

Mindful Presence

A Thematic Analysis of the Effects of
Mindfulness Practice on Therapeutic Presence

Niall A. Milton
Student No. 1632171

The thesis is submitted to the Quality and Qualifications Ireland (QQI) for the degree
MA in Counselling and Psychotherapy from Dublin Business School, School of Arts.

June 2015

Supervisor of Research: Mary Bartley

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	3
ABSTRACT	4
CHAPTER 1 – INTRODUCTION	6
1.1 Context	6
1.2 Aims & Objectives	7
CHAPTER 2 - REVIEW OF THE LITERATURE	8
2.1 Therapeutic Presence	8
2.2 The Neurobiology of Presence	10
2.3 Presence vs. Absence	11
2.4 Mindfulness Practice & Therapeutic Presence	12
2.5 Empirical Measures of Mindfulness & Therapeutic Presence	13
2.6 Conclusion	18
CHAPTER 3 - METHODOLOGY	20
3.1 Aims & Objectives	20
3.2 Research Sample	21
3.3 Recruitment	22
3.4 Data Collection	22
3.5 Thematic Analysis	23
3.6 Ethics	23
3.7 Limitations	25
CHAPTER 4 - FINDINGS	26
4.1 Introduction	26
4.2 Inhabiting the Present	27
4.3 Absence	31
4.4 Integration	35
CHAPTER 5 - DISCUSSION & CONCLUSION	40
5.1 Introduction	40
5.2 Inhabiting the Present	40
5.3 Absence	42
5.4 Integration	44
5.5 Conclusion	45
BIBLIOGRAPHY	48
APPENDIX A – INFORMATION SHEET	50
APPENDIX B – CONSENT FORM	52
APPENDIX C – INTERVIEW QUESTIONS	53
APPENDIX D – SAMPLE OF THEMATIC CODING	54

ACKNOWLEDGEMENTS

I would like to thank the following people:

Mary Bartley, my thesis supervisor, for her input & support.

Dr. Grainne Donohue, my research coordinator for her patience and clear instruction over the past two years.

My interviewees, who gave me their time and impressed me with their wisdom and honesty.

Finally, my mother Carol, for her love and estimable grammar skills.

ABSTRACT

Sigmund Freud spoke of therapeutic presence as emerging from an impartial, non-judgemental, evenly applied attention. Carl Rogers referred to therapeutic presence as the essential underlying process in the therapeutic relationship. It has been shown that therapeutic presence is a crosscutting concern in the therapeutic relationship regardless of modality. The quality of presence of the therapist has been found to have a positive influence on therapeutic outcomes. Emerging research in neurobiology suggests that mindfulness practice can have a positive impact on attentional abilities, working memory, present-centred focus and increased affect tolerance. The aim of this study is to enrich the existing research on therapeutic presence, to provide an investigation into the nature of absence in the therapeutic relationship and finally to support the hypothesis that mindfulness practice may be linked to increased therapeutic presence and therefore have a positive effect on therapeutic outcomes. A thematic analysis was applied to five semi-structured interviews. The findings were discussed under the following themes: Inhabiting the Present, Absence and Integration. This study found consensus among the interviewees that therapeutic presence was a core component to their work with clients and began with their own level of personal integration. The exploration of absence brought a deeper understanding to how mindfulness practice can bring more self-acceptance and less self-judgement to the therapist. Finally, the research strongly suggests that the integration of mindfulness practice may bring secondary benefits to the therapist such as increased attentional ability, an increase in perceived self-care & vitality and a decreased risk of burnout. This study found strong justification for further research on

the effects of mindfulness practice on the quality of therapeutic presence, especially in the case of longitudinal studies.

CHAPTER 1 – INTRODUCTION

1.1 Context

Over a hundred years ago Sigmund Freud (1912) described his ‘simple’ technique for working with patients as holding an ‘evenly suspended attention’ and not directing ones own attention to anything in particular. Freud claimed this spared the physician the strain of paying attention for long periods of time. More importantly Freud believed that directing one’s own attention to particular material had the effect of the practitioner following his inclinations. This is simply captured as, ‘he should simply listen, and not bother about whether he is keeping anything in mind’ (Freud, 1912). This idea is core to this research as it describes a deliberate attempt on the part of the practitioner to pay attention in the therapeutic engagement in a particular way. Carl Rogers referred to therapeutic presence as the essential underlying process in therapeutic relating (Rogers, 1980). In his later work Rogers believed that therapeutic presence underpinned his three core conditions of the person centred approach, empathy, congruence and positive regard. Now therapeutic presence is seen as an underlying component of the therapeutic relationship that cuts across most therapeutic modalities.

Research on the effects of sustained mindfulness practice suggests that cultivating grounding, centering and equanimity can expand a therapist’s ability to experience painful or intense moments in therapy with less reactivity (Lazar, et al., 2005; Siegel, 2010). With sustained practice, this allows the therapist to deeply feel another’s pain and resonate with it but also to let it go. Meditation practice has been found to calm

the autonomic nervous system thus allowing the therapist to engage with difficult feelings and sensations with clients but also to return quickly to a state of equilibrium and calm which allows for an improved quality of therapeutic presence (Geller & Greenberg, 2012). This study shall investigate the validity of the above in the context of the subjective experience of five practitioners with almost a century of therapeutic practice between them.

1.2 Aims & Objectives

The aim of this study is firstly to deepen and enrich the current research on therapeutic presence with a particular focus on preparation for presence and the moment-to-moment experience of therapeutic presence from the therapist's perspective. This research also looks at the issue of therapeutic absence, its causes and strategies for managing it. Finally, this research will investigate the specific benefits of integrating a formal mindfulness practice to the therapist with respect to therapeutic presence.

CHAPTER 2 - REVIEW OF THE LITERATURE

2.1 Therapeutic Presence

Geller and Greenberg (2002) define therapeutic presence as bringing one's whole self to the engagement with the client and being fully in the moment with and for the client, with little self-centred purpose or goal in mind. This involves the therapist using their whole self to be both receptively attuned and engaged in the present moment (Geller & Porges, 2014). Daniel Siegel describes therapeutic presence as 'the experience of openness to whatever arises in reality' or 'being open now, to whatever is' (Siegel, 2010). Buber states that healing occurs in the meeting of two people who can become fully present to each other, that in being present we are 'hallowing the everyday' (cited in Geller & Greenberg, 2002). In his later writings, Carl Rogers began discussing a precondition for his core conditions of empathy, unconditional positive regard and genuineness. This pre-condition underlying all the others he referred to as presence (Rogers, 1980). Roger's felt that when he was closest to his inner, intuitive self while working with clients, there was an increased quality of healing to his interventions.

Geller and Greenberg (2002) propose that increased therapist presence allows for an enhancement of attunement in the relationship. Affect attunement has at its core the notion that verbal and non-verbal responses from the therapist that match the client's inner feeling state are the catalyst for change. In this model, the therapist does not seek to influence, change or guide the client, but rather attempts to be as emotionally available to the client from moment to moment. The therapist makes the client aware of their availability to them through the process of active listening, displays of interest

and a soft responsive voice. The therapist's ability to accurately read the client's feeling state and provide timely responses is enhanced by a greater sense of presence in the therapeutic space.

Gabi (2008) describes therapeutic presence as the therapist's ability to be with all the therapeutic moments no matter the complexities, contradictions, difficulties, hope and loss they might contain. He makes the distinction between a form of narcissistic presence where the therapist is often unwittingly attempting to glorify themselves via intelligent interpretations that exhilarate and lend purpose to the encounter, and a presence that is focused on transformation via the experience of the co-created relationship. As Ghent (1990) suggests, there is a distinction between therapists whose emphasis is information (insight as the vehicle for change) and therapists whose focus is transformational (with change comes insight). This suggests that the therapist must moderate any sense of his or her own omnipotence in the relationship to remain truly present.

Geller & Greenberg (2012) describe a model of therapeutic presence detailing the different levels of presence possible in the therapeutic encounter. They offer that as the therapist moves from level to level, a deepening of connection is possible with the client. At the basic level, physical presence (light presence) encompasses the settling into the physical space, the initial contact with the client (possible small talk) and a basic awareness in the therapist of their own body. Psychological presence (partial presence) is hearing the client's story, or checking in and also listening with attunement, caring and openness. Emotional presence (presence with and for the other) involves responding with interventions and empathic responses in resonance

with the client. Transpersonal presence (presence with spirit) encompasses the following: body as a vessel; contact with deeper intuition; contact with spirituality. Relational therapeutic presence (all the levels) is oscillating between deep contact with the client and deep contact with oneself and being fully with and for the other yet with vitality and energy.

2.2 The Neurobiology of Presence

Daniel Siegel (2010) links the subjective experience of presence to the physical experience (in terms of neural activation) moment to moment in the therapeutic encounter. He frames this in terms of low and high levels of neuronal activation, which naturally occur in the interactions between neurons (physical) and the mind (mentalisation). The physical brain develops in response to the myriad of stimulus it receives from pre-birth to the present moment. Often these peaks and troughs are habitual and automatic, as the autonomic response has been trained over time. He suggests the key to being present is to move towards a more flexible, open plane of possibility and to recognise when rigidity and repetition are preventing a fresh outlook. The more receptive the therapist is to new stimulus in the present moment, the more they can shift into an unpredictable state where they are more receptive to new stimuli and a greater possibility exists to resonate with the client. In those terms, they may experience something of the client's physical and mental state without having direct experience of it themselves. Siegel states that mindfulness training is one way in which this state of openness may be cultivated (Siegel, 2010, p. 13).

2.3 Presence vs. Absence

It is useful to consider the various barriers to therapeutic presence and whether mindfulness practice has something to offer in mitigating them. Geller & Greenberg (2002) highlight the following: *Countertransference*: The therapist's internal or external actions shaped by past or present emotional content and vulnerabilities. Therapists are human beings and cannot be expected to be unmoved at all times by their own history as it is triggered by contact with a client. Geller & Greenberg assert that a greater level of presence can help the therapist manage their own countertransference and react appropriately. *Affect Tolerance*: Perhaps in a similar category to counter-transference, the therapist must have the ability to tolerate the affect of the client at times of intensity in the encounter. Otherwise the client may feel invalidated or unsafe if the therapist has turned away in order to protect themselves.

In their book, *Mindfulness and Psychotherapy*, Germer, Siegel and Fulton describe the effect that mindfulness practice can have on the therapeutic relationship. They describe attentional training via mindfulness as the 'antidote to a wandering mind' (Germer, Siegal, & Fulton, 2005). Mindfulness practice involves repeatedly and non-judgementally bringing one's attention back to the present moment, perhaps hundreds of times during a meditation session. Longer term, their claim is that this can have a major impact on the therapist's ability to return their focus to the client if they find their mind wandering.

2.4 Mindfulness Practice & Therapeutic Presence

The practice of mindfulness in therapy has been well documented from the client perspective (Kabat-Zinn, *Full Catastrophe Living*, 1991; Segal, Williams, & Teasdale, 2002; Siegel, 2010) but there is considerably less research into mindfulness practice and its effect on the therapist. Kabat-Zinn's definition of mindfulness is concise: Paying attention on purpose and in the present moment. Deliberate effort to maintain attention in the present moment enhances awareness of diversions from the present moment when they arise. Emotions, images and thoughts that distract from the present moment can highlight a tendency to ruminate on past memories and events or preoccupations with the future. By maintaining awareness in the present the tendency for rumination is reduced. Paying attention to the present moment means allowing whatever arises, both negative and positive, to enter into the person's experience in a non-reactive way. This is in contrast to avoidance or distraction from uncomfortable or distressing emotions and sensations. Past experiences that are associated with negative affect can eventually be met with less reactivity, worked with and integrated. Paying attention non-judgementally has the effect of softening negative self-evaluation, which can lead to destructive behaviours. Mindfulness teaches the practitioner to merely notice cognitive and emotional experiences rather than evaluating them. This increases cognitive flexibility and allows the felt sense to exist without cognitive judgement (Allen, et al., 2006).

Shapiro (2009) explored the integration of mindfulness practice in psychological settings and found there was strong evidence suggesting the integration of mindfulness into psychological work was important and viable. Shapiro & Carlson

(2009) note that sustained attention and concentration is critical for true presence in the therapeutic encounter. Geller & Greenberg (2012) link an increased level of focused attention in mindfulness practitioners to an increased ability to shift attention to different stimuli sometimes referred to as cognitive flexibility. When applied to the therapeutic encounter they found several components of mindfulness impacted the therapeutic relationship positively. Firstly, the ability of the therapist to hold sustained attention on their own experience as well as the client's led to an increase in perceived therapeutic presence. Secondly, the therapists showed higher levels of compassion both for themselves and for their clients. Henry, Schacht & Strupp (1990) showed that therapists with lower levels of self-compassion were more hostile towards their clients leading to poorer communication and negative client experiences. They linked this to poorer therapeutic outcomes due to what they called *counter-therapeutic interpersonal processes*. Thirdly, mindfulness practice has been shown to increase affect tolerance and reduce stress, tension and anxiety in the therapist leading to an increased ability to be more fully present with a client (Shapiro, Brown, & Biegel, 2007).

2.5 Empirical Measures of Mindfulness & Therapeutic Presence

A small number of studies have been conducted in order to broaden the understanding of therapeutic presence and indeed whether or not it can be measured with any accuracy. Geller & Greenberg (2002) conducted a qualitative study with seven participants comprised of experienced therapists who had published articles or books or otherwise become known for their investigations into therapist presence. The purpose of the study was to extract some common themes in the area of therapist presence and to try and formalise a model. The model that emerged was comprised of three components: preparing the ground for presence, referring to activities the therapist undertakes both pre-session and in their general life to prepare themselves for therapeutic presence. The process of presence, referring to the processes or activities the therapist is engaged in while in the therapeutic encounter. The actual in-session experience of presence, which provides a framework for describing the experience of the therapist and their sense of presence.

Geller, Greenberg & Watson (2010) conducted a further quantitative study into therapeutic presence during which they developed a measure called the Therapist Presence Inventory (TPI) of which there are two parts, the Therapist Presence Inventory - Therapist (TPI-T) and the Therapist Presence Inventory – Client (TPI-C). Their sample comprised of twenty-five therapists of varying modalities and one hundred and fourteen clients who met the DSM-IV criteria for major depression. Every third session, participating therapists completed the TPI-T and the therapist version of the Relationship Inventory (RI). Clients were asked to complete the TPI-C, Working Alliance Inventory (WAI) and the Client Task Specific Measure (CTSC-R).

These questionnaires allowed the researchers to measure the relationship between perceived presence and in-session change.

The results were then assessed to explore the relationship between therapist presence and the core conditions of the therapeutic relationship, empathy, unconditional positive regard, congruence and acceptance. The outcome of the study was that client's reported a positive change following a therapy session where they felt the therapist was present, regardless of the orientation of the therapy. Interestingly, in sessions where the therapist reported himself or herself as feeling more connected and present, the client did not necessarily report any difference from their perspective. The authors of the study hypothesise that while the therapist may subjectively be feeling more present, he or she may not be communicating it via body language and expression in the session. Part of their conclusion was to draw a distinction between the subjective experience of presence by the therapist and a more relational notion presence where a greater sense of presence is experienced by both parties within the relationship (Geller, Greenberg, & Watson, 2010).

In a study on the effects of pre-session centering using mindfulness for therapists on presence and effectiveness, Dunn et al. (2013) sought to discover whether mindfulness skills practiced by therapists had a perceptual effect on the outcome of their work with clients. They took 25 practicing trainee therapists and had them complete the TPI-T over a two-week period. Their clients were asked to complete the TPI-C. Of the population, a control group of therapists did not use any mindfulness or centering exercises prior to their sessions. Several interesting results were observed. Firstly, therapists that practiced mindfulness centering exercises prior to their sessions

reported increased perceived levels of presence in their sessions. The control group, who had not practiced the exercises, reported a lower perceived level of presence according to the TPI-T. Secondly, the researchers sought to correlate this result with the client's perceived level of presence in the therapist, they did not find any appreciable difference between the mindfulness group and the control group, regardless of preparation, the clients reported high levels of presence in both groups. However in terms of reported efficacy of the session, clients reported higher results in the mindfulness group. This outcome suggests that while no conclusion could be made about client's level of perceived presence in the therapist, there may be some component of mindfulness practice pre-session that has an effect on the perceived efficacy of the session (Dunn, Callaghan, Swift, & Ivanovic, 2013).

Collum & Gehart (2010) conducted a qualitative study on whether mindfulness practice would be of benefit to marital and family therapists (MFTs) during their training and early periods as practitioners. Unlike the previous studies, they did not use the TPI-T or TPI-C but rather performed a thematic analysis on weekly journal entries from 13 student MFTs willing to participate in the study. Two aspects of therapeutic presence and mindfulness emerged from the analysis. Firstly, being able to attend to their inner experience during sessions. Secondly, increased awareness of what was happening for the client. They reported being able to hold both these perspectives without becoming overly involved in one or the other, even in the case of difficult or emotionally demanding content in the session. Students attributed this increased feeling of being with the client in this way to the formal practice of meditation. The consensus was that meditation helped increase calmness in general, but also helped them become more aware of their inner chatter and to slow down a

sense of hurry or pressure in sessions. Finally, some of the participants used meditation to form a boundary between sessions or when arriving at clinical settings, this allowed them to set aside previous sessions or the outside world and focus on being present for the current client's session (Collum & Gehart, 2010). The researchers conclusion on the study was that while the sample size was limited, enough consensus existed to suggest positive benefits of mindfulness meditation to therapists in training. The fact that student therapists were used in the study does not automatically suggest that the findings would translate to more experienced practitioners. This highlight an area for further research.

Geller & Porges (2014) researched therapeutic presence as a catalyst for an increased sense of safety for both the therapist and client using real clinical vignettes. They use poly-vagal theory to explain this effect. This theory proposes that evaluation of safety is a continuous unconscious process that is occurring constantly in the therapeutic engagement mediated by the autonomic nervous system. Safety is communicated automatically via markers of social engagement (e.g. gestures, facial expressions, gestures and vocalisations). Their hypothesis is that cultivating therapist presence via mindfulness practice has the secondary gain of down-regulating learned defensiveness in the client. This creates a psychological state in both client and therapist that promotes growth and change. In one interview in the study with an experienced therapist using mindfulness meditation the therapist identifies two benefits of using mindfulness to enhance present moment awareness. She was more aware of the moment to moment connection with the client, noticing particularly moments of disconnection and the therapist's mindfulness practice prior to the session allowed her

to self regulate, better manage her own counter-transference and remain in richer contact with the client.

According to Geller & Greenberg (2002) compassion is a component that arises naturally from, and contributes to, the experience of therapeutic presence. Compassion is action arising from a desire to understand and alleviate the suffering of another. Compassion for self and for others is an integral part of mindfulness practice. In a qualitative study of fourteen Therapists, Vivino et al. (2009), found that compassion is broader than empathy in the sense that it is not sufficient to sit and resonate emotionally with a client but rather there is a component of taking action on the part of the therapist. They found that the cultivation of compassion for others involved primarily the active investigation and engagement in healing one's own suffering and pain. The implication here is that quality of presence with the client is in some way linked to the integration of a compassionate wish for oneself.

2.6 Conclusion

There is sufficient qualitative evidence to suggest that mindfulness practice can enhance the practitioner's ability to be more present in session through increased awareness and attention. As the primacy of the relationship is emphasised in modern psychotherapy, training for presence would seem to offer something to the therapeutic relationship as well as to the therapist.

Of the studies conducted, several of the more compelling results were from studies focused on Therapists in training. This suggests that attentional training using

mindfulness may be an asset to trainees in order to mediate their own responses in therapy. There is a suggestion here that more research is required using experienced therapists as the sample population. There is an open question remaining after reviewing the literature whether increased presence actually develops naturally with experience. As the therapist's experience of himself or herself in relationship broadens, presumably so does their ability to tolerate negative affect. This will be a feature of this current research.

Finally, there is lack of qualitative research on the topic of mindfulness and therapeutic presence despite a well-defined measure and methodology for measuring the relationship between presence and therapeutic outcomes. More research is required in this area to re-enforce the compelling hypothesis that preparing for presence via mindfulness can improve the quality of the therapeutic relationship and also have a positive effect on therapeutic outcomes.

CHAPTER 3 - METHODOLOGY

3.1 Aims & Objectives

A qualitative method was chosen for this research in order to allow for the rich inter-subjective experience of the practitioner to be explored. According to McLeod (2003) key components of qualitative research that lend themselves to this particular subject more so than quantitative research are: the interpretation of meaning rather than the measurement and analysis of variables; the necessity for reflection and self-awareness in the researcher; the researchers ability to interpret language as data. In order to elicit the qualities of the therapist's experience, the qualitative approach allows for a rich analysis of the dialectic between researcher and participant. The aim of this research is to explore the impact of formal mindfulness practice on a therapist's subjective experience of presence. The goal of a thematic investigation is to find commonalities in experience between participants while also illuminating the experience of the individual (McLeod, 2003).

Aim of Thesis:

The overall aim of this study is to explore the possible impact of mindfulness practice on therapeutic presence.

Objectives of Thesis:

- To explore the therapist's subjective opinions and experiences of therapeutic presence
- To explore impediments and difficulties in achieving and maintaining therapeutic presence, resulting in absence.
- To explore the potential value of mindfulness practice with regard to therapeutic presence
- To identify aspects for further research in this area which would add knowledge to the field of humanistic and integrative psychotherapy.

3.2 Research Sample

The participants were selected on the basis of membership of a professional body such as the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP) or the Irish Association of Counselling and Psychotherapy (IACP) and the requirement that they be currently engaged in one-to-one psychotherapy. The research population consisted of five qualified psychotherapists: three male and two female. Four of the participants had received similar training as humanistic and integrative psychotherapists; the remaining one had received training in psychosynthesis with Eckhart House. All participants had been working for more than ten years in private practice. Four of the participants had trained in a formal mindfulness course previously with three of the participants having trained as mindfulness teachers themselves. There were no exclusion criteria in the research sample and experience with mindfulness was considered a benefit but not a requirement.

3.3 Recruitment

The recruitment process involved randomly selecting and emailing various counselling centres in the greater Dublin area with an outline of the research and a call for participants. The centres were selected on the following basis: being places where therapist's work privately e.g. Mind And Body Works or The Newlands Institute; organisations advertising mindfulness based approaches on their public website e.g. 'mindfultherapy.ie'. An attachment with the introductory email outlined the purpose of the research and the nature of the thesis (see Appendix A). Initially there were two respondents to the unsolicited emails. The rest of the respondents were recruited using the snowballing technique (McLeod, 2003) where the first two participants provided contact details for another two. The final participant was recruited via the researcher's supervisor who knew a therapist with an interest in the subject. Furthermore during the selection process, the researcher was cognisant of maintaining a gender balance in the population as much as possible so had there been four male respondents initially for example, only three of those would have been selected for interview.

3.4 Data Collection

Data collection took the form of semi-structured interviews with questions derived from broad themes extracted from the existing literature as described by McLeod (2003, p. 74). All interviews were conducted at a time and location of the interviewee's convenience. Each interview lasted between 35 – 45 minutes. All were conducted in person except one, which due to the interviewee's schedule was

conducted over Skype. In all cases interviews were recorded using a digital recorder with the participant's consent.

3.5 Thematic Analysis

The interview data was analysed using thematic analysis as described by Braun & Clarke (2006). This allowed for common themes to emerge from the interview data supporting the research topic. The verbatim transcripts of the interviews were read several times to familiarise the researcher with the source material. Using the qualitative analysis technique described by McLeod (2003) the researcher followed a process of immersion, categorisation and coding. Sub-themes and super-ordinate themes were extracted as they emerged and each theme was analysed in the context of the broader aims of the study.

3.6 Ethics

When considering the ethical aspects of this study, information and procedures were shared with the participants prior to the interviews. The information sheet detailed in Appendix A provided contact details for the researcher, the purpose of the study, the length of the interview and the focus of the research. The participants were asked to read the information sheet and encouraged to ask any questions regarding any aspect of the interviews. They were made fully aware that they could withdraw their participation from the research at any point should they wish to do so. Every consideration was made to maintain the confidentiality of the interviews as well as the anonymity and privacy of the participants. This information was conveyed to them prior to their participation.

The treatment of audio files and transcripts was explained to the participants prior to their interviews. It was explained to each interviewee that the interview would be recorded and the recordings stored securely in password-encrypted form on a USB device. This device was itself stored in a locked drawer in the researchers home-office. It was explained that once the audio interviews had been transcribed they would be deleted and the transcriptions stored in encrypted form on a USB device. They were made aware that vignettes from the interviews could be used in the main body of the research to further explain or support theoretical assertions.

Full contact details of the research module supervisor were provided on the information sheet should the participant require further information. Prior to the interview, each participant was asked to sign a consent form stating his or her understanding of the contents of the information sheet. This consent form is included in Appendix B. The consent form asked the interviewees to acknowledge the following: they understood that their participation was voluntary; they understood that their identity would remain confidential at all times; they were aware of any potential risks in the study; they had been given a copy of the information sheet and consent form for their records. With regards to confidentiality, it was explained to the participants that their identity would remain confidential in the study itself and any further publications arising from the research such as journal articles or reports. Finally, the information sheet included some contact details for various counselling services should the participants require further support arising from the experience of being interviewed.

3.7 Limitations

While efforts were made to find therapists with considerable experience with clients from similar fields in the humanistic and integrative tradition, five participants is not a large enough sample to say conclusively how mindfulness impacts therapeutic presence. Furthermore, as the subjective experience of the interviewees was based on their present experience and own recall, it was not clear what the specific impact of mindfulness practice over time may have been as integration was occurring. An empirical observation over time would have brought more insight.

CHAPTER 4 - FINDINGS

4.1 Introduction

This chapter outlines the findings of interviews conducted for this research among a population of three male and two female psychotherapists. All interviewees have been working for more than ten years as therapists on a one to one basis with clients. While all interviewees considered themselves humanistic and integrative psychotherapists, their modalities varied. Two interviewees were working from a Gestalt perspective; two from the Person Centred Therapy perspective and one had trained in Psychosynthesis in Eckhart House. All interviewees except one had previously undertaken formal mindfulness training. In this and subsequent chapters, interviewees shall be referred to as P1, P2, P3, P4 & P5 in order to maintain confidentiality. As part of the thematic analysis, the interviews were thematically coded and themes and sub-themes were extracted to support the findings. A sample of this process can be found in Appendix D. The following superordinate themes emerged:

Theme A: Inhabiting the Present

Theme B: Absence

Theme C: Integration

4.2 Inhabiting the Present

In the interviews, the earlier questions focused on the Therapist's own ideas of what therapeutic presence meant to them and also what their own felt experience of being present was. Four of the interviewees (P1, P2, P3, P4) used similar terminology to describe their own sense of therapeutic presence, all mentioned availability for contact with the client and a sense of openness and attention. They also spoke of a sense of awareness of what was happening within themselves as much as what was happening from the client's perspective. These interviewees emphasised the importance of being aware of their own feelings and thoughts as much as possible in the present moment.

P1: ...I suppose another word would be embodiment, that sense of being really open and available. Almost porous... but with a boundary.

P2: Therapeutic presence for me would be actually engagement, being attuned to the client and working as much as possible in the moment.

Their consensus was that therapeutic presence begins with the therapist and their own emotional, mental and physical state. The implication was that if the therapist is experiencing difficulty themselves in either a physical or emotional way, their availability to the client is reduced and as a consequence, so is the quality of their presence.

P1 speaks of being available for contact and for relationship both with oneself and the client. During the engagement with the client, the therapist is participating in a relationship with himself or herself in some way and the quality of this intra-subjective relationship has an impact on their ability to be present. She felt if there is turbulence within the therapist, their ability to be therapeutically present to the client is reduced. P1 describes this:

My presence wasn't as good because I was quite concerned that I didn't have that real openness and spaciousness, I had to be a little bit defended, a little bit armoured, a little bit like... I don't know that anyone noticed it but I noticed it, I felt kind of clunky...

Among the interviewees, preparation for therapeutic presence ranged from formal mindfulness activities, such as sitting meditation for forty minutes or a body scan to various informal practices including short grounding exercises and paying attention to their bodily sensations in addition to being aware of whether their minds were particularly busy before their sessions. P1, P2 & P3 felt that a more formal mindfulness practice was more effective for them before beginning their work, if they had sufficient time.

P1: I may also do a formal practice if I have time. I might think, this is a great opportunity to do a body-scan, this would be a great opportunity to sit for forty minutes ... If I'm feeling particularly shaken by a session, or inadequate I might try and bring some compassion and remind myself that I'm doing the best I can.

P2: I've my mindfulness practice myself, so I would practice daily. So I suppose that would bring me into the moment. So I would come from that stance

P3: I would start the morning with something, with a gentle grounding exercise maybe mindfulness of breath, just checking in with myself.

P5 felt that with his experience and own monthly mindfulness practice over the years that he had done enough to not have to prepare in a formal way before his work. He felt he had integrated mindfulness to a sufficient level for it to become part of his way of being.

P5: We treat clients as though experiences have shaped the way they are. So if I have been shaped by meditation and mindfulness then I don't have to do it all the time because it is an integrated part of who I am.

Among the formal mindfulness sub-group (P1, P2 & P3), their answers to the earlier questions were very much focused on their inner world rather than their clients. Therapeutic presence for them began with an intimate relationship with themselves. P4 & P5 demonstrated a greater desire to focus on the client. However all the interviewees stated that therapeutic presence was core to their work and they felt that being present for the client was a core responsibility of the therapist. While P1, P2 & P3 felt their preparation was part of an on-going process of growth and integration; P4 & P5 viewed preparation as more finite and fixed. It was an aspect of preparation that had been done sufficiently in the past (P5), or it was a strategy to manage the physical aspects of the work rather than their intra-subjective experience (P4).

The interviewees were asked to consider whether their ability to remain therapeutically present had an impact on their clients. P1 felt it ‘hugely’ impacted the client. She felt that there was a tangible quality to presence that facilitated a sense of ‘deepening together’ with the client, being ‘further met’ in a creative and intuitive way. In her own words:

It is essential that I’m present, and its essential if I’m not present, I must acknowledge that to myself.

P2 believed that clients are usually more attuned due to their personal history, so may be very sensitive to the therapist’s level of presence:

I think clients are very much attuned because a lot of them would come from chaos and unstructured environments, they know when you are with them and they have a sense when you are not. And rightly so... you should be [present], that’s the job.

P3 stated his ability to be present allowed for a particular quality to emerge in the work with his clients.

I think there is a sense that for one of the first times in their life they felt seen and witnessed. There is that experience of that, that has been very significant for them and has a very significant impact on them.

4.3 Absence

The second major theme explores absence. In therapeutic terms, absence occurs when the therapist becomes distracted by an internal or external stimulus. In those moments, their attention has wavered from the client and has been transferred to something else. Were this to become habitual the client may feel they are not being heard or seen. All participants reported some difficulty with describing the felt sense of being present, but had no difficulty articulating aspects of the work that absented them. P3 articulates this:

It's more when I know that I am not present. When I'm present, I am just in it. But I'm very aware of when my mind goes off.

P1 describes therapeutic presence as the client and therapist deepening together in the present moment. In being available as best one can for relational contact and within that respecting the client's awareness of absence should it occur. In P1's own words.

They pick it up, you know, if I was to become absent. Maybe I can wing it but I think I'd pick it up if somebody was [absent] with me, and I think they would pick it up if it happened with them. They know and I know.

In the formal mindfulness sub-group (P1, P2 & P3), the participants spoke of how mindfulness practice had helped establish a strategy for dealing with distraction. An essential component of this was how self-judgement was managed. Mindfulness teachers often refer to non-judgement in the present moment as a strategy for overcoming difficulty during meditative practice. P1, P2 & P3 agreed that total non-

judgement in the present moment was perhaps not a complete strategy for a psychotherapist. P2 described this:

Even when they say we don't judge, well we actually do judge, we judge all the time, but it is ok as long as you don't hang around up there [in the judgemental thoughts], it is just a judgement.

P1, P2 & P3 described how interruptions or distractions in the present moment required some attention on their part in order to reflect on those judgements in the work with the client. But the key aspect of this was that they did not judge themselves harshly for being distracted. So while in their own mindfulness practice they could afford to let go of judgement, this was not entirely advised with a client, as their judgements may be important for the work. They describe this as follows:

P1: I often do say, what took me away there? Why is it so hard to stay with this person? What's going on? So I don't give myself a hard time but I would be curious about why it is difficult to stay there.

P2: Its ok for me to acknowledge I'm tired and how best to support myself in it, so then its ... ok I'm tired. Leave it there and now I've got to go and do this piece of work and be fully present.

P3: I tend to be quite relaxed about it [distraction], I tend to say 'this is all part of it'.

P4 & P5, both spoke of feeling they needed to do more when they felt irritated or bored by a client. In both cases they spoke of 'moving things along' or being more aware of being stuck in a pattern with a client. They had a distinctly different way of

talking about how they managed distraction. In a sense there was more focus on the external or the client as the source of the distraction rather than an internal process within themselves.

P4: It was so tiring trying to keep up with her basically, so that in itself kind of limited my ability to really feel present at times because the few times I did really encourage myself to stop [daydreaming], I just felt really disconnected. It was a really difficult piece of work

P5: Sometimes you could begin to get irritated by the person because the person has in a sense, rehearsed too much their script. And so they are telling you what is wrong... and you are beginning to say to yourself, and I going to be your therapist or are you just going to be using me as if you were your own therapist and I was your supervisor?

P1 describes an inclusive attitude towards distraction in her work, her formal training in mindfulness promotes acceptance of “what is” in the present moment.

There nearly always are distractions and if there are distractions, I include them.

Another source of absence among the participants was their counter-transference. This form of distraction is typically less obvious than moment-to-moment emotional, physical or environmental distractions. The participants were asked, with regards to their own mindfulness practice (if any) and their sense of therapeutic presence, whether these impacted their awareness and management of counter-transference in the relationship with their client.

P2 described an experience where her dislike for a client threatened to rupture their relationship and how her own mindfulness practice helped her with this.

That was difficult because I felt I wasn't [present]... it was in and out. The mindfulness was helping me because I think if I hadn't practiced mindfulness I think I would have actually stopped working with her, but I felt that she [client] needed a break.

P1 described how her mindfulness practice helped her with somatic counter-transference:

Especially with awareness of the body, why am I so tight? Why am I sitting here with my fists tight? Very much that kind of body awareness ... it would be much richer than before I started to practice [mindfulness] more seriously. My awareness of the counter-transference would be much more highlighted.

4.4 Integration

The interviewees were asked whether therapeutic experience or mindfulness practice, or both, had the most influence on their ability to remain therapeutically present.

P1, P2 & P3 agreed that it was both experience and their mindfulness practice that facilitated their therapeutic presence.

P1: I think its both, The reason I'm saying its not just experience is one of the things that comes out of my mindfulness practice rather than just out of my experience is a transparency... with practicing mindfulness, presence is easier. I don't feel I have to be anything, just who I am doing the best I can... there is more of an open presence.

P2: I think it's a little bit of both, but it's more mindfulness... and now I work with Gestalt, and compassion focused therapy. With mindfulness I'm just being. It's different.

P3: No it definitely has [mindfulness]... absolutely. Just in terms of even how I am myself, and in myself, absolutely. Some of that is developmental, some from experience, its definitely a more integrated thing for me.

As a counterpoint, P4 felt that experience was more important than any form of mindfulness practice he had engaged with.

I would put more importance on the experience part, purely from my perspective that with my experience growing with my years clocking up in a sense. I feel more confident in how I can communicate with clients.

P5 stated that at this point in his career it was preferable for him to let go of any daily practice and just trust in his experience. Between a monthly meditation and taking daily walks there was no specific preparation he felt he needed to engage with.

In the interviews, P1, P2, P3 & P5 spoke at length about ancillary benefits of mindfulness practice in the context of therapeutic presence. Mindfulness practice appeared to offer other qualities to the therapist over time, which contributed to a more subtle, present-focused experience.

P1 spoke of how her mindfulness practice led to her being 'easier with herself'. Her sense of bringing herself wholly into the therapeutic engagement in an integrated way appeared to resource her in her work as well as helping her avoid any of the pitfalls of becoming an 'expert' in the relationship.

I don't feel separate, the me in the chair is me. There is not a me Therapist and a me at home. It's myself I bring to the work.

She also referred to mindfulness helping her maintain perspective in her client work, preventing her from getting entwined or too caught up in the experience.

I think it goes back to that idea of mindfulness where it gives you a place to stand. So that you are actually not lost in the experience. So you are there, but there is a space and you need that bit of space. I'm present but I'm not totally entwined and enmeshed with the person and the stuff that is going on in between us. It does give me that place to stand, I can stay present and there is a space.

P2 uses a phrase to remind herself of the transient nature of thoughts. This concept is central to mindfulness practice; the person is not just their thoughts. Thoughts come and go.

I think, my big one is ‘thoughts are not facts’, particularly around emotions; I’ve said that 100s and 100s of times.

In terms of self-care, she found mindfulness helped her with that aspect of her work as well as accepting herself and her potential for failure.

That is mindfulness, it is treating yourself with gentleness and care, respect for yourself because I do think a lot of energy goes to other people... I do think mindfulness is you training your brain to think a different way. We have these set patterns and that’s why I think it takes time. And it doesn’t matter, you could fail 100 times but so what? Go again, failure is part of life, and failure is good because you know you can go again.

And finally, in terms of letting go of self-criticism.

As long as you are aware of... you know... ‘Maybe I didn’t do that the way I wanted’. ‘What is the learning for me?’ Well, let it go, stay in this moment, that moment is over.

P5 stated that an unexpected benefit of mindfulness practice in his therapeutic work and in his life was being more receptive to closure and being able to tolerate the unknown and be closer to his own sense of vulnerability.

I think one of the things that you get a result of mindfulness practice is that you actually become a little more receptive to closure. How it is all going to end. Because of that I always feel a bit more frail and fragile because at the end of the day, I don't have the final say what is going to happen in my life ... so I go into the meditation room and lay on my back and do my exercises, and I feel better.

P1 & P2 referred to compassion throughout their interviews in a way that suggested that it had become an integrated and essential component of their work. The term *compassion* is explained as a person's desire and action to understand and alleviate the suffering of another. This is disambiguated from empathy (the ability to resonate emotionally with another) and pity (coming from a place of fear within oneself). Compassion, like empathy is a quality that can be cultivated and worked on within the therapeutic relationship. Mindfulness practice can support compassionate action because it encourages the Therapist to be aware of his or her own difficulty in the present moment as well as an acceptance of the client's suffering in the present moment. Mindfulness offers an opportunity to reflect rather than react when compassionate action seems difficult.

P1 discusses how her own mindfulness practice brought another level of compassion for herself in her work.

I think it [mindfulness] supports you to stay present, especially bringing compassion because anything can happen in the room and you know, when you are in the wild it can go horribly wrong and you know just to really have compassion for yourself.

P3 reflects on self-compassion in times of difficulty and how the inner critic can be a powerful force at those times bringing self-repudiation. Her mindfulness practice helps her navigate that.

It's just that you are bringing a little bit of self-compassion, maybe it is a bit hard for you right now. That self-talk is a part of mindfulness, you know saying 'well hang on, this could be difficult right now' ... you know the critic comes flying through, and I do believe that the critic initially was there for a very positive reason, but sometimes it overwhelms us and somehow takes over and really it's being able to turn the dial towards the self-compassion version of you.

CHAPTER 5 - DISCUSSION & CONCLUSION

5.1 Introduction

This chapter aligns the findings from Chapter 4 with the literature from Chapter 2 with respect to the stated objectives of the research: to explore the therapist's subjective experience of therapeutic presence; to explore therapeutic absence; to explore the value of mindfulness practice with regard to therapeutic presence; to identify areas for further research. Once each theme has been explored with these objectives in mind a conclusion on the discussion and suggestions for further areas of research will be offered.

5.2 Inhabiting the Present

Therapeutic Presence as defined by Geller & Greenberg (Geller & Greenberg, 2012; Geller & Greenberg, 2002) is bringing one's whole self into the engagement with the client and being fully in the moment with an for the client with attunement and engagement. The majority of interviewees used similar phrasing when describing their sense of presence using terms such as engagement, availability, attunement, embodiment & spaciousness.

Among the interviewees the consensus was that good presence is crucial to a working therapeutic alliance. Good presence enhances the therapist's ability to be attuned and attentive in the present and also encompasses availability to the client's experience. This echoes Roger's (1980) sentiment that presence underpins the core conditions of therapy. Effectively without good presence, empathy, congruence and positive regard may be diminished because the therapist is not as available to the client's experience.

Geller & Greenberg (2012) offer a model of therapeutic presence as described in Chapter 2. This model describes therapeutic presence as multi-layered with the possibility of being present on different levels with the client. Among the participants who engaged in formal mindfulness practice on a frequent basis, the study found that they were working at a lower level on this therapeutic presence scale. Bringing themselves into the therapeutic engagement involved physical & emotional awareness and some degree of self-acceptance and self-compassion. In a sense their work began with themselves before the work with the client began. Their sense of presence encompassed an awareness of their own vulnerability and fallibility, which allowed for increased empathy with their client.

Three of the participants had integrated a formal mindfulness practice into their psychotherapeutic work for a number of years. With regard to preparing for presence, there was consensus among the three that formal mindfulness practice was essential to preparing themselves for their client work. This concurs with the research of Dunn et al. (2013) who found that formal mindfulness practice as part of preparation for psychotherapeutic work led to increased perceived levels of presence in therapists and reported efficacy of sessions.

With regard to the impact of therapeutic presence on the client, this study found that the interviewees strongly believed that the more present they were, the “further met” their clients felt and the more it was possible to deepen the therapeutic alliance. This is concordant with the research of Geller & Porges (2014) who found that increased therapeutic presence was a catalyst for an increased sense of safety and belonging in the client.

While the research suggests that in general clients are generally not aware of increased levels of presence in the therapist (Geller, Greenberg, & Watson, 2010; Dunn, Callaghan, Swift, & Ivanovic, 2013) this research found that the interviewees attributed more awareness to the client of the therapist’s level of awareness.

5.3 Absence

This study found that among the formal mindfulness interviewees there were distinct differences in how they managed absence versus the non-mindfulness group. From the findings the suggestion is that for the formal mindfulness practitioners, they brought their whole selves into the engagement in a way that allowed them to become more aware of when they were absenting from the session.

Three of the participants mentioned self-judgement as a source of absence. Their approach to managing self-judgement was similar to the suggestion of Kabat-Zinn (1991) that judgement will arise, but mindfulness can help mediate the response to it

to allow for less reactivity. Paying attention non-judgementally has the effect of softening self-evaluation. The approach taken by the participants was to take note that the judgement was there in order to feed it back into the work if applicable. Allen et al. (2006) found that mindfulness training increases cognitive flexibility in terms of merely noticing emotional and cognitive experiences and allowing them to be let go of in the present for possible later reflection. This study found a consensus among the mindfulness group that their mindfulness training had contributed to their own cognitive flexibility, allowing them to reflect on their judgements without being caught up in them. Germer, Siegal & Fulton (2005) found that this ability to notice judgements in the present moment without necessarily reacting to them allowed the therapist to quickly return their attention to their client and had the effect of reducing the impact of 'wandering mind'. According to Henry, Schacht & Stupp (1990) reduced self-judgement on the Therapist's part can reduce the risk of counter-therapeutic dynamics.

The existing research suggests that mindfulness practice may help practitioners to manage their counter-transference in a way that resources the therapist and helps them to remain present even when dealing with strong counter-transferential dynamics. Geller & Greenberg (2002) assert that mindfulness practice can help the therapist be more aware in the present moment of their counter-transference thus creating space between the feeling and the reaction. They also caution that therapists are also human beings, shaped by past and present emotional content, so acknowledging vulnerability is a component of therapeutic presence. This research found a consensus among the interviewees that vulnerability was always an underlying part of the work, but

mindfulness helped them mediate those feelings in the present moment and allowed them to return their attention to the client more quickly.

5.4 Integration

This study found that the majority of interviewees believed that both mindfulness practice, integrated into their daily lives and their experience as therapists contributed to an increased level of therapeutic presence. The significance of this finding is that Therapists with a number of years experience working in various modalities, i.e. Gestalt, PCT & Psychosynthesis believed that their mindfulness practice had changed the way they approached their work and their sense of availability to the client. As these practitioners have many years of experience working as psychotherapists the implication is they are better able to discern the impact of their mindfulness practice on their work as being significant or not.

Collum & Gerhart (2010) found that mindfulness practice enhanced the practitioner's sensitivity to their own inner experience while also holding an increased awareness of the client. Their participants reported that mindfulness helped them slow down inner chatter, gave them an increased sense of calmness and helped them reduce worry or pressure during sessions. This echoes the findings from Chapter 4 in terms of benefits of mindfulness practice to the interviewees. There was a consensus that mindfulness practice helped them to be softer with themselves in the context of self-judgement and to be more aware of their own vulnerability. Geller & Porges (2014) mention two other benefits of mindfulness practice echoed by this research. First, that mindfulness

enhances present moment awareness highlighting moments of disconnection with the client. Second, that mindfulness practice prior to the session allowed the therapist to self-regulate with the secondary gain of down-regulating the client. The interviewees in this study mention at least the first of those at length, but perhaps were not aware of the secondary gain described by Geller & Porges.

There was a consensus among three of the interviewees that mindfulness practice helped them bring more compassion for themselves into their work. They believed this had the ancillary effect of facilitating increased empathy and compassion for their clients. In the context of self-compassion leading to increased quality of presence, according to Geller & Greenberg (2012) compassion is a naturally occurring by-product of therapeutic presence and is thought to arise naturally from the experience of presence (Geller & Greenberg, 2002). Three of the participants made specific reference to self-compassion as a component of therapeutic presence. Their own ability to be less judgemental and more gentle with themselves helped them achieve a deeper level of presence. This concurs with the research of Vivino et al. (2009) who found that the cultivation of self-compassion was a form of attunement for others that begins with an attunement to oneself.

5.5 Conclusion

In the context of seeking to deepen an understanding of therapeutic presence this research clearly showed consensus among the interviewees that therapeutic presence is a tangible and essential element of psychotherapeutic practice. Far from it being an abstract or transpersonal concept, defying description, the interviewees in this study

seemed adept and familiar with the felt sense of being there with and for their clients in a present centred way with availability and openness. There is a high level of convergence between their description of therapeutic presence and the attitude adopted by mindfulness practitioners in their practice. In terms of therapeutic absence, this study found that mindfulness practice may offer strategies to manage distraction during client sessions in a way that promotes an attitude of curiosity and a level of self-compassion on the part of the therapist. In the face of counter-transference dynamics, mindfulness training can also offer a way to create space between the initial sensation and the reaction allowing the therapist to come back into the moment-to-moment experience of the session without self-repudiation and engage in the relationship with less reactivity. Finally, it is clear that there may be secondary benefits to mindfulness practice. There are indicators that Therapists practicing mindfulness are less likely to become enmeshed in the affectual experience of a session suggesting that mindfulness practice may contribute to healthier boundaries. From the inter-regulatory perspective, there is also the implication that mindfulness practice (helping to regulate the therapist) can have a positive effect on the client's own regulation. Of the formal mindfulness group, the interviewees suggested that mindfulness practice allowed them to share a deep and intuitive connection with their clients and facilitated them in bringing their whole selves into the therapeutic engagement.

With regards areas for further research, a longitudinal study measuring therapeutic presence as a therapist adopts a regular mindfulness practice may provide more insight. In this study, it was not possible to disambiguate the specific qualities brought by mindfulness practice from the interviewees' own experience. A longer-term study

might highlight the progression of levels of presence as a formal mindfulness practice is adopted and integrated. Another possible area for research is in the neurobiological realm. While some research has been done to date into therapeutic presence and neurobiology, it is this researcher's opinion that there are gaps with respect to the specific benefits of mindfulness as described from the neurological perspective.

The previously stated limitations in Chapter 3 still stand. The population size for this study was too small to derive conclusive results on the effects of mindfulness practice on therapeutic presence. However, there are strong indicators that mindfulness practice has much to offer the practitioner in their work both from the perspective of a more involved presence and their own self-care. It was clear from the interviews that while all the therapists were aware of mindfulness there were very different perspectives on how it could be applied.

BIBLIOGRAPHY

- Allen, N. B., Blashki, G., Gullone, E., Chambers, R., Knight, W., Ciechomski, J. L., et al. (2006). Mindfulness-based psychotherapies: a review of conceptual foundations, empirical evidence and practical considerations. *Australian and New Zealand Journal of Psychiatry*, 40, 285–294.
- Assagioli, R. (1965). *psychosynthesis - The Definitive Guide to the Principle and Techniques of Psychosynthesis* (1993 Edition ed.). London: Thorsens.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.
- Burgoon, J. K. (1985). *Nonverbal Signals - Handbook of interpersonal communication*. Beverly Hills, CA: Sage.
- Collum, E. E., & Gehart, D. R. (2010). Using Mindfulness Meditation to Teach Beginning Therapists Therapeutic Presence: A Qualitative Study. *Journal of Marital and Family Therapy*, 36 (3), 347-360.
- Dunn, R., Callaghan, J. L., Swift, J. K., & Ivanovic, M. (2013). *Psychotherapy Research*, 23 (1).
- Freud, S. (1912). Recommendations to Physicians Practicing Psycho-Analysis. In S. Freud, *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. London: Hogarth Press.
- Gabi, B. (2008). The Seam Between Life and Death and Therapeutic Presence. *American Journal of Psychoanalysis*, 68 (3).
- Geller, S. M., & Greenberg, L. S. (2012). *Therapeutic Presence A Mindful Approach to Effective Therapy*. Washington: American Psychological Association.
- Geller, S. M., & Greenberg, L. S. (2002). Therapeutic Presence: Therapists' experience of presence in the psychotherapy encounter. *Person-Centered and Experiential Psychotherapies*, 1 (1&2).
- Geller, S. M., & Greenberg, L. S. (2002). Therapeutic Presence: Therapists' experience of presence in the psychotherapy encounter. *Person-Centered and Experiential Psychotherapies*, 1 (1&2).
- Geller, S. M., & Porges, S. W. (2014). Therapeutic Presence: Neurophysiological Mechanisms Mediating Feeling Safe in Therapeutic Relationships. *Journal of Psychotherapy Integration*, 24 (3), 178-192.
- Geller, S. M., Greenberg, L. S., & Watson, J. C. (2010). Therapist and client perceptions of therapeutic presence: The development of a measure. *Psychotherapy Research*, 20 (5), 599-610.

Germer, C. K., Siegal, R. D., & Fulton, P. R. (2005). *Mindfulness and Psychotherapy*. New York: Guildford Press.

Ghent, E. (1990). Masochism, Submission, Surrender. *Contemporary Psychoanalysis* , 26.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology* , 58 (6), 768-774.

Kabat-Zinn, J. (1991). *Full Catastrophe Living*. New York: Dell Publishing.

Kabat-Zinn, J. (2003). Mindfulness-Based Interventions in Context, Past, Present and Future. *Clinical Psychology, Science and Practice* , 10 (2).

Lazar, S. W., Kerr, C. E., Wasserman, R. H., Gray, J. R., Greve, D. N., Treadway, M. T., et al. (2005). Meditation experience is associated with increased cortical thickness. *NeuroReport* , 16 (17).

McLeod, J. (2003). *Doing Counselling Research*. London: Sage Publications Ltd. .

Rogers, C. R. (1980). *A Way of Being*. Boston: Houghton Mifflin.

Segal, V. Z., Williams, J. G., & Teasdale, J. D. (2002). *Mindfulness-Based Cognitive Therapy for Depression* (2nd Edition ed.). New York: The Guildford Press.

Shapiro, S. L. (2009). The Integration of Mindfulness and Psychology. *Journal of Clinical Psychology* .

Shapiro, S. L., & Carlson, L. E. (2009). *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions*. 2009: American Psychological Association Publications.

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching Self-Care to Caregivers: Effects of Mindfulness-Based Stress Reduction on the Mental Health of Therapists in Training. *Training and Education in Professional Psychology* , 1 (2), 105-115.

Shore, A. N. (2012). *The Art and Science of Psychotherapy*. New York: W. W. Norton.

Siegel, D. J. (2010). *The Mindful Therapist: A Clinical Guide to Mindsight and Neural Integration*. New York: W. W. Norton & Company.

APPENDIX A – INFORMATION SHEET

Qualitative Research Study: An Exploration of Therapeutic Presence and Mindfulness

PARTICIPANT INFORMATION SHEET

Introduction

My name Niall Milton and I am a student in the final year of a Master of Arts in Psychotherapy at Dublin Business School (DBS). I am currently undertaking a qualitative research study which seeks to explore the relationship between therapeutic presence and mindfulness practice.

The study has received approval from the DBS Ethics Committee.

What is the purpose of the study?

You are invited to participate in this study if you are a qualified psychotherapist currently engaged in client work. The purpose of the study is to explore your understanding of therapeutic presence and your opinions on whether mindfulness practice has an influence on therapeutic presence.

What are the criteria for participation in the study?

Participants of this study must be qualified therapists who are actively engaged in client work and have experience of grounding or meditative exercises as part of a self care regimen.

What is involved in participation in the study?

Should you choose to participate in the study, you will be invited to take part in an hour long individual interview, with myself the researcher, at a location to be agreed between us. The interview will consist of a series of questions relating to the research question. The interview will be recorded and later transcribed by the researcher.

Will my identity and information be protected?

Your identity will be protected by a code known only to the researcher. This code will be used on all forms relating to your participation and on any additional notes taken in relation to the information obtained from. All identifying information will be removed during transcription of your interview to protect your anonymity, for example, pseudonyms will be given to those mentioned in your narrative. All data, including transcripts, will be coded and stored on the researcher's computer in a folder which is protected by a password known only to the researcher. All paper records will be kept in a file which will be locked. Audio recordings will be destroyed once transcripts have been made.

Can I withdraw from the study?

Participation in the study is entirely voluntary and you can withdraw consent at any time without prejudice.

Are there any risks of participating in the study?

If you feel distressed in any way during the interview, please make this known to the researcher and the interview can be stopped at any time. Likewise, if painful or distressing issues are evoked at a later stage, the opportunity of a therapy session, by way of de-briefing with a psychotherapist, can be availed of - see information below:

Aris Psychotherapy & Counselling Centre Dublin 2 or Balbriggan, North Co. Dublin	01-8020437 info@ariscentre.ie
Loreto Centre Crumlin Counselling & Psychotherapy Service	01-454 1078 loretocentrecrumlin@eircom.net
Alternatively, you can search for a registered psychotherapist, anywhere in Ireland, on the Irish Council for Psychotherapy's website http://www.psychotherapy-ireland.com/find/	

How can I get further information?

Should you have further questions regarding this study, please do not hesitate to contact either person below:

Researcher: Niall Milton niall.milton@gmail.com
Research Coordinator: Dr. Gráinne Donohue grainne.donohue@dbs.ie

APPENDIX C – INTERVIEW QUESTIONS

1. How would you interpret the term “therapeutic presence”?
2. How do you prepare yourself before sessions with clients?
3. Describe an experience of a session where you have felt especially present and free from distraction.
4. How do you think your level of presence impacts your client?
5. Can you describe a session(s) where you have found it difficult to remain present? What do you think affects your ability to be present in a session?
6. How aware are you of counter-transference in your work and how do you usually manage this?
7. Do you incorporate any mindfulness practice into your therapeutic work?
8. Does mindfulness practice or experience facilitate increased presence in your opinion? Or both?
9. Do you have any other thoughts on therapeutic presence & mindfulness?

APPENDIX D – SAMPLE OF THEMATIC CODING

Interview P1

Themes	Text	Codes	Location
Integration Self-Awareness Use of the body	Yeah... yeah... I suppose another word would be embodiment. So that sense of really being open and available. Almost porous. Not saying there is no boundary But... there is a space there in which you are fully there as best as you can and aware of the time when you need that space. Therapeutic? I suppose means feeling to me. I don't know if I think very differently about presence and therapeutic presence... between my presence and my presence in the therapeutic relationship.	Embodiment Availability Spaciousness Own-Presence	Pg.1 5-12
Client Relationship Openness & Presence	And an availability. Being available for contact, for relationship, to yourself and the other.	Availability Contact Relationship	Pg. 1 18-19
Use of the body Preparation for Presence	A lot of it depends on time. But I would do a checkin. An informal ... ehm... moment or two of mindfulness practice. It could be formal or informal check-in. How am I? How am I doing, how am I right now? What's my weather pattern? What am I noticing in my body?	Preparation Body Awareness Grounding	Pg.2 25-29
Vulnerability	Ehm... not to get rid of any wobbliness but to ground me, to earth me. They would be ways, I may also do a formal practice if I have time.	Wobbliness Time Own sense of vulnerability	Pg. 2 36-38
Vulnerability	If I'm feeling particularly	Inadequacy	Pg.2 41-

Self Care Self-Compassion	shaken by a session, or ... inadequate I might try and bring some compassion and remind myself that I'm doing the best I can.	Self-Compassion Vulnerability	44
Absence Awareness & Absence	Ehm. I don't know if I can answer it like that because there nearly always are distractions and ... and ... if there are distractions, I include them.	Distractions being normal & Useful	Pg. 3 69-71
Using Absence Self-judgement Client-Awareness	And using that. If there is a noise in the corridor, using that because the client has probably heard it too. It has happened that someone has said to me... "I didn't hear that until you mentioned it". afterwards, you begin talking to the client about wandering mind and realise afterwards that it was my mind that was wandering.	Respect for client awareness Vulnerability	Pg. 4 88-93
Absence Client Awareness	Oh, hugely... ehm... absolutely, they pick up, you know, if I was to become absent, you know, maybe I can wing it but I think I'd pick it up if somebody was with me, and I think they would pick it up if it happened with them.	Client Awareness Respect for client	Pg. 5 102-105