International Research Journal
Vol. 07 No. 02 2017
p-ISSN 2202-2821 e-ISSN 1839-6518 (Australian ISSN Agency) 82800702201702

Therapeutic Presencing in Nursing

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ABSTRACT – *This paper provides an operational definition of therapeutic presencing as a first step in the systematic analysis of the concept. The Wilsonian method of concept analysis provided the framework for the analysis. The researcher identifies themes explicated from the concept of therapeutic presencing to develop a clear understanding of the concept to nursing. Model cases illustrate the concept further. The result shows that Being, Receiving, Influencing and Participating are the themes most associated with the concept. Moreover, immersion, congruence and empathy were described as the qualities of therapeutic presencing in nursing. Further nursing research needs to test the theoretical relationship between concept of therapeutic presencing and outcome variables.*

Key words: Nursing, Caring; Therapeutic Presencing

I. Introduction

Therapeutic presencing is essential because it is the fundamental nature of nursing to be present with patients (Chase, Doona& Haggerty 1997, 13). It is important that concepts like therapeutic presencing should be clearly formulated. Concept formulation identifies and isolates core characteristics of a phenomenon of interest. Through observation, experience and reflection concrete sensory experiences are transformed into abstractions (King, 1975). Regularities and commonalities are extracted. Exceptions and contrary cases establish boundaries of the phenomenon. Concepts are tools, which allow us to categorize and classify phenomena, and thereby to propose and explore relationships between and among phenomena.

Concept analysis is contextual and subject to continuous re-evaluation as to utility (Chinn and Kramer, 1991). Three sources of experiencing interact to produce meaning. These include the word, the thing itself, and the feelings associated with the experience of the concept. Through communication this interior process is shared.

The Wilsonian method of concept analysis provided the framework for the analysis.. The steps taken to delineate the concept included: 1) identification of a plan to sample the literature, 2) identification and description of related concepts; 3) the extraction of themes and attributes 4) explication of interdisciplinary treatment of the concept, 5) description of possible model cases, and 6) identification of implications for future research.

II. Methodology

While the sampling method is most correctly described as a convenience sample, a finite number of articles related to presence were identified. Most of the articles were obtained and are included. The literature gathered from a rigorous search using CINAHL, PUBMED and BIOSYS were reviewed for pertinence to the phenomenon of therapeutic presencing. Despite the entry of the word into standard nursing textbooks, the review of the literature turned up only 10 references from CINHAL.

Early nursing authors who addressed presencing "borrowed" the term presence from existential philosophy and often cited Buber and Marcel (1971). Accordingly, these works were consulted for clarification of the etymology or origin of the terms. Contemporaneous to nursing's exploration of the concept, the psychotherapy literature was also beginning to incorporate the use of the term presence. To broaden the perspective, the use of the concept in this discipline was explored, specifically in the Gestalt and counseling literature.

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

The computer entry facilitated data grouping and re-grouping such that themes readily emerged. Subjectivity is clearly a

factor in this sort of analysis, especially when conducted by one author. However, since the commonalities were pronounced, the researcher has confidence in the consistency and appropriateness of my interpretation. Moreover, the data and sources are clearly identified establishing the sort of evidence trail common to qualitative research.

III. Results and Discussion

A. Identification and description of related concepts

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

Presencing entered the nursing literature in the late 1960's. Black (1967) described the application of existential concepts to nursing practice. She cited Martin Buber as the source for existential ideas of presence. She discussed the I-Thou manner of relating describing it as occurring in the present moment and as encompassing a way of relating to the other as a whole in true presence. By contrast, in the I-It relationship, the other is observed, measured or classified. Black advocated using the existential concepts of authentic presence, dialogue and commitment to enrich the nursing process. Despite lack of clear definition or research as to its outcomes, the concept of presence continued to appear with some regularity in anecdotal discussions. Textbooks describing nursing interventions described nursing presence. Eventually, textbook chapters were devoted to discussions of the use of therapeutic presence (Bulechek and McCloskey, 1985; Carson, 1989; Gardner, 1985; Gaut, 1992). Most authors have treated presence as a therapeutic modality or intervention.

Buber noted that life requires both the I-Thou and the I-It modes of interaction. Nursing, too, requires both sorts of interaction: When completing a complicated dressing change, the nurse must temporarily, objectify the body of the patient. The person of the patient is indeed embodied, and for this moment it is the condition of the body, which is the focus of the interaction. This may be heightened when it is therapeutically necessary for the nurse to inflict physical pain. Black cautioned that the needs to address physical interventions, to avoid entanglement with the patient, and to maintain objectivity were sometimes at odds with development of the I-Thou relationship that characterizes presence. The early nursing references to presence (Black, 1967; Paterson & Zderad, 1976; Watson; 1975) identified availability as a feature of presence and cited the work of the French philosopher, Marcel as a source for this idea. He wrote a great deal about the concept of presence, claiming that examination of this subjective experiential concept of being, was futile for it defied explanation or description and could only be fully apprehended by experience. It was Marcel who articulated the requirement of availability inherent in the concept of presence.

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

One of the major proponents of the centrality of caring in the practice of nursing, Watson was frequently referenced by those exploring presence or related concepts. She described transpersonal caring as entering into " the experience (the phenomenal field) of another and the other person enters into the nurse's experience. This shared experience creates its own phenomenal field and becomes part of a larger, deeper, complex pattern of life. "(1985, p.67). Marsden (1990) described presencing as a giving as well as a receiving of the self, born out of availability and quietness. Preconditions of presence were noted and included being in touch with own state of mind, sensitivity and receptivity to the beliefs and experiences of others. For Marsden, presencing has two dimensions: it conveys empathy and promotes well-being and autonomy. Presencing can meet spiritual needs. In the relationships with presence the nurse and client each experience their own and the others' uniqueness affirming cherished values, hopes, wants, needs.

Knowledge Consensus Conference of 1998 concluded that the essence of nursing practice is the development of the nurse-patient relationship (USA, 1998). Intentional presencing is essential in order for the nurse to know and understand what it means to be human and humans in relationship. This knowledge

provides the basis for the mutual selection of health promoting interventions. An intentionally therapeutic mode of being, incorporating the nurse's true presencing underlies this process. Other terms used to describe this fundamental aspect of nursing include interaction and mutuality. The engagement is mutual, an iterative process that includes giving and receiving and being humble.

Bugental (1987) described presencing as the quality of being in a situation in which one intends at a deep level to participate as fully as possible. Presencing is expressed through mobilization of one's sensitivities "both inner (to the subjective) and outer (to the situation and the other person)" (p. 27). He recognized two facets of presencing: accessibility and expressiveness. He said that accessibility was reflected in the degree to which one intended to allow whatever happens in the relationship to be important. This requires a dropping of usual defenses against being influenced by others. It suggests commitment. Expressiveness has to do with the degree to which one will allow one's inner self to be known by the other. Disclosing one's self implies effort. Bugental thought that presencing was a necessary precondition to a useful therapeutic alliance with the patient. Korb described presence as an unplanned for moment when the client and therapist become "a reciprocal I-Thou, through an act of faith we are unmediated presences to each other" (1990, p. 99). Speaking of the experience of presencing:

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

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

B. The extraction of themes and attributes

A review of several studies of studies (Butlein, 2005; Cooper, 2005; Fraelich, 1989; Geller& Greenberg, 2002; Jonas & Crawford, 2004; Phelon, 2004; West, 1997) of therapist presence and related constructs suggests a significant commonality of themes among therapists' attributions about their subjective experience of the qualities of presencing. For purposes of this paper, the researcher analyzed these to identify and categorize common themes. Four themes were identified: Being, Receiving, Influencing, and Participating.

Being pertains primarily to the nurse's internal attributes and relationship with themselves. It relates to the nurse's capacity to attend to themselves fully, as well as to their clients. It is revealed in the extent to which they are perceived as congruent, and reflects their level of psychological and spiritual development.

Receiving pertains to the nurse's receptivity, both in general and to the client's experience specifically.

Whereas Being has more of an intrapersonal focus, Receiving is more outwardly focused and interpersonal. Hence it includes nurse's awareness and perception of client's experience, as well as their capacity for empathy.

Influencing refers to the effects of the nurse's attention on the client. Beyond the direct results of the nurse's interventions, Influencing includes the implicit effects of the nurse's being that are perceived by the client as healing.

Participating pertains to the nurse's experience of involvement with the client in a therapeutic relationship that has both interpersonal and transpersonal aspects. It includes the quality of connection in the relationship, the degree to which that connection is experience as energetic, the perceives sense of a resonance between that nurse and client that transcends the ordinary boundaries of the self-object relationship, and the sense of mutual participation in a larger field beyond the limitations of time and space.

As it is not within the scope of this paper to review all of the qualities in detail, the following discussion will use this framework to review the major themes across studies as starting point for a more general discussion of the relevance of the construct "presencing" to the practice of nursing. Specific qualities will be selected for discussion based on the frequency with which they occurred, or the extent to which they are characteristic of, their respective categories.

Qualities of Presencing. Immersion was explicitly identified as a quality of presencing by several studies. It can be considered as a state of absorption in one's experience, in a sense presencing as "the process of being present to." Presencing has been described as being comprised of the qualities absorption, experiencing deeply with non-attachment, present-centeredness, and awareness. Immersion has also been described as being "alive, energized, "wide awake" yet so engaged in experiencing that "fifty minutes could pass in a flash, or a few minutes could seem to last for hours". The sense of timelessness has also been noted as a quality of the

p-ISSN 2202-2821 e-ISSN 1839-6518 (Australian ISSN Agency) 82800702201702

"expansion", which also includes enhanced awareness, sensation, and perception, as well as "inner spaciousness."

Presencing has been related to congruence, another of the major qualities. Congruence can be defined as consistency between levels of expression, such as verbal and non-verbal communication, as well as between self-concept and perceived presentation. Congruence falls within the larger theme identified here as Being and could be considered the keystone of that theme, constellating the other qualities in that theme such as development (personal and spiritual), spirituality, capacity for concentration, inwardly directed attention, and the ability to the be in the "here and now." To the extent that congruence reflects consistency between self-concept and presentation, inward attention seems to be a critical component, as congruence would be predicated upon self-knowledge and awareness of one's subjective experience.

Some variant of congruence was identified as a quality of presencing by several researchers. Terms that were used synonymously included, authenticity, genuineness, and transparency. High levels of congruence have been identified as a characteristic quality of presencing, and some specifically link congruence to Rogers' core conditions of therapy. It has been suggested that presencing is both the precondition of congruence and subsumes it.

Similarly, presencing has been seen to be both foundational to, and the expression of, empathy, another of Rogers' core conditions. Empathy can be understood as the ability to deeply understand and "feel into" another's experience. Empathy falls within the major theme identified here as Receiving, and can be considered as the culmination of several of the qualities contained therein. Attitudes of acceptance and open heartedness, alignment with the client, allowing and respect, interest and care, all set the stage for the kind of attunement to the client's experience that create the condition from which empathy emerges.

For some deep empathy transcends the subject-object boundary between nurse and client, allowing for a direct apprehension of clients' internal experience. Knowing across or beyond the limitations of ordinary communication relates to the nurse's perception, another theme in the category Receiving. Some researchers have explicitly identified intuition as a quality of presencing.

The transcendence of the subject-object border relates to another of the major themes, resonance, which has been described as the nurse and client aligning through a shared frequency and connecting at an energetic level. Identified qualities of resonance have included inner concentration, synchronization of movements, non-verbal communication, and a somatic perception of the others' feelings.

In this state, trust and intimacy, two of the qualities identified as relating to the theme of connection, are heightened and there is a sense of shared awareness; a sense of knowing that one is known. Some have described this level of connection as transcending both individuals, being grounded in a non-dual consciousness, or Unity.

The sense of mutual participation in a larger field is also one of the identified qualities of presence. This is reminiscent of Rogers' statement

> *At those moments, it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and has become part of something larger.*

The idea of mutual participation in a larger, energetic field that is in some sense universal or divine is closely connected with the idea of healing. Researchers Jonas and Crawford state,

> *Healing presence involves experiencing and placing awareness on these more central, nonlocal dimensions in which humanity is close and more universally connected to each other and the divine.*

In their study of healers' experience of presencing, they develop a model of four forms of healing presencing: alignment with God, immersion into a universal consciousness, transmission of spiritual energy, and interaction with spiritual forces or entities. "Subtle energy" and "energetic interconnectedness" are also referred to by West in his study of therapists who included spiritual healing in their work. He identified two forms of healing in this study, deliberate and incidental, comparing the latter to Rogers' description of presence in psychotherapy.

C. Explication of interdisciplinary treatment of the concept

Presencing has been demonstrated to be a useful construct to conceptualize the practice of caring in nursing from a transpersonal perspective. It has been used as a phenomenological heuristic to synthesize intrapersonal, interpersonal, and transpersonal dimensions of nurses' experience. In the intrapersonal dimension it touches on nurses' development, personal and spiritual. The interpersonal dimension of presencing addresses the nurses's capacity for, and experience of, profound relatedness and its implications for therapeutic functioning. The transpersonal dimension of presencing contextualizes relational depth in a resonant energetic field that transcends the relationship and, potentially, connects with that which is universal.

The construct can potentially serve as an organizing principle for theoretical integration, bringing together the conceptual domains of person-centered therapy, intersubjectivity theory, and transpersonal psychology, as well as grounding psychotherapy theory as a contemporary modality in the larger tradition of healing.

It is now generally accepted that the therapeutic presencing represents a significant variable as caring in nursing, but many studies have noted discrepancies between nursess' and clients' perception of the therapeutic presencing, suggesting that a deeper inquiry into how presencing is communicated would be useful.

These findings underscore the importance of self-knowledge and personal development for nurses. Useful research could be conducted exploring the intrapersonal antecedents of nurses' presencing, particularly as they relate to spiritual practice. From this perspective, it is interesting to consider how the cultivation of the qualities of presencing may constitute spiritual practice, in and of itself.

D. Description of possible model cases

Model Case Number 01.

"D.W. was a 37 year old male hospitalized psychiatric patient. His medical diagnosis was Schizophrenia. He had been hospitalized on the psychiatric units on numerous occasions. When not hospitalized, D.W. had a history of getting into trouble for strange behavior, especially for urinating on the floor of his room at a hotel where he lived. D.W. was very quiet on the hospital unit. Much of his time was spent lying on his bed in a large ward. He would occasionally pace the halls anxiously and mutter in an angry or fearful tone. He would stand in the hall and very carefully watch what people were doing. He admitted to having auditory hallucinations in the form of "voices."

D.W. would sometimes tell the nursing staff that people were going to harm him. His affect was usually flat. His behavior on the unit included only minimal interaction with other people. Environmental stimuli, especially people, were perceived by D.W. as threatening.

The nurse assessed D.W.'s nonverbal communication and diagnosed Fear (retreat to bed) and Anxiety (pacing and muttering). Initial intervention was acceptance of these behaviors.

The nurse then used therapeutic presencing with D.W.. When the nurse came on the unit he greeted D.W. by name. When he sat in the dayroom, the nurse would sit nearby and watch television or make brief comment about activities on the unit. The actual message was nonverbal: that the nurse was Not a threat and that it was safe to be near him. The nonverbal interaction with D.W. consisted of being nearby in a nonthreatening position. In this way, trust can be developed. The nurse utilized his presence by sitting with D.W. in as nonthreatening manner as possible. The goal of intervention with D.W. was for him to be able to choose a greater degree of contact with others and to increase his ability to relate comfortably with others. The nurse was present to D.W. without demanding interactional responses from the patient which he was unable to make at the time. At one point, the nurse was called by another patient who needed pain medication. When the nurse was about to go, D.W. asked, "Where are you going? I need you to keep me together!" This verbalization of the meaning of the nurse's presencing indicated D.W. 's active willingness to accept the nurse's presence in his time of anxiety (Gardner, 1985, p. 322)."

Model Case Number 2.

"Michael was a 6 year old male who had ingested a caustic lye solution when he was a 16 month old toddler. He suffered severe damage to his esophagus. He did survive, but he had to endure multiple hospitalizations and surgeries. The aftermath has been a chronic handicapping condition. Michael underwent a colonic interposition at age 4. Esophageal dilations every 2 weeks were begun to maintain patency of the reconstructed esophagus. Michael is still unable to swallow. He has a tracheostomy and a feeding gastrostomy tube. The esophageal dilations continue. They are now done under general anesthesia owing to Michael's level of apprehension and distress.

The nurse assessed Michael's apprehension and distress regarding dilation and diagnosed Fear and Threat related to security and independence needs. Initial intervention included acceptance of his protest behaviors.

The nurse then explored alternative coping behaviors with the child and the family. The nurse arranged to stay with the child prior to the procedure, during induction of anesthesia, and afterward. Michael expressed eagerness for the nurse to remain with him. The nurse accompanied Michael up the elevator to the operating room and remained with him in the operating room during the induction of anesthesia.

The nurse remained physically close to Michael and held his hand. Verbal reassurances ("I'll be right here") were given repeatedly. The actual message was: There is someone present who is focused solely on your welfare. The goal of the intervention was for Michael to accept induction of anesthesia without intense fear and physical resistance.

The nurse was able to practice therapeutic presencing as a caring intervention for Michael to reduce his fear of abandonment in a perceived hostile situation and thereby helped to decrease the traumatic aftereffects. As soon as Michael was under the anesthesia, the anesthesiologist who had witnessed the nursing intervention remarked to the nurse about how unusual it was for someone to accompany a child for anesthesia induction. The anesthesiologist commented about the success of the intervention. He noted that children of Michael's age usually fight anesthesia, yet Michael had remained calm and had fallen asleep quietly. He was aware of this induction as being less traumatic for the child. The threat and fear of the procedure was alleviated by the nurse's presence (Gardner, 1985, p. 322-323).

E. Identification of implications for future research

The concept, therapeutic presencing, as it applies to nursing, was developed by examining the use of presencing in the literature and by practitioners. Analysis of presencing by studying its use, was a way of seeing "what was common" for purposes of developing a conceptualization. Considering that presencing is viewed as a concept that has promise with respect to therapeutic development, analysis by studying use is especially relevant. Analysis of the use of presencing reveals a disposition; in other words the way nurses enact presence is disclosed.

Based on an examination of the use of presencing in nursing situations, the following definition of presence was proposed:

Therapeutic Presencing in nursing, is a therapeutic process of caring in nursing that occurs when nurse and the one being nursed (client) share in the experience of illness and suffering. The process is an interactive style through being, receiving, influencing and participating. Presencing is characterized by immersion, congruence and empathy through which the nurse conveys to the client availability for any contingency. There is confirmation that is mutual and results in affirmation of the persons involved.

The characteristics of presencing as a process were revealed by the analysis and included the following: being, receiving, influencing and participating. The last three of these attributes are referred to as defining characteristics for the concept. At this point, the conceptualization of presence includes therapeutic effect as a defining characteristic. Given the possibility that presencing, the process, might occur but without observing a therapeutic effect, this attribute should be viewed somewhat tentatively as a defining characteristic.

As a concept, presencing has the definitional form of a range definition (Ennis, 1969). Therefore, the definition of therapeutic presencing may be expressed in the form "therapeutic presencing is typically characterized by immersion, congruence and empathy.

The conceptualization of presencing resulting from this paper is dynamic rather than static. The concept was defined by examining the use of presencing in nursing through model cases. A concept that is defined in this manner is subject to change as nurse's view of the phenomenon might change. Moreover, as different types of practitioners from different nursing settings examine the concept, the conceptualization may be altered. In some settings, an entirely different context might be associated with presencing, the concept. For example, as the nurse cares for a woman in labor, presencing might apply but the perception of presencing, the concept, in the context of illness and suffering might not.

IV. Conclusion

The conceptualization of therapeutic presencing in nursing resulting from this study appears valid and reliable and shows promise for guiding practice. Additional studies should be conducted to improve on these qualities. Studies that address the utility of the concept are needed. Specifically, whether or not the application of the concept produces uniform results should be determined. The concept should be analyzed in different nursing contexts. This study focused on the perceptions of nurses practicing in acute care, hospital-based settings. Model Cases should be drawn from other settings, such as home health, psychiatric units, and ambulatory settings. The congruence of this conceptualization with use of the concept by nurses in these settings could be evaluated. Significant differences might facilitate further development of the concept. Additionally, it would be interesting to note what insight about the concept as a therapeutic modality could be provided by studies conducted in different settings.

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