HSA of fearing to speak up during a particular group supervision (BS) and unstructured learning in class (AS). In the beginning stage, Margaret viewed her HSA through the lens of her culture and upbringing, where she learned to subscribe to traditional gender roles as a woman and a caregiver. Therefore, Margaret felt intimidated when she had to speak up in various training contexts. However, as Margaret progressed further into her advanced stage and became more identified in the counsellor role, she felt less hindered by HSA, specifically her own critical thoughts about her performance. To manage her HSA, Margaret would focus on the task at hand rather than entertaining her momentary critical thoughts. However, Margaret did not mention whether she brought her HSA up for supervision, but she described her supervisor as very supportive and accepting of her. In the advanced stage, Margaret struggled to find moderately challenging clients who were ready and able to participate in counselling; a barrier to effect efficacious counselling actions with "no-shows" clients. Overall, Margaret reported feeling more integrated in her identity as a counsellor.

Steven

Similar to Margaret, Steven had all but one subtheme remained; exploring HSA through culture and upbringing (BS) to exploring HSA through a counsellor's perspective (AS). Steven experienced similar moments of HSA of disconnectedness for both stages of training. According to Steven, there was no direct clinical implication in

the beginning stage, unlike the advanced stage when he felt momentary aware of his frustration about a particular client and became more directive in his approach. To make sense of his HSA, Steven attributed his combativeness to his culture and upbringing; to be admired he had to be perceived as intellectual. In the beginning stage, Steven felt that he could still be admired if he could balance between disagreeing and being empathic. In the advanced stage, Steven adopted the perspective of a counsellor and reinterpreted his HSA as his desire for admiration; empathy and credibility would complement each other better (as compared to combativeness and empathy). In the advanced stage of his training, Steven aspired to be emotionally connected to his clients rather than focusing primarily on theoretical knowledge. Steven described the working alliance with his supervisor as open and mutual. He could share honestly with his supervisor who treated him like a colleague. However, Steven did not specifically mention whether his supervisor had provided him with constructive, specific, and changeable feedback about his counselling performance during the supervision (or simply intellectual exchanges). Overall, Steven seemed to have more moments of HSA during unstructured learning in the advanced stage; on one occasion HSA preceded countertransference and he defaulted to his combative self. Steven perceived an increase in his CSE and felt more able to tolerate his HSA.

Linda

For Linda, there was a temporal shift in two subthemes: exploring HSA through unpleasant childhood memories (BS) to exploring HSA through a counsellor's perspective, and interpreting HSA as learned childhood behaviours (BS) to interpreting HSA as covert desires (AS). In the beginning stage of training, Linda experienced HSA

of feeling conflicted during a particular group supervision when she perceived her group supervisor's behaviours as inappropriate. However, instead of conveying her disapproval directly to the group supervisor, Linda reacted passive-aggressively with her body language, but to no avail. Linda viewed her HSA through the lens of her unpleasant childhood memories and made sense that her passive-aggressiveness was a learned childhood behaviour to be heard. During a role-play with the lecturer in the advanced stage, Linda became momentarily aware of her resistance to change (to take responsibility in perpetuating her lack of sleep issues). Linda did not anticipate resistance and the HSA provided her with great insight about herself, particularly her relationship with herself. She viewed her advanced stage HSA through the lens of a counsellor and interpreted her resistance as a covert desire for self-compassion; Linda had always prioritised the needs of others over hers and her resistance to change (in the client's role) shed light on her not prioritising her basic needs. Hence, Linda shared that she could still be hindered by her advanced stage HSA and recognised the clinical implications of her HSA. Linda described her working alliance with her supervisor in the advanced stage as mutual and her supervisor treated her like a colleague. Their sessions together felt like having conversations and according to Linda, that helped in reducing her anxiety. However, Linda did not mention whether she was provided with feedback, modelling or opportunities for mastery of skills in the supervision. Overall, Linda perceived an increase in her CSE.

Amanda

Like Linda, there was a temporal shift in two subthemes for Amanda: exploring HSA through unpleasant childhood memories (BS) to exploring HSA through a

counselling theory, and interpreting HSA as learned childhood behaviours (BS) to interpreting HSA as opportunities for growth (AS). Amanda experienced HSA of bodily sensations during both stages of her training. In the beginning stage, she viewed her HSA of bodily sensations during a particular lecture through the lens of her unpleasant childhood memories and interpreted that as a way her body had coped with fear to keep herself safe within an unstable family system as a child. In the advanced stage, however, Amanda adopted the perspective of a counsellor to make sense of her bodily vibrations as a client during a particular class demonstration on exposure therapy. Despite the similarities between the two HSAs, Amanda's interpretations were very different. She viewed her advanced stage HSA as an opportunity for growth in which she could use her bodily cues as intuition to guide her therapeutic work. Amanda also learned from her HSA to be mindful of her work with clients with phobias not to assume what would (or would not) trigger them. Amanda shared that her supervisory working alliance was strong and positive. Her supervisor was supportive of her work and accepted her for who she was. She openly discussed her clinical concerns and counselling issues with her supervisor who provided her with constructive and specific feedback. It seemed like Amanda was provided with mastery of skills and modelling from her supervisor. Overall, Amanda perceived an increase in her CSE and felt competent in her role as an emerging counsellor.

Peter

Similar to Steven, Peter had all but one subtheme remained; exploring HSA through culture and upbringing (BS) to exploring HSA through a counsellor’s perspective (AS). Peter experienced similar moments of HSA of self-consciousness in

the two stages of training. In the beginning stage, Peter was self-conscious when he used formal English to communicate with his classmates and ensured Singlish (or colloquial English) would not slip out. He was afraid that his classmates might judge him when he used Singlish. Peter viewed his HSA through his culture and upbringing and made sense that Singlish was less superior to formal English. However, it was a part of his identity and the social group he grew up with. In the advanced stage, Peter adopted a counsellor's perspective to make sense of his HSA and reinterpreted Singlish as a language tool. In multicultural counselling, Peter's ability to inject humour and challenge clients with Singlish became an effective approach and he experienced an increase in his CSE. In the advanced stage, Peter described the supervisory working alliance as "very good" and his supervisor would provide him with constructive feedback, modelling and opportunities for mastery of skills. Overall, Peter perceived a more integrated counsellor self in the advanced stage.

Despite the fact that each of the nine participants had rather similar HSA, their interpretations were unique and personal. The participants' capacity to tolerate HSA seemed to have improved over time, and the intensity of their HSA seemed to have relatively decreased as well. Most of the participants perceived an overall increase in CSE. A few participants (like Lynn, Susie, Amanda, and Peter) reported having a strong supervisory working alliance and received constructive feedback, modelling and opportunities for mastery of skills from their supervisors. However, these participants did not mention whether they brought their HSA up in the supervision. A few participants (like Beatrice, Mary, Steven, and Margaret) were less specific about how

they were supported by their supervisors. However, all the participants acknowledged the impact of supervision on their counselling performance.

5.4 Chapter Conclusion

This chapter presented findings from the advanced stage that supported and expanded initial findings from the beginning stage. The following chapter will present the HSA trajectories of two participants over the course of their training. The single-case design with visual graphs was used to present the two participants' trajectories. The single-case design complemented the current QUAL-Quant study with a focus on the phenomenology of trainee counsellors' HSA. The individual cases also serve as illustrative examples for the remaining seven participants whose visual graphs are affixed to the end of the thesis (see Appendix K).

CHAPTER 6

Trajectories Across Training: The Longitudinal Phenomenology of HSA

> *Multiperspectival IPA retains a commitment to idiography in data collection and analysis but extends this by combining two or more focal perspectives, permitting us to consider the relational, intersubjective, and microsocial dimensions of a given phenomenon.* (Larkin et al., 2019, p. 183)

6.1 Chapter Introduction

In contrast to quantitative studies, which generate "universal" truths, qualitative methods have been criticised for their lack of credibility in data analysis (Creswell & Miller, 2000). Even though it is not in the interest of the current IPA study to search for a single "truth", this chapter seeks to honour the idiographic nature of IPA by complementing participants' HSA narratives with visual graphs derived from time-series data. Beyond statistical significance, the chapter argues that time-series data not only enhance participants' HSA stories but also lend support to Miller et al.'s (2018) study which claims that IPA is a contemporary qualitative approach suitable for counselling research. To present a detailed discussion of trainee counsellors' HSA trajectories over the course of their training while keeping to a suitable length for the thesis, two of the nine participants, Lynn and Beatrice's cases were selected for single-case discussion. This is a prudent approach in providing a balanced perspective to illustrate a case of consistency (with Lynn's) and inconsistency (with Beatrice's) between IPA themes and

self-report ratings. Furthermore, it is common for phenomenological studies, such as IPA to present participants' narratives as individual cases to highlight the nuances and complexities of their experiences (e.g., Nizza et al., 2018; Smith, 1994).Visual graphs and survey results for the remaining participants were annexed to the thesis (see Appendix K).

6.2 Visual Validity

The current research comprised a longitudinal IPA study, a qualitative method for exploring the meaning trainee counsellors associated with their HSA, and a smaller quantitative dataset derived from surveys administered across 18 time-points. As time-series data are frequently autocorrelated, the traditional parametric tests are inappropriate. According to Morley and Adams (1989), a single-case design is a recommended method for analysing time-series data, which is pertinent to the current research. In the next section, two of the nine participants' HSA trajectories will be presented as 'Single-Case'. The findings were generated from IPA analysis and visual inspection of time-series data. Visual validity refers to the accuracy of gathered research data in the form of graphs and is an essential characteristic in single-case design because it allows for visual inspection: clear and concise data organisation, graphs to make formative evaluations from data points, trends, and variability of data points (Kratochwill et al., 2013; Morley, 2018). Since the current study is an observational study and not an experimental study, visual validity is determined by visual inspection of trendlines of data points across the 18 time-points, with an upward trendline indicating an increase in the dependent variable over time and a downward trendline indicating a decrease. Both the inductive (IPA) and deductive (single-case) methods were used to

capture the essence of participants' HSA narratives and changes over time. Whilst Chapters 4 and 5 have addressed research questions (RQ) 1 and 2, respectively, this chapter will address RQ3 (in the Single-Case of Lynn and Beatrice) and RQ4.

RQ3. Are there observed individual changes in the level, trend and variability of trainee counsellors' HSA, SWA, and CSE over the course of training?

RQ4. How does trainee counsellors' changing HSA relate to changes in SWA and CSE over the course of training?

6.3 Survey Results

6.3.1 Descriptive Statistics

The group Mean, Median, and Standard Deviation of HSA across the three training contexts (during in-session, supervision, and coursework), supervisory working alliance (SWA) and counselling self-efficacy (CSE) are presented in Table 7. As hypothesised, the results show an inverse relationship between HSA across the three training contexts (in-session, supervision, and coursework), supervisory working alliance, and counselling self-efficacy over time span. Figure 13 shows the group downward trendline of HSA during in-session, supervision, and coursework setting at Time-point 1 (the 1st month of data collection), Time-point 6 (the 6thmonth of data collection), Time-point 12 (the 12th month of data collection) and Time-point 18 (the 18th month of data collection). The four time-points were chosen to align with specific junctures of training. For example, Time-point 1 is the start of data collection and serves as a baseline; Time-point 6 is the end of the beginning stage training; Time-point 12 is the mid-point of advanced stage training and supposedly the most intensive part of practicum; Time-point 18 is the end of data collection and serves as an endpoint.

Table 7

Descriptive Statistics

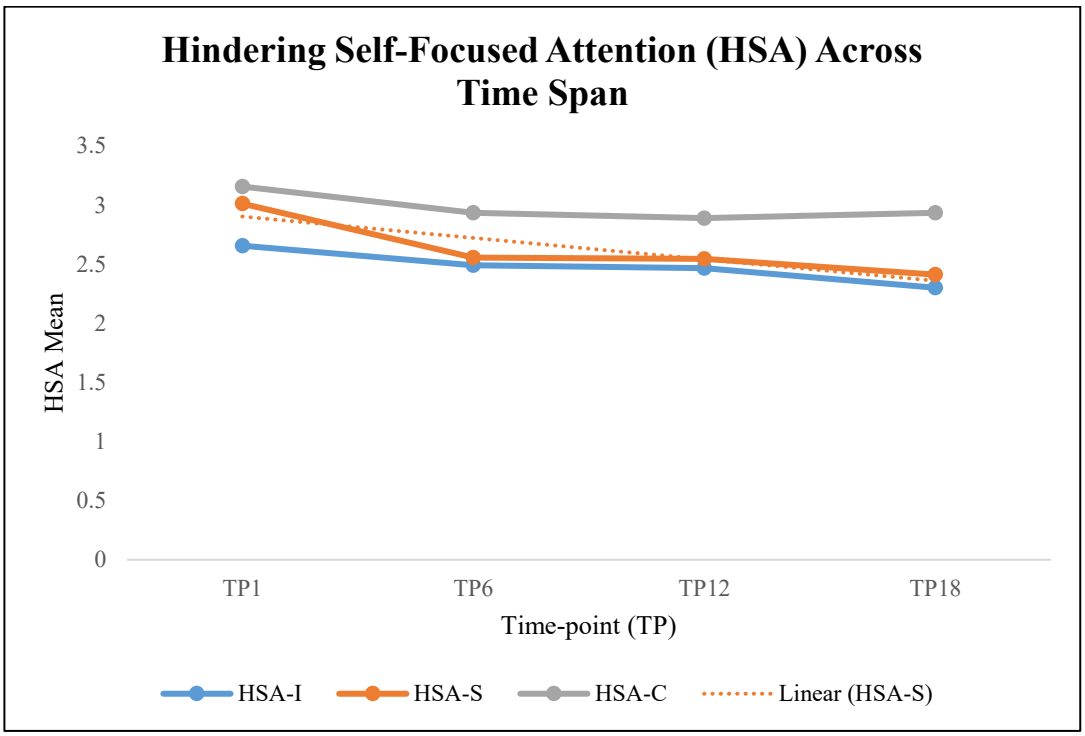
	Time-point 1			Time-point 6			Time-point 12			Time-point 18		
	Mean	Median	Standard Deviation	Mean	Median	Standard Deviation	Mean	Median	Standard Deviation	Mean	Median	Standard Deviation
HSA-I	2.66	3.2	0.93	2.49	2.20	1.07	2.47	2.40	0.78	2.30	2.20	0.64
HSA-S	3.01	3.3	1.00	2.56	2.40	1.08	2.54	2.40	0.86	2.41	2.70	0.82
HSA-C	3.16	3.2	0.31	2.93	2.80	0.65	2.89	2.90	0.45	2.93	3.00	0.35
SWA	4.93	5	0.96	5.22	5.00	1.05	5.22	5.20	1.54	5.84	6.40	1.41
CSE	4.97	5.3	1.14	5.54	6.30	1.95	5.36	5.70	1.57	6.30	7.00	1.56

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance, and CSE = counselling self-efficacy.

For visual clarity, only the trendline for HSA-S (HSA during supervision) is shown in the graph. Figure 14 shows the group upward trendline of supervisory working alliance and counselling self-efficacy across time-points.

Figure 13

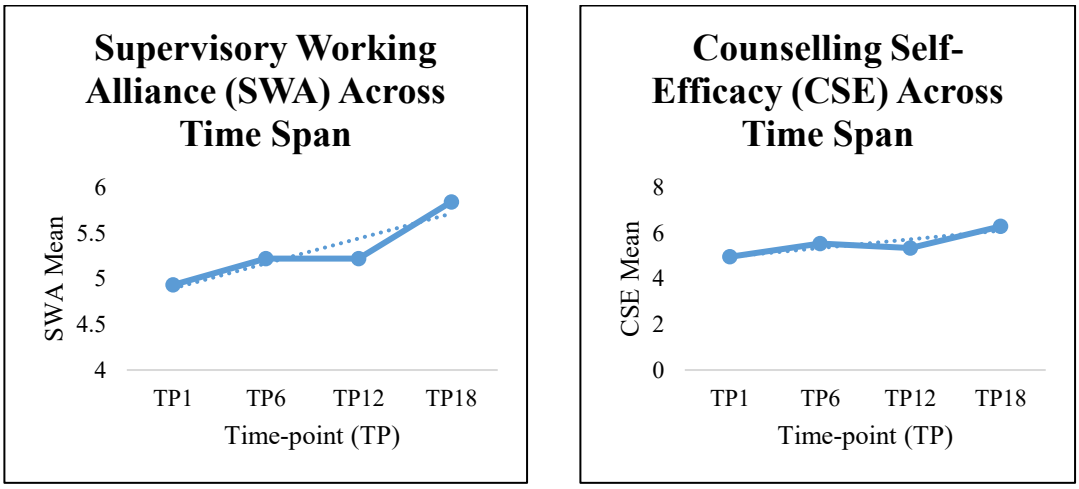
Group Hindering Self-Focused Attention (HSA) Across Three Training Contexts Over Time-point



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays

Figure 14

Group Supervisory Working Alliance (SWA) and Counselling Self-Efficacy (CSE) Across Time-point



From the results of the group analysis, participants reported experiencing moments of HSA most frequently in the coursework setting, with supervision as the second most frequent HSA context, and the in-session with clients as the least frequent HSA context. The results were consistent across the four time-points. This may have been due to the nature of coursework itself; the interactive nature of the learning experience such as lecture-discussions, group activities, peer role-plays, and presentations could introduce elements of uncertainties and unexpected challenges that could contribute to stress and anxiety. In addition, the dynamics of group interactions may contribute to a heightened awareness of evaluation among the participants themselves which may lead to self-consciousness. In comparison, supervision and in-session are one-on-one and therefore would likely be less intimidating for the participants; supervisors by their functional role are to ensure that trainee counsellors learn in a safe environment, whereas for in-session there is an inherent nature of power

differential within the therapeutic relationship which is often accentuated by factors such as clients' presenting issues, vulnerability, and dependence on counsellors for guidance. Moreover, supervision and counselling sessions would likely be less frequent than coursework components. Therefore, participants may experience less frequent moments of anxiety and self-evaluation in these contexts as compared to coursework setting. Comparing supervision and in-session contexts, the evaluative nature of the supervisor-supervisee relationships may contribute to participants experiencing more moments of anxiety and self-evaluation. Participants may view their supervisors as professional gatekeepers and feel the need to perform as compared to the in-session context.

Participants reported higher scores for their supervisory working alliances in the advanced stage (TP18) than in the beginning stage of training (TP1), whilst consistent scores between the two stages (TP6 and TP12). There could be various explanations for this. First, the establishment of a professional bond between the supervisor-supervisee dyad is not instantaneous but rather evolves over time. This temporal dimension considers that the depth and quality of the working alliance deepen as the dyad navigates the journey together. When supervisors provided opportunities for mastery of skills, encouragement and constructive feedback, participants gained more confidence and competence in executing counselling actions. Second, participants in the advanced stage of training would likely be given more challenging clients owing to their higher level of training. This would imply that they would experience more anxiety and self-evaluation and would likely turn to their supervisors for clinical support, which would foster the bond and self-efficacy beliefs further. The consistency in the scores between TP6 (end of the beginning stage) and TP12 (beginning of the advanced stage) might be attributed to

the reduced need for supervision owing to the commencement of the advanced stage practicum. Hence, they might require less frequent or intensive supervision compared to the later advanced stage of training (i.e., TP18). This could result in a stable working alliance score across the consecutive time-points.

Participants' counselling self-efficacy scores over the four time-points show an overall upward trendline with a dip in the mid-advanced stage of training (TP3). This may reflect the nature of the training programme; participants would generally be assigned more complex cases or a heavier caseload in the mid-advanced stage of their practicum to prepare them for their professional role upon graduating from the programme. Hence, they may experience more moments of anxiety, fear, and self-evaluation about their counselling competence during sessions with clients. This could be a critical juncture where participants experience the "conscious incompetence" phenomenon or the awareness of "not knowing" in their clinical work with clients. This may explain the reduction in their self-reported counselling self-efficacy scores in TP3 and when participants have the resilience to navigate past this, often and ideally with the support of their supervisors, they would assume an overall increase in their self-efficacy beliefs and working alliance, as seen in TP4.

6.3.2 Group Weighted-Tau Scores

Effect size measures, such as Kendall's τ for non-parametric tests are valuable in quantifying the magnitude of observed differences. The $\tau_{(time.score)}$ score for each variable is shown in Table 8. The meta-analysis conducted by Wattanawongwan et al. (2022) provided a benchmark for Tau-U values and effect size interpretations: </=.20 "very small sized effect", .21–.63 "small sized effect", .64–.88 "moderate sized

effect", .89–.97 "large sized effect", and .98–1.00 "very larger sized effect" (Wattanawongwan et al., 2022).

Table 8

Results of Weighted Scores from Tau Analysis Over Time ($\tau_{(time.score)}$)

Variable	Tau	Z	*p*-Value	95% CI
HSA-I	-0.19	-3.38	0.00	-0.3074<>-0.0819
HSA-S	-0.36	-6.19	0.00	-0.4686<>-0.2431
HSA-C	-0.16	-2.80	0.01	-0.2740<>-0.0485
SWA	0.25	4.33	0.00	0.1364<>0.3618
CSE	0.29	5.11	0.00	0.1814<>0.4069

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance, and CSE = counselling self-efficacy

The results show that participants experienced less frequent moments of HSA across the three training contexts (in-session, supervision, and coursework) over the course of training. The results were statistically significant with very small effect sizes for HSA-I and HSA-C, and a small effect size for HSA-S. The results suggest that as participants progressed from the beginning to the advanced stage of their training, they experienced less frequent moments of heightened awareness of their anxiety or internal distraction during in-session with clients, supervision with the clinical supervisor, and coursework setting with their classmates. The overall indication of increased SWA and CSE were also statistically significant with small effect sizes. The change in both the supervisory working alliance and counselling self-efficacy reflects that as participants progressed from the beginning to the advanced stage of their training, the bond between the supervisor-supervisee dyad became stronger whilst their beliefs about their ability to

perform counselling tasks also improved. To make sense of what could have contributed to the changes and how the changes in the variables (HSA, SWA, and CSE) related to one another, IPA findings could shed light and offer possible explanations.

When participants first joined the training, they reported having high and unrealistic expectations of themselves (e.g., Rose and Beatrice). They expected themselves to "be perfect" and "competent" and therefore experienced moments of heightened awareness of their emotions (such as anxiety, fear and self-doubt) across different contexts. For some participants, seeing clients for the first time was likely anxiety-provoking as well. They seemed to suddenly become aware of their low affect tolerance of their clients' background or counselling contexts (e.g., Lynn and Susie). In such situations, they became hindered by their momentary awareness of their negative feelings such as fear of rejection (for Lynn) or desire for isolation (for Susie). In addition, experiential learning in the context of classroom learning (i.e., the coursework component) also triggered moments of heightened awareness of critical thoughts and bodily sensations (e.g., Amanda and Margaret). For some participants, experiential learning which often involves group processes triggered sudden awareness of their self-consciousness of how they ought to react (for Linda) or speak (for Peter) in the presence of their classmates. Participants also experienced anxiety during supervision. Some participants viewed their supervisors as professional gatekeepers to evaluate them (like Beatrice and Rose). As a result, they experienced more intense momentary critical thoughts and feelings during supervision as compared to those participants who viewed their supervisors as supportive (like Amanda and Peter).

IPA findings further gathered that participants' past experiences had a major impact on their perceptions of themselves and reality. Participants who interpreted their childhood experiences as negative seemed to be affected more by their moments of anxiety and internal distractions as compared to participants who interpreted their childhood experiences as less negative. For these participants, their childhood experiences became a set of their stable counsellor characteristics that impacted them during training. IPA findings suggested that participants' unpleasant pasts amplified their vulnerabilities to negative affect (e.g., in HSA moments) and seemed to reduce their capacity to function in the counsellor role under optimal conditions, especially in the beginning stage.

However as training progressed, participants' HSA attenuated. For some participants, they may have acquired more theoretical knowledge from the various counselling modalities taught. Therefore, they became more capable of conceptualising their personal problems by utilising the various theories to reframe their perspectives in the advanced stage (e.g., Lynn and Amanda). Some participants consulted their supervisors regarding clinical issues and HSA moments (e.g., Peter and Susie). As a result, they may have gained more opportunities to learn from their supervisors, model after them, and receive more constructive feedback to boost their self-esteem or enhance counselling skills. Naturally, the supervisory bond would become stronger for this group of participants. Some participants who reported feeling less close to their supervisors seemed to feel more uncomfortable disclosing their clinical Issues or HSA moments to their supervisors. These participants were concerned about being judged or evaluated unfairly (like Beatrice), or they viewed HSA moments as personal and tried to manage

HSA on their own (like Mary and Margaret). Under such situations, the supervisory functions and relationships may become weaker. For some participants, they may have selected supervisors who matched their personalities or styles (e.g., Lynn and Amanda). Hence, it was easier for them to engage in open and honest communication with their supervisors. Overall, as participants progressed from the beginning stage to the advanced stage, the dynamics among these variables influenced and contributed to the change as reported in the results.

In the present exploratory study, the calculated effect size for $\tau_{(time.score)}$ while statistically significant, is characterised as very small and small, suggesting the results may lack practical significance. The small effect size underscores the need for cautious interpretation. However, the purpose of the current QUAL-Quant study was to explore participants' HSA moments and not to extrapolate to a wider population, hence the survey results have provided additional information to complement participants' stories.

In crafting this thesis, careful consideration has been given to maintain an appropriate and concise length for the thesis. The next section will elaborate in detail on two cases; Lynn's case was chosen because it exemplified a lower CSE mean score ($M < 5$) and consistency between the IPA themes and significant changes in HSA, SWA and CSE over the course of training. Both Susie's and Mary's cases had similar low CSE mean score as Lynn's and significant change in HSA-S but only Susie and not Mary reported significant changes in SWA results over the course of training. In contrast, Beatrice's case was chosen because it exemplified a higher CSE mean score ($M > 5$) and inconsistency between the IPA themes and non-significant changes in HSA, SWA and CSE over the course of training. Five participants had similar high CSE mean score like

Beatrice. Steven, Margaret and Linda reported non-significant change in HSA and SWA, whilst Peter, and Amanda reported significant change in SWA. The trajectories of the remaining seven participants, though not as comprehensive, can be found in the Appendices.

6.4 A Case of Consistency: Lynn's Trajectories

This section aims to answer RQ3: Are there observed individual changes in the level, trend and variability of trainee counsellors' HSA, SWA, and CSE over the course of training? Lynn's case was chosen because the IPA themes were aligned with the changes in her self-reported ratings, which were found to be significant.

6.4.1 Beginning Stage (IPA Themes)

In the beginning stage of training, Lynn experienced HSA of a need to please to avoid rejection during an initial counselling session with her client who was sent to her for mandated addiction recovery support counselling. Lynn reported feeling like a child, and she described it as "*like a child who was very afraid to offend and not be accepted*" (I1, p. 10). The HSA was hindering Lynn as she felt a related urge to constantly monitor her online behaviours to avoid coming across as "*judgmental*" by the client which could result in rejection.

Lynn viewed her HSA through the lens of her unpleasant childhood memory of being rejected twice by her best childhood friends. She described the pain of rejection as "*devastating*" (I1, p. 27) and she told herself that she would avoid rejection at all costs. As an adult, Lynn was aware of her compensatory pleasing behaviour to gain acceptance. Lynn interpreted her HSA as a manifestation of critical and self-conscious thoughts about how she ought to behave or look online. Additionally, Lynn made sense

of her HSA as underpinned by her intense fear of rejection; she would do whatever she could to please the client to be accepted. Lynn's covert desire for acceptance was significant enough during that particular in-session to suddenly trigger a momentary awareness of her self-consciousness and critical thoughts.

Fortunately, Lynn reported having a strong supervisory alliance with her clinical supervisor in the beginning stage of her training. According to Lynn, she requested a supervisor who matched her counselling orientation (more towards a humanistic approach). Lynn felt at ease to discuss her counselling issues with her supervisor. Even though Lynn shared that she did not share with her supervisor about her HSA in particular, she was open to discussing her own emotional inadequacy during that particular counselling session with her supervisor. According to Lynn, she was able to process her thoughts and emotions with her supervisor given the highly involved nature of the supervision. Lynn's supervisor sounded knowledgeable and skilful enough to guide Lynn to see alternatives and Lynn felt more competent to return to the client in the subsequent session. Lynn reported feeling less *"awkwardness"* (I1, p. 8) in the subsequent session and was able to establish rapport with her client. Lynn gradually learned to be more efficacious in counselling the client and she experienced an increase in her self-efficacy beliefs.

6.4.2 Advanced Stage (IPA Themes)

In the advanced stage of training, Lynn again experienced HSA of a need to please others at the same practicum site as the beginning stage. During a particular lecture on Cognitive Behavioural Therapy, more specifically on automatic thoughts, Lynn became suddenly aware of her HSA of a need to please to avoid rejection at the

practicum site. Unlike the beginning stage where Lynn attempted to please a social worker at the practicum site; in the advanced stage Lynn decided to stop pleasing that particular social worker and she withdrew from the practicum site.

Lynn viewed her HSA through the lens of the Transactional Analysis (Berne, 1973) which is a psychodynamic approach taught as a part of the coursework component. According to Transactional Analysis, each person has three states (i.e., Parent, Adult, and Child ego states). The way these ego states interact is derived from childhood experiences and they can impact individuals in adulthood. Lynn utilised Transactional Analysis to make sense of her HSA. She examined her moments of critical thoughts through her ego states and gained insight into her internal "*transactions*" or interactions between her "*Critical Parent and Rebellious Child ego states*" (I2, p. 3). According to Lynn, she made sense of her withdrawal from the practicum site as a countertransference from her Child ego state perceiving rejection, "*the social worker's voice often felt like the Critical Parent speaking*" (J9, p. 1). Lynn's HSA manifested as a series of self-blaming thoughts (from the Critical Parent ego state) and feelings of "*they don't like me*" (J9, p. 1) (from the Child ego state). Lynn acknowledged her covert desire to be accepted but when the Child ego state misread the cues and perceived rejection, instead of trying to please, she decided to withdraw to cope with the emotional pain.

Upon reflection, Lynn rationalised that as a counsellor, it would only be "*right*" to remain at the practicum site when she perceived rejection from the social worker (J9, p. 2). She perceived her reaction as "*irrational*" and "*dysfunctional*" even though it restored a sense of equilibrium to her system as she would not have to subject her Child ego state to so much emotional pain. Lynn recognised the clinical implications her

unresolved past could have on her. However, she felt that she was also able to empathise more with her clients and refrain from forcing change on them. Overall, Lynn believed that she was more aware of her own vulnerabilities from her HSA and perceived that as beneficial as compared to being in denial or oblivious which could be more harmful for her clients. Hence, Lynn felt that she could still learn from the episode despite it being unpleasant and she perceived herself as more congruent and integrated in her role as a counsellor.

Lynn continued to receive support from her clinical supervisor during the advanced stage, and she viewed supervision as a resource. Even though Lynn did not indicate whether she brought her HSA or countertransference up for clinical supervision, according to Lynn, she maintained a positive working alliance with her supervisor.

6.4.3 Trajectories of Variables (Self-Reported Measures)

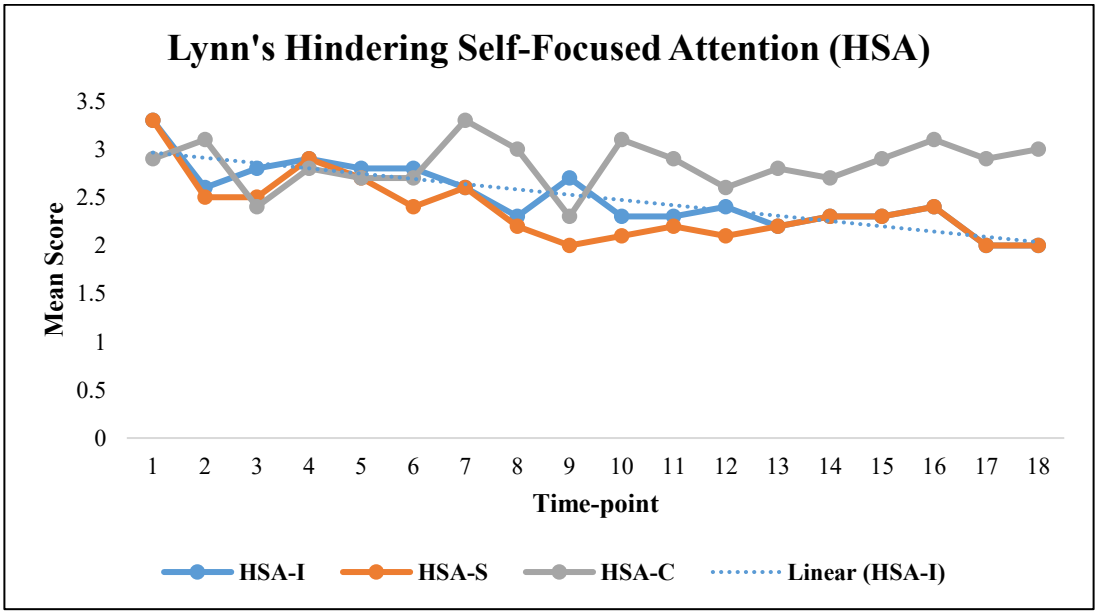
The graphs depict Lynn's HSA, SWA, and CSE over 18 months, leading up to her master's degree graduation as shown in Figures 15 and 16. In each graph, the horizontal (X) and vertical (Y) axes, respectively, represent the time-points and dependent variables. For visual clarity, only the trendline for in-session HSA is shown in the graph. Visual inspection of single-case time-series data aims to complement IPA findings and taken together provides a more comprehensive picture in understanding Lynn’s trajectories.

Figure 15 shows a downward trendline for Lynn’s HSA during in-session, and supervision, and an upward trendline for HSA in the coursework setting. Figure 16 shows an upward trendline for both SWA and CSE. As hypothesised, there is an inverse relationship between HSA during in-session and supervision (not in coursework setting),

SWA and CSE. This would suggest that as Lynn progressed from the beginning to the advanced stage of her training, she experienced less frequent moments of sudden awareness of her anxiety or internal distraction during supervision and her counselling session with clients but not in the coursework setting, while the supervisor-supervisee bond became stronger, and she perceived an overall increase in her self-efficacy beliefs to perform counselling tasks with clients. According to IPA findings, Lynn's subjective individual changes over the course of training reflected her idiographic experience of learning to become an efficacious counsellor; executing counselling actions, reflecting on counselling issues and personal characteristics that impeded effective counselling, and openness to learn from and receive feedback from the supervisor.

Figure 15

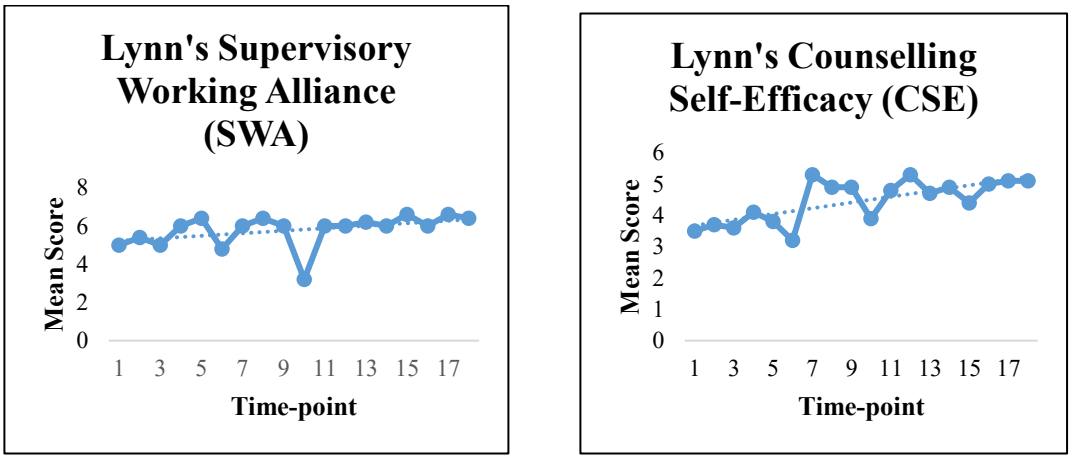
Lynn's Hindering Self-Focused Attention (HSA) across three training contexts over time-point



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays

Figure 16

Lynn's Supervisory Working Alliance (SWA) and Counselling Self-Efficacy (CSE) Across Time-point



In the beginning stage of training, Lynn shared that she was "*very afraid to offend*" (I1) the client and the desire for the client's acceptance intensified her HSA moments during in-session. Lynn perceived rejection as "*devastating*" (I1) and would avoid rejection at all costs. According to Lynn, she would try "*very hard to please others*" (J9) in order to be accepted. If Lynn had felt this way during her first in-session, she would likely have experienced similar HSA moments during supervision and coursework setting; to gain acceptance from her supervisor and her peers as rejection would be too painful for her. At this point in the training, the bond between Lynn and her supervisor had just started to develop. The supervisor established a safe place for Lynn to address her counselling issues and provided opportunities for Lynn to deepen her knowledge and skills. The supervisor was able to influence and motivate Lynn to return to the client to practise her counselling skills. Lynn experienced gradual success and her counselling performance improved. At the same time, Lynn's beliefs about her ability to

execute counselling actions and the supervisory working alliance also increased. The improvements might have reduced Lynn's HSA moments during in-session and supervision.

In the advanced stage, Lynn's HSA trajectories for in-session and supervision show a downward trendline, except for coursework setting suggesting that Lynn experienced less frequent HSA moments during in-session and supervision. Lynn's IPA findings gathered that part of the coursework requirement was for trainee counsellors to attend lectures on various counselling modalities and to apply the theories and techniques to themselves. It was an integral part of her learning process as she was able to personally experience the impact and nuances of the various modalities and this contributed to her empathic understanding of her personal issues and the clients' struggles with change. According to Lynn, the application of the theories to herself also contributed to other HSA moments (e.g., moments of self-blaming thoughts) in the lectures such as the one when she uncovered a countertransference at the practicum site. This would explain the upward trendline of Lynn's HSA in the coursework setting. In the advanced stage, Lynn continued to be open to seeking her supervisor for support and continued to receive assistance from the supervisor. This would increase Lynn's opportunities for mastery of skills. However, Lynn did not mention whether her supervisor supported her on the countertransference (or HSA). At Time-point 10, there was a significant dip in the SWA score suggesting a possible supervisory working alliance rupture. However, the subsequent rising scores would imply that the bond was strong enough to withstand the rupture, and the supervisor was effective in repairing the rupture which was likely necessary for Lynn's growth. According to Lynn, she continued

to receive modelling and constructive feedback from her supervisor. For Lynn, she felt that she was more congruent and integrated in her role as a counsellor in the advanced stage. Even though the countertransference had clinical implications, Lynn felt she could learn from it.

Table 9

Results of Lynn's Tau Analysis Over Time ($\tau_{(time.score)}$)

Participant	Variable	Tau	*p*-Value	CI 90%
Lynn	HSA-I	-0.65	0.00	-0.931<>-0.363
	HSA-S	-0.49	0.00	-0.774<>-0.206
	HSA-C	0.10	0.57	-0.186<>0.382
	SWA	0.40	0.02	0.115<>0.683
	CSE	0.50	0.00	0.213<>0.781
	CSE Mean (SD) 4.46 (0.69)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy

The current study adopted Wattanawongwan et al.'s (2022) benchmark for Tau-U values and effect size interpretations. The effect sizes show that Lynn experienced less frequent moments of HSA during in-session and supervision but more frequent HSA moments in coursework setting over the course of training. The effect sizes also indicate an overall increase in Lynn's supervisory working alliance and counselling self-efficacy over the course of training. The results were statistically significant with a moderate effect size for HSA-I, and small effect sizes for HSA-S, SWA, and CSE. The results were consistent with Lynn's IPA themes and visual graphs.

At the beginning stage, Lynn experienced more moments of HSA in supervision than coursework and in-session, but her HSA moments in supervision and in-session

continued to decrease over the training months. This could be explained by the consistent support Lynn received from her supervisor throughout her training, which assisted Lynn in her clinical work. Nevertheless, Lynn's HSA during coursework training (such as attending lectures) exhibited an upward trend, suggesting that she continued to experience moments of HSA during coursework training.

Lynn's IPA findings suggested that the context of the lecture provided Lynn with the opportunity and knowledge to apply the theories to herself. For example, when Lynn used Transactional Analysis to make sense of her reaction to withdraw from the practicum site, she uncovered that her Child ego state had misread certain cues and perceived rejection from the social worker. Lynn viewed the critical thoughts through the lens of Transactional Analysis; an internal conversation between her Critical Parent and Rebellious Child ego states. Hence, situations like this seemed to heighten Lynn's awareness. However, the change in Lynn's HSA in a coursework setting (HSA-C) was non-significant. This could be due to the limitation of the adapted survey which is meant for HSA during in-session. Hence the questions on the survey might not be nuanced enough to pick up Lynn's HSA in a coursework setting. Additionally, the survey was sent to the participants on a specific date monthly and therefore may not capture dynamic changes in Lynn's HSA in the coursework setting. This could have limited Lynn's ability to recall HSA moments in coursework setting accurately. However, it could be plausible that Lynn continued to experience moments of HSA (i.e., the need to please to avoid rejection) as the coursework setting inherently provided a larger group context, thus presenting more frequent opportunities for perceived rejections. The frequency with which Lynn experienced HSA moments could remain relatively stable,

or she could still be struggling with the vulnerabilities of the HSA moments, thereby explaining the non-significant change as observed in Lynn's HSA scores in coursework setting.

The small effect sizes for SWA and CSE were statistically significant suggesting Lynn's relationship with her supervisor continued to strengthen and that her CSE continued to improve over the course of training. The results were consistent with Lynn's IPA experiences. Lynn shared that her supervisor was a good role model and a valuable resource for her. She was able to translate the skills to her practical work which attenuated her HSA moments. The interplay among the variables worked dynamically in supporting Lynn's performance in the training environment. In the coursework setting, Lynn learned various counselling modalities to conceptualise both her clients and her personal issues; she then brought her counselling issues to her supervisor and learned to model after the supervisor who provided her with mastery experience and constructive feedback; she then returned to her clients to practise those skills and her self-efficacy beliefs about her ability to counsel improved; she gained more personal agency and was motivated to learn more.

Lynn's case exemplified consistency between her IPA themes and the self-reported measures she provided. This convergence reaffirmed and strengthened Lynn's overall self-assessment as a more congruent and integrated counsellor. The corroboration between her introspective accounts, as captured by the IPA themes, and her explicit self-evaluations from her survey data offered a compelling narrative of how Lynn perceived her identity as an emerging counsellor. The evidence from Lynn's qualitative and

quantitative data underscored the comprehensiveness of Lynn's trajectories over the course of training. The following section will present Beatrice's contrasting case.

6.5 A Case of Inconsistency: Beatrice's Trajectories

Beatrice's case was chosen because her IPA themes were inconsistent with changes in her self-reported measures that were non-significant.

6.5.1 Beginning Stage (IPA Themes)

In the beginning stage of training, Beatrice experienced HSA moments of fearing to be perceived as incompetent by her clinical supervisor. Beatrice acknowledged that she had high standards and strove for academic excellence. According to Beatrice, she felt intense pressure to avoid appearing incompetent during supervision as her supervisor was responsible for evaluating her practicum performance. Beatrice described her momentary emotion during supervision as "*fear of presenting myself as someone who is not good enough*" (J1, p.1). The HSA was hindering Beatrice as she felt a related urge to want to mask her incompetence further during supervision; she overprepared prior to supervision, answered all the questions that her supervisor asked to her best ability, and avoided asking questions that were germane to the client's issues.

Beatrice viewed her HSA through the lens of her culture and upbringing and it made sense that her socioeconomic background contributed to her high self-expectations. Beatrice viewed academic achievements as her "*ticket out of poverty*" (I1, p. 20) and adopted the belief "*go big or go home*" (I1, p. 18) to motivate herself in training. Beatrice interpreted her HSA as a manifestation of self-doubt, anxiety, and over-compensatory behaviours in supervision. Additionally, Beatrice interpreted her HSA as underpinned by her covert desire to succeed in life. Since Beatrice could not

benefit from supervision, she sought support from group supervision on her counselling needs and became a self-directed learner to bridge her learning gap. Beatrice prioritised her grades over anything else and perceived that as her best option for achieving success.

Beatrice characterised her relationship with her supervisor as "*formal and cordial*" (I1, p. 11). According to Beatrice, she perceived her supervisor as a professional gatekeeper and an assessor. Therefore, the relationship seemed more official than trusting. Beatrice was intentional not to bring up cases that would portray her as incompetent as she described "*is very important what the supervisor thinks about me, perception about me and my competence*" (I1, p. 5). Therefore, it would be assumed that Beatrice's supervisor had limited opportunities to model effective counselling actions and give her constructive feedback. Thus, maintaining a "*formal*" relationship was more effective in maintaining her sense of competence and strategic in accomplishing her academic goals.

6.5.2 Advanced Stage (IPA Themes)

Beatrice continued to experience moments of fear that her clinical supervisor would perceive her as incompetent in the advanced stage, and achieving academic excellence remained a consistent theme for her in the advanced stage. In contrast to the beginning stage, in which Beatrice's moment of HSA focused on her "*feeling of incompetence*", the advanced stage moment of HSA captured Beatrice's "*feeling of burnout*" when she felt "*tempted to call in sick just to lie down and do nothing*" (J5, p. 1). Beatrice was cognisant of the fact that both of her HSA moments were merely two sides of the achievement coin ingrained in her by her culture and upbringing. Beatrice's

socioeconomic background had instilled in her the importance of success and for Beatrice, she believed the only option was through academic achievement.

Beatrice interpreted her HSA as a manifestation of distracting thoughts and feelings of exhaustion. She recalled during a few lectures when she experienced moments of wandering thoughts about taking a break to relax for "*one more day*" (J4, p.1). The HSA was hindering as Beatrice felt a related urge to stop doing everything and could not focus on the lecture. Beatrice made sense of her HSA as her consistent, covert desire for life success and her exhaustion was a wake-up call for her to prioritise self-care. When Beatrice eventually received "*High Commendation*" from her clinical supervisor, she questioned whether her positive grades were due to her "*intentional masking of any hint of incompetence"* which further reinforced her belief "*not to appear vulnerable*" (J14, p. 1).

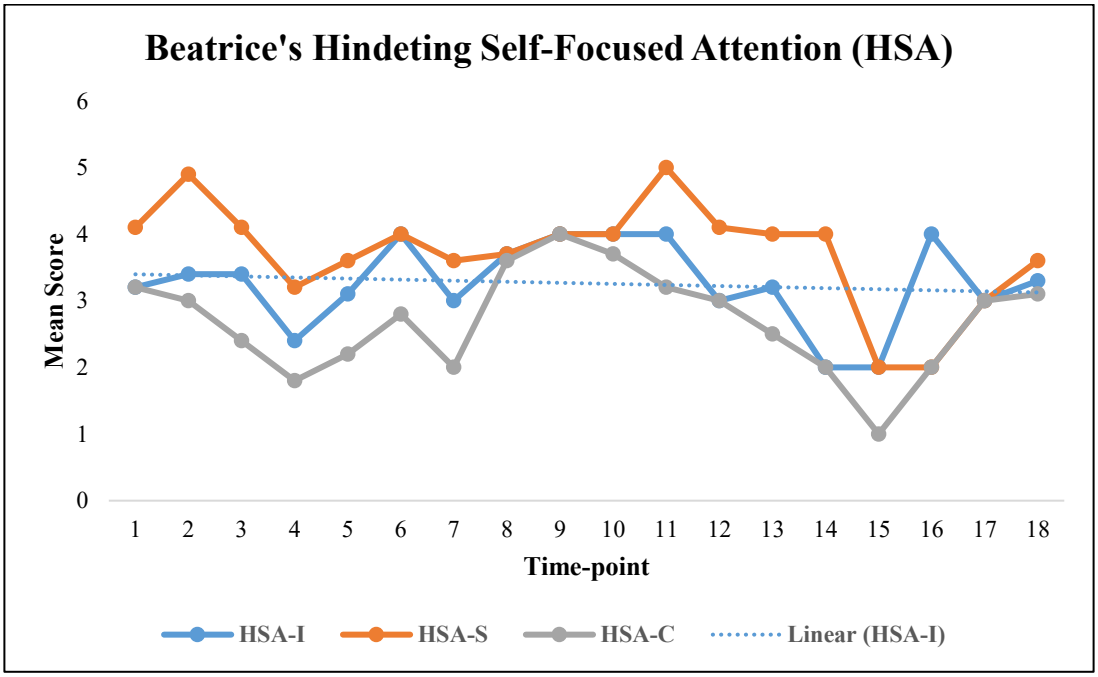
In the advanced stage, Beatrice was "*slightly more open*" (J9, p. 1) and brought up a few counselling issues in supervision. According to Beatrice, the supervisor provided her with modelling experiences and "*valuable feedback and guidance in a supportive manner*" (J9, p. 1). Beatrice felt that the bond between her supervisor and herself became closer and she was more trusting of her supervisor. Beatrice also mentioned that the supervisor provided her with encouragement, suggestions and strategies which aided her in learning to be efficacious with clients. She felt more competent in executing effective actions in counselling. Overall, Beatrice perceived herself as a competent counsellor in the advanced stage of training.

6.5.3 Trajectories of Variables (Self-Reported Measures)

The graphs depict Beatrice's HSA, SWA, and CSE over 18 months, leading up to her master's degree graduation as shown in Figures 17 and 18. In each graph, the horizontal (X) and vertical (Y) axes, respectively, represent the time-points and dependent variables. For visual clarity, only the trendline for in-session HSA is shown in the graph. Similar to Lynn's case, Beatrice's IPA findings will be complemented with her time-series data obtained from her self-reported measures to comprehensively look at her trajectories.

Figure 17

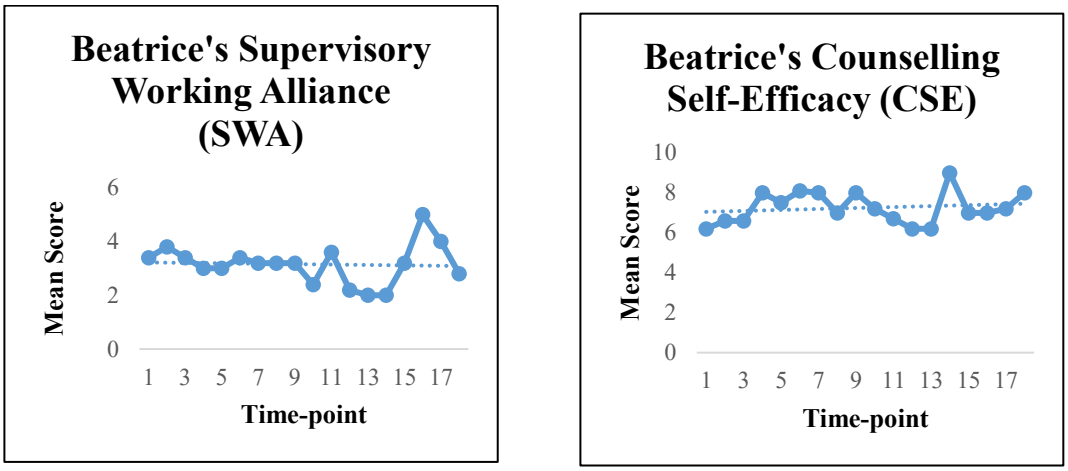
Beatrice's Hindering Self-Focused Attention (HSA) across three training contexts over time-point



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays

Figure 18

Beatrice's Supervisory Working Alliance (SWA) and Counselling Self-Efficacy (CSE) Across Time-point



Visually, Figure 17 shows a downward trendline for Beatrice's HSA during in-session, supervision, and coursework settings. However, none of these scores on her self-reported measures change significantly over time. Visually, Figure 18 shows a downward trendline for SWA and an upward trendline for CSE but again, the changes in SWA and CSE were not significant.

In contrast, Beatrice's IPA findings showed that she perceived herself as becoming more competent as the training progressed from the beginning to the advanced stage. Given that Beatrice already assessed her CSE as high at the outset of the study, there was minimal opportunity for substantial growth over the course of the training period. Her initial high ratings suggested that Beatrice entered the study with a strong sense of self-efficacy in her counselling abilities. However, the inconsistency between Beatrice's IPA accounts and her self-reported measures suggested that Beatrice could feel threatened by her fear of being perceived as incompetent. This deep-seated fear of

confronting the possibility of perceiving herself as incompetent was so intolerable for Beatrice that could have affected how she responded to the surveys; the mere thought of her assessing her own competence was too threatening.

Visually, Beatrice's HSA trajectories show a downward trendline across the three training contexts (i.e., in-session, supervision, and coursework setting) over the course of training but the change in her HSA was not significant. In the beginning stage of training, Beatrice was highly motivated to achieve excellent grades as she perceived that as the best option to break free of the poverty cycle. Beatrice was very afraid that her supervisor would perceive her as incompetent if she were to openly discuss her counselling issues with her supervisor. Supervision became the context where Beatrice experienced a heightened awareness of her anxiety and fear. As a result, Beatrice engaged in overcompensatory behaviour as a way to cope and manage her underlying feelings of incompetence. She overprepared for supervision, took excessive notes during in-session, and ensured that she could answer every question in supervision. In addition to Beatrice's desire to be perceived as competent during supervision, she expected herself to be competent in other components of the training such as the coursework component; she would read and reread her assignments multiple times before submission. Hence, Beatrice would likely experience similar HSA moments during in-session and coursework settings. However, failure to openly acknowledge or address any instances of HSA moments could undermine the opportunity for her to effectively manage or resolve HSA. Consequently, as the issues remained unaddressed, Beatrice might miss out on the potential for growth and self-awareness. Beatrice perceived herself to have the ability to perform her counselling tasks despite not having functional

support from her supervisor. Beatrice had a high level of CSE (i.e., near "complete confidence" on the CSE scale) and she believed that she could bridge the learning gap on her own. If Beatrice perceived herself to be competent, viewed her supervisor as an assessor of her performance and described their relationship as "*formal*" (I1), the SWA would likely be weak in the beginning stage of training.

In the advanced stage, Beatrice's IPA themes gathered that she had learned to manage her HSA moments through overcompensatory behaviour, and she acknowledged that the coping behaviour helped mask her internal sense of inadequacy and self-doubt, especially during supervision. At the same time, Beatrice was able to reframe her HSA as a motivator to continue working hard to achieve academic excellence. However, Beatrice's IPA findings also gathered that she was beginning to experience fatigue in the advanced stage of training and experienced moments of HSA of dread. As the counselling cases assigned to Beatrice were also getting more difficult, the fatigue compounded her HSA during the in-session. This would explain the variability of the time-series data (from Time-point 7 onwards) on Beatrice's HSA graph; despite her best efforts in coping, it was hard for Beatrice not to notice moments of her dissenting thoughts and emotions from her persistent drive for validation and competence.

In the advanced stage, Beatrice began to experience more setbacks in counselling clients, and she learned to seek help from her supervisor but exercised extreme care in her selection of counselling issues and the way she presented those issues to her supervision which she described as "*slightly but not 100% open*" (I2) in her supervision. Beatrice acknowledged that she doubted her counselling skills and she was more receptive to receiving feedback from her supervisor. Beatrice's supervisor guided her

and provided her with the opportunity for mastery and encouragement. Towards the end of the advanced stage, Beatrice acknowledged that she felt more trusting in her supervisor. This would explain the variability and overall downward and upward trendline of Beatrice's SWA and CSE, respectively (from Time-point 7 onwards). However, when Beatrice finally received a "*High Commendation*" (at Time-point 14) in the advanced stage, she was confused about whether she was indeed competent or "*masking her incompetence*". She felt lost as she questioned if she could be candid and vulnerable. IPA narratives gathered that Beatrice seemed to be still searching for the counsellor "self".

According to IPA findings, Beatrice's subjective individual changes over the course of training reflected her idiographic experience of learning to become efficacious with clients. However, the impact of Beatrice's socioeconomic background was complex; functioning as both a motivator and a barrier within the context of her development as a counsellor. When compounded with heightened awareness, HSA and Beatrice's stable counsellor characteristics (i.e., her socioeconomic background and beliefs) contributed to her doubts about other perceptions of academic excellence. As a result, she overcompensated in order to achieve good grades (e.g., over-preparing for supervision and refraining from asking her supervisor questions). Hence, the presence of HSA moments and Beatrice's stable counsellor characteristics bidirectionally interacted with the training environment and affected the way in which Beatrice made and executed counselling and supervision decisions (i.e., personal agency).

Table 10

Results of Beatrice's Tau Analysis Over Time ($\tau_{(time.score)}$)

Participant	Variable	Tau	*p*-Value	CI 90%
Beatrice	HSA-I	-0.06	0.73	-0.343<>0.225
	HSA-S	-0.27	0.11	-0.558<>0.009
	HSA-C	-0.08	0.65	-0.362<>0.205
	SWA	-0.17	0.32	-0.454<>0.114
	CSE	0.11	0.52	-0.173<>0.395
	CSE Mean (SD) 7.25 (0.80)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy

The current study adopted Wattanawongwan et al.'s (2022) benchmark for Tau-U values and effect size interpretations. Beatrice's survey results indicated that her HSA across three training contexts, SWA and CSE did not change significantly over time. According to Beatrice, it was important for her to be perceived as competent and she acknowledged the "mask of competence" she put on intentionally as a way to cope with her moments of HSA. Beatrice's overcompensatory behaviour was a defense mechanism to conceal her underlying feelings of inadequacy and may have unconsciously exaggerated her display of confidence, competence, or knowledge to project an image of proficiency to seek external validation from her supervisors, clients or peers. If Beatrice had adopted such a coping behaviour during the training, she might have experienced a similar moment of HSA during the research process. As a result, Beatrice may approach the surveys with a similar attitude either intentionally or unintentionally. Hence, Beatrice may respond to the survey questions in a biased manner due to social desirability to appear competent. Beatrice's IPA findings gathered that she struggled between "*being*

vulnerable to be open" (J14) and "*masking her incompetence*" (I1), which may explain the survey results.

The Self-Awareness and Management Strategies Scale (SAMS, Williams et al., 2003) used to measure HSA was divided into two subscales, anxious and distracting. It is the only survey instrument available to measure HSA at the point of the research. Hence, the questions may not be comprehensive enough to capture the nuances of HSA (i.e., beyond anxious and distracting) that participants experienced, such as Beatrice's HSA of fearing to be perceived as incompetent which may impact the survey results.

In an ideal situation, the role of a clinical supervisor is to provide functional support while acting as a gatekeeper to ensure that counselling remains ethical. If Beatrice had perceived her supervisor as an assessor, she would likely feel unsafe to disclose clinical issues (and her HSA). Beatrice claimed that she would not share anything that could potentially put her grades at "*risk*" (I1). As Beatrice intentionally chose not to discuss counselling issues with her supervisor, there may be fewer opportunities for her to learn from her supervisor and benefit from modelled counselling. The supervisor may not be able to provide Beatrice with constructive feedback or influence her to learn new skills or self-evaluate her counselling performance in a realistic and constructive way. Such an ambiguous relationship may have direct clinical implications; impeding Beatrice from learning to become efficacious with clients, moderating her performance anxiety in training (like HSA), and aligning her self-efficacy beliefs with actual counselling performance. Since it is difficult to manage such complexity, it may affect how Beatrice responded to the survey questions and therefore the results.

According to Larson (1998), trainee counsellors' high CSE scores do not translate to actual counselling performance. Beatrice may have overestimated her CSE relative to counselling performance; owing to her fear of being perceived as incompetent. Beatrice's self-reported performance may be an exaggerated display of competence intended to mask her inadequacy. Therefore, when Beatrice experienced difficulties in counselling clients, she may not have the knowledge or skills to execute effective counselling actions. She may then overcompensate in ways such as a constant need to avoid being vulnerable in supervision or a constant need to learn. This may explain the non-significant changes in her CSE scores. For Beatrice, her stable counsellor characteristics contributed to her beliefs about academic excellence in achieving success. However, the belief was so ingrained in her that any thought about her incompetence became simply unbearable and any action that could lead to failure became inconceivable. The pervasive pendulating thoughts between competence and incompetence (i.e., during HSA moments) thus rendered failure as utterly irreconcilable with her sense of self and counsellor identity.

Beatrice's case exemplified inconsistency between her IPA themes and the non-significant survey results. This divergence illuminated Beatrice's struggle to become integrated as a counsellor. The discrepancies between her introspective accounts, as captured by the IPA themes, and her explicit self-evaluations from her survey data offered a compelling narrative of how Beatrice's stable counsellor characteristics and the presence of HSA made her more susceptible to novice stress that became a barrier to her learning. The following section will review and discuss the two cases in the context of the SCMCT.

6.6 Cross-Case Analysis

In the current study, HSA is defined as "experiences of being troubled by an awareness of one's anxiety and other internal distractions that occur when providing counselling" (Wei et al., 2015, p. 43). Within the framework of IPA, cross-case analysis seeks to transcend individual experiences and examine the intersections and divergences in participants' HSA moments in a larger context of the Social Cognitive Model of Counselor Training (SCMCT, Larson, 1998). Through the lens of cross-case analysis, the following discussion will provide a holistic understanding of participants' HSA moments that is theoretically informed and practical to the field.

6.6.1 Hindering Self-Focused Attention

As mentioned in the review chapter, in the context of the SCMCT, HSA moments can be a specific type of anxiety that might affect trainee counsellors' self-efficacy beliefs and their presentations in supervision. Both Lynn and Beatrice experienced different HSA moments; their HSA manifestations were similar but with very distinct interpretations. Lynn's HSA moment of the need to please (for both stages) was different from Beatrice's HSA moment of fearing to be perceived as incompetent (in the beginning stage) and feeling of dread (in the advanced stage). Whilst Lynn's HSA manifested as self-consciousness and critical thoughts, Beatrice's HSA manifested as a feeling of fear and dread. For both, their HSA manifestations may be considered as a specific form of anxiety that affected their ability to perform as a counsellor. For example, Lynn was hindered by her HSA as she felt a related urge to monitor her online nonverbal cues to avoid possible client rejection in the beginning stage, and a countertransference reaction in the advanced stage. Beatrice was hindered by her HSA

as she found herself engaging in overcompensatory behaviours during supervision in both stages and not being able to focus during lectures in the advanced stage.

In both cases, HSA moments had an indirect clinical impact. In Lynn's case, she avoided exploring intense emotions with her client in the beginning stage and withdrew from the practicum site as a result of countertransference in the advanced stage. In contrast, Beatrice chose not to disclose pertinent counselling issues with her supervisor and experienced fatigue that impeded her learning in the advanced stage. Both Lynn and Beatrice's HSA were associated with their past experiences which affected them to varying degrees. In Lynn's case, her childhood friends' rejection was triggered in moments of HSA which preceded her countertransference. In Beatrice's case, her socioeconomic background served as a motivator for her to strive for academic excellence but also a barrier to her learning to become an efficacious counsellor. Both Lynn and Beatrice's past experiences that were triggered during moments of HSA moved from a distal to a proximal influencer. Through the lens of the SCMCT, HSA moments and manifestations compounded Lynn's and Beatrice's stable counsellor characteristics that increased their vulnerabilities and potentially became a barrier to their learning. Even though HSA was nuanced, both Lynn and Beatrice gained more knowledge about themselves from their HSA reflections.

6.6.2 Supervisory Working Alliance

The SCMCT underscores supervision as one of the critical components of triadic reciprocity. The model asserts that the provision of supervisory functions can happen only with a strong supervisory relationship. Lynn and Beatrice claimed to have a good working relationship with their supervisors. In Lynn's case, when she experienced HSA

moment of the need to please during in-session with a client who was sent to her for mandated counselling, she immediately sought support from her supervisor. Lynn shared with her supervisor her lack of tolerance for the client's intense emotions. Lynn's supervisor addressed her cognitive and affective inflexibility and provided Lynn with opportunities to practise mastery of skills in supervision. Lynn was able to model after her supervisor and reported counselling success in the subsequent session. In Beatrice's case, when she experienced HSA moment of fearing to be perceived as incompetent during supervision, she was unable to be open with her supervisor about her fear. As a result, Beatrice's cognitive and affective inflexibility could not be addressed, and Beatrice was deprived of the opportunity to learn from her supervisor. In addition, Beatrice's anxiety (as manifested as HSA) perpetuated, and the supervision context became unsafe for her. Therefore, while both of them reported a positive supervisory working alliance, Lynn's supervisor, to a larger extent, was able to carry out the supervisory functions to assist Lynn in learning to be efficacious more than Beatrice's. Consequently, Lynn's supervisor became her model who aided her performance, whilst Beatrice's supervisor became her assessor who evaluated her performance.

6.6.3 Counselling Self-Efficacy

Compared to Lynn's CSE score (M = 4.46), Beatrice had higher self-efficacy beliefs (M = 7.25) over the course of training based on her self-reported measures. Beatrice perceived herself as capable enough to execute effective counselling actions such as microskills and relationship skills in the beginning stage but encountered challenges in advanced counselling actions that involved a more complex integration of skills and conceptual knowledge. Despite that, Beatrice's self-efficacy beliefs remained

high in the advanced stage. Lynn, on the contrary, had lower self-efficacy beliefs during training based on her self-reported measures. She experienced anxiety during the in-session but was receptive to receiving support from her supervisor. She learned to manage counselling challenges, exerted considerable effort to achieve counselling goals, and gained success along the way. With gradual improvement, Lynn's self-efficacy beliefs increased.

According to Larson (1998), the amount of supervision and experience is not associated with CSE, and higher CSE beliefs do not translate to higher performance. Beatrice may have exaggerated CSE beliefs in order to manage her feelings of inadequacy. Lynn may have a more accurate assessment of her CSE as she was able to evaluate her performance based on her supervisor's feedback and modelling. The SCMCT would assume trainee counsellors with higher CSE would perceive anxiety (such as HSA) as challenging rather than debilitating. Despite having a higher CSE score than Lynn, Beatrice perceived her HSA moment as both a challenge and a barrier; HSA motivated her to work harder but also prevented her from learning from her supervisor. In comparison, Lynn's HSA moment was debilitating when she acted on her anxiety. Hence, from the two cases, a higher CSE belief was not indicative of the participants' counselling performance and anxiety beliefs.

From both Lynn and Beatrice's cases, it seemed like CSE was not a reliable measure of performance. This lack of association suggested that relying on CSE to gauge participants' competence could introduce inaccuracies when interpreting participants' competence, leading to either underestimation or overestimation of their actual counselling skills. The discrepancies underscored the need for more

comprehensive evaluation methods in assessing counsellor competence. In Lynn's case, she might lack insights into her own strengths and weaknesses. In Beatrice's case, she might inflate her competence for self-enhancement. For both of them, what remained consistent was the interplay between their set of stable counsellor characteristics and the HSA that bidirectionally interacted with their training environment. Therefore, it would be helpful to employ additional objective measures (e.g., supervisor's rating) to provide a more comprehensive assessment which will be discussed in the final chapter.

6.6.4 Novice Stressors

Skovholt and Rønnestad (2003) identified a list of seven novice stressors that trainee counsellors may experience during training, as mentioned in the review chapter. In the context of SCMCT, novice stress can manifest as anxiety (such as HSA) and anxiety can exist in any component of the triad as discussed in the review chapter (refer to figure 2). From the list, Lynn and Beatrice's novice stress can be subsumed under acute performance anxiety, the fragile and incomplete counsellor-self, the acute need for positive mentors (for Lynn), scrutiny of professional gatekeepers (for Beatrice), and glamorised expectations (for Beatrice).

Both Lynn and Beatrice experienced performance anxiety but in different contexts. Lynn experienced performance anxiety during in-session and Beatrice experienced performance anxiety during supervision. Lynn felt a need to please the client and the social worker at her practicum site to measure up to perceived expectations to gain acceptance. As for Beatrice, she felt a need to appear competent to achieve an excellent grade from her supervisor. In addition, both experienced a fragile counsellor "self" in the beginning stage of training. Lynn felt more integrated as a

counsellor in the advanced stage whilst Beatrice continued to feel incomplete and struggled to perform the role of a counsellor. Lynn and Beatrice acknowledged the impact of their past experiences and were aware that their unresolved personal issues could still be triggered (as HSA moments) during training. If that happened, they could be cognitively or emotionally impacted which put them in a vulnerable position threatening their counsellor identity.

Whilst Lynn experienced an acute need for a positive mentor to guide and support her, Beatrice on the contrary experienced the perceived scrutiny of a professional gatekeeper. Lynn was open to sharing her counselling issues with her supervisor who served as her counselling model to set clear goals, process cognitive and affective inflexibilities, and provide constructive feedback. Lynn felt that her supervisor could influence and motivate her to improve. In contrast, Beatrice withheld clinical information from her supervisor whom she perceived as an assessor to evaluate her performance. Even though both Lynn and Beatrice experienced anxiety (i.e., HSA as a specific type of anxiety) during supervision, Lynn's anxiety seemed to be constructive, aiding in her learning to become efficacious. Beatrice's anxiety seemed to contribute to her false sense of competence to manage that anxiety. Beatrice's glamorised expectations of training outcomes may have compounded her anxiety. She held herself to a higher standard of how she ought to be as a counsellor when she graduated. As a result, when she experienced an HSA moment, she overcompensated in order to maintain a sense of competence.

In summary, Beatrice's high self-efficacy beliefs generated from IPA were inconsistent with her non-significant CSE results. Beatrice was motivated to learn,

interpreted her HSA moments as covert desires, and chose not to disclose her HSA moments to her supervisor. This led to limited learning opportunities and potentially exaggerated CSE beliefs to manage feelings of inadequacy which could further impact the working alliance. Conversely, Lynn, who had lower self-efficacy beliefs and significant CSE results, associated her HSA moments with unpleasant childhood experiences. She relied on her supervisor for support which strengthened the working alliance further. Overall, the findings highlighted how the stable counsellor characteristics and the presence of HSA moments can increase vulnerabilities and influence the learning process for trainee counsellors.

6.7 Chapter Conclusion

This chapter discussed the utility of single-case design in complementing IPA findings. The cases of Lynn and Beatrice were chosen to illuminate a case of consistency and inconsistency. The next chapter will discuss the interplay between HSA, SWA, and CSE in the larger context of the Social Cognitive Model of Counseling Training (SCMCT).

CHAPTER 7

Overall Discussion and Conclusion: The Phenomenology of HSA

> *Interestingly, in the transition from Husserl to Heidegger, the idea of phenomenological knowledge which transcends context is largely discarded, primarily because the phenomenological enquirer is assumed to occupy a single position… But what if, as in IPA, each participant is acting as one among many phenomenologists? Collectively, they offer us a range of positions and perspectives.* (Larkin et al., 2019, p.195)

7.1 Chapter Introduction

Using IPA, the purpose of this QUAL-Quant 18-month-long study was to understand the meaning trainee counsellors associated with HSA and investigate how HSA changed with supervisory working alliance and counselling self-efficacy over the course of training. Each of the nine participants participated in a semi-structured interview in the beginning and advanced stages of their training. They further completed monthly surveys and journals during the study period. This concluding chapter revisits the rationale of the current study, provides a summary of the major findings, and an analysis of these findings in light of the previous research. This is followed by a discussion of the contribution of this research to developing a deeper understanding of HSA, the impact of HSA on the development of trainee counsellors in the context of the Social Cognitive Model of counsellor Training (SCMCT, Larson, 1998), and suggestions

for future research. The limitations of the study are discussed and a post hoc examination of IPA as a research methodology is evaluated.

7.2 Significance and Summary of Key Findings

There is a notable gap in the literature regarding HSA. Previous studies such as those by Fauth and Williams (2005), Wei et al., (2017), and Williams et al., (2008), predominantly employed quantitative methods, capturing HSA as a static phenomenon. Most of these studies are dated (e.g., Williams, 2003; Williams et al., 1997; Williams, Hurley, et al., 2003; Williams, Polster, et al., 2003). While these studies provided valuable insights into the prevalence and impact of HSA among trainee counsellors, they failed to account for its dynamic and contextual nature. This oversight is addressed by the SCMCT, which posits that novice stressors triggering anxiety (such as HSA) can arise in various proximal environments, such as supervision, coursework training, and in-sessions with clients (Larson, 1998). Thus, a phenomenological study utilising longitudinal qualitative research was necessary to understand participants' HSA experiences over time. The current study aimed to offer a more comprehensive understanding of participants' lived HSA experiences, which is crucial for developing effective training interventions and support systems. This study significantly expands the existing literature and provides insights into the continuity and change in participants' HSA experiences.

The current research explored trainee counsellors' HSA as a specific type of anxiety experienced by participants in the context of novice stressors. Combined findings found that participants with higher CSE and significant change in CSE during training showed motivation, viewed HSA moments as growth opportunities, and

perceived their supervisors as role models. IPA narratives revealed that these participants received mastery opportunities, modelling experiences, and constructive feedback from their supervisors. Conversely, those with high CSE but reported no significant change in CSE were also motivated but tended to view HSA moments as convert desires. They often avoided sharing HSA moments with their supervisors, leading to limited learning opportunities and possibly exaggerated self-efficacy beliefs to cope with feelings of inadequacy, which was found to weaken supervisory alliances. Participants with lower CSE were motivated and associated HSA moments with past unpleasant experiences, relying heavily on supervisors for support. Strong working alliances mediated between HSA and their self-efficacy beliefs. Overall, the study underscores how stable counsellor characteristics and the presence of HSA moments heighten vulnerabilities and impact learning outcomes. Table 11 provides a summary of the key findings.

Table 11: Summary of Key Findings

- In order to make sense of HSA, the participants viewed HSA through the lens of a counselling theory, cultural backgrounds and upbringing, and an objective counsellor.
- Adopting these perspectives allowed the participants to make interpretations of their HSA during training.
- The participants interpreted HSA as manifestations of critical thoughts, unpleasant emotions, body sensations and gestures across various training contexts that expanded prior studies of HSA of purely to in-sessions.

- In addition, the participants also interpreted HSA as their covert desires, learned childhood behaviours, and opportunities for growth which provided the participants with more knowledge about themselves and illuminated their stable counsellor characteristics.
- The presence of HSA moments and these counsellor characteristics increased participants' vulnerabilities that temporarily became a barrier to learning to become efficacious in counselling.
- Participants' CSE was not an indicator of their counselling performance. SWA could potentially mediate between HSA and CSE.
- Participants who shared their HSA struggles with their supervisors reported significant change in SWA over the course of training whilst some participants who chose not to share their HSA struggles with their supervisors reported non-significant change in SWA over the course of training.
- IPA narratives gathered that participants perceived themselves as more self-aware, less affected by HSA moments, and having increased self-efficacy beliefs. However, for some participants, their IPA narratives were inconsistent with their survey results which showed non-significant changes in their HSA, SWA, and CSE.

The findings have offered insights into the meaning of HSA as understood by the participants. The accounts revealed an emphasis on the centrality of "inner states awareness" in participants' experiences. Participants reported unpleasant cognitions, emotions, and bodily manifestations that over the course of training shifted in terms of

intensity, subjectivity, and interpretations. The participants' HSA moments were nuanced, intertwined with their lives, contextualised and context-dependent in an inextricable manner. The accounts of the participants converged on the prevalence of HSA moments during counsellor training; HSA could occur during in-session, supervision and in coursework setting.

Participants described their HSA moments as manifestations of critical thoughts, unpleasant feelings, bodily sensations and gestures over the course of training. Despite the similarity of participants' manifestations, their interpretations were unique. Participants' critical cognitions included self-questioning, self-doubting, and self-blaming thoughts. Participants' unpleasant emotions included fear, sadness, intimidation, self-doubt, anger, and resistance. Some participants found negative affect intolerable, especially in the beginning stage of training. They attempted to suppress, avoid or distance themselves from their unpleasant feelings whilst a few participants acknowledged their unpleasant feelings and learned to manage them in different ways. Some participants further reported bodily sensations such as vibrations, heart palpitations, and tightness in the jaw whilst other participants reported behavioural reactions like withdrawal from participation, avoidance, and using gestures to bring messages across. In addition, some participants further reported these manifestations momentarily impeded their self-efficacy beliefs; reduced their ability to counsel clients, contribute to group activities and remain focused in class.

Participants reported HSA moments as similar to anxiety. Their narratives revealed dissonant inner states, internal conflict, and avoidant behaviours. The majority of counselling training consisted of coursework and practical experience and participants

learned to conceptualise their personal often unpleasant past experiences with counselling theories in the advanced stage. On the one hand, training contributed to participants' HSA moments whereas on the other hand, the knowledge acquired from training helped them make sense of their moments of HSA. Several participants in this study were drawn to psychoanalytic theory (such as Transactional Analysis) to make sense of their HSA moments, which they interpreted as related to their childhood events. When these participants viewed their moments of HSA through the lens of Transaction Analysis (Berne, 1973), they used modality-specific concepts like "ego states" or "childhood script" to explain their HSA reactions. The ability to explain complex inner state experiences such as HSA moments with theories provided participants with a fresh and insightful perspective; uncovering hidden patterns and unresolved conflicts.

Some participants' stable counsellor characteristics (i.e., cultural differences and adverse childhood experiences) made them more susceptible to novice stress which became a barrier impeding their ability to perform. These participants viewed the environment and others around them through the lens of their differences which contributed to their lower self-esteem, varied emotions, and high self-expectations. When that happened, participants' ability to function at their optimal level was attenuated. Some participants drew a relationship between their HSA moments, cultural differences, socioeconomic backgrounds and adverse childhood experiences (like childhood trauma) which contributed to their beliefs and perceptions. Participants also interpreted their HSA moments as underpinned by covert desires for acceptance, success, harmonious relationships, assertiveness, and self-compassion. These covert desires illuminated their stable counsellor characteristics; they found themselves

experiencing feelings of inadequacy that affected their beliefs about their ability to counsel clients which became a barrier to learning to become effective with clients. As a result, their supervision and counselling outcomes were also affected. In the context of training, their stable counsellor characteristics and the occurrence of HSA moments were found either to diminish their motivation or increase their frustration; they became more self-conscious of their stable counsellor characteristics around others and evaluated themselves critically. As a result, their stable counsellor characteristics moved from distal to proximal influences and they experienced more anxiety and engaged in negative thought patterns that were not self-aiding.

Participants reported that social processes and experiential learning in the classroom setting contributed to their anxiety and self-focused attention. Within the social context of training, participants found themselves having to navigate dynamic interpersonal relationships, peer comparisons, and the immediate proximal environment like group supervision or lecture-discussion. The inherent vulnerability of experiential learning was found to intensify participants' self-consciousness and self-evaluation and for some participants, HSA moments became an inward scrutiny of their abilities, actions, and personal weaknesses. HSA moments were uncomfortable but for some participants, the heightened consciousness of their cognitions, emotions, and physiology in the moment was amplified which had indirect clinical implications; it led to countertransference reactions from some participants that affected their learning experience.

Overall, the present study revealed that HSA extended beyond in-sessions to other training contexts. Some participants experienced HSA moments during individual

and group supervision sessions. In such instances, these participants often chose not to disclose pertinent counselling issues or withdrew from active participation. Additionally, HSA moments also occurred in various components of the coursework, including peer-roleplay activities, lecture-discussion or simply during lectures themselves. When confronted with these situations, participants reported experiencing both emotional and cognitive inflexibilities which adversely affected their relationships with their peers, learning experiences, and ability to remain focused.

As participants progressed from the beginning to the advanced stage of training, some participants perceived an increase in conceptual maps or knowledge acquired from clinical successes through supervision. They perceived that the three salient supervisor functions (mastery, social persuasion and feedback) contributed to their counselling success and improved self-efficacy beliefs in performing counselling tasks. These components dynamically interacted and trainee counsellors' perceptions of their past experiences and interpretations of their beginning stage HSA moments also shifted. Despite HSA moments being uncomfortable for all participants, they showed varying capacities to manage their anxiety and internal distractions. Some participants became observers of their HSA moments and adopted a more balanced perspective of a counsellor. Adopting the lens of a counsellor to look at moments of HSA provided participants with the vantage point to comprehensively look at the HSA moments without judgements. When trainee counsellors were able to suspend judgements, they gained insights about their HSA moments and the interplay between the counsellor-client dynamic that further developed their conceptual maps.

Participants' reflections about their HSA moments primarily focused on the counselling process, personal concerns, and management strategies. Some participants engaged in guided reflection in supervision; thoughtful analysis and discussion of counselling issues under the guidance of their supervisors. A few participants found guided reflection helpful in their interventions and reflective analysis. For example, when their supervisors provided them with opportunities for mastery of skills or modelling, they perceived an increase in self-efficacy beliefs. They set clearer counselling goals, had more accurate self-assessments, and had more cognitive and affective flexibilities. They were also able to connect theoretical concepts learned in training to their work with clients. Participants also reported closer bonds with their supervisors in the advanced stage.

Some participants reflected on their HSA moments through journaling. The critical-rational duality of reflection enabled them to take a step back from their subjective HSA moments and intentionally re-examine them through fresh eyes. They gained insight into their personal concerns; and the impact of their unresolved past on their current training. For example, during experiential learning some participants found themselves triggered by their classmates, group members or group supervisors. Participants' journal introspection about their HSA moments revealed their past experiences and emotions being triggered and evoked. These participants also came up with a set of management strategies to mitigate HSA such as going for personal therapy, cognitive restructuring, leveraging peer support, and engaging in self-care and spirituality. HSA reflection enabled some participants to question their behaviours, beliefs, intention for change, and relationship with themselves.

Overall, participants' narratives revealed that when they engaged in HSA reflection, they gained more self-knowledge, and learned to be kinder and more patient with themselves. A few participants perceived themselves as more integrated in the role of a counsellor in the advanced stage. However, not all participants' IPA themes were consistent with their self-reported measures. Most participants with significant change in CSE over the course of training were found to have strong working alliances with their supervisors and were provided with constructive feedback. These participants were able to evaluate themselves more accurately as compared to those participants whose change in CSE was non-significant. Other possible reasons for the inconsistency between the qualitative and quantitative findings will be discussed in the Study Limitation section.

7.3 A Discussion of The Key Findings

7.3.1 HSA in the Context of Novice Stressors

IPA findings revealed the varied novice stressors that participants had to manage over the course of the training. Participants' accounts found that performance anxiety was rooted in the fear of not meeting expectations, making mistakes, or being evaluated poorly by their supervisors, and was triggered during HSA moments. Performance anxiety was found to be present in the proximal environment of in-session, supervision, and coursework setting. Participants experienced critical thoughts and unpleasant feelings about their performance in the presence of their supervisors, peers, and clients. When participants experienced HSA moments, their anxiety and self-consciousness impeded the work tasks as they were found to be self-focused and engaged in overcompensatory behaviours. This finding was consistent with prior studies that found trainee counsellors' awareness of their anxiety to be related to their counselling

performance (e.g., Skovholt & Rønnestad, 2003). The persistence of performance anxiety in participants' HSA moments was continued and shared over the course of training suggesting the inherent demanding nature of counsellor training and the importance of a supportive learning environment. For instance, Tolleson et al. (2017) recommended anxiety-reducing activities like mindfulness or role-playing. However, in the current study, role-play was found to be one of the anxiety-provoking contexts when clear guidelines were not put in place.

The heightened awareness of participants' stable counsellor characteristics amplified their fragile and incomplete counsellor "Self". For example, participants' socioeconomic backgrounds, "introverted" or "combative" personalities, and childhood trauma became a set of stable characteristics that affected how they showed up as trainee counsellors in the proximal environment. The incomplete counsellor "Self" manifested differently in HSA moments. The participants were found to be highly conscious of how they ought to speak, behave or appear in front of their peers, supervisors, or clients. The participants were afraid to be judged, evaluated poorly or rejected by others and found themselves engaging in familiar coping behaviours that were dysfunctional. They reported feeling less competent and doubted their abilities which highlighted their less integrated professional identity. The findings would lend support to previous studies that suggested trainee counsellors can be highly sensitive and reactive to negative feedback which can lead to feelings of self-doubt, insecurity and a negative outlook of "Self" (Skovholt & McCarthy, 1988; Thériault & Gazzola, 2010). The findings further expanded on Williams et al.'s studies (Williams, 2003a; Williams et al., 2008; Williams,

Hurley, et al., 2003) on self-focused attention that the presence of HSA moments and their stable counsellor characteristics could become a barrier to personal agency.

Participants perceived themselves as lacking clinical experience and as a result, having inadequate conceptual maps to manage difficult clients' issues. Participants' HSA moments illuminated their struggle to manage difficult clients or clients with "no-shows" in the advanced stage practicum. For example, clients who received mandated addiction-recovery support counselling might not be motivated to change while clients who were not receptive to counselling might not turn up for sessions. Participants found themselves struggling to support, build rapport and deliver effective counselling to clients whom they characterised as resistant or disengaged. Furthermore, when clients had "no-shows", participants faced disruptions in their practice which limited their opportunities to learn and refine their counselling skills. For some participants, these factors interacted in a dynamic way which seemed to constitute their critical incidents that were fraught with anxiety (Howard et al., 2006). In addition, participants' stable counsellor characteristics (e.g., adverse childhood experiences) were found to possess lower affect tolerance towards anxiety that could arise from HSA moments. This diminished capacity to tolerate emotional distress was found to compound heightened sensitivity. As a result, these participants perceived themselves as less competent in handling difficult counselling cases and had lower self-efficacy beliefs regarding their abilities to navigate the complexities of counselling. The findings would lend support to counsellor research indicating that trainee counsellors working in suboptimal training conditions tend to exhibit lower self-efficacy and perceive anxiety as more debilitating rather than as a challenge (Larson, 1998).

The participants described their supervisory relationship in different ways. Positive descriptions included good, professional, cordial, supportive, encouraging, close, and open. However, deeper analysis found participants' relationship with their supervisors could be ambiguous. The ambiguous relationship between the supervisor-supervisee dyad stemmed from the fear of being assessed poorly. Such dynamics could trigger HSA moments and create a sense of uncertainty and anxiety in participants, hindering open communication and the learning process. Some participants became hesitant to seek guidance, ask questions, or share vulnerabilities, fearing that such disclosures might be misconstrued as shortcomings or lack of competence. Consequently, participants also found the establishment of a secure supervisory bond difficult which further impacted the working alliance. This finding was consistent with prior studies on supervisory relationships which found positive working alliances as a critical component in determining trainee counsellors' competence (e.g., Bordin, 1983; Ladany, 2014). The finding was supported further by the work on novice stressors which found trainee counsellors to experience anxiety from the scrutiny of professional gatekeepers (Skovholt & Rønnestad, 2003). Whilst supervisors provide the environment for mastery of skills, modelling, and feedback, poor alliance in supervision could accentuate anxiety (like HSA moments) and nondisclosure.

In moments of HSA, participants reported experiencing heightened cognitive and affective arousal that were intense and uncomfortable. Their critical thoughts included negative self-talk or self-judgments whilst their unpleasant emotions were varied, such as sadness, fear, resistance, and anger. They found it difficult to exercise cognitive and affective flexibility as their negative thoughts and unpleasant feelings were amplified. As

a result, participants reported porosity or rigidity in maintaining emotional boundaries with their clients, supervisors, and peers. They found themselves reacting more personally which put them at risk of countertransference. The current finding corroborated with Gait and Halewood's (2019) study in acknowledging the vulnerability of trainee counsellors to countertransference as they generally lack reflexive skills to cope and process their experience and as a result, became preoccupied with either clients' emotional pain, theirs or both.

Participants reported high expectations of themselves as emerging counsellors over the course of training. The aspirations to perform exceptionally well were driven by a combination of factors such as the passion to help others, the pursuit of personal and professional fulfilment, pragmatic considerations for employment, and personal experiences. Participants' narratives revealed HSA moments of fear, anxiety, and self-doubt when they perceived that they had fallen short of their expectations. Some participants' intense desire to do well impacted their ability to navigate challenges and setbacks during training; they engaged in overcompensatory or avoidant behaviours overextended themselves and experienced emotional exhaustion and fatigue. Skovholt and Rønnestad (2003) mentioned that trainee counsellors with idealised views about counselling or who have glamorised expectations are more vulnerable to emotional reactivity. The current finding would lend support to counsellor training literature cautioning against the possibility of trainee counsellors with glamorised expectations developing a false sense of competence and intervening at critical points in their training (Larson, 1998).

The participants spoke of their supervisors as a resource in supporting their learning to become efficacious counsellors. While Skovholt and Rønnestad (2003) found trainee counsellors to be yearning for mentorship from professional elders, participants in the current study were found to have disparate perceptions about their supervisors. Participants who viewed their supervisors as assessors of their performance adopted a more cautious approach. Hence, these participants did not perceive their supervisors as models and modelling actions were limited in supervision. Participants who viewed their supervisors as counselling models reported having strong working relationships with their supervisors. They found their supervisors' counselling orientation and personality to be similar to themselves. In support of this, several studies have demonstrated the attachment styles of supervisees can have a positive association with supervisor working alliance and supervision satisfaction (An et al., 2020; Gnilka et al., 2012). When participants looked up to their supervisors as models, the provision of supervisor functions was found to positively influence participants' self-efficacy beliefs and personal agency.

7.3.2 HSA as Self-Awareness

The participants' accounts articulated their struggles between being self-aware and not being overwhelmed by it. They believed that a lack of self-awareness in counsellors could impede therapeutic work but acknowledged that HSA despite its momentary nature, was uncomfortable and could have clinical implications. When participants became acutely aware of their cognitive and emotional processes, they took notice of the complexity of self-awareness and its nuances. For example, self-awareness such as HSA was generally unpleasant, HSA contained valuable information about

themselves, HSA expanded their self-awareness, HSA was non-static and so were their interpretations of HSA, and HSA was similar to and had overlapped with other nuances of self-awareness. The finding would lend support to Williams et al.'s (2003) attempt to draw attention to the valence (positive or negative) and states (global or momentary) of self-awareness. Findings gathered that participants' negative valence of self-awareness such as HSA was linked to critical self-judgement, feelings of inadequacy, self-doubt and other negative emotions, and self-consciousness of personal challenges and shortcomings. When participants became momentary self-focused, it was a temporary state of consciousness that they characterised as HSA manifestations and inner desires.

The participants spoke of their HSA moments as a phenomenological experience of the world through their physical bodies (as bodily manifestations). Their bodies and minds were equally involved in the acquisition of knowledge. This is consistent with the phenomenon of "felt-sense" experience (Peace & Smith-Adcock, 2018) and somatic awareness (Athanasiadou & Halewood, 2011) where trainee counsellors learned to focus on their inner experiences. Participants mentioned that they started to pay attention to their negative thoughts, self-talk and emotions. Some participants employed counselling theories to explore and make sense of their inner self-talk (e.g., a conversation between the ego states). Participants also journaled to observe their thoughts to identify patterns of habitual thinking and feeling that were influenced by their past experiences and beliefs. Participants also reported learning to attend to their thoughts, emotions, and bodily sensations in the moment and not push them away. This was similar to Christopher and Maris's study on mindfulness which found trainee counsellors who practised being present and experienced their bodies reported an increase in tolerating

negative affect (Christopher & Maris, 2010). The current IPA findings and the survey data (i.e., significant weighted Tau results) confirmed that the participants were more tolerant of their HSA manifestations in the advanced stage.

A few participants spoke about HSA as similar to clinical intuition such that they used their bodily cues to guide clinical work. As with some of the participants in the current study, Witteman et al. (2012) found that participants use their feelings and sensations as similar to automatic processes in their work with clients. The authors argued that "gut feelings" or clinical intuition can be a valuable aspect of self-awareness guided by knowledge, experience, empathy and reflective practice. While not all participants in the study reported that they experienced "gut feeling" awareness in their HSA moment, a few participants mentioned that they could trust their bodily cues and their "gut" in making clinical decisions in the advanced stage of training. For these participants, the similar set of bodily sensations that caused them discomfort in the beginning stage was more tolerable in the advanced stage. In addition, they were able to decode bodily sensations to gain insights into themselves and clients. This finding was supported by extant literature which views therapists' emotional reactions, thoughts and responses to the clients as providing important insights into the clients' experiences and as such can inform therapeutic interventions (C. Cartwright et al., 2018; Gait & Halewood, 2019; Gelso & Hayes, 2007)

In contrast, some participants reported that when they became overly attuned to their bodily sensations or inner experiences like HSA manifestations, the awareness became countertherapeutic. These participants reported their HSA moments preceded countertransference. Similar to self-awareness, the concept of countertransference is

much debated (Gait & Halewood, 2019; Gelso & Hayes, 2007). Participants revealed that they were more affected by the emotions of their clients, peers, and supervisors in the beginning stage than in the advanced stage. However, some participants reported that their heightened self-awareness resulted in countertransference reactions that had clinical implications in the advanced stage. Studies on counsellor training found the development of self-awareness to be progressive (Skovholt & Rønnestad, 1992b, 2003) and trainee counsellors in the beginning stage may lack the knowledge and self-awareness to identify countertransference (Gelso & Hayes, 2007). These studies offer explanations for HSA moments that preceded countertransference; participants were more receptive to negative affect in the advanced stage and thus able to identify countertransference that ensued. Consistent with prior studies on countertransference, participants in the current study acknowledged the insights they gained about themselves (e.g., adverse childhood experiences), their clients (or others) or situations from countertransference.

7.3.3 HSA in Triadic Reciprocity

Participants' perceptions of their counselling self-efficacy (CSE) beliefs or their ability to perform counselling were dichotomised; a higher and a lower CSE group. Prior studies in self-efficacy beliefs found that trainee counsellors with higher CSE beliefs would be more motivated, effect more effort expenditure and would perceive anxiety as challenging than debilitating (Bandura, 1977; Larson, 1998). The group with higher CSE beliefs and showing consistency between IPA themes and self-reported CSE measures (i.e., statistically significant change in CSE) were found to be motivated over the course of training. They reported HSA moments as challenging; some participants from this

higher CSE group were receptive to disclosing their HSA challenges with their supervisors who provided them with learning opportunities, encouragement, and modelling experiences. Consequently, the participants were able to process their cognitive and affective inflexibilities with their supervisors who offered them constructive feedback to improve their skills and knowledge. The participants reported better HSA management strategies and counselling performance. Over the course of training, the higher CSE group who shared their HSA moments with their supervisors reported an increase in their CSE beliefs, supervisory working alliances and less frequent HSA moments.

Participants from the higher CSE group with inconsistent self-reported CSE measures (i.e., statistically non-significant change in CSE) who chose not to disclose their HSA moments also reported positive working relationships with their supervisors. For these participants, their IPA accounts gathered that they perceived themselves as competent and felt that they were getting better at managing their HSA, and their supervisory working alliances were strong over the course of training. However, their survey results showed otherwise (i.e., statistically non-significant change in HSA, SWA and CSE). The findings revealed that certain participants' stable counsellor characteristics (e.g., upbringing and socio-economic background) contributed to their high expectations of themselves and their perceptions of others (i.e., their supervisors). Instead of viewing their supervisors as mentors, they tended to perceive them as assessors. As a result, maintaining positive working alliances with their supervisors was deemed crucial and strategic. These participants appeared to compensate for any feelings of inadequacy by projecting a false sense of competence around others.

The current findings would lend support to prior studies on the salient supervisor functions namely, providing modelling experiences, social persuasion, and supervisor feedback (Daniels & Larson, 2001; Larson, 1998; Larson et al., 1992). When participants from the higher CSE group shared their HSA moments with their supervisors, they engaged in modelling behaviour after their supervisors or vicarious learning. Their supervisors as professional models were able to influence them, stimulate cognitive and affective arousal, and offer constructive feedback that was specific and implementable. This was particularly critical for participants who reported some stable counsellor characteristics that increased their susceptibility to novice stress (Larson, 1998; Ren & Jiang, 2021). Participants who perceived their cultural or past childhood experiences as a barrier to learning to become efficacious but had a strong supervisory working alliance were found to have better CSE outcomes; they believed in their capacity to influence their own actions which included managing HSA moments. In contrast, the group with higher CSE but chose not to disclose their HSA challenges had limited opportunities for mastery of skills, modelling experiences and received less constructive or pertinent feedback from their supervisors. Over the course of training, their supervisors were likely unable to fully carry out the salient supervisory functions which impacted the working alliance further. They could still perceive the supervisory working alliance as professional or formal, but the bond would likely not be as strong or trusting. For participants whose stable counsellor characteristics made them more vulnerable to novice stress (e.g., anxiety and HSA as a specific type of anxiety), this could significantly impact CSE outcomes. Participants from this group could risk having exaggerated CSE scores in order to cope with their feelings of inadequacy. The findings were supported by prior studies which claimed that CSE beliefs do not translate to actual

counselling performance and that a strong supervisory working alliance can be a mediator between the two variables (Bandura, 1977, 1997; Larson, 1998).

The participants with lower CSE beliefs were found to experience heightened anxiety from their HSA moments (i.e., significant HSA results). They reported cognitive and affective inflexibilities during their HSA moments and found anxiety from HSA moments was a barrier to learning to become efficacious. The participants' accounts gathered that they depended more heavily on their supervisors for support and guidance during their training. Their supervisors aided them in areas like counselling skills, case conceptualisation, and client management. In addition, the participants reported that constructive feedback, modelling of effective counselling techniques, and encouragement were essential for them to bolster their self-esteem. The participants felt that they could trust and be open with their supervisors and established strong working alliances. In support of this, several studies have demonstrated that trainee counsellors, especially those in the beginning stage or with lower self-esteem, were dependent on their supervisors (Ladany, Ellis, et al., 1999; Rønnestad & Skovholt, 2013; Skovholt & Rønnestad, 2003). While a positive supervisory working alliance may not translate to actual counselling performance for this lower CSE group, it is a critical component for a few participants whose stable counsellor characteristics contributed to their increased vulnerabilities. The provision of the supervisory functions, in particular, modelling in a safe environment, allowed the participants to gain mastery experiences, set realistic goals and accumulate success.

While participants' CSE beliefs and the strength of supervisory working alliances were found to be associative with HSA, the impact of the proximal environment could

not be undermined. Participants shared that when they were not supported adequately by the training institution or the practicum site, it could trigger HSA moments. For example, when safety and boundaries were compromised in a coursework setting such as during group supervision, peer role-play or lecture-discussion, some participants found themselves experiencing anxiety from HSA moments that hindered their learning and performance. The participants recognised the benefits of experiential learning, but they also reported feeling more self-conscious around others and more self-evaluative. Further studies also reported challenges and benefits of experiential learning citing group dynamics could contribute to positive and negative learning outcomes (Martin Kivlighan et al., 2019; Rees & Maclaine, 2016). Current findings also expanded on prior studies on self-focused awareness that found HSA moments could occur in coursework setting beyond in-session and supervision (Fauth & Williams, 2005b; Wei et al., 2017; Williams, Hurley, et al., 2003). Additionally, HSA moments in the coursework setting had a significant impact on how the participants perceived themselves and their classmates and supervisors.

The participants also shared that they struggled with stable clients' characteristics. Some participants talked about how their clients might not be ready for change. Hence, it was difficult for them to experience success. Some participants also talked about clients who did not turn up for counselling and that affected their self-efficacy beliefs. They reported experiencing HSA moments that exposed their vulnerabilities. The SCMCT (Larson, 1998) has posited that trainee counsellors who operated beyond the optimal conditions would struggle to learn to become efficacious. While HSA moments could permeate across different training contexts, the SCMCT

underscores the importance of how trainee counsellors' CSE beliefs, counselling actions, and the proximal environment (i.e., the triad) would bidirectionally interact with and influence one another. The findings have established the link between the stable counsellor characteristics and the presence of HSA could attenuate the triad in the context of the SCMCT.

7.3.4 HSA: Transforming from A Barrier to A Resource

The findings from this longitudinal study indicated that HSA served as both a barrier and a resource for trainee counsellors, with its impact varying significantly depending on the stage of their training. This was consistent with existing literature, which identified beginning stage trainee counsellors as particularly vulnerable to novice stressors (Beaumont et al., 2016; Gutierrez et al., 2017; Rønnestad et al., 2019). In the beginning stage of training, HSA predominantly acted as a barrier. Participants often found themselves overwhelmed by critical thoughts, unpleasant feelings, and intense bodily sensations that were challenging to manage. While these manifestations of HSA provided insights into participants' inner world and past experiences, this heightened self-awareness simultaneously hindered their ability to build relationships with clients, peers and supervisors. HSA also distracted them from learning and discouraged openness with supervisors due to the fear of being rated poorly. These HSA moments, though transitory, impeded participants' agency and their sense of Self.

In contrast, advanced stage trainee counsellors found themselves able to transform HSA from a barrier into a clinical resource. With increased counselling knowledge and practical skills, they learned to utilise insights gained from previous HSA experiences to navigate training contexts more effectively. Studies have established that

advanced stage trainee counsellors possess more enhanced conceptual maps and are more attuned with their inner states experiences (Dayal et al., 2015; Rønnestad & Skovholt, 1993). For example, a few participants who experienced critical thoughts during supervision and group activities reported using the deepened understanding of their inner conversation to guide themselves and remain present. This shift illustrated a growing ability to tolerate unpleasant affect and to harness anxiety for self-awareness.

The current findings aligned with other studies that highlighted the role of self-awareness in building empathy (Oden et al., 2009), guiding counsellors during countertransference (Coll et al., 2013; Colli et al., 2022), and enhancing their professional identity (Pieterse et al., 2013). By the advanced stage, participants reported being better equipped to utilise their bodily cues and tolerate negative affects, turning HSA into a resource to enhance professional identity and therapeutic relationships. This transition would underscore the importance of support and reflective practice in counselling programmes to help trainee counsellors navigate HSA challenges in the proximal environment effectively.

7.3.5 Continuing and Changing HSA Experiences Across Training

The findings from this longitudinal study provided a comprehensive analysis of how HSA changed over time among trainee counsellors. Collectively, HSA decreased as the participants advanced through their training, while SWA and CSE increased. This was evidenced by the group weighted scores that showed significant very small to small effect sizes. However, it is important to interpret these results with caution die to the limited sample size and the specific context of the study, which may not be generalisable to all trainee counsellors.

The IPA analysis provided an explanation for the survey results. In the beginning stage, participants generally lacked counselling knowledge and practical skills, leading them to view their HSA moments through the lens of their culture and upbringing, and unpleasant childhood memories that were very familiar to them. They interpreted their HSA as a set of manifestations including critical thoughts, unpleasant feelings, bodily sensations and gestures). These were also associated with covert desires, such as life success, acceptance, and assertiveness, and learned childhood behaviours, such as passive-aggressive, joking, and avoidant behaviours. Consequently, participants reported that these manifestations often hindered their learning process, strained their relationships with clients and peers, and reduced their openness with supervisors.

As participants progressed to the advanced stage of their training, there was a notable shift in how they interpreted and managed their HSA moments. Despite experiencing similar HSA moments in different contexts, they demonstrated increased affect tolerance and the ability to manage their HSA manifestations. This resulted in participants gaining more insights into the counselling process and their personal concerns. Participants highlighted that they learned to be kind and self-accepting, and they continued to view HSA moments as opportunities for growth. Some of the participants were also able to utilise HSA as clinical tools and self-management strategies. Equipped with more counselling knowledge and practical skills, participants reported deeper interpretations of their HSA moments, characterised by more profound insights and richer language. This was consistent with their advanced stage IPA subthemes. Participants began to view their HSA moments through the lens of a counselling theory and the perspective of a counsellor, leading to the emergence of these

two new subthemes in the advanced stage and the discontinuation of two subthemes from the beginning stage (i.e., exploring HSA through the lens of unpleasant childhood memories and HSA as learned childhood behaviours). This progression explained the survey results, which showed collective changes in participants' understanding and management of HSA.

Overall, the study found that while frequency of HSA moments decreased over the course of training, trainee counsellors reported increase in self-awareness and CSE. This shift reflected how they perceived HSA, originally viewed as a barrier in the beginning stage but later evolved as a resource for professional development and clinical effectiveness. Participants highlighted the crucial role of supervision in this transformation, which was consistent with existing literature, emphasising SWA as an essential component in supporting growth and development (e.g., Caldwell et al., 2018; Ybrandt et al., 2016). The findings underscored the importance of SWA in facilitating trainee counsellors' reflective practice, enabling them to harness their HSA experiences constructively and ultimately enhancing their professional identity.

7.5 Theoretical, Training and Practice Implications

Existing studies on momentary self-awareness such as HSA were predominantly cross-sectional and focused on the frequency with which trainee counsellors experienced HSA and its impact on counselling self-efficacy during in-session. The findings from this longitudinal QUAL-Quant study have several potential implications for theoretical development, counselling institutions, supervisors, and trainee counsellors in their practice. The subsequent sections will examine these implications.

7.5.1 Theoretical Implication: Unique Contribution to the SCMCT

Participants' accounts revealed that HSA is pervasive across various training contexts, manifesting in the core components of the SCMCT as a specific type of anxiety that can be a barrier to trainee counsellors learning to become efficacious. The model emphasises the interplay between trainee counsellors' personal agency, counselling actions, and the proximal environment, providing a comprehensive framework for understanding how they develop counselling efficacy during training (Larson, 1998).

Findings indicated that HSA could arise in various contexts within this framework, including supervision, coursework training, and direct client interactions during in-sessions. Each of these components presents unique challenges that can make trainee counsellors more susceptible to novice stressors leading to HSA moments. For example, participants reported experiencing the pressure to perform well in role-plays, fear of making mistakes in experiential activities, and heightened self-consciousness when around their peers, lecturers, and practicum managers. While the SCMCT recognises the primary function of supervisors in providing modelling experiences, social persuasion, and supervision feedback, current findings found supervision to be a context that triggers participants' HSA, making them feel less efficacious. Overall, this study extended the SCMCT by highlighting the pervasiveness of HSA and how HSA affects the triadic reciprocity.

7.5.2 Counselling Institutions: Introducing the Concept of HSA

All of the participants indicated that the concept of HSA was not explicitly covered in the required coursework. Instead of HSA, trainee counsellors were introduced

to the umbrella term “self-awareness”, which carried a positive connotation. Similar to existing literature, the training institution used self-awareness to refer to an inner resource that trainee counsellors could cultivate and guide the therapeutic process (Pieterse et al., 2013). However, there are two sides to self-awareness: self-awareness as a global knowledge of one’s values, perceptions and experiences and self-awareness as a moment-to-moment awareness of one’s feelings, thinking, and bodily sensations (Williams, 2003).

Exploration of momentary self-awareness such as HSA may be difficult for trainee counsellors to comprehend, especially beginning trainee counsellors. However, if beginning trainee counsellors have not been introduced to the concept of HSA, they may have an aversion to HSA because it would evoke a series of negative thoughts, unpleasant emotions, and bodily sensations or gestures. For those beginning trainee counsellors who have engaged in more body-awareness activities, such as mindfulness or meditation, they might have tolerated inner states discomfort more effectively. However, it would not necessarily translate into a better experience with HSA across various training contexts. Consequently, training institutions may consider introducing the concept of HSA (comparatively with self-awareness) to beginning trainee counsellors during their preparatory stage. This is due to the fact that trainee counsellors would naturally encounter more novice stressors once the course begins, making them more susceptible to HSA. Furthermore, it may be beneficial for training institutions to offer trainee counsellors a comprehensive list of resources aimed at addressing their HSA concerns. These resources could include guidance on effective coping strategies, such as mindfulness techniques or self-reflection exercises, to help them manage and

mitigate HSA moments. Additionally, providing information on available support services within the institution, such as counselling or peer mentorship programmes, can offer trainee counsellors avenues for seeking assistance and guidance when needed. Training institutions may consider incorporating self-awareness (both self-awareness as a trait and self-awareness as a state like HSA) into the counselling curriculum. By integrating self-awareness throughout the curriculum, trainee counsellors would learn to relate to themselves with self-compassion in order to cultivate their self-awareness trait. HSA moments may permeate across various training contexts, and for trainee counsellors whose stable counsellor characteristics made them more susceptible to novice stress may experience more intense HSA moments. Training institutions may consider screening trainee counsellors for mental health related concerns, ensuring confidentiality and non-discrimination, and integrating specialised modules on inner states awareness and HSA in multiple contexts. This may reduce the possibility of nondisclosure from trainee counsellors due to the nature of HSA.

7.5.3 Supervisors: Supporting HSA Experience

Supervision in counsellor education focuses predominantly on the clinical aspects of trainee counsellors' development and places less emphasis on their inner state experiences. Extensive literature, however, supports the critical role that a supervisor plays in the development and growth of a trainee counsellor, particularly the supervisor-supervisee working alliance that provides a secure environment for trainee counsellors' disclosure of clinical issues.

The dual role of a supervisor as a gatekeeper (or assessor) and a mentor causes confusion and inner conflict amongst trainee counsellors, especially those with

competence-related HSA. Despite this, supervisors are still responsible for fostering a positive supervisory working alliance with their supervisees. A trainee counsellor who experienced HSA related to a client could remain silent even with a positive supervisory working alliance. However, a negative supervisory working alliance would almost certainly lead to nondisclosure. Therefore, supervisors are encouraged to prioritise building a working relationship with their supervisees and agreeing on what to collaborate on during supervision. In addition, supervisors might consider serving as models for appropriate self-disclosure of clinical difficulties and promoting HSA literacy among trainee counsellors. The ability to articulate one's thoughts, emotions, and bodily sensations may not be comfortable for trainee counsellors, particularly those who have been taught since childhood to repress uncomfortable inner states.

On the subject of summative and formative assessments, supervisors might provide trainee counsellors with clearer guidelines on the primary function of supervision and openly address the dual role of mentor and assessor. By openly acknowledging this dual role, both supervisors and trainee counsellors can foster a collaborative and transparent supervisory dynamic characterised by mutual respect, trust, and constructive feedback. At the same time, acknowledging the nature of dual role b underscores the importance of maintaining accountability, professionalism, and adherence to ethical standards within the supervisory relationship. While it might not completely alleviate trainee counsellors' concerns about their performance, it might encourage those trainee counsellors who are anxious about receiving a poor evaluation but struggled with HSA experience to bring their HSA moment up during supervision. Most importantly, preparing trainee counsellors ahead of their summative assessment

would preclude supervision from becoming a context for HSA. In an effort to help trainee counsellors make meaning of their HSA moments, supervisors might purposefully provide trainee counsellors with opportunities to reflect on their HSA moments during supervision. With this knowledge, supervisors could assist trainee counsellors in tuning into their inner states and learning how to use "felt sense" awareness as a form of "clinical voice". This would correlate with the training outcome of fostering self-awareness in trainee counsellors, through HSA, to guide therapeutic work.

7.5.4 Practical Implications for Trainee Counsellors: Embracing HSA Experience

According to Larson (1998), trainee counsellors are human agents “constructing and regulating her or his actions while taking in feedback from his supervisor and client” (p.219). Self-reflection allowed trainee counsellors who struggled with HSA to comprehend their HSA experience. Self-reflection is the primary determinant of whether a trainee counsellor would reexperience the same HSA moment multiple times, become highly entrenched in one behaviour (such as withdrawing from participation), or learn from the HSA moment in such a way that either cognitive or affective meaning structures were changed (Boyd & Fales, 1983). Several participants in the study interpreted their HSA moments to be related to their negative past experiences. Therefore, trainee counsellors who experienced HSA moments might have some form of "woundedness" in their past. The concept of “wounded healers” refers to individuals in the helping professions (e.g., counsellors, therapists, social workers) who have personally experienced significant emotional or psychological challenges, trauma or adversity (Coaston & Lawrence, 2022; Dickeson & Smout, 2018; Straussner et al.,

2018). These individuals draw upon their own experiences of pain and suffering to support and develop a deeper understanding and connection with their clients. Hence, engaging in reflective or experiential learning could facilitate the process of shifting from one perspective to another while expanding self-awareness that contributes to their growth and transformation.

Trainee counsellors may wish to develop the habit of journaling about their training experiences, particularly those that elicited analogous HSA discomfort. Journaling during training would allow trainee counsellors to recognise recurring thoughts, emotions, or physiological sensations that are context-specific. Trainee counsellors may determine what to do with the information; do nothing, seek supervision, or undergo personal therapy. From the angle of personal agency, even if trainee counsellors had decided not to seek support and to maintain as status quo for the time being, it would be a deliberated decision made with self-knowledge. Hence, it would be assumed that they might be less vulnerable to HSA and more receptive to receiving support should similar HSA moments recur. Using modern technology, trainee counsellors may engage in more creative ways of self-reflection such as keeping a digital diary, doodle journal, voice journal or using journal apps. The benefits of leveraging technology to journal training experiences may extend beyond self-reflection; they may often release stress and enhance creativity.

Trainee counsellors may wish to disclose HSA struggles to their supervisors. While the fear of being evaluated is understandable, trainee counsellors who disclose clinical concerns are frequently viewed in a more favourable light than those who compromise the client's safety. Perhaps one way to ameliorate the situation would be to

present HSA through the lens of self-compassion; experiencing HSA as a human experience and adopting a balanced perspective to observe one's thoughts and emotions with openness and clarity. From the lens of the Social Cognitive Model of Counselor Training (SCMCT, Larson, 1998), trainee counsellors may reframe the HSA moment as an opportunity for growth and appreciate how the triadic reciprocity works in favour of them becoming efficacious counsellors.

To support the provision of effective training outcomes, trainee counsellors may consider personal therapy to address personal issues like conflicts within their family of origin, cultural biases, and unresolved issues in adulthood. While personal therapists may not be fully aware of specific HSA moments that their clients experience during their training, they can provide trainee counsellors with a safe space to explore and make sense of their HSA moments outside the training contexts. This would reduce trainee counsellors' fear of being evaluated or re-experiencing HSA moments in supervision. In addition, trainee counsellors may gain an understanding of the enduring traits that constitute their stable counsellor characteristics which can heighten their vulnerability to anxiety such as HSA. Trainee counsellors may learn to cultivate self-compassion and prioritise self-care practices to develop empathic attunement within themselves. This inter-connectedness not only enhances their capacity for empathy but also fosters resilience and empower trainee counsellors to navigate the challenges of training while embracing their stable counsellor characteristics.

The findings from this study have significant practice implications for trainee counsellors in managing HSA moments and potentially utilising HSA as a form of clinical intuition or modelling authenticity with specific clientele. The concept of

clinical intuition and authenticity in counselling has been explored in prior studies (Matise, 2015; Peace & Smith-Adcock, 2018; Witteman et al., 2012). Participants in the study reported increased sensitivity to the nuances of clients' emotions and behaviours due to their prior HSA encounters. They were able to trust their "gut feelings" more in attuning to clients' emotions and were more genuine and congruent with themselves and others. Utilising both clinical intuition and authenticity can foster trust and openness during sessions, allowing clients to feel safe and understood, which is well-established in counselling literature for counsellors to create a safe space (Interiano-Shiverdecker et al., 2024; Mori, 2018; Rogers, 1967, 2007).

Novice counsellors can utilise HSA moments as tools to develop self-awareness and empathy when working with clients experiencing high level of stress and anxiety. Experienced counsellors can leverage their understanding of HSA, based on their enhanced conceptual maps with prior HSA experiences, to model vulnerability and authenticity with clients facing self-esteem or performance issues. For example, a counsellor working with clients who have experienced adverse childhood experiences might share their own strategies for managing anxiety, thereby normalising clients' emotions and demonstrating that experiencing childhood adversities, though challenging, could led to growth. By incorporating HSA intentionally and appropriately into their clinical practice, both trainee counsellors and experienced counsellors can enhance their professional and therapeutic effectiveness, ultimately resulting in better client outcomes.

7.6 Recommendations for Future Research

The longitudinal QUAL-Quant that focused on trainee counsellors' HSA provides valuable insights into the dynamic process of self-awareness development, in particular the negative valence of self-awareness, within the context of counselling training. To advance the field and contribute to the existing knowledge, several recommendations for future research emerge from this study.

Firstly, it is imperative to investigate HSA for the general population of trainee counsellors. Participants in the current study were screened for HSA to ensure that they had a minimum mean score of 2.3 on the Self-Awareness and Management Strategies Scales (SAMS, Williams, Hurley, et al., 2003) in order to be included. The rationale was to ensure that potential trainee counsellors would have prior HSA moments to share. However, the screening requirement was not a criterion for prior studies on self-focused attention (Fauth & Williams, 2005b; Wei et al., 2015, 2017; Williams, Hurley, et al., 2003). In the current study, IPA findings drew parallels between participants' HSA moments to other studies such as a defining moment (Coll et al., 2019) or critical incidents (Furr & Carroll, 2003; Howard et al., 2006) which could elicit anxiety. As HSA moment is a specific type of anxiety that is commonly experienced like a defining moment or a critical incident among trainee counsellors owing to their developmental level, shedding light on this aspect will be useful. Therefore, future research of similar designs on trainee counsellors who score below the minimum requirement in this study would provide valuable information regarding the prevalence of HSA among trainee counsellors. Alternatively, quantitative longitudinal research with a larger sample would yield more generalisable findings.

Secondly, the current study adopted the SAMS (Williams, Hurley, et al., 2003) which was the only instrument available at the point of research. The survey which was meant for in-session was adapted to include supervision and coursework setting. Current findings reported that experiential learning such as lecture-discussion, peer role-play, and group activities (i.e., the coursework component) elicited more HSA moments for some participants. Therefore, it is important to validate and establish the reliability of the SAMS before making any modifications or adaptations. Since the current study has established a good Cronbach alpha (refer to Appendix L) for the adapted survey, future studies may consider retesting to confirm reliability. This research could inform the optimisation of the SAMS to ensure rigour and integrity.

Lastly, future research could address how HSA differs across different cultural groups or trainee counsellors with different sexual orientations to explore other dynamics that could affect how the HSA moment is experienced or interpreted. The "hindering self-awareness" or "hindering self-focused attention" may have different interpretations across different cultures. Studies have established that the Asian culture is more reserved and collectivistic and therefore may perceive HSA as a personal characteristic and something to be "fixed" or "hidden" like shame (Ha, 1995; Taylor et al., 2004). As a result, this may affect how participants would share their personal experiences due to cultural norms or social desirability. This research would enhance the cultural competence of counsellor training programmes and contribute to the development of more inclusive and effective pedagogical strategies.

7.7 The Study Limitations

7.7.1 The IPA Data Collection Process

The term “hindering self-focused focus attention” was replaced with “significant experience” during interviews to elicit participants’ HSA stories. The rationale behind this was to ensure that no element of bias would be introduced unintentionally that could have contradicted IPA’s principles; and to remain open and flexible for participants to make sense of their experiences (i.e., HSA moments). The consideration to use a more neutral term during interviews was based on cultural sensitivity and considerations. The word “hindering” may carry implicit connotations and influence participants’ responses considering the diverse backgrounds of the participants. This approach ensured that the interview setting remained non-judgemental and safe, and the researcher could establish rapport with participants throughout the interview. However, there might be a concern that by being too liberal on “significant experience”, participants could have provided more memorable events that evoked more intense emotions. Therefore, a way to overcome the limitation was to have participants journal their HSA moments monthly while at the same time ensuring that participants’ stories were collected from different sources to provide a more comprehensive understanding of HSA.

7.7.2 Maintaining Inductive with a Longitudinal Design

IPA is a qualitative methodology that purports to offer a relatively inductive approach to the analysis of the findings in order to reveal the subjective meanings of trainee counsellors’ HSA moments. As any human phenomenon is understood to be dynamic and a longitudinal study has made it possible to examine the HSA of trainee counsellors over 18 months. However, it has been difficult to maintain an inductive approach throughout the entire study due to the researcher's prior knowledge of the topic and her personal HSA moments during counsellor training. Consequently, the use of a reflective diary allowed for a reflexive approach that served as a personal check against

any potential threats posed by the researcher's personal biases to influence data analysis. In addition, the researcher underwent three rounds of bracketing interviews (prior to the first interview, prior to the second interview, and after data analysis) with an independent clinical supervisor throughout the entire research journey in order to identify personal assumptions and preconceptions that could introduce bias into data analysis (Rolls & Relf, 2006).

Familiarity with the participants might also be a cause for concern in a longitudinal study. Quantitative studies encourage researchers to remain anonymous to participants, whereas qualitative studies, such as longitudinal IPA studies, encourage researchers to introduce themselves to participants in order to create a safe environment in which participants can share their experiences. Therefore, there is a possibility that study participants provided information based on what they believed the researcher wished to find. The analysis of data would then be affected by participants' response bias. In addition, the trainee counsellors recruited for the current longitudinal study might feel obligated to "assist" the researcher in obtaining the research findings, given that there is an element of power differential between the trainee counsellors and the researcher. Considering all of these factors, the researcher engaged in active memoing and maintained professional boundaries throughout the entire research process. The researcher participated in regular research consultations with two academic advisors and underwent personal supervision to guide ethical work. The researcher also included a subjectivity statement to acknowledge the influence of her own opinions and potential biases on the study.

7.7.3 Interpretation of Data

One of the criticisms inherent to qualitative research methods such as IPA is the subjective nature of interpretation, which suggests that the researcher's final account lacks validity. In contrast to a quantitative study, it is not in the best interests of the IPA study to provide findings of a singular truth. Data triangulation, member-checking by participants on their transcripts and cluster of themes after data analysis, and independent checks of the data by the PhD supervisor who is familiar with the IPA methodology and has had already a few IPA publications all contribute to the trustworthiness of a qualitative study.

Lastly, it should be acknowledged that the quantitative data intended to complement the IPA study could have been accorded greater weight. This could have been accomplished by following different cohorts of trainee counsellors and investigating the relationships between HSA and other variables (such as supervisory working alliance and counselling self-efficacy) as a traditional quantitative study would. Having a quantitative study group does not lessen the significance or idiographic nature of IPA research; rather, IPA maintains its interest in the variability and diversity of human experience, as well as its search for convergences and divergences among a set of accounts.

7.7.4 Measures and Methodology

The measure of HSA (SAMS; Williams et al., 2003) relies on self-reported data, which can be influenced by various factors, such as social desirability and retrospective bias. Trainee counsellors may underreport their HSA frequency to present themselves in a more favourable light or overreport them if particularly intense moments are more vividly recalled. These biases can significantly affect data analysis and interpretation, making it challenging to obtain an accurate representation of HSA frequency. This

challenge extends to measures of SWA (BSWAI-T; Sabella et al., 2020) and CSE (SMSE; Lent et al., 2003). Additionally, the HSA measure may not fully capture the nuanced and dynamic nature of HSA. For example, the frequency and intensity of HSA moments can vary widely. For example, one trainee counsellor might experience HSA frequently in supervision and not class activities, while another might have the opposite experience. Hence, the measure may not be sensitive enough to account for these variations, leading to incomplete understanding of HSA. Therefore, gathering data form another source is recommended.

Another methodological limitation is the temporal aspect of measuring HSA. Longitudinal studies track trainee counsellors over extended periods and are often challenging to implement, resulting in smaller sample sizes. Despite the focus of the current study being IPA-focused, integrating qualitative and quantitative methods poses practical challenges, including the need for extensive time and expertise to analyse qualitative data, not to mention that qualitative findings are often context-specific and therefore, not easily generalisable.

7.8 Using IPA in This Research Project

The utilisation of IPA as a research methodology in understanding trainee counsellors' HSA is grounded in the principles of phenomenology (J. A. Smith & Osborn, 2008). IPA focuses on exploring and interpreting the lived experiences of individuals to gain a deeper understanding of their subjective realities. In the context of understanding trainee counsellors' HSA moments, IPA provides a nuanced exploration of the intricate and personal aspects of trainee counsellors' HSA, illuminating their unique challenges, valuable insights and meaning making of their HSA. A longitudinal

IPA research project has facilitated a broad and detailed account of the participants' experiences, giving voice to their unique HSA moments.

IPA studies advocate for a reflexive approach which is an integral part of phenomenological research, emphasising the researcher's self-awareness and reflexivity throughout the research process (J. A. Smith et al., 2009). This approach acknowledges that the researcher plays an active role in shaping the interpretation of participants' experiences, and therefore encourages the researcher to explore their own biases, assumptions, and preconceptions (Eatough & Smith, 2008). One of the main issues throughout this project was a lack of guidelines about how to manage preconceptions and biases while the researcher is actively involved in the research process. Smith et al. (2009) recommended the researcher to practise reflexivity while at the same time recognising the challenges to remain inductive.

Pertaining to the current study, the researcher reflected on her perspectives and how they might influence the interpretation of the participants' accounts. This self-awareness has allowed for a more nuanced understanding of the dynamic interplay between the researcher and her participants while coming together in the hermeneutic circle, co-constructing meaning.

7.9 Chapter Conclusion

This study has shed light on the trainee counsellors' lived HSA moments during their training. HSA interpretations shifted from being unpleasant and challenging in the beginning stage to being more nuanced and tolerable in the advanced stage. The research revealed that HSA as a specific type of anxiety was found to be pervasive across various training contexts. Notably, trainee counsellors' stable counsellor characteristics and the

presence of HSA moments were found to impact triadic reciprocity. The study encouraged training institutions, supervisors, and trainee counsellors themselves to approach HSA moments with a renewed perspective within the broader context of the Social Cognitive Model of Counselor Training in the development of trainee counsellors.

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APPENDICES

A. Invitation Letter

JAMES COOK UNIVERSITY AUSTRALIA

Invitation Letter to Participants

Dear Graduate Certificate/Diploma Students of ECTA,

Introduction of Research Project Prior Recruitment
My name is Catherine, and I am currently enrolled as a doctoral student at James Cook University in Singapore. I am working on a research project titled A Longitudinal Mixed Methods Study on Trainee Counsellors' Self-Awareness Experiences.

Beginning counsellors frequently encounter novice stress during their training, and the benefits of self-awareness in assisting trainee counsellors in coping with novice stressors are well established. However, self-awareness like any human phenomena is unlikely to remain static over the course of training and whether there are any downsides to self-awareness is less well-understood. My study aims to address this gap.

To fully understand this phenomenon of self-awareness, I am seeking 12 participants to follow up over the course of training. As part of the study, you will be asked to participate in two face-to-face interviews and complete monthly surveys and brief journals. It is hoped that understanding how self-awareness changes over time, and if there are any downsides to self-awareness, will inform practices in clinical supervision and counsellor training.

To express my heartfelt gratitude, you will receive cash as token of appreciation for the invaluable time and effort you contribute to this purposeful project. Each Participant will receive S$5 for each monthly survey, S$7 for each monthly journal, and S$50 for each interview. Please see the Participant Information Sheet for more details about participation.

Meanwhile, if you have any questions for me about my study before recruitment, please contact me at muihua.toh@my.jcu.edu.au

B. Information Sheet

JAMES COOK UNIVERSITY
AUSTRALIA

INFORMATION SHEET

PROJECT TITLE: A longitudinal mixed methods study exploring trainee counsellors' self-awareness experiences

You are invited to take part in a research project about trainee counsellors' self-awareness experiences during counsellor training program.

Beginning counsellors frequently encounter novice stress during their training, and the benefits of self-awareness in assisting trainee counsellors in coping with novice stressors are well established. However, self-awareness like any human phenomena is unlikely to remain static over the course of training and whether there are any downsides to self-awareness is less well-understood. My study aims to address this gap. It is hoped that understanding how self-awareness changes over time, and if there are any downsides to self-awareness, will inform practices in clinical supervision and counsellor training.

The study is being conducted by Mui Hua Catherine Toh and will contribute to the completion of Doctor of Philosophy (Health) at James Cook University, Singapore.

This study is open to student counsellors who are enrolled into Executive Counselling and Training Academy (ECTA), an SAC recognised institution and meet the following three selection criteria:

1. Have counselling practicum experience (including peer roleplay),
2. Have clinical supervision experience,
3. Met the screening survey requirement.

If you agree to be involved in this 16-month qualitative study, you will be asked to complete monthly surveys, journals and be invited to be interviewed at the beginning and advanced stage of the counsellor training program.

a) Each monthly survey and journal should only take 15 minutes to complete. The survey includes questions about your self-awareness experiences during clinical sessions, supervision, and coursework training. And in the journal, you will be asked to reflect upon an experience that was significant for you.
b) The interview is conducted via either face-to-face or zoom online depending on the local Safe Management Measures implemented during the Covid-19 pandemic. The interview, with your consent will be audio-recorded, and should take approximately 1 to 1.5 hour of your time. The face-to-face interview will be conducted at James Cook University Singapore. Date and time of interview will be mutually agreed upon.
c) There is also a demographic questionnaire and informed consent form that you will be requested to complete at the start of the study and prior to each interview, respectively.

The interviews will be audio-recorded and transcribed verbatim. No personal identifiers will be stored together with the interview data. Direct quotes from the interview and data from the questionnaires may be used in the thesis write-up and for any further research reports or papers that may be submitted for publication or presentation in an academic journal or conference. The data and quotes used on these platforms will not be

identifiable in any way. This includes any identifying information such as geographic locations or unique events. These will be removed and replaced with a generic descriptor. Only the principal investigator and her advisors will have access to the data. Recommendations will be shared with counselling institutions in support of counselling program.

Taking part in this longitudinal study is completely voluntary and you can stop taking part in the study at any time without explanation or prejudice. Participation in this study is entirely separate from your counselling training and participation or non-participation will not affect your training outcomes. If you decide to withdraw from the study, we will destroy all your data and not use any data collected up to your withdrawal. After the study is completed, audio-recordings of the interview will be destroyed. The data collected from the interviews and questionnaires will be kept for five years after publication. If there are no publication results from this research, the research data will be destroyed five years after the completion of the research.

You will receive cash as a token of appreciation for the invaluable time and effort you contribute to this purposeful project. This research is important as counsellors is often a resource clients utilise in their healing journey and with your participation, it is hoped that understanding how self-awareness changes over time, and if there are any downsides to self-awareness, will inform practices in clinical supervision and counsellor training.

As the study involve you sharing your personal experiences, you may experience distress during interview or journaling. In the event that it occurs, you can either withdraw from the study, seek counselling at the site, or external support from a list provided during interview. The list of external support is also provided in the table below:

Description	Hotline Number
1. Brahm Centre Assistline (Phone counselling)	6655 0000
2. Singapore Association for Mental Health Hotline (Mental health hotline)	1800 283 7019
3. Hear4U (Counselling via Whatsapp voice/text)	6978 2728
4. Shan You Yuan Yuan Helpline (Phone Counselling)	6741 0078
5. The Senior Helpline (SAGE) (For anyone aged 50 and abv OR anyone who wants to enquire about issues related to older persons – counselling)	1800 555 5555
6. Sage Counselling Centre (Various resources for seniors, including helplines and face to face counselling)	6354 1191
7. Care Corner Counselling Centre Hotline for the Mandarin–speaking community with family, marital or personal problems.	1800 353 5800

8. https://www.msf.gov.sg/dfcs/familyservice/default.aspx (Family service centre locator for counselling services)	-

If you have any questions about the study, please contact - **Mui Hua Catherine Toh and/or Dr Joanna Barlas.**

Principal Investigator:
Mui Hua Catherine Toh
College of Healthcare Sciences:
James Cook University
Email: muihua.toh@my.jcu.edu.au

Supervisor:
Dr Joanna Barlas
College of Healthcare Sciences:
James Cook University
Phone:
Email: Joanna.barlas@jcu.edu.au

If you have any concerns regarding the ethical conduct of the study, please contact:
Human Ethics, Research Office
James Cook University, Townsville, Qld, 4811
Phone: (07) 4781 5011 (ethics@jcu.edu.au)

C. Informed Consent

This administrative form has been removed

D. Recruitment Poster

RECRUITMENT POSTER

A longitudinal mixed methods study exploring trainee counsellors' self-awareness experiences

Participants needed

You are invited to take part in a longitudinal research project exploring trainee counsellors' self-awareness experiences during your course of training. The study is being conducted by Catherine Toh and will contribute to her research thesis in Doctor of Philosophy (Health) at James Cook University, Singapore.

Participants Requirements:

- Graduate-Certificate student enrolled in 2-Year Professional Counselling Program recognised by SAC,
- Possess counselling AND supervision experiences,
- Meet the screening requirement.

Token of Appreciation:

- S$5 per survey; S$7 per journal; S$50 per interview.

You will be invited to:

- Provide informed consent, demographic information, and email address
- Complete monthly survey (5mins),
- Complete monthly journal (10mins),
- ZOOM* online interview of 1 to 1.5 hours, once during Graduate-Diploma Stage and once during Advanced Stage.

**Face-to-face can be arranged depending on Safe Management Measures implemented due to Covid-19 pandemic.*

Your response is kept strictly confidential. If you have any questions about the study or would like to participate, please contact:

Principal Investigator, Mui Hua Catherine Toh (Ms) of James Cook University, Singapore, email muihua.toh@my.jcu.edu.au

E. JCU Ethics Approval H8579

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F. Interview Schedule (Beginning Stage)

SEMI-STRUCTURED INTERVIEW SCHEDULE

Steps:

1. Obtain verbal informed consent, emphasise confidentiality of interview
2. Completion of demographic survey and informed consent form
3. Conduct interview (upon participant's agreement, start recording on Zoom)

Introduction

Thank you for participating in this interview. As mentioned in the informed consent form, what you say during the interview will be kept confidential, and no names will be linked to the interview data. The purpose of this interview is to explore your self-awareness experiences during your counselling training program in Singapore.

During the interview, you may hear the term "Significant experience". It refers to a particular event that occurred during your counselling session with a client, or during supervision with your supervisor, or while attending a particular coursework training session at the counselling institution. In response to this event, you experienced strong emotions, deep thoughts, or took notice of your actions or reactions that were either uncomfortable or troubling, or that you wished had not occurred or that you could have reacted/responded differently. For example, during a classroom activity, you noticed your heartrate increased and started to feel a bit nervous and worried that your contribution would be judged.

I will be asking you some in-depth personal questions regarding these significant experiences. Please do not feel the urge to answer the questions immediately as you may

need time to think and reflect upon some of the questions. In the event that happens, just let me know and it is okay for me to wait.

If at any time you do not feel comfortable in answering any of the questions, please do not hesitate to let me know and we can skip the question and move on to the next one. Do you have any questions for me before we begin? May I start recording?

Press RECORD

Interview Questions

Warm Up Questions

What brought you in to the counsellor training program?

What aspects of the training program are you enjoying?

What aspects of the training program that you find challenging?

1. Please share with me a significant experience that occurred during your time as a counsellor (if trainee mentioned non-HSA related, go to (a))
   a) Were they any negative experiences during your time as a trainee counsellor?

2. How did you react in this significant experience?
   a) What were your thoughts, feelings, and actions?
   b) Were there any times when such thoughts between your thoughts, feelings, and actions did not align?
   c) How did you cope with these differences between your thoughts, feelings, and actions?
   d) How did you reconcile with these differences between your thoughts, feelings, and actions?

3. How did these differences between your thoughts, feelings, and actions impact your (context such as in-session, supervision, or coursework)? For example were there any consequences whether you choose to ignore or attend to these differences?

4. What were your thoughts, feelings, and actions after that significant experience?
    a) What did you do, want to do, or feel like doing after this significant experience?

5. How easy or difficult was it for you to make these decisions?

6. What did you think or feel helpful for you in this significant experience? (if participant only share positive information, then proceed to (a))
    a) What about some of things that were unhelpful?
    b) How did your past experiences beyond your counsellor training influence on the way you reacted or dealt with this situation? (for example, before the participant join counsellor training, when he/she was young, or current experiences)
    c) How did your past experience beyond counsellor training impact on the way you reacted or dealt with this situation?
    d) Do you have a word or a phrase to describe this significant experience?

7. How did this significant experience impact your understanding of yourself? (Though IPA does not talk about future, this question 6 shall become the 'past' of participant's second IPA interview, thus provide a connection point between present and past, and meaning making of past in the present)
    a) How did this understanding of yourself prepare you for advanced stage?
    b) With this understanding about yourself, what are some concerns that you may have progressing further in counsellor training?
    c) Do you have a word or a phrase to describe the way you see yourself at this current stage?

Conclusion

This is the end of the interview. I really appreciate your time and sharing.

- How has it been like for you to share about your experience?
- Do you have anything you would like to add?
- Do you have any questions for me?

Again, everything you shared will be kept confidential and I will email you as mentioned in the informed consent for member-checks without any identifiers. Thank you so much!

Press STOP

G. Interview Schedule (Advanced Stage)

SEMI-STRUCTURED INTERVIEW SCHEDULE

Steps:

1. Prepare tissue in advance if face-to-face interview. Obtain verbal informed consent, emphasise confidentiality of interview
2. Completion of demographic survey and informed consent form
3. Conduct interview (upon participant's agreement, start recording on Zoom)

Introduction

Thank you for participating in this interview. As mentioned in the informed consent form, what you say during the interview will be kept confidential, and no names will be linked to the interview data. The purpose of this interview is to explore your self-awareness experiences during your counselling training program in Singapore.

During the interview, you may hear the term "Significant experience". It refers to a particular event that occurred during your counselling session with a client, or during supervision with your supervisor, or while attending a particular coursework training session at the counselling institution. In response to this event, you experienced strong emotions, deep thoughts, or took notice of your actions or reactions that were either uncomfortable or troubling, or that you wished had not occurred or that you could have reacted/responded differently. For example, during a classroom activity, you noticed your heartrate increased and started to feel a bit nervous and worried that your contribution would be judged.

I will be asking you some in-depth personal questions regarding these significant experiences. Please do not feel the urge to answer the questions immediately as you may need time to think and reflect upon some of the questions. In the event that happens, just

let me know and it is okay for me to wait. I may be taking some notes that I might want to come back to you later.

If at any time you do not feel comfortable in answering any of the questions, please do not hesitate to let me know and we can skip the question and move on to the next one. If you do feel distressed, I may stop the interview to check in with you to make sure that you are okay. You may take a break, stop the interview, or withdraw from the study.

Do you have any questions for me before we begin? May I start recording?

Press RECORD

Interview Questions

Warm Up Questions

How has the advance stage of training been for you?

What have been interesting?

What have been challenging?

More general way of approaching:

I asked everyone to speak about their significant experience during the beginning stage of training. Some spoke about their significant experience in supervision and practicum, while others talked about coursework like peer role-play, lecture, and group discussion. In this second interview, I would like to learn more from you about your significant experience during the advance stage of training.

As a start

1) In the current advance stage, can you give me another recent significant experience?
    a. How did you feel?
    b. How did you think?

   c. How did your body react to these feelings/ thoughts?
   d. In what ways are these reactions the same?
   e. In what ways are these reactions different?

2) In the first interview, you spoke about (prompt experience).
   a. In what ways are your reactions to the recent experience similar with the previous experience?
   b. In what ways are your reactions to the recent experience different from the previous experience?
   c. How have your perceptions changed? Reactions, thoughts, feelings, interpretations
   d. How have your reactions changed?
   e. How have your thoughts/feelings changed?
   f. How have your interpretations changed?

3) In the current training stage, how are memories of your childhood experiences affecting your training?
   a. How do you perceive these memories now?
   b. How are you feeling now while talking about them?
   c. What are your thoughts now as you mention about them?
   d. In what ways are these reactions the same as compared to the first time we spoke about them?
   e. In what ways are these reactions different as compared to the first time we spoke about them?

4) As the advance training is coming to an end in a few months' time, do you think you observe any changes in how you see yourself now as a counsellor in how you responded in your significant experience?
   a. How are these perceptions of yourself helpful in your professional counsellor role?
   b. How are these perceptions unhelpful?

5) Looking back to your "old self (mine words)" (either HSA triggered self/childhood self), what do you want to tell your old self?
   a. How do you think the old self might respond?
   b. What else would the old self be telling you now that you are going to be a professional counsellor?
   c. Do you have a word/metaphor to describe this journey that the old self has taken?

Conclusion

This is the end of the interview. I really appreciate your time and sharing.

How has it been like for you to share about your experience?

Do you have anything you would like to add?

Do you have any questions for me?

Again, everything you shared will be kept confidential and I will email you as mentioned in the informed consent for member-checks without any identifiers. Thank you so much!

Press STOP

H. Journal Prompt

UNIQUE CODE

M1

Journal Reflective Prompts

Dear participant, in this brief journal, you are being asked to reflect on a significant experience that occurred during your counselling training. You may want to use the prompts below to guide your reflection.

Significant experience refers to a particular event that occurred during your counselling session with a client, or during supervision with your supervisor, or while attending a particular coursework training session at the counselling institution. In response to this event, you experienced strong emotions, deep thoughts, or took notice of your actions or reactions that were either uncomfortable or troubling, or that you wished had not occurred or that you could have reacted/responded differently. For example, during a classroom activity, you noticed your heart rate increased and started to feel a bit nervous and worried that your contribution would be judged. (No word limit but you might aim for 200-300 words)

1. Where did this significant experience occur (In-session with client, during supervision or coursework training)?

2. How would you describe this significant experience?

3. Give a brief description of the background or context of this significant experience.

4. What were your feelings and thoughts when you had this significant experience?

5. What were your immediate reactions then?

6. How helpful/unhelpful was it when you reacted this way?

7. How would you react differently now?

8. What have you learnt from this significant experience?

I. Survey Battery

Trainee Counsellors Self-Awareness Survey - M18+Demo

Start of Block: INTRODUCTION

INTRODUCTION You are invited to take part in a research project to investigate trainee counsellors' self-awareness experiences during counsellor training. The survey will take about 10 minutes to complete. You will receive a token of appreciation of S$5 for your time.

End of Block: INTRODUCTION

Start of Block: INFORMED_CONSENT

Consent I understand the aim of this research study is to investigate trainee counsellors' self-awareness during the counsellor training program. I understand that my participation is voluntary. By clicking the "Yes" button, I consent to take part in this survey. By clicking the "No" button, I do not wish to take part in this survey.

O YES (1)

O NO (2)

Skip To: End of Survey If I understand the aim of this research study is to investigate trainee counsellors' self-awareness... = NO

End of Block: INFORMED_CONSENT

Start of Block: Code

Code Please enter your assigned verification ID provided.

_____

End of Block: Code

Start of Block: DEMO

Gender What is your gender

- O Male (1)
- O Female (2)
- O Indeterminate (3)
- O Intersex (4)
- O Unspecified (5)

Age What is your age?

_____

Marital Status What is your marital status?

- O Single (1)
- O Married (2)
- O Divorced (3)
- O Widowed (4)
- O Separated (5)

Race What is your race?

- O Chinese (1)
- O Malay (2)
- O Indian (3)
- O Others (4)

Educ What is your highest attained educational level?

- O Pre-U/ 'A' Levels (1)
- O Polytechnic Diploma (2)
- O University Degree (3)
- O Masters Degree (4)
- O Professional Degree (MD, DDS, JD) (5)
- O Doctorate (PhD) (6)

BegSup Was your GD clinical supervisor same as GC?

- O Yes (1)
- O No (2)

AdvSup Was your MS clinical supervisor same as GD?

- O Yes (1)
- O No (2)

End of Block: DEMO

Start of Block: IMPSA

Q1 Please rate the degree to which you agree with each statement.

	Strongly disagree (1)	Somewhat disagree (2)	Unsure (3)	Somewhat agree (4)	Strongly agree (5)
Self-awareness is important for trainee counsellors. (1)	C	O	C	O	C
Self-awareness has been included in the counsellor training program. (2)	C	O	C	O	C
Self-awareness has an impact on my counselling self-efficacy. (3)	C	O	C	O	C

End of Block: IMPSA

Start of Block: SA10

1 How frequently do you have thoughts about your performance or abilities as a therapist during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

2 How often do you become aware of feeling anxious during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

3 How often do you experience awareness of negative self-talk (e.g. self-critical thoughts, distracting thoughts during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

4 How often do you experience moments of heightened self-awareness (e.g. moments when you become increasingly aware of your thoughts, feeling overwhelmed or feeling the desire to yawn, etc.) during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

5 How often does your self-awareness feel more like self-consciousness (e.g. negative or critical concerns about yourself, what you said, or your physical self, such as needing to sneeze) during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

Page Break

6 How often do you become aware of your physical self during a session (e.g. nodding your head, smiling, laughing, crying, tension, hand movements) during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

7 How often do you become aware of thinking about issues unrelated to the client or supervisor or lecture (e.g. outside stressors, needing to return a phone call, paperwork, etc) during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

8 How often do you find that your self-awareness (e.g. pulls your attention from the client or supervisor or lecturer, causes you to feel upset or distracted) is hindering during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

9 How frequently do you experience self-awareness that you feel distracts you from what your client or supervisor or lecturer is saying or doing (e.g. when a client or supervisor or lecturer says something that reminds you of an issue in your own life or of something about another client or supervisor or lecturer) during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

10 How often do you feel that your thoughts and reactions have interfered with your performance as a therapist or supervisee or student (e.g. you “tuned out” and didn’t hear what your client or supervisor or lecturer just said) during your:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
a) therapy session (1)	C	C	O	C	C
b) supervision (2)	C	C	O	C	C
c) coursework training (3)	C	C	O	C	C

End of Block: SA10

Start of Block: BSWAIT5

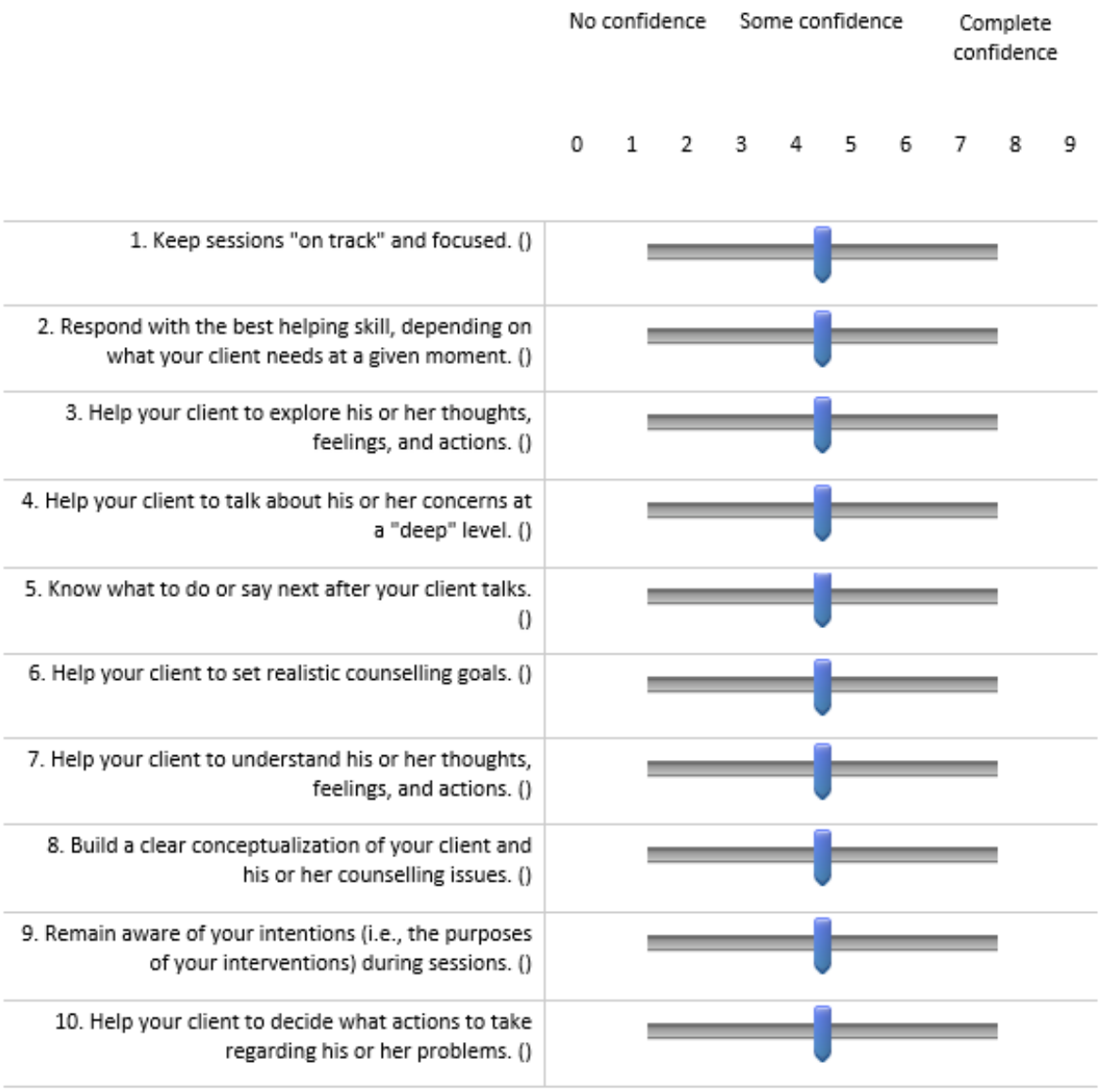
SWA Please indicate the frequency with which the behaviour described in each of the following statement seems characteristic of your work with your supervisor.

	Almost never (1)	Very seldom (2)	seldom (3)	Occasional (4)	Frequent (5)	Very frequent (6)	Almost always (7)
I feel comfortable working with my supervisor. (1)	O	O	O	O	O	O	O
My supervisor welcomes my explanations about the client's behaviour. (2)	O	O	O	O	O	O	O
My supervisor treats me like a colleague in our supervisory sessions. (11)	O	O	O	O	O	O	O
I work with my supervisor on specific goals in the supervisory session. (19)	O	O	O	O	O	O	O
My supervisor's style is to carefully and systematically consider the material I bring to supervision. (18)	O	O	O	O	O	O	O

End of Block: BSWAIT5

Start of Block: CASES10

CSE Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counselling most clients.



End of Block: CASES10

Start of Block: HrsComp

Hrs In this month, what is the estimated number of hours you have spent on:

0	1	2	3	4	5	6	7	8	9	10

therapy session ()	
supervision ()	

End of Block: HrsComp

J. Poetic Evocations

During the data analysis and writing phase of my research, I discovered a deep familiarity with all the participants and their transcripts. This intimacy developed naturally as a result of the extensive time spent engaging with each individual transcript, and consequently, with the HSA experiences of each participant. However, upon writing up the findings, I recognised that much of the original material could not be included. Despite my efforts to preserve a narrative thread for each participant throughout the analysis, I knew that inevitably I had to sacrifice parts of their individual stories. Inspired by Ohlen (2003), I decided on crafting poetic evocations for each participant's HSA moments. Preceding each poem was the original text from the transcript. It is with the hope that readers will appreciate the nuanced insights revealed through this condensed narrative form.

Reference:

Ohlen, J. (2003). Evocation of meaning through poetic condensation of narratives in empirical phenomenological inquiry into human suffering. *Qualitative Health Research, 13,* 557-566

Lynn (HSA of feeling the need to please)

LYNN 07:24

Erm, I think my challenge is, depending on the, depending on the, depending on the profile of the clients, and the assumptions I make, before I actually speak to them, erm the assumptions that I have, and in my own preparation, my own thinking er, that that is a challenge, I think. Erm and it's only in the course of counselling and really talking to the clients that some of the, my assumptions, I mean, they are refuted or they are reinforced [giggle] erm and so, that is that is one of the, erm and also not allowing that not allowing those assumptions to affect the, the alliance yeah, affected the interaction, not allowing the client to become aware, I mean, not becoming too obvious with my own, like fears or anxieties…

LYNN 19:52

Is like you're very afraid to offend. You're very afraid to offend also very afraid that you will not be accepted, or there's a strong desire to be to want to be accepted. Yeah. Um, you know, children, they, I think like, as a child, you want people, you want the adults to affirm you and like you and accept you, and then talk to you. Yeah. So, at that point, I did feel like a child in that way. I wanted my client to accept me, I wanted my client to talk to me, I wanted my client to think that I, I want to talk to you. Yeah. And so that that was how I felt like, like a child or children, they, they want the adults to, "Eh come play with me, come talk to me, you know, I just want to play with you and I just want you to accept me as a child", and so I did feel that we I was very afraid of being rejected actually.

LYNN 21:39

…is it's okay to have these thoughts just don't let it affect the session too much. What I need to do in the first session is to build rapport and then ask factual information that won't deal too much with the emotions. Yeah, erm because when you start talking about things that deal with emotions, you or some things that are subjective, then then there will be more of this er dissonance and then [giggle] you, it will get worse, I feel. Yeah, because emotions are quite difficult to control and so go, just block, block it [giggle] and deal with the factual objective stuff, ask questions about the family background, you know, just go through the like step by step things, rather than allow too much rather than talk about the feelings part, and so I just have to bite the bullet and erm and just get through the discomfort and ask those subjective questions... Yeah. So things that deal with emotions or attitudes or those others I didn't, I just try to avoid la. Yeah, don't go and stir up my own biases or things that might make me express like, huh [laugh], kind of negative sort of expression or response [giggle]. Yeah. So that's, that's why how I make sense of it I think it's natural, I can't, I can't stop it. Yeah.

LYNN 08:18

Um, I mean, from that lesson, I thought about my own, I thought about how, I mean, I was just quite, I became aware, maybe not amused, but aware of how some of these automatic thoughts and statements I play my mind, it's, it's irrational. I mean, it was is it significant because they, there was just sort of an awareness like, moment of enlightenment. I mean, if that, yeah, um, you know, why do you think, you know, talking to myself, is, why do you think like that? [laugh] Why have you been thinking like that? Or why have you been responding or reacting like that is just not true? Yeah, some of these statements that play in my mind. It's related to what I've mentioned earlier about being critical of myself and how Critical Parent or Rebellious child. Yeah. So, to me that that was quite a significant point of awareness and also reflection, and I think with that, right, and then the, the, with that, with, with that awareness and that sort of point of enlightenment and a bit of amusement of myself, I also realize, I mean, I also learned about, I l also realized, eh, actually, I can do something about it and then the interventions I can use on myself also.

LYNN 12:31

The critical parent is just saying, Why are you thinking like, why are you thinking like, that is not the truth? Yeah, why thinking like that? It's not the truth.

LYNN 12:50

The child. They don't like me.

LYNN 57:15

Yeah, of course, of course it has. Yeah, definitely. Because unless it's wherever I learn is integrated with my own growth as an individual, it's a bit difficult to be authentic and genuine. I feel this personally, I feel unless I'm growing authentically. It's difficult to help someone. Yeah. Because is the therapeutic alliance, it's, it's engaged this engagement. It's just difficult to completely be a technical. It's not technical. It's not a technical thing that's happening. Like, that's, that's where, for instance, you solve your problems. Not that. Yeah. It's out of the interaction. That the genuineness. Yeah, I mean, I could, as a trained oo experience counselor, you can do have a lot of cues, you have a

bag of tools that can help them. That's okay. Right. But then I still feel that the, the depth and the authenticity, it's would be the most helpful.

LYNN 1:02:14

To describe to the child... "Is okay just let it go." (laugh)

I think my challenge is,

the assumptions I make, that is a challenge, I think.

I mean, not allowing those assumptions to affect,

the alliance, I mean.

I did feel like a child.

I wanted my client to accept me,

I wanted my client to talk to me,

Eh come play with me,

come talk to me,

I just want you to accept me,

I was very afraid of being rejected actually.

Emotions are quite difficult to control,

so just block, block it,

that's how I make sense of it,

I can't stop it.

Why have you been thinking like that?

Why have you been responding like that?

…some of these statements,

that play in my mind.

The critical parent: Why are you thinking like that?

The child: They don't like me.

Integrated with my own growth as an individual,

unless I'm growing authentically.

It's difficult to help someone.

To the child: Is okay,

just let it go.

Beatrice (HSA of fearing to be perceived as incompetent)

BEATRICE 05:42

How was it like? I would say it's a, it's a bit nerve-wrecking, like, erm because I was anxious. If, like, what happened, what would happen if I miss information? Yeah. Because, because I always think that I only have one chance like, [laugh] we can't revisit the session anymore so yeah, the first session was a lot of worries, anxiety and just feeling er overwhelmed. Yeah. [laugh]

BEATRICE 10:15

… I want to be someone who's competent enough to help someone erm because like they are sharing with us their most vulnerable times and moments so I wouldn't want to be like, oh, just get the degree done with [laugh], like, I want to actually to acquire skills, and then like erm, increase my competency and also like, in terms of my personal hopes for my education journey, I also hope to do a lot better in that sense la so I guess, yeah, that reflects it in my work with my clients.

BEATRICE 17:02

… because they are the one responsible for grading so yeah, I feel like my fear of incompetence has held me back from speaking about things that I am curious about or I would like to clarify was like, for example, if I asked, "What would one typically do in such a situation?" Then the supervisor might think that, "Oh, she doesn't know what you should do in this situation so she's not competent." So I refrain from asking questions like that and I usually do my own research after that so my supervision was just very cordial and like, me asking me talking about things that I already know. [laugh] Yeah.

BEATRICE 22:19

Before, before the supervision, I tend to over prepare. So like, for example, if I have seen a client, maybe like, five or six times, and then I'm seeing my supervisor for the first time to talk about her, then I would have all five or six case reports open in front of my window [laugh] right in front of me, so that, you know, if she ask any questions that points to any session at any point, then I will immediately have the answer. … my

tendency to over prepare, like, I feel like I need to have every question answered before the session, so that I can answer the question in her session.

BEATRICE 29:11

… like if the grade component is involved then me, sharing or being vulnerable or telling my supervisor about things I don't know would directly translate to lower grades, so I wouldn't want that la. So yeah, for me, it's in during the course of my study, it's something that I have to avoid. [laugh]

BEATRICE 11:35

I would say also, in the beginning, a lot of my fear is like to my grades, my performance on, you know, like whether I can score a good grade. Because I eventually want to pursue the path of in academia, which is like, very important for me. So that was my initial fear. But I think now, I would say, you know, it's less intense. And I also prioritize, you know, like, my competencies because of like, whether I can confidently serve my clients. So I guess that's like, it's a slight shift in clarity, you know, rather than just 100% focus on the academic performance. I felt like my fears also come from other areas, like, for example, not being able to counsel well, yeah.

BEATRICE 13:03

I have slowly learned to let go because, you know, given that I'm also doing my full time work I recognize that I don't have the capacity to always aim for the highest score. So I'll just do what I can within my own capacity and my own means. Yeah.

BEATRICE 22:10

I guess a lot of these missed opportunities come from not clarifying not asking questions. Like, for example, I think recently, in the DSM five lectures, I've also missed quite a few. Like, I find that the definitions can be very flexible. And it's the entire thing is manmade thing rather than, you know, the actual symptoms and actual diagnostic criteria. So I was kind of curious the difference between DSM for the DSM five, what made those changes and then who is the person deciding are these changes, but I didn't

want, you know, make myself look bad. So I didn't clarify these questions I have. So these are like the little missed opportunities that I see and I felt that, you know, now that I'm aware, maybe I should ask more questions.

It's a bit nerve-wrecking,

I always think that I only have one chance,

the first session was,

a lot of worries, anxiety and just feeling er overwhelmed.

I want to be someone who's competent,

I want to acquire skills,

my fear of incompetence has held me back,

from speaking about things I am curious about.

I refrain from asking questions,

talking about things that I already know.

I tend to over prepare,

then I will immediately have the answer.

I need to have every question answered,

if the grade component is involved,

being vulnerable or telling my supervisor,

it's something that I have to avoid.

In the beginning,

a lot of my fear,

my grades, my performance,

whether I can score a good grade.

Slowly learned to let go,

the capacity to always aim for the highest score,

I can within my own capacity

my own means,

maybe I should ask more questions.

Mary (HSA of feeling frustrated)

MARY 05:46

I guess, it's [pause] in a way, in a way like, okay, there are many different things going on when when I'm in a group [laugh] discussion, not not going not just going on outside, but going on inside [laugh]. So I guess it's er, how do I do describe, just let me let me think about how to kind of put it together. [long pause] Yeah, I think okay, it kind of varies, depending on the situation, but I don't know, I at least based on what I've experienced so far, sometimes erm I feel irritated okay during group discussions, because not so much because of what people say or do but it's because oftentimes er, ... they'll be like, so what are we supposed to discuss? And what are we supposed to do? Then I'm like, is no one paying attention? … So I feel like, I paid attention, I'm telling you what was supposed to be done, but why you all not listening to me, you know, that kind of thing. So I feel like that waste time [laugh], waste time because normally like, during group discussions, we might be located certain time for it ah, it can be 5, 10, 15 minutes, … maybe we should look at this or something like that, I find it very frustrating is like why am I putting in so much effort to facilitate and I'm not gaining anything from it. Yeah.

MARY 15:21

Right, right, in a way yeah, because I mean, the thing is, it's something that has to be, I mean it's not a task that has to be completed but if like, the lecturer tells us to do it, just do it la [laugh]. You know, it's part of the class activity and like, it's supposed to benefit everybody but if people are not taking it seriously, for whatever reason, then I find that, like, it's very unfair, you know, it's very unfair to other people yeah and it also, and this is how it just helps me to inform this, is partly why like, you know, every time I feel like group discussions, not very fruitful for me, because I don't learn much [laugh]. I only learn what I don't like about myself [laugh], I don't really learn much about it doesn't really okay, for me personally, like, at least I don't feel like it adds value to my learning with regard to like, the topic in question.

MARY 50:21

I think for that, for that, okay, it wasn't exactly a discussion, it was more of a role-play, group role-play of sorts. Right. So I think that during then, I felt rather, I felt I experienced a lot of mixed feelings but mostly not so good feelings. So I recall like I felt, I felt rather frustrated, exasperated, and even a certain degree of like numbness. Yeah.

MARY 51:25

I guess for myself, for myself, you know, when I experienced like, such a rather highly emotional, or rather emotionally charged situation, right, I will tend to just disengage. Yeah, I notice myself like disengaging mentally. So I will just kind of go into a state of, like blankness or numbness, where I'm not, it's a very weird state, like a state where you know, I'm not feeling or thinking much except that I feel that I want to get out of the situation.

MARY 53:26

Yeah. [laugh] Yeah. So I mean I'm still there. I'm still sitting there. I'm still listening. Right. But inside, you know, I feel like I am kind of shutting down zoning out already.

MARY 1:00:29

Okay, so so when I say I walked out, it wasn't an immediate response, right. It was after maybe five minutes, so at least within that that timeframe between when the thing happened, and when I walked, I was actually kind of just rooted there, but in my mind, I'm like thinking, you know, should I stay or should I go? There, what was going through my mind, right, and then after that, if I stay, I feel like I'm not feeling good. If I don't stay at the same time, you know, if I just walk out, just walk out, then. … Yeah. So it may sound a bit selfish but I think at that point in time, I felt like if I can't do anything, and if it is emotionally draining me, there's not much point for me in staying stuck when I could leave. So that's what I did.

Many different things going on in a group [laugh],

I feel irritated:

What are we supposed to do?

No one paying attention?

I feel like that waste time [laugh],

I find it very frustrating:

Why am I putting in so much effort?

I'm not gaining anything.

I don't learn much,

I only learn,

What I don't like about myself [laugh].

Group role-play of sorts,

A lot of mixed feelings,

I felt rather…

frustrated, exasperated, and numbness.

I notice myself disengaging,

Into a state of blankness or numbness,

It's a very weird state,

Shutting down zoning out.

Should I stay or should I go?

I'm not feeling good.

I just walk out, just walk out.

Susie (HSA of desiring isolation and HSA of feeling annoyed)

SUSIE 08:45

It was about how counselling children is like, basically understanding the emotions, what the child is feeling? What kind of traumatic experience they like go through? And yes, is about like, feeling like the parents don't love them. I think that really bothers me a lot and the sense of wanting to belong, you know like wanting to, the attachment style as well. Yeah, so a lot of things regarding about children were covered and it was hearing stories about the lecturer having to counsel children that kind of hit very differently, because you kind of know how it feels like to be children and then so this feeling was inside of you so you just felt very sad for this child to experience whatever they experienced back then. Yeah.

SUSIE 10:19

I felt like I was, I felt like the inner child inside of me was very dominant back then. Yeah and thoughts of negative thoughts of like feeling useless, feeling like no one loves me, no one cares about me. [pause] Yeah, they just came back. Yeah.

SUSIE 11:16

It's still as per normal. Like my body is still as per normal, it's just about feeling heart pain which I feel the heart cringing kind of emotional kind of pain not physical kind. Yeah so teary eyes maybe. Yeah. It was just a lot of trying to hide my feelings, kind of body reaction but then inside like brain is just lots of ruminations, negative thoughts.

SUSIE 12:52

Joke around... joke around. Yeah, as I know people always think that I don't have worries. I am a joker you know always making people laugh, happy go lucky. Yeah, that's that's how I portray to people at least. Once I'm just alone right, yeah, everything kind of just crumples down, build a facade la, like don't want people to worry, don't want people to question and ask because it's back then, it wasn't easy talking about, it was very negative, I can't say negative, unhelpful you know, I also can't say other emotions, but just emotions that were not talked a lot within the society itself yeah, like

sadness, angry. Yeah so I think it stops me from portraying that, "Oh, I'm feeling sad, I'm feeling lonely." Yeah. So I guess it's like building a facade.

SUSIE 54:09

You're no longer the child, no longer the inner child, no longer the child that I used to be, no longer someone that wanting to isolate myself because if I were to think of isolation, I would think of the child back then when I was in a foetal position, trembling where I was, just want to be alone. Yeah so yeah, growing up from that foetal position into just facing what is coming towards me, I think that there is really hard work for me.

SUSIE 04:40

And right there and then, I just apologize to her and like, I tell her I don't mean to laugh at her experience of losing her mom, but I just was laughing at how ridiculous I think the exercise is. Like I'm not laughing at her. But she didn't seem convinced and it kind of, it didn't kind of, it affects me. It makes me think a lot about how I'm always like joking around with people, like you know, I can be serious also, but I just always have the tendency of wanting to joke.

SUSIE 12:11

I usually when I joke around it wasn't, there wasn't someone who would tell me like you need to stop joking around. Yeah. So probably when I'm alone, then I would reflect upon what had happened. Maybe I shouldn't have joked around like this, yeah, because it just doesn't seems right and sometimes my jokes can be too overboard. Yeah, and and I think friends also find it difficult to directly tell me that is not nice. Not like that classmate who is very daring.

SUSIE 15:00

So because I grew up watching my parents quarrel, and I guess I didn't like conflicts and yeah, I didn't like, I don't know how to deal with conflict, and when people want to like confront me so I get panicky I also feel like what happening, did I do something wrong?

Yeah so I think it also makes me think about why I joke around a lot is to I guess compensate what I lost. Yeah.

SUSIE 16:18

Compensate the young me, the child who has to live through parents quarrelling, have to live through, live through not being able to see what's harmony like, so I guess I want to feel that I wanted to share that people can have harmony, yeah.

The sense of wanting to belong,

Like the inner child inside of me…

Like feeling useless,

Like no one loves me,

No one cares about me,

Feeling heart pain, heart cringing, emotional pain, teary eyes,

Trying to hide my feelings, lots of ruminations, negative thoughts.

I am a joker, making people laugh.

Once alone, everything just crumples,

It's like building a facade.

Think of the child back…

Was in a foetal position, trembling.

I'm always joking around,

Maybe I shouldn't have joked around…

Watching my parents quarrel,

I didn't like conflicts,

I get panicky,

Did I do something wrong?

I joke around a lot,

Compensate the young me,

Not being able to see,

What's harmony,

I wanted to share…

Harmony.

Steven (Awareness of combativeness and HSA of (dis)connectedness)

STEVEN 08:20

…So I've just gotten a bit better at, like just being a bit more honest, to be honest, just just saying, how I feel and trying to be honest, when people tell me how they feel, and trying to understand it better and just like trying to strip away all the "bullshit" for "want to be a better you" word, and strip away all the layers and just communicate in a way that's very honest. And maybe, maybe that's something that that everybody wants to do, or some people feel like they can't do. It's difficult, right? Like it's everyone talks about being honest and having honest communication, but it's difficult. It's there's lots of sort of sub tiers and layers of the onion that that get peeled away and so I've enjoyed that process of just, you know, it's improved some of my personal relationships, it's been difficult in the past. I just try and say things a bit more truthfully now.

STEVEN 19:00

I don't think it's like an aha moment. I think it's like an evolution, I think something. It's very, very rare that I wake up one day and go, ah, the sky is not blue, it's actually purple and I've been wrong all these years. It's not, it doesn't for me, it doesn't quite work like that. It's just this, it starts off with this little kind of voice in the back of your head that says, maybe you were wrong about that. [laugh]Then the voice kind of like keeps going a bit and then you sort of learn a bit more and then the voice gets a bit louder, you learn a bit more in the voice gets a bit louder and then you kind of slowly start to realize that over the course of several years, you could have done things better. You could have, you know, you could have perhaps been a bit more forgiving of people so you know.

STEVEN 27:55

… I was pretty combative like, I've always been pretty combative. I've always worked in sales jobs and convincing people of things and, you know, making arguments and, you know, so I was always seen as argumentative and they, I, I used to sort of pride myself on that, because I thought it was a sign that I was smarter than other people.

I could, like, do these mental gymnastics and verbal gymnastics and dance around people and be the big hero and but, like, no one really thinks that, that's very cool, [laugh] unfortunately, no one comes out of the conversation going, …

STEVEN 1:05:50

I think the combativeness was never real. I think it was just a mask. I thought, honestly, I think it was just, like some kind of like, Lina (pseudonym) would call it the script, and it was just, it was just what, what my, maybe what my dad expected of me, perhaps, but it was never, it was never real. I don't think I think it was...

STEVEN 10:18

…. And kind of it's a physical sensation. You feel I feel like here (palm touching heart) like right sort of that where the heart allegedly is, you know, if something changes, or your mental state changes, or you realize something.

STEVEN 17:12

…. And I just kind of reflected a little bit about what, what it meant to make sure there's like a little sort of, you know, moment where you just sort of reflecting on the circumstance and kind of trying to, as much as possible, make a deal with yourself that you'll be as connected as possible in all situations. You know, and it's, it's not really, it's not quite good enough to say, it was just a lecture, so it doesn't really matter that much. You know, once you get into that sort of slippery slope, then, you know, where does it end? Right. I was just like a, just a client that I know quite well don't want to get into a habit of making excuses.

STEVEN 19:10

… I want to sort of keep the standards of connectedness high and I'm using this example as it maybe it's a tiny example. Maybe like some people might not even think like this. They might go you know, just sort of get there and tick off that lecture. And don't worry about it. Yeah, it's not quite good enough. That's fine. But for me, personally, I want to I like it, maybe it's maybe it's an aspirational thing because I'm probably, definitely not

always going to be able to do it. There's, there's always times where you're gonna get like, pulled in a different direction or whatever the thing may be, but you got to have like, you got to aspire to something, right? You got to have like something that you that you want to do or you want to be, otherwise you will be nowhere.

STEVEN 20:50

… I was talking about before with taking the best parts of people. One of the ideas I'm really interested in is this idea of credibility, like, where does it come from? How do you get it? What are the cues? You know, sometimes you have to talk about it and some people do it too much. Some people talk about, you know, they go into, the lecturers kind of spend the first 20 minutes talking about all the things they've done trying to boost her and credibility. So I just, I find that a really fascinating piece about how to gain trust and credibility without trying too hard or wasting too much time. So I think there's maybe an art to that, that I'm genuinely interested in.

STEVEN 42:56

Yeah, I think ones, ones are more evolved state. So when I'm talking about being honest, and peeling the layers off the onion, and they're kind of inputs, right? They're things that you, you do, you don't physically peel the layer of the onion, but you, you allow time, and you will, you know, the onions, it's like a self peeling onion, right? If you if you, if you did the right things, the onion somehow, like, you don't even need to peel it peels itself. So they're the inputs, and I think that connectedness is the is the output in some way, it's the resultant thing that happens from trying to listen well.

I've just gotten a bit better,

A bit more honest,

Trying to be honest,

Strip away all the "bullshit",

having honest communication.

It's like an evolution,

It starts off with this little kind of voice,

In the back of your head,

Voice kind of like keeps going a bit,

Voice gets a bit louder…

I've always been pretty combative.

I was always seen as argumentative.

I used to sort of pride myself,

I was smarter than other people,

Do these mental gymnastics and verbal gymnastics and dance around people and be,

The big hero!

The combativeness was never real…

Dad expected of me,

It's a physical sensation,

Where the heart allegedly is,

Something changes,

Your mental state changes,

Make a deal with yourself that you'll be as connected.

Keep the standards of connectedness high,

It's an aspirational thing,

To gain trust and credibility

There's maybe an art,

Peeling the layers off the onion,

Like a self-peeling onion, the inputs,

Connectedness, the output.

Rose (HSA of being perfect)

Rose withdrew from the course after the first training year but consented her data to be used.

ROSE 06:35

…, after so long and you know, you want to do well, that driver of being perfect, but then I realized it's not worth it. So this semester, right, I'm trying to really not do that. Yeah, so it was a bit challenging, but I think it's getting better in terms of the management of stress.

…, I'm very directive, right, so I'm like, Okay, I must follow this, like SFBT say, step one, step two, okay, I must do step one, then now must do step two, why I can't do that. And yeah, oh, then I'm like, am I focused on like, am I supposed to do this? You know like what I'm saying, but I'm not, I cannot do the step two now what do I do, then I panic, right? Inside I panic, but outside, but I'm like, you know, like, inside, like what to do and then I do it wrongly. I think I, this semester, I screwed up my first peer counselling first session, because I was so directive, I mean, I think in the wrong way. .., But because I thought we were supposed to practice the modality, right. But apparently, of course, we need to be flexible for the client needs, which I did not practice. So I think the rapport building was damaged. I mean, like, not not established properly. And then, of course, it's my classmates, so she didn't like he or she didn't blame me but then I took it badly. I think the second session also I took it badly.

… Then I was like freaking out, like, I did so many things, right, like, but I just like, Okay, this whole thing is ruined, then I think it affected me quite bad, then I talked to my supervisor and then and then I think she encouraged me to like, look at the positives, and also that, you know, we are human, human make mistakes.

But the challenging really was challenging I think I was upset that night before I went to sleep, because we ended the call quite late at night then I was upset the next morning again. And I was also upset for like, whenever I think about it, so I don't know how many times a day, not not not that many maybe I thought about it like three, four times and I kept thinking, what should I have done [empahsis] instead [emphasis]? You know?

Yeah, then I realize, oh, no, I'm spiraling down this, I'm spiraling down these like negative thoughts and these things then I was like okay, okay.

… then I started to get a more neutral thing and then I stopped blaming myself after a while. So I think I handled because I talked to my counselor, like two or three days after it happened or something so it helped me to calm down, and to stop, like, thinking about it. But then the that that first night itself, I was very upset. I just kept blaming myself and then I remember having some psychosomatic symptoms, like maybe I was feeling hot in the face when I, when my client told me that and also, I was sweating in my palms. I don't sweat in my palms unless I'm nervous or upset. Then I also had, it was a, yeah, I couldn't sleep. Yeah. A bit. Yeah, I was thinking about it before I slept.

ROSE 22:50

So the external organization, right, oh, yeah um, so basically, I clocked for 10 hours, but I think of it as zero because, okay, I may have just talked to one elderly person and tried to practice some micro skills and then out of the rest of the hours, maybe five hours are not useful skills, hours.

And then I'm, so I'm a bit concerned how I'm going to finish my other 10 hours but like, I tried to volunteer with some organizations, both of you need to get the internship position to begin, then I had this like, major conflict or dilemma whether I should continue the masters because if I cannot, even you know, I don't and I didn't even enjoy the befriending or outreach sessions because of the organizational reasons like, and then I don't know whether it's …., oh, this whole thing is a bit too ambiguous and then I sort of freaked out. Right. So I'm thinking, okay, maybe I need a break, maybe to just get my head clear, right? So every two months, I think I freaked out once, right, the first time, I freaked out was when we couldn't find any, like, I couldn't find anywhere to take me in for practicum and I do literally apply to at least and I called like, 50 places, right?

ROSE 37:57

The want to be perfect. [laugh] It is bad because even my supervisor pointed out a lot of times, right, like, I need to, I need to take a step back and, what to say something like, feel good about myself with regards to what I did right instead of focusing on the wrong

things I did like when she asked me to reflect then I keep telling her all the mistakes I made. Then she's like, why do you criticize yourself so much? Because she told me something like, reflection is to see you know what right, what are the good things to do, and then just a bit of things you can improve.

But my reflection is more like self criticism so I mean, obviously, she probably can psychoanalyse me and see me for who I am but like, I didn't realize I thought reflection is just point out all your mistakes and then let's let's let's see how we can avoid them in future that kind of thing, without saying anything. So this, even until now, I'm finding, I'm finding it very very hard to to do a proper reflection as what my supervisor wants me to do so yes, to answer your question.

That driver of being perfect,

I'm very directive,

I must follow this,

I must do step one,

must do step two,

Inside I panic,

I screwed up.

I was so directive,

I took it badly,

I was like freaking out,

I think it affected me quite bad,

I was upset the next morning again,

I thought about it like three, four times,

I'm spiralling down this,

I just kept blaming myself,

Psychosomatic symptoms,

I was feeling hot in the face,

I was sweating in my palms,

I couldn't sleep,

Major conflict or dilemma whether I should continue the masters,

I freaked out,

I need a break,

Every two months, I freaked out once,

I called like, 50 places,

The want to be perfect.

My reflection is more like self-criticism,

Reflection is just point out all your mistakes,

Very, very hard to do a proper reflection.

Margaret (HSA of fearing to speak up)

MARGARET 08:10

… in group settings I I feel more anxious I would say that so many factors as that's My nature also. I'm a bit introvert and not not assertive and this talking in public setting or in a group setting had been always a challenging ever since I mean my school days so when …

So here, I feel even more nervous because I'm, I'm an outsider so I may not understand the things that everyone understands so clearly, or maybe so, so all those factors make me feel open up my mouth, like others might judge me or that I think that's the that's the reason behind me. I don't think that deeply in that context, but that could be the reason that I could be judged because I'm my education… compared to Singapore, education is not that sophisticated and maybe my language skills, maybe not that brilliant, like the people who speak English here. So all those factors make me a little intimidated, I would say and also, I am not a professional, all the other peers working in some field and I'm a homemaker. So, so I feel a bit self-conscious and intimidated in group settings so for that has always been a challenge for me to talk. Yeah.

MARGARET 12:39

Like it feel in the group supervision sessions, maybe like when everyone talks and contributes, I will be sitting there having an internal conflict within myself, like pushing myself open your mouth and say something, and then I will, don't do that. So I will feel that pressure building up and want and then I would like, like, with so much in effort, I will think of a point and then somebody would have told them already express that so I can't talk about that later. Sometimes because of this pressure and internal struggle I can't even I can't also think clearly. So later on, when the session is over, I would get all sorts of comments and opinions I would have shared but at that moment, I wouldn't get that because of this pressure that I feel. So I think we have so far we had about three group supervision. The first two, I didn't utter a word and last one which we had last month I went telling to myself like, like put your chin up and … the both group supervision I was 100% quiet, didn't talk a word. So, so I will sit through the session

having this internal dialogue with me why I am not able to talk? Why am I like this? So I will, one part of me will be struggling throughout the session. judging myself. Yeah.

MARGARET 19:17

Yeah, this lack of confidence and assertiveness, I get easily intimidated if, I'm also a person like, like a little little... I, I look into other people's facial expressions and tones and how they interact that affects me a lot. If people don't have the eye contact or a little gesture that shows me that they don't enjoy the interaction with me that affect me a lot. So sometimes I have to tell myself like yes, just be yourself and no matter how the other things are going around. So you will be, after even, maybe after learning the TA (Transactional Analysis) concept, and I'll be at your adult ego state. [laugh] …

MARGARET 26:58

Yes, like I will let talk to myself okay, be confident and like okay, that don't have to think about that something yeah to soothe me and get my confident level. Yeah, maybe I think in terms of that I have improved a little bit not that much of a preparation only about what I have to talk but I think I don't think much about like other people judging me that kind of a thought is not that much. Now because maybe I know the group and yeah, I learnt about being open to communication and know some of other people who also have the same problem they don't feel comfortable talking in public. So it's I don't I don't look down on me that much now I think, okay, it's I am like this but that doesn't mean that I have to look down on me. So maybe I'm more compassionate towards me now.

MARGARET 28:54

I think more of about an acceptance when when you ask when I think I have accepted myself bit like I realized that I it's it's not a must to like I had to change myself.

It's okay to be what I am and and yeah, in this course, it it didn't really push me towards like I have to present and I have to develop that public presentation skills kind of a push it's not there I think. Yeah, the way the course is going so far, at no point I feel that push

that need that I have to learn this skill to be able to present. So, I I kind of accepted myself and and the outside factors also didn't demand that from me so that would mean to ease I think so maybe that might have helped me to feel better and not not more intimidated like when I when the lectures ask someone to come… I never felt that push that I have to challenge my inability so I'm kind of accepting and fine being, more peace with me yeah.

MARGARET 40:28

I don't know, maybe I reflect a lot like. Like, the fear, I just like after learning the schema therapy, and all those things, some incidents like I could able to connect, oh, maybe that contributed to me, because I remembered like, the child pulled the when we were talking about the disturbing childhood memories, I remembered, like, in the, whatever the memories I have about my kindergarten, the negative memories, I think, I don't have any positive like joyful memories I one or two memories, that is I have about getting punished by a teacher with the, with the ruler like, for something that I didn't say that I'm person to something, I was absent minded. And I got, like, gotten beaten up with a ruler in my palm that I remember and so vividly and a little child who wanted, who admired my clip clip and that's, I think that's only one clip I would have had at the time and she took it and then she looked at it and then she ran away with the clip those things I remembered. So I was connecting, okay, maybe is that what made me quiet to be quiet? I was like, I started to become not talking and not like, like not being noticed and wanted to be because the teacher hit me for not not saying I'm present or something I don't know she was taking, getting the count of the students. So I could relate to I was thinking of that what made me who I am now. That kind of reflection I'm able to make and think around and reflect on it…

A group setting had been always a challenging,

I'm an outsider,

Others might judge me,

My education,

My language skills,

I am not a professional,

I'm a homemaker.

When everyone talks and contributes,

I will be sitting there having an internal conflict within myself,

Pushing myself, “open your mouth and say something!”

I will feel that pressure building up

I can't even… I can't also think clearly.

I didn't utter a word,

Having this internal dialogue with me, judging myself.

I get easily intimidated,

People's facial expressions and tones,

Eye contact or a little gesture,

Affect me a lot.

I have to tell myself, “be at your adult ego state!”

I have improved a little bit,

I don't think much about other people judging me,

People who also have the same problem,

I don't look down on me,

I'm more compassionate towards me.

I have accepted myself,

It's not a must,

To change myself.

It's okay to be what I am,

Being more peace with me.

I reflect a lot about the disturbing childhood memories…

getting punished by a teacher for something that I didn't say,

gotten beaten up with a ruler,

Maybe is that what made me quiet,

What made me who I am now.

Linda (HSA of feeling conflicted and HSA of feeling resistant)

LINDA 10:10

Yeah, let me think [pause] I think I remember [pause] Okay, I don't know if this counts, but during the counsellor training, we had to be, we had to do groups supervisions, right, and there was one group supervisor, whom I felt was... but I don't know whether I was like, and that was when I was like, "Oh, my God, am I like, think too much into it or am I too sensitive?" I was like, so in like because everybody looked like they were okay but in my head in... internally, I was like, "That doesn't sound right, that doesn't look right" you know, and, but everybody was still like smiling politely and everything and like, going in the flow, I was trying to, like, look at some of my classmates faces to see if they, they felt the same thing I did but nobody, like, gave me the confirmation that I wasn't alone in these thoughts and, as can you imagine like, it was a three-hour session. In that three hour, I felt so uncomfortable, because I didn't know if I was the only one feeling like the group supervisor wasn't appropriate, so I kept it and there was even a time when I was supposed to answer that.

I felt like I kind of showed him that I was upset with how he was conducting the thing, but very passive-aggressive, you know, because [laugh], yeah, so I was passive-aggressive. I almost lashed out, but I didn't because I was in a group of classmates but I was also uncomfortable…

LINDA 20:18

It was various thoughts, but it was mostly whether I could trust myself that that was all happening. Because I was like, "How can it be [laugh]? You know, like, why, why? What? How could you? How could you, as a group supervisor give us such an uncomfortable, unpleasant experience?" Yeah, that was mostly I couldn't believe it. But also I was living in it. And I don't know if, if it were to happen another time.

Like, if, if I could relive the moment, again, I would have stood up and like, spoken up, or like, during the break time, I could have, like, you know, went to the side and tell him like, "Oh, I'm actually uncomfortable when you did this." But I think the other

uncomfortable thing was that I kept quiet and like just sat through it all passive-aggressively simmering in my thoughts [laugh].

LINDA 45:34

[pause] The first thing that came to me when you ask me that question is like, I just felt very uncomfortable in my, in my stomach, I felt very queasy. I feel extremely queasy, almost nauseous, because I don't know it's such an uncomfortable [pause] to have like, I mean, one thing, it did feel unsafe, but I know I will was safe right and this whole passive-aggressiveness, which I hate, it bothered me. But also, I didn't want to be like, full confrontational, and to disrupt the class just because I needed [laugh] to, like, validate my own feelings. I just, I feel very confused as to when it was okay to have spoken up. Yeah. I'm just wondering how many, how many other times would it take me before I confidently, can just like, hey, you know, just matter of fact, just say, just for education sake.

LINDA 05:04

I asked a question. Like, how, I asked the trainer, the coach, we call her the other coach, like, how do you deal with those who are resistant to change? And she was like, Okay, come up. Are you okay to do a role-play? Let me show you. Like, I was like, Yeah, sure. I felt like I wouldn't be resistant. You know, I, Yeah. And it's just like, okay, so she spoke about, we were in groups, right. And I played the client. My problem was sleep problems, which I told you earlier. Yeah. And, yeah, okay, I'm okay. I can change, I can do this. But when I was put in the the spot as a client in front of the whole class, and I was also embodying, like, my most authentic self, I felt, I felt the resistance coming up, whether I like it or not, like, the way she asked me the question and do it… So and I kept, and she just kept pushing and pushing and pushing, I felt like, Oh, my God, this is hot. Like, it was so challenging. And I could feel that I've never felt this way before in class, in front of class. I was shaking. I was shaking or sweating. I still played it cool. By like, you know, breaking humor and everything for the class, like, very dramatic, like, wanting to sit down like, like, just like wiping off sweat, that kind of stuff. But I could

feel my face, especially like, quivering, like trembling, you know, and I was hoping I was like telling myself, Oh, my God, I hope they don't hear it in my voice…

LINDA 08:25

I think I think it was the act of verbalizing, like hearing my self talk about the problem that I was having. And hearing me say all of that, like everything I set out to my coach. I heard it back for myself. And I'm like, wow, that's a real problem. You know, like, why are you saying all this yourself? Like? Well, I was saying it out immediately I had an internal dialogue back to me, it's like, why are you so hard on yourself? Why are you doing all this? Did you hear what you say? And immediately I was like, reacting and like, I don't know like, if I feel I felt

LINDA 25:26

Okay. I think it all happens, because of a lot of life changes as well. And like, again, last year, I was more, the first six months, I was a class monitor. I also felt like a bit burnt out, because I went, I had a full time job after like, seven years of working freelance. And then I think that burnout kind of like, made me withdraw and like things like, Oh, everybody sucks, you know, like, everyone's just like, burdening me and I'm only doing so much leave me alone, that I become like, in a way, unhappy, bitter, you know, that, like, I didn't even want to, like engage with classmates and everything. And that's why maybe the passive aggressive also come from a bitter place, like, not rested, you know, and unhappy place, and also one that was full of self doubt... You know, like, it makes it safe for me to like, just be who I am, like, even if I'm afraid to like to ask questions or like that, I think that's why the passive aggressiveness died. Because I allowed myself to open myself up to the world and know that I don't have to be passive aggressive. There's nothing to be passive aggressive about because these people will accept me as I am. And even if I make mistakes, maybe I wouldn't cry but I know that if I did

LINDA 28:15

I think it's, I've been focusing on Self Compassion over the last year or so. And like, the theory is, the concept was difficult to grasp at first, because I was like, who doesn't love themselves, like, you know, who doesn't love themselves? The compassion is like, the

love is love, but I wish somebody would have told me about the kindness. You know, like, that is like the key word, like to be kind to yourself, and to be kind to yourself means it was a huge thing, because like, I can be kind to others no problem. Like, you know, I, my value is that but when it comes to being kind to me, it's like, it's so it's a foreign concept, although like it should be so simple, but it's like, because I've been reflecting… I tell myself throughout the year, and every time I learned it, okay, let's be kinder here let's be kinder there all to myself and self-compassion the biggest change I've had in self-development.

Am I too sensitive?

That doesn't sound right,

That doesn't look right.

In that three hour, I felt so uncomfortable,

The group supervisor wasn't appropriate…

I kind of showed him that I was upset,

I was passive-aggressive,

I almost lashed out,

It was various thoughts,

Why? What? How could you?

I couldn't believe it.

I kept quiet.

Passive-aggressively simmering in my thoughts,

I felt very queasy,

It did feel unsafe,

This whole passive-aggressiveness,

I hate, it bothered me.

I feel very confused,

How many other times would it take me before I confidently,

Just say!

Are you okay to do a role-play?

I felt like I wouldn't be resistant.

My problem was sleep-problems,

I felt the resistance coming up,

I've never felt this way before…

I was shaking,

Sweating,

I could feel my face,

Quivering,

Like trembling,

The act of verbalizing,

Hearing my self-talk,

Wow, that's a real problem!

I had an internal dialogue back to me,

Why are you so hard on yourself? Why are you doing all this?

A lot of life changes

I become like, in a way, unhappy, bitter,

The passive aggressive - from a bitter place:

Not rested,

Unhappy place,

Full of self-doubt.

Passive aggressiveness…

Died.

Open myself up to the world,

Nothing to be passive aggressive,

These people will accept me,

Self-Compassion,

Concept was difficult to grasp,

Being kind to me?

It's a foreign concept,

In self-development

Amanda (HSA of bodily sensations)

AMANDA 05:45

Okay, this is one of the incidents I can share, which happened during class, I think the lecture was talking about human development and ACE, adverse childhood... you know, adverse childhood events, right, I think. So as he was going through the slides, I really felt my whole body was shaking because when, actually what happened was when he was going through, you're saying, oh, no, people, typically people who has gone through that kind of childhood will have all this, you know, effects in a way, you know, like, probably they, when they study, they can't really concentrate a lot of stuff, then I don't know why I was so stirred up at some point I actually openly shared to the class, which I normally don't, that whatever is shared in the lecture is real, because I went through it. suddenly this, like, there's an understanding that what I went through as my childhood really causes those things that resulted in my marriage failing in a way I responded in my marriage. So it was so real to me that I just kind of thought I will, I just felt so moved to share that is not just theory, you know, that I can vouch for it, that whatever the lecturer say as possible consequences are truth, because I experienced it and that's one of the thing that led to my perfectionism, because when my parents were, my father's a bit abusive, then my mom was mild, but I witnessed them having fights. So for me, I'm always the peacemaker when I was a kid, so I'm always the one with my antenna up like, Okay, what, you know, if my dad faces, face changes, then I'm immediately my antenna is up, and like, in my mind is always, "I cannot make mistakes." So if my dad asked, "Where did my mom go?" I must give the perfect answer. Otherwise, there's drama in the house, you know, constantly in that very intense state of trying to maintain peace.

AMANDA 14:18

I don't know. It's a bit maybe that's where the vibration came. I felt the same. I never have these kinds of things before this feeling of physical tension until after I had my PTSD, which is my burnout because I was bullied at work it was very, very intense. It was a very, very bad burnout. So the experience I had was first time I felt it was when I went to see office counsellor. You know, they sent me to a professional counsellor and

then at that moment, when I took up my cup, my hand was shaking. That was the first time I realized my body is shaking and that's when the counsellor told me like, this is not good, because, you know, it's psychosomatics, you know, and the issue is not even me is actually the person that so I shouldn't be receiving counselling is actually should be the other person was bullying me should get that kind of counselling. But I kind of that was the first moment I felt the body sensation that when I say something that is so deep and difficult, my body will start, you know that the, the tension will start building up so much like the whole body shakes. So in my body doesn't physically shake, it's just like, there's a lot of vibration in the body, I can feel it, it builds up until my chin, my jaw is tight. So it's really I can feel something coming up my body and it's like, okay, it's like, so this fight or flight response, you know, like, I know, somebody's attacking me but yet I need to force myself to be professional…

AMANDA 02:02

I started to feel my body vibrate, I don't, I feel really, really lousy. So that's, I was very aware of my physiological response, I couldn't breathe even so at some point, I just was so disturbed. I kind of just, but I sat with it. So basically, I think, from hindsight, that was a mistake. I should have stopped and just walked out, but I sat through it. And then I walked out of the class, but then when I walked out of the class to take a breather, right, well, I realized it was you know, the vibration and all it's quite bad. You know, then following that lecture. The next day, the very same night I had like, nightmares of lizards. I couldn't sleep… why I had that effect, that I never had before so it was a new awareness for me.

AMANDA 06:41

My physiological response wasn't good. I didn't I didn't react toward her. I just like I just kind of just in front of the classes. I was seated. I just kind of said shit this bad. That I kept saying, "I'm feeling it. I'm feeling it." That's what I did. But I did not lash out at her. I didn't say no, I don't want to do this. I didn't say please stop. I didn't do that. I just kind

of express how I felt. Then later, I did explain I said, it's I said it shocked me because I didn't know I will have the response just with words...

AMANDA 10:22

My heart rate was very fast. My usual was my resting heart rate is usually about 60 plus at the moment because I had my Apple Watch he was 90 over just sitting down it rammed up very fast. So, very fast heart rate, I feel my body vibrating my breathing became very shallow. Yeah, so very tense or the whole body is just tense then i have headaches right after the lecture.

AMANDA 12:49

Different kinds of fear, like, the lizard one is really fear, like, you know, if I see a baby lizard I'll freeze, even in the house, then I will scream for help…

AMANDA 15:23

That to me, like ACEs is a lot about the how I look at the case this because I was depressed when basically blaming because of the way I perceive the situation, right... And like going through TA right, I understand all these stuff about injunctions and drivers. So I got a lot of moments like "Ah, okay, that's why Dad is like that. That's my mom is like that." That's why I have all these injunctions. But what can I do then I want to rewrite my script. So what kind of script I want, okay, this so I can change… But fear is but different. So fear is something I always found that is so deep in my subconscious. I don't even know where it came from…

AMANDA 31:35

I was at peace. So for me, I felt the bubbling was necessary for me to say a point. Like, let's be fair, that's just not everybody. You know, then I left it as it is, and I felt it was enough. So that was the difference in the culture, I felt I have a need to defend my position. And that's why I was angry. Now, I don't see the need to defend but I do need the need to express.

AMANDA 32:33

…Now at this level, maybe it's also because masters and we're learning or during counselling is to respect people's view, respect accept them as they are so I think that was a big shift for me that you know, it's okay, you know, that's just who you are if that's how you think so be it is you. But I will state certain facts that, you know, to get the perspective right. So I kind of is in that place, which I think that's the whole counselling journey also taught me.

AMANDA 34:03

It's a gift. I think. Okay, one of the things I learned, I found out during the whole Masters is that my intuition is very strong. I'm a very, I'm a very strong intuition with people. I have a very good sense of people…

The lecturer was talking about human development…

I felt my whole body was shaking,

I don't know why I was so stirred up,

Is real, because I went through it!

My childhood causes those things…

That led to my perfectionism,

I'm always the one with my antenna up like,

I cannot make mistakes!

That's where the vibration came…

Feeling of physical tension.

Psychosomatics!

I felt the body sensation,

The whole body shakes,

A lot of vibration in the body,

It builds up until my chin,

My jaw is tight,

This fight or flight response,

Somebody's attacking me!

I didn't know I will have the response,

Just with words,

My heart rate was very fast,

rammed up very fast,

I feel my body vibrating,

My breathing,

Shallow.

Lizard-

Is really fear!

ACEs-

Is about the how I look!

TA-

Injunctions and drivers,

I want to rewrite my script!

Fear is-

Deep in my subconscious,

I felt the bubbling was necessary,

For me to say a point,

It was enough.

I don't… need to defend,

I do need… the need to express.

Counselling is-

To respect people's view,

A big shift for me-

The whole counselling journey

It's a gift-

I found out,

My intuition is very strong.

Peter (HSA of self-consciousness)

PETER 03:30

I think first off is the, I don't know use the word 'language buster', competency of English. As for myself, I'm not that academic so during the course, whether is it the, I think is mainly during the interaction whereby I'll need to articulate my thoughts, so I might not be using those [pause] I think I'm using really simple words to express things lah, you know, not so much of those complex vocabulary, for example, those are, yeah, so I guess at times, I will feel slightly, I don't use the word inferior but I think that somehow I do feel that, "Er, am I able to understand and do well in the course?" But based on the experience, I think I do have my own strengths as I see things in the simpler form. Yeah, so I guess it just gives a different perspective in that sense to the to the discussion. Yeah. So that's how I'm at peace now.

PETER 05:39

It does likely, I mean, I will admit the thoughts did arise, I think, is when the lecturer affirms that I'm on track, that my points are valid so I think it just give that reassurance in that sense, but I, that that self-doubt did arise.

PETER 06:22

Okay, for example, just the, or yesterday where we have a class discussion, then, a question was posed for us to describe the theory in a sentence. Okay, in our own words, so I wrote mine pretty quick. Yeah and I stopped there and the rest of the students they are still writing then when it's our turn to present they give more than one sentences [laugh] so that with also with all the some complex, I mean, maybe not complex lah, I mean, vocabulary, whereas mine is just one sentence with simpler simple words. But I guess it's it's also how I interpret or I just yeah, but I think it's just me so, but at least from the teacher point of view is, my sentence is relevant so it just it affirms me in that sense.

PETER 09:49

It's just like a "wow" then yeah kind of thing.

PETER 10:03

I think it's also the impression that they are able to articulate it out in that manner. [pause] yeah.

PETER 14:55

Wow

PETER 15:25

I think might be the one where by the way they speak, yeah, so as using proper English, pronunciation, then those flow I think that part where I'm working to improve or I think there is a part where the trigger when they speak up.Yeah, so I think for me is I have the impression that whenever some basic, give a sense of their command of English, for example, you know, there is not much Singlish or certain words that are being pronounced correctly. Yeah, so I think that might be the sense.

PETER 16:57

[pause] I think I'll be mindful of my choice of words during the conversation.

PETER 17:11

Like, or how I'll phrase, I think I'll be mindful of my speech. I think it's just the fact where I'm taking as a, no, yeah, well, I think those are those people are not my common, people who I'll interact so and for me, I would also like to take a chance to practice the proper pronunciation as well. So I think that's where I will switch on to a practice mode per se.

PETER 23:05

I know that is a temporary. Yeah, because I know I need to buck up. Yeah, so as long as I'm taking action, so I should be, it just takes time to get there.

PETER 12:18

Also, I'll be conscious, conscious, yeah, that I will watch how I say things and I also take that as an opportunity to practise saying formal English, the pronounce, pronunciation yeah, and stuff like that. Because it's not a setting that I'm commonly in. Yes. Hence, I also want to take the opportunity to learn and to practice it as well.

PETER 14:25

I think using Singlish is always a subconscious thing that I can just slip it out very easily. So formal English is where I will need to be very conscious to watch my pronunciation, Yes.

PETER 16:09

I think right now I would be conscious of when I'm using it Yeah, so I will use it intentionally to relate certain points or to build that certain rapport.

PETER 20:41

So, for example, for the Malays, there has been a fine balance between work or studies and personal time, so, I could use the word "chill" or "relax" or "lepak" to describe an event where after they work hard, that's where they take a rest. And when they are taking a rest just enjoy themselves and be at ease and totally just take a well deserved rest.

PETER 21:46

because that is the word that they are using now. Ya hence, and I think, I'll say is their trend. So hence, this word hat they are using now, just "chill", and in terms cultural aspect, then I'll just use "lepak" where that word have been used.

PETER 24:52

I think slowing down it allows me to be thoughtful of the way I express my view or the contents and I'm able to focus on the small details like in terms the phonics wise, like the pronounce the “d”, the “l’, the “s”, which most of the time, they are missing when we speak Singlish or when we are when we are speaking too fast.

PETER 26:39

Not my natural way, but at least I am. Now, example at this instance, I'm aware of my bodily feeling, that I'm conscious that I'm talking, how the intonation is coming out…

PETER 29:38

I think it gave me the cue, should, I have I mean, it has not happened before but I guess that it gives me a cue of the state of mind or the emotion that I'm currently present, because I'm neutral so example if, if I'm in a situation whereby I'm panicky, my tone will be speaking fast, my body will be sweating. So I guess now having this baseline then I know so should there be instances where my physiology has gone away from the baseline then I can take it as a cue to slow down or to regulate myself.

‘Language Buster',

Competency of English,

I'm not that academic,

I'm using really simple words to express,

Somehow, I do feel that,

Am I able to understand?

Do well in the course?

I will admit the thoughts did arise,

Self-doubt did arise.

To describe the theory in a sentence,

I wrote mine pretty quick.

not complex,

One sentence with simple words,

It's how I interpret.

Wow!

They are able to articulate it out in that manner!

Wow!

The way they speak,

Using proper English,

Pronunciation,

Flow,

There is a part,

The trigger when they speak,

There is not much Singlish,

I'll be mindful of my choice of words,

I'll be mindful of my speech.

Those people are not my common people,

I think that's where I will switch on to a practice mode,

I know that is a temporary,

I need to buck up,

It just takes time to get there.

I'll be conscious,

conscious,

Singlish is always a subconscious thing,

Can just slip it out very easily.

Use it intentionally,

To relate certain points,

To build that certain rapport,

"chill"

"relax"

"lepak"

Is their trend, cultural aspect,

Focus on the small details,

Phonics,

The “d”,

The “l’,

The “s”,

Aware of my bodily feeling,

The cue,

This baseline,

My physiology,

To slow down,

To regulate myself.

K. Participants' HSA Interpretations and Visual Graphs

Mary

In the beginning stage, Mary experienced HSA of frustration during group activities. She looked at her HSA moment through the lens of her upbringing as a single child. Mary made sense that when her learning outcomes were compromised during that particular group activity, it led to a countertransference reaction where she eventually remained silent and withdrew. In the advanced stage, Mary viewed her HSA of frustration during a particular peer role-play through a counsellor's perspective and became aware that her countertransference reaction was being triggered by her past unpleasant group experiences. In both stages, Mary's HSA moments preceded countertransference. Throughout the course, Mary had a good relationship with her supervisor. However, she did not disclose her HSA moments to her supervisor as she perceived that her HSA moments were not a supervisory issue and preferred to be self-reliant. She felt that she was more aware of her HSA moments and recognised the impact of her past could still be triggered. Mary viewed her HSA and countertransference as learning opportunities. Mary's IPA accounts gathered an increase in her perceived self-efficacy when she compared it to the beginning stage, but her CSE change was non-significant.

Mary belonged to the lower CSE group (M = 4.42) but her change in CSE was non-significant. Mary's change in HSA-S was statistically significant suggesting that she experienced less frequent HSA moments during supervision. Mary had likely benefited from supervision since the focus of supervision is to support trainee counsellors in learning to become efficacious and that was important for Mary. A few reasons could explain Mary's non-significant results for HSA-I, HSA-C, SWA and CSE. First, the adapted SAMS scales (Williams, Hurley, et al., 2003) might not be able to capture Mary's unique HSA moments accurately during the coursework setting. Mary could still be experiencing HSA moments (i.e. HSA of frustration) during in-session and coursework setting when she felt that she was not able to have her learning needs met (e.g., her stable counsellor characteristics). Second, Mary's stable counsellor

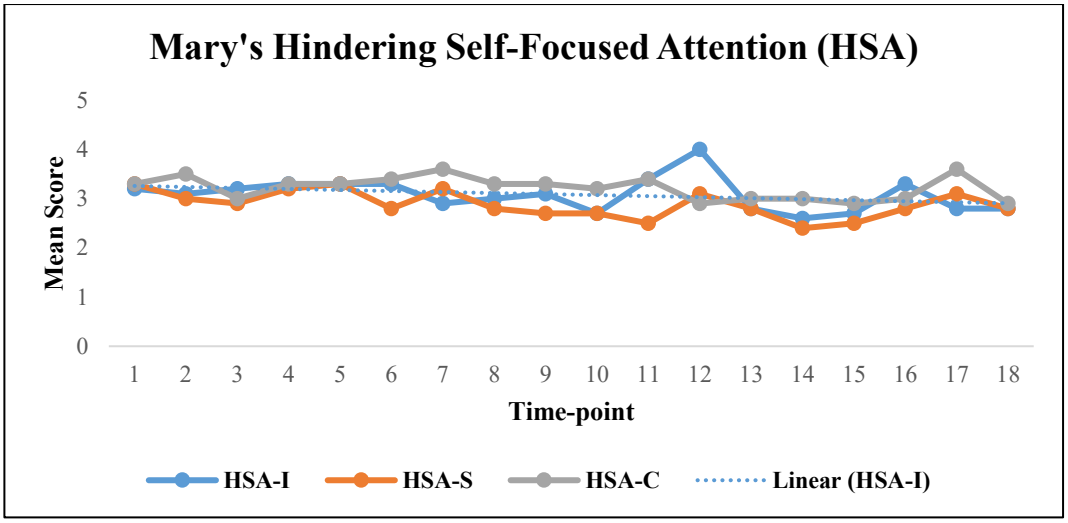
characteristics might have influenced how she connected with and perceived the role of her supervisor. If Mary perceived that she could be self-sufficient, the working relationship would be more ceremonial than functional. Third, without the support from her supervisor Mary's counselling competence would likely be affected.

For Mary, glamorised expectations and rigid emotional boundaries were the catalysts of her novice stress in the larger context of the training environment. When Mary had high expectations of her learning outcomes, she seemed to experience disillusionment during training and that became a source of her frustration (e.g., HSA moment of frustration). As a result, she was unable to exercise cognitive and emotional flexibilities which exacerbated her frustration further and led to countertransference (e.g., withdrawal from group activities). Compounded by her stable counsellor characteristics, Mary struggled to reconcile between being self-reliant and trusting others to be vulnerable to achieve her learning needs.

Results of Mary's Tau Analysis Over Time ($\tau_{(time.score)}$)

Participant	Variable	Tau	*p*-Value	CI 90%
Mary	HSA-I	-0.24	0.16	-0.526<>0.042
	HSA-S	-0.38	0.03	-0.663<>-0.095
	HSA-C	-0.31	0.07	-0.598<>-0.030
	SWA	0.27	0.12	-0.016<>0.552
	CSE	0.24	0.16	-0.042<>0.526
	CSE M (SD) 4.42 (0.68)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy



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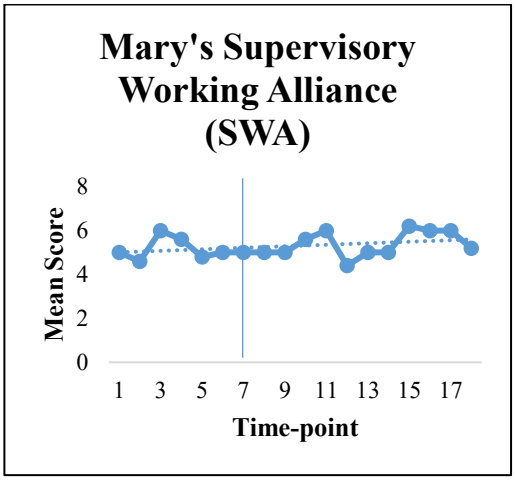
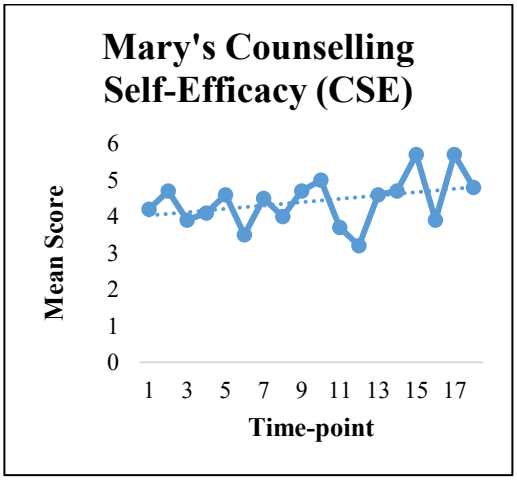




Note: Mary reported a change in supervisor in the advanced stage of training in time-point 7

Susie

In the beginning stage of training, Susie experienced HSA of desiring isolation at the practicum site. Susie looked at her HSA moment through the lens of her unpleasant childhood memories of her parents fighting and she made sense of her HSA moment as her learned childhood behaviour for safety. In the advanced stage, Susie experienced HSA of feeling annoyed during a particular peer role-play on grief. This time, she made sense of her HSA moment through the lens of her culture and upbringing and interpreted her HSA moment as her covert desire for harmony which she did not have as a child. In both instances, Susie experienced countertransference. Similar to Mary, Susie's HSA moment preceded countertransference. Susie felt safe enough to bring her HSA moments up for supervision and had a positive working alliance with her supervisor. Susie acknowledged the benefits of supervision on her personal and professional development. However, Susie still felt incompetent.

Susie belonged to the lower CSE group (M = 3.02) but her CSE change was non-significant. Statistically significant change in Susie's HSA-S suggested that she experienced less frequent HSA moments during supervision. This could be due to her strong working alliance with her supervisor which also reported significant results. Susie's IPA narratives further captured the bond between Susie and her supervisor. Susie felt supported by her supervisor and received modelling opportunities in supervision. A few reasons could explain Susie's non-significant changes for HSA-I, HSA-C and CSE. First, the adapted SAMS scales (Williams, Hurley, et al., 2003) might not be able to capture Susie's unique HSA moments accurately during the coursework setting. Second, Susie's counsellor's characteristics might have contributed to how she responded to the surveys. Owing to her unpleasant childhood experiences, Susie would continue to be sensitive to her own emotions and others (like clients and classmates) and could still be struggling with HSA during in-session and in coursework setting. Susie's low self-esteem could have affected how she perceived her competence (i.e., CSE).

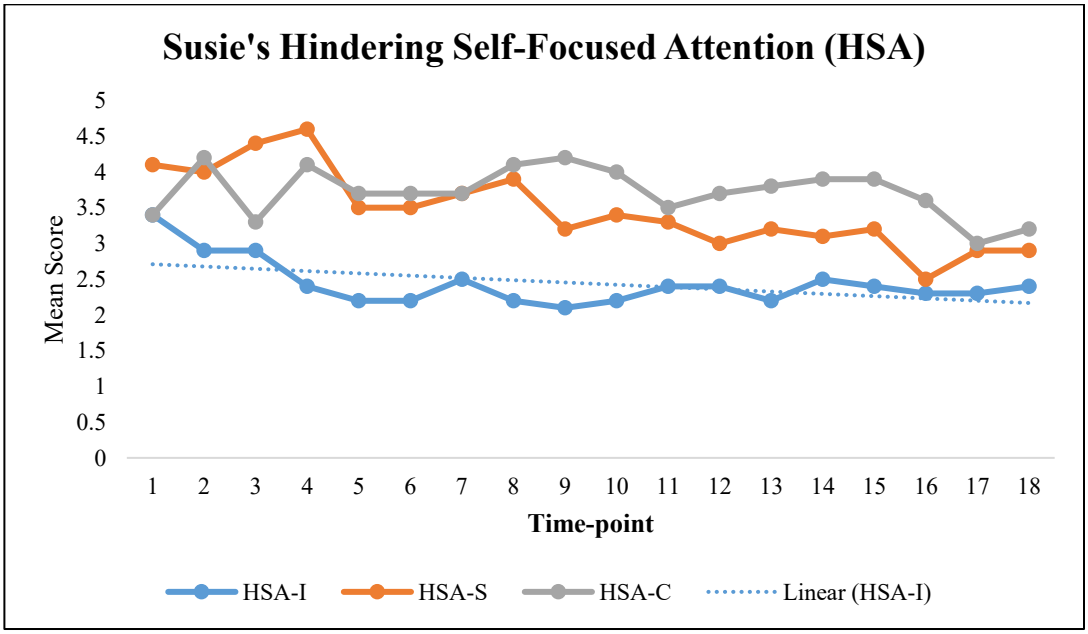
For Susie, acute performance anxiety, fragile and incomplete counsellor self, and the acute need for a positive mentor were the catalysts of her novice stress in the larger context of the training environment. Susie's stable counsellor characteristics contributed

to her vulnerabilities around others (clients and classmates). She was sensitive and had low self-esteem. As a result, it was very easy for Susie to doubt herself and struggle to develop her counsellor identity during training. Naturally, Susie would want to depend on her supervisor for support. Susie's supervisor thus played a very essential role in her development. The supervision context became a safe place for Susie to gain insights into her inner state experience and learn to develop her sense of self.

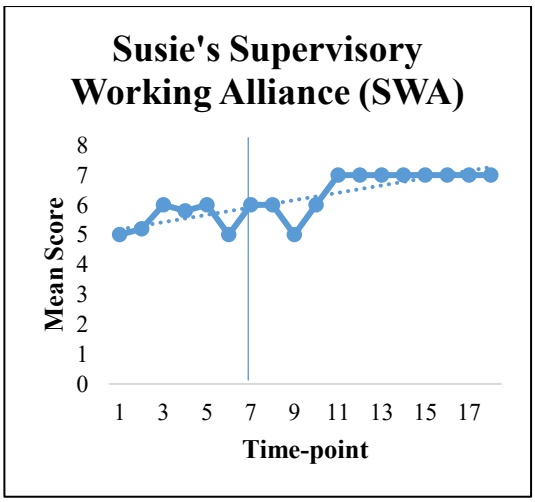
Results of Susie's Tau Analysis Over Time ($\tau_{(time.score)}$)

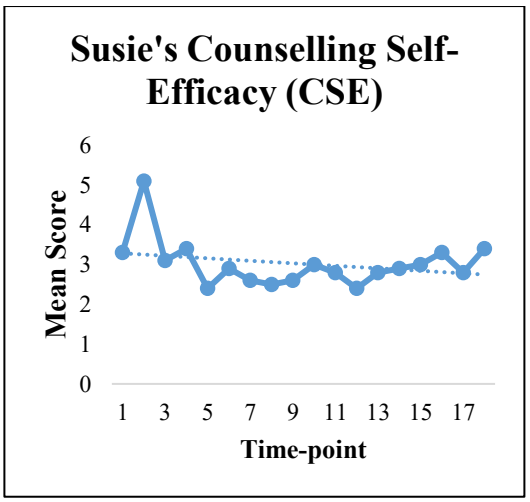
Participant	Variable	Tau	*p*-Value	CI 90%
Susie	HSA-I	-0.20	0.26	-0.480<>0.088
	HSA-S	-0.73	0.00	-1<>-0.448
	HSA-C	-0.18	0.29	-0.467<>0.101
	SWA	0.59	0.00	0.304<>0.872
	CSE	-0.03	0.88	-0.310<>0.258
	CSE M (SD) 3.02 (0.61)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays





Note: Susie reported a change in supervisor in the advanced stage of training in time-point 7

Steven

In the beginning stage of training, Steven experienced HSA of disconnectedness in his personal life. He acknowledged his tendency to want to win arguments and struggled to "peel the layers" to be "honest" in the beginning stage. Steven made sense of his HSA moment through the lens of his culture and upbringing and recognised the impact that his dad had on him such that he wanted to be seen by others as intelligent and successful; to be admired for his intellect. In the advanced stage, Steven experienced HSA of disconnectedness during a few lecture-discussions with different classmates where he became suddenly aware of his "combativeness" and the negative reactions from his classmates. He made sense of those HSA moments through the perspective of a counsellor and interpreted his HSA moments as a covert desire for admiration. Steven's IPA accounts captured his desire to become a credible counsellor that his clients would admire. Steven claimed to be more "connected" with others in the advanced stage of training and hence felt an increase in his counselling abilities.

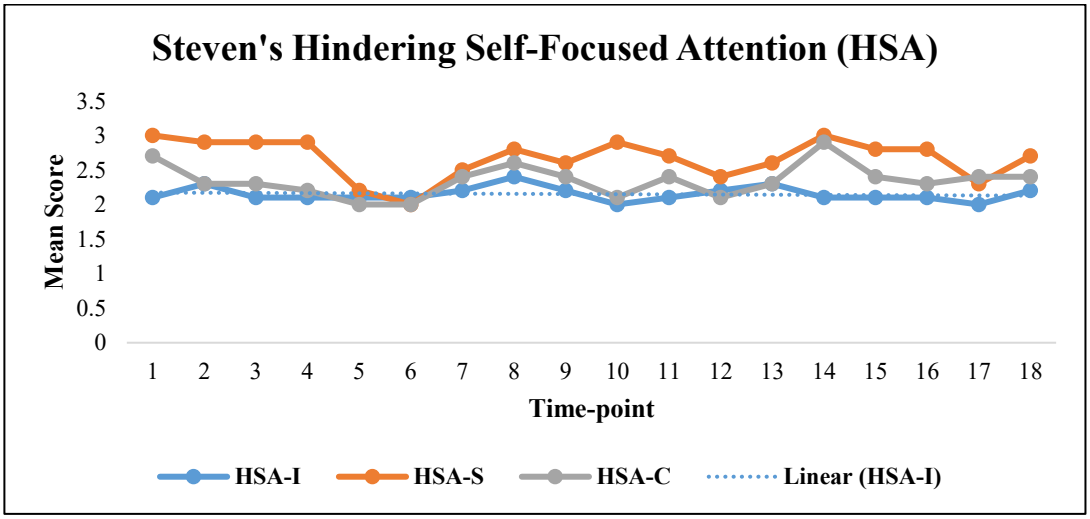
Steven belonged to the higher CSE group (M = 6.82) and the change was significant suggesting that his self-efficacy beliefs increased over the course of training. Steven's IPA accounts gathered that he had more challenging cases in the advanced stage, and he was more reflective about his HSA moments which surfaced during training and came up with HSA management strategies. However, the non-significant change in HSA suggested that Steven still experienced HSA moments across various training contexts. Steven found supervision to be helpful and he enjoyed having intellectual exchanges with his supervisor who treated him like a colleague. A few reasons could explain Steven's non-significant results for HSA and SWA. First, the adapted SAMS scales (Williams, Hurley, et al., 2003) might not be able to capture Steven's unique HSA moments accurately. Second, Steven could still be experiencing HSA but found it difficult to "peel away the layers" in responding to the surveys. Owing to his stable counsellor characteristics, Steven might have also behaved in a socially desired manner in front of his supervisor to be seen as "intelligent" and therefore, the SWA, which was already high to begin with, was unlikely to deepen.

For Steven, inadequate conceptual maps, glamorised expectations and incomplete counsellor self were the catalysts of his novice stress in the larger context of the training environment. Steven expected himself to be "intelligent" and he perceived himself to be able "to dance around people" in the beginning stage of training. In the advanced stage of training, Steven hoped to be admired for his "credibility". Naturally, Steven would expect a lot from himself to achieve his glamorised expectations. However, as the field of counselling was very different from his previous sales role, his sense of "disconnectedness" became triggered during his HSA moments. Steven candidly acknowledged his struggle to embody empathy, recognising that the role of a counsellor demanded a distinct skill set and qualities that he had yet to cultivate. Steven grappled with the challenges of reconciling his idealised self with that of a counsellor.

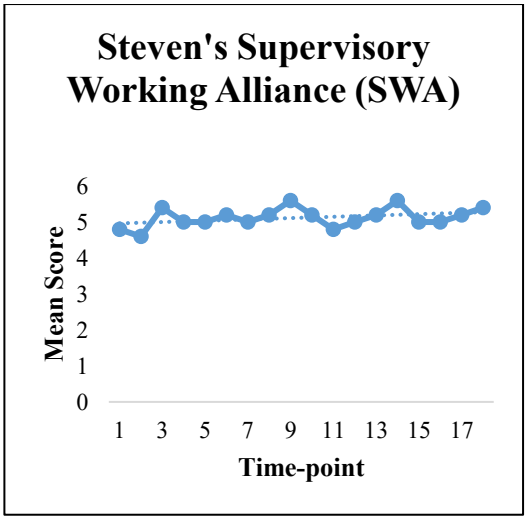
Results of Steven's Tau Analysis Over Time ($\tau_{(time.score)}$)

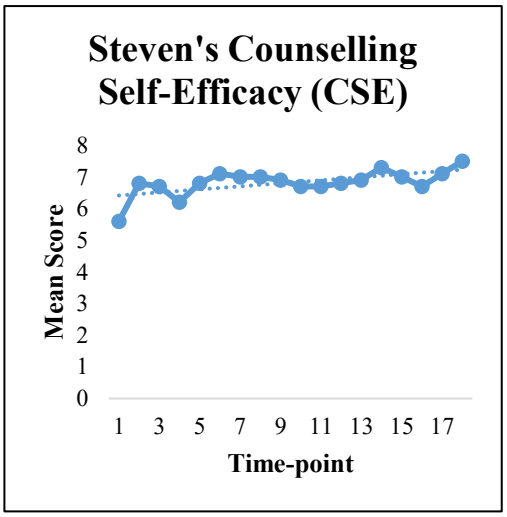
Participant	Variable	Tau	*p*-Value	CI 90%
Steven	HSA-I	-0.06	0.73	-0.343<>0.225
	HSA-S	-0.16	0.34	-0.447<>0.120
	HSA-C	0.13	0.45	-0.153<>0.415
	SWA	0.25	0.14	-0.029<>0.539
	CSE	0.39	0.03	0.102<>0.669
	CSE Mean (SD) 6.82 (0.41)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays


Steven's Supervisory Working Alliance (SWA)
Mean Score
0
1
2
3
4
5
6
1 3 5 7 9 11 13 15 17
Time-point


Steven's Counselling Self-Efficacy (CSE)
Mean Score
0
1
2
3
4
5
6
7
8
1 3 5 7 9 11 13 15 17
Time-point

Margaret

In the beginning stage of training, Margaret experienced HSA of fearing to speak up during a particular group supervision. Margaret recalled feeling intimidated and nervous to speak up and express her thoughts in group supervision. Margaret viewed her HSA moment through the lens of her culture and upbringing where she learned about familial and gender roles. In the advanced stage, Margaret again experienced a similar HSA moment and adopted the perspective of a counsellor to look at her HSA moment. Margaret realised the pressure she put on herself to "perform" in front of others compounded her intimidation. Margaret interpreted the HSA as her covert desire for assertiveness during both stages of training. She desired to be assertive enough to gain financial and personal independence. Margaret claimed to have a good working relationship with her supervisor and expressed her hope for her supervisor to push her outside her comfort zone. Margaret did not bring her HSA moment up for supervision, but IPA accounts gathered that she came up with HSA management strategies through journal reflection. Margaret felt that she was more competent in the advanced stage but acknowledged her disappointment when clients had "no-shows".

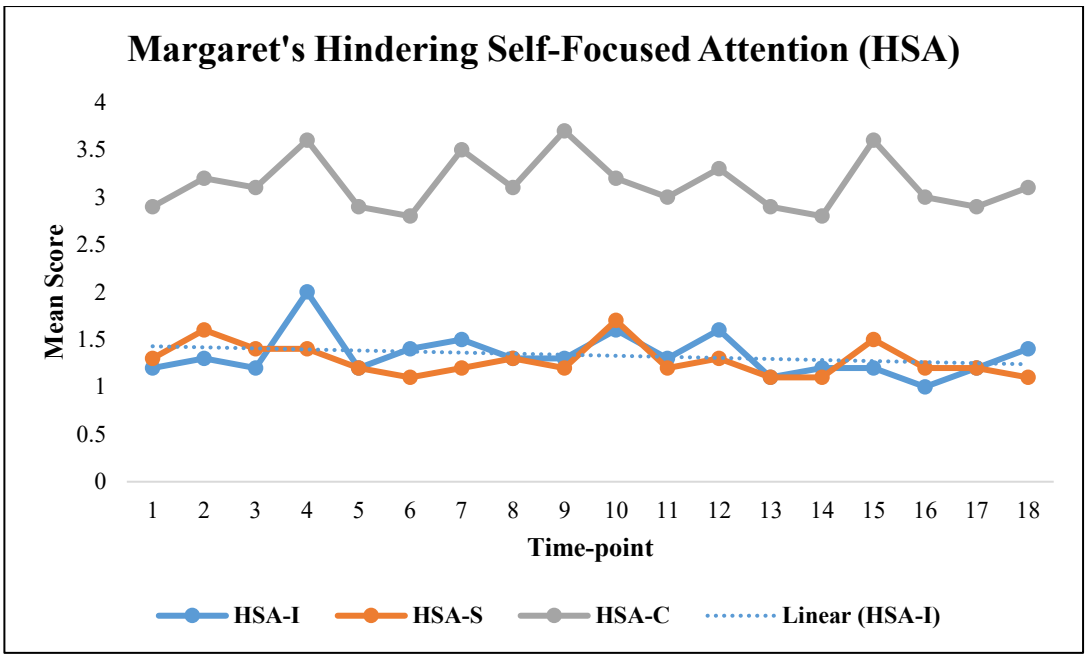
Margaret belonged to the higher CSE group (M = 6.42) but the CSE change was non-significant. IPA gathered that Margaret found HSA moments increasingly tolerable, but her change in HSA did not show that. While Margaret shared that she had a positive working relationship with her supervisor, her SWA change again did not show that. There seemed to be a therapeutic rupture when Margaret transitioned from the beginning stage to the advanced stage of training (i.e., from TP7 to TP10) that might have contributed to how Margaret perceived the working alliance. While Margaret felt that her CSE had increased in the advanced stage, her CSE change was non-significant as well. A few reasons could explain Margaret's non-significant changes. First, Margaret's cultural upbringing might have contributed to her low self-esteem and contributed to her high sensitivity around others (e.g., clients, peers, and supervisors). Alternatively, Margaret's counsellor characteristics could have made her more susceptible to anxiety and became a barrier to her competence and forming a relationship with her supervisor whom she perceived as another authoritative figure.

For Margaret, acute performance anxiety, fragile and incomplete counsellor self and porous emotional boundaries were the catalysts of her novice stress in the larger context of the training environment. Margaret struggled to speak up in front of others and felt intimidated around others. She was afraid that others might judge her and as a result, compounded her anxiety (i.e. HSA moments) and exacerbated her pressure to "perform". Despite having lived in Singapore for more than a decade, Margaret still felt like an "outsider" and she recognised that as contributed to by her culture and upbringing. Margaret's stable counsellor characteristics made her more susceptible to novice stressors which became a barrier to her development as a counsellor. She doubted herself in the counsellor role and found herself overidentifying with her clients' emotions. Despite having the competence, Margaret felt that her true abilities could not shine through in moments of her HSA.

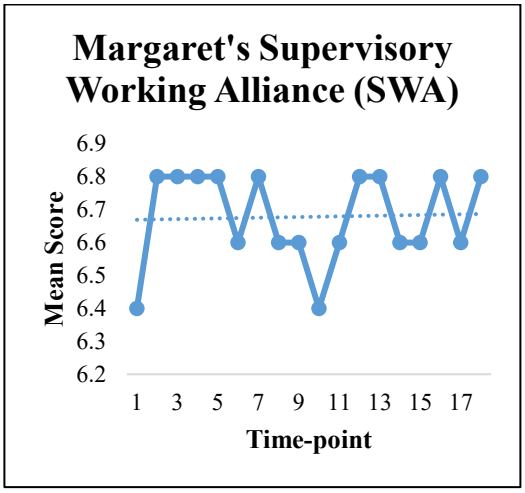
Results of Margaret's Tau Analysis Over Time ($\tau_{(time.score)}$)

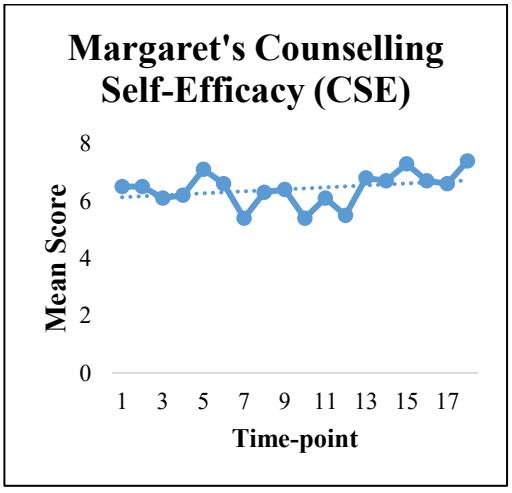
Participant	Variable	Tau	*p*-Value	CI 90%
Margaret	HSA-I	-0.13	0.45	-0.415<>0.153
	HSA-S	-0.30	0.08	-0.585<>-0.017
	HSA-C	-0.07	0.70	-0.349<>0.218
	SWA	-0.02	0.91	-0.303<>0.264
	CSE	0.26	0.13	-0.022<>0.545
	CSE Mean (SD) 6.42 (0.58)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays





Linda

In the beginning stage of training, Linda experienced HSA of feeling conflicted during a particular group supervision. Linda's HSA manifested as a series of self-doubting thoughts and conflicted emotions and she recalled reacting passive-aggressively during the group supervision to show the group supervisor her disapproval of his behaviour, but to no avail. Linda viewed that HSA moment through the lens of her unpleasant childhood memory when she learned to behave passive-aggressively to be heard by her family members. In the advanced stage of training, Linda experienced HSA of feeling resistant during a particular role-play with the lecturer. In that role-play, Linda assumed the role of a client struggling with lack of sleep; a personal issue that Linda was facing at that point in time. Linda made sense of her HSA moment through the perspective of a counsellor and realised that she had been unkind to herself all along. Linda felt that she was prioritising others' needs above hers. She interpreted her HSA as a covert desire for self-compassion to be an effective counsellor. Throughout the training, despite positive supervision experiences, Linda did not bring her HSA moments up for supervision. She also requested a change of supervisor when she transitioned from the beginning to the advanced stage. Linda reported positive working alliances with her supervisors but expressed that she had expected more from her supervisors in helping her to master skills. Overall, Linda perceived an overall increase in her self-efficacy beliefs.

Linda belonged to the higher CSE group (M = 6.17) and her CSE change was significant suggesting that Linda experienced an overall increase in her beliefs about her counselling competence. Linda's HSA-S change was also significant suggesting that Linda experienced less frequent HSA moments during supervision but her change in SWA was non-significant. A few reasons could explain Linda's non-significant changes in HSA during in-session and coursework setting (i.e., HSA-I and HSA-C), as well as her supervisory relationship (SWA). First, Linda could still be experiencing HSA around her clients or classmates. She could still be feeling conflicted or resistant when she prioritised her clients' (or classmates') needs over hers. Linda had different supervisors in the advanced stage. She might have felt more supported and closer to the advanced

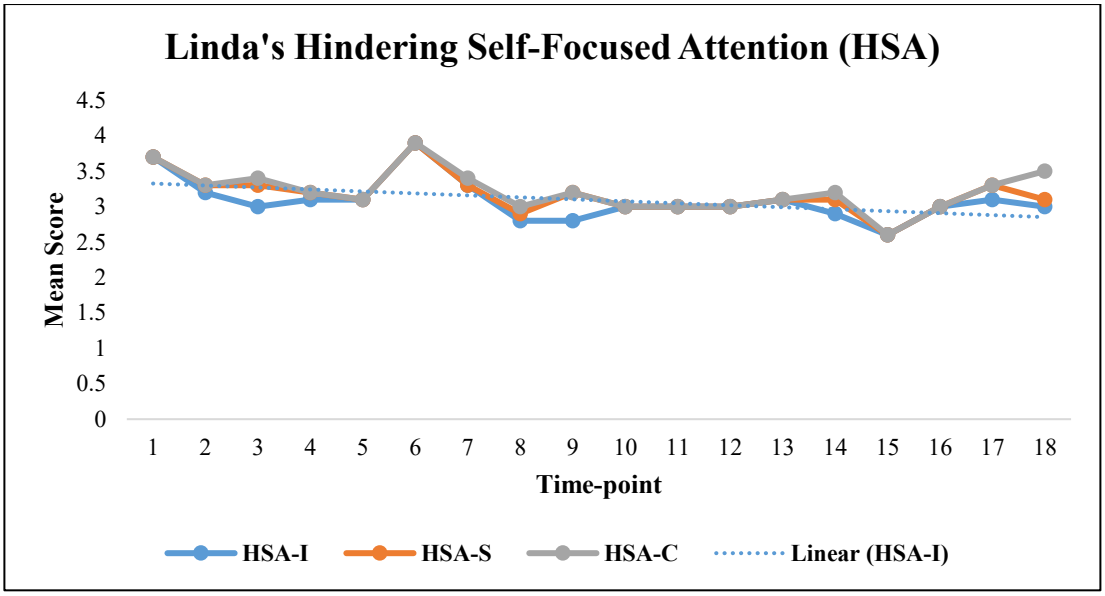
stage supervisor (as observed from TP 15 onwards), but the survey results might not be able to capture that.

For Linda, fragile and incomplete counsellor self and porous emotional boundaries were the catalysts of her novice stress in the larger context of the training environment. Linda was afraid that others might judge her and as a result, struggled to voice out her needs. Owing to childhood experiences, Linda learned that anger was bad and consequently, as a counsellor, she found it challenging to maintain healthy emotional boundaries with both her clients and classmates. Linda's stable counsellor characteristics left her vulnerable to novice stressors impeding her professional growth. Despite her aspiration to be an effective counsellor, Linda reported still searching for her authentic counsellor identity.

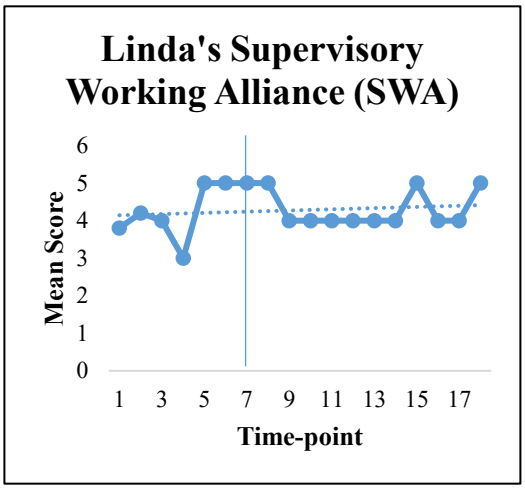
Results of Linda's Tau Analysis Over Time ($\tau_{(time.score)}$)

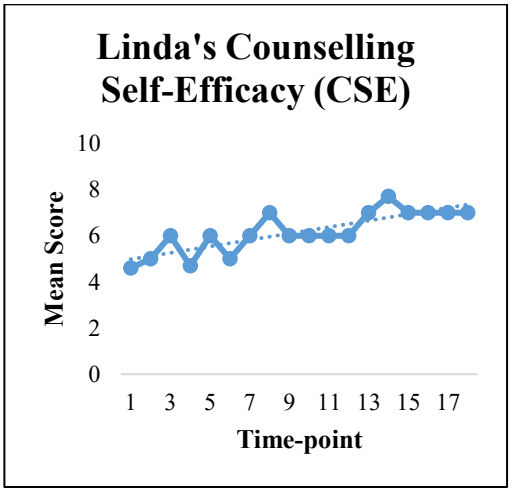
Participant	Variable	Tau	*p*-Value	CI 90%
Linda	HSA-I	-0.31	0.08	-0.591<>-0.023
	HSA-S	-0.37	0.03	-0.650<>-0.082
	HSA-C	-0.27	0.12	-0.552<>0.016
	SWA	0.07	0.70	-0.218<>0.349
	CSE	0.60	0.00	0.317<>0.885
	CSE Mean (SD) 6.17 (0.91)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays





Note: Linda reported a change in supervisor in the advanced stage of training in time-point 7

Amanda

In the beginning stage of training, Amanda experienced HSA of bodily sensations during a particular lecture on adverse childhood events. Amanda viewed the HSA moment through the lens of her unpleasant childhood memory and interpreted that as her body's reaction to coping with fear. Amanda's IPA narratives gathered that she found herself to have high self-expectations as a result of her childhood experiences. In the advanced stage, Amanda experienced a similar HSA of bodily sensations but viewed it through the lens of a counselling theory to discern the differences between the beginning stage and advanced stage HSA moment. This time, Amanda interpreted her HSA of bodily sensations as a spiritual gift, a "bodily cue" or "intuition" that she could rely on in her clinical work. Similar to Mary and Susie, Amanda's HSA preceded countertransference that were insights Amanda gained from her HSA moments. Amanda had different supervisors in the beginning and advanced stage of training, and she reported having very strong working relationships with them. Amanda shared that she felt safe to bring her HSA moments up for supervision. Amanda revealed that she felt competent in her counselling performance and desired to be a "wounded healer" but her CSE change was not significant.

Amanda belonged to the higher CSE group (M = 6.18) but the change in CSE was not significant. Amanda's significant HSA change (i.e., HSA-I and HSA-S) indicated that she experienced less frequent HSA moments during in-session and supervision suggesting that over time, she was more able to manage her HSA or more tolerant to her HSA of bodily sensations. Amanda's IPA accounts gathered that her supervisors were able to address her cognitive and affective processes with her and Amanda's SWA result confirmed that (i.e., significant change in SWA) although there was a very up-down pattern to her scores. A few reasons could explain Amanda's non-significant results for HSA-C and CSE. First, the adapted SAMS scales (Williams, Hurley, et al., 2003) might not be able to capture Amanda's unique HSA moments accurately (i.e., HSA of bodily sensations during coursework setting). Second, owing to her unpleasant childhood experiences, Amanda's stable counsellor characteristics might have left her vulnerable to her HSA when she was around others and hindered her

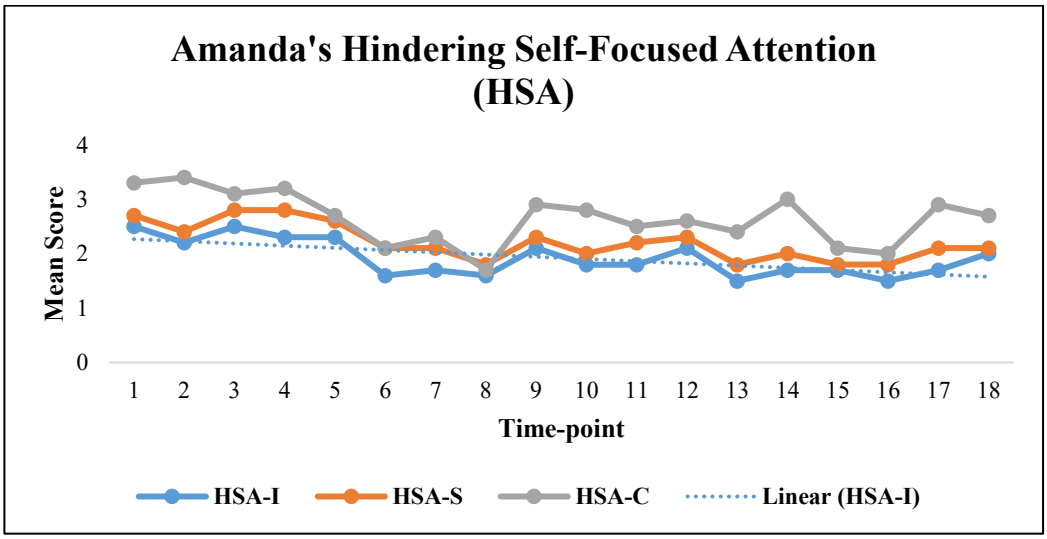
performance (i.e. the non-significant results were indeed true findings). Third, Amanda's high CSE right from the start of training might have affected the result.

For Amanda, fragile and incomplete counsellor self, glamorised expectations and porous emotional boundaries were the catalysts of her novice stress in the larger context of the training environment. Owing to her childhood experiences, Amanda was very sensitive around others and as a counsellor, it became challenging for her to maintain healthy emotional boundaries with others. Amanda acknowledged that her stable counsellor characteristics left her vulnerable to her self-expectations which might cause her to overidentify with her clients. Fortunately, in the advanced stage, Amanda was able to trust her body more but there remained a concern for Amanda between being overwhelmed by her bodily sensations and utilising them in developing her sense of self.

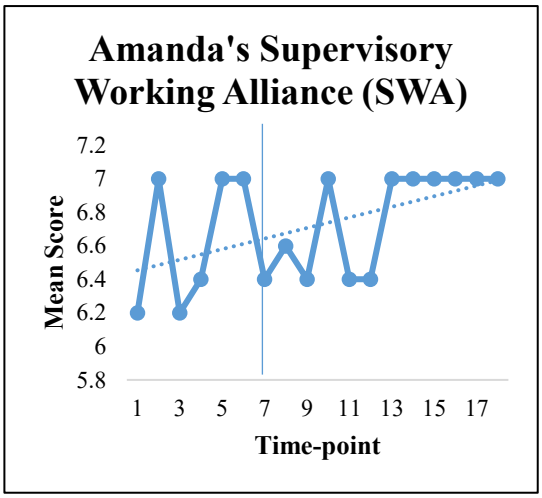
Results of Amanda's Tau Analysis Over Time ($\tau_{(time.score)}$)

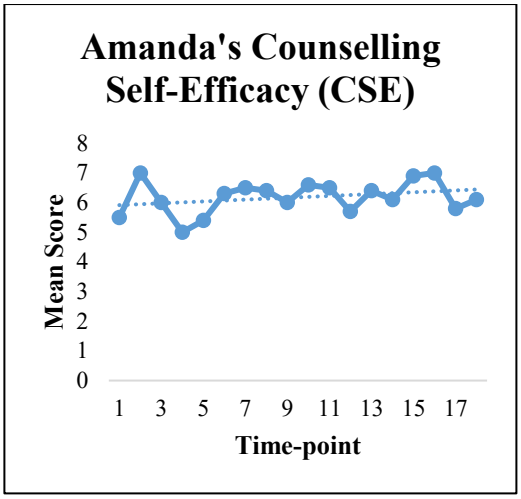
Participant	Variable	Tau	*p*-Value	CI 90%
Amanda	HSA-I	-0.42	0.01	-0.709<>-0.141
	HSA-S	-0.48	0.01	-0.768<>-0.200
	HSA-C	-0.33	0.06	-0.611<>-0.043
	SWA	0.35	0.04	0.063<>0.630
	CSE	0.20	0.26	-0.088<>0.480
	CSE Mean (SD) 6.18 (0.56)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays





Note: Amanda reported a change in supervisor in the advanced stage of training in time-point 7

Peter

In the beginning stage of training, Peter experienced HSA of self-consciousness when using formal English to speak to his classmates. He was mindful not to slip into Singlish, a colloquial form of English which Peter perceived to be inferior. Peter perceived his classmates as "those people" who were not the clique of friends he would hang out with. Peter looked at his HSA moment through his culture and upbringing, associating Singlish with a certain sociodemographic group. In the advanced stage, Peter experienced a similar HSA moment, but he adopted the perspective of a counsellor to make meaning of his HSA moment. This time, Peter interpreted his HSA moment as a clinical resource to establish rapport with his clients of diverse cultural backgrounds. In addition, Peter realised that his HSA manifestation included bodily cues that allowed him to remain present during the session. In both stages of his training, Peter interpreted his HSA moments as opportunities for growth. Peter reported having strong working relationships with his supervisors who were supportive. Most importantly, Peter felt accepted by his supervisors for who he was. Despite not disclosing his HSA moments to them, the acceptance from his supervisors was an implicit way of modelling that Peter learned and developed his competence.

Peter belonged to the higher CSE group (M = 7.07) and his CSE change was found to be significant. Peter's changes in HSA-C and SWA were also significant suggesting that Peter experienced less frequent HSA moment in coursework setting and an overall increase in his supervisory working alliance over the course of training. Peter's IPA accounts gathered that he had positive working alliances with his supervisors and that his supervisors provided a safe environment for him to model after them. Peter felt that he was able to speak to them normally without the fear of being judged. Additionally, he reported that their affirmations were instrumental in developing his confidence. A few reasons could explain Peter's non-significant HSA changes during in-session and supervision (i.e., HSA-I and HSA-S). First, the adapted SAMS scales (Williams, Hurley, et al., 2003) might not be able to capture Peter's unique HSA moments in coursework setting accurately. Second, Peter experienced significantly higher HSA of self-consciousness in coursework setting than both in-session and

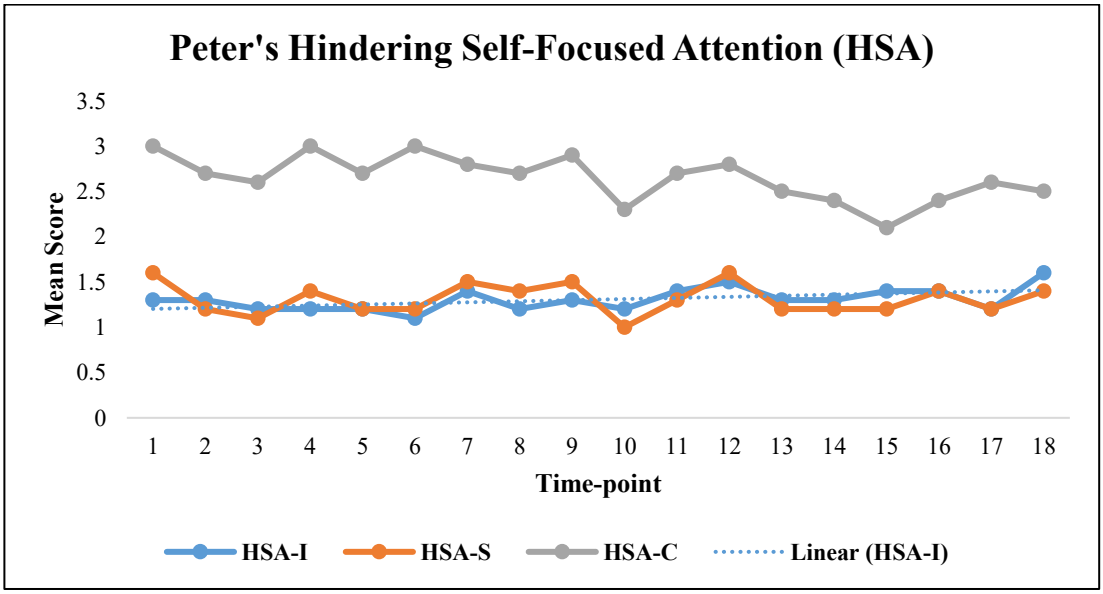
supervision which could imply that he was not hindered by his HSA in those two contexts (i.e., the non-significant HSA change in HSA-I and HSA-S).

For Peter, fragile and incomplete counsellor self and acute need for a positive mentor were the catalysts of his novice stress in the larger context of the training environment. Owing to his culture and upbringing, Peter had felt that others might judge him based on his academic background. Despite Singlish being part of his identity, Peter was embarrassed by it due to social stigma. Therefore, when he was able to gain acceptance from his supervisors, Peter's self-esteem also improved. Peter was able to model acceptance for himself and as a result, was able to establish an integrated counsellor self by the end of the training.

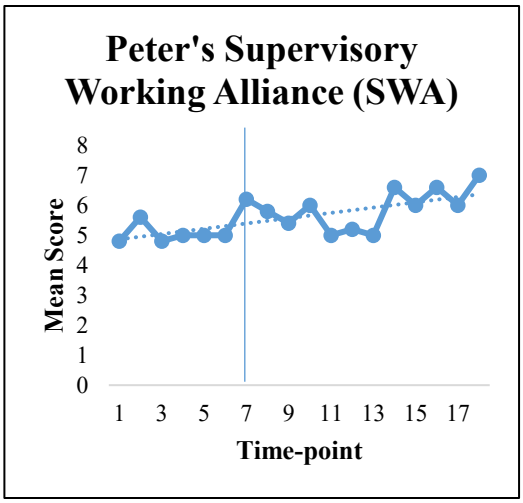
Results of Peter's Tau Analysis Over Time ($\tau_{(time.score)}$)

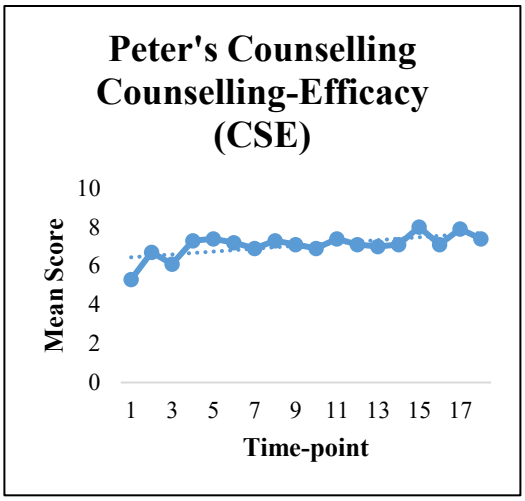
Participant	Variable	Tau	*p*-Value	CI 90%
Peter	HSA-I	0.31	0.07	0.030<>0.598
	HSA-S	-0.01	0.94	-0.297<>0.271
	HSA-C	-0.44	0.01	-0.728<>-0.161
	SWA	0.51	0.00	0.226<>0.794
	CSE	0.38	0.03	0.095<>0.663
	CSE Mean (SD) 7.07 (0.61)			

Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays; SWA = supervisory working alliance; CSE = counselling self-efficacy



Note: HSA-I = HSA during in-session with clients; HSA-S = HSA during supervision; HSA-C = HSA during coursework training such as attending lectures or peer role-plays





Note: Peter reported a change in supervisor in the advanced stage of training in time-point 7

L. Cronbach's Alphas for Current Study

Month 1	Alpha	Month 2	Alpha	Month 3	Alpha	Month 4	Alpha	Month 5	Alpha	Month 6	Alpha
HSA-I	0.96	HSA-I	0.94	HSA-I	0.94	HSA-I	0.93	HSA-I	0.96	HSA-I	0.97
HSA-S	0.96	HSA-S	0.97	HSA-S	0.96	HSA-S	0.97	HSA-S	0.96	HSA-S	0.97
HSA-C	0.51	HSA-C	0.79	HSA-C	0.69	HSA-C	0.90	HSA-C	0.84	HSA-C	0.89
SWA	0.70	SWA	0.85	SWA	0.90	SWA	0.96	SWA	0.94	SWA	0.95
CSE	0.93	CSE	0.95	CSE	0.96	CSE	0.97	CSE	0.99	CSE	0.99

Month 7	Alpha	Month 8	Alpha	Month 9	Alpha	Month 10	Alpha	Month 11	Alpha	Month 12	Alpha
HSA-I	0.95	HSA-I	0.96	HSA-I	0.97	HSA-I	0.97	HSA-I	0.96	HSA-I	0.96
HSA-S	0.95	HSA-S	0.96	HSA-S	0.97	HSA-S	0.97	HSA-S	0.97	HSA-S	0.97
HSA-C	0.93	HSA-C	0.87	HSA-C	0.94	HSA-C	0.89	HSA-C	0.75	HSA-C	0.83
SWA	0.93	SWA	0.93	SWA	0.93	SWA	0.92	SWA	0.94	SWA	0.97
CSE	0.98	CSE	0.99	CSE	0.99	CSE	0.98	CSE	0.98	CSE	0.98

Month 13	Alpha	Month 14	Alpha	Month 15	Alpha	Month 16	Alpha	Month 17	Alpha	Month 18	Alpha
HSA-I	0.95	HSA-I	0.89	HSA-I	0.88	HSA-I	0.96	HSA-I	0.93	HSA-I	0.89
HSA-S	0.96	HSA-S	0.96	HSA-S	0.91	HSA-S	0.90	HSA-S	0.94	HSA-S	0.94
HSA-C	0.73	HSA-C	0.85	HSA-C	0.95	HSA-C	0.84	HSA-C	0.68	HSA-C	0.61
SWA	0.99	SWA	0.99	SWA	0.98	SWA	0.98	SWA	0.97	SWA	0.98
CSE	0.99	CSE	0.98	CSE	0.99	CSE	0.99	CSE	0.99	CSE	0.99

M. Poster and Oral Presentations

Toh, MH.C., Barlas, J., & Singh, S. (2022, July 1-15). *Am I competent enough? A mixed-methods longitudinal study exploring trainee counsellors' lived hindering self-awareness experiences and its influence on counselling self-efficacy* [Poster Presentation]. Harvard-UCL Summer Course 2022 "Emotional Well-Being and Physical Health" UCL, London, United Kingdom.

Toh, MH.C., Barlas, J., & Singh, S. (2022, December 3-4). *Am I competent enough? A mixed-methods longitudinal study exploring trainee counsellors' phenomenological hindering self-awareness experiences and its perceived influence on counselling self-efficacy* [Conference Presentation]. Joint-Higher Degree Research Conference 2022 "Postgraduate Passages: Navigating Research and Networking in the Next Normal" JCU, TU and URM, Singapore.

Toh, MH.C., Barlas, J., & Singh, S. (2023, March 24-28). *An Interpretative Phenomenological Analysis of trainee counsellors' phenomenological hindering self-awareness* [Conference Presentation]. 6th International Academic Conference on Research in Social Sciences 2023, Oxon, Oxford, United Kingdom.

N. Search Strategy

This is a comprehensive view of the search terms and databases that informed the study.

Search filter #	Search Terms
#1	self-aware*
#2	Mindful*
#3	felt-sense
#4	clinical intuition
#5	embodiment
#6	countertransference
#7	stress*
#8	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7
#9	counsel* supervision
#10	counsel* training
#11	counsel* education
#12	counsel* role-play
#13	counsel* group supervision
#14	counsel* discussion
#15	#9 OR #10 OR #11 OR #12 OR #13 OR #14
#16	trainee*
#17	student*
#18	intern*
#19	#16 OR #17 OR #18
#20	#8 AND #15 AND #19
Truncation symbols (*) were used to search for various word endings. For example: "counsel* training" would search for "counseling training," "counsellor training," etc.	
Databases Searched: PubMed, PsycINFO, Google Scholar, Scopus, Web of Science, JSTOR	
Searched Period: 1990-2024	