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Client Perceptions of the Therapy Room: Effects of Homely Therapeutic Landscapes

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Abstract

There is very limited research exploring the effects of a homely therapeutic landscape design on the psychological wellbeing of clients attending outpatient psychotherapy. In particular, very little is known about the impact of office design on client perceptions of their therapist and the quality of care they anticipate receiving. Ample data support the idea of healing environments; this has important implications for the field of clinical psychology. The theoretical framework underlying this study is the Tripartite Model, which states that people view spaces as most meaningful when they promote positive feelings of comfort, belonging, and security. Focusing on college students currently in counseling, this mixed methods exploration sought the answer to four questions: (a) What specific homely items are present in their therapeutic environment? (b) How may these items be impacting clients' wellbeing? (c) How may these items be impacting their perceptions of the therapist? and, (d) What is the connection between their experience of the physical space and the quality of care they associate with these items in the room? The results suggest that homely therapeutic landscapes are positively correlated with wellbeing, but not perceptions of the therapist or quality of care. Therapists may glean from these findings that the therapeutic space can help promote self-disclosure and introspection, as well as aid emotional regulation and awareness. Future research should include a more specific measure of the association between the strength of the therapeutic relationship and homely therapeutic landscapes, as well as multicultural considerations for therapeutic environments that might aid the comfort of diverse clients.

Keywords: homely therapeutic landscape, college counseling, wellbeing, quality of care

Client Perceptions of the Therapy Room: Effects of Homely Therapeutic Landscapes

Research spanning the last century has shown that the environment has tremendous effects on components of psychological wellbeing. Numerous fields have studied this phenomenon such as environmental psychology, architecture, ecopsychology, education, and sociology. Additionally, different facets of the healthcare system have made changes to their organizational environments to make them more therapeutic for patients. However, this redesign movement has, so far, not been widely implemented in the fields of psychology and mental health. For the few studies that have targeted this issue in outpatient mental health care, researchers found that homely therapeutic landscapes have been perceived more favorably by clients and have positively affected the quality of care they expected to receive.

Theoretical Frame

One theoretical frame that encapsulates this topic is the Tripartite Model developed by Scannell and Gifford (2010) in the field of environmental psychology. This model addresses the topic of place attachment, which is "the bonding that occurs between individuals and their meaningful environments" (Scannell & Gifford, 2010, p. 1). It suggests that people can have connections to physical places that can affect different facets of wellbeing. The Tripartite Model describes three variables that play a role in place attachment: (a) person, (b) psychological process, and (c) place.

The variable 'person' considers *who* is attached, and how the attachment is based on individual or collective ideals of meaning. From an individual perspective, place attachment is strongest for places that evoke personal memories or have some degree of a personal tie, which contributes to a more stable sense of self. Places that are linked to personal milestones and growth also lead to a greater attachment, as well as places that have ties to cultural or historical

events (Scannell & Gifford, 2010).

The variable ‘process’ deals with *how* the attachment develops in terms of its affective, cognitive, and behavioral effects. In regards to affect, attachment to a place typically occurs when there is an emotional connection. Relph (1976) stated that emotional bonds occur when an environment satisfies a basic human need. In a similar vein, Brown, Perkins, and Brown (2003) concluded that attachment to place depends on a general sense of wellbeing and can instill positive emotions such as love and contentment or negative emotions such as fear and ambivalence. Therefore, it is important for an environment to evoke positive feelings that lead to a healthy, meaningful attachment (Scannell & Gifford 2010).

The cognitive component of process states that, “the memories, beliefs, meanings, and knowledge that individuals associate with their central settings make them personally important” (Scannell & Gifford, 2010, p. 3). Attendant to this, Fullilove (1996) stated that cognitive familiarity is essential for place attachment because people feel more content when they know a place and have a sense of self in that environment. Additionally, when an individual feels a sense of familiarity, it creates feelings of belonging and support. The behavioral component of process addresses how attachment is expressed. When there is a positive attachment, individuals seek proximity and closeness. However, as in Bowlby’s constructs of safe haven and secure base (Bowlby, 1988), attachment security ensures that when individuals enjoy this proximity and have positive feelings about it, they can come and go from it easily (Fried, 2000).

Lastly, the variable ‘place’ deals with *what* the attachment is to in terms of social and physical features. For example, in terms of physical features, Hidalgo and Hernandez (2001) found that individuals had the greatest place attachment to their home and the items that encompass it. Also, factors such as proximity to others and meaningful places and the presence

of amenities are regarded as influential for place attachment. In general, however, research shows that people do not necessarily become attached simply to physical features of an environment, but to their symbolic meanings (Stedman, 2003).

In terms of social features, Riger and Lavrakas (1981) found that bonding to an environment depended on a sense of belonging and familiarity. Also, people are more likely to become attached to settings that promote group identity and social relationships; for example, people may feel more connected to places that share their demographics of social class, race, and age. However, distinctiveness is also important because people like to feel that their place is special in some way (Scannell & Gifford, 2010).

Place identity, described by Proshansky et al. in 1983 (as cited in Gieseking et al., 2014), is similar to the concept of place attachment. Place identity is defined as an aspect of a person's broader self-identity, including the knowledge and feelings they develop from everyday experiences in spaces (Gieseking et al., 2014). In studying place identity, researchers have examined how 'at home' individuals feel, and how much they value and feel connected, to a space (Cuba & Hummon, 1993). The difference between place attachment and place identity is that place attachment develops from the familiar relationship between a person and a place and how attached to it they feel (Scannell & Gifford 2010), whereas place identity develops from the feelings, ideas, and meanings a person derives from a place that influence their identity within that space (Gieseking et al., 2014).

Overall, both place attachment and place identity can benefit positive memory building, a sense of belonging, personal growth, needs fulfillment, goal support, self-regulation, an experience of positive emotions, and feelings of security and freedom. These positive associations and outcomes emerge from a relationship with the space itself, but, notably, they

can also emerge alongside the social interactions occurring in that space (Scannell & Gifford, 2010).

Of course, the therapy relationship also develops in a particular place, where both place attachment and place identity grow alongside of the personal connections. Regardless of paradigm and relational components, successful therapy should feel restorative. Thus, a path to healing includes provision of a space where clients feel safe, where they may experience a sense of belonging, and believe that, there, they can grow and receive what they need. When clients return to therapy on a regular basis and work with one therapist for a while, they will be forming attachments to the whole of the experience; they may benefit even more from entering a space that feels, in itself, therapeutic and inclusive for them.

Problem Conceptualization

Research in diverse areas of healthcare has consistently shown that the environment can significantly influence psychological wellbeing, and that "the symbolic qualities of the physical surroundings can facilitate the therapeutic process" (Canter & Canter, 1979, p. 5). The idea of homely therapeutic landscapes has been considered when designing some healthcare settings, such as general hospital rooms and nursing homes; however, there is minimal comparable research into the design of mental health therapeutic offices. Some explorations have been conducted on the impact of design on patient wellbeing on inpatient hospital units, most of it outside of the United States in the United Kingdom.

A significant number of individuals seek psychological care in private practice and outpatient settings on a regular basis. As of 2007, the number of people in outpatient therapy was estimated at 170 million, or 3.18% of the U.S. population (Olfson & Marcus, 2010). However, despite the large number of people who seek outpatient psychological care, research on the

therapeutic qualities of these settings is rather limited. Although there are not many studies to date, those conducted thus far have yielded quite consistent findings. However, these data have not generally been disseminated and implemented to inform the design of everyday therapy offices. The aesthetics of a therapist's office should help promote wellbeing, as clients come to therapy distressed and in search of psychological health. Therefore, a greater importance should be given to the design of these offices. Treatment efficacy, client satisfaction, and commitment to therapy may increase if clients are immersed in an environment in which they feel held and comfortable.

Key Terms

Therapeutic Landscape

A therapeutic landscape is a "conceptual framework for analysing physical, social, and symbolic environments as they contribute to physical and mental health and wellbeing in places" (Curtis et al., 2007, p. 592). More specifically, it is a "well-designed, welcoming, safe, and effective" environment that aims to "lift the spirits and help patients to recover" (Gesler et al., 2004, p. 123). A therapeutic landscape also often eliminates environmental stressors, connects patients to nature, and creates positive feelings and behaviors (Malkin, 2003). It can further refer to the architectural, ambient, and interior design/aesthetic features of the environment (Harris et al., 2002). Other terms have been used synonymously to describe this idea such as 'healing environments' (Gesler et al., 2004), 'therapeutic environments' (Canter & Canter, 1979), and 'moral architecture' (Edginton, 1997). For this study, I simply use the term 'therapeutic landscape.'

Homely

The term ‘homely’ can be defined as a place that is “simple but cozy and comfortable, as in one's own home” (Oxford, 2018). This British definition of the word is commonly used in the research likely because most of the inquiry has been conducted overseas. I also adhere to this term and definition in accordance with the previous research; however, it should be noted that it is synonymous with the U.S. variation: “homey” (Oxford, 2018).

A homely therapeutic landscape is essentially any environment that includes specific aesthetic and physical features that would typically be seen in one’s home. These features are ones that evoke in clients positive feelings of safety, comfort, and calm (Dyck et al., 2005). Features that can evoke these feelings are, for example, soft furnishings, bright or soothing colors, potted plants (Curtis et al., 2007), natural lighting, views of nature (Douglas & Douglas, 2005), carpets, and decorative pictures or artwork (Harris et al., 2002; Mazis & Canter, 1979).

Psychological Wellbeing

Psychological wellbeing can be defined as encompassing the domains of mood, stress, comfortability, and safety (Edginton, 1997). When an environment promotes psychological wellbeing, a client should feel safer, more comfortable, less stressed, and have a more positive mood in that place (Malkin, 2003).

Perceptions of the Therapist

Perceptions of the therapist can be defined as encompassing aspects of qualification, orderliness, boldness, and friendliness. This refers to how the client perceives the therapist in each of these four domains, based on Nasar and Devlin’s (2011) conclusion that these factors were important for a client’s favorable perception of the therapist.

Quality of Care

The term ‘quality of care’ is used in this study to address the perceptions and anticipations that clients have for the quality of care they are receiving considering the design of a therapy office. This perception is based on both their observation of what the therapy office looks like, as well as their initial and ongoing experience of their therapy in that space. A client’s belief in the quality of care they will receive will be based on Nasar and Devlin’s (2011) conclusion that features of the therapist and the therapeutic space are predictive of a client’s favorable expectations for the treatment they will receive.

Literature Review

To date, most of the research on homely therapeutic landscapes has not been conducted in outpatient mental health offices and mainly explored inpatient facilities and hospital design. Despite the lack of variety in research settings, the findings are consistent. Homely therapeutic landscapes have been found to have positive effects on aspects of psychological wellbeing and behavior over a variety of related studies and settings.

Healthcare Settings

The therapeutic landscapes of healthcare settings have been studied, exploring the effectiveness of design changes that have been implemented to promote greater care and wellbeing for patients. Settings including, for example, general hospitals, nursing homes, homecare, childcare centers, and inpatient units have changed the design of their facilities to better serve the healing process of their clients.

General Hospital

In their paper evaluating hospital design programs in the United Kingdom, Gesler et al. (2004) argued that a redesign of hospitals that considers a holistic framework of treatment is

needed. They referenced numerous beneficial aspects of the physical environment such as lighting, color, noise levels, cleanliness, and spaciousness. Natural landscapes have also been found to be helpful for patient healing. For example, Ulrich (1984) studied two groups of patients in a United States hospital post gall bladder surgery. He found that the group who had windows in their recovery room with a view of nature as opposed to a brick wall recovered faster and experienced less psychological distress. Other hospitals are beginning to bring nature indoors through the addition of plants and indoor gardens, or even adding "backlit photographs of woodlands and rushing rivers" to their operating rooms, as is the case in a hospital in Minneapolis (Gesler et al., 2004, p. 119).

In a related study, Harris et al. (2002) interviewed 380 discharged patients from different departments of six hospitals to measure satisfaction levels and perceptions towards the hospital environment. The researchers asked about features such as lighting, presence of windows, room size, furnishings, colors, artwork, and cleanliness. Patients similarly reported greater satisfaction with colored walls, the presence of artwork, comfortable furniture, window views of nature, larger rooms, adequate lighting, and clean rooms. Patients also positively referenced the homely atmosphere of the rooms as warm and cheerful. The researchers did not find any significant group differences between departments, further emphasizing the consistent findings regarding homely therapeutic landscapes across various populations and settings (Harris et al., 2002).

In another similar study, Douglas and Douglas (2005) explored patient perceptions of a hospital setting in the United Kingdom. The researchers found that physical attributes of the hospital setting effected the wellbeing of patients. For example, factors such as natural lighting, views of nature, adequate temperate and noise levels, bright and interesting décor, and a welcoming atmosphere were regarded as beneficial. These findings are also underscored in

Kalantari's (2014) review of work conducted by Karin Dijkstra in the United Kingdom describing the positive effects of ambient, architectural, and interior features of the hospital environment. For example, features such as lighting, music, scent, windows, spatial layout, coloring, artwork, furniture, and natural elements had positive effects on patients' healing process and wellbeing, notably reducing patient stress levels.

Nursing Homes

Studies on nursing homes yields similar conclusions to those conducted in hospitals. For example, Lawton's (1979) study of patients in a nursing home, found that sensory aspects of the environment were regarded as important for the elderly and frail patients. The patients enjoyed having the environment be bright, textured, and contrasted. They reported that this type of environment was more therapeutic than the typical institutional environment.

Homecare

In one study of homecare settings for chronically ill and disabled individuals, researchers found that the homely environment evoked feelings of safety, comfort, privacy, and control for patients. These qualities were valued by patients as central to their care and wellbeing. Additionally, their level of comfort contributed to uninhibited self-expression. Overall, the aspect of being cared for in their home was regarded as a central component of their healing process (Dyck et al., 2005).

Childcare

In their study of children with intellectual disabilities in schools, Mazis and Canter (1979) found that items such as carpets, older and more comfortable furniture, and pictures were perceived positively. In another child study in a children's inpatient hospital, Rivlin and Wolfe (1979) found that the presence of murals, sculptures, and pictures "provided an aesthetically

pleasing and serendipitous experience" (p. 48).

Inpatient Mental Health

While the previous studies did not address mental health settings, a few explorations over the last 25 years have looked at the value of therapeutic landscapes for inpatient mental health settings. Notably, interest in the importance of physical space for psychiatric patients dates back at least a couple hundred years ago with The York Retreat in England, which was remodeled in the mid-nineteenth century. The York Retreat may well have been the first inpatient hospital designed with a therapeutic landscape in mind. A goal of the hospital design was to create a sense of "cheerfulness through the carpets, 'lively painting,' and wallpaper" because it "reduced the gloom and was seen as providing a beneficial atmosphere for the patients" (Edginton, 1997, p. 96–97). Skylights, plants, and bright paint colors on the walls were also included to add to the cheerful atmosphere (Edginton, 1997).

In a related more contemporary vein, Devlin (1992) focused on staff perceptions of a New England adult inpatient hospital before and after a redesign of the day halls on four of their units. The redesign included different paint and wallpaper, carpets, more lighting, new furniture, curtains, and plants. The main goal of the renovations was to make the units appear more homely. Before and after the renovations, staff were asked to rate these physical design features on a five-point Likert scale from *very good* to *poor*, as well as rate the stimulation of the ward on another five-point Likert scale from *very stimulating* to *not at all stimulating*. Patient behavioral mapping data was also collected for a month prior to the renovations and a month after the renovations (Devlin, 1992).

Devlin's (1992) study had significant main effects for the factors studied including physical design features (furnishings and plants) and ward stimulation. Regarding patient

behavior, patients were rated as exhibiting less stereotypical behaviors after the redesign, such as sitting, laying, or standing; patients were observed to be more active and spent greater time in the renovated room. Patients were also reported as less difficult and having higher morale (Devlin, 1992). The results of this study should be viewed cautiously, however, due to the effects of novelty; given that the unit redesign was new for participants and may have contributed to changes in behavior and mood purely due to being in a fresh environment.

Several studies have examined the design of inpatient hospitals in the United Kingdom (UK). One such exploration examined what aspects of the environment staff believed contributed to their wellbeing after a redesign of the building (Wood et al., 2013). Data were gathered through interviews and discussion groups where nine staff members shared their thoughts on the units before and after the redesign. The researchers found that the comfortable, quiet, and relaxing atmosphere of the redesign was described as optimal by staff. The addition of plants and contact with nature, comfortable furniture, and safe spaces were regarded positively. Overall, staff believed that the aesthetically pleasing and secure environment contributed to their wellbeing while at work (Wood et al., 2013).

In a different but related study, wellbeing was assessed through qualitative discussion groups by Curtis et al. (2007), but, in this exploration, the researchers studied patients instead of staff. The main themes gathered from these interviews were respect and empowerment, freedom and openness, privacy, homeliness and contact with nature, places for expression, and integration into the community. Overall, patients reported that the homely atmosphere of the hospital was therapeutic in terms of feeling comfortable and safe; indeed, patients described feeling more comfortable and safer there than they felt out in the community.

Patients in the Curtis et al. (2007) study also reported feeling attached to the homely

environment, referencing features such as soft furnishings, potted plants, and bright colors. Additionally, large amounts of natural light, the presence of plants, and the warmer and more relaxed atmosphere were viewed as important for decreasing the institutional feel. The authors concluded with a cautionary message: there needs to be a balance between feeling comfortable and creating a desire to stay. The homey hospital is still not a permanent home; while it is beneficial for the atmosphere to be conducive for wellbeing and healing, it can't become so comfortable that patients regard it as a long-term residence or the sole source of security and care (Curtis et al., 2007).

These findings have been replicated in the United States. For example, in one study of a VA center, décor features such as warm colors, carpets, plants, and artwork were associated with higher ratings on the Ward Atmosphere Scale, a measure of staff and patient perceptions of and desires for the atmosphere of the inpatient unit (Corey et al., 1986). Similarly, in their systematic review of literature referencing psychiatric ward renovations and their impact on patient outcomes, Papoulias et al. (2014) arrived at conclusions in accord with findings from these earlier studies. Over many studies and types of therapeutic environments, homeliness, natural or soft lighting, and contact with nature are consistently regarded as positive throughout the literature by both staff and patients.

Negative Effects

As most of the literature previously discussed strengthens the idea that homely therapeutic landscapes have positive effects on wellbeing, many of these studies also discuss how a typical, sterile therapeutic or medical environment has negative effects on wellbeing. Throughout the literature, the therapeutic environment has been described as "drab" (Canter & Canter, 1979), "gloomy" (Edginton, 1997), "disorienting" (Lawton, 1979), "constraining"

(Harris et al., 2002), and "monotonous" (Devlin, 1992). Both patients and medical personal alike have frequently described the environment negatively, not as a place that fosters comfortability, positive mood, or progress.

Other aspects of the typical therapeutic environment have been described negatively, such as the lack of freedom that windows can create amongst the highly-secure inpatient setting (Gesler et al., 2004). Additionally, the "hospital art" typically used has been viewed by patients as adding to the institutional atmosphere, as opposed to creating an "aesthetically pleasing experience" (Rivlin & Wolfe, 1979, p. 48). Research has also shown that the drabness of typical institutionalized settings, without stimulation or rewarding aesthetics, has been found to negatively impact cognitive and emotional development (Weinstein & David, 1987). Overall, when a healthcare setting has a less homely and more institutionalized atmosphere, it is often regarded as unsettling, depressing, restricting, and ultimately non-therapeutic for patients (Lawton, 1979).

Implications for Treatment

Research has shown that aspects of one's physical surroundings can facilitate the therapeutic process by making clients feel welcomed, safe, and happy (Canter & Canter, 1979; Gesler et al., 2004). As previously outlined, there are several negative implications of typical therapeutic environments that don't have a homely therapeutic landscape design. Instilling a homely therapeutic landscape in healthcare settings can have positive effects on client behavior and psychological wellbeing.

Behavioral Impact

One outcome of receiving care in a therapeutically designed environment is that it positively effects patient behavior. Higgs (1970) found that schizophrenic patients at a United

States VA hospital who were moved to a homelier therapeutic landscape setting displayed less pathological and stereotypical behaviors as measured on the Brief Psychiatric Rating Scale. Devlin (1992) had a similar finding: patients who were moved to a new unit with more natural, comfortable, and pleasant aesthetic features engaged in less stereotypical and disruptive behaviors.

Some research has found that "the nice and homely therapeutic environment encouraged the improvement of patients' sense of self-worth and motivation for self-care" (e.g., Curtis et al., 2009, p. 345). A heightened motivation for self-care is applicable to all healthcare settings and is important for clients seeking mental health care as well. A related body of research has found that bright colors and a homely environment can create uninhibited self-expression (Edginton, 1997). While this is not an outcome that would be viewed positively in an inpatient setting, it is important for people whose behavior and/or appearance is not well accepted in the community so that they have a safe place to be themselves and not feel judged. A decrease in self-inhibition might also facilitate outpatient therapeutic progress if it accompanies greater authenticity and presence (Curtis et al., 2007).

Psychological Impact

One specific outcome of receiving care in a therapeutically designed environment that is aesthetically pleasant and comfortable is that it decreases emotional distress and contributes to positive moods (Devlin, 1992; Gesler et al., 2004). When the environment is predictable and comfortable, it fosters feelings of security and trust (Weinstein & David, 1987). Also, when there is an ample connection to nature, whether through natural paintings, windows, or the presence of plants, the environment supports a greater sense of freedom, perhaps overriding feelings of isolation or excessive constraint (Gesler et al., 2004). Overall, even these more indirect

connections to nature have consistently been shown to positivity effect mood, stress levels, and cognitive performance (Positive Psychology Program, 2014).

Homely therapeutic landscapes also enhance wellbeing because they assist in "the ability to identify and interpret interior affective states and imaginatively grasp the minds of others, the enhancement of emotional awareness and empathic capacity, and exploration of self-consciousness and identity" (Rose, 2012, p. 1348). In other words, being in an environment that promotes feelings of safety, security, decreased stress, and positive feelings can help to elicit greater introspection and emotional connection.

In regards to diagnoses, a study conducted in Canada found that inpatients diagnosed with Major Depressive Disorder, whose rooms received more sunlight, had faster recovery rates. However, this study did not include confounding variables such as medication, illness severity, and time patients spent in their bedrooms. A study conducted in Italy found a similar decrease in depressive symptoms for patients diagnosed with Bipolar Affective Disorder who had East-facing rooms. However, this research had comparable limitations (Papoulias et al., 2014). The relationship between symptom reduction in different diagnostic groups and therapeutic landscapes offers some promising directions for further inquiry but it is not well established at this time.

Therapy Offices

Few studies on homely therapeutic landscapes have targeted the setting of outpatient and private practice psychotherapy offices. Notably, the handful of studies that have been conducted on outpatient mental health settings have found results quite similar with those conducted in other health and inpatient mental health settings. Given the strength and consistency of results across related research, it is likely that outpatient psychotherapy clients will respond comparably

to homely environments.

Prior and Current Research

The literature that has addressed outpatient mental health settings includes both non-juried journal articles and empirical studies. For example, a journal article written by Tori DeAngelis (2017) that appeared in the APA Monitor, consolidates environmental psychology research and interview findings regarding the beneficial effects of therapy office design. DeAngelis quotes Sally Augustin, an applied environmental and design psychologist and founder of Design with Science, who stated that therapy offices should create "a calm and refreshing environment to balance the rigorous mental and emotional work of therapy" (DeAngelis, 2017, p. 56). According to Dawn Gum, director of interior architecture at the national firm EwingCole, "natural light is a big mood booster, so when possible, incorporate windows or skylights" that "look out on calming, natural scenery" (DeAngelis, 2017, p. 56). Gum also stated that soft lighting increases comfort and relaxation, and views of nature can lower blood pressure (DeAngelis, 2017).

Based on her review of environmental psychology research, DeAngelis (2017) further states (without presenting the supporting empirical evidence) that having a chair for the client that can be moved creates a greater sense of control for the client, while a chair that has a high back facilities protection. Further along these lines, according to Lynn Bufka, APA's associate executive director of practice, placing a table next to the chair allows the client to feel that they have more territory, as they can place their belongings on it. In regards to communication, DeAngelis cites research conducted by EwingCole showing that round tables support better communication, whereas computers on the table impede communication (DeAngelis, 2017). Another set of common-sense recommendations in the DeAngelis (2017) article address respect

for the socioeconomic status of clients by selection of office furniture in the economical middle–range. For example, if expensive furnishings are used, but the therapy population is lower-class, it can alienate clients (DeAngelis, 2017).

One empirical study on therapeutic environments conducted by Devlin et al. (2013) concludes that an additional way in which to promote consideration for diverse client populations is to have artwork that demonstrates openness to multiculturalism. In their research, Devlin et al. asked participants to rate photographs of a therapy office based on their judgment of the therapist's openness to multiculturalism, sense of welcoming, competence, and how direct they imagined the therapeutic style. The photos varied in their display of art objects based on number of items and their cultural emphasis (reflecting either a western or multicultural tradition). Participants included college students and adults from the local community. Notably, the college group of participants was mainly European American, while the community group of participants was mainly ethnic minorities (Devlin et al., 2013).

The researchers found that therapists were regarded as more open to multiculturalism when there were more art items displayed from a nonwestern tradition. Additionally, the community sample was more favorable than the student sample toward the therapist when more of the objects on display could be characterized as multicultural. Notably, when the items suggested a high western tradition, the therapist was regarded negatively on all domains from the community sample, but more positively by the student sample (Devlin et al., 2013). It makes sense that an appraisal of homeliness is rooted in a feeling of belonging and attachment to an environment that is in accordance with one's own cultural values and/or sensitive to various cultures.

Yet another interesting aesthetic feature of therapeutic landscapes found to be beneficial

is the presence of items and views that create positive distractions. Research conducted by Andrade et al. (2017) found that items that can create a distraction, such as artwork and views of nature, can decrease client stress levels. Even further, DeAngelis (2017) contemplates that fish tanks and pastoral landscapes might also be helpful for clients in therapy to help alleviate their distress when they feel in need of some distraction during a sensitive discussion.

Another interesting avenue of exploration into the therapeutic landscape is an original study examining the effect of wall color on self-disclosure. To this end, Karin Dijkstra (2009) compared therapy rooms that were white in color versus green based on previous research suggesting that green walls—as well as blue—had been shown to reduce anxiety and stress (Jacob & Suess, 1975). In Dijkstra's study, college students were randomly assigned to either the white wall or green wall conditions, and were shown pictures of the therapy rooms through a simulated counseling session. Self-disclosure was measured by the Rotter Incomplete Sentences Blank test (Rotter & Rafferty, 1950). Participants also rated their impressions of the therapist by completing the Counselor Rating Form (Corrigan & Schmidt, 1983), and the professional quality of the therapy room on a 7-point adjective scale (Dijkstra, 2009).

Dijkstra (2009) found that participants in the white wall condition were more likely to self-disclose, had more positive impressions of the therapist, and the room in general—and walls in particular—were perceived as more professional. However, the researcher cautions that these results may not translate to actual healthcare settings as the study involved a simulation (Dijkstra, 2009). Clearly, there are many other important factors that go into creating an atmosphere of professionalism in therapy. Yet, it is notable that even these details may suggest ways in which to make clients feel more comfortable and secure in the therapy room, and perhaps to encourage self-disclosure about sensitive emotions and closely-guarded information.

In a related exploration, Miwa and Hanyu (2006) studied the effects of homelike office decorations and lighting on client self-disclosure and impressions of their therapist. The decorations in their study included pictures, flowers, a tablecloth, and an area rug; the room either had no decorations or all of these. The lighting was either bright florescent ceiling lights, or dim wall and table lamps. The population being studied included college students, and each student was interviewed in the therapy room using the Ego Identity Status Interview (Muto, 1979). Participants were also given the Affective Appraisal Scale (Hanyu, 2000) to measure their impressions of the environment, and the Personal Characteristic Scale (Hayashi, 1978) to measure their impressions of the therapist. Lastly, self-disclosure was measured by speaking duration and 7-point Likert scales for how much they spoke, how private the topics, and how relaxed they felt (Miwa & Hanyu, 2006).

Miwa and Hanyu (2006) found that dim lighting and the presence of decorations had positive effects on both self-disclosure and impressions of the therapist. In the dim lighting group, patients spoke more about themselves and reported greater feelings of safety, comfort, and relaxation. The participants in this group also rated their therapist as more pleasant, good–humored, familiar, pretty, and modest (Miwa & Hanyu, 2006). However, interestingly, there was no statistical effect of the presence of home-like decorations. In fact, while clients self-disclosed more in the dim lighting condition, they did so to an even greater degree when there were no decorations in the room. By contrast, in the bright lighting condition, clients self-disclosed *more* when there were decorations in the room (Miwa & Hanyu, 2006). One possible inference that can be made about these results is that the lighting effected the degree to which clients either noticed or were affected by the decorations. When there is dim lighting, clients may be less affected by the items in the room and feel more comfortable. When there is

bright lighting, clients may notice the decorations more and be affected by them to a larger degree. However, given the simulated research design, it is not easy to generalize from these findings to more naturalistic conditions.

Finally, in a series of studies most closely related to this dissertation, Nasar and Devlin (2011) examined client perceptions of a therapy office, the quality of care they expected to receive, and their perceptions of the therapist. The study was mainly quantitative with one open-ended qualitative question. To study these factors, the researchers showed participants—undergraduate and graduate college students—color photographs of 30 therapy offices in New York City taken from the perspective of the client's chair. To gather operational characteristics of the offices, these photographs were first given to a sample of graduate students who rated the therapy offices on 7-point scales for Simple–Complex (the number of different objects in the office), Spacious–Cramped, Orderly–Disorderly, Neat–Messy, and Modern Style–Traditional Style. Another sample of graduate students rated the offices on two additional 7-point rating scales; Hard office–Soft office (comfortable surfaces and textures) and Impersonal–Personalized (personal items displayed). After conducting a principal component analysis, the researchers combined the disorderly, messy, cramped, and complex scales into one and labeled it 'orderly,' and the personalized and soft scales and labeled it 'soft/personalized.' There was high interobserver reliability for each of these characteristics (Nasar & Devlin, 2011).

In their main study, the sample of participants were again undergraduate and graduate students who were split into two groups. For the first group, Nasar and Devlin (2011) examined whether there was an association between therapy offices characterized as orderly, soft, or personalized and perceived quality of care and comfort in the office. Participants in this group were asked to rate each office for the quality of care expected and how comfortable they would

feel in it on 7-point scales ranging from *very poor* to *very good*. For the second group, the researchers examined whether there was an association between the same office characteristics and perceptions of the therapist. Participants in this group were asked to rate the expected therapist in each office on three 7-point scales: Unqualified–Qualified, Timid–Bold, and Friendly–Unfriendly. All participants answered one open-ended question asking about the characteristics of the office that stood out to them; they were provided with a list of décor features to rate on a 5-point scale for their importance (Nasar & Devlin, 2011).

The researchers found that "as perceptions of softness/personalization and order increased, so did expectations about quality of care, comfort, boldness, and qualifications of the therapist" (Nasar & Devlin, 2011, p. 315). Additionally, perceived friendliness increased with increases in softness and personalization. Overall, softness and personalization had larger effects than did order and led to more willingness for subjects to say they would want to select that therapist.

The offices rated most positively by participants were described as comfortable, nice, clean, warm, inviting, and professional, whereas the offices rated most negatively were described as cluttered, cramped, messy, uncomfortable, and unprofessional. Lastly, in terms of aesthetic and physical features of the office, "neatness and chair comfort were rated as most important, followed by order, space, style, and color" (Nasar & Devlin, 2011, p. 317). These features were followed by specific items present in the office such as decorations, books, and diplomas. Demographically, the researchers found no difference in ratings related to race, gender, ethnicity, or class year (Nasar & Devlin, 2011).

In an extension of this previous study, Devlin and Nasar (2012) examined whether client perceptions of the therapy office would be similar to those of the therapist; the authors were

interested in whether therapists would agree with the "client" evaluations. Using the same photo methodology of their previous study, the researchers thus additionally asked licensed psychotherapists to evaluate the quality of care, comfort in the setting, and therapist qualities they expected clients to experience in each office. Devlin and Nasar (2012) then compared the results of this study to the findings of their previous study.

The results were consistent with the previous study in that therapist participants rated comfort and orderliness as important for impacting judgements of both the therapist and the office. They were also similar in placing high importance on softness/personalization for perceived quality of care and comfort. For other variables, there was a moderate agreement between therapist and client perceptions. Therapists were generally accurate in predicting how clients would perceive the office and how aspects of the offices would affect them. However, for perceptions of the therapist's qualifications, students rated orderliness as more important than did therapists. This data set suggests that the environment of an outpatient office may have a significant impact on client comfort and healing; further, therapists could benefit from a more thorough understanding of how their office space affects their clients (Devlin & Nasar, 2012).

Research Questions and Hypotheses

This study offers additional insight into the actual physical and aesthetic elements of a therapeutic landscape that matter most. The Devlin and Nasar studies (2011, 2012), while interesting, have three limitations that the current project addresses: (a) the studies employed a photograph of a therapeutic landscape and not the client's physical office; (b) their subjects were students and not actual therapy clients; and (c) they assessed the expectation for care, not the lived experience of it.

Devlin and Nasar suggested that future explorations should investigate the impact of the

therapy office on therapeutic outcomes by surveying participants who have experience of treatment in an outpatient therapy office, and asking them about the therapy office they actually use (Devlin & Nasar, 2012). This study thus served to build on the findings of the Devlin and Nasar studies (2011, 2012) by asking therapy clients about their perceptions and experiences of their actual therapy offices, while also broadening the focus on experience to different aspects of wellbeing beyond just comfort.

Through a quantitative survey with one open-ended qualitative question, I study the presence and effects of homely therapeutic landscapes in outpatient mental health settings—specifically the college counseling population—by addressing the following questions:

1. How many specific homely items are present in the physical space/therapeutic landscape of the therapy office?
    - Hypothesis: I expected that the higher number of homely items checked off as present in the therapy room, the higher the positive ratings on components of wellbeing.
2. How do clients believe the homely therapeutic landscape impacts different aspects of their wellbeing?
    - How does the physical space impact their level of stress?
        - Hypothesis: I expected a negative correlation between the presence of homely items and stress levels.
    - How does the physical space impact their level of comfort?
        - Hypothesis: I expected a positive correlation between the presence of items deemed as homely and client comfort in the room.
    - How does the physical space impact their mood?

- Hypothesis: I expected a positive correlation between the presence of items deemed as homely and a more pleasant mood in the room.

3. How does the homely therapeutic landscape impact their perceptions of the therapist on domains of qualification, orderliness, boldness, and friendliness, apart from the therapeutic relationship?
    - Hypothesis: I expected a positive correlation between homely items being present and positive perceptions of the therapist on domains of qualification, orderliness, boldness, and friendliness.
4. How does the homely therapeutic landscape of the therapy office influence the client's perceptions of the quality of care they are receiving?
    - Hypothesis: I expected a positive correlation between the presence of homely items and a higher quality of care that the client associates with the therapist.
5. A single qualitative question asks participants to describe in their own words what they perceive to be beneficial about the therapeutic landscape of their therapy office; how it affects their wellbeing and their progress in therapy.

Method

A pragmatic research paradigm was used in this study to gain knowledge of individual client perceptions and the effects of setting design on their experience of being in therapy. The objective was to increase awareness of how the design of therapy offices can impact clients and, potentially, the therapeutic relationship. A pragmatic approach is best suited for this research study because it can reflect the diverse views of any psychotherapy clients and their unique interpretations of the environment.

A parallel mixed methods research design was employed so that both qualitative and quantitative data could be collected simultaneously to answer the research questions. A parallel design was chosen to decrease any implicit manipulation by the researcher that could emerge through inquiry about certain quantitative results, thereby influencing the qualitative results. More specifically, an embedded design was used for this study because the inferences made from both data collection methods can be combined and allow me to make meta-inferences about the research questions.

Quantitative Design

A quasi-experimental design was used to address the quantitative research questions because the presence or absence of a homely therapeutic landscape was not manipulated and, therefore, participants were not randomly assigned to groups. The independent variable is the presence of an office that portrays a homely therapeutic landscape as measured by the number of *specific aesthetic items* that are in the therapy room. The dependent variables are: (a) *wellbeing* (combining the variables of stress, comfort, and mood); (b) *perceptions of the therapist* (combining the variables of qualification, orderliness, boldness, and friendliness); and (c) *associated quality of care.* In other words, this study looks at the relationships between homely items being present in the therapy room and their impact on aspects of client wellbeing, as well as on client perceptions of the therapist and the level of care they feel they are receiving.

Participants

To continue with the population demographics used in the studies conducted by Devlin and Nasar (2011; 2012), the target population was undergraduate and graduate students engaged in college counseling in the United States. The desired sample size was around 85 students (N=85) for a medium effect size (ES= .30) with a=0.05 (Cohen, 1992). Participants were not

excluded from the study on any basis, including diagnosis, in order to get a sample that was representative of the population being studied.

To recruit participants, the survey was available through social media and email. I dispersed a link to the survey through Antioch University's Listserv, allowing all current and prior (if they are still enrolled in college elsewhere) students of Antioch to receive the email. This email encouraged recipients to forward the survey link along. A link to the survey was also uploaded through my personal social media (Facebook) account, and those who met criteria to take the survey were encouraged to do so, as well as forward the link on their own pages. Additionally, recruitment emails with a flyer were sent to both directors of training at college counseling centers and psychology program chairs at various colleges across the U.S., asking them to post the flyer in their waiting rooms or on their bulletin boards. To encourage participation, participants of the study had the option of entering to win one of four $25 Amazon gift cards.

Measures

Items. To measure what types of homely items are present in the therapy room, I provided participants with a checklist based on items consistently listed as important in previous research on homely therapeutic landscapes [see Appendix A for the list of items]. The items included, for example: a window, curtain, area rug/carpet, lamp, dim lighting, natural light, plant, comfortable furniture, artwork, other decorations, views of nature, colored walls (i.e., not white), wallpaper, therapist personal items, and therapist credentials displayed. The instructions for this checklist asked participants to put a checkmark next to the items that are present in their therapy room.

Wellbeing. To measure wellbeing, participants offered their self-assessment of how the

physical space of the therapy room affects their experience of stress, comfort, and mood. This is consistent with previous research mentioned in the literature review that reflected the importance of targeting stress and mood, as well as the research of Nasar and Devlin (2011) that studied physical comfort. It was my decision to include these three factors under the heading of 'wellbeing.' The scores on these three questions were added together to reach one general score of wellbeing. Participant stress was measured using a 5-point Likert scale ranging from *very stressed* to *not at all stressed*. Participant comfort was measured using a 5-point Likert scale ranging from *not at all comfortable* to *very comfortable*. Participant mood was measured using a 5-point Likert scale ranging from *not very pleasant* to *very pleasant* [see Appendix A for wellbeing instructions and scales].

Perceptions of the Therapist. Participant perceptions of the therapist were measured using 5-point Likert scales for four categories: How qualified, orderly, bold, and friendly they believe the therapist to be. Nasar and Devlin (2011) found that softness (i.e., the presence of items deemed 'soft' and comforting) and personalization were positively related to expectations about quality of care and perceptions of the therapist in terms of boldness, friendliness, and orderliness. They chose these variables due to high interobserver reliability (α>.77), and by conducting a principal component analysis that yielded eigenvalues greater than 1.0. (Nasar & Devlin, 2011). The scores on these four questions were added together to reach one general score of 'perceptions of the therapist.' The first scale ranged from *very unqualified* to *very qualified*, the second from *very messy to very orderly*, the third from *very timid* to *very bold*, and the fourth from *very unfriendly* to *very friendly* [see Appendix A for perception of therapist scales and instructions].

Quality of Care. The quality of care from therapists that participants believe they are

receiving was measured using a 5-point Likert scale ranging from *very poor* to *very good* [Appendix A]. The instructions for this scale asked participants to rate the quality of care they would expect to receive or are receiving. This is consistent with Nasar and Devlin's (2011) study inquiring about the association of homely therapeutic landscapes with the perception of care received.

Analysis

Two separate Pearson product-moment correlational statistical analyses with one within-subjects independent variable and two dependent variables (i.e., wellbeing and perceptions of therapist) were used for this study. A Spearman correlational statistical analysis was necessary to determine the relationship between the independent variable and the dependent variable of *quality of care*, as *quality of care* had an ordinal measurement and was not a continuous variable. Both wellbeing and perceptions of the therapist were whole scores once the subscores were added together, thereby becoming continuous variables whereas the quality of care score remained a Likert-scale variable (Minitab, 2019). Correlational analyses compared the relationships, and their level of strength and direction, between the independent variable and each of the dependent variables (Cohen, 1992). Three separate analyses were run for each of the dependent variables [Tables 3, 4, and 5].

Qualitative Design

A phenomenological design was used to address the qualitative research question. This design was chosen because it emphasizes the subjective experience of each participant, and it allows for data collection on each client's perception of the therapeutic environment and how it affects them. All participants who responded to the quantitative portion of the research also answered this question.

Data Source

Individual data was collected through one open-ended question asking participants to describe their perceptions of the therapy room and how it affects them. The qualitative question was located after the quantitative questions, but before the checklist of items. The qualitative question stated: “In your own words, how does the look and feel of your therapist’s office effect your progress in therapy and overall sense of wellbeing? Please describe your experience of being in that space” [Appendix A].

Analysis

Thematic Analysis (TA) was used to gather themes from the qualitative responses. This method allows for consistent themes and patterns, as well as unique responses, to be gathered across all participant responses. Thematic Analysis is descriptively rich, flexible, and inductive. It involves six steps for researchers: (a) familiarizing themselves with the data, (b) developing initial codes/categories, (c) combining the codes into overarching themes, (d) reviewing those themes, (e) defining and naming the themes, and (f) writing a narrative report of the findings (Braun & Clarke, 2006). The goal of using this analysis was to further enrich understanding by helping to determine some of the meaning held by participants for different aspects of the therapeutic landscape that they find beneficial [Table 6].

Procedure

First, using Antioch University’s Listservs, I recruited undergraduate and graduate students who were currently attending college counseling [Appendix B]. Then, I uploaded a link to the survey on my personal Facebook account through a single post and encouraged others to share it on their own accounts [Appendix C]. By encouraging others to forward the survey either through Facebook or email, I intended for the link to reach individuals who were currently in

undergraduate studies, and who were of differing ages and from different geographic locations.

After a few months with limited participation, I emailed training directors and psychology department chairs at approximately 500 universities and college counseling centers. This email [Appendix D] asked recipients about their willingness to post a flyer promoting the survey [Appendix E] on their department or counseling center bulletin board, resulting in posting at about 70 sites. Interested participants could either click on a link in the recruitment email or scan the QR code on the flyer which took them to the Informed Consent page of the survey [Appendix F].

The Informed Consent notified participants of the purpose of this study, assurance of their anonymity and rights, and instructions for how to participate in the gift card raffle by sending me an email with "Raffle" in the subject line. Their electronic signature (obtained by clicking "yes") then forwarded them to the survey, starting with a demographic questionnaire consisting of seven questions [Appendix A]. If any participant indicated that they were not *currently* receiving counseling on campus they were not allowed to continue with the survey questions. Next, qualified participants were prompted to start the 10-item survey beginning with the eight quantitative questions, followed by the single qualitative question, and ending with the checklist of items.

To ensure anonymity, the link to the survey could be opened through all outlets (via both email and Facebook), but Survey Monkey did not link any identifying information to the completed survey. A setting was chosen on Survey Monkey that inhibits IP addresses from being tracked or recorded. Once the desired sample size was reached, the survey link was automatically deactivated and data analyses were completed. Additionally, the email addresses of those participants who chose to enter the gift card raffle were kept in a password protected document

on my personal computer, and only I had access to them.

Once I closed the survey, all raffle emails were put into a randomized online generator and four winners were chosen. The winners were contacted separately through email with the code so they could access their digital gift card credit. Survey data were then downloaded and stored onto my personal computer, in a password protected document, while I completed data analyses. Survey data and participant emails will be securely stored for the recommended three years, upon which all data, including the Survey Monkey account, will be permanently deleted or deactivated.

Data Analysis

The quantitative data of this study were analyzed using both a Pearson product-moment correlational statistical analysis (referred to as a Bivariate Correlation test) and a Spearman correlational statistical analysis through SPSS (due to one variable having an ordinal measurement). First, for each completed survey, the items that were checked off in the checklist were added together to reach one overall score of 'homely items present' with a score ranging from 0–14. Next, the scores for the *wellbeing* questions addressing stress, comfort, and mood (items 8–10) were added together to get one overall score of 'wellbeing' ranging from 0–15. The scores for the *perceptions of the therapist* questions addressing qualification, orderliness, boldness, and friendliness (items 11–14) were also added together to reach one overall score of 'perceptions of the therapist' ranging from 0–20. The *quality of care* score (item 15) remained separate and scores could range from 0–5. Three separate correlational analyses were run to correlate the number of items present with wellbeing, perceptions of the therapist, and quality of care received. Once all quantitative analyses were completed, Thematic Analysis was used to code the qualitative response, gathering overarching themes from participants on what they view

as influential about their therapy office and how it affects their progress in therapy.

Results

A total of 84 participants completed the quantitative portion of the survey. One survey was incomplete except for one answer, and therefore not included in any analyses or descriptive data. Seven participants did not complete the dependent variable question (i.e., checklist of number of items) but completed the majority of the survey, and were therefore included in the analyses as their independent variable answers were valid. Several participants did not provide all of their demographic data. A total of 76 participants completed the qualitative portion of the survey, however, one ambiguous response was not recorded (participant stated “not a client” as their response). Therefore, 75 responses were included in the qualitative analysis.

Demographic data shows that the majority of participants were female (N=64), aged 18–21 (N=50), undergraduate students (N=63), and attended either public (N=38) or private (N=39) universities. The most prevalent majors of study for participants were psychology (N=17), other (N=17), and biology (N=15). The number of therapy sessions attended were consistent across the three options: 1–5 sessions (N=28), 6–10 sessions (N=28), 11 or more sessions (N=27) [see Table 1 for a summary of the demographic data].

Quantitative

Three separate correlational statistical analyses were used to compare the relationships between number of items present and client wellbeing, perceptions of the therapist, and quality of care. Two Pearson product–moment correlational statistical analyses (referred to as a Bivariate Correlation test through SPSS) were used to compare the independent variable and client wellbeing and perceptions of the therapist. A Spearman correlational statistical analysis was used to compare independent variable and quality of care.

Descriptive statistics show that, for wellbeing, the mean (*M* =12.04, *SD*=2.192) was moderately high, with most participants indicating that they feel comfortable, less stressed, and pleasant in their therapist's office. For perceptions of the therapist, the mean (*M*=16.44, *SD*=2.356) was also moderately high, indicating that most participants view their therapist as more qualified, orderly, bold, and friendly. For quality of care, the mean (*M*=4.52, *SD*=.702) was significantly high, indicating that most participants perceived that their therapists would provide a high quality of care. For the number of items present in the therapy room, the mean (*M*=8.78, *SD*=2.963) indicates that more than half of the 14 items listed were present in most therapeutic offices [Table 2].

The positive and significant correlation between number of items in the room and wellbeing indicates that the number of items present in the therapy space may positively affect components of psychological wellbeing, $p<0.05$ level, r=.269 [Table 3]. The number of homely items present in the therapy room is associated with client comfort, stress, and mood. The non-significant correlation between number of items in the room and perceptions of the therapist suggests that the number of items in the therapy space, or the presence of a homely therapeutic landscape, may not affect how the client perceives their therapist, $p>0.05$ level, r=.033 [Table 4]. There was also no significant correlation established between number of items in the room and perceived quality of care, $p>0.05$ level, rho= -.159 [Table 5].

Qualitative

Four overarching themes emerged from Thematic Analysis of the qualitative data: (a) *comfort* (N=38), (b) *openness* (N=22), (c) *specific objects* (N=7), and (d) *negative experience* (N=8).

Comfort

The comfort theme related to responses that reflected feeling calm and comfortable in the therapeutic space, and included two underlying categories: *objects* (N=21) and *ambiance* (N=17). The objects category referred to responses that endorsed feeling comfortable in the therapeutic space due to specific objects that were in the room. For example, one participant stated “The room/office has a great view outside the window that allows a lot of natural light in. I think the “naturalness” is reflected in our conversations and my general disposition” (Response #25). Another expressed “It really affects me. It’s spacious with comfortable couches. It has snacks and tissues and fluffy pillows” (Response #18). Many of the responses referred to objects such as natural sunlight, dim lighting, windows, personal decorations, comfortable furniture, and colorful artwork. A few responses also referenced fidget toys and noise machines, with one participant stating that “fidget devices create a calm and safe environment” (Response #68) and another expressing that they “appreciate the white noise machine outside the office door” (Response #69).

The ambiance category referred to responses that described feeling comfortable in the therapeutic space due to the atmosphere of the space and how it made participants feel. Many of the participants described the therapeutic space as calm, pleasant, organized, soothing, and cozy. One participant referred to the homeliness of the space by stating “I get a sense of the therapist’s style from the room and that can make me more comfortable cause it’s like I’m visiting someone else’s place” (Response #13).

Openness

The openness theme related to responses that reflected participants comfort with self-disclosure and an ability to be themselves in the therapeutic space; openness included two

underlying categories: *safety* (N=9) and *relaxing* (N=13). The safety category referred to responses that endorsed feeling safe and secure due to the therapeutic space, with one participant referring to it as a "safe haven" that is "necessary for my therapy and recovery" (Response #3). Another participant wrote that, "the look and feel effects my progress in therapy because it feels like a safe place for me to speak about things that aren't easy to talk about" (Response #61).

The relaxing category reflects participants responses of feeling more relaxed, and therefore able to self-disclose, due to the homely landscape. Several responses referred to being able to be more open, honest, self-reflective, self-expressive, and, "unwind and do good work" in (Response #21). One participant stated that, "Her space is spiritually and mentally aware and it makes me feel very comfortable. I feel like I can openly express myself in there without being judged" (Response #17). Another expressed that "peaceful and organized" spaces help them "disclose fast or regulate faster" (Response #76).

Specific Objects

The specific objects theme had one underlying category of *distraction* (N=7). Participant responses referenced specific calming objects in the room that had the ability to help distract them during highly emotional or dysregulated moments. One participant stated that, "It's grounding to have pleasant things to look at in calm colors." Several responses referred to fidget toys, views outside of windows, or and compelling objects in the room that participants use or look at when feeling anxious. One participant noted that the therapist provided tea and coffee; holding and drinking from a cup was a welcome distraction during difficult conversations (Response #65).

Negative

Lastly, the negative theme included responses that were not consistent with the

hypotheses of this study, and instead referenced the negative or null effects of the therapeutic space. This theme included two underlying categories of *no effect* (N=4) and *anxiety-provoking* (N=4). The no-effect category refers to responses which stated that participants did not believe the therapeutic space affected them in anyway or that they didn't pay attention to their surroundings.

The anxiety-provoking category referred to participant responses that described their feelings of discomfort in the room and referenced aspects of the room they did not like, noting, for example therapist spaces that were too small, bare, or had uncomfortable furniture. One participant stated that, "The table that separates us reminds me of a place where police take criminals for questioning" (Response #15). [See Table 6 for the overarching themes, categories, and example quotations].

Discussion

Research has consistently shown that our environment has substantial effects on aspects of wellbeing, mental health, and personal perceptions. The Tripartite Model emphasizes the relationship between physical space and attachment, positing that people become attached to spaces that foster belonging, emotional connection, comfort, personal growth, a fulfillment of needs, regulation, and security. Despite evidence that most therapists make an effort to decorate their offices, there is limited research on the salience of the therapy space to the experience of wellbeing in outpatient treatment.

Specific research on homely therapeutic landscapes has mainly evolved within healthcare settings, particularly hospitals. The few research studies that have looked at homely therapeutic landscapes and the design of offices—specifically counselor offices in college counseling settings—have found results consistent with the findings of studies on the impact of healing in

other spaces. Taken together, the extant body of research has found that homely therapeutic landscapes can positively affect aspects of client wellbeing, such as stress and mood, as well as client perceptions of the quality of care they will receive from their therapist. Additionally, researchers have found that specific aspects of such environments are considered important by clients such as level of comfort, natural light and 'soft' details, personal items of the therapist, and details that create a sense of security and warmth.

In this study, I replicated and expanded on the findings of Nasar and Devlin's (2011) protocol in which they asked college counseling clients to share their perceptions of photos of therapy office spaces. By recruiting actual college counseling clients, I studied similar variables including perceived quality of care and perceptions of the therapist (orderly, qualified, bold, and friendly). I further expanded on findings from previous research that suggests our environment affects aspects of psychological wellbeing such as comfort, mood, and stress. To quantify features of a homely therapeutic landscape, I included a checklist of items mentioned in the research as typical components of a homely landscape.

Interpretation of Results

There is a significant relationship between homely items in a therapist's office and psychological wellbeing. Quantitative results suggest that homely therapeutic landscapes (i.e., therapy rooms that contain homely items) are positively related to aspects of client wellbeing such as heightened mood, decreased stress, and increased comfort. This significant relationship is consistent with previous research findings. For example, several studies (e.g., Andrade et al., 2017; Dijkstra, 2009; Ulrich, 1984) found that a more homely space contributed to a decrease in patient stress. Participants in some studies labeled the homely space as more satisfactory and beneficial to their wellbeing than an institutionalized space (e.g., Corey et al., 1986; Devlin,

1992; Douglas & Douglas, 2005; Harris et al., 2002; Wood et al., 2013). Lastly, participants in several studies directly addressed their increase in comfort, safety, and mood due to features of the homely therapeutic space (e.g., Curtis et al., 2007; DeAngelis, 2017; Dyck et al., 2005; Positive Psychology Program, 2014). The consistency of these prior and current results together makes a compelling case for a relationship between homely items and psychological wellbeing for psychotherapy clients. These data lend further credence to the framework of the Tripartite Model: *clients feel better in spaces that are designed with their healing in mind.*

I found no significant relationship between homely items in a therapist's office and perceptions of the therapist. Homely therapeutic landscapes in my study were not associated with client perceptions of their therapists in terms of friendliness, orderliness, boldness, or qualifications. These findings diverge from previous research suggesting that aspects of the physical environment like decorations and dim lighting do influence how clients perceive their therapists (e.g., Miwa and Hanyu, 2006). In explorations of community samples, researchers similarly found that certain items in the therapy space can impact client's perceptions of the therapist in terms of multicultural openness, and how accepted or alienated clients may feel in the space (e.g., DeAngelis, 2017; Devlin et al., 2013.

I included this question to replicate Nasar and Devlin's (2011) exploration. These researchers found that aspects of the hypothetical photographed homely therapeutic landscape affected how participants perceived the therapist. Those participants expected that therapists with offices that were orderly, personalized, and had soft furnishings would be more bold, qualified, and friendly. In that study, participants further reported that they would be more willing to pursue therapy with those therapists and in those spaces.

It is notable, therefore that there is a difference between the expectations for an imagined

therapeutic encounter and the experience of the real thing. My study, asking about an actual human connection, concluded that the participants' perceptions of the therapist with whom they have already established a relationship were not affected by the number of homely items in the office. It is quite possible that whatever college students may anticipate about the therapy experience beforehand, their actual engagement leads them to pay attention to other dynamics and factors.

For example, it's possible that the development of the therapeutic relationship over time may take precedence over aesthetic factors in how the client comes to perceive their therapist. In my study, participants were evenly distributed over the number of sessions attended: an equal number of participants reported either attending 1–5 (N=28), 6–10 (N=28), or 11+ (N=27) sessions. Thus, it may not significantly matter what clients first think of a space or view its salience to the boldness, qualifications, and friendliness of their providers over time as much as common factors (i.e., therapeutic alliance, empathy, goal consensus and collaboration, positive regard, and affirmation, etc.).

Contrary to expectation, I also did not find a significant relationship between homely items in a therapist's office and participants' perception of quality of care. By contrast, positive ratings of the quality of care one expects to receive was consistently found in prior studies, with participants viewing therapists as more competent, open, qualified, and professional when a more homely therapeutic landscape was present (e.g., Devlin et al., 2013; Dijkstra, 2009; Miwa & Hanyu, 2006). Nasar and Devlin (2011) similarly found that the college students in their study provided higher ratings on expectations for quality of care when the therapy space was more orderly and personalized, and included soft furnishings.

The difference in results may reflect again the distinction between research subjects'

expectations for care and the assessment of current clients thinking about their actual personal therapy rooms and real therapists. My participants were reflecting on a significant ongoing relationship, not making inferences about a pictured therapeutic space. Participants in my study most likely already viewed their therapists as competent and able to provide good care—that's one reason why they were continuing to attend appointments. Indeed, a closer look at the high mean value for *quality of care* (*M*=4.52, *SD*=.702) suggests a generally strong level of satisfaction with the level of care.

Qualitative Results

Comfort. The qualitative results suggest that participants value aspects of the therapeutic space that contribute to physical, cognitive, and emotional comfort. These results are also consistent with the quantitative results suggesting a positive relationship between homely therapeutic landscapes and psychological wellbeing. Participants directly stated that certain items, such as artwork and fountains, helped to increase their mood, as well as fill the space and offer soothing qualities. Participants discussed the value of natural light, the presence of windows to look out of, and comfortable furniture for increasing happiness and comfort levels.

In particular, the presence of windows and natural light is a consistent finding in previous literature on homely therapeutic landscapes, suggesting that it is highly important in fostering positive feelings and a sense of safety (Douglas & Douglas, 2005; Ulrich, 1984). Participants in my study also referred positively to the ambiance of a space when it was "warm," "inviting," or "calming." One participant reported that such a setting helped to put their "mind at ease." These are qualities that often emerge in the literature, suggesting, understandably, that clients prefer spaces that have a less institutionalized, more home-like atmosphere (Curtis et al., 2007; Curtis et al., 2009; Devlin et al., 2013).

Consistent with Devlin and Nasar's (2011) findings, some of my participants noted positive experiences in therapy spaces that were neat and clean. One stated, "I find my therapist's office to be a neat, secure, and calming space without extra noise or clutter." It is likely that orderliness is important to some clients. However, it is not hard to imagine, conversely, that some college students might experience a less-organized office as more homely; while others actually have no preference or don't notice the space in those terms. In the quantitative question, orderliness was aggregated along with friendliness, qualifications, and boldness creating an overall perception of the therapist. With regard to a feeling of comfort with the therapist, the variety of qualitative responses adds more specific texture to the statistical data on this topic.

Openness. The qualitative results also suggest that a homely therapeutic landscape positively influences the rate of self-disclosure, honesty, and authenticity within therapy. Participants wrote about the level of comfort and security they felt in their therapy room, stating that it allows them to "freely express" themselves and feel safe discussing "sensitive subjects." Participants noted the utility of calming items such as dim interior lighting and windows for natural light in helping them more openly express themselves, think clearly, and share about their struggles. This is consistent with previous research suggesting that wall color (Dijkstra, 2009), decorations and lighting (Miwa & Hanyu, 2006), and homely qualities (Dyck et al., 2005; Edginton, 1997) can influence self-disclosure. Additionally, Rose (2012) stated that homely therapeutic landscapes assist in both introspection and emotional awareness. An increase in self-disclosure, self-awareness, and safety is essential for therapy; it has a significant role in the progress of treatment. It is interesting to speculate about the relationship between greater self-disclosure and sense of overall *wellbeing* in a homely therapeutic space: as clients are

feeling more comfortable and less stressed, they may be more likely to share and feel more open to the whole experience of being in psychotherapy.

Specific Objects. Participants referred to specific objects in the therapy room that contribute to feeling grounded, comforted, relaxed, and secure. This qualitative theme further fleshes out the general experience of wellbeing in a homely therapeutic landscape. The items listed by participants as most salient were consistent with previous literature on specific items/objects that are considered beneficial in therapeutic spaces—and the checklist they completed at the end of the protocol (e.g., Corey et al., 1986; Douglas & Douglas, 2005; Harris et al., 2002; Rivlin & Wolfe, 1979). Within those studies, participants referred to plants, artwork, warm colors, soft furnishings, sunlight/windows, dim lighting, curtains, and carpets. The responses in this theme are consistent with both DeAngelis' (2017) study where distractions such as fish tanks and artwork were considered important, as well as Andrade et al.'s (2017) finding that artwork and views of nature offered good distractions to thereby alleviate client stress.

My participants similarly spoke about calm colors, windows, fidget objects, a rotating display on a computer screen, and artwork. The explanations offered in support of certain objects, such as artwork or a window, offer depth and meaning. For example, respondents described how a certain item might offer a "welcome distraction" thereby allowing them to manage the intensity of eye contact and giving them needed time to regroup and self-regulate.

While not all of the specific items included on the checklist were mentioned in the qualitative responses, the overall high mean of items reported in the therapy spaces of participants (M=8.78, SD=2.963) suggests these participants were largely being treated in offices that offered homely therapeutic landscapes; many seemed to be aware of particular objects in that space, and noted their importance for their general positive experience of therapy.

Negative. The few responses that I coded as *negative* refer predominantly to a lack of perceived impact from the items in the room. Only in a very few cases did participants describe the objects in the room as negative or contributing to an actual decrease in aspects of wellbeing. For example, some participants stated specifically that the space did not affect their progress in therapy and that the items in the room did not contribute to calmer feelings. Other explorations similarly concluded that the presence of decorations had no effect on participant rates of self-disclosure (e.g., Miwa and Hanyu, 2006). These qualitative findings suggest greater nuance than most quantitative accounts: for some noteworthy minority of people, the presence of decorations or homely items may not affect them at all or be viewed as salient to their therapeutic work.

A few respondents discussed elements of the space that actually contributed to greater anxiety for them. For example, one participant viewed items in the room as distractions that interrupted their thought process; these things did not in any way help them self-regulate and decrease their stress. Another participant stated that the space made them feel "enclosed and trapped." This observation is consistent with previous literature suggesting that people prefer larger spaces (Gesler et al., 2004; Harris et al., 2002). A third talked about feeling like they were in a police interrogation room because they met with their therapist across a table. These few responses give a small window into the diversity of experiences; when a client comes in and sits down, they may not always feel the sense of welcome, safety, and belonging that they will need to have positive therapeutic experiences.

Clinical Implications

There are several implications of these research findings for clinical practice. Foremost, when we look at both the quantitative and qualitative data together, it is clear—in concert with

previous research—that a homely therapeutic landscape is positively related to aspects of client wellbeing. Participants appeared to view the space as influential and important for their fuller engagement within therapy. How we select, decorate, and attend to our work space has implications for the creation of a stronger working alliance and may even facilitate a more productive course of treatment. A careful consideration of the physical space can add to our strategies for promoting client wellbeing and progress, as well as increase their mood and decrease feelings of stress. We focus, rightfully, on the therapeutic relationship, but this may be enhanced when our clients can feel safe and comfortable sitting with us in a homely space.

The qualitative data suggest two further elements with implications for clinical practice. First, the therapeutic space has the potential to elicit feelings of safety and security as well as an increased likelihood of self-disclosure. As practitioners, we should be mindful of items and features that promote our client's sense of comfort, ability to self-disclose, and capacity for self-expression. Second, distractions can be positive; therapists would do well to create a space that might assist in self-regulation—through artwork, fidget-toys, or a window with a view.

The experience of safety is particularly salient within a trauma-informed care framework; clients who are struggling to manage their emotions during a stressful conversation about past traumatic experiences may particularly benefit from a space that invites regulation, healthy distraction, comfort, and safety. Because a sense of belonging and fit is so critical, therapists would do well to ask their clients about how the space affects them to support their overall wellbeing. This inquiry might extend to the whole experience of coming to therapy—from the parking area or public transportation, to access into the building, comfort in the waiting area, and the seating in the office.

Limitations

One limitation of this study is its potentially weakened validity. For one, the sample size was smaller than originally determined ahead of time by statistical power analysis (Cohen, 1992). Second, the number of responses for the independent variable was smaller than the number of responses for the dependent variables, thereby further limiting the statistical power and generalizability of my findings, as well as creating greater confounding variability in what contributed to participants' dependent variable scores (i.e., if participants did not complete the checklist of items but did complete the dependent variable questions, they may have been referring to other influential factors beyond a homely therapeutic landscape that impacted their scores). Also, while the scales and variables used is this study were mainly drawn from Devlin and Nasar's (2011) study, the inclusion of a checklist of items at the end was not standardized. This lack of standardization negatively impacts analysis and the generalizability of findings.

Another limitation of the study is the presence of several possibly confounding variables that could have their own association with the experience of a therapy office, including for example, previous outpatient work in the community, the therapeutic relationship and diagnosis, a student's major in school, theoretical models of treatment, the therapist's status and years of training, or client SES and other diversity and multicultural factors—all may be salient to how a client enters therapy and comes to perceive the therapeutic landscape as homely or not.

While perceptions of the therapist and perceived quality of care can be affected by environmental factors, they are likely influenced by other variables as well. For example, perceiving one's therapist as friendly and qualified likely stems from personal characteristics and presentation even more than perceptions of the physical space in a college counseling center. Given the experiential and nonverbal elements of the therapeutic enterprise, this exploration was

certainly not determinative of all that may contribute to perceptions of the therapist or care to be received, how this actually happens, and to what degree it is necessary for change—especially in generally brief work on a college campus.

Indeed, it is quite possible that a gifted therapist and a motivated client could have a productive relationship in a bare or generic office space. These findings do not challenge what is already well-established about the centrality of the therapeutic relationship in effecting desired changes. It is possible that the perceived quality of care may be separate from any awareness of the space itself, suggesting that other variables (e.g., the therapeutic relationship, therapist credentials, other common-factor therapist and client qualities not studied here) may exert greater influence on client expectations of their therapist and the care they will receive. However, it surely also matters that therapists cultivate a welcoming and nurturing physical space in which to practice. Given the significant relationship between a homely space and client wellbeing, as well as the value participants placed on feelings of comfort and openness in the therapy room, it is evident that the physical space is important, too.

Perhaps due to selection bias—the study included lots of psychology majors and people interested in talking about their therapy experience—most participants indicated positive aspects of wellbeing, favorable perceptions of the therapist, and a belief in the quality of care they were receiving. The high mean scores for each variable suggest a high-end skewed cluster of responses for each item. Similarly, the mean score for number of items present in the therapy room was also moderately high, indicating that the specified items were often present in therapy spaces. Given these high means and ratings, it is evident that participants generally had positive experiences in their therapeutic spaces. If, as Miller et al. (2007) conclude, therapy and therapist's success rates fall along a bell curve, these positive data do not accurately represent the

more diverse and balanced range of responses expected for psychotherapy clients. Perhaps a different recruiting strategy and a larger sample would yield a more normal distribution of responses and range of client experiences.

Directions for Future Research

Given the variables studied, future research could explore how a homely therapeutic landscape affects the therapeutic relationship specifically. The variables of *perceptions of the therapist* and perceived *quality of care* may be components of, or influenced by the therapeutic relationship; future regression analyses might determine how much of the variance might be accounted for by the homely therapeutic landscape. A larger study might also provide a more meaningful range of responses, allowing for greater clarification on how a homely therapeutic landscape relates to the therapeutic relationship and overall experience in treatment.

Future research would do well to also include a greater consideration of multiculturalism and the experience of diverse clients coming to a therapist's office for treatment. For example, it is important for clinicians to express multicultural openness through the design of their office, and to remain mindful of any items that may be perceived as extravagant when working with a more marginalized economic population. Future research could explore the relationship between items present in the therapeutic space that promote multiculturalism and aspects of client wellbeing, perceptions of the therapist, and expected quality of care across a more explicitly diverse sample. Additionally, this study sought to replicate some of the structure of Devlin and Nasar's (2011) study by recruiting college-based participants. Thus, the vast majority of respondents were 18–21 years old and undergraduates. Future research might consider the impact of age and generational cohort on the experience of homely therapeutic landscapes.

Future explorations might also include an expanded consideration of office design,

beginning with the entire experience of coming to therapy. What is the impact of the larger environment—getting to the facility, parking, entering the building? If clients have physical disabilities or other special needs, is the experience welcoming both outside of the room and within the space (i.e., is it spacious enough, does it offer furniture that is easy to get in and out of, is it supportive of all body sizes and shapes? [Hartwell-Walker, 2016]).

Finally, the time I've spent on this study has spanned the years both prior-to and during a global pandemic. Very few, if any, therapists are currently practicing in their offices. The homely landscape a client now sees on a screen might be reduced to a bookshelf or a painting in a therapist's home; or, as much of the current telehealth webinars and discussions have promoted, a blank wall with little to no decorations so that distractions are limited and the virtual session is not negatively affected. The client's own physical surroundings may range from great comfort and privacy to none at all. For these clients who have made the transition to teletherapy, it would be interesting to know what, if any, elements of the therapist's office they miss the most. Perhaps we can learn even more about what mattered to them, asking them to look back on the experience of being in that lost space.

Conclusion

This research study sought to answer the question of how a homely therapeutic landscape is related to aspects of client wellbeing, perceptions of the therapist, and perceived quality of care for college students currently receiving counseling services on their campus. With the addition of a qualitative question, this study further sought to understand how clients view their therapy spaces and what physical and/or aesthetic components of the space they consider to be important. While the quantitative results did not suggest that homely therapeutic landscapes are related to quality of care and perceptions of the therapist, they did confirm the value of a

well-considered therapy office for a sense of wellbeing; participants associated the space with comfort and as a positive influence on mood and stress.

The qualitative results were rich and descriptive highlighting the importance of a calming and relaxing office environment as well as the value of specific objects to offer solace and comfort. Homely therapeutic landscapes may contribute to an increase in self-disclosure, self-regulation, and emotional awareness, all important qualities for successful treatment. In a moment in history when people turn to therapy because they feel fearful, sad, confused, and isolated, a homely therapeutic landscape can convey, even before the therapist says a word: *You are welcome; you belong; here, we are safe.*

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Appendix A

Survey

Please complete the following questions by writing in or checking off the answer best describing you:

Are you currently receiving counseling services on campus? (Yes or No): _____

(If your answer is 'NO,' please discontinue this survey)

How many individual sessions have you had with your *current* counselor in *one consistent* therapy office? _____

Age: _____

Year of Study:

Undergraduate: _____

Graduate: _____

Gender Identity:

Female: _____

Male: _____

Transgender: _____

Other: _____

Which of the following best describes your current academic setting?

Private University: _____

Religious University: _____

Public University: _____

Which of the following best describes your current major of study?

Biology: _____

Chemistry: _____

Physics: _____

Art: _____

Psychology: _____

Anthropology: _____

Sociology: _____

History: _____

Math: _____

Computer Science: _____

Communications: _____

Political Science: _____

Business: _____

Economics: _____

Literature: _____

Nursing: _____

Engineering: _____

Education: _____

Other: _____

For the following questions, please circle the number on the scale that best indicates how you feel in the counseling room:

1) How comfortable does the physical space of your current counseling room make you?

1 2 3 4 5

(not at all comfortable) (mildly comfortable) (averagely comfortable) (moderately comfortable) (very comfortable)

2) How stressed do you feel by the physical space of your current counseling room?

1 2 3 4 5

(very stressed) (moderately stressed) (averagely stressed) (mildly stressed) (not at all stressed)

3) How does the physical space of your current counseling room impact your mood?

1 2 3 4 5

(not very pleasant) (mildly pleasant) (averagely pleasant) (moderately pleasant) (very pleasant)

4) How qualified do you perceive your counselor to be?

1 2 3 4 5

(very unqualified) (mildly qualified) (averagely qualified) (moderately qualified) (very qualified)

5) How messy vs. orderly do you perceive your counselor to be?

1 2 3 4 5

(very messy) (mildly messy) (averagely messy/orderly) (moderately orderly) (very orderly)

6) How timid vs. bold do you perceive your counselor to be?

1 2 3 4 5

(very timid) (mildly timid) (averagely timid/bold) (moderately bold) (very bold)

7) How friendly do you perceive your counselor to be?

1	2	3	4	5
(very unfriendly)	(mildly unfriendly)	(averagely friendly)	(moderately friendly)	(very friendly)

8) What is the quality of care you associate with and expect to receive from your counselor?

1	2	3	4	5
(very poor)	(mildly poor)	(averagely good)	(moderately good)	(very good)

Please write-in your answer to the following question:

In your own words, how does the look and feel of your therapist's office effect your progress in therapy and overall sense of wellbeing? Please describe your experience of being in that space.

_____

_____

_____

_____.

Please place a checkmark next to each of the following items that are present (at least one) in the room where you receive counseling:

Area rug/carpet: _____

Curtain: _____

Window: _____

View of nature: _____

Plant: _____

Lamp: _____

Dim lighting: _____

Natural light: _____

Comfortable furniture: _____

Artwork: _____

Other decorations: _____

Counselor's credentials displayed: _____

Counselor's personal items displayed: _____

Painted/colored walls or wallpaper (i.e. not white): _____

Appendix B

Recruitment Email

Hello. My name is Amanda Knapp. I'm a doctoral student in Antioch University New England's Clinical Psychology graduate program. For my dissertation, I am finding out about how, if at all, the design of therapy offices effects clients, their healing process, and their perceptions of the therapist. I hope you will consider participating. Are you:

-A current undergraduate or graduate college student?

-At least eighteen years old?

-**Currently** receiving counseling services on campus?

If you answered yes to all of these questions, you are eligible to participate. If you are interested, please click the link below to complete a brief survey. You will also be invited to enter a raffle to win one of four $25 Amazon gift cards! If you know any other students currently in counseling who might be interested, I would be grateful if you shared this survey link with them.

Thank you for your time, help, and participation!

Sincerely,

Amanda Knapp, M.S.

Antioch University New England

Appendix C

Facebook Post

Hello! As part of my graduate degree I am completing a project to raise awareness of how, if at all, the design of therapy offices effects clients, their healing process, and their perceptions of the therapist. To participate, you need to be an undergraduate or graduate college student, at least eighteen years old, and *currently* receiving counseling services on campus. If you meet these criteria and are willing to complete a brief survey, I've attached the link below. Those who complete the survey can be entered in a raffle to win one of four $25 Amazon gift cards! I would also greatly appreciate if you would forward this post to others. Thank you!

Appendix D

Email to Directors

Hello,

My name is Amanda Knapp and I am currently a graduate student in Antioch University New England's Clinical Psychology PsyD program. I am completing my IRB approved dissertation research and am hoping to reach students who are utilizing on-site college counseling services. I am studying clients' general thoughts of therapeutic office spaces and how the physical space effects them. Given that your campus has an on-site Counseling Center, I was wondering if you would be willing to generously post flyers with the link to my survey in your Center's waiting area? If so, I have attached it below to save some time. Thank you very much for your time and consideration!

Thank You,

Amanda Knapp, M.S.

Antioch University New England

Appendix E

Flyer

Be a Research Participant

- Are you a current undergraduate or graduate student?
- Are you at least 18 years old?
- Are you *currently* receiving counseling services on campus?

Then you can participate!

Description: Complete a 10-15 minute online survey asking about your counseling room and how it affects you.

You can win a $25 Amazon gift card!

For questions please contact: Amanda Knapp, M.S., or the Chair of the Antioch University New England Institutional Review Board

Link to survey	Link to survey	Link to survey	Link to survey	Link to survey	Link to survey	Link to survey

Appendix F

Informed Consent

Project Title: Client Perceptions of the Therapy Room: Effects of Homely Therapeutic Landscapes

Name of Principle Investigator: Amanda Knapp, M.S.

Name of Organization: Antioch University New England, Clinical Psychology Department

1. I understand that this study is of a research nature.
2. I understand that by participating, I may choose to separately send my email address to the researcher (email provided above) for a chance to win one of four $25 Amazon gift cards.
3. Participation in this study is voluntary. I may refuse to enter it or may withdraw at any time without creating any harmful consequences to myself.
4. The purpose of this study is to examine the impact of therapy office design on client wellbeing and perceptions of the therapist.
5. As a participant in the study, I will be asked to complete the following survey. The survey should take approximately 10-15 minutes.
6. The risks, harm, or discomfort of this study should be minimal. If I feel uncomfortable with the research questions, I may stop taking the survey at any time.
7. Although this study may offer no direct benefit to me, additional benefits might be:
    a. Enhancing a general understanding of how physical features of a therapist's office impact wellbeing and therapeutic care.
    b. Helping therapists learn how to best design therapy offices to promote client wellbeing and healing.

8. The survey information I provide will be anonymous and confidential. I understand that the researcher has chosen for my IP address to not be recorded by this site.
9. I understand that the only identifying information that may be provided will be of my own choosing, if I decide to send the researcher my email address for a chance to enter the gift card raffle. I understand that my email address will not be linked to my survey.
10. If I have any questions about my rights as a research participant I may contact the following people: The Chair of the Antioch University New England Institutional Review Board, or the Provost and Campus Chief Executive Officer (CEO) at Antioch University New England.

By clicking below, I am agreeing to this informed consent. The survey will follow.

If you experience any discomfort after participating in this project, I encourage you to reach out to your campus Counseling Center and seek support as needed. Thank you.

Table 1

Demographics

Variable and frequency total	Sub-variable	Frequency	Percent	Valid percent	Cumulative percent
Number of Sessions	1-5	28	33.3	33.7	33.7
	6-10	28	33.3	33.7	67.5
	11+	27	32.1	32.5	100.0
Total		83	98.8	100.0	
Age	18-21	50	59.5	60.2	60.2
	22-25	17	20.2	20.5	80.7
	26-29	11	13.1	13.3	94.0
	30+	5	6.0	6.0	100.0
Total		83	98.8	100.0	
Year of Study	Undergraduate	63	75.0	75.9	75.9
	Graduate	20	23.8	24.1	100.0
Total		83	98.8	100.0	
Gender	Female	64	76.2	76.2	76.2
	Male	13	15.5	15.5	91.7
	Transgender	4	4.8	4.8	96.4
	Other	3	3.6	3.6	100.0
Total		84	100.0	100.0	
University Type	Private	39	46.4	47.0	47.0
	Religious	6	7.1	7.2	54.2
	Public	38	45.2	45.8	100.0
Total		83	98.8	100.0	
Major of Study	Biology	15	17.9	17.9	17.9
	Chemistry	2	2.4	2.4	20.2
	Art	2	2.4	2.4	22.6
	Psychology	17	20.2	20.2	42.9
	Anthropology	1	1.2	1.2	44.0
	Sociology	2	2.4	2.4	46.4
	Math	2	2.4	2.4	48.8
	Computer Science	4	4.8	4.8	53.6
	Communications	2	2.4	2.4	56.0
	Political Science	4	4.8	4.8	60.7
	Business	1	1.2	1.2	61.9
	Economics	2	2.4	2.4	64.3
	Literature	1	1.2	1.2	65.5
	Nursing	3	3.6	3.6	69.0
	Engineering	4	4.8	4.8	73.8
	Education	5	6.0	6.0	79.8
	Other	17	20.2	20.2	100.0
Total		84	100.0	100.0	

Note. n= (83-84)

Table 2

Descriptive Statistics

Measure	N	Min	Max	Mean	Std. Dev.
# of Items	77	1	14	8.78	2.963
Wellbeing	84	5	15	12.04	2.192
Perceptions of Therapist	84	10	20	16.44	2.356
Quality of Care	84	2	5	4.52	.702

Table 3

Wellbeing Correlation

Variable		# of Items
Wellbeing	Pearson	.269*
	Sig. (2-tailed)	.018

*. Correlation is significant at the 0.05 level (2-tailed).

Table 4

Perceptions of the Therapist Correlation

Variable		# of Items
Perceptions of the Therapist	Pearson	.033
	Sig. (2-tailed)	.779

Note. Correlation is not significant at the 0.05 level (2-tailed).

Table 5

Quality of Care Correlation

Variable		# of Items
Quality of Care	Correlation Coefficient	-.159
	Sig. (2-tailed)	.167

Note. Correlation is not significant at the 0.05 level (2-tailed), and correlation is negative.

Table 6

Qualitative Themes

Overarching Themes	Categories	Examples
1. Comfort (n=38)	Objects (n=21)	• "His computer displays rotating artwork on the screen which I found the most comforting feature." –Response #8 • "My counselor has a little fountain that makes noise, and I find it comforting that whenever there are gaps in conversation it is not completely quiet." –Response #27 • "There is plenty of light and comfortable sofas, chairs, and blankets." –Response #60 • "I'm very glad there's a window, and that sunlight shines through it when I'm there- it makes me feel happy and real." –Response #70
	Ambiance (n=17)	• "It is very relaxing and not cluttered/dirty meaning that my mind is kind of at ease." –Response #1 • "The homey environment makes me feel more comfortable because it doesn't feel intimidating or cold." –Response #46 • "I think it's important for my therapist's office to be inviting and warm." –Response #59 • "I find my therapist's office to be a neat, secure, and calming space without extra noise or clutter." –Response #75
2. Openness (n=22)	Safety (n=9)	• "It gives me a sense of comfort that in turn offers security for me to freely express myself." –Response #5 • "Telegram light is dim and makes me feel safer when discussing sensitive subjects." –Response #14 • "I feel safe to be myself." –Response #47
	Relaxing (n=13)	• "It feels calm and relaxing and makes me feel able to be open during sessions." –Response #4 • "Helps to clear my head and think logically and not over think situations." –Response #22 • "My being comfortable in the room helps me be more open and honest and thus progress with therapy." –Response #26 • "It makes me feel comfortable to talk and think about my problems." –Response #62
3. Specific Objects (n=7)	Distraction (n=7)	• "She had some artwork on the wall which helps to look at when I'm particularly anxious." –Response #48 • "I face a window so I can look outside if I don't want to make eye contact." –Response #45

(table continues)

Table 6 (continued)

Overarching Themes	Categories	Examples
4. Negative (n=8)	No Effect (n=4)	• "Sometimes I look at what's around in the room, but it doesn't affect my comfort or distract me." –Response #10 • "The look doesn't really matter on my progress." –Response #19
	Anxiety-Provoking (n=4)	• "The space makes me feel very enclosed, somewhat trapped." –Response #35 • "Sometimes I get distracted by her office and my train of thought gets interrupted." –Response #52

Note. n= (75)