

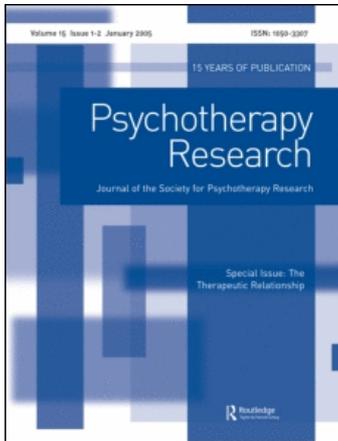
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Therapist and client perceptions of therapeutic presence: The development of a measure

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Abstract

The authors developed two versions of a therapeutic presence measure, based on an earlier model of presence (Geller & Greenberg, 2002)—Therapeutic Presence Inventory—therapist (TPI-T) and client (TPI-C) versions—to measure in-session therapeutic presence. They explored their reliability and validity in two studies. In the first, items generated from the previously established model were subjected to analyses and expert ratings. In the second study, therapists and clients rated therapists' presence postsession. Therapists also completed the Relationship Inventory, and clients assessed two additional factors: session outcome, using the Client Task Specific Measure—Revised, and therapeutic alliance, using the Working Alliance Inventory. Findings revealed that both versions of the TPI had good reliability and construct validity. However, TPI-T had low predictive validity and the TPI-C showed good predictive validity. In particular, clients reported positive therapeutic alliance and change following sessions when they felt their therapist was present with them.

Keywords: experiential/existential/humanistic psychotherapy; process research; psychotherapist training/supervision/development; test development

Therapeutic presence is defined as bringing one's whole self into the encounter with clients, by being completely in the moment on multiple levels: physically, emotionally, cognitively, and spiritually (Geller & Greenberg, 2002). Presence involves (1) being fully in contact with one's self in the moment, while being (2) open, receptive, and immersed in what is poignant in the moment, with (3) a larger sense of spaciousness and expansion of awareness and perception (Geller & Greenberg, 2010). This grounded, immersed, and expanded awareness is accompanied by (4) the intention of being with and for the clients, in service of their healing process (Geller & Greenberg, 2010). The inner receptive state involves therapists' complete openness to clients' multidimensional internal world, including their bodily and verbal expressions, as well as openness to their own bodily experience of the moment in order to access the knowledge, professional skill, and wisdom embodied within. Being fully present then allows for an attuned responsiveness that is based on a kinesthetic and emotional sensing of the other's affect and experience as well as one's own intuition, skill, and the relationship between.

Therapeutic presence has been proposed as an essential therapeutic stance (Bugental, 1987, Geller, 2001; Geller & Greenberg, 2002, 2010; Hycner, 1993; Hycner & Jacobs, 1995; May, 1958; Schneider & May, 1995; Shepherd, Brown & Greaves, 1972; Webster, 1998). Therapeutic presence can increase the therapist's listening and attunement skills and provide a more effective way to respond to a client that is right for that person in that moment. Presence also allows the therapist to work at a relational depth, which further deepens the therapeutic relationship so the client can feel open and safe to work with difficult issues (Mearns, 1997; Mearns & Cooper, 2005).

Geller and Greenberg (2002) constructed a model of therapeutic presence based on a qualitative study of interviews with seven expert therapists. The model of therapeutic presence included three broad categories essential to therapeutic presence: preparing the ground for presence, the process of presence, and the actual in-session experience of presence. The latter two categories (process and experience of presence) were used as the basis for developing the self-report measures, given that the current study

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was focused on developing a measure of in-session therapeutic presence. The first category, preparation of presence, was not drawn on for the development of the TPI for two reasons. First, the development of the TPI was focused on in-session therapeutic presence (vs. pre-session and life practices that are reflected in the preparation category). Second, it was deemed complicated to measure one's personal life commitments and the relationship with in-session presence, and this exploration seemed more appropriate as a separate study.

Although there is overlap between the larger categories of the process and the experience of therapeutic presence, there is also distinction. The process of presence, which can be subdivided into the three categories of receptivity, inwardly attending, and extending and contact, refers to the processes or activities that the therapist engages in when being therapeutically present, or what the therapist "does" when he or she is present (Geller & Greenberg, 2002). Although presence comes from within, it is expressed in different internal processes and external behaviors, which allows for a relational presence and deepening connection to occur. In brief, the process of presence involves receptively taking in all aspects of the client's in-the-moment experience, inwardly attending to how that experience resonates in the therapist's own body along with an openness to the therapist's own intuition and professional knowledge in relation to the client's in-the-moment experience, and extending and making contact with the client from this internal experiential awareness of the moment.

Therapists' in-body experience of presence reflects what they feel or experience when they are being fully present and includes four categories: immersion, expansion, grounding, and being with and for the client (Geller & Greenberg, 2002). The experience of presence involves a sense of immersion in the moment with clients while feeling an expansion of awareness and sensation, being tuned into the many nuances that exist in any given moment with the client, within the self, and within the relationship. The experience also consists of feeling grounded in a healthy and integrated experience of self, while entering the clients' experiential world and any other felt experience. Finally, therapists are present while maintaining the intention to be with and for the clients in their healing process.

Although there is some overlap of the qualities of presence and Rogers' (1957) therapist-offered conditions (TOCs) of empathy, congruence, and unconditional positive regard, we believe that presence is a distinguishable quality that provides a foundation for and encompasses all of the conditions.

Rogers himself noted the importance of therapeutic presence:

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 my self is very clearly, obviously present (cited in Baldwin, 2000, p. 30).

Rogers suggested that presence may be a larger condition or fluid TOC. However, existing measures of the TOC, most notably the Relationship Inventory (RI; Barrett-Lennard, 1986), do not assess this overarching quality.

Although the therapeutic alliance has been shown to be an essential ingredient in therapeutic change (Bordin, 1979; Horvath & Greenberg, 1986; Lambert & Barley, 2001; Lambert & Simon, 2008), there exists a gap in knowledge of which factors contribute to a positive therapeutic alliance (Horvath, 1994). Safran, Crocker, McMains, and Murray (1990) identified three key therapist features that impact a positive alliance: the therapist's recognition of here-and-now relationship problems as they occur, use of the alliance rupture to explore client's negative experiences and feelings, and the therapist's ownership of personal struggles in the therapeutic relationship and how this contributes to the client's negative experiences and feelings. The theme in both the research on client and therapist factors involves a focus on the here-and-now relationship and awareness of the present-moment experience both in the therapist and in the client.

Presence has been posited as an essential step in building and maintaining a therapeutic relationship and alliance with the client (Bugental, 1987; Hycner & Jacobs, 1995; Geller & Greenberg, 2002, 2010; Rogers, 1980). However, the existing measures of the alliance (Working Alliance Inventory [WAI]) and the therapeutic relationship (RI) do not include aspects of presence, and no research measure exists to date to substantiate that claim.

More recently, references to mindfulness have exploded in the literature (Bien, 2006; Cole & Ladas-Gaskin, 2007; Germer, 2005; Germer, Siegel, & Fulton, 2005; Hick, 2008; Linehan, 1993; Mace, 2008; McKay, Brantley, & Wood, 2007); however, we see therapeutic presence and mindfulness as distinct in two important ways. First, mindfulness is a technique that can help to cultivate the experience of presence. Second, mindfulness is primarily presented in the literature as an approach to work with one's own or with the client's internal world, whereas

therapeutic presence is an internal and relational therapeutic stance that includes the therapist's present-centered sensory attention in direct relation to the client's in-the-moment experience. Roemer and Orsillo (2009) contend that in cultivating a present-focused therapeutic stance, beyond just mindfulness practice, research is clearly needed to guide the recommendations for optimal therapist training. The development of a measure of therapeutic presence, which does not exist to date, would provide the basis for further research and training in therapeutic presence.

Hence, the goal of the current study is to develop a self-report measure of the in-session process and experience of therapeutic presence from both the client's and the therapist's perspectives as well as to explore the reliability and validity of these versions of the measure. The development of a therapeutic presence measure can help to identify whether presence correlates with these important factors (therapeutic alliance and aspects of TOC), which have been shown to explain variance in treatment outcome (Lambert & Barley, 2001).

Study 1: Development of the Therapeutic Presence Inventory, Therapist and Client Versions

The main goal for this aspect of the study was to develop and refine two versions of the self-report Therapeutic Presence Inventory (TPI)—therapist (TPI-T) and client (TPI-C)—to measure in-session therapeutic presence (Geller, 2001).

There were four stages to the development of the TPI-T: item selection, item refinement, scale construction, and scale refinement/construct validity. Each stage built on the results and findings of the previous stage. A fifth step involved the development of a preliminary measure of clients' perception of therapists' presence (TPI-C).

Item Selection

The items were formulated to meet the following objectives: Items should represent the process and the experience of presence, and their components, in the model of therapeutic presence, and satisfactory items should discriminate between absence and presence of the process and the experience of therapeutic presence. In formulating the items, we used simple and straightforward phrasing of items to maximize face validity, relevance, and readability. As well, several items were written referencing the same construct to allow for choosing the most suitable items.

One hundred fifty items (75 items each for the process of presence and the experience of presence) were generated by extracting the central sentences and themes used in the development of the model of therapeutic presence. For the process of presence, 25 items from each category (receptivity, inwardly attending, and extending and contact) were generated. For the experience of presence, 25 items were chosen from each of the first two categories (immersion and expansion), 10 from the third category (grounding), and 15 from the fourth category (being with and for the client). The ratio of items chosen reflected the ratio of items representing the categories developed in the model. There was a balance of items reflecting when presence was present or absent.

Item Refinement

Two expert raters (one male and one female) independently reviewed the list and eliminated items that were thought to be redundant, wordy, unclear, or difficult to rate in a questionnaire format, leaving a revised list of 84 items. A second review by two other experts resulted in the elimination of 52 additional items. The final list of 32 items reflected the core aspects of the process and the experience of therapeutic presence.

Scale Construction

The 32 items of the TPI-T included an equal number of positive and negative statements (16 each). Each item was presented on a 7-point Likert scale ranging from *completely* to *not at all*. Sixteen of the 32 items reflected the process aspects of therapeutic presence (seven positively written and nine negatively written). Six of these 16 items reflected receptivity, five reflected inwardly attending, and five reflected extension and contact. The remaining 16 items (nine positively written and seven negatively written) represented the experience of therapeutic presence. Four of these items reflected immersion, six reflected expansion, three reflected grounding, and three reflected being with and for the client. Although there was some overlap of items from category to category, the best fit was chosen through discussion with an expert rater and examination of the categories.

Scale Refinement/Construct Validity

To ensure construct validity of the TPI-T, nine expert raters, two women and seven men, were asked to review and rate the 32-item TPI-T. All experts were currently in a clinical practice and had been practicing psychotherapy for a minimum of

10 years. Six practiced from an experiential perspective, two from an existential perspective, and one from a dialogical perspective. The experts were provided a brief definition of presence as well as the 32-item TPI-T and were asked to perform several tasks. The first was to rate items on a scale of 1 (*clearly related to presence*) to 5 (*clearly negatively related to presence*). After confirming that the expert ratings classified all items as positive or negative, the rating was converted to a score of 1, 2, or 3. A score of 1 indicated that the item was “clearly” related to presence (scores of 1 and 5 were combined to reflect items clearly reflecting presence and non-presence). A score of 2 indicated that the item was “somewhat” related to presence (scores of 2 and 4 were combined to reflect items somewhat reflecting presence and nonpresence). Items for which experts indicated no relationship or gave a neutral or “I don’t know” response were scored as 3, classifying these items as unclear. A mean rating for each item was calculated; six items were omitted based on a mean rating of 2 or greater.

For the second task, the experts were asked to rate the original 32-item TPI-T after two sessions with two separate clients, one after a session in which they felt they were highly present and one after a session in which they felt they were not present. All 32 items were used to test the presence measure in order to further validate the items that accurately represented presence. Scores on TPI-T rated after high- and low-presence sessions were compared using a paired-sample *t* test. Those items that were not found to differ significantly between therapist-reported “highly present” sessions and “not present” sessions were omitted from the final version of the measure. Findings indicated that there were significant differences between high and low presence on all items except for three, one of which was identified in the first task as not representative of presence. Hence, a total of eight items identified as not reflective of presence were eliminated, six from the first task and two from the second, based on expert ratings.

The third task for experts was to provide general feedback on the items of the scale as a whole. An examination of expert comments confirmed difficulties with four of the eight items that were eliminated from the first two tasks. Three additional items were identified as difficult, and also had a high overall mean rating on the first task (range, 1.8–1.9), and were eliminated, and one item was reworded.

Additional analyses confirmed that the remaining 21 items reflected therapeutic presence. The overall total score on the 21 items was calculated from experts’ ratings on sessions in which they felt they were highly present and sessions in which they felt

they were not present. Paired *t* tests on total scores indicated that therapist-identified “highly present” sessions were rated significantly higher than “not present” sessions, $t(8) = 9.92, p < .001$.

The 21-item revised TPI-T consisted of 11 positively written items and 10 negatively written items. Ten of the 21 items reflected the process aspects of therapeutic presence (receptivity, $n = 4$; inwardly attending, $n = 2$; extending and contact, $n = 4$). The remaining 11 items represented the experience of therapeutic presence (immersion, $n = 4$; expansion, $n = 4$; grounding, $n = 1$; being with and for the client, $n = 2$). Again, overlap occurs, with items reflecting more than one category, but the best fit was chosen. The TPI-T was demonstrated to have good face validity because it is based on the model of therapeutic presence as well as expert comments and ratings.

Development of Preliminary Measure of Clients’ Perception of Therapists’ Presence

To assess whether there were differences between how therapists rated their experience of presence and how clients perceived therapists’ presence, a measure of client-perceived therapeutic presence was developed. The development of the TPI-C involved two steps: (1) generating items from the TPI-T and the model of presence that could be reflected in clients’ experience and (2) refining the items to a measure that reflected the process and experience of clients’ perceived presence of the therapist.

Item and Scale Development

The researchers initially selected a sample of 15 items that both (1) reflected the model of therapeutic presence and (2) were reflected in the TPI-T. Items were chosen based on ability to convert from a therapist-rated item to a client-perceived item and ease in rating as a perceived presence item. These items were worded to reflect clients’ perceptions of therapist presence and placed in a questionnaire format similar to the TPI-T.

Item and Scale Refinement

Three of the 15 items were chosen by the primary researcher and one expert rater for client’s perception of therapist’s presence: “My therapist’s responses were really in tune with what I was experiencing in the moment” to reflect the process of therapeutic presence; “My therapist was fully there in the moment with me” to reflect the experience of therapeutic presence; and “My therapist seemed distracted” to reflect client’s perception of the therapist not being present and to serve as a check for acquiescent responding. The three items were set

to the same 7-point Likert scale used for the TPI-T. The TPI-C has good face validity because items chosen were based on the model of therapeutic presence as well as confirmation from expert raters.

Study 2: An Exploration of the Reliability and Validity of the Therapeutic Presence Inventories

Method

The main goal for this study was to explore the reliability and validity of the 21-item revised TPI-T and the three-item TPI-C.

Participants

Therapists and clients participated in one of two randomized clinical trials on the treatment of depression, one at York University (Goldman, Greenberg, & Angus, 2006) and the other at Ontario Institute for Studies in Education/University of Toronto (Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003), and were administered the TPI-T and TPI-C, respectively.

Therapists. There were 25 (21 female and four male) therapists in the current study. Four were registered psychologists, two had their PhD in clinical psychology but were not yet registered, and 19 were advanced doctoral students. Eight therapists offered cognitive-behavioral therapy (CBT), four offered only process-experiential therapy (PE), and the remaining 13 therapists offered both PE and client-centered (CC) therapy. Therapists ranged in age from 26 to 46 years ($M = 36.06 \pm 5.65$ SD), and ranged in experience from 1 to 15 years ($M = 5.8 \pm 4.62$ SD).

The therapists who offered PE and CC intervention received 24 weeks of manualized training by two experts in these modalities (Greenberg, Rice, & Elliott, 1993; Greenberg, Rice, & Watson, 1994). In the year before commencement of the study, they received training in CC therapy for 8 weeks as well as an additional 8 weeks each in two-chair and empty-chair work. The CBT therapists received 12 weeks of manualized training by an expert in this modality (Beck, Rush, Shaw & Emery, 1979, Padesky & Greenberger, 1995). The therapists in all conditions also received weekly supervision throughout the study.

Clients. The sample consisted of 114 clients (39 men, 75 women) who met *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition [DSM-IV]; American Psychiatric Association, 1994) criteria for major depression and scored at least 50 on the Global Assessment of Functioning scale of the DSM-IV. Intervention distribution was as follows: CBT, $n = 33$; PE, $n = 63$; CC, $n = 18$. Clients

ranged in age from 21 to 65 years ($M = 40.78 \pm 10.34$ SD); 45 (39.5%) were never married, 44 (38.6%) were married, 24 (21.1%) were separated or divorced, and one (0.8%) was widowed. In terms of education, 26 (22.8%) had completed high school, 65 (57%) had postsecondary school or college training, and 23 (20.2%) had a postgraduate degree. One hundred two (89.5%) clients were Caucasian, nine (7.9%) were Asian, and three (2.6%) were Hispanic. There were no significant differences between treatment groups on any of these variables.

Measures

TPI-T. For each of the 21 items of the TPI-T, therapists were asked to rate their predominant experience—presence or nonpresence—during the session just completed using a 7-point Likert scale ranging from *completely* to *not at all*.

TPI-C. This measure was formatted similarly to the TPI-T, but its three items were structured for clients to assess their experience of therapist presence or absence.

WAI (Horvath & Greenberg, 1989). The 12-item WAI (short form client version) assesses the therapeutic alliance. Each of three subscales—Bond, Goal, and Task—contains four items reflecting an aspect of the client-therapist relationship. Using a 7-point Likert scale, clients rate the degree to which the items characterized their relationship. The WAI has been demonstrated to have internal consistency (range, .87–.93) and good predictive validity (Horvath & Greenberg, 1989).

Client Task Specific Measure (CTSC-R; Watson, Schien, & McMullen, 2010). The CRSC-R focuses on tasks involved in therapy and relationship conditions, measuring in-session change (Behavior Change subscale, 13 items) and clients' greater self-awareness and trust (Awareness and Understanding subscale, three items). Using a 7-point Likert scale, clients rate the degree to which each item reflected changes in intrapsychic conflict, problematic reactions, and interpersonal problems based on the session just completed. The CTSC-R has been demonstrated to have high internal consistency (range, .94–.97), high item-total correlations (range, .90–.96), and good predictive validity for outcome in depression (Watson et al., 2010).

RI (Barrett-Lennard, 1973). The 40-item short form, therapist version, was used to assess the relationship between therapeutic presence and the core conditions of the therapeutic relationship, including empathic understanding, congruence, level of regard, and acceptance. RI has been shown to have split-half reliability, with coefficients for the therapist data ranging from .88 to .96. The RI has also been

shown to have good predictive validity with respect to outcome (Barrett-Lennard, 1986).

Procedure

Clients who were found suitable and who consented to treatment were offered 16 sessions of individual psychotherapy once a week and were randomized to treatment. After each session, clients were asked to complete a packet containing a number of measures. The measures of interest for the therapeutic presence study were the CTSC-R and the WAI. The TPI-C was added at Sessions 3, 6, 9, 12, and 15.

Therapists completed the TPI-T immediately after Sessions 3, 6, 9, 12, and 15 and the RI after Session 12. To further protect against socially desirable responding and prevent any carryover response from one session to another, the therapist questionnaires were provided every third session commencing from the third session. This was to protect against therapists answering dishonestly if they felt they had a few bad sessions in a row and must hide that information.

We began the study immediately after the third session based on the general notion that the therapeutic relationship is generally not well established until or after three sessions (Barrett-Lennard, 1986; Horvath & Greenberg, 1986). Providing the measure before the third session seemed pointless and taxing on therapists when they were only just beginning to make contact with their clients. In addition, it was assumed that this delay in reporting would allow time for the dyad to establish a relationship and for presence to be a naturally occurring part of the therapist's style.

Presence is thought to be a state condition that can vary from session to session. Hence, questionnaires from therapists and clients in each dyad in all five sessions (Sessions 3, 6, 9, 12, and 15) were independently used in the analysis assessing reliability and validity of the questionnaire.

Results: Reliability and Validity of the TPI-T and TPI-C

Factor Analysis

Items on the TPI-T and TPI-C were submitted to a principal-axis analysis to explore whether the scale reflected one or more factors. All the items on both measures loaded greater than .40. On the TPI-T, the 21 items fell under one main factor with an eigenvalue of 10.50, reflecting 50.01% of the variance (see Table I for factor loadings). Similar results were found based on a factor analyses on each of the three therapy types, with one central factor emerging (eigenvalue range, 8.95–11.95) accounting for a range of 45.34 to 53.29% of the variance. Further

Table I. Factor Loadings for the 21-Item Therapist Presence Inventory-Therapist Version: Principal-Axis Analysis ($n=522$)

Item	Factor loadings 1
1. I was aware of my own internal flow of experiencing.	.42
2. I felt tired or bored.	.58
3. I found it difficult to listen to my client.	.69
4. The interaction between my client and I felt flowing and rhythmic.	.78
5. Time seemed to really drag.	.54
6. I found it difficult to concentrate.	.73
7. There were moments when I was so immersed with my client's experience that I lost a sense of time and space.	.55
8. I was able to put aside my own demands and worries to be with my client.	.71
9. I felt distant or disconnected from my client.	.80
10. I felt a sense of deep appreciation and respect for my client as a person.	.64
11. I felt alert and attuned to the nuances and subtleties of my client's experience.	.82
12. I was fully in the moment in this session.	.82
13. I felt impatient or critical.	.61
14. My responses were guided by the feelings, words, images, or intuitions that emerged in me from my experience of being with my client.	.68
15. I couldn't wait for the session to be over.	.64
16. There were moments when my outward response to my client was different from the way I felt inside.	.61
17. I felt fully immersed with my client's experience and yet still centered within myself.	.82
18. My thoughts sometimes drifted away from what was happening in the moment.	.63
19. I felt in synchronicity with my client in such a way that allowed me to sense what he/she was experiencing.	.79
20. I felt genuinely interested in my client's experience.	.75
21. I felt a distance or emotional barrier between my client and myself.	.74
Eigenvalue	10.50
Variance	50.01%
Alpha coefficient	.94

analyses were conducted for each therapy session, with one central variable emerging (eigenvalue range, 9.44–10.98) accounting for a range of 44.93 to 52.26% of the variance. Hence, the 21 items were viewed as composing a single score, labeled therapeutic presence, which further supported the construct validity of the measure. Hence, the total score of the TPI-T was used in the remainder of the analysis.

On the TPI-C, the three items resulted in one factor with an eigenvalue of 2.03, accounting for 67.59% of the variance (see Table II for factor loadings). Similar results were found across the three therapy types, with one factor emerging (eigenvalue

Table II. Factor Loadings for Three-Item Therapist Presence Inventory-Client Version: Principal-Axis Analysis ($n=364$)

Item	Factor loadings 1
1. My therapist was fully there in the moment with me.	.91
2. My therapist's responses were really in tune with what I was experiencing in the moment.	.87
3. My therapist seemed distracted.	.67
Eigenvalue	2.03
Variance	67.59%
Alpha coefficient	.75

range, 1.9–2.11), accounting for 64.27 to 70.3% of the variance. Results were also similar for each therapy session, with one factor emerging (eigenvalue range, 1.80–2.30) accounting for 60.13 to 76.62% of the variance. These findings reflect a unidimensional measure with good construct validity. Hence, a composite score of the three items in the TPI-C was used in future analyses to reflect client's perceptions of therapist presence.

Preliminary Analyses

An investigation was conducted to see whether there were differences between the sessions (3, 6, 9, 12, and 15) and therapy types (CBT, PE, CC) on the TPI-T and the TPI-C separately. A repeated measures analysis of variance (ANOVA) was computed on the TPI-T total score and TPI-C total score of all measures across sessions and therapy type. No interaction effects between session number and therapy type were found for either measure. Further investigation showed no significant differences between the sessions on the TPI-T or the TPI-C. Hence, TPI-T and TPI-C measures across all sessions were used in the remaining analyses.

Significant differences were found between the therapy types on the TPI-T, $F(2, 111) = 28.54$, $p < .01$, and TPI-C, $F(2, 81) = 13.21$, $p < .01$. Bonferroni post hoc tests indicated that CBT therapists rated themselves lower on the TPI-T than did PE therapists and CC therapists, and PE therapists rated themselves lower than CC therapists. Bonferroni post hoc tests on the TPI-C indicated that CBT clients rated their therapists lower than did PE and CC clients, but PE and CC clients were not significantly different from each other on their perception of therapist presence. Because the TPI-T differed among all therapy types, further analyses will control for these differences. An interesting and similar finding was that the RI also differed among therapy types, with CBT therapists rating themselves lower than PE and CC therapists on aspects of the therapeutic relationship.

Preliminary ANOVAs were also conducted among therapists across both versions of the presence measure, and results indicated no differences. Hence, a simpler model was conducted in future analyses because we determined that results from a mixed model would not be substantially different from what we obtained.¹ Further, we could not account for therapist effects in the current sample through nesting in a mixed model, given that therapists only saw two to four clients each and there would have been too many cells to provide for a thorough analysis.

To investigate the relationship between therapists' experience of presence and clients' perception of therapist presence, we calculated TPI-T and the TPI-C correlations with each other on the whole group and across therapy types. Significant correlations were found for the group as a whole. Although statistically significant, this finding is a result of a large sample size and may not be clinically or descriptively significant because the correlation on the whole group was low ($n = 358$, $r = .20$, $p < .01$). The lack of strength in the relationship between therapists' and clients' ratings on the presence measures was similar when examined across therapy types. For example, the TPI-T and TPI-C were modestly correlated in the CBT group ($n = 85$, $r = .25$) and not significantly correlated in the PE ($n = 187$, $r = .12$) and CC ($n = 86$, $r = .09$) groups.

Analyses were conducted to confirm the reliability and the relationship of the subscales in each of the additional measures used in the current study. The client measures, WAI and CTSC-R, were included to assess predictive validity with the TPI-T and TPI-C, whereas the therapist-rated RI was used to explore construct validity with the TPI-T. The reliability and scoring procedure for the current sample are described shortly.

WAI. Reliability coefficients were conducted and confirmed on the WAI on the data in the present study; Cronbach's $\alpha = .909$. Correlations among the Bond, Goal, and Task subscales of the WAI were calculated and significant correlations were found between all ($r = .712-.834$, $p < .01$). Given the significant correlation between subscales, all subsequent analyses were conducted with the total WAI scale.

CTSC-R. In the current study, Cronbach's $\alpha = .893$, indicating good reliability of the CTSC-R in this sample. With respect to scoring, the two subscales of the CTSC-R have not been shown to differentiate session change and hence are used as a total score or overall session outcome measure (Watson et al., 2010). This was confirmed in our sample, where subscales were significantly correlated with each other ($r = .70$, $p < .01$). Hence, an overall session outcome score was used for the CTSC-R.

RI. In the present study, the following Cronbach's alphas were calculated for each subscale: Empathy, .89; Unconditionality of Regard, .81; Congruence, .82; and Level of Regard, .91. The RI is used in this study to examine construct validity with the presence measure; hence, each subscale was examined separately in relationship to presence.

Reliability of TPI

Reliability was calculated by computing Cronbach's alpha, with a set minimum criterion of .80. On the TPI-T, Cronbach's alpha was .94 across the total sample. Similar results were found when calculating Cronbach's alpha for data within each session (range, .93–.95). Similar results were found across the therapy types, with alpha ranging from .92 to .95. This indicated good reliability that is consistent across therapy types. On the TPI-C, Cronbach's alpha was .82 across the total sample. Similar results were found when calculating Cronbach's alpha for data within each session (range, .78–.85). Similar results were found across the therapy types, with alpha ranging from .79 to .84.

Response Bias

The response bias of acquiescent responding on the TPI-T and TPI-C was assessed by correlating the mean of the positively keyed items with that of the negatively keyed items, before the negative items were reversed, on each measure (significance level set at $p < .01$). On the TPI-T, the resulting negative correlation on the total sample was $r = -.71$. Correlations across all three therapy types ranged from $r = -.65$ to $-.77$. Results indicate that the scale, for the most part, did not evoke this form of bias from therapists in this sample. On the TPI-C, the resulting negative correlation on the total sample was $r = -.43$. Correlations across all three therapy types ranged from $r = -.35$ to $-.59$. Results indicate that the scale, for the most part, did not evoke this form of bias from clients in this sample, although correlations between positively and negatively keyed items were lower on the TPI-C than on the TPI.

Concurrent Validity

Concurrent validity was assessed by examining the relationship between therapists' ratings on the TPI-T and the TOCs of empathy, congruence, level of regard, and acceptance as measured on the RI. Table III displays the correlations between the 21-item TPI-T and the four subscales of the therapist-rated RI. The data are presented for each of the three therapy types—CBT, PE, and CC—and for the total sample combined. With regard to the total sample, the TPI-T correlated significantly with

Table III. Correlations between the TPI-T and the RI Therapist Subscales for the Total Sample and across Therapy Types

RI subscale	TPI-T			
	Total sample ($N = 278$)	CBT ($n = 86$)	PE ($n = 158$)	CC ($n = 34$)
Empathy	.59**	.53**	.56**	.71**
Congruence	.41**	.21*	.42**	.37*
Level of Regard	.34**	.21*	.32**	.36*
Unconditionality of Regard	.29**	.25*	.23**	.27

Note. TPI-T, Therapist Presence Inventory—therapist version; RI, Relationship Inventory; CBT, cognitive-behavioral therapy; PE, process-experiential therapy; CC, client-centered therapy.
* $p < .01$. ** $p < .001$.

all four subscales of the RI. Significant regression coefficients were also found between the TPI-T and all of the therapist RI subscales: Empathy, Congruence, Level of Regard, and Unconditionality of Regard (see Table IV). Wilks's lambda (converted to F) is $F(4, 271) = 30.29$, $p < .001$.

Predictive Validity

The relationship between therapists' (TPI-T) and clients' (TPI-C) ratings of therapeutic presence and clients' ratings of the therapeutic alliance and client session outcome were conducted to assess predictive validity. A multivariate regression model was used to assess regression of the independent variables (TPI-T and TPI-C) on the dependent variables (WAI and CTSC-R), controlling for therapy types. No significant interaction effects were found between the TPI-T and the therapy types on any of the dependent measures. Evaluating bivariate relationships also indicated overall nonsignificant results. No significant interactions were found between the TPI-T and the therapy types on any of the dependent measures. Multivariate test results indicated that there was no significant relationship between therapists' self-reported presence (TPI-T) and clients' reported therapeutic alliance (WAI) and

Table IV. Regression Coefficients of TPI-T and RI Subscales (Controlling for Three Therapy Types)

Dependent variable	R^2 (total) ^b	$F(1, 271)$	B^a	SE
RI Empathy	.36	116.70**	5.03	0.47
RI Congruence	.23	35.43**	3.35	0.56
RI Level of Regard	.29	20.87**	1.34	0.29
RI Unconditionality of Regard	.26	15.26**	1.69	0.43

Note. TPI-T, Therapist Presence Inventory—therapist version; RI, Relationship Inventory.

^aUnstandardized regression coefficient. ^bTotal R^2 across sample = .32

** $p < .001$.

session outcome (CTSC-R). Regression coefficients between the TPI-T and the WAI and CTSC-R were also not significant.

With respect to client perceptions of therapist presence, no significant interaction effects were found between the TPI-C and the therapy types on any of the dependent measures; hence, the homogeneity of slopes assumption was satisfied. Evaluating bivariate relationships indicated that all three therapy types showed a positive relationship between the TPI-C and the CTSC-R and WAI. Because there were no interaction effects and the relationship between the independent and dependent variables had a similar slope across all therapy types, the data were combined and submitted to a multivariate regression model. Multivariate test results indicated that there was a significant relationship between clients' reports of therapist presence (TPI-C) and reports of the therapeutic alliance (WAI) and session outcome (CTSC-R). Wilks's lambda (converted to F) is $F(5, 348) = 44.61, p < .001$. Significant regression coefficients were found between the TPI-C and session outcome and the therapeutic alliance (see Table V). Hence, clients' reports of therapist presence showed a significant relationship with clients' ratings of session outcome and the therapeutic alliance.

Discussion

This study demonstrated the development, reliability, construct, and concurrent and predictive validity of two versions of a measure of therapeutic presence: therapist self-ratings and clients' perception of therapist presence (TPI-T and TPI-C). The association between clients' perception of therapist presence and a positive therapeutic relationship and therapeutic

alliance (Bugental, 1987; Geller & Greenberg, 2002, 2010; Schmid, 1998; Thorne, 1992) was supported in the current study. An interesting finding was the correlation between therapists' ratings of presence and each of the TOCs, suggesting an association between presence and the relationship conditions, but also a difference. This supports our proposal that presence is related to empathy, congruence, and unconditional positive regard but yet is different in nature.

Presence was found to be higher in PE and CC therapies than in CBT therapy, where presence is not viewed as highly integral to the approach. The relationship conditions of empathy, congruence, and positive regard were also found to be significantly higher in PE and CC therapies compared with CBT, a finding we would expect from the theoretical value of these constructs in PE and CC therapies.

The current study found significant correlations between the subscales of the RI, which reflect previous literature suggesting a lack of independence between the TOCs. It has been suggested that the high correlations between the TOCs suggest a global therapist quality (Gormally & Hill, 1974). Perhaps therapeutic presence reflects this global quality that encompasses the TOCs and yet goes beyond them. In this vein, the relationship conditions can be seen as a way for therapists to communicate to clients that they are fully in the moment. This research is suggestive of Rogers's later postulations about the nature of presence as a possible overarching condition.

Another important finding is the predictive relationship between clients' ratings of therapist presence and having a positive change after the therapy session and sense of the therapeutic alliance, regardless of theoretical orientation of the therapy. This finding suggests an important relationship between clients' experience of their therapists' presence and having a good therapy session and therapeutic relationship.

Therapists' self-ratings of presence were not found to significantly relate to clients' reported session outcome or the therapeutic alliance. It is important to note that the latter finding is reflective of psychotherapy research in general (Duncan & Moynihan, 1994). Clients' experience of the therapist is strongly associated with session outcome and alliance, whereas therapists' experience of themselves is less significant with respect to the therapeutic alliance, process, and outcome. For example, Rogers concluded that it is the degree to which the client perceives the therapist as being unconditionally accepting, empathic, and congruent that is the main factor for good therapeutic outcome (Rogers & Truax, 1976). The findings of this study suggest that it may be the degree to which clients perceive the therapist as

Table V. Regression Coefficients of TPI-C, CTSC-R, and WAI (Controlling for Three Therapy Types)

Dependent variable	<i>df</i>	<i>F(df, 350)</i>	<i>B</i> ^a	<i>SE</i>	<i>R</i> ²
WAI					.38
Therapy type	2	2.206			
TPI-C	1	176.600**	2.258	0.438	
Therapy	2	2.100			
Type × TPI-C					
CTSC-R					.14
Therapy type	2	1.260			
TPI-C	1	43.410**	0.173	0.077	
Therapy	2	1.445			
Type × TPI-C					

Note. TPI-C, Therapist Presence Inventory—client version; CTSC-R, Client Task Specific Outcome—Revised; WAI, Working Alliance Inventory.

^aUnstandardized regression coefficient.

** $p < .001$.

present that impacts session outcome and the therapeutic relationship.

One possibility for the nonsignificant relationship between therapist-rated presence and clients' session outcome and the therapeutic alliance is that therapists may be experiencing presence within themselves but not communicating it or expressing it effectively. There may not be a one-to-one correspondence between what is experienced inside the therapist and what is expressed behaviorally. A second reason may be clients' inability to receive the potential intensity of this state of being. A theory of relationship based on therapeutic presence suggests that therapist presence will lead to clients' presence, so that they are somewhat matched in their ability to be present with each other (Geller & Greenberg, 2010). It is possible that clients need to feel open to therapists' presence, or some degree of presence within themselves, to fully experience the presence of the therapist.

In summary, we discovered that therapists' presence is related to their experience of the therapeutic relationship, and that clients' perception of therapist presence relates to session outcome and the therapeutic alliance. The development of the TPI-T and TPI-C can feasibly contribute to the developing understanding of the value of presence in the psychotherapeutic process. Hence, a theoretical exploration of how therapists develop presence and how clients can be receptive to their therapists' presence can, we hope, evolve from this initial investigation.

Limitations

A number of limitations were identified with the current study. First, self-report may have limitations in capturing such a subtle and complex internal experience as therapeutic presence. Second, the number of items ($n=3$) on the client measure is small. However, Niemi (1986) argued that measures with few items can have adequate reliability, and, in fact, scale reliability does not necessarily increase with test length. To assess this statement, analyses were conducted to see whether there would be similar results with an expanded measure. In particular, a Spearman-Brown prophecy formula was conducted, which suggested that this measure would have adequate reliability when items were doubled (α was estimated to be .86; that is, if the TPI-C three-item measure was expanded to six items, it would also show adequate reliability).

Third, although the therapies assessed in study 2 were from PE, CC, and CBT traditions, including more therapists of diverse theoretical backgrounds (i.e., CBT, psychodynamic) in the questionnaire development (study 1) may have grounded the

questionnaire development in this proposition that presence is essential across different therapy approaches.

Finally, given that therapists rated both presence and relationship domains and clients rated both perceived presence and perceived alliance, there may have been an issue of shared-method variance. Because there were no significant associations between constructs from different rating sources, shared-method variance may have been an issue.

Implications for Future Research

Future research models would benefit from incorporating behavioral observations, which may provide further understanding of the relational qualities of therapeutic presence. A comparison of behavioral cues (e.g., vocal tone, body posture, facial expression, eye contact) in both therapists and clients and in the relationship may indicate greater or lesser presence, both felt and received. From recognition of these behavioral cues, an observational rating system of therapeutic presence can be developed. Changes in physiology could also help to understand the experience of therapeutic presence. Future research could also explore client qualities that allow them to receive presence, such as openness or absorption. Clients' attachment style could also be explored in relationship to their ability to receive their therapist's presence.

Further, we suggest that a mixed-model approach could be considered for future research as a more comprehensive analysis, taking into account the nesting of clients within therapists. We determined in the current research that the mixed-model results would not be substantially different from what we obtained given that there were no differences among therapists found in the preliminary ANOVA. In fact, we are able to explain a substantial amount of information with a simpler model with the analyses we conducted. However, we do recognize that a mixed model would take into account all of the explanatory variables in their multilevel context and, therefore, may provide more confidence in, and confirmation of, the results already noted.

In conclusion, the development of the TPI-T and TPI-C and the preliminary results that indicate clients' perceived presence is related to a positive therapeutic alliance and session outcome should not be ignored. This research, combined with our previous study (Geller & Greenberg, 2002, 2010), helps to build a theory of therapeutic presence that includes both therapists' cultivation of presence and clients' receptivity to presence and the deeper relationship that can ensue from both. The measures of presence, in combination with behavioral or observational measures, can be a useful component to enhance further understanding of the holistic

concept of presence and its place in the therapeutic alliance and positive therapy process and outcome.

Note

¹ In case of interest, a scholarly reference on this point is Gelman and Hill (2007, p. 247).

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