EJQRP (2024) Vol. 14, 44-61 ISSN: 1756-7599

European Journal for Qualitative Research in Psychotherapy
www.EJQRP.org
European Association for Integrative Psychotherapy

Learning from embodied tension: A naturalistic multimodal single case study of nonverbal expressions and interactions in a psychotherapy training process

Cecilie Hillestad Hoff, Helene A. Nissen-Lie, & Hanne Strømme

Department of Psychology, University of Oslo, Norway *E-mail:* c.h.hoff@psykologi.uio.no

Abstract: This multimodal single case study explored how nonverbal communication was handled in a psychodynamic training process**.** Using a multimodal qualitative method, video recordings of a 39 sessions psychodynamic therapy process (with a female therapist treating a male client with relational issues), parallel supervision sessions, and Interpersonal Process Recall interviews with the client and therapist, were analyzed within the framework of Reflexive Thematic Analysis (RTA). The analysis yielded three themes: a) The therapist's insecurity seemed to have compromised her capacity to use her own bodily signals to facilitate the exploration of emotions together with the client; b) The therapist and the supervisor were sensitive to the nonverbal cues from the client, but supervision did not explicitly explore how the therapist could use this sensitivity to moderate her own bodily signals and inform her clinical interventions; and c) Supervision supported the therapist in tolerating embodied tension in the therapeutic relationship*.* This study illustrates the close relationship between therapists' capacity for emotion regulation and their nonverbal relational skills. A more open exploration of the trainee's emotion regulation capacities in supervision may have supported her to deal more effectively with her own and the client's nonverbal expressions.

Keywords: Nonverbal psychotherapy skills; Synchrony; Therapists' emotion regulation; Training; Video recordings of psychotherapy/supervision

A growing number of interdisciplinary research studies suggest that affect as communicated through body language, and facial expressions serve fundamental regulating functions in psychotherapy, as in all human relationships (Benecke et al., 2005; Doering, 2022). In psychotherapy, clients may verbally express an intention to explore their inner thoughts and feelings, but simultaneously, through nonverbal cues such as gaze behavior, laughter, or nonverbal tension, signal difficulties with exposing themselves in the therapeutic setting

(Eubanks et al., 2023). Correspondingly, therapists may through nonverbal expressions implicitly communicate difficulties related to the therapist role (Foley & Gentile, 2010). Hence, to fully comprehend the relational dynamics in psychotherapy, therapists must cultivate their sensitivity to their own and clients' nonverbal expressions, and the ability to use both verbal and nonverbal knowledge modalities forms an essential part of therapists' relational capacities (Altmann et al., 2020; Castonguay et al., 2023; Grace et al., 1995; Gullestad, 2022; Hill et al., 2020).

When clients experience difficulties in the therapeutic relationship, these sentiments are, as Safran et al. (1990) argue, most often expressed indirectly, through sarcasm, passive-aggressive behavior, or nonverbal cues. When these expressions signal criticism towards the therapist, they may trigger the emotional vulnerability of the therapist in a way that requires a specific set of relational skills (Castonguay et al., 2023). To address these feelings directly can be a threatening experience, and especially among inexperienced therapists there is a natural tendency to avoid this, or to respond defensively to the "threat" (Safran et al., 1990). Furthermore, it is demanding to develop these skills because they depend on the therapist's own emotion regulation capacities (Gross et al., 2019).

Literature Review

During the last decade, an increasing number of studies have empirically explored how nonverbal communication plays out in naturalistic therapy settings. Altimir & Jiménez (2021) for example, used advanced camera technology to investigate how affect regulation involves a process through which both clients and therapists experience and regulate internal affective states, while expressing those consciously and unconsciously through verbal and nonverbal channels. Another line of research has investigated how nonverbal synchrony, defined as "the coordination of patient's and therapist's movement" (Ramseyer & Tschacher, 2011, p. 284) evolves in the therapeutic relationship. Although empirical research so far has produced contradictory results regarding the relationship between nonverbal synchrony and outcomes (Ramseyer & Tschacher, 2014; Ramseyer, 2020; Zilcha-Mano, 2024), it has established that such a relationship exists beyond coincidence (Altman et al., 2020; Bar-Kalifa et al., 2023; DeresCohen et al., 2021). In a recent review of the topic, Atzil-Slonim et al. (2023) conclude that facilitation of dyadic synchrony is a core therapeutic skill that occurs at a nonverbal level and underlines verbal therapeutic work.

Despite this, empirical research on nonverbal aspects of psychotherapeutic competence and how it develops, is scarce. As Ramseyer and Tscacher (2011) argue, research exploring the development of the alliance in psychotherapy has prioritized speech content over nonverbal behavior. They further highlight that nonverbal aspects of alliance formation usually have been assessed at either the level of the client or the therapist, ignoring the interaction within therapeutic dyads. As Atzil-Slonim et al., (2023) stress, very few studies have examined how therapists facilitate dyadic synchrony in ways that lead to beneficial outcomes.

Kinseth (1989) noted that clinical intervention on client nonverbal behavior is remarkably unsystematic and encouraged clinicians and supervisors to pay attention to patterns of multichannel communication in which verbal and nonverbal expressions give meaning to each other. Despite this, the knowledge gap regarding nonverbal behavior in psychotherapy is also notable in the empirical literature on supervision and nonverbal expressions. Grace et al. (1995) found that with a brief training in nonverbal attending and responding skills, trainees increased their responses to client nonverbal behavior, which subsequently led to higher client ratings of the working alliance. However, to our knowledge, no studies have investigated how supervision affects the relationship between trainees' emotion regulation capacities and their ability to respond adequately to clients' nonverbal expressions of emotional strain in the therapeutic relationship. Accordingly, to gain more insight into how training programs should be formed to support trainees' development of nonverbal skills to optimize treatment outcomes, there is a need for more empirical studies, both ideographic and nomothetic.

Incorporating nonverbal expressions in psychotherapy research requires novel research strategies by use of video recordings of naturalistic therapy sessions, *enabling direct observations of how nonverbal cues are played out in the therapeutic encounter* (e.g., Altimir & Jimenéz, 2021; Altmann et a., 2020; Barros et al., 2016; Ramseyer & Tschacher, 2014; Ramseyer, 2020). By observing video recorded naturalistic therapy sessions and supervision sessions we wanted to investigate how nonverbal expressions and interactions, such as gaze behavior, smiles, laughter, body posture, and nonverbal tension were expressed and handled in psychotherapy and supervision. Additionally, one semistructured interview and one Interpersonal Process Recall interview (Elliot, 1986) were conducted both with the therapist and the client to compare with those observations.

We also included a description-note from the clinical supervisor to gain access into her reflections of the process
after we had analyzed the other sources of data. By use of this multimodal method the subjective perspectives of the informants were triangulated with observational data (Braun & Clarke, 2013).

Aims and research questions

The aim of the study was to investigate how the use of a multimodal method approach could enable an exploration of the gap between what was communicated verbally and nonverbally during therapy, and to shed light on how nonverbal communication was handled in the training process. We developed the following research questions based on our analysis of a clinical case in which there was a marked nonverbal tension between the client and therapist: How did the psychotherapy trainee use nonverbal knowledge modalities, along with verbal knowledge modalities when relevant, to handle the nonverbal communication in promoting client change? How did supervision support the student therapist in cultivating her ability to simultaneously utilize both verbal and nonverbal modalities?

Methodology

Design and Study Setting

This study had a naturalistic, multimodal design, and was composed of a combination of three different qualitative approaches: (1) direct observations of video recorded therapy and supervision sessions, (2) two interviews with the therapist and the client, and (3) an independent description-note from the supervisor. To enable a detailed exploration of how the nonverbal interactional patterns played out in the therapeutic relationship, we decided to do an in-depth analysis of withincase complexities rather than across cases (Levitt et al., 2021; McLeod, 2010). By observing the video recorded therapy sessions on a micro-level, we gained access both to the verbal level of the therapeutic dialogue, and to the implicit nonverbal forms of communication, both from the therapist and the client. Observations of the supervision sessions, which were video recorded too, enabled a detailed investigation of both verbal and nonverbal interactions in the supervision group, and shed light on how nonverbal communication was addressed in supervision.

This single case study is part of the Nordic Psychotherapy Training Study (NORTRAS). This is a large-scale longitudinal study collecting video recordings of therapy and supervision sessions at the Internal Clinic at the Department of Psychology,
University of Oslo. At the end of their six-year study program in clinical psychology, students offer supervised individual psychotherapy to clients at the university clinic and attend three-hour weekly group supervision sessions. The qualifications of the trainee at the end of this program are comparable to most graduate training programs (i.e., PsyD) or PhD programs in clinical psychology elsewhere.

Participants

The student therapist, referred to as Emily, is a Caucasian female in her twenties. She is in her last year of the psychology study program and has previously had various therapist experiences from short term therapy, but not from intensive therapy.

The client, referred to as Marcus, is a Caucasian male a couple of years older than Emily. In his application to the student clinic, he expressed that he had difficulties with getting in touch with, and expose, his emotions, which led to distress in his close relationships.

The supervisor is a Caucasian middle-aged female who is a researcher and an experienced clinical psychologist and supervisor in psychodynamic psychotherapy.

Case-selection and data material

The selected case is a psychodynamic training therapy. It was suggested by the third author, due to her prior knowledge of the case, as particularly suited for an in-depth case study of relational competence, because the therapist was judged to go through a substantial change in her ability to evoke an emotional contact with the client.

The case consists of thirty-nine therapy sessions, where thirtyeight were video recorded (*n=38*), and fourteen supervision sessions, where eleven were video recorded (*n=11*). The missing therapy session was not video recorded because it was conducted as a zoom meeting. The three missing supervision sessions are evenly spread throughout the process and were not video recorded due to technical issues.

The interviews

The interviews with the therapist and the client were conducted by the first author. In each case, the first interview followed a semi-structured interview guide (Appendix A1). The interviews were performed as an explorative dialogue about the informants' experience of the therapy process, the therapeutic relationship, and the process of change. It started out with open questions about the process. Only in the final phase were the specific questions about nonverbal behavior addressed.

The second interview was informed by the Interpersonal Process Recall procedure (Elliot, 1986). Such an interview uses video-assisted recall to access often unspoken experiences in interactions (Meekums et al., 2016). Before the interviews, the first author selected passages from the video recorded material of the therapy sessions that were considered particularly important for investigating the research questions. This included five passages from sessions (1), (2), (7), (13), and (19), where the nonverbal interactional pattern within the therapeutic dyad was tense and seemed unsynchronized, and two passages from session (27) and (29) where there was a more relaxed and synchronized interactional pattern between the client and the therapist.

During the interviews, the informants and the interviewer watched these passages together, and the informants were asked about their immediate reflections to the material. All interviews were video recorded. The first interview with Marcus was lacking sound. To compensate for this, the first author wrote down his answers later the same day, and the questions considered most important were repeated during the second interview.

Description-note from the supervisor: One of the members in the research team was the clinical supervisor in the selected case. She had firsthand knowledge of the training process, which could add nuances and complexities to the data analysis, reaching beyond an observational perspective. In a description-note, she wrote down reflections of her perception of the therapist´s development, the client's development, and the quality of the therapeutic relationship. This note was used to shed light on the other data and was not included in the analytic process until later.

Data analyses

The analysis of the video recorded data material was conducted within the frame of Reflexive Thematic Analysis (RTA; Braun & Clarke, 2006; 2019). As this method is developed to systematically study complex phenomena, it is well suited for capturing the complexities of our research topic where we aimed to investigate both explicit and implicit forms of communication and see these multiple streams of communication modalities in the context of the dynamics in the therapeutic relationship. In line with the principles of RTA, we aimed to achieve a reflective and thoughtful engagement with our data and the analytic process (Braun & Clarke, 2019), to follow the principles of an inductive RTA, and meet the clinical material with openness and reflexivity (see e.g., Levitt et al., 2021). The process involves the following six steps (see below): (1) Familiarizing oneself with the data; (2) Generating initial codes; (3) Generating themes; (4) Reviewing themes; (5) Defining themes; and (6) Creating the report (Braun & Clarke, 2013). In accordance with this, the data analysis proceeded through the following stages:

(1) Initially, the aim of the first author was to explore important aspects of the relational skills of the trainee therapist in the selected case. She started to observe the therapy and the supervision sessions in chronological order. In their first meeting, the research group watched three passages from therapy session (1) and (2), and all three researchers spontaneously commented that there was a tense atmosphere in the therapeutic relationship. In the beginning of the second meeting, in order not to "contaminate" the observer stance of two of the authors, we decided that the clinical supervisor should not participate in this first part of the analysis but instead write a description-note.

(2) In the further process the first author watched all the therapy and supervision sessions, taking notes of her immediate reflections. She discussed selected parts of the material with the other author. We became aware of how Marcus displayed tension through his nonverbal behavior, e.g., by shaking his leg repetitively, taking on and off his wristwatch, and withdrawing his gaze. Emily also communicated tension nonverbally, for example through a quick speech and a high pitch in the tone of her voice. These nonverbal tensions were not verbalized during the therapy process. Thus, a preliminary first finding which struck us was that the tense atmosphere was intertwined with *a lack of open exploration of the nonverbal interactional patterns.* We became particularly interested in passages where Emily's interventions were incongruent with Marcus' nonverbal cues. For example, we became aware of a scene from session (5), where Marcus talked about how he felt it was difficult to tell his colleagues about his therapy, but not his boss. While talking, he smiled uncomfortably and withdrew his gaze. Emily

responded by saying *That is interesting*. We discussed how this intervention failed to incorporate Marcus' nonverbal expressions in advance of her intervention, leading to an observable decreased emotional contact between them. We became interested in how Emily generally attuned to Marcus' nonverbal expressions in her interventions and decided to narrow the research questions towards her ability to utilize nonverbal knowledge modalities in her therapeutic work.

(3) The first author selected parts of the material that was of particular importance for the research questions (therapy session 2, 5, 6, 7, 8, 13, 19, 27, 29, supervision session 1, 2, 4, 7). The material was transcribed verbatim, including nonverbal expressions (with detailed descriptions of nonverbal behavior). For the therapy sessions we developed codes such as *withdraws gaze, bites his nails hard,* and *eats his words* (see table 1). For the supervision sessions, we developed codes such as *the corporal uneasiness is a pain, and gazes sincerely at the supervisor.* The two authors coded selected parts of the material from the therapy sessions (5 and 13) individually and discussed and modified the coding process. When coding nonverbal expressions, we realized that it was necessary to see the nonverbal expressions in relation to the verbal dialogue, thus at this step return to again include relevant verbal data.

(4) The first author conducted the individual interviews with Emily and Marcus. She transcribed the interviews verbatim, and coded the material, resulting in a development of codes such as *therapist verbalizes a fear of being critical, therapist expresses an observed change in the clients' nonverbal expressions*, and *the client remember "being all over the place".*

(5) Based on the RTA analysis of the therapy sessions, supervision sessions, and the interviews, the first author generated suggested themes. She then selected clinical examples illustrating the different themes and presented and discussed these with the other author.

(6) Finally, the clinical supervisor shared her description-note with the rest of the group and was informed by the first author about the development of the more specific research questions and the themes. The supervisor took part in our further meetings where we discussed her thoughts, together with the two other authors´ reflections during the prior analysis. We discussed the themes and found the themes below (Findings) that in our view best represented the complex data.

Transcripts	Codes therapist	Codes client	Comments
E: Mm. So, for how long do you have to wait, considering her needs? M: (withdraws gaze, bites his nails hard) Until she is finished ("eats his words", tightens the muscles in his jaw, withdraws gaze) with what she is doing (smiles). E: (giggles) And that takes a long time? M: That varies (withdraws gaze, smiles). E: Ok.	How long do you have to wait? Giggles That takes a long time?	Until she is finished with what she is doing. Withdraws gaze Bites his nails hard Eats his words Tightens muscles in his jaw Smiles That varies. Withdraws gaze Smiles	The way he is eating his words, biting his nails, and tightening his jaw as he speaks gives the impression that he is withholding some feelings. The quality of these movements is harsh and rough. Is he angry or frustrated because he must consider his wife's needs? She is giggling. This response does not incorporate his nonverbal cues. How to understand her laughter? Is it a response to his smile?

Table 1: Illustrations from transcripts

The research team/reflexivity

The research team consisted of three researchers, all with extensive clinical experience from psychotherapy and supervision and all primarily anchored in a psychodynamic perspective. The first author is a PhD candidate and a Clinical Psychologist. She has a background as a choreographer and dancer within contemporary dance. When working with the

transcription of the nonverbal aspects of the data material, she experienced that her knowledge of how the body can communicate inner states, supported her in the analyses. As such, we believe that her professional experience with embodied ways of communication enriched the transcriptions of the data material and added strength and nuances to her clinical understanding. The second author is a Professor and Clinical Psychologist, and the third author is an Associate Professor and Clinical Psychologist.

In line with the consensual qualitative method of Hill et al. (2005), we adhere to the idea that we as a group consisting of psychologists with extensive experience, both as clinicians and researchers, are specifically prepared for observing and reflecting upon this form of clinical material. In line with the principles of RTA, we have aimed to be collaborative, reflexive, and creative during the analytic process. Rather than attempting to achieve consensus within the group, our different perspectives were used to sense-check our ideas and explore multiple interpretations of the data (Braun & Clarke, 2013). For example, we had different understandings of how to interpret the quality of a smile. Whereas one researcher saw the smile as a regulative maneuver, another underlined the insecurity in the smile. In these situations, we looked at the data again, and discussed in detail how our interpretation was anchored in the observed data. As such, we experienced how our different perspectives encouraged us to remain open and flexible in our analytic approach and enriched our understandings of the material.

According to Braun and Clarke (2006; 2013; 2019; 2021), reflexive research demands that the researchers acknowledge their role in production of knowledge and reflect on how their various positions might shape the collection and analysis of data. As the research team is anchored in a psychodynamic perspective, this has obviously shaped our way of understanding the data. Still, during our observations, we aimed to be conscious of not looking for empirical support for theoretical concepts, but rather let the data be in the foreground. Thus, as researchers we had to increase our awareness of implicit as well as explicit theoretical preconceptions and be willing to put them under scrutiny.

Ethical issues

The project is approved by the Data Controller at the University of Oslo and has received a Letter of Exemption from the Regional Committee for Medical & Health Research Ethics in Norway. We acknowledge the vulnerability of the therapist, the client, and the supervisor associated with being observed and analyzed. During the process, they have had the possibility of reading the material and contribute with their own perspectives. We have obtained written consent from all participants, and they have approved of the submitted version of this manuscript.

Findings

The reflexive thematic analysis of the video recorded material and the interviews/ IPR interviews with the informants yielded three themes: a) The therapist's insecurity seemed to have compromised her capacity to use her own bodily signals to facilitate the exploration of emotions together with her client, b) The therapist and the supervisor were sensitive to the nonverbal cues from the client, but supervision did not explicitly explore how the therapist could use this sensitivity to moderate her own bodily signals and inform her clinical interventions, and c) Supervision supported the therapist in tolerating embodied tension in the therapeutic relationship. As different aspects of the material, independently of the chronological order of the training process, illuminate each theme, the presentation does not follow a temporal pattern, but is structured according to the themes to present complexity by triangulating information from different data sources.

Theme a) The therapist's insecurity seemed to have compromised her capacity to use her own bodily signals to facilitate the exploration of emotions together with her client.

During our observations of the therapy sessions, we recognized a lot of tension in the nonverbal interactional pattern between Emily and Marcus. This tension played out especially in the first four months of the treatment process and were never openly addressed during sessions. In the following passage from the beginning of session (1), Emily talks quickly with a high pitch in the tone of her voice. Her facial expression signals eagerness and enthusiasm. While she is talking, Marcus withdraws his gaze and looks down on the floor or out at the room with a flickering quality of his gaze. He smiles uncomfortably, moves around in his chair, scratches his forehead, and corrects his clothes several times.

E: There, welcome!
M: Thank you.

E: I have already introduced myself on the phone, but my name is Emily.
M: Yes.
E: So, yes, welcome to the student clinic. Uhm, we will be working here for a while, so in the beginning, I will spend some time to get to know you better.
M: Yes.

As Marcus says *Yes* at the end of this passage, he is leaning his body and face away from Emily. When he moves his body back into the chair, he continues to look out at the room with a flickering gaze, looking uncomfortable and disturbed. Emily smiles to Marcus, apparently to try to evoke emotional contact. Her eager facial expression does not seem to match Marcus' discomfort. The nonverbal interactional pattern is non-synchronized, and Emily appears to resort to an automated, learned strategy to try to reassure Marcus, instead of using her own bodily expressions to down-regulate his uneasiness, e.g., by a sincere facial expression that adhered to Marcus' difficulties. When Marcus turns his body and face away from Emily, he may have signaled that he felt she was not in sync with him.

During the IPR interview, after watching this passage, Emily said: "Oh, that was uncomfortable to watch. I notice that I speak quickly and smile a lot. He must have noticed how insecure I was". Marcus said: "I seem very uncomfortable. I get uncomfortable now, when watching it. I haven't been still for a second (….) I guess it is an expression of an inner tension".

In the further therapy process both Emily and Marcus continued to signal a markable tension nonverbally. Marcus displayed strong difficulties in sharing his thoughts and emotions. When he struggled to start the sessions and with knowing what to say, his nonverbal tension was more prominent. Emily could verbally encourage Marcus to explore his thoughts or feelings, but simultaneously through nonverbal cues signal uncomfortable feelings evoked in the situation. In the following passage from the beginning of session (8) Marcus is clapping his hands a couple of times as he smiles and withdraws his gaze, before he closes his eyes and scratches his face. He sighs heavily, and then speaks with a trembling voice which develops into a nervous laughter as he gazes out at the room with a flickering gaze.

M: Yes…what should we do today?
E: (Giggles loudly) Mm.
M: Like, I don't have anything (…) concrete today.

Again, we see that Emily's and Marcus' nonverbal expressions are tense and non-synchronized. Emily does not downregulate her own, and Marcus', emotional tension. Instead, her loud laugher gives the impression that she is aroused by Marcus' laughter and struggles to regulate her own emotions in the moment.

At the end of his first interview, Marcus was asked whether he thinks he had the same kind of motoric uneasiness in other situations at the time, and he responded: **"**No, no. I don't think so. It had to do with the situation"*.* At the end of her first interview, Emily was asked about her own body language during therapy sessions. She said*:*

In the beginning, I think I was pretty self-conscious. Like, how I appeared and what he would think of me. (….) It was very difficult, and I think it was very much caused by the client's expression. I felt like what can I contribute with here?

Observations of the supervision sessions revealed that Emily during supervision had a different nonverbal behavioral pattern than during therapy sessions. Here she was calm, natural, and came forward as competent and skilled. During the interviews, neither Emily nor Marcus showed any prominent signs of nonverbal tension. In our further analysis, we aimed to explore these contradictory behavioral patterns.

In her first interview Emily expressed that she knew that Marcus, in an interview with the supervisor in advance of the process, had asked if Emily was younger than him. She felt that she had to compensate for her young age by being more competent or by saying "the right things". She underlines that her insecurity made it difficult for her to approach Marcus with a natural facial expression:

I thought about that, how it is for him to sit here with a therapist who is younger than him. I felt a need to compensate for that, by being competent and say the right things (…) And then, to stay in that insecure position. I didn't know what to do (….) It is difficult to be a novice (….) Like, with my face, how should I put it?

In the first part of Marcus' interview, before he was told that nonverbal communication was the topic of the study, he revealed that there was something in the relationship with Emily that he experienced as difficult. When trying to explore these difficulties he associated by himself to Emily's body language:

I: Let us take a closer look at your relationship with your therapist. How did you experience that?
M: (Laughs). Uhm, that's difficult. Well, she seemed a bit insecure (….) I don't know what it was, maybe there was something about the body language.

Later in the same interview, after the topic nonverbal communication was introduced, he particularly mentions Emily's facial expressions:

I: In what sense were you aware of what Emily communicated nonverbally to you?
M: I don't know if I was conscious of that back then. But thinking about it now, I feel that it was like she sometimes sat like this (demonstrates an empty facial expression), as if she was waiting for me to come up with something.

In her description-note, the supervisor reveals that she was aware of Emily's nonverbal expressions: "In the work with the patient, some of her (Emily's) insecurity and 'motor' nervousness came through". However, observations of the supervision sessions revealed that they never explicitly addressed Emily's nonverbal expressions in therapy. During her interview when Emily was asked about this, she sounded surprised when she said "No, I can't remember us talking about that". When the supervisor was informed of this finding, she emphasized how she was impressed by Emily's ability to work with Marcus' difficulties in getting in touch with his emotions. She underlined Emily's courage and her willingness to come forward with her vulnerability and insecurity. At the same time, the supervisor expressed that she may have sensed a need in Emily to protect her inner state. She reflected on whether this may have made her more careful in her interventions and might have contributed to an avoidance of a deeper exploration of the uncomfortable feelings that played out between Emily and Marcus.

In sum, this theme demonstrates that the nonverbal interactional pattern between Emily and Marcus during the first four months of treatment was recognized by a prominent nonverbal tension which was not verbalized during the therapy. Emily did not use her body language to regulate her own and Marcus' inner states, and their bodily expressions during sessions were largely non-synchronized. Even though both Emily and the supervisor were aware of how Emily through nonverbal cues signaled tensions and insecurity, this was not explicitly addressed in supervision.

Theme b) The therapist and the supervisor were sensitive to the nonverbal cues from the client, but supervision did not explicitly explore how the therapist could use this sensitivity to moderate her own bodily signals and inform her clinical interventions.

In the beginning of the first interview, Emily was asked what stood out for her thinking back at the therapy process. She immediately associated by herself to Marcus' nonverbal expression: "He was constantly fiddling with his watch and was very uneasy (….) I understood this uneasiness as an expression of how difficult it was for him to be in treatment". Here, Emily demonstrates that she was aware of Marcus' nonverbal expressions and used this sensitivity as a vantage point for psychological interpretation.

Observations of the therapy sessions revealed that Emily never commented explicitly on Marcus' nonverbal expressions. Later in her first interview, she was asked about this:

I: How do you think it would have been for you to comment on Marcus' nonverbal expressions?
E: I think I would have been afraid that he could experience me as critical or devaluating. But [I] think I would have done it now. Uhm (…) I must have learned something.

Another question of interest for us was whether Emily implicitly used her sensitivity to Marcus' nonverbal expressions to inform her interventions. We found several examples where she did not incorporate Marcus' nonverbal ques. In the next short sequence from session (7), Emily and Marcus are talking about his wife who needs a lot of time to work at home. He feels that he must take her needs into account and does not feel free to watch TV. As he speaks, he withdraws his gaze, bites his nails hard, "eats his words", and tightens the muscles in his jaw.

E: Mm. So, for how long do you have to wait, considering her needs?
M: Until she is finished with what she is doing.
E: (Giggles) And that takes a long time?
M: That varies.

Here, Marcus seems to communicate his frustration nonverbally. The muscular activity in his jaw and the harsh quality of his nail-biting may signal that he is getting in touch with some aggressive feelings and that these feelings are stronger than he is able to verbalize. In her response, Emily does not demonstrate a sensitivity to these nonverbal cues, for example by saying "You seem angry". When she giggles, Marcus smiles uncomfortably and withdraws his gaze, and this could signal a feeling of not being met and understood by Emily. In

the group, we discussed whether Marcus' smile at the end of his utterance could manifest a need to regulate his own anger, and we were wondering whether Emily's giggling could be a response to Marcus' regulating smile. In this perspective, her laughter may represent her own need to regulate Marcus', and maybe her own, aggressive feelings.

In her IPR interview, having watched this scene, Emily reacts like this:

> (Laughs)…Oh…yes, well, he is biting his teeth together and he seems very irritated. And I really go along with it, laughing, and fending off the irritation (….) There is no seriousness there! Maybe it was too scary for me to go into it.

Marcus, after watching the same scene, said:

> In that situation, I talk about how I feel that my needs are de-prioritized. And when she laughs, maybe she is doing that because I laugh (….) I think I just felt that what I said was banal. It is a bit tragicomical.

In supervision session (1), Emily addressed her observations of what Marcus communicated nonverbally: "There is a lot of uneasiness, nonverbally. His body says something else than what he verbalizes". The supervisor seemed to address this when she metaphorically incorporated the embodied aspects of the dialogue. For example, in supervision session (4), when the group were discussing the interaction between Emily and Marcus, she said: "You have to dance the dance". In the same session, she encouraged Emily to notice Marcus' form and underlined how the tone of his voice tended to be monotone and displayed a lack of emotional contact. In supervision session (2), they discussed whether Emily should comment directly on her observations of Marcus' nonverbal behavior:

> Group member: It may be too early in the process, but how would it have been for you (Emily) to talk more about his body language?
> S: (….) To comment on the body (...) is a difficult discussion. If Emily comments on what she observes, this could make him feel that he loses control. This is very challenging, and it is always a discussion, to comment on the form or not. We use these interventions carefully, and with clinical "fingerspitzengefühl" (….) To comment on his form could make him feel that he needs to be careful. Someone would say, yes, do it immediately, but I think it is wise to wait him out.

In the further process, the group never returned to discussing this again. In her first interview, Emily was asked whether they in supervision discussed possible ways of intervening on Marcus' nonverbal cues:

> E: We talked a lot about his characteristic form. But I cannot remember…
> I: Do you think it would have been useful if you talked in supervision about ways of intervening on his form?
> E: Yes, that would have been useful.

Marcus, in his first interview, was asked how he retrospectively thinks it would have been if Emily had commented on his nonverbal expressions:

> M: I think it would have been redemptive. If she had commented on it, we could have talked about it, and sort of put it away. I think that would have brought something out in the light.
> I: And do you think it would have been useful for you to talk about what caused the nonverbal uneasiness?
> M: I'm sure it would have been.
> I: Do you think you could have felt criticized somehow if your body language had been commented on?
> M: No, I don't think so.

In her retrospective reflections the supervisor conveyed that she generally is careful both with commenting on students' nonverbal behavior and advising students to comment on client's nonverbal behavior. She underlined the vulnerability of both students and clients, and how direct comments on nonverbal cues, which one is not necessarily aware of, can induce shame and self-criticism.

In sum, this theme underlines how Emily was sensitive to Marcus' nonverbal expressions, but did not use this sensitivity to, explicitly or implicitly, inform her clinical interventions. In supervision, they discussed Marcus' nonverbal uneasiness, but they did not explicitly explore *how* Emily could work with her own bodily signals to better adjust to Marcus' uneasiness. Early in the process, the supervisor advised Emily not to comment on Marcus' nonverbal expressions, and they never returned to discussing this.

Theme c) Supervision supported the therapist in tolerating embodied tension in the therapeutic relationship.

When observing the therapy sessions in the final phase of the therapy, from session (27) and onwards, the authors felt that something had changed in the interaction between Emily and Marcus. They both appeared more relaxed and in tune with

each other. Whereas Marcus earlier in the process often lent his body slightly away from Emily, he started session (27) by moving his chair a bit closer to her. The next scene happens later in session (27). Here, Marcus has just told Emily that he recently has learned that a close colleague of his is moving to another country. Emily gazes directly at Marcus with an open quality of her gaze and with a sincere facial expression. As she begins to speak her body posture is slightly collapsed.

> E*:* Yes. Afraid of being lonely.
> M: Yes. Uhm…and also with the relationship lately, that it has been so turbulent, so that became a part of it, that if it was to break, I felt in a way that I didn't have any (…) safety net.
> E: Mm, important supporters.
> M: Yes.

As Marcus verbalizes his feelings, he meets Emily's gaze, and maintains eye contact with her. When he talks to Emily about the turbulence in his relationship with his wife his body posture slightly collapses so his body becomes synchronized with Emily's. Through the whole scene, there is a prominent decreased discrepancy between what was communicated verbally and nonverbally, both from Emily and Marcus, and a higher level of synchrony in their body movements and facial expressions, compared to previous sessions.

During her IPR interview, when Emily had watched this scene, she said: "I feel more comfortable watching this. I am much calmer, not so hasty. As if I don't have to cover up things in the same way". When Marcus, in his IPR interview had watched the same scenes, he said:

> Uhm. I don't know, I feel that she is mirroring me with her body language. Her body posture is a bit collapsed, and my body posture is a bit collapsed. I think (...) I am more relaxed about sitting there and talking about my feelings.

The supervisor, in her description-note also commented on how the process moved forward, and that there was a change in the relational dynamic towards the end: "The therapy was challenging (...) but went on and moved slowly from the surface level to a deeper level of connection (…) The client was gradually more involved and committed to the therapy".

During his first interview, Marcus expressed how he felt that he during the therapy became more able to be in touch with and verbalize his feelings:

> It has been easier for me to express myself, my thoughts, and feelings. And it may be that something about the therapy helped me with that. All the sessions, sitting there for 45 minutes and talk about my feelings. I think that was helpful.

During her first interview, Emily expressed how difficult it was for her to be in the therapeutic setting with Marcus in the beginning of the treatment. Here, she expressed how she had to work hard to handle this, and underlined how supervision was important for her:

> Supervision helped a lot. To tell the others how difficult I felt it was, and to get their support (….) Early in the process we created an acceptance for tolerating what is coming. So, it felt very safe. And the supervisor managed to convey that she would tolerate and accept feelings and put them into words. I felt home in that group.

In sum, this theme summarizes how Emily felt that the tension and uneasiness that dominated the first parts of the therapy process created a need in her to increase her tolerance for the tension that played out between herself and Marcus. In her interviews, Emily underlined how the support she felt from the supervisor and the group constituted a necessary part of the training process.

Discussion

In this study we aimed to explore how a multimodal method enabled a detailed exploration of a psychotherapy training process. Specifically, we wanted to investigate the therapist's abilities to use both verbal and nonverbal knowledge modalities to promote client change and to explore how supervision supported her in cultivating these abilities. The results demonstrated that both Emily and Marcus experienced difficulties in the therapeutic relationship. The evoked emotions were expressed through nonverbal tension which was never openly explored during the process. Whereas Marcus revealed that he retrospectively believed it would have been helpful if Emily had commented on his nonverbal expressions, the supervisor early in the process advised Emily not to comment on Marcus' nonverbal cues, as she felt that he may feel criticized, at least early in the process. Even though the nonverbal tension continued to dominate the first four months of the therapy, the supervision group never returned to this discussion. The results also reveal that Emily's bodily signals were never openly addressed during the training process.

We cannot know how the process would have developed if Emily's bodily signals were explored more openly in supervision. Neither can we know how the therapy would have developed if Marcus' nonverbal tension was more openly addressed during the process. Given that the discussion of this in the supervision group happened early in the process, the supervisor's advice to await commenting on Marcus' nonverbal cues seems reasonable. She feared that Marcus may feel criticized and observed, which subsequently could give him a feeling of not being met and understood by Emily. What seems to be more intriguing is that the supervision group, even though the nonverbal interactional tension in therapy continued, never returned to this discussion.

When something stands out in a clinical material without being openly discussed, it raises a question of why this happens. It seems reasonable to discuss whether this, at least partly, was rooted in the dynamics in the therapeutic and/or the supervision relationship. Emily underlined in her interview that she in the therapy setting felt self-conscious and uncertain of her abilities to help Marcus. She may also have felt that Marcus implicitly conveyed a doubt in her abilities as a therapist, reinforcing her doubt in herself. As these feelings were implicitly expressed through nonverbal cues it is easy to understand that it was difficult for Emily to address these unspoken subtleties directly (Castonguay et al., 2023; Safran et al., 1990).

As the results demonstrate, the supervisor in our case is generally careful with commenting directly on nonverbal cues, in fear of inducing self-criticism and shame, both in students and clients. She underlined Emily's courage and her willingness to come forward with her vulnerability and insecurity. At the same time, the supervisor expressed that she may have sensed a need in Emily to protect her inner state. She reflected on whether this may have made her more careful in her interventions and might have contributed to an avoidance of a deeper exploration of the uncomfortable feelings that played out between Emily and Marcus.

Our case raises several dilemmas concerning how direct supervisors should be when supervising students and how much we should expect from trainees when it comes to learning the more complex aspects of relational competence, such as nonverbal skills. Moreover, a reasonable question is whether the difficult emotions that in our case were expressed nonverbally must be verbalized to be worked with, or whether they sometimes rather should be handled implicitly.

In her interview, Emily underlined that she felt it was necessary for her to increase her tolerance of the nonverbal tension in the therapeutic relationship. She emphasized that the support she felt from the supervisor and the supervision group, where they affirmed her emotional strain, helped her to better tolerate these difficult emotions. Apparently, this may have contributed to therapeutic change, where the nonverbal tension towards the end calmed down and Emily and Marcus nonverbally were more attuned. A reasonable discussion is whether Emily's inner work during the process at a deeper level led to an increased emotional contact between herself and Marcus, which again led to decreased nonverbal interactional tension and a higher level of nonverbal synchrony. Thus, one could argue that this change had taken place at a nonverbal level, and some may proclaim that nonverbal interactions in general must evolve at such implicit levels.

However, Atzil-Slonim et al. (2023) argue that synchrony is a skill that can develop through training. They encourage therapists to attend to what occurs at the nonverbal level between clients and themselves, and to be aware of their own affective and bodily states as they change in response to client's nonverbal cues (pp. 914-915). Similarly, in their alliance-focused training program, Eubanks et al. (2023) seek to support therapists to advance their emotion regulation capacities by helping them to recognize, accept, and explore their own and their client's emotions. By helping therapists to mentalize about their experiences in therapy, they support the therapists' capacity to organize these experiences and thereby to reduce their anxiety (Muran & Eubanks, 2020).

It seems reasonable to discuss whether a more explicit focus in supervision on Emily's affective and bodily states in response to Marcus' nonverbal tension could have eased her capacity to help him regulate these states. By providing a verbal language for what occurred at a nonverbal level between Emily and Marcus, the supervisor may have been able to support Emily more explicitly to recognize, tolerate, and explore these unspoken subtleties. This may have eased Emily's capacity to consciously modulate her bodily expressions to regulate Marcus' feelings, rather than resorting to her previously learned regulation strategies. This again may have facilitated Emily's ability to use her awareness of Marcus' bodily expressions to inform her clinical interventions, explicitly or implicitly, and invite him to a joint collaborative exploration of what was transpiring between them (Eubanks et al., 2023).

In the literature, different labels refer to interventions that capture what clients communicate in the immediacy of the therapeutic encounter. Kiesler (1988) and e.g., Safran &

Kraus (2014) and Eubanks et al. (2023) use the term *metacommunication* to refer to the verbal exploration of the unfolding relationship between the therapist and the client, which occurs when therapists disclose to clients their perceptions of and reactions to clients' actions. Similarly, Hill (2020) refers to these interventions as *immediacy*, defined as "the helper inquiring about or disclosing immediate feelings about the client, self in relation to the client, or the therapeutic relationship" (p. 281). These labels differ from the psychoanalytic conceptualization of *transference interpretations* (Gullestad & Killingmo, 2020, p. 157 f.) as they include therapist´s self-disclosure, which normally is excluded from the psychoanalytic repertoire.

Kiesler (1988) emphasizes that these interventions represent one of the most powerful tools in the therapeutic repertoire. By responding to the client in a manner that is different from what he usually experiences in social interactions, the therapist can bring what is covertly communicated out in the open, thus helping the client to become more aware of his contribution in relationships. As these interventions may come as a surprise for the client and have the power of activating emotions that the client implicitly avoids, using them require that the therapist tolerates that these strong feelings are activated, both in themselves and in the client (Gullestad, 2022).

As Hill (2020) notes, "a first step in learning to use immediacy is becoming aware of nonverbal cues from clients about possible distress related to the relationship" (2020, p. 287). Hence, therapists who are sensitive to clients' nonverbal expressions are more able to recognize, attend to, and solve ruptures in the alliance (Castonguay et al., 2023; Eubanks et al., 2023; Hill, 2020; Safran et al., 1990). Hill et al. (2014) found that, in a study of sixteen psychodynamic psychotherapies, eight of the five clients who participated in a post-therapy interview remembered and profited from immediacy. In the same study, they found that therapists initiated immediacy more often with fearfully attached clients compared to clients who were generally less anxious and avoidant in their interactions with others (Hill et al., 2014; Hill, 2020).

Thus, some empirical evidence supports that clinical sensitivity to, and interventions on, nonverbal cues, can facilitate client´s emotional awareness and insight (Hill et al., 2014). These interventions might be more urgent, but also more challenging, when working with avoidant clients, because they to a larger degree than securely attached clients have difficulties with verbalizing their emotions, and thus tend to express these emotions nonverbally. With these clients, an important question is concerned with to what extent they are consciously withholding their emotions, or whether they have difficulties with mentalizing, and thus verbalizing their feelings. Hence, when therapists avoid addressing nonverbal cues, they may miss an opportunity to explore this important distinction.

For beginner therapists, who naturally feel vulnerable and insecure (Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2013), it can, as with Emily, be particularly challenging to intervene on nonverbal cues. Based on this study, we have summarized some advice that might be helpful regarding how supervisors preferably can attend to and include nonverbal expressions and interactions in training. Firstly, supervisors may inform trainees about the importance of nonverbal interactions in general, to normalize how both therapists and clients express emotions surpassing what is verbalized. Moreover, when addressing these issues, supervisors may encourage trainees to look for discrepancies between verbal and nonverbal behavior, both in themselves and in their clients, thus aiming for an increased awareness of the unspoken subtleties communicated nonverbally. Here, supervisors may also inspire trainees to enhance their sensitivity to, and acceptance of, their own bodily reactions during sessions, to advance their skills in modulating these inner experiences to up-regulate or down-regulate the inner states of clients (Atzil-Slonim et al., 2023). Supervisors may use role-play to deliberately practice (e.g., Rousmaniere & Vaz, 2021 – In press) synchrony skills and clinical interventions on nonverbal cues in a safe atmosphere. Finally, when video recordings of therapy sessions are used in supervision, these can be utilized to explicitly evaluate therapist´s and client´s nonverbal behavior, and the nonverbal interactions between them.

As this study illustrates, supervisors need clinical sensitivity to do sound evaluations of how to work with nonverbal cues. In this, supervisors must do individual evaluations of whether interventions addressing nonverbal expressions will be too overwhelming for the student, thus hindering the learning process, or whether absence of such interventions may curb a potential redemption of interactional tensions in the therapeutic relationship. When making these judgements, supervisors must consider the inner state of themselves, the student, and the client. Moreover, they must evaluate the dynamics in their relationship to the student, and the strength and quality of the therapeutic alliance. Finally, in group supervision, the supervisor must consider the climate and the student`s position in the group.

Strengths, Limitations & Future Research

An important limitation with our study is the missing data. Three of the supervision sessions were not video recorded. Additionally, the semi-structured interview with Marcus was lacking sound. Moreover, this study makes use of nonverbal observational data, which implies a challenge to verbalize in qualitative analysis. A triangulation of our observational data with data from the interviews supported us in securing a certain validity in our interpretations. Nevertheless, it is important to underline the tentativeness of our perspectives. We cannot determine exactly which components instigated changes or not. However, the way we see it, these obstacles should not hinder us in including nonverbal expressions when studying the complexities involved in psychotherapy training. In our opinion, our study illustrates an opportunity to further develop sensitive methods suitable for investigating important nuances inherent in the process of achieving relational, therapeutic competence. Our aim is to continue to develop and use this multimodal method to do more systematic research on the variations in use of nonverbal aspects across cases in psychotherapy training.

As this is a single-case study, the results may not be valid beyond this case. Still, an ideographic perspective may uncover nuances and complexities that may be missed when investigating larger data samples (Flyvbjerg, 2006). Bearing in mind how affect is expressed nonverbally within every therapeutic dyad it seems reasonable to argue that the topics we have discussed may be valuable beyond our single case (Levitt, 2021).

Conclusion

Crucial aspects of psychotherapy take place at a nonverbal level, and therapists need to cultivate their nonverbal relational skills to be optimally effective in facilitating client change. Our study illustrates how the development of these skills are closely related to therapists' emotion regulating strategies. The results suggest that the therapist's insecurity challenged her capacity to consciously adapt her own bodily responses to the client, and further made it difficult for her to use her sensitivity to respond to the client's nonverbal cues as well as to inform her clinical interventions explicitly and implicitly. Moreover, the results suggest that the client was highly conscious of the nonverbal tension in the therapeutic relationship, and that he felt it would have been redemptive if this tension had been verbalized. Hence, our study demonstrates how embodied tension - when it is not consciously attuned to - may be in danger of becoming an "absent presence" in the therapeutic setting, resulting in a missed opportunity to bring significant aspects of the therapeutic relationship to the surface. By supporting therapist trainees in becoming more aware of their own bodily responses to clients and providing a language for what nonverbally is transpiring in the therapeutic relationship, supervisors can deliberately support therapists' cultivation of their nonverbal relational capacities.

Acknowledgements

The project is funded by internal grants from the Department of Psychology, University of Oslo.

We would like to express our deepest gratitude to Emily, Marcus, and the clinical supervisor. Your openness and generosity have made it possible for us to learn from your experiences. We would also like to thank Hanne Weie Oddli for her valuable contributions to the manuscript.

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About the Authors

Cecilie Hillestad Hoff is a clinical psychologist, a psychoanalyst (IPA), and a PhD-candidate at the Department of Psychology, University of Oslo, Norway. She has 17 years of clinical experience and runs her own small private practice in Oslo. Her research interests are Psychotherapy training, Clinical supervision, Psychodynamic/psychoanalytic theory, and Nonverbal aspects of psychotherapy.

Helene Nissen-Lie is a clinical psychologist, PhD, and Professor at the Department of Psychology, University of Oslo, Norway. She has 22 years of clinical experience and runs her own small private practice in Oslo. Her research interests are Therapist effects and Therapist Characteristics, Psychotherapy process and outcome research, Psychodynamic/psychoanalytic theory, and Mechanisms of change in psychotherapy.

Hanne Strømme is a clinical psychologist, a psychoanalyst (IPA), PhD, and an Associate Professor at the Department of Psychology, University of Oslo, Norway, where she is Head of the internal Clinic of Psychodynamic Therapy and PI of the research project "The Nordic Psychotherapy Training Study" (NORTRAS). She has 25 years of clinical experience and runs a small private practice in Oslo. Her research interests are Clinical supervision, Psychotherapy training, Psychotherapy process and outcome research, and Psychoanalytic/psychodynamic theory.

Appendix

Interview with the therapist

The therapy: Looking back at the therapy process, what stands out most for you? Can you give some examples? Retrospectively, what changes do you think you went through during the process? Can you describe your immediate reflections of how you learned this? Thinking back at the process, are there things you feel that you were not able to work with?
The supervision: Let us look at the relationship to your supervisor. How did you experience that? What do you think made you experience it like that? Did the relationship change during the process? If so, how? Were you at some point surprised by this? How did the supervisor structure the process? What do you think of this form of supervision? Did you want something else from supervision? Where there some things you missed, or some things you were not able to work with? Why did you miss that?
Nonverbal communication: Thinking back at the process, to what extent do you think you were aware of the nonverbal communication between you and the client? To what extent do you think you were aware of what you communicated nonverbally to the client? To what extent do you think you were aware of the client's body language and nonverbal expressions? To what extent were you aware of what the client communicated nonverbally to you? Do you think the client's nonverbal expressions influenced you as a therapist? Do you remember if you at any time commented on the client's body language or nonverbal expressions during the process? If yes, how did you experience this? If no, do you remember if you were thinking about this during the process? If no, do you have any thoughts about why you did not comment on this? If no, how do you think it would have been for you to comment on the client's nonverbal expressions? Do you remember if you at any time talked to the client about the nonverbal interactions between you? Do you remember if you talked about the client's nonverbal expressions in supervision? Do you remember if you talked about possible ways to intervene on the client's nonverbal behavior in supervision?

The interview and research context Do you think that your participation in this research project in any way has affected your training process? How do you feel that we managed to talk about your experiences during training? How do you feel about the topics I addressed? What do you think about my way of interviewing you, regarding your possibilities to describe how the training process was for you? I do not have any more questions. Is there something you want to add before we finish?

Interview with the client

The current situation Could you say something about what made you apply for psychotherapy? How were you doing at the time? Could you say something about how you are doing now, when it comes to your relationship with yourself, other people, and your work? If you think back at you situation at the beginning of your therapy, and compare it with how you are doing now, what would you say?
Outcome Thinking back at the treatment you had, do you think it has contributed to the changes you have described? When you started the treatment, you felt that your problem was…..Do you believe that you during the treatment changed your perspective on your problem? What was helpful in the treatment? (Something you realized, some experiences during the process, some things the therapist said or did?) Something you said or did? Do some specific memories come to your mind? Were there any specific topics you felt were particularly important to talk about? What was it about you that made the therapy useful? Was the treatment different than you expected? Thinking back at the therapy now, is there anything you feel that you were not able to work with?

Relationship with the therapist Let us take a closer look at your relationship with the therapist. How did you experience that? What stands out when you think about her? Do you feel that you became attached to her? Did you feel that she could understand you? Did you feel that she considered what you expressed or needed? Did you feel safe? How did the fact that she was a student affect you? Were you concerned about her age? Did you have confidence in her competence as a therapist? Do you think she changed during the process? Did your relationship change during the process? If so, how? Were you surprised by this change? Were there things you missed during the therapy? If yes, what do you think made you miss this? How free do you think you felt in letting her know, if there was anything you wanted to be different? In sum, how would you describe your relationship with your therapist?
Nonverbal communication Thinking back at the process, to what extent do you think you were aware of the nonverbal communication between you and the therapist? To what extent do you think you were aware of what you communicated nonverbally to the therapist? To what extent were you aware of the therapist's body language and nonverbal communication?
To what extent were you aware of what the therapist communicated nonverbally to you? Do you think that the therapist's nonverbal expressions influenced you? Do you remember if the therapist at any time commented on your body language or your nonverbal expressions? If yes, how did you experience this? If no, do you remember if you were thinking about this during the process? If no, how do you think it would have been if she commented on it? Do you remember if the therapist at any time talked about the nonverbal interactions between you?
The interview and research context Do you think that your participation in this research project in any way has affected the treatment? How do you feel that we managed to talk about your experiences in therapy? How do you feel about the topics I addressed? What do you think about my way of interviewing you, regarding your possibilities to describe how the therapy was for you? I do not have any more questions. Is there something you want to add before we finish?