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Counselling workspace design and therapeutic practice

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Abstract: This paper investigates the relationship between the design of the counselling workspace and therapeutic practice for individuals who self harm. Architectural science encompasses how a built environment physically fits its function; in this paper the subject of investigation is how the design of the counselling workspace affects its function, the delivery of mental health services and therapy. Firstly, the counselling workspace design is discussed across three key themes which were significant points of overlap between architecture and clinical literature during the literature review undertaken. These themes include: self disclosure; territories, self image and autonomy; and body language in therapy. Secondly, the research methods relevant to understanding the significance of counselling workspace design in therapy are discussed. Thirdly, following fieldwork research undertaken by the author, a table of design initiatives is presented. This is suitable for architects and designers working in the design of counselling workspaces, and is also expanded to the wider field of designing for mental health and designing for inpatient and/or hospital care.

Keywords: Therapy; built environment; self harm; interior design.

1. Introduction

> "When circumstances necessitate a change in offices, in the case of a patient who has been visiting for some little time, it takes the patient and therapist part or all of an interview to settle down in the new environment. This would seem to indicate that in a therapeutic situation an emotional overtone develops that is unique and defies description" (Law, 1948).

Within this paper, the counselling workspace is defined as the space where a therapeutic/counselling session occurs. This is typically an interview room/office type space, and is inclusive of physical items, such as a table, chairs, bookshelves and similar; physical aspects such as ceiling height, colour, lighting levels and similar; and other aspects such as control, personalisation, territories, interpersonal distances and similar, all forming what Stanley Law describes as 'the therapeutic situation' (Law, 1948). These

spaces are common across a wide range of treatment service providers where mental health clients may be treated, such as hospitals, private clinics, and community service providers. Each consumer[1] will encounter such a space and will also likely encounter this environment for an extended period of time or over a number of visits, thus are the subject of initial examination within this paper as they are both widely utilised and regularly attended.

2. Counselling workspace design: Literature review

Whilst treatment of mental health conditions occurs in a range of settings, including specific mental health agencies, hospitals, community service centres, schools and private practices, each has a certain room in common: a counselling workspace, which will be encountered by the consumer. This particular space has been reported as a factor that can influence the relationship between therapist and consumer, as well as therapeutic outcomes (Iwai *et al.*, 1983).

The counselling environment is regarded within clinical literature as having an effect on a consumer's sense of wellbeing (Gross *et al.*, 1998; Ulrich *et al.*, 2008). Consumers' experience of such spaces can have a highly emotional dimension (Pressly and Heesacker, 2001) which is suggestive that environment design should be investigated as a potential means to influence therapeutic efficacy. Further, individuals have differing abilities to censor or suppress their environments (Dijkstra *et al.*, 2008) and a stressed patient has reduced capacity to exclude environmental distractions (Samuelson and Lindauer, 1976), suggesting the environment of a counselling workspace may have more impact for these individuals whom often arrive in a distressed state. Research also suggests that layout has strong psychological dimensions for consumers in therapy, and may form a pathway to addressing issues of the self (Liddicoat, 2015). This is suggestive that the counselling workspace may be influential in consumer anxiety levels and therapeutic efficacy.

Linking the design of counselling workspaces to communication and consumer self-disclosure is another major area of research. Self-disclosure, communicating personal information about oneself to another individual(Strassberg *et al.*, 1978), can be confronting to a consumer (McLeod and Machin, 1998) and is less likely when the consumer is in an anxious or worried state (Ignatius and Kokkonen, 2007). However, this self-disclosure is important for the physician or counsellor to plan suitable treatment (Cegala *et al.*, 2004). Studies demonstrate that non-verbal cues in communication account for more variance in the message than verbal cues in communication, sometimes as high as a ratio of 1:20 (Argyle *et al.*, 1971). The interplay of verbal and non-verbal cues is of significance in a counselling context (Gladstein, 1974) and non-verbal variables have been analysed with reference to communication in counselling settings, including distance, body position and body motion (Dinges and Oetting, 1974). These non-verbal communication aspects may be affected by the design of the spatial environment (Sommer, 1974). Non-verbal communication is also of particular significance for individuals who self harm, who find conventional language means of communication as not meeting their needs, and who use their bodies as communication to others via self harming (Horrocks and House, 2010). The following paragraphs discuss how aspects of the counselling workspace, as identified in the existing literature, have an effect on consumer self-disclosure.

Research shows a wider distribution of light leads to perceptions of greater spaciousness (Martyniuk *et al.*, 1973), greater amounts of floor space are judged to be larger (Benedikt and Burnham, 1985), as

1 The term 'consumer' is used within this paper to describe the individual who is the user of mental health services. This term is favoured within contemporary literature and mental health practice.

are rectangular rooms over square (Sadalla and Oxley, 1976). Building upon the notion that a larger room may generate feelings of freedom and spaciousness (Meyers-Levy and Zhu, 2007), Okken et al reported through their own investigation that an increase in room size positively influenced consumer comfort and self-disclosure, and that these consumers also preferred a smaller interpersonal distance when the room was large. It is also suggested that limited space within a room may induce crowding perceptions which can decrease communicative behaviours (Sundstrom, 1975). Research examines the effect of personal space and distance variables on human behavior (Argyle and Dean, 1965), and this notion within counselling settings (Stone and Morden, 1976). Studies by Lecomte, Hall and others are suggestive that distances between 30"/76.2cm and 50"/127cm between consumer and therapist produce highest self-disclosure, which is closer than social distance (defined by Hall as 80"/203.2cm) and also "not the culturally expected conditions for counselling interactions" (Hall, 1963; Lecomte *et al.*, 1981). Meagher and Marsh suggest that affordance in an environment, that is, the opportunities for behaviour it affords, will increase feelings of spaciousness (Meagher and Marsh, 2011). Atmosphere is also implicated in self-disclosure in counselling workspaces: "Is the atmosphere conducive to thinking and reflection? Is the encouragement of conversation and discussion desirable?" (Smith and Watkins, 2010). Spaces consisting of resistant surfaces and bright lighting are suggested as increasing consumers' feelings of non-control over their environments (Sommer, 1974). This is suggestive that atmosphere, spatial layouts, and the notion of spaciousness are influential in consumer self-disclosure, and in turn therapeutic outcomes.

3. Counselling workspace design: Research methods/approaches

Many counselling theorists and practitioners assert that there is a link between counselling environment design and therapeutic outcomes (Pressly and Heesacker, 2001). However there is also an acknowledged lack of research in this area (Pressly and Heesacker, 2001), with many existing studies which examine the impact of the designed environment on counselling practice have focused on the public areas, such as common rooms in in-patient psychiatric facilities, rather than counselling rooms (Corey *et al.*, 1984). Further, many studies only focus on therapist perspectives of the issue rather than interviewing patients/consumers (Pearson and Wilson, 2012). This is suggestive that a multi-source data collection methodology is ideal, where both the counsellors, consumers, and other related parties such as patient carers, may partake in data collection. Fieldwork undertaken by the author involved a series of focused one-to-one interviews with consumers, therapists/counsellors, carers, architects/designers and design experts/researchers, in order to understand consumer experience of built environments delivering therapy. This data was analysed through a thematic network (Attride-Stirling, 2001) and the data re-interpreted to draw conclusions on spatial perception, and implications for the design of built environments to best support the function of therapy. Open ended questions were asked in order to facilitate participants expressing their views on the issues being investigated (Creswell, 2003). The interviews lasted from forty minutes to ninety minutes depending on interviewee's responses to interview questions. This exploratory qualitative analysis (Attride-Stirling, 2001) was undertaken with the five respondent groups noted above, including: 12 consumers of mental health services, 12 practicing therapists/counsellors, 3 carers of loved ones with a mental illness, 4 architects/designers who practice in the field of designing built environments for mental health; and 5 design experts/researchers who work and research in the field of design for mental health. For in depth interviews, as were undertaken, the number of interview respondents were deemed significant enough to draw substantial conclusions (Miles and Huberman, 1994). The interview respondents were from

Australia, New Zealand, England and Iran, and were undertaken in 2015. Cases of existing built environments delivering mental health services were also analysed in order to provide another lens for observing human experience and understanding the effect of counselling room environmental features. Ten cases were analysed, two in New Zealand and eight in Australia. Analysis of the cases was framed within a cases analysis tool developed by the author which focused on the translation of the factors arising from the interviews into the language of designing spaces. This data set as a whole was analysed through a thematic network (Attride-Stirling, 2001) and the data re-interpreted to draw conclusions on spatial perception, and implications for the design of built environments to best support the function of therapy.

4. Counselling workspace design: Design initiatives

Following fieldwork undertaken by the author, a table of design initiatives is outlined below for architects/designers working in the field of designing for mental health service delivery. These initiatives presented extend beyond aspects of the design of the counselling workspace, to include wider areas, such as waiting areas and inpatient bedrooms, which also impact the delivery of mental health services and efficacy of treatment being offered. As arose from the fieldwork data analysis, the physical fit of a building to its function, in this case the delivery of mental health services, is not limited to only the counselling workspace design, and as such, design initiatives for other spaces within delivery facilities are tabled to best consider how to design spaces to support the function of delivering mental health services. These design initiatives are presented below, in order of scale from large to small, including: Facility Wide Design Initiatives; Waiting Area; Counselling Workspace Interior Layout; Counselling Workspace Furniture and Fitting Selection; and Inpatient Bedrooms. Each design initiative is also noted as either related to function and manageability, or to therapeutic processes and psychological outcomes, or to both.

Each table was derived by firstly gathering suggestions arising from the fieldwork data collection undertaken, verifying or elaborating these through a comparison to existing literature within architectural discourse and clinical/social work fields, and examining these through the thematic network analysis to best understand their significance, relations to therapeutic outcomes, and intended architectural articulation as voiced by interview participants. These were then arranged into sets, through a consideration of scale and/or location within a healthcare facility, which gave rise to each table presented below. The tabled design initiatives are suggestions arising from the study undertaken, but further research is needed in order to understand the mechanism of how these architectural initiatives influence mental wellbeing, and their efficacy, through further qualitative data gathering, careful post occupancy evaluations and control studies.

Facility wide design initiatives (see Table 1) were predominantly concerned with wayfinding strategies, both to increase functionality/usability of spaces and to reduce stress experienced by the users. In relation to functionality, this related to issues of surveillance and lines of sight, and having a linear journey through the facility as experienced by the user undergoing counselling. This was seen by consumers as a metaphor for therapeutic progress, and afforded a greater sense of empowerment. Reducing stress is achieved through the inclusion of greenery and green spaces, such as courtyards, and layering of spaces in terms of their privacy for greater spatial and behavioral comprehension and articulation of territories.

Table 1: Facility wide design initiatives

Facility Wide Design Initiatives		
Design Initiative	Functionality/ Manageability	Therapeutic/ Psychological
Abundant use of nature and greenery, including visual access to natural elements as well as physical presence in the interior spaces. Artificial presence, such as through photographs of landscapes, is also seen as beneficial, but should be included in addition to physical presence of nature, not instead of.		✓
Include spacious and airy atria and entry spaces. A low ceiling in these areas is considered quite detrimental.		✓
Include facilities for patients to develop skills such as kitchens, for control and empowerment.	✓	✓
Overall layout should have no dead ends in circulation. Have multiple spaces able to be accessed from circulation paths, not a circulation route which ends in one space, which feels enclosing.		✓
Interaction between inside and outside created by several different buildings on a campus which is well landscaped is considered ideal.		✓
Have discrete entry points to protect privacy. Access to the practice is part of the journey, and so must be private and secluded and feel separate from the outside world. Consider a layering of thresholds at the entry point.		✓
Include niches off corridors for informal discussions.	✓	
Spaces have visual connection to other spaces and do not feel fully enclosed.		✓
Provide controllable, dimmable lighting to promote a sense of calm.	✓	✓
Do not have internal rooms.	✓	✓
Layouts that are not 'octopus' like in plan. Layouts which resemble a figure 8 with courtyards at the centres and a staff station at the central connection point allow visibility and surveillance for staff and access to courtyards for all.	✓	
Include a gradation of spaces in terms of their privacy from entry to occupied spaces to allow people to adjust. Privacy gradients ensure that a consumer never leaves a counselling room/private space and goes directly into a large communal space. Use spaces such as a seating area in between. What can also be useful is a threshold area within a door with a lowered bulkhead and differing floor treatment; this denotes a more private spatial boundary.		✓
Do not physically separate consumers from staff, particularly in reception areas, such as having a fish-bowl type reception desk.		✓
Include internal gardens where possible. Minimise exposed concrete in gardens/courtyards.		✓
Have a linear journey from waiting area, to counselling workspace, to exit.		✓
Include a de-escalation space post-counselling, for self-soothing and rebalancing. This is to be private, include a space for walking/pacing, some natural elements (such as a potted plant, natural photograph or view to a courtyard), comfortable seating, and sensory modulation materials.		✓
Minimise use of lifts after a counselling session (not an ideal exit strategy).		✓
In communal spaces, such as waiting areas, make them more open plan and differentiate walking areas by lowering the ceiling or changing the floor finish or lighting. If one is going to walk through a large space, the design needs to differentiate the spaces for walking in and the spaces for being static in.	✓	

Waiting area design initiatives (see Table 2) were predominantly concerned with physical and psychological privacy. This was a primary concern for consumers, and affected their mental states prior to counselling and the extent to which they were able to engage in the therapy sessions. Physical privacy related to aspects such as managing lines of sight in the environment and audial privacy. Psychological privacy related to how safe or unsafe a user felt, by being exposed, and the notion that by being confronted with another consumer, or overhearing them, they felt overwhelmed with the magnitude of their own thoughts and feelings as well as those of others sharing the space and intruding in their own psychological space.

Table 2: Waiting area design initiatives

Waiting Area		
Design Initiative	Functionality/ Manageability	Therapeutic/ Psychological
Ensure that the therapist and the consumer enter the counselling workspace together, rather than the consumer waiting inside the counselling workspace alone, which is intimidating.	✓	✓
Manage lines of sight so that consumers never feel on display in waiting areas.	✓	✓
Furniture should not be arranged in lines; this is too formal and impersonal.	✓	✓
Do not have televisions in the waiting areas; views to landscapes or artwork are preferable.		✓
In waiting areas, a consumer should be able to see everyone that they can hear, and not see or hear anyone outside of the direct space. Discrete partitioning/separation in waiting areas is ideal to allow a consumer to be on their own, yet aware of others in the space.		✓
A waiting consumer should not be able to easily hear other conversations in the waiting area; muffled, indiscernible noise is acceptable.		✓
Separation of consumers from other consumers where possible is ideal.		✓
Minimise use of glass doors, windows in doors, and glass separations. This makes the consumers feel scrutinised and controlled.	✓	✓
Consider furniture selection (such as winged armchairs) or other such private cubicles to protect identities of consumers, and allow them to not see another consumer, even from behind.		✓
Do not allow the consumer to see the counsellor entering and exiting the office from the waiting area.		✓

Counselling workspace interior layout design initiatives (see Table 3) relate to how the physical design of the space promotes consumer self-disclosure, communication, empowerment and psychological safety. The layout of the room has strong metaphorical messages to the consumer, particularly in relation to ‘space for the mind’, and circular layouts being reminiscent of ‘going around in circles’. Self-disclosure and communication are affected by the spatial arrangement, which directly affects the therapeutic processes. Empowerment relates to how the space might be flexible, and be adjusted to meet individual consumer needs, and allow them to enact and develop a sense of agency within physical space. This is supportive of therapeutic processes, which also aim to develop sense of

self and agency. As the design is considered from a larger scale (facility wide) to a smaller scale (counselling workspaces) the notion of psychological freedom becomes more significant. Wider scales were found to be less significant to notions of empowerment, identity, sense of self and agency for the consumer than smaller scales; the engagement with specific rooms and spaces, their physical design and layout, had more psychological significance than larger scale considerations. This is suggestive of a closer engagement with these counselling workspaces, and a stronger connection between the design of these spaces, mental states and therapeutic processes.

Table 3: Counselling workspace interior layout design initiatives

Counselling Workspace Interior Layout		
Design Initiative	Functionality/ Manageability	Therapeutic/ Psychological
Promote flexibility in the interior layout, with moveable furniture, objects, and enough space to allow this rearrangement of environment.	✓	✓
Have one entry door which is used to enter the counselling workspace, and have this door visible and accessible by all chairs in the room. Where the consumer sits should have more ready access and a clear line of sight to this door (do not have their back to the door). If necessary, an additional egress path can be provided through a doorway to a courtyard, which appears enclosed from the room, but may have a discrete side door. Do not have additional doors from the counselling room which are unclear where they lead.	✓	✓
Seating layout should provide for seating between therapist and counsellor which is at 45°. Seating directly opposite is too confrontational. There should be a side table for each person, which can be adorned with a lamp, plant or items such as tissue boxes. This can be moved between seats if the consumer desires a barrier. There should be no intervening desk, coffee table or barrier between therapist and consumer, and enough room that if both people were to stretch out their legs they would just touch feet. There is also room for each chair to be moved forward or backward from this position. A couch may also be specified to allow the consumer to sit closer or further from the therapist. There should be a piece of artwork or a window directly in front of the consumer's seat, to allow them to disengage visually. Include an additional chair which is not to be occupied by a person but is a space for the consumers' mind (equivalent to the personal space of one person). This also makes the space feel more natural and informal. Even spacing between the chairs is also ideal; do not have one chair off to one side, for example. Chairs should all face the centre of the room/each other.	✓	✓
A spacious room of approximately 5m x 5m x 5m is suggested. (3.5m x 3.5m x 2.4m at minimum.) If there is a smaller floor area, have an increase in ceiling height.	✓	✓
Counselling workspaces on the ground level if possible; fluctuating cognitions can cause consumers to destabilise; being able to see ground and sky is idea; in this situation. If the space is on the second or third level, have some anchoring aspects like a view to a tree nearby, to anchor and give a sense of connection to the ground.		✓
Where administration functions are also included in the counselling workspace, have this in a separate area. All computer screens should be off during a session	✓	

and not visible to the consumer.	
The composition of the room as a whole should not be circular – this is seen as a metaphor for 'going around in circles' in therapy (often the case with very small counselling spaces).	✓

Counselling workspace furniture and fitting selection design initiatives (see Table 4) are significant in two key ways: firstly, reducing stress, and secondly, through symbolic meanings. By reducing stress, through soft lighting, informal furniture, and minimal anti-ligature features, the consumer is able to more readily engage in the therapy, which illustrates how the design of the space is supporting its function of therapy. Consumers also attach symbolic meanings to features, which were found to be significant and directly impacted the therapeutic processes. For example, having an overly personalized room allowed for the presence of the therapist to be dominant, both within the physical space, and within the psychological therapeutic space occupied by therapist and consumer, which reduced engagement in therapy by the consumer. Materials showing trace and previous inhabitation made consumers feel connected to and distracted by previous consumers who had occupied the space, and these consumers' potential mental health issues, and so must be avoided.

Table 4: Counselling workspace furniture and fitting selection design initiatives

Counselling Workspace Furniture and Fitting Selection		
Design Initiative	Functionality/ Manageability	Therapeutic/ Psychological
Informal furniture selection is considered a better choice than furniture which is very formal. However, the furniture should be clear in their function and the overall function of the room.	✓	✓
Minimise the presence of security and anti-ligature features.	✓	✓
Include artwork, which is detailed in nature, and able to be viewed easily by the consumer.		✓
Provide storage space for art materials and sensory modulation equipment.	✓	
Consumer and therapists' chairs should be either matching, or all different but of a similar level of quality and formality, with optional cushions. Therapist and consumer should have equal eye level. Furniture that permits movement should also be considered, such as swinging egg chairs or rockers of some sort. Provide a choice of seating options for the consumer including at least two chairs and a space on the floor. Provide cushions and a rug for the consumer to engage with. Couches should not be oversized. Leather, vinyl or wooden furniture is preferred, or upholstery that is not at all worn and is well maintained. Ensure furniture does not keep the imprints of previous inhabitants.		✓
Overhead and fluorescent lighting is not ideal. Side lamps are preferable. Natural light is also emphasised.	✓	
Minimise use of vinyl on floors; instead select wooden floorboards or tile. In general, select materials that will not show trace or weathering over time.	✓	✓
Promote consistency of items/props in the space – variation is threatening (it makes the consumers feel they must deal with the chaos internally, so regularity of the environment makes them feel safer).		✓

Do not allow the therapist to personalise the space to a high degree; this presence disallows the patient to be comfortable and present in the space, physically and psychologically.	✓
Minimise the inclusions of bookshelves where possible (this reinforces the stigma and separation between therapist and consumer). Where books are included they should be behind glass doors.	✓

5. Conclusion, limitations and future research directions

The design initiatives presented in this paper were developed through fieldwork undertaken by the author, with the aim of understanding perceptions of spatiality of individuals who self harm, and the design initiatives which are significant in the built environments of their therapy. This is a defined user group, individuals who self harm, thus further research is suggested for the applicability and significance of these design initiatives to other mental health conditions. This study began with the focus on counselling workspace design, but concluded with design implications for wider areas of built environments delivering mental health services, such as waiting areas and circulation, as these were also evidenced significant in supporting the function of these built environments. Thus, further and more specific research is also suggested into the use of the tabled design initiatives for designing spaces for mental health outside the counselling workspace, such as inpatient ward design. Research is also suggested into each design initiative, its experience and significance in relation to other design initiatives which might be employed; this is not a definitive list of design strategies but rather a platform upon which further research can expand the possibilities for architects and designers to draw from.

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