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Title Page

WHAT CLAIMS ARE MADE ABOUT CLIENTS AND THERAPISTS' EXPERIENCES OF PSYCHOTHERAPY ENVIRONMENTS IN EMPIRICAL RESEARCH?

A SYSTEMATIC MIXED STUDIES REVIEW AND NARRATIVE SYNTHESIS

(Dr Tara Morrey, Dr Michael Larkin and Dr Alison Rolfe)

Abstract

Aims: To synthesise and evaluate evidence about experiences of psychotherapy environments. *Methods:* Studies were identified from systematic literature searches of Psycinfo, Assia and Web of Science. Selected studies were published in English between 2002 and 2016. Fifteen studies met the inclusion criteria. A quality appraisal process indicated that the quality of evidence was 'moderate' across included papers. *Findings:* In the narrative synthesis we use the concept 'mereology' to underscore the mutually-constitutive relationship between person, world and practice. In this context, themes of *relating, containment* and *process* each highlight the integral and nuanced influences of the environment on the therapeutic endeavour. *Conclusions*: In therapeutic training it would be beneficial to utilise the concept of a 'mereological system' (reflecting how a person and their environment shape each other and constitute a whole) to show how environmental features may affect clinical practice. Designers may also benefit from using this concept for the purpose of improving therapeutic environments. Further research which explores features of the therapy as part of a mereological system may pinpoint other aspects which facilitate beneficial therapy outcomes.

Keywords: therapy environment; systematic review, experiences, psychotherapy, counselling

Introduction

Experiences of the therapy *environment* are rarely studied empirically, but a 'good' environment may contribute to health and wellbeing (Fenner, 2011; Pressly & Heesacker, 2001). The way in which the environment is experienced in therapy may also have an impact on other aspects of therapy, such as therapeutic relationship and process (Bondi & Fewell, 2003; Fenner, 2011). Both the therapeutic process and relationship are explored in contemporary psychotherapy research (Duncan, Miller, & Sparks, 2004; Horvarth, Del Re, Fluckiger, & Symonds, 2011), and both can affect therapy outcomes (Asay & Lambert, 1999; Baldwin, Wampold & Imel, 2007). It is also generally agreed (e.g. see Papoulias et al., 2014) that Ulrich's influential study (1991) opened up an important way of thinking about the effects of immediate context on health outcomes, and that psychology appeared to be the mechanism for this relationship. Ulrich reported that considerable light, views of nature, art and an experience of control, all have noticeable effects on the reduction of stress. Given this existing evidence of how other aspects of context and process can affect outcomes in psychotherapy, it is important to explore the role which may be played by the immediate environment.

(a) Empirical Research: Psychotherapy Environments

Previous systematic reviews into the experience of mental healthcare environments have explored *psychotherapy environments* (Pressly & Heesacker, 2001) and *psychiatric environments* (Papoulias, Csipke, Rose, McKellar, & Wykes, 2014). The one prior literature review on experiences of therapeutic environments is nearly 20 years old (Pressly & Heesacker, 2001). The authors defined the environment as a

physical, affective and interpreted space (after Venolia, 1988). They used this definition to focus upon eight physical environmental stimuli that may affect the therapeutic process. The environmental stimuli reviewed were: accessories, colour, furniture and room design, lighting, smell, sound, texture and thermal conditions.

Their review reported on some promising insights, such as research indicating that colours in room décor may have the potential to influence psychological and bodily responses (e.g. brighter colours may be associated with more positive emotional experiences). However, the literature at this time was sparse, and the reviewers had to include studies from a very broad range of settings, drawing on data from different child or adult participant groups. The eight categories of stimuli seem appropriate to the literature in this review, which is relatively 'concrete'. Whilst Pressly and Heesacker discuss some implications for therapy in relation to their findings, it is difficult to translate their suggestions to a therapy environment in the absence of a strong theoretical or conceptual context.

(b) Empirical research: psychiatric healthcare environments

Psychiatric healthcare purposes might be considered to be akin to talking therapy purposes. Despite some important differences, they both deal with experiences of psychological distress, and they both have the alleviation of that distress as one of their common intended outcomes. The environments where psychiatric care occurs may take place in hospitals, secondary care and in private settings. Due to the medicalised nature of some of these environments and the need for both pharmacological and psychological interventions there may be a predominance of medical model perceptions of both the therapeutic work and the environment

(Hammersley, 2016). Both the setting and the perception of psychological distress may be understood through disease and cure-based thinking. There is, however, emerging empirical literature exploring psychiatric in-patient settings that is considering ways in which medicalised settings can adapt to provide therapeutic healing environments. For example, the 'Design in Mental Health Network' published a booklet summarising the empirical research indicating what may be beneficial in environmental design in in-patient psychiatric settings (Reavey, Harding and Bartle, 2017).

A systematic review of the psychiatric ward as a therapeutic space by Papoulias et al. (2014) also reports that evidence is relatively scarce, and that evidence-based design approaches must be developed for psychiatric facilities, as they have been for physical healthcare settings. The authors concur with Djkstra et al. (2006) when they suggest that psychiatric and physical healthcare facilities need to preserve privacy, be well maintained and contribute to a sense of safety. They further suggest that 'homely spaces' may contribute to patient well-being in psychiatric settings. In terms of the impact of design on the outcomes of treatment, the researchers suggest findings are inconclusive.

Papoulias et al. (2014) recommend further research that explores the environmental experiencing of different stakeholders. This is because they may experience ward design in different ways, a range of study methodologies are suggested in order to gain a holistic understanding of the complex experiencing of mental healthcare environments and the effects on health and wellbeing.

Aims

In this paper we report the findings of a new systematic mixed studies review focused upon the experience of psychotherapy environments. We adopt a narrative synthesis developed through a simple model to outline the findings across this cluster of heterogenous studies.

Therapy contexts have a distinctive character and function. These environments are 'visited spaces' (i.e. usually not residential) for clients. The environment is therefore only ever experienced by clients in the light of its therapeutic function. For therapists, the environment is also a workplace. It is important to review studies that consider the distinctive nature of engagement with therapy environments in facilitating movements towards wellbeing.

This review incorporates studies on psychotherapy environments only, published between 1996-2016. The publishing parameters for this search were set quite broadly over a twenty-year span. This is because initial searches had indicated there were few studies in this field. In the event, the retrieved papers that met inclusion criteria all were published between 2002-2016.

Method

Search Strategy

Aim: to retrieve empirical papers where experiences of the *psychotherapy environment* were the main focus.

A strategy was used across three databases: Psycinfo 1996-2016, Assia 1996-2016 and Web of Science 1996-2016).

Table 1 – Search Strategy near here

See the PRISMA flowchart below outlining the search strategy. This is followed by Table 2 which Summarises Study Characteristics across these papers.

PRISMA Flowchart

The PRISMA Flowchart (See Figure 1) shows the process towards inclusion of empirical papers where individuals' experiences of the *psychotherapy environment* are a central feature.

Figure 1 PRISMA Flowchart near here

Table 2 Study Characteristics near here

Quality Appraisal Process

The quality appraisal criteria developed by Sale and Brazil (2004) were used to appraise each paper. These criteria offer a cross-paradigm, overarching framework for appraising mixed methods, quantitative and qualitative studies in health-related studies.

The quality criteria goals were transferred to a template for each kind of paper (qualitative and quantitative). Each study was then rated according to each criterion and then given an overall best fit rating. These were green (high quality), amber (medium quality) and red (poor quality). This process was carried out by the first researcher and cross-checked by the second and third researchers. See Table 3 following the 'Overview of Quality Issues' for a summary table of the quality appraisal process.

Overview of included papers

The fifteen included studies utilised a range of quantitative and qualitative methodologies. Eight quantitative papers incorporated different approaches to analysis such as factor analysis (Devlin et al., 2009; 2013; Miwa & Hanyu, 2006) or content analysis, primarily (Ito-Alpturer & Uslu, 2010; Nasar & Devlin, 2011), with some papers incorporating surveys (Pearson & Wilson, 2012; Whittaker & Latchford, 2007). Some studies included a control group (Nasar & Devlin, 2011) or a comparison group, such as (Miwa & Hanyu, 2006), and others did not (Ito-Alpturer & Uslu, 2010).

Seven qualitative papers used different methodologies. This included, Thematic Analysis (Braun & Clarke, 2013) from a constructivist perspective (Nikendei et al., 2016) and Grounded Theory (Minton et al., 2008; Price & Paley, 2008). Participant groups were also varied, for example, community (Devlin et al., 2013), student (Ito-Alpturer and Uslu, 2010; Devlin et al., 2009), therapist and client participant groups (Fenner, 2011, 2012; Soares et

al., 2013). Study settings ranged across different countries, such as United Kingdom, Australia, Turkey, USA and Japan.

Study foci included: the importance of the therapy room to therapists and clients (Bondi & Fewell, 2003; Fenner, 2011; Soares et al., 2013), the location of services (Itu-Alpturer & Uslu, 2010; Swartz et al., 2002), the effects of art, credentials, objects, views, zones, to the therapy experience (Devlin et al., 2009; Devlin et al., 2013; Fenner, 2011; Nasar & Devlin, 2011) and to impressions of the therapist (Devlin et al., 2009; Devlin et al., 2013). The effects of lighting on client self-disclosure (Miwa & Hanyu, 2006) was also a focus.

Overview of quality issues

The Quality Appraisal Summary (see Table 3, p.18) indicates that seven of the fifteen papers received a green (high) quality) appraisal rating using Sale and Brazil's (2004) quality criteria. Four of these studies were quantitative based papers (Devlin et al., 2009; Devlin et al., 2013; Nasar & Devlin, 2011; Miwa & Hanyu, 2006). Three were qualitative studies (Fenner, 2011; Fenner, 2012; Nikendei, 2016). Four studies received an amber (medium) quality appraisal rating. Two were quantitative papers (Soares et al., 2013; Whittaker & Latchford, 2007), and two were qualitative papers (Bondi & Fewell, 2003; Price & Paley, 2008).

Four studies received a red (low) quality appraisal rating. All four studies are included in the review as this literature review is aiming to explore experiencing of therapy environments from the paucity of literature currently in this field. Quality appraisal does not generally lead to study exclusion on the basis of rating (Booth, Papaioannou and Sutton, 2012).

Two of these were quantitative papers (Ito-Alpturer & Uslu, 2010; Swartz et al., 2002. Two were qualitative studies (Pearson & Wilson, 2012; Minton et al., 2008). The Pearson and

Wilson (2012) study draws to the fore the range of physical, symbolic and emotional effects that the counselling environment may elicit in counsellors and clients. The Minton et al (2008) study incorporates a focus on the effects of changing rooms during the counselling process. This is a pertinent issue in some organisational settings where counselling is not the primary task and the value of a consistent therapeutic frame is not understood (Carroll, 1997).

The mixed quality ratings suggest that findings in the narrative synthesis that follows need to be approached cautiously. Findings from some of the amber and red-rated papers however, do concur with findings from some of the green appraisal rated papers. The overall quality rating for papers in this review is medium (amber). See Quality Appraisal Summary in Table 3 below for an overview of the quality appraisal process.

Table 3. Quality Appraisal Summary near here

Narrative Synthesis – Therapeutic Environment Experiencing

A narrative synthesis approach was selected due to the heterogeneous nature of the included studies and the scarcity of studies exploring therapy environment experiences (Popay, Roberts, Sowden, et al., 2006). The variety of study foci and study designs referred to in the 'overview of quality issues' meant that study findings in relation to therapy environments were being explored for different purposes. Comparisons between study findings for similarities and differences was therefore difficult. Our preliminary synthesis focused on one or more of the following physical environment themes: 'Preferred Features', 'Experienced Qualities ' and 'Consequences for Psychological Work'. We clustered the findings under these headings on a simple matrix. Once this extraction process was complete, it was evident that the 'Preferred Features' column seemed to be important *in relation* to the way these features were experienced by participants. This was an illuminating realisation as it enabled similarities and differences in findings to be understood through a homegenous lens of experience. 'Experience' in this instance paradoxically encompasses the contextual nature of subjectivity (Finlay ,2011) and the idiographic environments in each study, regardless of the differences in study foci or study design. This suggested that the physical features seemed to be understood in terms of relating to the therapist, experiencing safety and trust through the therapy and in terms of the experienced psychological work.

To conceptualise and capture these relationships we developed a simple theoretical model. We used a cross-case analysis approach to narrative synthesis (Pope, Mays & Popay, 2007) and drew on our observations about the cross-cutting patterns in the data extraction matrix, and also on some core ideas about person-environment systems from Wapner and Demick (2000)'s work in environmental psychology. These ideas helped us to give structure to the patterns in the data extraction matrix for our narrative synthesis (Pope, Mays & Popay, 2007). This involved incorporating findings from each study in one or more of the three

aspects that comprised the model to try and work with the complexity of experiencing (see Table 4 – Synthesis of Therapy Environment Experiencing).

Our proposed theoretical model describes a *mereological system* where the person and environment are understood as a single integrated system (see Figure 2 – Therapeutic Environment Experiencing Model). A ‘mereological system’ refers to the way that a person and a particular environment shape each other, and together constitute a whole. The adjective ‘mereological’ refers to part/whole relationships and is developed in areas such as phenomenological philosophy (Husserl, 1970). It is used here to show how the contextual features that make up the dynamic of psychotherapy (therapeutic relating, containment and process) all interact with the particular participants in the studies, *and* with the particular physical environments in which therapy takes place. In the section which follows, we explain how each of these mereological categories provides a distinct and useful perspective on the literature to help us to understand how therapy environments are experienced, and to illuminate the dynamic and contextual aspects of such experiences.

Figure 2 – Therapy Environment Experiencing Model near here

Table 4 – Therapy Environment Experiencing near here

Mereological Relating

Mereological Relating reflects the claims made in nine papers suggesting that responses to the therapy room and its features are an integral part of the therapeutic relationship. Claims made seem to involve extending the concept of therapeutic relating to personifying the environment and therapist as an integrated entity, to whom the client then relates. The findings focus on therapist and environmental cues concerning 'first impressions', developing a therapeutic relationship and processes of 'adaptation'. That is, working with features we do or do not have in common, in order to connect to and form a bond with, the other person ('therapist-environment' entity).

Firstly, claims of three USA-based studies (Devlin et al., 2009; Devlin et al., 2013; Nasar & Devlin, 2011) and one aspect of a Japanese based study Miwa and Hanyu, 2006), suggest that first impressions matter. The Miwa and Hanyu (2006) study involved undergraduate students in a random assignment to one of four conditions in order to explore physical variables which may facilitate or inhibit the development of relationships between counsellors and clients. The four conditions involved different degrees of bright/dim lighting and bare/homelike décor. Findings suggested that dim lighting facilitated more relaxed feelings and more favourable impressions of the therapist. The three USA-based studies involved undergraduates from different colleges in the North Eastern USA and one also involved local community residents (Devlin et al. ,2013). These studies used photographs of therapy rooms in between participants experimental designs. Findings suggest that clients are searching for environmental messages that point towards professional competence, through displays of credentials (Devlin et al., 2009) and the display of multicultural pictures/objects, this increased perceptions of 'welcomeness' in participant responses (Devlin et al., 2013). Impressions of therapists' warmth are suggested through interiors

which convey softness and order (Devlin et al., 2009; Devlin et al., 2013; Nasar & Devlin, 2011) and dim lighting (Miwa & Hanyu, 2006).

Secondly, claims about how features of the therapy room may act more or less helpfully as an extension of the therapist, are reported in two studies. These are Fenner's (2011), qualitative, phenomenologically-focused study involving five client/art therapist pairings in Melbourne, Australia. The second study is Price and Paley's (2006) UK grounded theory study, involving six Psychodynamic therapists working in the National Health Service (NHS) in the UK. Views to nature and features of the room may act as a "benevolent collaborator" (Fenner, 2011, p.254) for the therapist. For example, views to nature provide a balance and enhance the therapeutic capacities of the therapist. From the client's perspective, the therapy room may be experienced as a "manifestation of therapist care" (Fenner, 2011, p.855). In the Price and Paley (2006) study however the environment is a disconnecting rather than connecting component of mereological relating. Price and Paley (2006) suggest that the therapist needs to manage their sense of professional identity and reflective capacities more overtly, to maintain facilitative relating in "unsupportive" environments such as the NHS (Price & Paley, 2006, p.22). This is because of the undermining effects of therapist anxiety about room provision and lack of control in an environment not primarily about therapeutic work.

Thirdly, the relationship with the therapist may involve adaptation which may also be environmentally-mediated. Claims about features of the therapy room that the client perceives as 'like-me-ness' seems to be relevant (Fenner, 2012; Minton et al., 2008). Fenner's (2012) paper is a study offshoot from the Fenner (2011) paper. Clients may read similarities between themselves and their therapists, visually, through responses to aspects of the therapy room (Fenner, 2011). This may involve a search for shared

(Fenner, 2012) perspectives, such as spiritual values through the use of certain colours and objects in the room, or different values, like untidiness of the therapy room (Fenner, 2012).

Minton et al.'s (2008) UK-based Grounded Theory study explored fifty-six clients' experiences of changing rooms during the course of therapy in an NHS Psychotherapy service for adults with eating disorders. The findings suggest that 'adaptation' in relating may also involve experienced degrees of equality with the therapist, through neutrality of room décor, or chair size (Minton et al., 2008). Construed differences to the therapist which then involve adaptation, may include subjective interpretations and reframing. For example, a client participant's reframing in Fenner's (2012) study occurred, when a certain degree of room messiness, not normally valued, became associated with being a 'good artist'.

Finally, ending therapy seems to highlight therapeutic relationship and environment interconnections, including a loss of attachment figures for some day clinic participants in a therapy setting experienced as a 'safe haven' (Nikendei et al., 2016). The researchers in their Germany-based study reported on the qualitative Thematic Analysis findings from thirty-four severely depressed client-participants four weeks after discharge. Day-patient participants learnt early in treatment that therapists cannot provide all-embracing care and that they need to resume responsibilities on returning to home environments. These findings seems to suggest that both the environment and perceived therapeutic care have different psychological consequences.

Mereological Containment

The papers reviewed in this section identify key claims and issues that relate to creating a secure physical and symbolic therapeutic frame in which therapy takes place (Milner, 1952, Gray, 2012). Twelve papers refer to claims made about containment. Some of the claims made are highlighting the vulnerability of both therapists, in terms of a sense of professional identity which may hinder their capacity to facilitate containment, and clients, a sense of vulnerability, when the therapeutic frame is not experienced as secure.

Claims made about perceptions of therapeutic containment in relation to features of the therapy room were included in five papers (Fenner, 2011; Fenner, 2012; Miwa & Hanyu, 2006; Nasar & Devlin, 2011; Pearson & Wilson, 2012). Pearson and Wilson (2012) in their phenomenological study, explore whether there is an ideal counselling room design. They recruited thirty-four counsellors from professional associations in Australia. Findings include the need to create a warm and welcoming informal environment for clients and a "holding space" (Pearson & Wilson, 2012, p.51). This is described as the blend of a comfortable physical environment which may include a preference for larger work spaces with a conducive relating environment, conveying the therapist's capacity to hold the client psychologically.

Nasar and Devlin (2011) in their correlational study, recruited 242 students from two colleges in the USA to consider impressions of therapists' offices based on photographs. The results indicated that participants selected photographs of offices based on associations with comfort, quality of care and qualities of the therapist. The researchers claim that more softness and order in lay out and décor may create not just impressions of comfort, but also of safety and an expectation of therapy being

beneficial. Dim lighting may also facilitate a sense of safety and confidentiality in therapy evidenced by an increase in self-disclosure in these conditions (Miwa & Hanyu, 2006).

Fenner (2011) suggests that some clients may also seek safety visually, by identifying their own special features within the therapy room, which support their sense of psychological security. Features such as special objects, like client participant Sandra's orange table-cloth. Therapists may also support themselves so that they can create a safe psychological environment for clients through particular features, such as therapist participant Cate's own painting on her therapy room wall.

Secondly, claims about physical and symbolic aspects of the therapy room that affect a sense of client privacy, confidentiality and autonomy are reported in six of the papers. Privacy and accessibility of the therapy room and therapy centre may be preferred (Ito-Alpturer & Uslu, 2010; Whittaker and Latchford, 2007). Ito-Alpturer and Uslu's (2010) study based in a Turkish University focused upon student perceptions of a counselling service managing both accessibility and privacy. Findings suggest that ease of access to the counselling location on a university campus was considered important. Privacy, in terms of adequate soundproofing and not being seen by other students, was also cited as important.

Whittaker and Latchford's (2007) study exploring ninety-one clinical psychologists satisfaction with their West Yorkshire based working environments, concurs with these claims. Findings suggest that privacy was perceived as important. Some respondents questioned the adequacy of soundproofing and being free from the gaze of others.

Fostering a sense of personal control and facilitating choice was also found to be relevant in a study of thirty-nine therapist and client dyads according to findings in

Soares et al. (2013) Portuguese study. Findings highlight the relevance of an "autonomy support(ive)" environment (Ryan et al., 2011 in Soares et al., 2013). This may also suggest that clients find the therapy environment a safe place where they are guided towards their own decision making. This process is viewed as important for therapy outcomes (Williams et al., 2007).

Privacy and control in therapy may be undermined by unexpected changes. Minton et al. (2008) in their grounded theory study of client experiences in a psychological therapy service in the UK, claim that changing rooms during therapy, may undermine client safety and associated senses of privacy and confidentiality.

Finally, when therapists feel that their professional identity is undermined by the organisational setting, this may affect their capacity to provide a containing environment (Price & Paley, 2006; Swartz et al., 2002). Price and Paley (2006) report that anxieties about role confusion, and lack of regular space fit for therapeutic purpose can undermine professional identity and therapists' capacity to contain clients.

Swartz et al. (2002) in their pilot study concur with these findings. The researchers were investigating the provision of community mental health care for depression in a supermarket setting in Western Pennsylvania. Therapists participants found that limited access to phones and lack of a reception point were difficulties. Therapists also reported a challenge to their professional identities through providing therapy services in the supermarket.

Mereological Process

This is referring to five papers which make claims about the interconnection between therapeutic process, containment and specific therapy environments. Process is referring to psychological activity and to claims about experiences of the therapy room as integral to this work. This integration may be experienced as more, or less, facilitative for clients' therapeutic progress.

Firstly, two connected studies in this review Fenner (2011) and Fenner (2012) indicate in three 'client themes' and two of their 'therapist themes' how experiences of the therapy room are an integral part of the therapy process. The client theme 'views of nature' supports the client through facilitating a sense of perspective, freedom and calm. Visual connections with particular objects or features inside the therapy room, such as a particular zone may also be experienced by therapists and clients as facilitating for the therapeutic process (Fenner, 2011; Fenner, 2012). The client theme 'light/visual components' also describes how the use of light enhances the client's experience of security, freedom and creativity (Fenner, 2012). The therapist theme 'light/visual components' (Fenner, 2012) highlights how visual experience of the room is central to therapeutic activity. For example, a therapist participant explains how she looks at a photograph on her desk as a way of containing her anxieties and providing self-nourishment when working with a distressed client.

The combination of mereological containment and mereological process and their interconnection with specific therapy environments (Bondi & Fewell, 2003; Price & Paley, 2006; Soares et al., 2013) fosters a dynamic that may facilitate improved psychological wellbeing. This interconnection seems to be illuminated through claims in Bondi and Fewell's (2003) case study of voluntary sector counselling provision in

Scotland. Data from postal survey and interviews led to findings that suggest therapy can be interpreted in terms of boundary juxtapositions - externalising the inner experiencing of clients and internalising exterior spaces (Bondi & Fewell, 2003). Counselling crosses everyday boundaries of privacy but explores boundaries within which therapeutic relationships and processes occur.

Price and Paley (2006) in their Grounded Theory Model also illustrate interconnections between therapeutic process (in this study this is working with conscious and unconscious processes) and maintaining safe containment in an NHS environment, where room changes and intrusions occur. Findings suggest that where therapists can manage environmental issues and work with conscious and unconscious processes the difficulties are reduced. These studies may suggest that a consistent and private physical environment and a facilitative emotional environment, together, may foster movement towards wellbeing.

Discussion

Overview of Narrative Synthesis Claims

The narrative synthesis draws together key claims about therapeutic environment experiencing using a contextual Therapeutic Experiencing Model. This model outlines three features that integrate the *purpose* for being in the environment with particular *ways* of inhabiting a therapy setting. These features are mereological relating, containment and process.

Mereological relating highlights study claims about the relationship between the client, therapist and environment. The claims across nine studies in this section highlight the importance of incorporating the environment within the unfolding therapeutic relationship. It is less clear what it is specifically, about the environment, or about the therapist in the environment, that contributes to first impressions of the therapist. The literature provides a relatively narrow range of rather concrete examples, and it is not clear what the full range of relevant contextual and subjective features might be. This is because the studies in this review where first impressions are a focus are using designs that manipulate particular room features to gauge participants' responses, such as photographs displaying more or fewer therapist credentials in the room (Devlin et al., 2009; Devlin et al., 2013; Nasar & Devlin, 2011).

Findings also suggest that mereological relating occurs as an integrated 'bonding' (Fenner, 2011; Fenner, 2012). However, it is not fully clear *how* relational-environmental bonds develop, because the Fenner (2011, 2012) papers are the only studies so far that consider the subjective nature of environmental experiencing *in* the development of a therapeutic relationship. It is also not clear what sort of adapting processes are occurring in mereological relating for clients and therapists. So far,

findings suggest that both therapist and client interpretations are occurring that enable them to adapt to each other (Fenner, 2011; Fenner, 2012; Price & Paley, 2006).

Mereological containment highlights findings in twelve studies which emphasise the importance of creating a containing environment for clients. What is less clear, is how therapists and clients are managing 'vulnerability points'. That is, what happens when therapists do not feel their professional identity is fully recognised. Price and Paley's (2006) study findings highlight this issue. It is also less clear how clients may be experiencing those physical and symbolic environmental features that undermine their sense of privacy, confidentiality and autonomy (Minton et al., 2008).

Mereological process claims made in five papers indicate that the physical therapy environment is an integral feature of the therapeutic process. A combination of mereological containment and process, in specific therapy environments, may foster a dynamic movement towards psychological wellbeing. It is reasonably clear across study findings in this review that mereological containment and process interconnect with the physical environment (Bondi & Fewell, 2003; Nikendei et al., 2016; Price & Paley, 2006; Soares et al., 2013). What is less clear, is how these features inter-relate in terms of client experiencing and affect the functional delivery of therapeutic work.

Our review provides an update and a significant development on the most relevant previous review in this field. Pressly and Heesacker's (2001) review is now 16 years old and drew on papers published in the 1970's to 1990's. Pressly and Heesacker's (2001) review is largely focused on physical stimuli. The more recent literature in our review however, is more orientated towards therapy context. More current papers exploring the counselling environment specifically, are included in the current review

(1990's-2016). The papers are of varied quality however, so findings may be considered cautiously for specific counselling contexts.

Implications for Practice, Policy and Research

There are implications for practice, policy and research when considering mereological relating, containment and process in therapeutic practice. In terms of practice, stakeholders involved in therapy services can consider what is helpful or hindering for therapy practice. This may involve reviewing all three areas referred to that implicate physical, organisational and relational aspects of service provision. Secondly, in counselling training programmes teaching that incorporates the affective and psychological relevance of objects, zones and visual trajectories in therapy rooms may facilitate counselling trainees to work more overtly with mereological process with clients. Thirdly, mereological relating adds a further dimension to the relevance of the therapeutic relationship in successful therapy (Asay & Lambert, 1999). Therapists can draw further upon mereological relating in their work. This may include considering how therapy rooms can facilitate helpful first impressions. This may also involve taking into account the relevance of window views, objects, art and spatial segments of the room that clients and therapists may both interpret and accrue, as part of their affective bonding.

Therapy room (re)design could be conceptualised in terms of reflecting upon the dynamic of therapy as a mereological system. Designs which utilise the idea that visual trajectories, objects and zones are an inherent part of the therapy may be beneficial for both warmth and welcome and as symbolic outlets for psychological experiencing.

Further research utilising a range of methodologies, such as ethnographic studies, may contribute to holistic understanding about how therapists and clients are working with psychological experiencing in specific therapy environments. This may help to illuminate ways that mereological relating, containment and process are inter-relating.

Conclusion

Our quality appraisal suggests a reasonable overall quality for studies in each section of the synthesis. Our analysis emphasises how psychological experiencing, which is the *purpose* for being in a therapy setting, influences experiencing of the environment. This is a shift from other reviews, where the focus is on the effects of physical environment stimuli on health. The narrative synthesis in this review involved the development of a Therapeutic Experiencing Model comprising of mereological relating, containment and process. This review is highlighting how this new understanding would be of beneficial use in counselling practice and counselling environment (re)design. Future studies that explore the effects of mereological relating, containment and process may help to illuminate further the nature of these systemic interconnections. The purpose of increasing our knowledge of environmental influence is in order to facilitate improved wellbeing for clients and generate conducive working environments which support therapists in this endeavour.

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Table 1 – Search Strategy

Paper Restrictions	**Search A** Engagement with psychological/mental health environments	**Search B** Physical settings for psychological work	**Search C** Terms relating to psychotherapy/ psychology	**Combined Search: A *or* B *And* C**	**Exclusions**
Published 1996-2016 English Language Peer Reviewed	*"Therapeutic environment" or "therapeutic setting" or "therapeutic space" or "ward environment" or "ward atmosphere" or "psychosocial environment" or "therapeutic climate" or "therapeutic landscape"*	*"therap* room" or "counsel* room" or "therap* office" or "counsel* office" or " "psychol* office"*	*Terms relating to: psychotherapy or psychology.*	N=2583	Not empirical Research related to children Not primarily about environmental experience Theoretical papers Papers included: N=15

Table 2 Study Characteristics **Author/Date**	**Participants/Setting**	**Method**	**Main Findings**
Ito-Alpturer and Uslu (2010)	Questionnaires: 120 Turkish University Students (18-29 years) Interviews: 11 students (M=3, F=8) females) University Counselling Service.	Quantitative: 1. Questionnaire 2. Interviews with therapist Content Analysis - verbal descriptions in 1 and 2.	**Accessibility** – ease of accessing location. **Privacy** –fear of being seen, visibility of counselling service. **Comfort** –physical environment of therapy room – exterior/ interior.
Bondi and Fewell (2003)	Counsellors, Trainee Counsellors, Counselling Service Managers. All Scottish voluntary sector counselling services catalogued and those not catalogued via professional bodies (BACP, COSCA), local authorities, projects. Interviewees - 2 urban settings (Edinburgh and Glasgow) and 2 rural settings (Highlands and Islands).	Qualitative Interviews - 12 themes.	Main themes: **Positionings**: counselling as inverted knowledge. **Boundaries**: reframing relations of care. **Spaces**: between outside in and inside out.
Devlin, Donovan, Nicolov, Nold, Packard and Zandan (2009)	227 undergradutates e in Northeast USA. M=42, F =182 (2 not complete demographic page).	Quantitative Between participants design Qualitative comments Factor analysis of rated qualities.	**Overall:** higher number of credentials on view gives more positive judgments of therapists' qualifications and energy.
Devlin, Borenstein, Finch, Hassan, Lanotti and Koufopoulos (2013)	154 undergraduates in North East, USA. 57 adults, mainly Latino residents in community local to campus.	Quantitative Between-subjects design Factor Analysis Qualitative comments	4 Factors **Competence** (both groups rated as quite favourable in multicultural high display. **Multiculturalism** Welcomeness (both groups rated as quite favourable in multicultural high display) **Direct Style**
Fenner (2011)	Phase 1 - Researcher account - experience of 4 therapy rooms.	Qualitative	12 common therapist themes and 10 common client themes produced.

	Phase 2 n=5 client/therapist pairings recruited from Melbourne region, Australia.	Phase 1 - heuristic (to inform design of phase 2 from own experience. Phase 2 separate data collection from clients and therapists. Procedure: making an art work in response to experience of being in the room. Qualitative Interview Thematic Analysis	**Overall:** deep attachments to place, objects and zones in room provide support and stabilising influences on therapy for both groups
Fenner (2012)	Australian client/therapist participants N=9 in 9 therapy rooms. 1 = researcher.	Qualitative Within participatory inquiry paradigm. Procedure: photographed part of room that held their interest. Artwork created based on experience of the room. Qualitative Interview Thematic Analysis	**Client themes:** Client 'visually reads' similarities and differences between herself and therapist. Views to nature support a sense of freedom and perspective. **Therapist themes**: Visual experience of the room is central to therapeutic activity. Aspects of the room consciously utilized as metaphor in the process of therapy.
Minton, Olenik & Priest (2008)	Clients: N= 56, F= from psychological therapy service for adults with eating disorders, UK.	Qualitative Grounded Theory	**The model** – 'One door opens, another closes' – incorporates 4 primary elements in the experience of changing therapy rooms. Changing therapy rooms during on-going psychological work can affect people in terms of: Feeling safe Finding comfort Feeling valued Feeling equal
Miwa and Hanyu (2006)	80 Japanese undergraduates ,also clients. M=39 male, F= 41	Quantitative Random assignment to one of four conditions: 1 and 2 - with or without home like decorations 3 and 4 type of lighting (bright or dim) Structured interview Questionnaire	Dim lighting facilitated: more pleasant, relaxed feelings, more favourable impressions of interviewer, more self-disclosure, than bright lighting.

		Factor Analysis	
Nasar and Devlin (2011)	Combined sample across 4 studies: 242 undergraduate participants in USA, M= 65, F= 177.	Quantitative Exploratory correlational and naturalistic study Content Analysis of open-ended responses 4 studies involved responses to 30 photographs of psychotherapy offices	Participants differentiate among offices when thinking about therapist they may choose, reflected in appearance of office. Office choices consistent with character of offices associated with comfort, quality of care, qualities of therapist as qualified or bold. Rated importance of 23 factors confirmed importance of order and softness. Neatness and chair comfort rated as most important.
Nikendei, Haitz, Huber, Ehrenthal, Herzog, Schauenburg & Dinger (2016)	Sample of depressive patients from RCT, n=35 Heidelberg, Germany (M-18, F= 17).	Qualitative Constructivist Thematic Analysis	26 themes developed for in patient and day clinic groups. Group integration (inpatient group) and skill transfer to everyday life (day clinic group) are distinct differences observed between each group.
Pearson and Wilson (2012)	34 counsellors. Recruited through professional counselling associations in each state in Australia.	Qualitative Phenomenological Focus group used to formulate questionnaire 34 responses analysed for major and minor themes using 2 models (Miles and Huberman, 1984,Glesne and Peshkin, 1992)	Ideal attributes suggested: Preferences for larger work spaces. Natural use of light. Use of aesthetically pleasing décor. Provision for clients to have a choice of seating. Soundproofing. Fresh air.
Price and Paley (2008)	6 therapists M=3, F=3 Northern England, UK.	Qualitative Grounded Theory Social constructionist perspective	Overarching core category: 'Reflective organisation and management of the therapeutic setting'. 4 interacting sub categories: External pressures and conflicts Internal pressures and conflicts Resources Professional Practice Complex matrix of conscious and unconscious pressures and conflicts to be managed to avoid disrupting therapy.

Soares, Lemos, Oliveira, Lucas & Roque (2013)	39 Portuguese therapist/client dyads (14 therapists and 39 clients)	Quantitative Correlational study	No significant differences found (p>05) concerning clients and therapists' perceptions of the therapeutic environment over 4 periods of evaluation. Significant correlation found between client participants perceptions of the therapeutic environment and subjective wellbeing (subscale of CORE_OM, r=.466) but only for 5th session.
Swartz, Shear, Frank, Cherry, Scholle & Kupfer, (2002)	USA F=12 who met DSMIV criteria for a depressive disorder, rural mental health clinic.	Quantitative 16 weekly sessions of supportive psychotherapy with CBT elements F=6 completed study **Statistical methods** Wilcoxon rank-sum tests for continuous variables used and chi square analyses for categorical variables.	Significant improvement on measures of depression and anxiety for 6 participants who completed study. **Therapists reported:** Limited access to phones. Difficulties with no access to check in desk. A challenge to personal identity. **Participants reported:** Greater accessibility. Perceived reduction in stigma. Convenient range of services in one location.
Whittaker and Latchford (2007)	N=91 clinical psychologists (F = 74% aged: 30-60, UK.	Quantitative Questionnaires 5-point Likert Scale	**Responses:** **Privacy** (quality of soundproofing and free from gaze) –36% - this was not met. **Room appearance** - 24% - room was shabby/poorly maintained. **Temperature** - 56% - temperature not adequately regulated. **Same room** – 83% - able to use same room each week. **Wheelchair access** – 36% - room not accessible for wheelchairs. **Panic alarm** – 62% - no functioning panic alarm. **Importance of room** - 93%- room as 'Important' or 'Very Important'. 57% - room detrimental to therapy process.

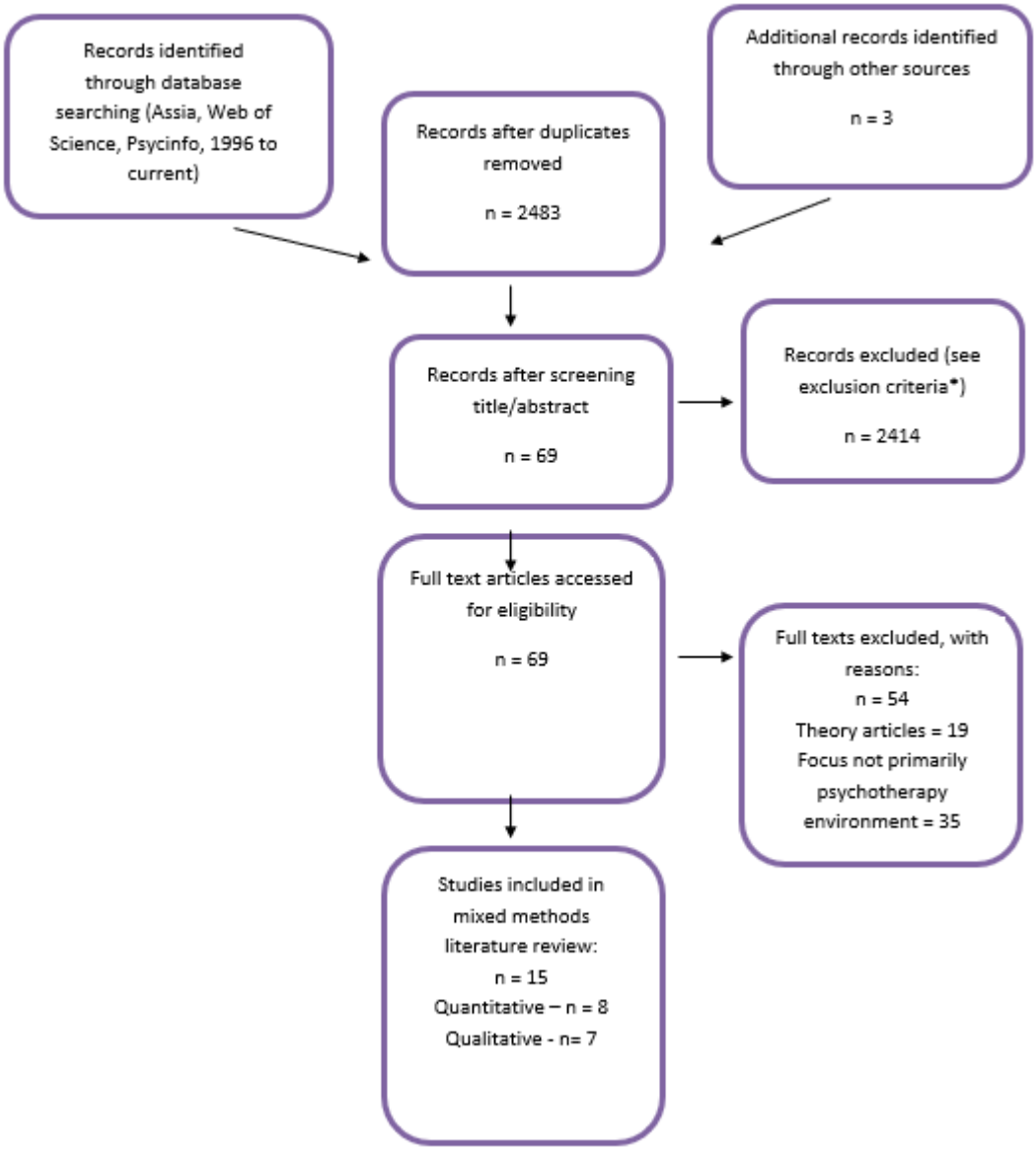
Table 3 – Quality Appraisal Summary

- ✓ (item adequately addressed); X no (item not adequately addressed); tick X partially (item partially addressed); NS (not stated); (NA not applicable). Overall ratings for each criterion: High (green), Medium (amber), Low (red)

Author/Date	Type of Study	Truth Value (Credibility vs Internal Validity)	Applicability (Transferability/Fittingness vs. External Validity/Generalisability)	Consistency (Dependability vs. Reliability)	Neutrality (Confirmability vs Objectivity)	Appraisal Rating
Devlin et al. (2009)	Quant	✓	✓	✓	NA	
Nasar and Devlin (2011)	Quant	✓	✓	✓	NA	
Devlin et al. (2013)	Quant	✓	✓	✓	NA	
Miwa and Hanyu (2006)	Quant	✓ x	✓	✓	NA	
Soares et al. (2013	Quant	✓ x	✓	✓	NA	
Whittaker and Latchford (2007)	Quant	✓ x	✓ x	✓ x	NA	
Ito-Alpturer and Uslu (2010)	Quant	x	x	✓ x	NA	
Swartz et al. (2002)	Quant	x	x	✓	NA	
Fenner (2011)	Qual	✓	✓	✓ x	✓ x	
Fenner (2012)	Qual	✓	✓	✓ x	✓ x	
Nikendei et al. (2016)	Qual	✓	✓	✓	✓	
Price and Paley (2008)	Qual	✓	✓ x	✓	✓ x	
Bondi and Fewell (2003)	Qual	✓ x	✓ x	x	✓ x	
Pearson and Wilson (2012)	Qual	x	✓ x	x	x	
Minton et al. (2008)	Qual	x	✓ x	x	✓ x	

Table 4 – Therapy Environment Experiencing

Mereological Relating-Claims	Mereological Containment- Claims	Mereological Process-Claims
Features of the therapy room that contribute to impressions of the therapist.	Perceptions of therapeutic containment in relation to therapy room features.	Interconnection between therapeutic process and containment in specific therapy environments.
Features of the therapy room that act as an extension of the therapist.	Physical/symbolic aspects that affect client privacy, confidentiality, autonomy.	Therapy room and its features as an integral part of the therapy process for therapists/clients.
Features of the therapy room that the client perceives as 'like-me-ness'.	Therapists' professional identity.	
Experiences of losing the therapist as an attachment figure and reintegrating into home/social environments post therapy.		


Records identified through database searching (Assia, Web of Science, Psycinfo, 1996 to current)
Additional records identified through other sources
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Records after duplicates removed
n = 2483
Records after screening title/abstract
n = 69
Records excluded (see exclusion criteria*)
n = 2414
Full text articles accessed for eligibility
n = 69
Full texts excluded, with reasons:
n = 54
Theory articles = 19
Focus not primarily psychotherapy environment = 35
Studies included in mixed methods literature review:
n = 15
Quantitative – n = 8
Qualitative - n= 7

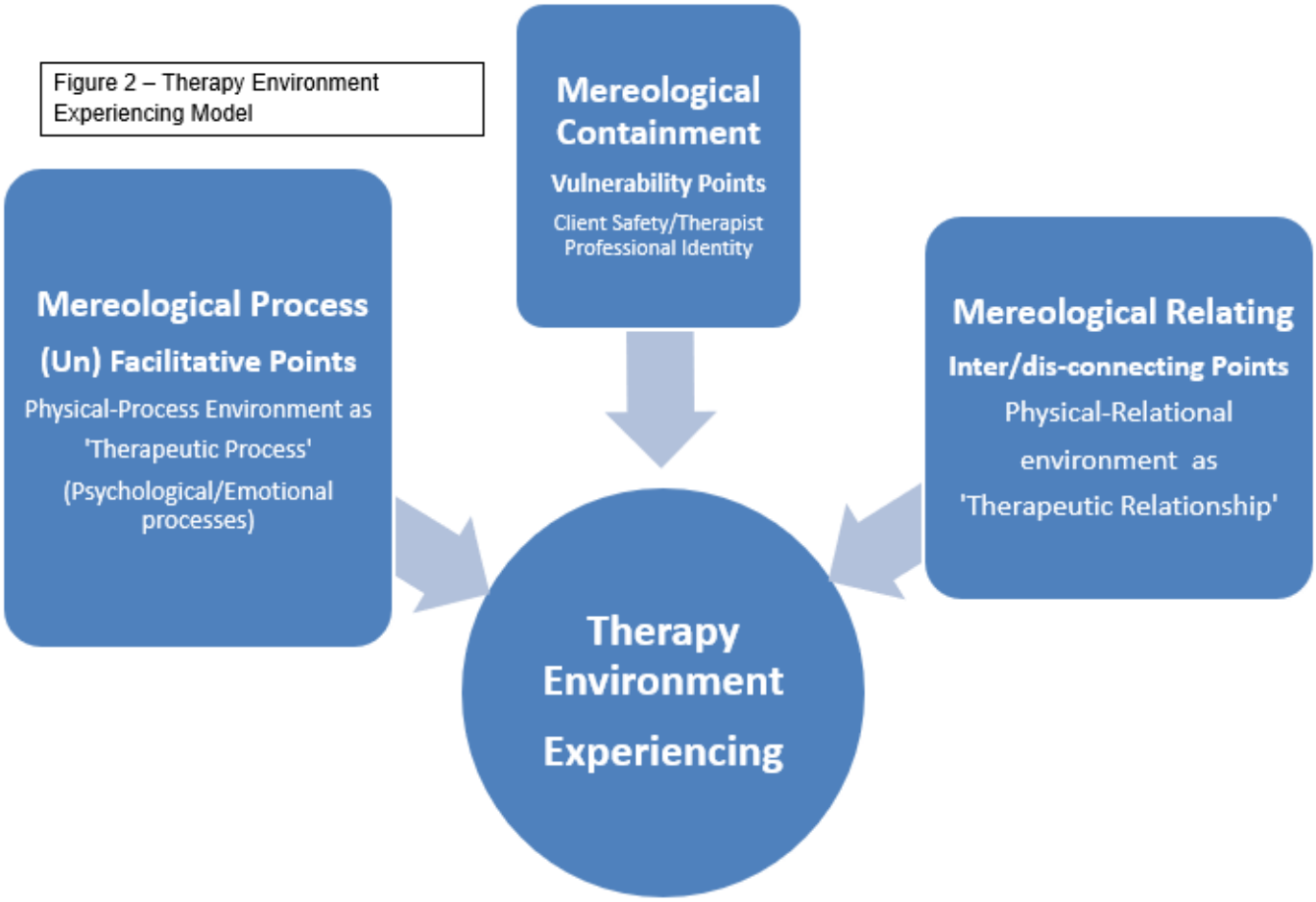

Figure Captions

Figure 1 – PRISMA Flowchart

Figure 2 – Therapy Environment Experiencing Model