The Concept of Therapeutic Presence in Nursing

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Summary

An expert consensus panel concluded that caring is a moral imperative in nursing and that the use of the nurse's true presence within the nurse client interaction is foundational to caring. The usefulness of the construct of therapeutic presence and a belief in the efficacy of presence as a treatment modality have been generally accepted as valid. A review of the literature, however, revealed that the value of the concept of presence has been accepted without clear definition or empirical evidence. Furthermore, the impact of technology-mediated presence has not been studied.

Two factors contributed to this state of affairs. First, practicing nurses seem to have intuitively accepted the concept as a "good fit" with their own clinical experiences. Second, research regarding presence continues to be somewhat stymied by the non-empiric nature of the concept and the relative difficulty of doing qualitative research (i.e., securing funding and designing meaningful studies). Thus, the concept of presence has entered the mainstream of nursing theory and practice with little critical examination or research-based analysis. This paper reviews the concept of presence in the nursing literature and in related disciplines to develop a clear concept for the study of presence in nursing. The process followed included: 1) identification of a plan to sample the literature, 2) identification and description of related concepts; 3) the extraction of themes and attributes 4) explication of interdisciplinary treatment of the concept, 5) description of possible model cases, and 6) identification of implications for future research This work is foundational to the exploration of the effects of technology mediated nurse client

interaction. A preliminary study to explore the experience of receiving routine psychiatric care via videophone (or similar) technology is described.

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1 Introduction

The explanatory value of clearly formulated nursing concepts is key to the development of nursing science. Concept formulation identifies and isolates core characteristics of a phenomenon of interest. Through observation, experience and reflection concrete sensory experiences are transformed to abstractions (King, 1975). Regularities and commonalities are extracted. Exceptions and contrary cases establish boundaries of the phenomenon. Concepts are tools, which allow us to categorize and classify phenomena, and thereby to propose and explore relationships between and among phenomena.

1.1Method of Concept Development

Concept analysis is contextual and subject to continuous re-evaluation as to utility (Chinn and Kramer, 1991). Three sources of experiencing interact to produce meaning. These include the word, the thing itself, and the feelings associated with the experience of the concept. Through communication this interior process is shared. The steps taken to delineate the concept of nursing presence included: 1) identification of a plan to sample the literature, 2) identification and description of related concepts; 3) the extraction of themes and attributes 4) explication of interdisciplinary treatment of the concept, 5) description of possible model cases, and 6) identification of implications for future research (Rogers, 1993).

1.2 Sampling Section

While the sampling method is most correctly described as a convenience sample, a finite number of articles related to presence were identified. Most of the articles were obtained and are included. The nursing literature was reviewed for references to presence. Despite

the entry of the word into standard nursing textbooks, the review of the literature turned up only 17 CINHAL references. Other methods were utilized to supplement the findings. The reference lists and authors cited by textbook chapters were entered into a computer-aided search.

Early nursing authors who addressed presence "borrowed" the term from existential philosophy and often cited Buber and Marcel. Accordingly, these works were consulted for clarification of the terms origins. Contemporaneous to nursing's exploration of the concept, the psychotherapy literature was also beginning to incorporate the use of the term presence. To broaden the perspective, the use of the concept in this discipline was explored, specifically in the Gestalt and counseling literature.

1.3 Literature Retrieval and Data Collection

All of the located items were read to establish a general tone and sense of the concept. Following this, they were re-read and direct quotes and paraphrases were entered into a computer file to aid data retrieval and analysis. The goal was to identify the attributes of presence as described by various authors and to discover commonalities and themes. The data was coded to identify source and discipline. The items were then grouped and re-grouped as similar cases and categories began to emerge. An effort to note and group the relevant aspects of antecedents, consequences, related concepts, and surrogate terms was made.

1.4 Data Analysis

The computer entry facilitated data grouping and re-grouping such that themes readily emerged. Subjectivity is clearly a factor in this sort of analysis, especially when conducted by one author. However, since the commonalities were pronounced, I have confidence in the consistency and appropriateness of my interpretation. Moreover, the data and sources are clearly identified establishing the sort of evidence trail common to qualitative research.

2 The Literature

The dictionary definition of the word presence, especially some of the secondary meanings, offers insight to the specialized meaning of the word as used in nursing theory. The dictionary defines Presence as: 1. the state or fact of being present. 2. Immediate proximity in time or space. 3. a. the area surrounding a great personage, especially a sovereign granting an audience 3.b. a person who is present. 4. a. a person's manner of bearing, mien or carriage. 4. b. a quality of poise and ease of performance that enables a performer to create a close and sympathetic relationship with his audience, 5. a supernatural influence felt to be nearby. The word is derived from the Latin praesentia, a form of the word praeesse which means "to be present before others"(Flexner, 1987).

Presence entered the nursing literature in the late 1960's. Black (1967) described the application of existential concepts to nursing practice. She cited Martin Buber as the source for existential ideas of presence. She discussed the I-Thou manner of relating describing it as occurring in the present moment and as encompassing a way of relating to the other as a whole in true presence. By contrast, in the I-It relationship, the other is observed, measured or classified. Black advocated using the existential concepts of authentic presence, dialogue and commitment to enrich the nursing process.

Despite lack of clear definition or research as to its outcomes, the concept of presence continued to appear with some regularity in anecdotal discussions. Textbooks describing nursing interventions described nursing presence. Eventually, textbook chapters were devoted to discussions of the use of therapeutic presence (Bulechek and McCloskey, 1985; Carson, 1989; Gardner, 1985; Gaut, 1992). Most authors have treated presence as a therapeutic modality or intervention.

2.1 Philosophical Foundations

Buber noted that life requires both the I-Thou and the I-It modes of interaction. Nursing, too, requires both sorts of interaction: When completing a complicated dressing change, the nurse must temporarily, objectify the body of the patient. The person of the patient is indeed embodied, and for this moment it is the condition of the body, which is the focus of the interaction. This may be heightened when it is therapeutically necessary for the

nurse to inflict physical pain. Black cautioned that the needs to address physical interventions, to avoid entanglement with the patient, and to maintain objectivity were sometimes at odds with development of the I-Thou relationship that characterizes presence.

The early nursing references to presence (Black, 1967; Paterson & Zderad, 1976; Watson; 1975) identified availability as a feature of presence and cited the work of the French philosopher, Marcel as a source for this idea. He wrote a great deal about the concept of presence, claiming that examination of this subjective experiential concept of being, was futile for it defied explanation or description and could only be fully apprehended by experience. It was Marcel who articulated the requirement of availability inherent in the concept of presence.

Paterson and Zderad (1976) described a theory of nursing derived from Martin Buber's concept of the "I-Thou" relationship. Buber characterized this relationship as a fully present understanding of the other without a concurrent loss of the concrete self. He saw this in contradistinction to empathy in which the experience of the other takes on an "as if it were one's own" quality, with a suppression or a diminution of the concrete sense of self. Thus, he conceived of empathy as having a quality of transporting or injecting one's self into or onto another with the loss of one's own experience. Paterson and Zderad defined presence as" A mode of being available or open in a situation with the wholeness of one's unique, individual being; a gift of the self which can only be given freely, invoked or evoked" (1976, p 132.).

One of the major proponents of the centrality of caring in the practice of nursing, Watson was frequently referenced by those exploring presence or related concepts. She described transpersonal caring as entering into " the experience (the phenomenal field) of another and the other person enters into the nurse's experience. This shared experience creates its own phenomenal field and becomes part of a larger, deeper, complex pattern of life. "(1985, p.67).

Marsden (1990) described presence as a giving as well as a receiving of the self, born out of availability and quietness. Preconditions of presence were noted and included being in touch with own state of mind, sensitivity and receptivity to the beliefs and experiences of others. For Marsden, presence has two dimensions: it conveys empathy and promotes well-being and autonomy. Presence can meet spiritual needs. In the relationships with presence the nurse and client each experience their own and the others' uniqueness affirming cherished values, hopes, wants, needs.

Knowledge Consensus Conference of 1998 concluded that the essence of nursing practice is the development of the nurse-patient relationship (USA, 1998). Intentional presence is essential in order for the nurse to know and understand what it means to be human and humans in relationship. This knowledge provides the basis for the mutual selection of health promoting interventions. An intentionally therapeutic mode of being, incorporating the nurse's true presence underlies this process. Other terms used to describe this fundamental aspect of nursing include interaction and mutuality. The engagement is mutual, an iterative process that includes giving and receiving and being humble.

2.2 Examples of the Concept in Borrowed Theory

Bugental (1987) described presence as the quality of being in a situation in which one intends at a deep level to participate as fully as possible. Presence is expressed through mobilization of one's sensitivities "both inner (to the subjective) and outer (to the situation and the other person)" (p. 27). He recognized two facets of presence: accessibility and expressiveness. He said that accessibility was reflected in the degree to which one intended to allow whatever happens in the relationship to be important. This requires a dropping of usual defenses against being influenced by others. It suggests commitment. Expressiveness has to do with the degree to which one will allow one's inner self to be known by the other. Disclosing one's self implies effort. Bugental thought that presence was a necessary precondition to a useful therapeutic alliance with the patient.

Korb described presence as an unplanned for moment when the client and therapist become "a reciprocal I-Thou, through an act of faith we are unmediated presences to each other" (1990, p. 99). Speaking of the experience of presence:

> We are at once in contact and in a state of confluence being present simultaneously. My client is present with a clear sense of his/her contact boundary; although aware of my presence, his/her focus is inward. I am present in my wholeness (an extended state of congruence in Roger's use of that term) with an empathetic focus on my client. We are in a numinous state of contact and confluence that is life-giving and healing for us both."(p. 101).

Ederer, Geller and Gruber (2000) explored current psychotherapeiutic beliefs based on Carl Rogers model of client centered practice. They stated that presence encompasses attentiveness, bodily and sensory openness, enhanced awareness, connection, integration, and focus. An awareness of being there with and for the client is perceived b the therapist and communicated to the client simultaneously.

3 Related Concepts

3.1 Empathy

Empathy was identified as a related concept. Travelbee (1976) hypothesized that empathy was dependent upon the sharing of a similar history,which would allow the nurse to understand and make predictions about the patient's behavior. Empathy, as described by Travelbee, was neutral and only acquired the potential to do good or bad through the actions, which it provoked. Sympathy was differentiated from empathy by the accompanying desire to alleviate distress. Sympathy is incompatible with detachment but requires enough distance to preserve one's own experience.

Carl Rogers (1951) described empathy as occurring when the therapist is able to assume the internal frame of reference of the client. In doing so, he can then perceive the world as the client does and communicate something of this empathetic understanding back to

the client. Therapeutic presence is the quality of being fully in the moment, intentionally focused on the possibility of benefit to the client.

Kristjansdottir (1992) emphasized the active component of empathy, describing it as the ability, based on reflection and knowledge base, to imaginatively project oneself into the experience of another. She analyzed the various extant definitions of empathy, and classified them as representative of three main types. The first is the ability to imaginatively explore facets of another person's role. The second was the ability to anticipate and understand the thoughts, feelings, and behaviors of another. Third, was the emotional experience of sharing the experience or feelings of another person without necessarily predicting or cognitively understanding them. For the nurse then, empathy would involve both accurate perception of the client's experience and the ability to communicate that perception in a supportive way.

3.2 Rapport

Rapport was used by Travelbee (1976) to mean an actual experience that cannot be seen but that can be inferred and recognized by the participants. In rapport, both nurse and patient grow. She stated that the development of rapport requires creativity and imagination hooked to the ability to take action. "Rapport is the experiential aspect of the human to human relationship. Rapport is a process, a happening, an experience or a series of experiences, undergone simultaneously by nurse and the recipient of her care" (1976, p. 150).

Bugental (1986) contrasted presence with rapport, noting that although rapport referred to the quality of the relationship between the therapist and the patient, rapport is considered to be compatible with clinical detachment. He noted that full presence has been regarded as a form of countertransference by some psychotherapists. He stated that it was time for a new paradigm for psychotherapy, to recognize the centrality of subjectivity.

4 Inconsistent Data from the Review of the Literature

Rogers noted that one of the difficulties in the analysis of the data in an evolutionary approach to concept development, was how to treat data that does not fit with the emerging themes. Such data need not be incorporated into the final concept, but should be discussed as a part of establishing an auditing trail.

4.1 Presence as Channeling

Lavoie (1983) spoke of presence as a means of becoming a channel for the healing power of God's love. The passive quality inherent in this idea is not reflected in the work of other nursing authors. Korb (1990), a psychotherapist, addressed a oneness with God and the universe as a component of the experience of presence, but specifically denied that it was a passive channeling of God's power or love.

4.2 Presencing as Social Control

Wilson used the term presencing in her study of the Soteria House. This was a grounded theory study of a therapeutic community for patients with schizophrenia. The major treatment modality was the manipulation of the infracontrol system. Wilson used this concept to refer to methods designed to allow for the acceptance of a wide range of deviant behaviors and the application of the least intrusive means of social control. Mere presencing was the physical presence of a committed trained staff person designed to reduce unacceptable behaviors (that is to say, excessive breaking of glass, climbing out of windows, or like behaviors representing an immediate threat to life). "The mere presence of other people is basic to social control of patients at Soteria" (1976, p 136). Although this use of the word is often included in reviews of presence (Gilje, 1992; Fuller, 1991), the intent and consequences are quite different. The critical attributes of presence are not exhibited in this application of the word

5 Antecedents of Presence

Most authors addressed two antecedents. Empathy, the ability to feel what another feels, was frequently suggested as an antecedent to presence. In order to have the necessary preservation of the concrete experience of the self, several authors suggested that self-awareness or self-presence was need. Without losing sight of one's own self, the nurse temporarily brackets his/her own experience to hear clearly what it is the other offers.

Carson (1976) regarded self-knowledge as a prerequisite to presence. There are five prerequisite conditions for presence according to Fish and Shelley (1985). These are empathy, listening, humility, vulnerability and commitment.

6. Consequences of Presence

Most authors speak of comfort, peace, and understanding as consequences of utilization of presence as a nursing intervention. Benner noted that "being there" provided comfort for the patient when there were no other effective interventions. Paterson spoke to the benefits of alleviating loneliness: "To give this gift of time and presence a person has to value the outcomes of relating" (1978, p. 54). Although there is no clear-cut research on which to make these claims, many authors suggested that healing may be facilitated. These claims are based on anecdotal observations (Fuller, 1991). Other benefits mentioned included the facilitation of self-disclosure leading to insight (Bugental, 1986), and the reduction of struggling (Fuller, 1991).

7 Attributes of Presence

7.1 Physical Proximity

The concept of presence as used in nursing seems to require the physical attribute of proximity. Colazzi said of presence: "This requires encountering the patient, co-existing with him for some moments in time and space for the purpose of mutually illuminating the experience"(1975, p. 200). Forrest (1989), in her study of patient's perceptions of the experience of caring, found that "Being there" was a theme that emerged. In her qualitative study exploring nurse's perceptions of presence, Fuller (1991) found that ICU nurses referred to "Just being there" as an intervention associated with presence.

The possibility that one could internalize the other in such a way to allow presence to occur in phone conversations or other technology-aided communications has not, so far as this author could ascertain, been addressed. One study (Hackett, 1964) found that patients who were informed that their cardiac monitors were under the 24 hour surveillance of the nurse, reported that they felt protected by the availability of the nurse if they should need her. So, in some aspects the technology became a surrogate for the physical proximity of the nurse.

7.2 Availability

The early nursing references to presence (Black, Zderad & Paterson, Watson) identified availability as a feature of presence and cited the philosophical works of the French philosopher, Marcel as a source for this idea. Marcel (1971) spoke of availability as a willingness to enter into the experience of presence and in doing so, to meet the needs of the other without regard to whether or not the other has in any way earned the right to the effort. This also implies an attitude of willingness to extend oneself to another without any expectation that one will be "paid back". In Larson's (1987) investigation of the perceptions of caring behaviors, one of the Q-sort items which both patients and nurses ranked highly was accessibility as a behavioral manifestation of caring. Marsden stated that presence was "born out of availability" (1990, p. 540). In a study of post-myocardial infarction patients, Cronin and Harrison (1988) found that availability of the nurse and apparent competence were the two most highly valued manifestations of nursing care. Reiman (1986) found that when patient's described noncaring behavior they referred to the quality of being physically present but emotionally distant.

Authors in all disciplines used the word openness "Encounter is the experience of mutual openness of one toward the other" (Colazzi, 1975, p. 200.). Paterson and Zderad defined presence as " A mode of being available or open "" (1976, p 132), and spoke of "an openness, a receptivity, a readiness, or an availability" (p. 30). Availability seems to encompass the quality of openness. Humility and vulnerability were two of the qualities which Fish and Shelley (1985) considered to be a part of the experience of presence. These are also qualities which make the therapeutic self more available to the person.

7.3 Authenticity

Authenticity or being genuine emerged as an attribute of presence. Watson (1976) spoke of sincerity as a necessary part of the caring experience. Marsden wrote of the need to be in touch with one's own state of mind, to be able to express sensitivity and receptivity to the belief's and experiences of others. The word authentic was used by Black (1967) as a descriptor for presence. Parse (1990) described the true presence of the nurse as " a way of 'being with' in which the nurse is authentic and attentive" (p. 139).

Authenticity has been particularly well articulated in the borrowed literature. According to the psychotherapist Mark O'Connell (2000) the use of one's authentic being in the counseling relationship fosters client growth. Optimally, this occurs through spontaneous and authentic engagement informed by intuition, empathy, and clinical judgment**.** The need to drop the defenses that one normally utilizes in social relationships was mentioned by Bugental (1987). He also described the subjective experience in true presence as having the qualities of both feeling aspects and congruence between content and immediate experience without qualifications of perceptions.

7.4 Reciprocity

In the analysis of the literature, the mutuality of presence was a consistent finding. It appears that this mutual reciprocity may be one of the distinctions between empathy (which seems to be an antecedent for presence) and presence. Empathy can be experienced by one partner in a dyad. Although "the feeling component emanates from continuous human field/environment interaction" (Alligood, 1991, p. 87), that is to say, it is a manifestation of the interaction, it may only be experienced by one. Presence, by contrast, occurs in the intersubjective experience. In their discussion of presence, Paterson and Zderad (1976) referred to the quality of mutuality as having "reciprocal flow" (p. 31). Colazzi described man as "embodied subjectivity in a unity of reciprocal interaction between himself and the world" (p.199). In this view, the nurse and patient actively constitute the relationship. She contrasted this with a perspective whereby the

nurse observes the patient and attempts to read behavioral cues in an effort to deduce what the patient may need.

7.5 Engagement/Connection

Swanson-. Kauffman (1986) found that women felt cared for when they experienced the nurse as understanding, doing for, enabling and being with. She elaborated the quality of being with as encompassing an existential parallelism of feeling; as feeling with and sharing the emotions of the experience. The engagement process was aptly described by Forrest (1989):

> Caring is first and foremost a mental and emotional presence that evolves from deep feelings for the patient's experience. Being able to put oneself into the patient's position is the source for the depth of feeling which allows the nurse to 'put the patient first' in both mind and action. (p. 818)

7.6 Meaning

The shared meaning of the experience of presence emerged as a valued aspect of the process. Colazzi put it well:

> The nurse must attempt to enter the reality of the patient's world and to see the objective properties from his standpoint. This requires encountering the patient, co-existing with him for some moments in time and space for the purpose of mutually illuminating the experience (.p. 200).

She felt that nursing must address the meaning of the experience of health and illness to the patient. The emphasis on the meaning of the experience stems from the concepts roots in existential thought.

7.7 True Presence

Parse's Theory of Human-becoming (1992) described human beings as open beings, co-creating becoming with the universe, recognized by patterns of relating and able to exercise situated freedom. She defined the goal of nursing as enabling the patient to

achieve quality of life. In true presence, the actions of the nurse reflect the belief that the patient has within himself a unique way of being and health can be achieved via a process of the patient imagining and choosing valued outcomes. In nursing as conceptualized by Parse, the real value and power of nursing rests in the mobilization of true presence.

8 Model Case

No model case was identified in the nursing literature. Several were considered, but they did not encompass all of the identified attributes of presence or they did not evoke the experience. Some were written too abstractly to add clarity. The qualitative study of Fuller contained many examples from different cases, but no one case was self-standing. Roger's method of concept analysis does not advocate construction of a model case.

9 Presence as a Concept

Presence is intimately tied to a certain non-judgmental receptivity to the experience of the other. Empathy and self-presence (awareness) are its antecedents. Presence is dependent upon the ability to access both personal experience and knowledge in order to form a working hypothesis of the experience of the other. This is marked by the absolute willingness to abandon this hypothesis if communication of information (be it verbal or non-verbal) from the client should show a discrepancy of any kind (a stance of humility). The hypothesis is shaped in simultaneous co-creation with the patient. The nurse must be willing to drop any prior convictions about the nature of the patient's experience. There must be an openness to allow meaning to emerge from the encounter. Any editing function from higher centers will tend to interfere with the process, to introduce a layer of intellectualization, which interrupts the immediate nature of the input. That unedited quality of the feeling tones, as in empathy, must be allowed to emerge. Both parties will share in the experience and both will take from it some satisfaction. There may be a benefit to the patient in terms of pain reduction, anxiety reduction, alleviation of loneliness and perhaps healing. While writers speak of presence as occurring in a transpersonal energy field, it is unclear what aspects of communication (verbal, nonverbal, sense based or language based) are essential to the work of presence. This is

critical because these channels of person-to-person communication are not fully replicated in virtual conferencing or other modes of tele-nursing. Yet, the willingness of persons to engage in meaningful communication via telephone or chat rooms implies that people, at least some people under some circumstances, are able to compensate for these deficiencies and to benefit from tele-mediated nursing presence.

10 Implications

Although a clearer concept of presence was the end product of this process, many questions remain. If presence can indeed comfort and heal our patients, we must design studies to document this outcome. If the antecedents to presence are in fact as described above, then we must investigate whether or not there are effective strategies for teaching nurses to acquire these skills and talents. As our society moves towards greater uses of medical technology, and begins to scrutinize the value of all bedside services, it would behoove us to have a firm research base on which to rest our claims for patient benefit. We must tease out those essential aspects of person-to-person interaction which are required for the experience of presence, and evaluate how technology mediated interactions may differ.

Initial conversations with psychiatrists and patients currently receiving care via real time streaming video technology indicate that clients seem far less disconcerted by the technology that many clinicians had speculated. One psychiatrist mused that in today's television dominated culture, many patients are already accustomed to becoming engaged with a story line and its characters via television. Thus they are already primed to engage with a health care provider via similar technology.

A qualitative research project to interview chronically mentally ill clients receiving part of their care via real time streaming video technology has been designed and is in its preliminary stage. Bracketing interviews to try to suspend researcher preconceptions re: the possible inhibiting or facilitating effects of such technology on the quality of the provider-client relationship are underway. A related project at the University of Tennessee College of Nursing is underway to explore the relationship of nurse trait

empathy with the patient care quality outcomes for a major tele-nursing center (pimary investigators: Mary Gunther and Ginger Evans). This type of work is key to the preservation of the caring moral imperative of nursing as new technologies are broadly adopted. I believe that nursing's commitment to the holistic care of the patient and our claims to promote health have found favor with nurses and clients because they resonate with our cherished beliefs and experiences about the care giving relationship. But, nursing theories which do not also clearly rest on research will not meet the societal expectations of a profession.

As we move to integrate emerging technologies into new models of health care delivery, nurses must adjust to a world in which the client may no longer be physically present in the same space as the nurse. Instead, the client may interact with the nurse via streaming video technology or the patient may only be represented by lab values or imaging studies relayed via the internet. For the patient, the nurse may be a disembodied voice, a video image, or a text message. As Sandowlowski writes "The posthuman conflation of bodies and information poses the greatest challenge yet to the secure place, presence, and identity of nursing in health care." (2002).

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