

Counsellor presence: bridging the gap between wisdom and new knowledge

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Presence is the counsellor's way of being with clients as distinguished from the application of technique and it involves a meeting between counsellor and client. Presence fits intuitively in the realm of the therapeutic relationship and master therapists from different therapeutic traditions have described how their presence with clients contributes to the success of counselling, yet the topic is virtually absent from the research literature. We examine the reasons for this disparity, provide a critical examination of the literature on the therapeutic relationship and on presence, and suggest that emerging scientific paradigms offer new strategies for studying such complex, holistic phenomena as presence.

Keywords: counselling; counsellor education; therapeutic relationship; therapeutic presence

When counsellors open authentically to the being of the client and to the immediacy of the relationship, they are being present. Historically counsellors from different theoretical orientations have written about their experiences of the therapeutic value of being present (Buber, 1970; Bugental, 1987; Freud, 1961; May, 1958; Reik, 1948; Rogers, 1961). The concept of presence distinguishes a counsellor's way of being from the application of technique. Because of its subjective nature, a universal definition of presence does not appear in our empirically informed literature. Being present enables authentic connection between people, the foundation of relationship. The relationship is shown to be a significant contributor to positive therapeutic outcome. As such, counsellor presence has relevance for counselling practice and for counsellor training. In contrast to the potential significance of counsellor presence, the topic is virtually absent from empirically informed literature.

The purposes of this article are fourfold: 1) to provide a critical examination of the literature that does exist on counsellor presence and its contribution to the therapeutic relationship; 2) to offer explanations for the omission of presence from explorations of the therapeutic relationship; 3) to use emerging scientific paradigms to frame new ways of studying such complex, holistic phenomena as presence; and 4) to consider some of the training and policy implications that might result if presence was considered a common factor of the counselling relationship. In addressing these

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purposes we assume that presence is best understood through the use of a post-modern lens. Presence is defined as the state of being present, as with others or in a place, and as such presence is used as the noun and being present the verb for the same phenomenon.

Counsellor presence: a common factor of the therapeutic relationship?

Common factors research is devoted to finding factors that contribute to therapeutic outcome across theoretical orientations and has led to the identification of four common factors in client change (Ahn & Wampold, 2001; Asay & Lambert, 1999; Hubble, Duncan, & Miller, 1999; Lambert, 1992; Lambert & Cattani-Thompson, 1996; Wampold et al., 1997). The four 'common factors' are identified as client, relationship, hope and technique factors (Hubble et al., 1999; Lambert, 1992). Client or extratherapeutic factors comprise the personal and environmental resources that the client brings to the therapeutic process. Hope factors, also called placebo or expectancy factors, refer to the extent to which the counsellor engenders confidence in therapy itself and in the possibility of change. Technique factors include therapeutic interventions. Relationship factors encompass therapist qualities as well as the alliance between counsellor and client. According to Lambert (1992), Hubble et al. (1999) and others (Horvath, 2005; Martin, Garske, & Davis, 2000; Norcross, 2002; Stevens, Muran, Safran, Gorman, & Winston, 2007; Watson & Geller, 2005; Zuroff & Blatt, 2006) the therapeutic relationship contributes significantly to therapeutic outcome, second only to client factors in accounting for variance. Vocisano and colleagues found the more effective therapists in their study attended to the therapeutic relationship more than less effective therapists (Vocisano et al., 2004).

But what is meant by 'the therapeutic relationship?' In psychoanalysis, the therapeutic relationship is conceptualised as comprising transference, counter-transference and the alliance. Although 'disagreement exists over the nature of the alliance and its essential components' (Nuetzel, Larsen, & Prizmic, 2007) processing the transference aspects of the relationship forms a central thrust of the therapy (Gelso & Carter, 1994, p. 297). In the person-centred approach, Carl Rogers (1957) outlines six conditions necessary and sufficient for therapeutic change which include therapist congruence, empathy and unconditional positive regard within the context of contact between therapist and client. Bordin (1979) sought a definition of the therapeutic relationship that would span theoretical orientations. He proposed that the working alliance, a term used interchangeably with the therapeutic relationship, comprises three aspects: goal, task and bond. Bordin's (1979) model has been widely researched (Bachelor & Salamé, 2000; Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005; Dunkle & Friedlander, 1996; Horvath & Greenberg, 1989; Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Watson & Geller, 2005) and stands as the dominant model in the literature. Gelso and Carter's (1985; 1994) model, emanating from a psychoanalytic conceptualisation of the therapeutic relationship, also has three components: working alliance, transference and a real or undistorted relationship. Empirically informed research on the therapeutic relationship, including the instruments used to measure it, almost exclusively reflects and applies variations of these conceptualisations.

In further deconstruction of the therapeutic relationship, various therapist qualities have been isolated and linked with strong alliance ratings (Ackerman &

Hilsenroth, 2003; Bachelor, 1995; Dunkle & Friedlander, 1996; Fauth & Nutt Williams, 2005; Najavits & Strupp, 1994; Sexton, Littauer, Sexton, & Tommeras, 2005; Watson & Geller, 2005). In a meta-analysis of clinician interventions related to alliance, Hilsenroth and Cromer (2007) note the following therapist qualities and attitudes significantly relate to positive alliances: empathy, support, exploration, activity, confident collaboration, appreciation, trust, warmth, attunement, potency, competence, respect, attentive, engaged listening and appearing to understand the client without being judgemental. Causality cannot be assumed in either direction. In fact, therapist qualities are treated as part of the alliance itself in several measures (Gaston & Marmar, 1994; Gelso et al., 2005; Gomez-Schwartz, 1978; Luborsky, 1976; Saunders, Howard, & Orlinsky, 1989). In another line of research on therapist qualities, Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens (2003) created what they call a portrait of the master therapist. Based on a series of qualitative studies, the authors organised the characteristics of 'the Highly-Functioning Self' of the therapist and included such descriptors as comfort with ambiguity, motivated learner, emotionally mature, open to change, self-aware, congruent, attends to self-care and interpersonal skills. Similarity exists between these characteristics and those identified by other researchers (e.g., Ackerman & Hilsenroth, 2003; Dunkle & Friedlander, 1996; Hilsenroth & Cromer, 2007; Najavits & Strupp, 1994; Sexton et al., 2005), but Jennings et al. (2003) added a level of complexity by including paradoxical characteristics and by thickening the description of therapist characteristics. Paradoxical characteristics include for example 'Drive to Mastery *and* Never a Sense of Having Fully Arrived; Ability to be Deeply Present with Another *and* Often Preferring Solitude; Great at Giving of Self *and* Nurturing of Self' (Jennings, et al., 2003, p. 65, emphasis in the original). Regardless of causality, these studies suggest the relevance of therapist qualities to the strength of the relationship.

We are proposing that counsellors' presence is pertinent to their ability to establish an effective therapeutic relationship. Those who have studied presence propose conceptually that counsellors' ability to be present enhances their capacity to build a stronger alliance and a more therapeutic relationship (Geller, 2003; Pemberton, 1977; Phelon, 2001). There is also overlap among descriptions of the qualities of master therapists (Jennings et al., 2003), therapist qualities associated with positive therapeutic alliances (Hilsenroth & Cromer, 2007) and descriptions of counsellor presence. Presence, as both an intra-personal counsellor factor and as a co-constructed, intersubjective experience, fits intuitively in the realm of the therapeutic relationship and yet there is no sign of presence in theoretical models of the relationship. Descriptions of presence in psychotherapy literature point to its place as a common factor in the therapeutic relationship as well as to the importance for further inquiry.

Theoretical representations of presence

While the term 'presence' is absent from the models of and empirically informed literature on the therapeutic relationship, therapists from diverse theoretical orientations have written in clinically informed literature about their experience and the significance of presence. A common language of presence does not exist (Phelon, 2001) as writers have worked in relative isolation, but the common wisdom in their experience appears in the words they chose. In the psychoanalytic context, Freud advised therapists to use 'evenly hovering attention' as opposed to selective or

forced attention (Freud, 1961). Theodore Reik wrote of listening with the third ear as his way of describing presence, hearing 'what is expressed noiselessly, what is said *pianissimo*' and warning that 'The psychoanalyst who must look at all things immediately, scrutinize them, and subject them to logical examination has often lost the psychological moment for seizing the fleeting, elusive material' (1948, p. 145). These descriptions evoke a sense of what may be called presence and are reminiscent of the characteristics of the master therapist illuminated by Jennings et al. (2003) as well.

In Martin Buber's (1970) I-thou relationship, presence takes on the dimension of a meeting. True presence in direct encounter with 'You' is the only way to know oneself as an 'I' and experience being alive (Buber, 1970, p. 67). This view of presence contrasts with a conception of presence as intrapersonal (Pemberton, 1977).

Existential therapists emphasise presence in the therapeutic relationship as 'true communication from existence to existence' (Binswanger, cited in May, 1958, p. 81). The therapist is 'an alive human being' (May, 1958, p. 80). May introduces the words 'experiencing' and 'participation' into being present. 'It is sheer folly to think that another person can be known by analysis or formulas; here understanding as participation comes into its own' (May, 1989, p. 67). An additional ingredient in the therapist's ability to be present comes from 'the courage of imperfection', meaning the ability to fail (May, 1989, p. 142). Bugental described presence as 'mobilization of one's sensitivity – both inner (to the subjective) and outer (to the situation and the other person(s) in it) – and through bringing into action one's capacity for response' (1987, p. 27). In existential theory, people experience anxiety due to the inevitability of the conditions of living: death, isolation, meaninglessness and freedom. It is the connection and presence with others that helps people confront, accept and tolerate these conditions.

In person-centred therapy the counsellor's task is 'being immediately present to his client, relying on his moment-to-moment felt experience in the relationship' (Rogers, 1989, p. 16). Rogers added the qualifier 'accurate' to the more common use of the word 'empathy' in establishing his necessary and sufficient conditions for change. Being present in the client's world, in a 'moment-to-moment sensitivity in the here and now, in the immediate present' (Rogers, 1989, p. 16), counsellors are more likely to offer accurate empathy.

In Gestalt therapy, the concept of presence plays a central part in the therapy process and is considered healing in and of itself (Gold & Zahm, 2008). Here, being present means making authentic contact – either with oneself or with the environment – which includes awareness at the sensory as well as the cognitive level (Korb, Gorrell, & Van De Riet, 2002). Authentic contact is not passive, not something that just happens when in the presence of another. According to Laura Perls (1992), it is an activity. 'I make contact on the boundary between me and the other. The boundary is where we touch and at the same time experience separateness' (Perls, 1992, p. 53).

Being present then exists in the context of dialogue at the contact boundary. What Yontef (2007) called 'the dialogic relationship' is characterised by inclusion and confirmation, authentic presence and self-disclosure and a commitment to dialogue (p. 282). Korb (1988) described her experience of presence this way: 'I am aware of nothing but the present; I see and hear clearly with no impediment or interruption; my perceptions do not alternate between figures for there is only one figure, the whole of what is present' (p. 100). Korb characterised her experience as intrapersonal

and at the same time this state of presence allows her to make more unimpeded contact with her clients (Korb, 1988, p. 101).

Stern (2004) investigated the present moment, an aspect of the experience of presence. He identified 'features of a clinically relevant present moment' as: awareness or consciousness, not a verbal account of an experience; felt in the now; of short duration; psychologically significant; a holistic happening; temporally dynamic; unpredictable; involving a sense of self; and varying in importance (Stern, 2004). He drew on neurological research to support some of his conclusions. One example is of 'mirror neurons' that fire in the brain of one person observing another person. 'We experience the other as if we were executing the same action, feeling the same emotion, making the same vocalization, or being touched as they are being touched' (Stern, 2004, p. 79). Other mechanisms help synchronise one person's movements with another's, allowing them to participate in each other's experience. Stern added that 'implicit knowing' is part of the present moment, a knowing that is 'nonsymbolic, nonverbal, procedural, and unconscious in the sense of not being reflectively conscious' (Stern, 2004, p. 113), similar to Reik's (1948) 'listening with the third ear'. In Stern's description of the therapeutic present moment, boundaries between counsellor and client become permeable, as in Korb's (1988) 'numinous ground', even as the selves remain differentiated – intersubjectivity rather than fusion (Stern, 2004, p. 77). In the intersubjective present moment,

You have your own experience plus the other's experience of your experience as reflected in their eyes, body, tone of voice, and so on. Your experience and the experience of the other need not be exactly the same...But they are similar enough that...a "consciousness" of sharing the same mental landscape arises. (Stern, 2004, p. 125)

There are noticeable similarities between Stern's intersubjective present moment and Buber's (1970) I-thou meeting.

Buddhist philosophy and practice is finding its way into psychotherapy (Anderson, 2005; Aronson, 2004; Geller, 2003; Welwood, 2000). Buddhist mindfulness practice is used to develop awareness and acceptance of what is, as opposed to what is wished to be, and to detach from the desire for particular outcomes. Welwood called this 'unconditional presence' (2000, p. 141). Shunryu Suzuki, a teacher of Zen Buddhism, coined the term 'beginner's mind' that expresses the open, humble nature of presence. 'In the beginner's mind there are many possibilities, in the expert's there are few' (Suzuki, 1973, p. 21). Welwood (2000) described the value of beginner's mind to therapy: '...when [counsellors] operate from not-knowing, they are more likely to embody authentic presence. Letting themselves not know what to do next invites a deeper quality of stillness and attentiveness into the work' (p. 142).

It is stunning to juxtapose these powerful descriptions of presence with its absence from empirically informed literature on the therapeutic relationship. It seems clear that studying this phenomenon holds importance for the counselling profession. The following is a review of studies of presence to date.

Empirical representations of presence

Few empirical studies of presence have been undertaken for reasons that will be explored in the next section of this article. Those that do exist are summarised here. These studies offer preliminary support for conceptualisations of presence and show pioneering efforts to explore this phenomenon.

Pemberton (1977) studied five therapists purposefully selected for their reported effectiveness and presence. The purpose of his study was to arrive at an operational definition of presence and develop a model of how presence is 'achieved, maintained and lost' (Pemberton, 1977). Pemberton's model of presence was derived from his observations of the therapists at work and from follow up interviews. However, he did not delineate the coding or distillation process. The value of this study lies in three areas. First, Pemberton (1977) put forth his notion of the forces that enable or generate presence: focusing, extending and enfolding. Second, he concluded that presence is an intrapersonal phenomenon rather than an interpersonal one. The coming together described by other writers, Pemberton suggested, happens when both people are individually present at the same time, in the relational realm. He called this 'meeting' (1977, p. 5). Third, he claimed that healing is 'the immediate result of presence or meeting' (1977, p. 6). Healing was described as a momentary process, happening over and over again, the outcome of which is authenticity, centeredness, purpose, clarity and autonomy (1977, p. 7). This claim fits with conceptualisations of presence described in the previous section of this article.

Fraelich (1989) conducted a phenomenological study of presence in which he interviewed six practicing psychotherapists. Fraelich analysed the transcripts using methodology delineated by Moustakas (1994) to identify the essential structures of the phenomenon of presence. He reported the following thematic structures of presence: (1) presence as spontaneous occurrence; (2) immersion in the moment; (3) openness of being; and (4) living on the cutting edge. Fraelich concluded that his study substantiated the existence of presence, previously addressed only theoretically, and suggested presence as a powerful influence in psychotherapy. Fraelich did not reference Pemberton's (1977) study and noted that no quantitative or qualitative studies had been conducted up to that time on the nature of presence. This illustrates the marginalised status of the study of presence and lack of communication among researchers on presence.

Phelon (2001) tackled the exploration of presence using several innovative methodologies. She began with a hermeneutic study of texts addressing presence from a variety of fields. Next a panel of experienced therapists, chosen for their experience of a therapist's presence, refined the categories derived from the hermeneutic study in two cycles of a process of 'sympathetic resonance' (Phelon, 2001, p. 6) to arrive at the final distillation. The final distillation yielded nine elements that Phelon (2001) grouped into three interactive categories: (a) development and growth, which includes seasoning, commitment to personal growth, integration and congruence, and spiritual practice and belief; (b) qualities of awareness, including attentional ability, inner awareness and kinesthetic aspects of presence; and (c) therapeutic alliance, including alignment with the client, and receptivity (p. 128). Phelon called this study an 'intuitive inquiry' (Anderson, 1998, 2000, cited in Phelon, 2001, p. 5). This study demonstrates an attempt to create methodologies that enable researchers to apply rigour while investigating complex, intangible phenomena.

Presence in the context of medical healing takes on a more spiritual quality, although the spiritual dimension of presence also shows up in Phelon's (2001) study. Literature from the nursing field attempting to define presence has been primarily conceptual and descriptive (clinically informed), just as it has in the field of psychotherapy. Three dimensions of presence emerge from that literature that McDonough-Means, Kreitzer, and Bell (2004) identified as physical (being there),

psychologic (being with), and spiritual. All three dimensions compare with how presence has been described in therapy. Also useful from the medical healing literature is the conceptualisation of presence on a continuum, rather than as dichotomous (being present or not) (Osterman & Schwartz-Barcott, 1996). The continuum model – from presence to partial presence to full presence to transcendent presence – also operationalised presence to an extent and may be adaptable to research in psychotherapy. Curry (2003) investigated the phenomenon of healing presence in the naturopathic relationship. Here, as in the nursing studies, presence was looked at as a curative or healing factor. Curry (2003) identified her study as an organic inquiry, a psychospiritual approach. In the analysis qualitative interview data, Curry and her co-researchers settled on a synthesis statement and seven categories of components of healing presence. In the synthesis statement, they described the experience of healing presence in the naturopathic relationship and attributed potential transformative properties to the experience. While maintaining methodological rigour, Curry (2003) added the element of the sacred to the study not only in the phenomenon under study but in the research process itself – a both-and approach that would seem oxymoronic in a positivist paradigm.

Geller (2001) conducted a two-part study of therapeutic presence. First she interviewed seven therapists who had written about or were proponents of therapeutic presence. From a five-stage analysis of the interview data Geller constructed a model of therapeutic presence, which was then checked by a panel of experienced therapists (Geller, 2001). This study employed and delineated systematic qualitative methodology. The resulting model of presence comprises three parts: (a) preparing for presence; (b) the experience of presence; and (c) the process of presence. Geller noted that presence is a holistic experience so that each of these parts overlaps and intertwines with the others. The therapists in the study also referred to presence as a continuum, expressed in terms of the intensity of the connection (Geller, 2001). In the second part of Geller's (2001) study, she developed a measure of presence, the Therapeutic Presence Inventory (TPI), based on the model of presence derived in the first part of the study (p. 117). This study makes four contributions to the study of presence. First, consistent with findings that clients' ratings of the working alliance are most predictive of therapeutic outcome (Bachelor & Salamé, 2000; Clemence et al., 2005; Fitzpatrick, Iwakabe, & Stalikas, 2005; Horvath & Symonds, 1991), client ratings of therapist presence on the TPI were more predictive of both the alliance and session outcome than therapists' ratings (Geller, 2001, p. 182). Second, clients' ratings of therapist presence correlated with their ratings of the working alliance and with session outcome, the first empirical evidence suggesting that presence figures in some way in both. Third, the TPI offers a reasonably reliable measure of therapeutic presence that may be useful in further research. And fourth, the 'preparation for presence' part of the model of therapeutic presence offers guidance in beginning to think about training counsellors to be present.

These studies provide the profession with descriptive data and some as yet unsupported suggestions of a relationship between being present and positive therapeutic relationship and healing outcome. The factors and elements of presence identified in these studies form a mosaic that begins to tell a story of the experience of presence across theoretical orientations. And it is a story set in the context of the therapeutic relationship.

Understanding and investigating presence: a lost opportunity?

In light of the importance of presence, we are led to ask why the topic has been so minimally explored. Several points are to be made here.

The first point is that the profession seems to have settled on a few models of the therapeutic relationship or working alliance. The models of the therapeutic relationship conceptualised by Rogers (1957), Luborsky (1976), Bordin (1979), Gelso and Carter (1985, 1994) and the measures derived from them dominate the research literature. Adam Horvath, whose body of research has centred on the therapeutic relationship, stated in a 2005 review of the literature:

Firstly, we need more theoretical debate about the construct of the relationship. The relatively brief period between the original theoretical/conceptual formulation and the development of measuring procedures that in practice defined the construct for research that followed likely foreclosed the opportunity to examine the implications and possible limitations of the concept as first presented by Luborsky (1976) and Bordin (1979). (Horvath, 2005, p. 4)

This theoretical foreclosure has limited a full examination of this important phenomenon (Elvins & Green, 2008; Horvath, 2005; Horvath & Luborsky, 1993; Norcross, 2002; Norcross, Beutler, & Levant, 2006). Even attempts to extract other factors that combine to create the therapeutic relationship have stayed within previously delineated ground. For instance, Hatcher and Barends (1996) conducted a factor analysis of ratings of the therapeutic relationship by 231 outpatient clients in an attempt to isolate core alliance factors that correlated with client-perceived improvement in therapy. They used three established measures of alliance – the Working Alliance Inventory (Horvath & Greenberg, 1989), the Helping Alliance Questionnaire (Luborsky, 1976), and the California Psychotherapy Alliance Scales (Gaston & Marmar, 1994) – and found two factors that correlated with outcome: confident collaboration and idealised relationship. Clemence et al. (2005) replicated the correlation between confident collaboration and outcome in a study of 125 clients at a university counselling centre. In their study of 66 clients diagnosed with major depressive disorder, Watson and Geller (2005) examined the relationship between Rogers's therapist-offered conditions (empathy, congruence and positive regard) and outcome as mediated by the working alliance (goal, bond and task).

In the report of the American Psychological Association Division 29 Task Force, *Psychotherapy Relationships that Work* (Norcross, 2002), the authors argued that the therapeutic relationship and the therapist as a person had been excluded from empirically supported treatments despite numerous studies demonstrating the contribution of both to therapeutic outcome. Through their inclusion criteria, the authors drew on concepts already identified as part of the therapeutic relationship. There was again little room for new elements or for expanded conceptualisation. If not enough empirically informed research existed on a factor (i.e. confrontation, credibility of therapy or therapist), it was not included in the report. The recycling of studies and models leaves the field with a poverty of language and a false sense of precision about the therapeutic relationship. The Task Force emphasised the credibility of established models of the therapeutic relationship in making a case for including the therapeutic relationship on the lists of empirically supported treatment components but it also perpetuated a limited definition of therapeutic relationship.

The second point is that approaches to studying the therapeutic relationship have taken an atomistic rather than a holistic approach which leaves out complex phenomena such as presence. Ackerman and Hilsenroth (2003), Dunkle and Friedlander (1996), Hilsenroth and Cromer (2007) and Norcross (2002) separated the therapist's contribution to the therapeutic relationship into discrete elements that may influence outcome. In identifying empirically supported elements of the therapeutic relationship, the American Psychological Association Division 29 Task Force took a fragmenting rather than holistic view of the relationship. The authors were not unaware of this limitation and stated that the term 'elements' 'denotes components, parts, or aspects – implying that it is not the entire story' (Norcross, 2002, p. 7). Not only may studying elements not be the 'entire story', it may be a different story altogether than the whole from which the elements are drawn. The relationship is a whole system, understanding of which is limited, if not skewed, by taking it apart and studying the pieces.

The third point is the unexplained discrepancy between counsellor and client perceptions of the relationship. Client ratings of the therapeutic relationship more consistently predict outcome than either counsellor or observer ratings (Fitzpatrick et al., 2005; Horvath & Symonds, 1991; Tryon, Blackwell, & Hammel, 2007; Watson & Geller, 2005). Bachelor (1995) explored the client's perspective of the alliance in a qualitative study and found client responses clustered around three types of alliances: nurturant, insight-oriented and collaborative (p. 324), implying that not all clients respond to the same type. In a more recent study, coding of client interviews yielded 11 common alliance formation factors including some factors that are not included in the prevailing models such as setting, presentation and body language, nonverbal gestures and session administration (Bedi, 2006, p. 26). However, the study focused on the initial period of alliance formation (first two sessions) which may present a different picture than a period of deepening alliance for instance. In addition, only 'concrete, specific, and behavioral' factors were included (Bedi, 2006, p. 33) which leaves out more abstract interactional or process factors. While these studies illuminate some of what the client perceives of the alliance, they still do not address the discrepancy between client and counsellor ratings of the alliance. They do, however, call into question the viability of the existing models and/or measures of the therapeutic relationship.

The fourth point is that the meta-analysis has become the foundation for accepted knowledge claims about the therapeutic relationship (Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Martin et al., 2000; Norcross, 2002). Examining the list of references generated for this literature review we found that the sources cited most often were meta-analyses (data supplied by PsycInfo). The purpose of this analytic procedure is to synthesise the current knowledge base about a phenomenon. What is gained in breadth is lost in depth of understanding. In taking a broad view, the meta-analysis paints an impersonal picture of a very personal encounter. The profession is left at a distance from the moment to moment experience of a relationship. The new wisdom is not found in the synthesis of an existing body of data but in going deeply into the subjective experience of being present.

Finally, holistic, subjective, process phenomena such as presence fall outside the usual order of positivist science which has dominated research in the social sciences. The positivist paradigm promises a linear, predictable world that can be known objectively. Positivist inquiry is about narrowing the focus of study to definable variables and controlling other influences, with the ultimate goal of prediction and

verification of a true reality. It takes the world apart and studies the pieces in order to understand the whole. All of the above combine to disqualify presence as a viable phenomenon for study. In the realm of psychotherapy research, Norcross et al. (2006) stated that 'The critical issue, then, is not whether research should inform practice to the greatest extent possible, which is a proposition that hardly seems debatable. Rather, the concern is the types of psychotherapy (practice and research) that are privileged by the current preferred research methodology' (p. 278). Not only are types of psychotherapy privileged but also certain models of the therapeutic relationship and, even more basically, what constitutes evidence for study at all. Blais and Hilsenroth (2007) warned that 'methodcentric reasoning', seeing one's preferred methodology as superior, is narrowing the conversation on empirically supported treatments. The limitations of empirically informed research on the therapeutic relationship and on presence described above all stem from a positivist orientation toward knowing.

New directions for policy and the study of presence

The policy implications of expanding the examination of presence pertain to both inquiry and training. Kuhn (1996) in his classic book *The Structure of Scientific Revolutions* clarified the context in which the limitations of positivist research can be understood. Kuhn called the dominant scientific paradigm at any point in history 'normal science' which 'is predicated on the assumption that the scientific community knows what the world is like' (Kuhn, 1996, p. 5). A shared commitment to a paradigm ensures that its practitioners will investigate the kinds of research questions most easily answered by theories consistent with that paradigm. A paradigm is essential to scientific inquiry as it helps researchers formulate questions, select methods and create boundaries around what is relevant. At the same time a paradigm 'often suppresses fundamental novelties because they are necessarily subversive of its basic commitments' which limits scientific inquiry (Kuhn, 1996, p. 5).

Positivist science has been the 'normal science' of recent history. The central task of positivist science is objective verification of facts about an ultimately predictable world (Crotty, 2003). But there are phenomena that researchers are not prepared by this paradigm to investigate. Kuhn described that when a paradigm ceases to be able to ignore such anomalies, 'then begin the extraordinary investigations that lead the profession at last to a new set of commitments, a new basis for the practice of science' (Kuhn, 1996, p. 5). In the paradigms emerging from such a scientific revolution multiple, complex realities exist in parallel, and prediction and control give way to uncertainty and possibility. The impossibility of objectivity makes room for constructed understanding of phenomena. These ideas come in part out of quantum mechanics and chaos and complexity theory and have been embraced and applied in biology, mathematics, sociology and now psychotherapy. They offer 'a fresh way to proceed with old data, forgotten in desk drawers because they had proved too erratic' and suggest 'the futility of studying parts in isolation from the whole' (Gleick, 1987, p. 304).

The availability of post-positivist paradigms invites researchers to rummage through their 'desk drawers' and pull out data or curiosities that did not fit previous research structures. Therapeutic presence is one of those curiosities. It is important to take presence out of the drawer at this time because of the opportunity to make new discoveries about its meaning and importance, or to identify new knowledge about

the ways in which counsellors acquire and use their capacity to be present. We envision that a variety of research studies are possible, most of which will fall into one of three categories: investigations that examine the conceptual structure of presence, investigations that examine counsellors' experience of presence, and investigations that examine the therapeutic value of presence from the perspective of both client and counsellor.

Regarding the conceptual structure of presence, the counselling profession's understanding of the importance of presence may have been hampered by the absence of a coherent conceptual framework. As we described earlier in this paper, the therapeutic importance of presence has been illustrated from a variety of theoretical and philosophical traditions as well as in the descriptive findings from the few studies on presence (Fraelich, 1989; Geller, 2001; Pemberton, 1977; Phelon, 2001). Each of these traditions and studies informs counsellors' understanding of presence in its own right but little has been done to demonstrate the common elements of the models. In response it appears that clinicians select a favourite interpretation of presence and overlook others. Rather than being forced to select a favourite, we believe the profession would be advantaged by having a taxonomy of presence that encompasses the key contributions of the different traditions. At a minimum, such a taxonomy would respond to the need to identify a common language of presence (Phelon, 2001) and provide the foundational work for systematic qualitative and quantitative inquiry into this phenomenon.

The limitations of the research on the therapeutic relationship and the disqualification of the experience of presence from the research literature demonstrate the need for discovery. Creative investigations of presence in the context of the new paradigm will admit subjective experience as evidence, and allow the counsellor's experience of being present to be examined intact, as a whole. One example is to explore how counsellors make meaning of their experience of being present in different phases of their development from novice to master therapist. Therapist qualities that have been associated with positive therapeutic alliances seem akin to descriptions of being present, e.g. engaged listening and appearing to understand the client without being judgemental (Hilsenroth & Cromer, 2007), as do the qualities of master therapists, e.g. being congruent or fully oneself and the ability to form relationships (Skovholt, Hanson, Jennings, & Grier, 2004). Are these qualities available only to those who are naturally favoured with them or only come with experience? Future research might explore if and how such qualities can be developed. Further, the discrepancy between counsellor and client rating of the alliance (Tryon et al., 2007) has yet to be adequately analysed. Exploring the client's perception of the counsellor's presence throughout the duration of the relationship may shed light on the discrepancy either in qualitative inquiry or quantitatively using the TPI developed by Geller (2001). The findings of such explorations would have implications for counsellor training and supervision as well as for ongoing professional development. In addition there is a need for further examination of the claims that presence is healing (e.g. Pemberton, 1977), that it connects in some way with the therapeutic relationship (e.g. Geller, 2001), and that it allows both counsellor and client to ride the waves of uncertainty inherent in post-modern life. Investigating these claims will enhance our understanding of the importance of the counselling relationship and the importance of counsellor presence.

Advancing the profession's understanding of presence also has policy implications for counsellor educators and supervisors. Current instructional practices in

counsellor education programmes will need to be modified to accommodate more holistic learning experiences that focus on the whole person, counsellor and client alike. As the profession of counsellor education has become more scientific in its orientation, it has emphasised a modernist orientation to instruction that grooms the counsellor to be a technician. Counsellors are taught how best to use various techniques, but less emphasis is given to the importance of being with a client, being present. As more becomes known about the nature and importance of presence, counsellor educators will be better positioned to include it as a factor for selecting the next generation of counsellors.

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