WHAT DOES THERAPIST PRESENCE LOOK LIKE IN THE THERAPEUTIC ENCOUNTER? A RATIONAL-EMPIRICAL STUDY OF THE VERBAL AND NON-VERBAL BEHAVIOURAL MARKERS OF PRESENCE

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Abstract

Humanistic approaches to psychotherapy recognize therapeutic presence as necessary to sharpening one's attunement to ongoing dynamics of intra and interpersonal processes, to promoting empathy and in developing a strong working alliance. Despite its purported value, however, little empirical research has explored the nature of presence in the psychotherapeutic encounter. Following a task analytic methodology, the current study used both rational (model building) and empirical (observational) strategies to investigate how highly present therapists manifest presence through verbal and non-verbal behaviours. As part of a larger research program this study 's aim was to observe behavioral markers of therapeutic presence that will inform an observational measure for examining this phenomenon at an in-session, process level of analysis. Results from the present study show that therapist presence is linked to a constellation of verbal and non-verbal markers that reflect four modes of expression, which were named 'here', 'now', 'open', and 'communion'. The final model that emerged included prominent behaviours such as stable/poised body posture, unwavering eye gaze, responsive nodding and facial expressions, and vitality in face, body, and vocal tone. Implications for the development of an observational measure are discussed, along with limitations and suggestions for future research.

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Mindful

(Mary Oliver, 2004)

Every day
I see or I hear something
that more or less kills me with delight,
that leaves me like a needle in the haystack of light.
It is what I was born for -
to look, to listen,
to lose myself inside this soft world -
to instruct myself over and over
in joy and acclamation.
Nor am I talking about the exceptional,
the fearful, the dreadful,
the very extravagant -
but of the ordinary,
the common, the very drab,
the daily presentations.
Oh, good scholar,
I say to myself,
how can you help but grow wise
with such teachings as these -
the untrimmable light of the world,
the ocean's shine,
the prayers that are made
out of grass?

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"Looking back now, it is surprising to me how long I overlooked the fundamental

importance of presence to therapeutic work (Bugental, 1987, p. 46)."

"People who are pleased with their psychotherapy experience seldom report that it

was a practitioner's dazzling verbal interventions that brought about significant

changes. Rather, our satisfied customers mention the quality of our presence and

the sense that we care (McWilliams, 2004, p. 132)."

Despite the value attached to presence in the psychotherapy literature over the years, empirical

research has only begun to scratch the surface of its inner-workings and influence in therapy. Using the

rational and empirical strategies of task analysis methodology (Greenberg, 2007), the current study

investigates the behavioural components of therapist presence in process-experiential and client-

centered treatment of depression. Mapping out the core behaviours of therapist presence is the first step

toward the development of an observational measure of presence (the second and future phase of this

research program), which will make it possible to examine many interesting and hitherto unexplored

research questions about therapeutic processes linked to presence.

Although this study occurred in the context of experiential and client-centered therapy for

depression, the nature of therapist presence is regarded as an integrative, common factor in therapeutic

work (Geller, Pos, & Colosimo, 2012), and as such the implications of this work can extend to other

therapy contexts, an issue that will be explored later in the discussion section of this paper. We begin

by detailing the value of presence in therapy and the rationale for the present research. Following this is

a discussion of various conceptualizations of 'presence' outside of psychotherapy, namely in the fields of healthcare and virtual reality, a discussion that will eventually be funneled towards an articulation or definition of therapeutic presence that served as a map or guide in the present research.

Rationale of the Present Study

The three therapist-offered conditions articulated by Rogers (1957) – empathy, unconditional positive regard, and genuineness - are commonly held as core, effective elements of therapy linked to a strong working alliance, client growth, and positive treatment outcome (Bohart & Watson 2011; Farber & Doolin, 2011; Kolden, Klein, Wang, & Austin, 2011; Norcross, 2011). But, as the following statement by Roger's indicates, there may be something more primary happening in the therapeutic encounter providing the foundation for these therapist-offered conditions:

> I am inclined to think that in my writing I have stressed too much the three basic
>
> conditions (congruence, unconditional positive regard, and empathic
>
> understanding). Perhaps it is something around the edges of those conditions
>
> that is really the most important element of therapy – when myself is very
>
> clearly, obviously present (in Baldwin, 2000, p. 30).

The therapist's capacity to be present - provisionally defined as a matter of "'being-there' (*dasein*) in the purest sense" (Bugental, 1965, p. 383) -is considered fundamental and necessary for supporting many crucial therapy processes that promote good treatment outcome. Therapist presence is associated with establishing and maintaining a good alliance (Geller, Pos, & Colosimo, 2012; Geller, Greenberg, & Watson, 2010), and, shared moments of presence between therapist and client, referred to as co-presence or relational depth (Cooper, 2005), may signify the strength and richness of that therapeutic relationship. Presence is also thought to be a good quality of a therapist, one that optimizes his/her empathic receptivity and sensitivity to the client's inner world (Geller & Greenberg, 2012). Presence with oneself is also implied to scaffold the capacity to contact deeper levels of the self needed for

experiential and emotional processing (Pos, Greenberg, Goldman, & Korman, 2003; Gendlin, 1996; 1990). As such therapists use their capacity to be present to 'tune in' to experience.

This paper maintains that presence is an important therapeutic element that deserves empirical attention. The psychotherapy literature contains much theoretical discussion on the clinical significance of presence for therapists, clients, and the therapeutic relationship, most of which derives from Existential-Humanistic theorists and clinicians (Bugental 1987; Schneider & Krug, 2010). At the level of scientific research, however, work on therapeutic presence is just beginning to emerge and as such there is only a small body of related studies. In fact, although some related measures exist in the nursing and virtual reality communities (both discussed later) only one extant measure of presence has been developed in psychotherapy research. This measure - the Therapeutic Presence Inventory (TPI) - is based on the work of Geller (2001; Geller, Greenberg, & Watson, 2010) and contains both a therapist version (TPI-T; therapist reports on their own presence) and a client version (TPI-C; client reports on their therapist's presence). Results from Geller et al. (2010) show that both versions demonstrate sound psychometric properties, but that clients' perceptions of therapist presence (TPI-C) are better predictors of the therapeutic alliance and session outcome than therapists' self-reports of their own presence (TPI-T). There are a few possible explanations for this latter finding. It may be that therapists are not very accurate judges of their own functioning related to presence in-session, a common finding with other measures in the clinical field (Lambert, 2007; Meehl, 1954). It could also be the case that the client and therapist versions of the TPI are measuring slightly different phenomena. And lastly, the relative predictive value of the TPI-C over the TPI-T may signify that it is equally important for therapists to go beyond feeling present to actualize and express presence to clients in session via verbal and non-verbal communication. It is the explicit and observable display of presence that ultimately concerns the present study.

Although the TPI has been shown to be a useful research tool, like all models and measures it does have limitations. One limitation of the TPI-C is that it contains only three items that are relatively global and vague. For example, "My therapist was fully there in the moment with me" does not capture the subtleties of what it means to perceive someone as 'fully there in the moment with me'. As Geller et al. (2010) advise in their report, one way for presence research to advance is to develop a robust observational tool to measure behavioural cues of presence. In other words, there is a need for researchers to identify the observable manifestations of therapists in session that reflect presence. The current study follows this call.

Aim of Current Study

The primary aim of this study was to develop a model of observable therapist in-session behaviours linked to presence. The active research question, therefore, can be summarized as, "How does a therapist embody his or her presence verbally and non-verbally throughout a session?" The secondary aim was to inform a second phase of a fuller research program of which this study is a part- namely the development of an observer-measure, which can then be used to test new hypotheses in future psychotherapy process research.

Conceptualizing Presence

As a concept presence has garnered attention in many different professional fields such as occupational therapy (Reid, 2009), nursing (Finfgeld-Connett, 2006), virtual reality (Schumie, Van Der Straaten, Krijin, Van der Mast, 2001), and psychotherapy (Geller, 2001; Geller & Greenberg, 2012; Krug, 2009). The current investigation focuses on the nature of presence in the context of the psychotherapeutic encounter between therapist and client. What follows is a description of presence from a phenomenological-experiential perspective that illuminates some of its subtle and overlooked aspects and how it relates to psychological well-being. This is followed by a discussion of recently

developed models of presence in psychotherapy, nursing and virtual reality literatures. Finally, I outline how presence has been operationalized in the present study.

Perhaps the simplest albeit elusive understanding of presence that deserves mention is implied by existential and Buddhist philosophy, in which presence reflects the interdependent nature of life. Buddhism describes this nature as groundless and non-dual (i.e. no real separation between 'self' and 'other'). This view of presence is not usual in psychological research and practice, limited mostly to the domain of transpersonal psychology (Wilber, 2000), most likely because it opposes the dualistic assumptions held in scientific research (i.e. there is a self 'in here' discovering something 'out there'). Bradford (2007) offers a nice distinction between a conditional, threshold level of therapeutic presence and a non-dual unconditional presence. He highlights that both forms involve awareness of the here and now, but to move beyond a threshold level into unconditional presence requires that the person not hold to 'any particular something'. It is the difference between a therapist 'doing something' or 'wanting something to occur' in a moment of therapy - which, it can be argued, suggests that he or she is attached to a particular thought, notion, belief, feeling, etc. and thus that the therapy work is predicated on *something* - and a radical letting go of any kind of reference point, including the seemingly solid sense of *me* or *I*. In a mode of unconditional presence, therefore, the therapist sees the client and the therapeutic moment at hand with much greater intimacy and wholeness.

For Rogers (1961) and other humanistic-existential therapists (Bugental, 1965; Yalom, 2002; Schneider & Krug, 2010) the capacity to have a dynamic and ongoing access to experience - both intrapersonal and interpersonal (Krug, 2009) - is a key attribute of psychological health, authentic living, and therapeutic change. Presence is thought to afford one greater awareness of the various aspects of one's being, helping one to realize one's situation, strengths, limitations, and gradually to actualize one's human potential. In contrast, inauthenticity, suffering, anxiety, and distorted awareness ensue when one is habitually non-present with and thus cut-off from experience.

In various literatures, presence has been described as denoting involvement in, immersion in, and responsibility to one's experience. In this vein, Bugental (1987) describes presence as a matter of "…how genuinely and completely a person is in a situation rather than standing apart from it as observer, commentator, critic, or judge (p. 26)", and he further posits various depths of presence according to levels of interpersonal interaction - *formal*, *contact maintenance*, *standard*, *critical occasions*, *intimacy*, and *personal/collective unconscious*. As such presence is not viewed as an intellectual activity or something to be 'found' somewhere else. Rather, it is considered an embodied and artful way of being, occurring in exact time and place. And when brought into relationships, it is consistent with Buber's (1958) I-Thou encounter within which a person sees another "I", not as an object of interest but as a real existing 'Other' in the world. In such an encounter there is an affirmation of each person's humanity and the possibility for a moment of genuine intersubjective dialogue. I believe that the capacity to be present facilitates such an I-Thou encounter.

Bugental (1987) makes a helpful conceptual distinction of presence by viewing it as comprising two facets - accessibility (openness) and expressiveness. These can be regarded as orthogonal (intersecting) axes, meaning that one can be high on both, low on both, or high on one and low on the other. This points to the possibility that therapeutic presence may not only demand an openness to experience but that the therapist communicates to the client in some way that the experience has been received, thus further supporting the rationale for studying the behavioural expressions of presence. If this were true, it would be in line with Bohart & Greenberg's (1997) view that in order for empathy to count as a therapeutic process, it must not only be experienced but communicated as well.

The notion that presence involves accessibility and expressiveness makes sense within the process of psychotherapy, as therapists must balance their time between listening to a client's narrative and expressing themselves (for example, to offer an empathic reflection). The former might be when a therapist can rely on being present in an accessible fashion (though there is some important non-verbal

expressiveness that occurs during listening, such as facial expression), while the latter might be opportune to convey presence through expressiveness (e.g., hand gestures; vitality in voice).

Recent empirical work on therapeutic presence by Geller and colleagues (Geller & Greenberg, 2002; Geller, Greenberg, & Watson, 2010) has helped elucidate its core features and how it relates to other therapy processes. Geller's model of therapeutic presence (Geller & Greenberg, 2002; Geller & Greenberg, 2012) is based on a qualitative study of expert therapists' reports on how they experience being present with clients. The therapist-participants were provided a standard definition of presence from the literature and were asked to reflect on this phenomenon over the next few therapy sessions. Therapists were then interviewed using a general interview format that included specific questions about the cognitive, physical, and emotional aspects of their experience of presence. The analysis of these interview transcripts eventually lead to three main categories and their corresponding sub-categories. The first category is 'preparing the ground for presence' and includes pre-session and in-life factors that set the stage for being present. The second category relates to the 'process of presence' and involves mediating qualities of receptivity, inwardly attending, and contact. The third category is 'experiencing presence' and includes what is actually occurring for therapists in moments of presence, namely immersion, expansion, grounding, and being-with-and-for the client. Geller and colleagues (Geller, Greenberg, & Watson, 2010) eventually used the latter two categories (process and experience of presence) to devise the Therapeutic Presence Inventory (TPI) mentioned earlier.

Defining Presence in the Current Study: Expressed Therapist Presence

For the purposes of the current study therapist presence is defined as: therapist behaviours through which he/she maintains and observably shows a tightly embodied engagement of the immediate (here-now) unfolding experience of the therapeutic encounter in a way that is with-and-for the client's process. Alternatively non-presence is defined as therapist behaviors through which he/she fails to maintain and observably display embodied engagement in immediate (here-now) unfolding experience

of the therapeutic encounter in a way that is with-and-for the client's process. Non-presence is seen as arising from any process that interferes with, blocks, or prevents the therapist from communicating that he/she is present.

Embodiment of Presence in Therapy

There is a history of research demonstrating the important role played by facial expressions, body posture, eye contact, and other bodily cues in expressing attitudes and feelings during interpersonal interactions (James, 1932; Mehrabian, 1969). Although there is no line of research on 'presence behaviours' per se, the extant models and ideas of presence do provide clues as to what a therapist might be doing or saying in a mode of deep presence. For example, consider the following selection of items from Geller's TPI measure (Geller, Greenberg, & Watson, 2010) and how they might manifest as observable therapist behaviours (I have included in parentheses behaviours that are conceivably linked to each item):

1. I felt alert and attuned to the nuances and subtleties of my client's experience (*upright body posture)*

2. I felt genuinely interested in my client's experience (*face shows interest)*

3. The interaction between my client and I felt flowing and rhythmic (*synchronous movements)*

5. I felt tired or bored (Reverse; *slouched posture)*

6. I found it difficult to concentrate (Reverse; *frequent shifting of arms/body*)

Psychotherapy researchers have found certain therapist behaviours to be associated with specific perceived therapist qualities and other therapeutic processes. I will argue here that it is possible that some of these behaviours may capture behaviours that may be more appropriately assigned to provision of therapist presence. If, in fact, one views presence as a fundamental pre-requisite for the provision of other therapist processes such as successful empathic attunement, it would not be surprising that in the literature measures of these other therapist behaviors would perhaps be conflated

with behaviours more purely linked to presence. Previous research on therapist processes, then, may have found relationships between therapist behavior and therapy processes because therapist presence remained unmeasured. For example, forward trunk lean and eye contact have been linked to perceived empathy (Haase & Tepper, 1972; Dowell & Berman, 2013) as well as a strong working alliance (Dowell & Berman, 2013). Yet I argue that eye contact, tightly linked to perception and embodied non-verbal communication, may likely and perhaps more importantly be involved in therapist presence than empathy, as it reflects a non-verbal manner with which the therapist shows they are locating the client in space and intending connection with the client. Again, to reiterate the aim of this master's thesis, the present intention is not to lay claim to therapist behavior that should only be related to therapist presence (future research will be required for this) but instead to identify and delineate a behavioural constellation (i.e. the key non-verbal and verbal expressions) that coherently reflects therapists' presence and that will later be used to inform the development of an observational measure of this therapist variable. After these aims are accomplished then psychotherapy research will be able to re-examine and refine extant measures of empathy or other therapist variables that may well be correlated with a measure of presence. At such a time it may be possible to more successfully differentiate these variables.

Presence in Healthcare and Virtual Reality Domains

The concept of presence has also been studied in healthcare communities (Reid, 2009; Epstein, 2001; Foust, 1998). The nursing field has been particularly interested in the nature of presence and its positive implications for nurses and patients. Foust (1998) developed a 16-item scale of presence that captures a person's general capacity to be open and connected to others in a non-judgmental way. The scale is comprised of four factors - value of self and others, transactional dialogue, connection and mutuality, and availability. Similar to the case in psychotherapy, presence in this field has remained somewhat 'foggy' and not clearly differentiated from other related concepts such as caring and

empathy (Finfgeld-Connett, 2006). In an attempt to clarify the nature of presence, Finfgeld-Connett (2006) conducted a meta-synthesis of presence in the nursing literature that yielded the following threefold model: 1) *antecedents* or base of presence, which includes the patient's need and openness for presence in conjunction with the nurse's willingness, level of maturity, morality, and work environment (in other words, both the nurse and patient must be ready to be present in any given moment); 2) interpersonal process *attributes* of presence, the genuineness, sensitivity and vulnerability between patient and nurse; and 3) *outcomes* of presence, namely the enhanced well-being of nurses and patients.

Another field that has valued and studied presence is the virtual reality (VR) community. Researchers in this field have realized the primacy of the experience of being present to the success of a virtual environment (VE) and to gaming applications, and, as such, the literature here offers a rich source of information on the experience of presence. Indeed, they have a journal entitled *Presence* and annual professional workshops specifically devoted to the subject. This setting offers a helpful analogue to the study of presence in psychotherapy and daily life. However, it is important to note that being present in a VE is not synonymous with being present in therapy, a caveat explored further below.

Presence - which in VR is commonly held as the sense of feeling 'really there' in a virtual field (Meehan, Razzaque, Insko, Whitton, & Brooks, 2005) - is highly valued because it is perceived as a main indication of the quality and effectiveness of a VE. Researchers in this field have conceptualized presence in different but overlapping ways. For example, Witmer and Singer (1998) articulated a two-pronged theory of presence that includes *immersion* and *involvement* in the VE, Kim and Biocca (1997) use a transportation metaphor and speak of presence in terms of *arrival* (being-there) versus *departure* (not-being-there), and Slater and Steed (2000) discuss the transitional nature of presence whereby individuals move between competing 'environments', namely a VE versus a real/laboratory environment. Further, the virtual reality literature contains an abundance of self-report questionnaires

assessing the degree of presence one experiences within a virtual environment (for a review, see Schumie, Van Der Straaten, Krijin, Van der Mast, 2001). Although the various measures tap into different aspects of presence, there is much overlap in the factors and themes that they cover. The following list summarizes the common elements across these measures:

- Spatial presence; body perceived as 'really there' linked in VE

- Involvement/awareness devoted to VE, it 'captures one' when in it

- Responsiveness; the VE responds/is affected by one's actions within that VE

- Naturalness of VE interactions; realness; genuineness; believability

- Interface quality; no interferences or distractions; sensory sharpness

- Engagement/exploration of space

VE researchers have also investigated potential underlying causes of feeling present by looking at individual differences amongst players, the qualities of the environment, and the interaction of the person in the environment. In one study of individual differences, Thornson, Goldiez, and Le (2009) conducted a factor analysis of over 100 items derived from a conceptual framework of individual qualities of players that lead to the experience of presence. The result was a six-factor model termed the Tendency toward Presence Inventory, which measures the likelihood of experiencing a state of presence and includes the following capacities: spatial orientation (feeling oriented in an environment); 'passive' cognitive involvement (becoming absorbed as an observer, such as when watching television); 'active' cognitive involvement (becoming absorbed as a 'doer', namely when playing video games); introversion; ability to construct mental models; and empathy (the tendency to 'feel for' the other characters in the VE, to consider their perspective and in turn have resonant feelings). All of these characteristics ultimately amount to a gamer's likelihood of truly feeling connected to and becoming immersed in a VE, of feeling 'really there'.

Schumiet et al. (2001) report the following qualities of the virtual environment, and the person's interaction in it, that are linked to feeling 'really there':

- High sensory quality; vividness; realness: "It feels like I am really here."

- Consistency; minimal distraction/interference/'noise': "Nothing takes me away from there".

- Interaction abilities: "Mutual impact between myself and environment occurs"

- Anticipation of effects; "I can sometimes predict what will happen there".

- Control/agency: "I can make things happen there".

Overall, the VR literature offers a foothold for understanding how therapists are present with clients and perhaps how clients perceive their therapist as present in a shared intersubjective space. As mentioned above, one basic assumption of presence in VR is that there are always two competing environments a person can be present to - the VE and the real environment. The realm of presence research in virtual reality literature is of course devoted to the former (Le, 2004). For example, Slater and Steed (2000) studied 'breaks in presence' by assessing transitions over time as participants felt shifts in the environment in which they felt present. Consideration of competing environments offers a helpful guide for studying this phenomenon in psychotherapy. One implication is that therapists must skillfully 'stay with' and 'return to' the therapeutic encounter and not 'depart from or leave it' by entering into a secondary or internal environment of personal feelings or distracting thoughts. Another aspect, the player's capacity to impact the environment, can also be translated into the psychotherapy process. Perhaps when therapists respond to their clients in a manner that is consistent and animated, clients feel they and their therapists are really with one another.

However, as alluded to earlier there is one important caveat to consider when comparing presence in therapy with presence in virtual reality. As mentioned, the common ground for these two kinds of presence seems to lie in the notion of 'staying' in the environment - gamers stay in the technological or

'artificial' environment and therapists stay in the therapeutic environment, and the task in both cases is to 'not leave' experientially and perceptually. It should be noted, however, that a very important difference is found in the nature and intrinsic values of the environments in which a person feels present. On the one hand, the gaming environment provides a pleasurable and entertaining experience but arguably does not hold much humanistic value - that is, it does not engender qualities considered important for well-being, such as personal growth, positive interpersonal relationships, self-acceptance, etc. (Deci & Ryan, 2008). In other words, it can be argued that sustaining presence in a virtual environment will not make us happy or transform our lives. In fact, getting absorbed in a video game or cell phone can have negative consequences like ignoring people around you, or at the extreme end can be fatal (e.g., texting and driving). On the other hand, the therapeutic environment is rich in value, involving qualities of interpersonal contact, authenticity, shared intersubjectivity, and acceptance. Being present in therapy therefore has totally different and growth-promoting implications compared to the kind of absorbed presence one experiences while playing a virtual reality game or watching an Imax movie.

Differentiating Presence from Mindfulness, Empathy, and Relational depth

In order to explore and test the assertion that presence is a fundamental therapy factor with its own merits, however, it is also important to disentangle it from related variables. While a thorough disentanglement of these concepts is beyond the scope of this thesis and perhaps the present state of empirical research on these variables, the following discussion briefly compares and contrasts the concept of presence with three similar concepts in psychotherapy - mindfulness, empathy, and relational depth.

First, there is a very close connection between mindfulness and presence. In fact, often these terms are used interchangeably or paired together as 'mindful presence' (Brach, 2012), and mindfulness meditation has been used to help therapists-in-training cultivate presence (McCollum & Gehart, 2010).

Brown and Ryan (2003) developed a now well-researched measure of dispositional mindfulness, the Mindful Attention Awareness Scale (MAAS), which strictly assesses attention to and awareness of whatever is happening in the here and now. From this vantage point, mindfulness and presence can be seen as reciprocal processes. The controlling of awareness inherent to mindfulness - i.e. staying focused in the here and now - may first require an embodied presence to the perception through which we become aware and with which we attend, and further that mindfulness helps sustain an embodied presence over time.

Another model of mindfulness is represented by the Five Factor Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, and Toney, 2006), which includes the facets *observing* and *describing* one's experience, *acting with awareness*, and *non-judging* and *non-reacting* to experience. This suggests once more that presence may be fundamental to mindfulness - that mindfulness suggests a capacity to maintain present awareness without engaging in more complex cognitive processing of the contents that enter awareness. Therefore, while these views of mindfulness bare a striking overlap with aspects of therapeutic presence and may appear synonymous at first glance, I argue that they are separate (albeit related) phenomena. The distinguishing point of presence, as will be maintained in this study, is what I would argue are behaviors by which therapists display their connections to presently unfolding embodied aspects of experience (Levin, 1985) – the tuning into and toward the multi-sensory world felt by the body in the here and now- whereas the aforementioned views of mindfulness emphasize a capacity to maintain a non-attached awareness of the contents of experience.

Empathy and presence also appear to be overlapping constructs. Carl Rogers described empathy as the capacity to "perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the 'as if' condition" (Rogers, 1959, p 210). The main distinguishing feature between empathy and presence seems to be that presence is a more primary phenomenon whereas empathy involves

higher order capacities related to understanding. This is why therapeutic presence is regarded as a foundation from which other processes like empathy are thought to emerge (Geller, Pos, & Colosimo, 2012). There is early evidence to support the unique role of therapeutic presence beyond its overlap with empathy. Clients' perception of therapist presence has been shown to uniquely predict the working alliance while controlling for empathy (Pos, Geller, & Oghene, 2011). More research is needed to elucidate the differences, similarities, and interplay of these constructs. One hypothesis in this vein would be that empathy partially mediates the relationship between therapeutic presence and other therapy processes like the alliance. A full mediation effect would not be expected here because therapeutic presence is thought to contribute to several processes - in other words, empathy is probably not the only avenue through which presence impacts the therapeutic process. Another potential and very important way presence benefits the therapeutic process is through its link with the human body's vagal system (Porges, 1998, 2001), which essentially provides neurophysiological substrates for behaviours of social engagement and safety. For example, the vagal system is partly responsible for the communication of affect through facial expressions, vocalization, and head tilt. Therapists who are present may very well be activating this neurophysiological system in their bodies and therefore providing an environment for the client that is perceived as safe and engaging, leading perhaps to a strong alliance and the client's personal agency to face difficult problems.

Another conceptual relative of presence is relational depth (Mearns, 1997; Cooper, 2005). In one study, Cooper (2005) defined relational depth as:

"A feeling of profound contact and engagement with an Other, in which one simultaneously experiences extremely high and consistent levels of empathy and acceptance towards that Other, and relates to them in a highly transparent way. In this relationship, the Other is experienced as acknowledging one's empathy and acceptance - either implicitly or explicitly - and is experienced as fully congruent and real."

The key distinction between relational depth and therapist presence appears to be that the former emphasizes qualities of the relationship, the emergent 'in-between', and thus includes details subsumed by a larger concept of presence. I would argue that one experiences relational depth as a consequence of an experience of being present with another present Other in a presently unfolding relationship. I choose in the present study to articulate a larger overarching concept of presence with consequences for behaviours at both the individual level and relational levels. As such, it can be argued that presence plays a similar role here as it does with empathy by scaffolding the experience of relational depth. In other words, relational depth may be possible only when one or both people in a dyad embody presence.

Method

Participants

The sample consisted of eight therapist-client dyads that participated in the York Psychotherapy Research Center's outcome study comparing Client-Centered and Process-Experiential treatment of depression (Goldman, Greenberg, & Angus, 2006). Each participant was randomly assigned to one of the treatment modalities. See Table 1 for descriptive information on the dyads included in this study. Therapists and clients were Caucasian with the exception of one Asian female client. Inclusion criteria for the depression study were as follows: a DSM-III-R diagnosis for major depressive episode; a Global Assessment Score greater than 50 on the Structured Clinical Interview for the DSM-III-R (not including seriously impaired individuals shown to respond best to psychotropic medication); a score equal or greater than 16 on the Beck Depression Inventory; and informed consent for therapy and audiovisual recording. The exclusion criteria were as follows: DSM-III-R diagnosis of another Axis-I disorder (excluding anxiety disorder); or an Axis-2 diagnosis of borderline personality disorder, antisocial or schizo-affective disorder; concurrent addiction disorder; high risk for suicide; current participation in psychotherapy or use of psychotropic medication for depression.

Procedure

The current study used an adaptation of task analysis methodology to explore the behavioural expressions associated with therapist presence. The following is a description of task analysis as classically used in industrial and behavioural settings, followed by a discussion of how task analysis has been employed in psychotherapy process research as well as in the present study.

Background of task analysis. Task analysis involves a dialectical exchange between theory and empirical observation in order to build a model of a given task performance. In industrial contexts (Semprevivo, 1976) this strategy can be used for several purposes, including to a) *define* tasks subsumed in a given job (e.g., the 'job' of computer programming involves 'tasks' such as logical analysis, coding, testing, and documentation), b) determine the appropriate *order* of tasks to complete the job (logical analysis must happen first, followed by coding, etc.), c) establish whether two or more tasks may be *performed simultaneously*, and d) determine the *status* of a particular job at any given point. Psychologists (e.g., Piaget, 1954; Newell & Simon, 1972) began adapting forms of task analysis to investigate the steps involved in cognitive and behavioural task performances. Currently task analysis is a prominent method used in applied behaviour analysis (Cooper, Heron, & Heward, 2006) to delineate the sequence of actions required for the completion of specific tasks; for example, identifying the step-by-step process for washing hands, tying shoes, and brushing teeth.

The task analytic approach has also entered the domain of psychotherapy research, introduced first by Greenberg (1984, 1991, 1996, 2007). Here the notion of 'job' and 'task' has been re-conceptualized according to the psychological work and processes that occur in therapy. In emotion-focused therapy, for example, researchers have studied the cognitive-affective states clients must traverse to successfully resolve unfinished business with a significant other as well as intrapersonal conflict (Greenberg, 1996, 2007) and in the resolution of undifferentiated global distress (Pascual-Leone & Greenberg, 2007).

This approach has also been used in other contexts such as investigations of the patterns of how clients receive interpretations during psychodynamic therapy (Joyce, Duncan, & Piper 1995).

Task analysis: Present study. In the present study I was not interested in the sequence of 'within presence' behaviours per se, nor how presence is followed by other processes to constitute a larger session or process outcome. Rather, my focus was more fundamental, *identifying* the core behavioural indicators of therapist expressed presence. Thus expressed therapeutic therapist presence is the target or 'task' being analyzed in this study. This intention is in line with the first purpose of task analysis mentioned above by Semprevivo (1976), which is to define the necessary components of a particular job (i.e. behavioural components of being present). Once these markers are identified, future research can then investigate whether there are certain sequential patterns in presence behaviour.

A complete task analysis proceeds in two general phases. The first is the discovery phase, which emphasizes working within the context of discovery to build models. In this phase one uses both rational (top-down) and empirical (discovery based and bottom-up) strategies to rigorously observe and categorize performance of the task. In the second, or validation phase, one generates and tests hypotheses based on the derived model one has constructed within the discovery phase in order to empirically validate the model obtained as well as to use obtained research results to rejig the model if required. The present research study undertook the rational-empirical discovery phase of task analysis.

Before detailing the steps of task analysis performed in this study, it is important to at least briefly highlight the benefit of using both rational and empirical approaches in psychological research. As phenomenologist Merleau-Ponty (1962, p. 58) stated, "In order to understand truly what has been discovered about man, we must, therefore, combine induction with the reflective knowledge that we can obtain from ourselves as conscious subjects." Merleau-Ponty (1964) then explains that Husserl called this 'eidetic psychology' - eidetic referring to vivid mental images and forms. It follows that researchers, perhaps especially in psychology, might benefit by understanding a phenomenon *first*

through direct experience and intuition (to see the essence of the phenomenon) and *then* by empirical investigation of facts, patterns, and relations. The rational and empirical analyses of task analysis are therefore in line with Husserl's recommendation of an eidetic psychology.

Further, as noted in Greenberg (2007), the underlying epistemology of task analysis is also linked to dialectical-constructivism (Greenberg & Pascual-Leone, 2001), a view of reality as both partly objective as well as socially constructed. The advantage of task analysis, therefore, is that it allows interplay between these aspects of reality - the rational phase draws primarily from social construction and the empirical phase primarily from objective analysis.

Stages of the discovery phase. Following Greenberg's most recent (2007) guidelines, the discovery phase is complex and can be broken down into the following sequential components.

1. Specify the task. This step typically involves developing precise behavioral criteria of a problem state related to the research question. For example, in order to study the resolution of 'unfinished business' or 'self-critical split' it is important to first specify what is meant by this term and the certain psychological constellation of feelings and meanings that clients experience in such states. This allows the researcher to accurately identify the starting point of the task analysis. Thus, the question at this point is, "What does 'X' look like?"

Normally, to establish the key behavioral markers of a client's initial problem state, the researcher empirically studies therapy cases that clearly embody the state as well as those that clearly do not embody the state. Through distinctive feature analysis, the researcher compares and contrasts these cases until a level of saturation is met regarding the key markers of the problem state, resulting in a clear delineation of the task marker. At this point, the problem state is well defined and the researcher is in good position to proceed in the task analysis.

The present study is interested in the performance or display of therapist presence. Here, therapists' performance of providing presence was selected from a previous research project in which clients rated

their therapist on the Therapeutic Presence Scale-Client version (TPI-C; Geller, 2002; Geller, Greenberg, & Watson, 2010). Therapists rated at or above the 90th percentile were used as exemplars of "high" presence and those rated at the 10th and 5th percentile as exemplars of "low" presence. These groups and the subsumed cases marked the starting point of the empirical analysis (explained in step 5). Since these said client ratings had been shown to predict other therapy processes they were considered valid client measures of presence (Pos, Geller & Oghene, 2011); and the assumption here is that clients did identify, and record via the TPI-C, their observation of meaningful qualitative differences between high and low presence therapists in their performance of behavioral anchors of embodied presence.

2. Explicate investigator's cognitive map. This step required that I, as investigator, explicate my personal perspectives and assumptions before building a rational model of presence. I have implicit knowledge of presence that may impact the rational model I develop. For example, as a meditation practitioner and previous investigator of mindfulness and compassion, it behooves me to explicitly articulate my intuitions, ideas, and theoretical leanings on presence and how I view it relative to other related concepts. My thinking is very much in line with experiential, humanistic, existential, and Buddhist views of presence that I briefly covered in the introduction of this paper. In short, I maintain that presence is a human potentiality that is the foundation of other subjective and relational process such as active listening, empathy, and compassion. I also maintain presence can be cultivated with sustained practice, namely meditation, and integrated into one's daily life.

Specifying in advance what I think I know is an important first step because it serves as a baseline and record against which I can compare what I later observe in both the rational model (Step 4) and through empirical observation (Step 5). It is also important because it is in accordance with Husserl's notion of 'eidetic psychology', and with its emphasis on experientially and intuitively understanding research topics in addition to objective analysis. Further, this attempt to explicitly state my

preconceptions facilitates what phenomenologists call 'bracketing', the ability to set aside ideas in the service of seeing phenomena more purely and honestly.

3. Specify the task environment. The task environment or context within which this study occurred is sessions of individual experiential treatment of depression that occurred during the York 2 to outcome study (Goldman, Greenberg, & Angus, 2006). Specifically, therapists were trained in and provided process-experiential/emotion-focused therapy (Greenberg & Watson, 2006) and/or client-centered therapy (Rogers, 1951). Session lengths were approximately 60 minutes and took place in a university psychology clinic.

4. Construct a rational model. As previously mentioned, a rational analysis is conducted prior to the empirical analysis in order to establish a hypothetical model of the relevant phenomenon, which can then serve as a reference point for subsequent comparison (Greenberg & Foerster, 1996). The rational analysis should be comprehensive and may draw from multiple sources of information, including scientific literature, clinical judgment, and lay conceptualizations.

Drawing from several sources of literature and clinical intuition, the present study aimed to build a theoretical model of how therapists express their presence in this task environment. This process lead to a reasonable and rational understanding of the components involved in therapists' expression of presence that are a) observable to an outside observer, b) likely perceived by the client and c) would lead the client to report their therapist as present. See the results section for a presentation of the rational model. This model represents an educated guess as to what is expected to happen in the real world and serves as a record against which the empirical analysis can be compared. This step is particularly important later in the task analytic process if one wishes to demonstrate that something new or unexpected has been discovered from the empirical observation or analysis; that is, when it has yielded observations that were not included in the rational model.

The literature considered in the rational model of therapist presence is reflected in the introduction of this paper. Contemporary models and measures of presence were reviewed from diverse fields such as nursing (Bishop & Scudder, 1996; Gilje, 1993; McDonough-Means, Kreitzer, & Bell, 2004; McKivergin & Daubenmire, 1994), virtual reality (see Lee, 2004 for a review), neuroscience (Porges, 1998) and psychotherapy (Geller & Greenberg, 2012). Also thoroughly reviewed were theories on the nature of presence as an underlying factor of core relationship conditions (Bozarth, 2001; Bugental, 1965, 1987; Geller & Greenberg 2012; Geller, Greenberg & Watson, 2010; Schmid, 1998; Thorne, 1992; Wyatt, 2000).

5. *Conduct empirical analyses*. After developing the rational model, the observational stage of task analysis begins. A detailed account of the procedure used in the empirical analysis is outlined in the next subsection 'procedure of empirical observation'. Essentially, video recordings of therapy sessions rated high and low on therapist presence were first identified and then systematically observed by two researchers.

The empirical phase is a reiterative process that becomes increasingly refined and continues to the point of saturation (Glaser & Strauss, 1967) - that is, when observing new cases no longer yields novel information or added refinement. This means that it was necessary to examine additional good and poor cases as needed. It is also important to note that during this process potential methods for how the identified behavioural markers identified by the research observers might best be measured was also considered and developed. Specific steps outlined in Greenberg (2007) were used as a guide throughout this phase.

6. *Synthesize a rational empirical model*. Next, the fully saturated rational and empirical models were compared. The empirical model was used to corroborate, elaborate, or modify the rational model, such that any changes made in the initial rational model will accurately reflect the actual therapist performances.

7. Construction of the observational measure. Finally, the revised model, informed by both rational and empirical sources, may be used to establish observational markers and a methodological basis for measuring these markers. The development of a measurement tool of expressed presence was beyond the scope of this study and will be completed in a future research project. How the present project might inform construction of such a measure will however be briefly addressed in the discussion.

Procedure of current study: Empirical observation. As mentioned in Step 1, therapy cases were purposefully selected on the basis of TPI-C scores, representing good and poor performances of presence (see Table 1 for descriptive information). Following Greenberg's (2007) advice, the first phase of observations included three good cases and three poor cases. These were initially selected as exemplars of presence and non-presence and were thoroughly investigated one by one. In the second phase the researcher selected two poor presence sessions for observation from therapists who had also been rated as highly present by their clients in two good presence sessions. This contrast analysis provided an opportunity to examine within therapist differences in their good and poor presence performances. Finally, two additional cases - one poor and one good - were selected and analyzed to see whether any new themes emerged that could be added to the empirical model. Overall, 10 therapy sessions were examined in the empirical analysis - including eight therapist-client dyads, two of which were observed on two occasions (in the phase 2 'contrast analysis).

It is important to note that biases and theories, although likely to inform observation, were carefully reflected on and bracketed during these observations so as not to interfere with potentially new and unexpected elements of therapist performances. One concrete way the raters bracketed their preconceptions was by minimizing any referencing to or thinking about the previously established rational model. This was not hard to do given that the session coding occurred several months after the rational model had been established. No re-visiting of the rational model occurred during the empirical coding phase.

Two raters - a clinical psychologist and a clinical psychology graduate student (the author) - rigorously observed the video recorded therapy sessions. The raters observed the entire session in five-minute segments, and each five-minute segment was meticulously examined twice. In the first round raters attended to the therapist's non-verbal behaviours and in the second round to verbal behaviours. Raters met on a weekly basis for video observation. Each five-minute segment was rated independently, with dialogue and consensus engaged in and sought after each segment was observed. Thus, at the end of a segment, the video was stopped and the raters discussed their observations. This process seemed to optimize the capturing of relevant behavioural data and minimize that of more irrelevant data.

Comparing good and poor performances helped differentiate key behavioral features of expressed presence from behaviours that are less specific and irrelevant. Furthermore, assessing poor performance cases served to highlight not only the absence of behaviors that might have occurred in the good presence cases but also unique behaviours associated with clear examples of therapist diversion from presence. I term these moments 'non-presence', 'presence failures', 'leaving behaviours', or 'therapist absence'. As such, examining poor presence cases therefore offered a rich source of potentially measureable behaviors of deviations from presence that would be negatively scored in the final observational measure.

Results

Rational Model of Expressed Presence

Expressed therapist presence was defined in this study as *communicating that one is here-now, with and for the client's process.* Conversely, a relative lack of presence, or 'non-presence', was defined as *the outcome of any process that interferes with, blocks, or prevents the therapist from communicating that he/she is present.* The rational model presented below is based on this multi-faceted description of presence. It is important to note that what follows is meant to capture *a* model of expressed presence,

not *the* model. There are many possible ways to conceptualize the expression of presence; hopefully the present effort is fruitful.

After carefully considering the literature on presence and reflecting on how it is embodied in daily life and by therapists in the psychotherapeutic encounter, four higher-order modes of expression, or themes, were used to organize the rational model. These include 'here', 'now', 'open', and 'communion'. Together these modes reflected what I considered as distinct yet related ways in which presence may manifest. Figure 1 illustrates these themes and the sub-factors embedded within them. The following is an explanation of each one, including a description of what potentially occurs when it is lacking or deficient.

Theme 1: '*Here*'. This theme refers to the therapist maintaining awareness and embodiment of the immediate therapy environment, in which the client's process is salient and paramount. See Figure 2 for the concrete therapist behaviours hypothesized as linked with this theme. Essentially, 'being here' suggests that the therapist's body and therefore awareness is submerged in this context/place. Central to this aspect of presence is how therapists participate, and engage in such a way as to communicate they are 'here in this therapy room and place'. Equally important is the expectation that highly present therapists naturally show a prompt return and re-engagement to this place after being distracted 'to some other place' in some way. Let us now take a closer look at what is meant by being fully 'here' as a therapist. This should provide a rationale for the potentially observable behaviours listed in Figure 2.

Being 'here' in this place means the therapist is deeply immersed in the client's experience as it is expressed concretely in the therapeutic dialogue. Being immersed and sensitively involved with the client further requires that the therapist embody a sufficient amount of vital responsiveness to place. The environment in which the therapist becomes present is therefore the therapy room and its contents and the array of stimuli, meanings, and experiences that this entails. The therapist is present to the client, the self (in relation to the therapeutic work), and the relationship. Thoughts and feelings that

occupy the therapist's awareness in session that are not related to the 'therapeutic environment' can be considered extraneous and warning signs of a loss of presence. These extraneous impulses are likened to a 'secondary environment' that pulls for the therapist's attention. For example, while listening to a client the therapist might sense that they are hungry and begin to 'leave' via fantasizing about 'being somewhere else' eating food or making plans for dinner.

Being 'here' in the therapeutic environment also implies that the therapist is not self-centered, such that the focus of attention is entirely or almost entirely on the client's experience. Indulging in thoughts about dinner while a client is sharing their story is self-centered - the key word being *indulging*. Of course such distractions are likely to arise even in highly present therapists. The crucial point is that present therapists put an end to distractions, nip them in the bud as it were, in order to be fully 'here'. Continually sustaining and returning awareness to being with the client is supported by the therapist's basic willingness and interest to engage in the therapeutic encounter.

Absence or *'not-here'*. The therapist is distant or distracted from the client's immediate experience, preoccupied instead with personal thoughts, feelings, bodily sensations, and/or environmental noises, all of which contribute to a sense of being 'somewhere else'. Personal reactions of the therapist such as addressing a potential alliance rupture or a moment of skillful self-disclosure that are used toward the therapeutic process are the exception. Therapist shows fatigue or low energy levels that cause him or her to lose contact with perceptions of the client. These are likely communications to the client that "I don't want to be here".

Theme 2: *Now*. This mode is about the dynamic link to the flow of time in session as well as the immediacy of the present moment - what is happening right now. See Figure 3 for specific (potential) therapist behaviours linked to this theme. The therapist shows a readiness to track the client and is highly synchronized moment-to-moment with the client's experience such that verbal and nonverbal responses are prompt and well timed. The therapist may also draw (or attempt to draw) the client's

attention to the present moment, thereby bringing the client back to what is happening 'now'. For example, a therapist might make an effort to slow down a client who speaks with a fast tempo or who habitually focuses on the past or future. The therapist might also bring the client into the immediate moment by pointing out *what* the client is doing right now via process identifications (Rennie, 1998) - e.g., "You're really feeling/thinking/debating/avoiding right now." Of course, past or future-oriented narrative always occurs in the present, so paralleling the client's experience may also count toward conveying a sense of 'now-ness' to the client. Even more so, would be a comment such as " I just noticed we're in the future right now'.

Absence or '*not-now'*. Therapist is disconnected and unsynchronized with client's experience. Responses tend to be delayed, choppy, or ill timed. If the client loses touch with the present moment, the therapist does not make an effort to connect back to 'now'; thus, the client may spend most of his or her time avoiding experience or unaware of the present impact or meaning of their narrative. The therapist might also attune in a delayed way, ignoring what just was said to attune instead to something said earlier without noting that. This communicates 'I'm not in the now, I'm in the then".

Theme 3: *Open*. This mode is about being open and 'tuned into' the live choreography of the unfolding moment. Figure 4 shows specific verbal and non-verbal therapist markers in relation to this theme. The therapist's body/mind in this mode is like a radio receiver, picking up the channel of the therapeutic encounter with all sense organs. The therapist attunes to his or her own sensory experience - including thought (perceptions, images, cognitions) - as well as the experience of the client. The client of course *is the primary source* of the therapist's sensory experience- that is, the therapist senses the nuances and subtleties of the client's present behaviour and their therapeutic process. Similar to the theory of presence in virtual reality, the therapist is present to the primary environment of the client's experience and tunes out any secondary, non-relevant environments that may be competing for attention, like sounds emitted outside of the therapy room. The therapist embodies an attitude toward

the client and 'material' in the session that is relaxed, open, flexible, and non-assuming, and she

accepts and allows the client's process to unfold without fear or any kind of selective filtering.

Absence or '*closed*'. Openness is diminished to the degree that the therapist is distracted from the

immediate encounter with the client. Fantasies, fear, boredom, fatigue, and lapses in attention all

weaken the therapist's sensory acuity of the client; this is likened to the body's radio receiver picking

up interference signals. This in turn reduces the therapist's sensitivity and receptivity in the present

session. An attitude that tends to 'filter' experience - e.g., judgmental, rigid, anxious, or presumptuous -

may also function to block or interfere with being fully 'open' to receiving information from the

client's experience.

Theme 4: *Communion*. This mode of therapeutic presence is based upon being *with and for* the

client's process. Figure 5 illustrates the hypothesized behaviours associated with this theme.

Togetherness, partnership, and intimacy are characteristics of the communion theme. Client and

therapist are two 'open systems' sharing the same intersubjective space, as if co-travelers in the world.

In order to be with the client in this way the therapist brackets the ego and its self-related interests and

concerns, and is ready, willing, and able to selflessly engage with the client. The therapeutic

relationship is genuine, egalitarian and humanistic, and in line with Buber's (1958) I-thou encounter.

Overall, the therapist is a safe and caring Other that maintains an attitude of compassion, kindness, and

genuine interest. The following statement by Yalom (1980, p 373) on the I-Thou relationship reflects

the communion theme of presence: "If one relates selflessly, one is free to experience all parts of the

other rather than the part that serves some utilitarian purpose. One extends oneself into the other,

recognizing the other as a sentient being who has also constituted a world about himself or herself."

Absence or 'separate'. When communion is lost, there is separation or 'disconnect' in the

relationship. Instead of a blended intersubjectivity or merging of client and therapist, the therapist and

client appear to be two closed systems exchanging information. This kind of therapeutic meeting is

superficial and sterile. The therapist may be relating from his or her own theories or self-interest and is thus not fully immersed in the client's experience. There are signs of the therapist 'holding back' in some way, not sharing totally in the client's process.

Empirical Model of Expressed Presence

Overall, the initial rational model accurately predicted many therapist behaviours later identified through the empirical analysis phase of the task analysis. The empirical analysis resulted in four separate models. Figures 6 and 7 are devoted to the physical and verbal behaviours linked to therapist presence, respectively, and Figures 8 and 9 are devoted similarly to non-presence behaviours. In an effort to demonstrate how the markers are grounded in the data, Tables 2 and 3 offer a selection of verbal markers and the corresponding transcript excerpt from which they originated. Vocal tone and physical markers are not included in these tables because they are best reflected in the audiovisual recordings; however, the titles of these markers (e.g., 'constant, unwavering eye gaze', and 'soft vocal tone') are fairly straightforward descriptions of the observed behaviour. Let us now consider some key points revealed in the empirical analysis.

The first notable finding relates to the structural difference between the rational and empirical models (compare Figures 5, 6, and 7). Instead of being organizing around the abstract themes used in the rational model (i.e. here, now, open, and communion), the empirical model was constructed along more basic categories of verbal (i.e. vocal tone, minimal encouragers, and response quality) and non-verbal (face, nodding, arms/hands, and posture) communication (legs and feet were initially considered as a non-verbal category, but were quickly dropped due to a clear lack of relevance). The reason for the structural difference in the models is twofold. First, the categories of the empirical model provided a more practical and optimal foothold for the observation of presence behaviours. When studying physical patterns, therefore, the researcher could reliably cover each verbal and physical domain. And second, the structural themes naturally emerged early in the observation phase of therapist presence

behaviours; in fact, they were established by the end of the first observed session. The researchers found themselves naturally tuning to these two tracks of observable behavior and in so doing also discovered, or were lead to observe, that therapists consistently expressed presence-related behaviours within these general verbal and bodily categories. Although the abstract themes were not used as anchoring points in the empirical model, they were retained for their theoretical value and are eventually brought back into the picture in the final synthesized model.

Although the rational model was quite accurate, the empirical analysis revealed many new markers of therapist presence other than rationally modeled and therefore is more comprehensive. In terms of accuracy, only five of the rationally forecasted behaviours were not noted in the empirical analysis and thus do not appear in the empirical model. These five markers include:

1. Communion and contact occurring in dyad (COMMUNION)

2. Therapist not self-focused, but totally immersed in client's process (COMMUNION)

3. Awareness of time in session (NOW)

4. Responses are timely/smooth (not delayed/choppy) (NOW)

5. Therapist speaks from his or her own bodily (resonant) felt sense (OPEN)

The first two markers - in line with the communion theme - are abstract qualities that were not on the researchers' observational 'radar' at the time of the empirical analysis, primarily because the analysis focused on concrete behaviours. These abstract markers, however, are highly relevant to presence and do appear to be partly reflected by other behaviours such as warm vocal tone, strong attention, and stable body posture. For this reason, the decision was made to incorporate these markers into the final synthesized model under the added category (to be discussed later) of 'Abstract/relational'.

The last three rational markers listed above were carefully reconsidered in relation to the raw observational notes of the empirical analysis and the overall model, and it appears they are conflated with or subsumed by related behaviours; the third marker is aligned with 'orients dialogue in time', the

fourth is imbedded in 'synchrony/harmony/flow in dialogue' and the fifth blends in with 'experiential language'. These markers were therefore integrated accordingly in the synthesized model.

Finally, the empirical analysis showed that therapists typically expressed two or more presence behaviours simultaneously. Consider for example the first excerpt highlighted in Table 2: in addition to the therapist's accurate reflection is a warm vocal tone and experiential language, as well as many non-verbal markers such as eye gaze and poised body posture. All of the markers identified in the empirical model, therefore, represent a constellation of presence (and non-presence) behaviours that can manifest in many possible patterns.

Synthesized Rational-Empirical Model of Expressed Presence

Figures 10-14 represent the culmination of this study's endeavor to map the verbal and non-verbal behaviours associated with the communication of presence. The organizing categories of the empirical model were retained in the synthesized models, and the abstract themes of the rational model (now, here, open, and communion) were added next to each marker. It is important to note that several markers are paired with two or three abstract themes, supporting the overlapping nature of the theoretical aspects of presence. For example, the second marker of the 'face' component in Figure 13 - 'therapist embodies a flat, tired, bored, and/or uninterested facial expression' - is affiliated with 'not-here', 'blocked', and 'separate', meaning that this behaviour communicates (at a higher level of abstraction) that the therapist was away from the immediate moment, blocked from a deeper experiencing of the client, and only loosely engaged in the client's process.

Further, the synthesized model added an additional category of 'Abstract/relational markers' (see Figure 14). The reason for this addition was to capture important qualities of the communication of presence (and non-presence) that the researchers noted in the empirical analysis but that happen to be more abstract or based upon certain client expressions. These markers might prove fruitful later in the research program when development of the observational measure is underway.

Discussion

This study is the first of its kind, one that systematically investigated key observable behavioural components of therapeutic presence explicitly displayed by therapists. This study rested on the assumption that clients who have used three global items of the Therapeutic Presence Inventory (Geller, Greenberg, & Watson, 2010) while rating their therapist's level of in-session presence could do so because their therapist manifested being present through certain observable behaviors. As such, I also assumed that these behaviors could be explicated by researchers and eventually be translated into an observational measure in order to advance research on this important therapist behavior.

Using a task analytic methodology, ten performances of presence (five good and five poor) established in a previous study were rigorously examined. From this I developed an emergent final model of presence that synthesized two previous models - one rational, one empirical - established during the investigation. First, the rational model was constructed based on a synthesis of extant relevant literature and clinical theory, and suggested four core modes of presence: 'here', 'now', 'open' and 'communion'. And second, an empirical model emerged from rigorous observation of five successful and five unsuccessful performances of in-session therapist presence. The final model identifies verbal and non-verbal observable behaviors that distinguish high versus low performance of therapist presence. These behavioral markers hopefully will serve development of a future observable measure of therapeutic presence.

Observer Versus Client Measures of Process

The first question the informed reader may ask is: "Why bother?". If clients can rate their therapists easily on three global items that predict other therapist processes (Pos, Oghene, & Geller, 2011; Geller, Greenberg, & Watson, 2010), and if client measures are most often better predictors of outcome and processes than therapist or observer measures (Lambert, 2007, Meehl, 1954) why bother explicate

presence behaviors intended for eventual use in an observer measure? Several arguments can be made in favour of this line or research.

First of all our understanding of this phenomenon is still developing. Nonetheless, clients have rated therapist presence and these ratings have been shown to uniquely relate to the therapeutic alliance (in-session and later sessions) beyond therapist empathy (Pos et al., 2011). This speaks to the fact that this therapist process is both a distinctive process and one worthy of deeper understanding and further investigation. More specific and concrete explications of therapeutic presence will facilitate the advancement of this line of research, and the present study has made an effort in this direction.

Another consideration is that it is highly likely that therapist presence is a transtheoretical therapist process. Rogers identified therapist presence as fundamental in humanistic therapies, as has McWilliams in psychoanalytic approaches and Yalom in existential approaches. This suggests to us that presence may be the primary ingredient in the development of the alliance. This means that while in a humanistic model therapist presence is related to empathy (Pos et al., 2011) in another model it may relate to tasks such as successful interpretation or more effective work with exposures. Future research across approaches will require valid, reliable, and replicable measurement of this process independent of client or therapist. The model of presence arrived at in this study does not preclude creating a more precise client as well as observer measure that can be used in other therapy contexts. The most important issue accomplished here is that presence has for the first time been 'unpacked' into some of its apparent components. Hopefully future research will test the usefulness of these distinctions.

Thirdly, if in fact therapist presence is a transtheoretical therapist process of import, training programs and supervisors within these programs will want a model of behaviors that they can refer to when helping student therapists develop this capacity. As a clinical area we do not simply wish to know what therapist process is important but *how* the therapist engages in this process. As such, clinical

research at its best yields knowledge that can be transferred into practice. The model of presence established by this study has begun to 'map' behavioral markers of presence that can be used in training. The model can also be used to inform process research, real or analogue. For example in future research one might engage therapists to express the markers found here, and even control for some markers (i.e. body posture, eye gaze manipulation) to further validate the importance of some behaviors versus others.

In relation to the above point I would like to note that while research has often found that client measures are best, observer measures can be established. A case in point it the Measure of Expressed Empathy that has been developed by Watson & Prosser (MEE; 2002). The MEE is a successful observer measure that has operationalized behaviour of expressed empathy and that has lead to more refined research on empathy as well as informed training. For example, Spigelman (2011) found that therapist expressed empathy (MEE) in session one predicted not only session one alliance but also clients emotional processing in future sessions, thus highlighting for therapists the importance of activating empathy from the beginning of treatment. Therefore good observer measures of process are possible and important goals.

Can We Be Confident of the Final Model of Presence Suggested Here?

Even while this is the first study to develop a model based on empirical observation of the provision of therapist presence, a good measure of its validity can come from revisiting extant models and searching for agreement or coherence between them and the model that emerged from this study.

Interestingly, after completing the empirical analysis, I, the researcher, came across a presence 'observation schedule' appended to Bugental's (1987) *The Art of the Psychotherapist*. I was blind to this schedule untill after the analysis was complete. From an expert who studied presence with passion and insight, Bugental's schedule consists of 14 items (apparently derived from his own clinical intuition and experience) that can be scored on a Lykert-type scale. The following is a selection of

items from Bugental's scale: "Was what Y said to O clear and understandable?"; "Did Y seem to understand what O had to say"; "Estimate the deepest level of presence Y reached/O reached"; Estimate Y/O's most frequent level of presence"; "Did Y/O seem genuinely open, accessible?";"Did Y/O seem to want to put out, to express him/herself?";"Did O have the impulse to withdraw from the conversation?" I would argue that several items point more to the process of empathy than presence, which speaks to the difficulty of disentangling these two processes. However, more important is that these items leave the 'how' of expressing these processes unarticulated. As such, while his measure validates the importance of presence as a phenomenon, the present model can be viewed as having better provided potential objectively observable behaviors that may instantiate the presence process to which Bugental is pointing.

Another obvious comparison I must make is to the only extant measure with considerable empirical support at present, Geller's Therapeutic Presence Inventories, therapist and client versions. The final model of expressed presence does lend support to, and is supported by, Geller's (Geller & Greenberg, 2002; Geller, Greenberg, &Watson, 2010) model and measures of therapeutic presence. The modes of expressing presence in this study, in particular those articulated in the rational model - here, now, open, and communion – as well as the empirical behavioural markers I have articulated can be argued as being closely linked to the 'experiencing presence' category in Geller's model, which she defines as including therapist 'immersion' (being absorbed, alert, focused), 'expansion' (having energy/flow, inner spaciousness, enhanced sensation/perception), 'grounding' (centered/steady), and 'being with and for the client' (intention for client's healing, lack of self-conscious awareness). However, as mentioned above in relation to Bugental's measure, Geller's model articulates higher order concepts that rely on the receiver or provider of presence to evaluate their having occurred, and as such they do not directly point to observable and measurable behaviours. They do however offer at least some convergent validity to the behaviours identified in the present study.

Additional validity for the model of presence established here, especially related to observable behavior, comes from neuroscience, in particular from Porges' (1998, 2001) work on polyvagal theory. Porges has articulated how mammals have developed a phylogenetically newer level of stress response with which we, as human beings, use interpersonal and social engagement to deal with stress. Therapy is the quintessential instantiation of dealing with stress through social engagement. Porges notes that the activation of this system (involving the 10th cranial, or 'vagus', nerve) is contingent on the experience of safety between those engaging with each other. Furthermore, and most interesting, Porges points to the fact that the muscles of the face and speech, as well as tears, are affected when this newer social engagement system is active. The facial muscles express warmth, softness, and a lively non-frozen expression, and the voice must also be responsive and relaxed. The present model identified these very behaviors in therapist presence, as well as opposing markers such as flaccid or non-expressive facial expression in cases of non-presence. It would add empirical validity to both Porges' model as well as the presence model suggested here to measure the vagus system (vagal tone) in future research on therapeutic presence.

The finding of non-presence behaviors, essentially observable loss of connection, also finds support from additional literature. I articulated in the introduction that the virtual reality literature has identified that players within virtual reality environments (VEs) find themselves less present when responding to stimuli from other 'secondary' environments, such as noises in the lab where they are playing the virtual game. In other words, the players have a capacity to 'be present' in only one of two competing environments in any given moment, and the likelihood that they will 'leave' the primary virtual field depends on the quality of the VE (e.g., sharp details, easy to manipulate, no delays/glitches, etc.) and individual differences (e.g., absorption). Similarly, therapists must somehow manage to stay with the flow of therapy and not be hindered by irrelevant stimuli. I argue that the non-presence or 'leaving' behaviours included in my model - for example, slouched body posture - reflect

moments in which the therapist was experiencing a relative withdrawal from the primary therapeutic environment into the therapist's internal world. In this case, the therapist would need to recognize their relative absence, ignore the irrelevant thoughts/feelings, and tune the bodily channels back into the immediate encounter - in other words regain presence.

There are likely many ways therapists lose their presence in-session. One common denominator might be the desire to escape painful feelings like fear, boredom, fatigue, physical discomfort, uncertainty, or even dislike of the client. One could argue that anxiety plays a fundamental role here and is involved in many leaving behaviours. Automatic action tendencies within the experience of anxiety and fear are hypervigilance to danger, freezing, avoiding, escaping, and 'sham rage' (LeDoux, 1999). All of these behaviors interfere with the relaxed perception and warm social engagement required of therapeutic presence. Furthermore, anxiety is neurologically connected to other fight-flight functioning within the autonomic nervous system. During 'flight' facial muscles become lax (Porges, 2001), and flat facial expression was observed in low presence cases in the current study. Therefore, fear of the client or fear of the work of psychotherapy may be a prime predictor of non-presence. Indeed, recent research has shown that the perceived anxiety of a communication partner predicts a lowered sense of connection during an interpersonal exchange (Cooper, 2012).

How Can the Present Model Inform an Observer Measure of Therapist Presence?

The intention of the current study was that the final model of therapist presence markers would eventually inform an observational measure. I will now turn to issues of measurement and the potential construction of an observer measure, as well as how such a measure could pave the way to additional empirical investigation of presence.

An important consideration when constructing any measure is that it be easy to use and parsimonious. The model that I offer here, however, is complex and includes many markers of presence and non-presence. Therefore, the markers identified in the current final model will have to be

further 'pruned' and translated into either individual items for rating, or scales/factors (perhaps relating to the four themes of here now, open and communion) upon which individual items may load. A number of intermediate research projects may be required to establish which of the items observed in the final model are most essential. One viable strategy toward this end is to code each of the observable behaviors in real time, perhaps including duration of the behaviours as a variable, so that each of the markers can be examined as an individual predictor of other therapy processes expected to link to presence, such as empathy or emotional processing. This type of method could be accomplished using software programs such as *The Observer XT* or *Theme*; the latter would allow us to examine presence behaviours across time in fine detail. Factor analysis of presence markers may also be required to validate the presence themes I have identified.

It is also important to consider the fact that therapists often employed multiple presence behaviours either simultaneously or selectively. For example, consider the following brief transcript segment from a good-presence case:

T: "so I'm angry at you for" (9 seconds of silence)

C: "basically walking out without walking out"

This segment was coded as 'grounding the client in experience', 'using the client's internal frame', 'allowing silence', and 'warm vocal tone', in addition to physical markers such as 'eye gaze' and 'stable body posture'. Therefore, in addition to future research having to test individual markers that the present model has offered, insight into how these individual behaviors might converge to intensify the manifestation of presence will be important to explore. Again, *Theme* software may be able to identify if sequences of the identified behaviors create higher order and more complex choreography of presence.

Once a final observer measure of presence is established another important research task that such a measure will allow is to further differentiate therapist presence from other therapist processes such as

the alliance and empathy. It is my considered opinion that the ten dimensions of the MEE (Watso & Prosser, 2002), for example, have absorbed the concept of presence. As such, some of the scales of the MEE (e.g., vocal concern, vocal expressiveness, warmth/interpersonal safety, therapist looks concerned/engaged) may actually be conflated with therapist presence and, if that is true, would more appropriately be a part of an observer measure of presence. Of course, other MEE dimensions, such as 'conveys understanding of feelings/meaning', appear to tap into empathy more purely. Differentiating the MEE from the current model of presence will further validate both models while also establishing important distinctions between presence and empathy. This would also help us deepen our understanding of how presence contributes to the alliance.

The Issue of Individual Differences: Therapist and Client

Individual differences in attitudes or styles may inform the style within which a therapist might habitually manifest presence or the preferences a particular client may have in receiving presence behavior from the therapist. For example, one basic finding implied in the results (specifically the empirical analysis) that may inform future research is that therapists in this study were found to embody presence from two basic positions - 1) as a listener, in which the non-verbal markers were more salient, and 2) as a responder, in which the verbal markers became salient. This finding is in line with Bugental's (1987) view of presence as involving availability and expression, and might help facilitate the work of observational raters. We know from individual difference theory or measures such as the Meyer's Briggs Instrument, neurolinguistic programming (Bandler & Grinder, 1983) and gestalt theory (Perls, Hefferline & Goodman, 1951) that individuals differ in their tendencies to be introverted or extraverted, to refer to internal or external experiences, to be more intuitive versus sense based, or to prefer certain perceptual channels versus others. These preferences and a potential mismatch between therapist and client preferences may add noise to our attempts to establish

relationships between presence and other variables. Very large samples will be required to explore these issues.

Also, some therapist behaviour may be more salient to clients than others and predominate in both the therapeutic interaction and the client's experience of presence from these behaviors. For example, one highly present therapist continuously and subtly rubbed her hands together (a point against presence for extraneous body movements) yet at the same time communicated total immersion in the client's experience with strong eye gaze and facial expressiveness. The client apparently attuned to the pro-presence behaviours and rated the therapist as high in presence. Research on constructing an observational measure of presence will have to take into consideration that some presence behavior may be more salient to the client, and that the salience of some non-present behaviors will have to be considered within the context of simultaneous presence markers.

Application for Clinical Training and Practice

One of the most important applications for the model of presence that emerged in the present study is that it might benefit training programs of burgeoning therapists, as well as support the continued development of more experienced therapists. The behavioural markers and abstract themes highlighted in this study can serve as signposts to help guide therapists in developing their capacity to be present as well remind them that they can be guided back on track in moments of distraction. For example, a therapist may become aware of their fidgeting, slumped posture, or low energy in session, and, realizing the importance of these qualities, take care of them on the spot. A strength of both the empirical and rational models is that neither demanded perfect presence but instead gave voice to the fact that acts of 'returning' to the present are important. This is very much in line with the concept and practice of mindfulness, in which a loss of attention is expected to occur occasionally, and the core task involves not just sustaining attention but seeing when distraction arises and shifting attention back to the present moment (Chambers, Chuen Yee Lo, Allen, 2008). As I argued earlier in the introduction,

mindfulness can function to re-establish and deepen therapeutic presence (see the relevant section of the introduction for a distinction between these two constructs). The model of presence in this study therefore might be incorporated into therapist training programs that already work with mindfulness.

Additionally, the presence model here offers both abstract themes and concrete markers to help guide therapists in experientially developing presence. The abstract modes of 'here', 'now', 'open', and 'communion' are important aspects of therapeutic presence and, if a therapist feels a need to strengthen one of these areas, it might be possible to selectively cultivate a specific mode with extant and tailored practices (the nature of such practices will require further consideration). For example, a therapist who feels firmly grounded in the present moment with clients but for some reason tends to feel divided or separate in the therapeutic encounter may very well benefit from focusing on their capacity for communion. Future research efforts should draw upon other important literatures to articulate more fully the various ways therapists lose their presence in-session and become 'non-present'. Particular areas to focus on might be therapist distraction, pre-occupation, rumination, and self-consciousness while interacting with a client. Researchers, therapists, and trainers alike would benefit from understanding more about how therapists experience these hindrances (mentally and bodily) as well as effective ways to transcend them.

The concrete behaviours of presence identified in the current model, such as stable body posture, provide clear signposts for deepening presence in session and returning to presence after slipping into states of non-presence. Therefore, therapists would be encouraged to cultivate presence in its different modes and to become familiar with particular antidotes to non-presence – to stop fidgeting, to regain a poised posture, or to muster up the energy to fully participate in the session. If presence is as crucial to the development of the working alliance and provision of empathy as we believe, and if cultivating presence is possible through certain practices and exercises, then it really is important for therapists to

take their presence seriously and for clinical trainers to teach students how to actualize their natural capacity for presence. It is a win-win situation for trainers, therapists, and most importantly clients.

It is important to note that the 'goal' of presence training should not be in the spirit of 'adding' something to a therapist's repertoire or imposing some kind of belief system on therapists, but simply to help people experientially connect with their potential to be present (and gain awareness of when they are non-present) in therapy and everyday life.

Limitations and Future Directions

All research has limitations. First, this study was undertaken within exclusively experiential therapy sessions (client-centered and process-experiential (EFT)) within which being present to experience is an implied therapist task. On the one hand this was helpful for the current study as it provided a rich context in which to study presence. On the other hand this context may have limited the observation of poorer examples of therapist presence, thereby limiting potential variance observed in presence behaviors. In fact, no therapists were rated lower than four out of seven on the TPI scale. Nonetheless, key behavioural differences were still observed in this sample based on high versus low presence rankings, and, furthermore, two therapists were each rated as high and low in presence in different sessions. This speaks to the fact that variance in therapist presence was observed both between and within therapists in this study and as such confidence in the findings is added. Still, future research will benefit from studying presence in very low-presence sessions, perhaps by observing therapists in early phases of training, or devising analogue studies that can manipulate a range of presence levels. Findings of the present study, however, can only validly be viewed as markers of presence in experiential therapy. The findings require replication in sessions from other therapeutic modalities such as CBT and psychodynamic approaches.

In this vein, an interesting line of research is developing in the field of exposure therapy for anxiety disorders that involves the use of virtual environments within which to conduct exposures (i.e. making

certain exposures that are impractical or costly, such as flying, seem as real as possible) (Price, Mehta, Tone, & Anderson, 2011). However, this point of view on presence does not appear to be considering the interpersonal nature and implications of presence - relating to a present Other. Considering the increased use of technologies in the provision of treatment (Caspar, 2004) future research on outcomes may fruitfully explore the absence of therapist presence in outcomes from technology-based treatments.

A further limitation of the present study was that all clients in this study suffered from depression. It may be that presence is more or less important as a facilitative human condition depending on the disorder with which a client is struggling. One could argue, for example, that the willingness to be present is itself somewhat 'in trouble' within a depressed population. This argument is supported by evidence that clients who are actually clinically depressed often first report memory difficulties. These memory difficulties are often thought by assessors to be the result of memory encoding difficulties due to reduced attention in the moment of encoding, rather than result from memory retrieval difficulties that clients often assume are at work (Groth-Marnat, 1997; Lezak, 1995). The growing work on understanding presence has therefore probably benefited by occurring within both the experiential model and the depressed population, because experiential therapists try to be present, and depressed clients may be most positively impacted by therapist presence compared to other disorders.

Moreover, different disorders may have different interpersonal implications in terms of the degree to which clients afford the possibility of presence to the therapist. For example, the classic therapist experience with a client suffering from Narcissistic Personality Disorder (NPD) - 'Just shut up and listen' (H. Brooker, personal communication) - indicates one is afforded less verbal presence behavior with a client with NPD but perhaps more non-verbal. Therefore, effective presence for a client suffering from depression may look different than being present with a client struggling with an avoidant personality, social anxiety, attention deficit disorder, psychosis, or post-traumatic stress disorder. As such therapist presence may have to be differentially balanced between its poles of

'availability' and 'expressiveness' depending on the client. Clients with dominant interpersonal styles may afford the therapist less expressiveness, whereas a submissive client may pull for more expressiveness. Therefore, as Watson (personal communication) has argued in relation to empathy, presence cannot be practiced rigidly or without considering these client-matching issues. A similar point has been made in the nursing literature, in which a patient's need and openness for presence is regarded as a prerequisite condition for its provision (Finfgeld-Connett, 2006).

A further limitation to this study was that cultural variability was not considered. We do know that the sample was largely embedded in a Canadian-Caucasian context, but even this classification is highly heterogeneous. Thus cultural influences that potentially shape how one expresses or perceives presence were not evaluated - in fact, the idea that presence is shaped by cultural values and conventions has not been explicitly addressed in the psychological literature to my knowledge. This points to an interesting area for future research. For example, although constantly attending the client with eye gaze - i.e., looking up at the client, making eye contact - was found to be a very important element of therapist presence in the current study, this might not hold true in every culture. A study by McCarthy, Lee, Itakura, and Muir (2006), for example, found that when thinking about the solution to a problem during a face-to-face interview, Japanese participants tended to look down while processing their thoughts whereas Canadians looked up. Thus the meaning or function of eye gaze between the groups was the same (i.e. cognitive processing) but the behavioural manifestation differed (i.e. upward vs. downward gaze). This is a subtle phenomenon, but I believe it holds interesting implications for the relationship between cultural competence as a therapist and therapeutic presence. Continuing the example of eye gaze, one implication is that therapists might consider adapting *the way* in which he or she embodies and expresses presence in the moment - for example, in perceiving the client's downward or upward gaze, and, understanding the cultural context as well as the context of the therapeutic moment, the attuned therapist would allow the client the space to process their thoughts instead of

trying to lock gaze. Future research should examine cultural factors and how they interact with the therapist's embodiment of presence, the client's perception of therapist presence, and co-presence between client and therapist.

An additional point to consider for this study's results is that not all therapists were observed on multiple occasions or across multiple clients. Also, the same client rarely rated their therapist as high and low across therapy (with one therapist exception which was coded in this study). A larger sample would allow greater control for both individual therapist effects as well as individual client effects. However, using the task analysis methodology, I attempted to build a model of the embodiment of presence *per se*. Whether individual therapists were more present by nature, or some clients more difficult or easy to be present with will be for future research to explore. It may interest the reader, however, that some provisional exploration of patterns in presence ratings across Geller's (2001) entire data set was undertaken - specifically, TPI-C scores for of all therapists within that previous research project on therapeutic presence is displayed in Figure 15. To interpret this figure, the boxes represent therapists and the lines represent clients (i.e. client's TPI-C scores across therapy sessions) - thus, a box that includes multiple lines indicates that one therapist worked with multiple clients. If presence is a trait-like factor of the therapist, then therapists would be expected to receive consistently high or low ratings across different clients. What Figure 15 largely suggests, however, is a general tendency of variability in perceived presence; some therapists were consistently rated as highly present by multiple clients, while others received a mixture of ratings across time from multiple clients. This variability reminds us of the questions awaiting future research. Do client's influence the therapist's ability to be present in session? For instance, are there certain client characteristics or issues that most therapists struggle to be present with? Or is it perhaps the case that some therapists are in fact more skilled at maintaining high levels of presence throughout therapy, regardless of client conditions.

Conclusion

Despite the limitations discussed above, I remain committed to the underlying assumption of this study, namely that presence is a fundamental, adaptable, and observable way of being that is an essential therapist behavior that will continue to be important to explore. The current model of presence is innovative and offers an empirical step towards continuing to investigate presence in psychotherapy, of which an observer measure is a 'must' next step. Being present as a therapist was identified in this study as being 'here', 'now', 'open', and 'in communion' with one's client, and was reflected in many verbal and non-verbal concrete behaviours imbued with vitality, attention, and responsiveness. I hope this study eventually contributes to continued interest in therapeutic presence and will be of some benefit to future research and clinical practice.

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Table 1

Descriptive information about the therapist-client dyads in this study

Case #	Therapist Gender	Client Gender	Therapist Presence	TPI-C rating (1-7)	Session #	Treatment
1	F	M	High	7.00	6	Client-Centered
2	F	F	High	7.00	12	Client-Centered
3	F	F	High	7.00	3	Process-Experiential
4	F	F	Low	4.00	6	Client-Centered
5	F	F	Low	4.33	6	Client-Centered
6	M	F	Low	5.33	6	Client-Centered
7	F	F	High (contrast case 5)	6.33	9	Client-Centered
8	F	F	High (contrast case 4)	6.67	15	Client-Centered
9	M	F	High (additional)	7.00	9	Process-Experiential
10	F	F	Low (additional)	5.33	15	Process-Experiential

Table 2

Sample of categorization of presence verbal behaviours in empirical model

Presence Marker	Transcript Excerpt
Reflections consistently accurate	[Case 412] T: I imagine it's hard, I notice the tears came / when we were talking about you know when you're in church and there you are and you know the other kids stop crying after +five C: yeah+ T: minutes and and G. doesn't and C: yeah T: and I guess that leaves you feeling kind of maybe inadequate as a +mother C: I've+ always felt like I was a bad mother T: yeah C: because I couldn't um T: yeah C: I couldn't um get him to be good
Responses in client's internal frame; "I" language	[Case 415] T: knowing where you're getting to it's like you said "I know I have a really strong purpose, it's really strong", whether you know what it is now or not it's like "I don't know exactly what it is but just knowing that - I have that"
Captures implicit	[Case 429] C: so I missed out on that and just little things T: it sounds like some regrets, or? C: yeah
Shared language	[Case 412] T: it's been a C: it's been a hard week T: a hard week C: yeah extremely difficult T: yeah
Communion and contact occurring between therapist and client (Abstract theme)	[Case 415] C: if we have the faith and +understanding T: and accepting+ the journey accepting the path as what it is C: is very deep there T: mm-hmm C: very, very deep there. I share that with you, and that spoke to me to the point where it brought tears in my eyes (incomprehensible) today hmmm

Table 3

Sample of categorization of non-presence verbal behaviours in empirical model

Non-presence Marker	Transcript Excerpt
Inaccurate reflection	[Case 423) C: um ah I've just had so much trouble getting myself going and I'm getting fatter and fatter and I'm eating and eating and not doing anything. Actually I am doing things, I'm not doing what I want to do so T: Kind of stuck C: No
Missing poignancy of client's story	[Case 421] C: Like I've tried to do a few things this week that were umm, like I haven't visited a cousin I have here, I haven't seen for years, and we don't know each other that well T: mm-hmm C: but she's always, you know, liked me, and I thought she was nice and T: mm-hmm C: she's about 10 years older. And they had me over for dinner, and you know, I don't know her husband or her kids or anything T: mm-hmm C: but it was kind of, it was nice though, it was kind of awkward, but it was nice to go there and uh, maybe start a new sort of friendship with another cousin again T: a friend C: yeah. And umm, I also went out with a friend of mine who's, like sort of wants to go out with me or something, but I'm not, I'm holding back, and I, I'm not sure if it's because I don't like him or it's because I'm not trusting anything, and T: mm-hmm C: uh, played squash with him once and you know he asked me out for a drink and dinner. It's the same story, you like, you know he wanted to give me a kiss goodnight, and I was like, 'no' (laughs).
Therapist is abstract, detracting from client's embodied experience	[Case 403] C: yeah because you know sex is not only showing my love and him for me but if I wanted sex, I could just go like leave him and like go have sex with someone else T: Yeah (laughs) C. right but I don't want to do that so is it really the sex that I'm really dying for? T: well if you say I guess the sex is the expression, is one expression of love

HERE
- Participating/engaging moment to moment in a concrete way
- Settled in the room; "staying behaviours"
- Returning to location (re-engaging as a participant)

NOW
- Immediacy
- Readiness (to respond)
- Responsiveness to client
- Dynamic link to flow of time; matching client's tempo

PRESENCE

OPEN
- Openness/acceptance of experience
- Sensitivity/receptivity

COMMUNION
- Intending client
- Willingness (to accept)
- Contact
- I-Thou relating; selfless

Figure 1. Condensed version of rational model of expressed therapist presence: Core interdependent aspects and their subsumed components.

1. Identifies/points to something materially important/poignant in client's words or gestures 2. Calls client back to this place/body E.g. "I can see in your face …" 3. Consistent micro attunement/minimal encouragers in language (I heard what you said) 4. Therapist recalls a detail about client from previous session (post hoc marker of 'here'- *I was there when you said that*) 5. Vocal tone expressively matched to client 6. Return to moment statements E.g., "Can you say that again?")	1. Continuous, consistent physical markers of listening E.g., Consistent nodding 2. Body & posture is calm/comfortable/stable 3. Therapist points to or indicates her own embodied felt sense in the moment 4. Therapist's eyes and body consistently intends/locates client 5. Promptly returns gaze or body movement to core position after 'momentary not-there-ness'

'HERE'
(presence)

Verbal   'NOT HERE'   Non-Verbal
                (non-presence)

1. Therapist response is removed from client's concrete experience; language overly abstract or cognitive *2. Interrupting client "I'd rather go somewhere else"* *3. Does not answer/address client's direct question* *4. Vocal tone lacks expressiveness; flat; mechanical; not matching client's tone/tempo* *5. Therapist makes irrelevant statement and does not re-connect to client's experience, "I am somewhere else"*	*1. 'Spotty' listening; attention frequently shifts away from client* *E.g., fidgeting during client narrative* *2. Therapist facial expression conveys lack of interest/engagement* *E.g., bored; drowsy, looks away* *3. Body orientation & posture is rigid, unsteady, appears uncomfortable, slouched*

F*igure 2.* Part 1 of Rational model: Hypothesized therapist behaviours linked to 'being here' in-session.

1. Therapist directly checks in with client to explore immediate experience E.g., "What is that like for you now?" 2. Frequent, responsive use of minimal encouragers "I am not missing a thing" 3. Responses are timely/smooth (not delayed/choppy) 4. Statements are consistently attuned with client's experience "I am with you"

1. Micro-attunement of body E.g., nodding and tilting head is in sync with client's tempo and meaning 2. Awareness of time in session E.g., de-compressing with 10mins left in session; smooth termination of session

'NOW'
(presence)

Verbal   Non-Verbal

'NOT NOW'
(non-presence)

1. Responses slow down or stop client's process *E.g., choppy responses; not attuned to client's feelings* *2. Infrequent or 'robotic' use of minimal encouragers*

1. Posture not responsive when client's poignancy demands it, "I missed it" *E.g., sitting back when client is communicating at an intimate level* *2. Therapist ends session abruptly*

Figure 3. Part 2 of Rational model: Hypothesized therapist behaviours related to 'being now', timing and synchrony in-session.

1. Verbal indications of acceptance, compassion, and willingness to experience through vocal tone and/or meaning 2. Therapist shares his or her own bodily (resonant) felt sense 3. Therapist responds to edge of client's experience, "I am open to the possibilities" 4. Therapist expresses readiness to accept or follow client's question, correction, direction	1. Posture is open, communicates comfort and ready willingness 2. Eye gaze is steady, soft 3. Therapist gestures to own felt sense E.g. points to gut

'OPEN'
(presence)

Verbal   Non-Verbal

'BLOCKED'
(non-presence)

1. Negative reaction toward client (verbal) E.g., vocal tone conveys contempt *2. Therapist often appears to miss salient parts of client's story and promotes own agenda*	*1. Negative reaction toward client (bodily) E.g., face shows annoyance* *2. Extraneous body movement E.g., frequent fidgeting/shifting* *3. 'Closed' posture and/or facial expression E.g., therapist looks bored, disinterested, judgmental*

Figure 4. Part 3 of Rational model: Hypothesized therapist behaviours linked to openness and receptivity.

1. Expresses curiosity, interest, care
    E.g., Therapist genuinely inquires about
    experience; warm vocal tone
2. Minimal encouragers convey acceptance
   and compassion
3. Therapist uses client's words and
   metaphors, "I am willing to speak your
   language"
	1. Communion and contact occurring in dyad
	2. Therapist shows interest in client
	    E.g., genuine/concerned facial expressions
	3. Genuine shared laughing/smiling
	4. Body language, eye contact, facial
	   expression convey interest, curiosity,
	   genuineness and willing contact
	4. Therapist not self-focused on own body,
	   but totally immersed in client's process

'COMMUNION'
(presence)

Verbal   *'SEPARATE'*   Non-Verbal
(non-presence)

1. Therapist response is too far behind or
   ahead of client's meaning
2. Therapist tone is contentious,
   undermining or judgmental
3. Therapist imposes own metaphors and
   style of communication
	1. Looking away frequently
	2. Body language is 'closed'; apparent
	   separation in the dyad
	3. Therapist looks tired, bored, disinterested,
	   annoyed, afraid
	4. Therapist attends to self
	    E.g., frequent self-soothing behaviours, or
	   sighs

Figure 5. Part 4 of Rational model: Hypothesized therapist behaviours linked to communion and togetherness.

FACE
1. Eye gaze constant; strong attention on client, communicates intention towards and location of client
2. Facial expressions are variable, demonstrative, and responsive
3. Notable dynamic responsive expressions: softness/warmth, concern
4. Face shows vitality, aliveness
5. Matched expressions in dyad, synchronicity

ARMS/HANDS
1. Use of hand gestures (vitality) linking with verbals and pointing (to body or objects)
2. Synchrony in dyad's hand movements
3. Minimal extraneous hand movements when listening to client
4. Extraneous movements are stopped promptly and/or do not interfere with therapist listening or client's narrative

Bodily Markers of Presence

NODDING/HEAD
1. Nodding:
   - is responsive/contingent to client's story (i.e. not automatic)
   - varies in intensity and frequency
   - shows vitality/energy
   - punctuates understanding
   - shared pattern in dyad (i.e. nod together)
2. Head movements (e.g., tilting or leaning) used to track subtleties of client's story
3. Synchrony of head movements in dyad

POSTURE
1. Therapist has a core listening posture, characterized as: poised, restful, calm, comfortable, grounded, upright (not slouched), and/or stable
2. Body conveys vitality/energy
3. Deviations from core posture are promptly followed by a return to same or alternate stable position
4. Body synchrony in dyad (dyad share posture or shift in posture)
5. Physical proximity to client (esp. seen in empty chair work)

Figure 6. Empirical model of therapist non-verbal behaviours associated with presence.

MINIMAL ENCOURAGERS	VOCAL TONE

MINIMAL ENCOURAGERS
1. Used frequently, sensitively,
   contingently to communicate receptivity
2. Convey contact, tracking, and validation
3. Variability; matches client's tone/energy

VOCAL TONE
1. Caring/soft/warm
2. Expressiveness/vitality
3. Variability, contingent with client's
   experience

Verbal Markers of Presence

THERAPIST RESPONSES

CONSISTENT ACCURACY
1. Reflections consistently accurate; 'on the same wavelength' as client (not behind, not ahead)
2. Response captures implicit meaning
3. Some use of process identifications
4. Responses frequently in client's internal frame; "I" language
5. Therapist avoids making self-focused connections not in service of client's experience
CONNECTING TO MOMENT
1. Connects meaning to past material; recalls past material (post-hoc presence)
2. Brings, or attempts to bring, client into immediate experience; shift from abstract to concrete
3. Experiential language; points to deeper experiencing
4. Orients dialogue in time
5.Questions that communicate wish to connect with and explore client's meaning
COMMUNION
1. Genuineness (conveyed through content); communicates therapist feels safe with client
2. Positive regard/ advocating for client; conveys "I like being with you"
3. Content of response communicates willing interest in client
4. Shared language in dyad- therapist picks up and uses client words
5. Synchrony/harmony/flow in dialogue

(*Behaviours equally shown in p and non-p cases - but rationally linked to presence)
1. Use of metaphor; client picks up metaphor
2. Therapist coveys perception of client "I hear/see/feel you"
3. Therapist makes client laugh (client is impacted by therapist/environment)

Figure 7. Empirical model of therapist verbal behaviour associated with presence.

FACE

1. Frequent breaks in eye contact/gaze on client - or gaze is constant but paired with a flat facial expression or mechanical nodding
2. Facial expression:
   - tired, bored, flat or flaccid, lacking warmth
   - not linked with client's energy/tempo

ARMS/HANDS

1. Frequent extraneous hand and body movements
2. If therapist has a beverage in session, she/he takes frequent sips in a way that interferes with listening
3. Uses hands to prop up body or head (appears slouched or tired)

Bodily Markers of Non-Presence

NODDING/HEAD

1. Infrequent nodding; communicates 'frozenness'
2. Nodding not paired with facial expressivity (of engagement/connection), conveys disconnect within therapist
3. Mechanical nodding (not linked to client's narrative); conveys mechanical technique

POSTURE

1. Body appears flat and un-energized
2. Therapist may not have a core body posture that they consistently maintain or return to in session
3. Therapist physically exits room, client waiting

Figure 8. Empirical model of therapist bodily behaviour associated with non-presence.

MINIMAL ENCOURAGERS
    1. Flat/unexpressive, robotic
    2. Not contingent with client's experiencing

VOCAL TONE
    1. Flat/unexpressive
    2. Conversational/neutral
    3. Does not match client's
       tone/tempo/energy

Verbal Markers of
Non-Presence

THERAPIST RESPONSES
1. Inaccurate reflection; out of tune with client's experiencing
2. Misses poignancy of client's story
3. Therapist uses abstract language that detracts from embodied experience
4. Therapist does not match or compliment client's tempo and tone of speech
5. Therapist attached to own thought; tries to get a word in edgewise
6. Therapist interrupts client's silence without tune into it
7. Low or choppy synchrony/harmony/flow in dialogue

Figure 9. Empirical model of therapist verbal behaviour associated with non-presence.

MINIMAL ENCOURAGERS
1. Used frequently, sensitively, contingently to communicate receptivity -NOW/OPEN/HERE
2. Convey contact, tracking, and validation -HERE/COMMUNION
3. Variability; Matches client's tone/energy -NOW

VOCAL TONE
1. Caring/soft/warm -COMMUNION
2. Expressiveness/vitality -HERE
3. Variability; Contingent with client's expressed variability and experience -HERE

Verbal Markers of Presence

THERAPIST RESPONSES
1. Reflections consistently accurate (not behind, not ahead) -HERE
2. Connects meaning to past material/ Recalls past material (post-hoc presence) -HERE
3. Brings client into immediate experience/ Shift from abstract to concrete; Experiential language; Points to something materially important in client's words/gestures -HERE
4. Questions that communicate wish to connect with and explore client's meaning -HERE
5. Some use of process identifications (e.g. "You are really mulling that over.") -HERE/NOW
6. Some capturing of implicit/deeper meaning -OPEN
7. Therapist speaks from his or her own bodily (resonant) felt sense -OPEN
8. Responses frequently in client's internal frame; "I" language -COMMUNION
9. Content of response conveys genuineness/positive regard/interest -COMMUNION
10. Shared language - therapist picks up and uses client's words -COMMUNION
11. Synchrony/harmony/flow in dialogue; Responses timely/smooth (not delayed/choppy) - COMMUNION/NOW
12. Therapist allows for silence - HERE/OPEN/COMMUNION
OTHER (Less distinguishing behaviours)
12. Therapist avoids self-focused statements not in service of client's process -COMMUNION
13. Therapist inhibits a thought/expression to allow client to speak - HERE
14. Orients dialogue in time; Awareness of time in session -NOW

Figure 10. Synthesized model 1 of 5: Verbal markers of therapist presence

FACE

1. Eye gaze constant; strong concentration on client -HERE/COMMUNION/OPEN
2. Expressions are variable, demonstratively anchored to the client's process- NOW/HERE
3. Dynamic responsive expressions: softness/warmth/concern -COMMUNION
4. Shows vitality/aliveness -HERE/OPEN
5. Matched expressions in dyad; synchronicity -COMMUNION/NOW

ARMS/HANDS

1. Hand gestures show vitality; link with verbals; Pointing (to body/objects) - HERE
2. Synchrony of dyad's hand movements - NOW
3. Minimal extraneous hand movements when listening to client; movements are stopped promptly and/or do not interfere with therapist listening or client's narrative -HERE/OPEN

Bodily Markers of Presence

NODDING/HEAD

1. Nodding:
   - Responsive/contingent to client's story (i.e. not automatic) -HERE
   - Varied intensity/frequency -NOW
   - Shows vitality/energy HERE
   - Punctuates understanding -HERE/OPEN
   - Shared pattern in dyad (i.e. nod together) NOW/COMMUNION
2. Head tilting/leaning tracks subtleties of client's story HERE/OPEN
3. Synchrony of head movements in dyad COMMUNION/NOW

POSTURE

1. Core listening posture, characterized as: poised, restful, calm, comfortable, grounded, upright (not slouched), and/or stable -OPEN/HERE
2. Body conveys vitality/energy - OPEN/HERE
3. Prompt return to core posture after deviation -HERE
4. Body synchrony in dyad (shared posture or shift) -NOW
5. Physical proximity to client (e.g., forward lean) -COMMUNION

Figure 11. Synthesized model 2 of 5: Bodily markers of therapist presence.

MINIMAL ENCOURAGERS	VOCAL TONE
1. Flat, robotic - *NOT-HERE/NOT-NOW* 2. Not contingent with client's experiencing - *CLOSED/NOT-NOW*	1. Flat/unexpressive -*NOT HERE* 2. Conversational/neutral - *CLOSED* 3. Does not match client's tone/energy - *NOT-NOW*

Verbal Markers of *Non-Presence*

THERAPIST RESPONSES

1. Inaccurate reflection; out of tune with client -*NOT-HERE; SEPARATE*
2. Misses (does not respond to) poignancy of client's story -*BLOCKED*
3. Therapist uses abstract language that detracts from embodied experience - *NOT-HERE*
5. Therapist attached to a thought; tries to get a word in edgewise - *BLOCKED*
6. Therapist interrupts client's silence without tune into it - *NOT-HERE*
7. Low or choppy synchrony/harmony/flow in dialogue; Therapist does not match or compliment client's verbal tempo -*NOT-NOW*

Figure 12. Synthesized model 3 of 5: Verbal markers of therapist non-presence.

FACE
1. Frequent breaks in eye contact/gaze; or constant gaze is paired with a flat facial expression or mechanical nodding - *NOT-HERE/SEPARATE*
2. Facial expression: tired, bored, flat/flaccid, lacking warmth/interest - *NOT-HERE/BLOCKED/SEPARATE*
3. Expressions not linked with client's tempo -*NOT-NOW*

ARMS/HANDS
1. Frequent fidgeting hands/arms - *BLOCKED*
2. If therapist has a beverage in session, she/he takes frequent sips in a way that interferes with listening -*NOT-HERE*
3. Uses hands to prop up body or head - *NOT-HERE/ NOT-NOW/BLOCKED*

Bodily Markers of Non-Presence

NODDING/HEAD
1. Infrequent nodding -*NOT-NOW/NOT-HERE*
2. Mechanical nodding (not linked to client's narrative); Nodding not paired with facial expressivity -*NOT-HERE*

POSTURE
1. Body appears flat, un-energized, uncomfortable -*NOT-HERE/BLOCKED*
2. Therapist does not have a core body posture that they consistently maintain or return to in session; frequent shifting - *NOT-HERE*

Figure 13. Synthesized model 4 of 5: Bodily markers of therapist non-presence.

PRESENCE

  1. Communion and contact occurring between therapist and client
  2. Therapist totally immersed in client's process (not distracted, self-focused, or distant)
  3. Therapist seems genuinely interested in the dialogue.

Abstract/Relational
Markers

NON-PRESENCE

1. Therapist and client do not seem to be connected in the intersubjective space; there is an obvious blocking of deeper 'meeting' or 'encounter'; the therapist appears to be 'holding back' in some way, not sharing or giving themselves totally in session
2. Client provides feedback that the therapist is not accurate, not listening, or not remembering what has already been said.
3. Client and therapist spend much time disconnected from immediacy of present moment - of what is occurring now, and what *now* means to the client.
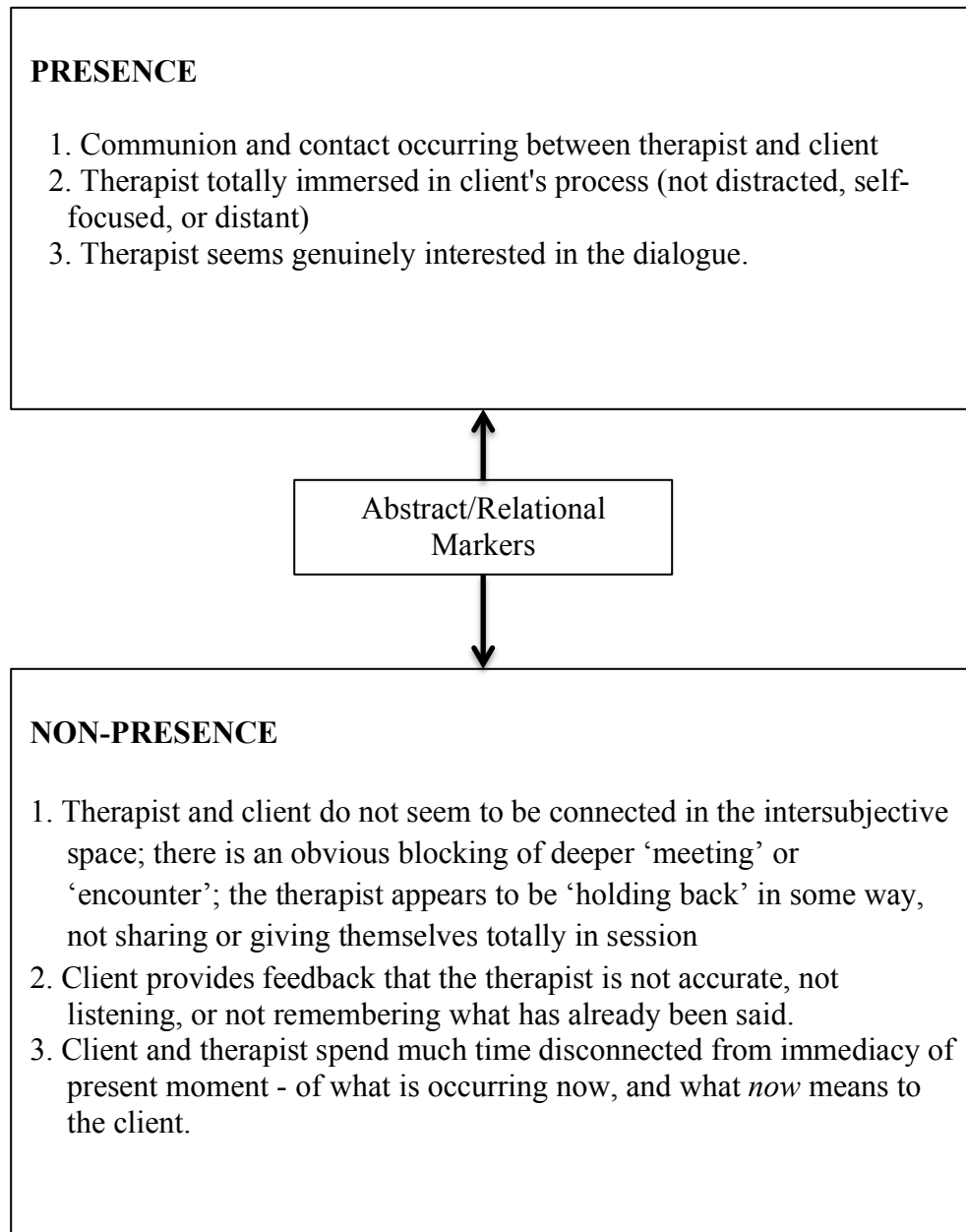
Figure 14. Synthesized model 5 of 5: Abstract/relational markers of therapist presence and non-presence.
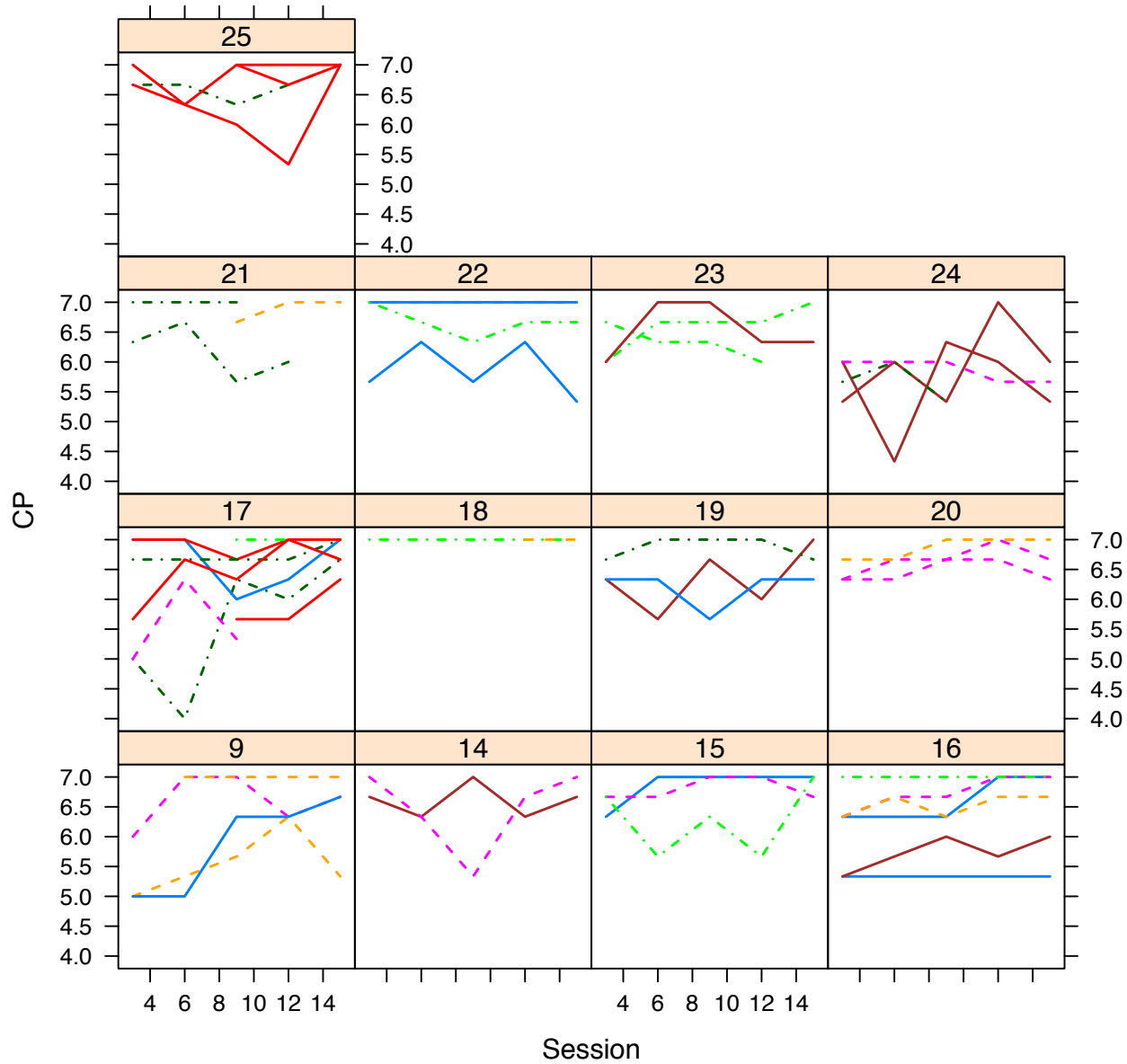
Figure 15. Client ratings of therapist presence (TPI-C) from a larger data set of 13 therapists. Each box represents one therapist, each line a client (i.e. therapists worked with multiple clients). Note. CP = client presence rating.