Clients' Lived Experiences of Rooms Used For Talking Therapies in the NHS

Thesis

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Abstract

Background: There has been little research into how clients experience rooms that are used for talking therapies within the National Health Service (NHS), despite the NHS being the single largest provider of talking therapies in the UK. This study used a qualitative approach to explore how clients experience the physical space of the therapy room.

Aims: This qualitative study aimed to explore client's lived experiences of the physical environment of therapy rooms, used for talking therapies in the NHS.

Methods: Qualitative data were gathered through semi-structured interviews with six participants who had received a 1:1 talking therapy, in at least one therapy room, in an NHS setting (primary or secondary care). The data were analysed using Interpretative Phenomenological Analysis (IPA) to develop themes, which were then discussed with reference to existing literature and in terms of implications for practice.

Findings: Three superordinate themes were developed. 'The journey to the room' related to the physical and psychological journey that clients took to enter therapy rooms, encompassing accessibility, attention to the wider building and previous experience of therapy rooms. The second superordinate theme of 'the hospitality of the room' encompassed client's experiences of how they were 'catered' for within the room and how they felt in relation to the space and the therapist. The final superordinate theme of 'cure or space to explore' related to the appearance of the room and the 'message' that it gave the participants about the origin and maintenance of their issues and the purposes of talking therapy.

Conclusion: The findings have implications for individual therapists and service providers within the NHS. Client's experiences of rooms can impact upon their ability to engage with the therapy and the therapist. Practitioners and service providers need to consider the impact of the therapy rooms that they use, including the wider setting that the rooms are situated in and consult with individual clients, to ensure that rooms are meeting their needs.

Contents

Background and Rationale

This study addresses a significant gap in the literature, by employing a qualitative approach to explore client's lived experiences of the physical environment of rooms used by the National Health Service (NHS) to deliver talking therapies. Prior to the Covid-19 pandemic, most face-to face (non-online) talking therapy (all forms of counselling and psychotherapy) took place in a room. There had however, been little research attention given to client's experience of the physical environment of the therapy room and the meaning that clients make of the room and their experiences. Although the Covid-19 pandemic (which occurred partway through this present study being conducted), has resulted in a significant change to the way that many therapy sessions are delivered, with video and telephone sessions increasingly utilised, there are still many clients who would prefer to have face-to face sessions within a therapy room and who will request this. Furthermore, for certain therapies such as trauma therapy, or therapy with very distressed clients, where there can be increased risk and difficulty in conducting the therapy, it can provide additional safety, to be in the same room when delivering the therapy. For these reasons it is important that the physical environment of the therapy room is given consideration. It could also be argued that, as the pandemic has prompted therapists and service providers to reconsider how talking therapies are delivered and how clients can continue to access services in a safe and inclusive way once restrictions are lifted, now could be the ideal time to be conducting research into client's experiences of therapy rooms. This could help to ensure that post-pandemic therapy environments are appropriate, comfortable, facilitative and accessible. For the purposes of this paper, the terms 'talking therapies' or 'therapy' will be used to encompass all forms of counselling and the term 'therapist 'to describe the

counsellor/psychotherapist/psychologist delivering the therapy and the term ‘therapy room’ to define the room where the talking therapy takes place.

The therapy setting can have an impact upon the emotional states of clients (Sklar, 1988) and is often considered by therapists to be an important part of the ‘frame’ (Gray, 2013) of therapy. There are, therefore, important questions regarding whether the therapeutic space can influence client motivation, trust in the working alliance, and client outcomes (Pearson & Wilson, 2012). To date, other than my previous published research (Sinclair, 2021), which I will outline further below, there has only been one other small-scale study (Minton et al., 2008) that has qualitatively explored clients’ experiences of rooms that are used to deliver talking therapies within the NHS. Talking therapies within the NHS have been delivered from a range of different settings such as hospitals and GP surgeries for some time and increasingly more diverse rooms are being used, particularly within Improving Access to Psychological Therapies services (IAPT). Within IAPT, rooms within the community such as office space in children’s centres and even community rooms in supermarkets are used, particularly to deliver group psycho-educational courses. However, it is not clear how clients experience these rooms and what effect using these dual-purpose rooms might have on the client, as well as the process and outcome of therapy. Many secondary care services share rooms amongst services, which can also influence room availability, and result in a lack of consistency of room for the client. Furthermore, NHS therapy rooms often have a ‘clinical’ appearance and my previous research (Sinclair, 2021), found that clients and therapists expressed a preference for less clinical rooms.

It seems important that clients are consulted and given a voice about therapy rooms; this is of particular importance to the profession of counselling psychology, where first-person accounts are prioritised and where issues of power are considered and attended to. Not giving clients

voice about the rooms that they receive talking therapies in serves to maintain a practitioner-client power imbalance. However, it is important to remember that therapists may also not have power or choice over the rooms that they use, particularly within the NHS. McKellar (2015) suggests that gathering service user views on the physical environment of mental health care buildings is a way of valuing the views of service users. Without research into this area, how can therapists and therapy providers ensure that the rooms they use are conducive and not hindering to therapeutic conversations? Often, therapists and therapy providers may think that they instinctively know what would constitute a 'good' therapy room, however, their 'knowing' is often not based upon research or client feedback. A significant amount of research has focussed on what is done in the room, through comparing different therapy modalities and approaches, however, little research attention has been given to the room itself and the impact on the therapeutic dyad and the therapy.

Within healthcare more generally, there has been a lot of research into the interaction between the physical environment of the healthcare environment and the patients/service users that use it, with much of this being quantitative. However, it has also been noted that, in terms of research methods "the interface of person and environment in real situations may be simply too complex to capture in a linear experimentally controlled test." (Codinhoto et al., 2008, p. 61). The use of a wider array of research methods therefore seems important in capturing the complexity of people's experience of healthcare environments and this study has been intentionally designed to capture a wider-angled view.

Relevance to Counselling psychology

This study utilised a qualitative approach to explore clients' lived experiences of NHS therapy rooms. It provides important in-depth data on how clients can experience the physical environment of therapy rooms; what that is like for them and the meaning that they make of it, as well as

the impact that this can have on the client, therapeutic relationship and outcome of therapy. Counselling psychologists will often work in NHS settings, in training, or after qualification. This data will be helpful to therapists and therapy providers and the field of counselling psychology, in understanding more about how clients experience and can be affected by the physical environment of a therapy room, how a client's issue may affect their experience of a room, and which types of rooms/room variables may be less conducive, to delivering therapy. As counselling psychologists are directed to address issues of power and be able to 'establish safe environments for practice' (Health and Care Professions Council [HCPC], 2015); the study also will be in keeping with the ethos of counselling psychology and provide an important contribution to the evidence base for 'safe' and functional practice environments. This study is also important as the evidence base involving actual clients is sparse. This study will provide an original opportunity for client's voices to be heard on this issue, particularly in a qualitative way; this is important as counselling psychology prioritises first person lived experience.

Literature regarding the physical environment of therapy rooms.

The 'healing setting'

Frank and Frank (1993), in addressing common factors; the ingredients found in all types of therapy regardless of modality, identified a 'healing setting' as one of the four 'effective features' common to therapy. An important question is: what function does the therapy room/ 'healing environment' serve? Frank and Frank (1993) suggested that the therapy room is a healing setting and that the healing setting provides two functions which aid therapy. Firstly, it helps to establish the role of the therapist, increasing their "prestige" in the mind of the client and the expectation of the help that may be received. Secondly, it provides a safe place where clients can feel secure and safe for the duration of the

session. What exactly constitutes a ‘healing setting’ is an under researched area. DuBose et al. (2018, p. 54), in their paper exploring the concept of ‘healing spaces’ in healthcare, through a database-review of evidence design-based literature, define a healing space as:

> “Spaces that evoke a sense of cohesion of the mind, body, and spirit. They support healing intention and foster healing relationships.”

They further suggest that there were four major areas, that characterised healing: Psychological (how the environment ‘supported’ the management of emotions and helped mitigate depression and anxiety), Self-efficacy: (how the environment helped to facilitate a sense of control and coherence), social: (how the environment supported the development and maintenance of connections with others), and functional (how the environment provided safety and the opportunity to undertake basic activities, with minimal assistance). These areas were also highlighted as important to clients in surveys and interviews, in my previous research (Sinclair, 2021).

In further considering the contribution or function of the healing environment or space, within the healthcare environment, DuBose et al. (2018, p. 47) explain:

> “The environment cannot cause healing to occur but can facilitate engagement in behaviors and emotions that support healing; the environment can induce physical and emotional responses such as happiness, joy, and relaxation; and the built environment can enhance individual control and functionality—all of which are antecedents to healing.”

The contribution of the built environment to ‘healing’ within talking therapies is less direct than the influence of the built environment upon physical health conditions (e.g., poorly built wards that can contribute to infection spread) and it can therefore be difficult to capture and ‘measure’

aspects of the environment that are helpful or unhelpful to the healing process or outcomes in counselling and psychotherapy. Reactions to the built environment are very subjective and it is therefore important that research in this area is designed in such a way as to capture the subjective and 'emotional' responses that individuals can have to the built environment and rooms used for talking therapies. Altringer, (2010), in discussing psychiatric ward design, noted that the interaction between the 'Emotional experience of healthcare' and health facility design is an under researched area that warrants further research, particularly in terms of patient outcomes. She also suggested that service providers often prioritise 'functional efficiency,' over all else; often to the detriment of providing an environment that is experienced as therapeutic and 'healing' to service users

Environmental psychology and evidence-based design

Within the wider field of environmental psychology, research has consistently shown that physical settings can have an impact upon the people within them (Maslow & Mintz, 1956; Rice et al., 1980; Ulrich, 1984). The physical environment can also affect the impressions that people have, of individuals inhabiting a particular setting (Devlin, 2008; Gosling et al., 2002; Maslow & Mintz, 1956). In terms of buildings used for healthcare purposes, the physical environment of healthcare settings has been shown to be more likely to elicit feelings of dissatisfaction than satisfaction (Arneill & Devlin, 2002; Devlin, 1995). Devlin (1995) also found that people are more likely to comment about the physical environment when it is of poor quality; perhaps indicating an expectation of a certain level of quality, which if not met leads people to comment. In recognition of the importance of the physical environment of healthcare settings, evidence-based design is increasingly being used in the field of healthcare architecture, in the planning and design of healthcare buildings. In these situations, the physical setting is purposefully designed to achieve desired aims. This can enhance the healing setting and increase the well-

being of patients and staff (Stevenson et al., 2010). It has also been shown to reduce recovery times and facilitate improvements in patients mood and behaviour when used in psychiatric units and general hospitals (Gross et al., 1998; Whitehead et al., 1984). Furthermore, the way that an institution has been designed can convey its' philosophy of care (Stevenson et al., 2010).

Codinhoto et al. (2008, p. 29), following a consideration of the literature made the following assertions, with regard to the interaction between humans and the built environment:

- "The built and social environment cannot be considered as separate environments."
- "The built environment is perceived (or 'read') through the use of our senses, which stimulate our cognition in the first place.
- "Cognition can be stimulated when the 'natural' environmental balance is disturbed, through the 'readability' of the features of the built environment or through humans' priorities."
- "The psychological impacts caused by the built environment may lead to subsequent physical or physiological consequences"

These assertions are all of relevance to the present study and inform both the rationale for conducting the study and the relevance of environmental psychology for psychological therapy environments.

Psychologically informed environments

The concept of 'psychologically informed environments' (PIE) (Keats et al., 2012), includes a recognition of the importance of the physical environment when working with people with complex needs. Originally discussed in a government paper on how services could best meet the needs of homeless people, through adopting a holistic approach based on psychological principles related to the ethos and approach of the service, as well as a consideration of the physical environment that services were

delivered in, PIE has since been adopted by many services. PIE is comprised of five key principles and 'the physical environment and social spaces' are one of the key principles:

> "Designing and managing the social environment is central to developing a psychologically informed service. Thoughtful design, preferably one with service user input, based on thinking through the intentions behind a service, can result in useful changes in the way a building is used, and how it is valued by staff and clients" (Keats et al., 2012, p. 17).

Specifically, noise and acoustics of a building, light (daylight and artificial), outside open green areas and art/aesthetics are listed as areas that services should consider when adopting a PIE approach. Moreover, it is recognised that a service should consider the specific needs of the group of clients/service users that they cater for and design the environment with specific purposes in mind, to meet their needs. Within this approach, how psychologically safe clients feel within the spaces is considered important and the quality of the space, in terms of interaction and whether it allows the kinds of interactions that are needed, is also attended to. Service users having a sense of ownership of the space is also considered as part of the quality of the interactive space. Within a PIE approach, a need to monitor the impact of the service upon service users is also considered integral: "You cannot claim to deliver effective client-focused services if you do not know what effect they have on clients" (Keats et al., 2012, p. 26). This is interesting to consider with regards to the therapy room, in terms of recognising the need for research and service evaluation at a practice-based level, as well as more meta level research.

The physical environment of therapy rooms

Little research attention has been given to therapy rooms, specifically. The majority of existing research into the therapy room (Chaikin et al., 1976; Devlin & Nasar, 2012; Devlin et al., 2009; Miwa & Hanyu, 2006; Nasar & Devlin, 2011) has been of experimental design and used students (usually psychology students), as opposed to actual clients. Psychology students may not be representative of the client population. The current study will address this, by using actual former clients, giving descriptions and experiences of actual NHS therapy rooms. One study that did use actual clients was Backhaus' (2009) mixed methods study of the physical environment of the therapy room in the United States, involving seventy-three therapists and one hundred and fifty-three clients who were surveyed using a questionnaire containing qualitative and quantitative components. Findings from her study suggested that individual aspects of the physical environment of the therapy room, such as lighting and sound, were perceived as more important than other aspects; further findings from this study are described below. My previous study, (Sinclair, 2021) a mixed methods pilot study into the various components of the physical space of the therapy room, involving twenty-four clients and twenty-one therapists, also used actual clients. Findings were that comfortable seating, position of the seating, temperature, soundproofing, and accessibility of the room, were identified by clients and therapists as the most important features. These individual aspects of rooms will be considered in more detail below and the findings of my previous research have informed the design of the present study, as explained further below.

Many existing studies have also involved participants looking at photographs of rooms and noting their opinions or reactions to the rooms. Although there is research that suggests that photographs can be a valid method of collecting data about environments (Stamps, 1990), it is

questionable whether an overall experience of a therapy room, including noise and smell could be gained from viewing a photograph.

Seating

Seating in therapy rooms can vary in terms of type, height and position. Clients and therapists considered seating to be the most important item of furniture within therapy rooms in Backhaus' (2009) mixed methods study. The preference was for large, comfortable and soft seating.
Therapists within Pearson and Wilson's (2012) study thought it was essential that a choice of seating (different types and sizes) was provided for clients. Furthermore, a statistically significant number of therapists considered the physical comfort of the client, to be a necessity. Interaction distance was highlighted as another key factor by Pressly and Heesacker (2001), who noted that although clients can have differences in preference; in general, they tend to prefer intermediate distances, of between 1.2 to 1.5 metres. Certain groups of people may have different needs regarding interaction distances and Pressly and Heesacker (2001) point out that individuals with schizophrenia, for example, can have larger 'body buffer zones'. It is also important to note that cultural differences can also play a part in preferences, with clients from certain cultures preferring smaller interaction distances (Remland et al., 1995).

Lighting

Lighting has been shown to play an important part in the environment of therapy rooms. Miwa and Hanyu (2006), in their study involving 80 students being 'interviewed' by a counsellor, found that dim lighting facilitated self-disclosure and increased communication. Similarly, Gifford (1988) also found that participants performing a letter writing task, increased the level of their self-disclosure when in a room with dim lighting as opposed to one with bright lighting. Backhaus (2009) in her study of actual clients (as opposed to students) and therapists found both groups

preferred subdued or natural lighting, with natural light coming through windows as first choice and lamps second choice. Pearson and Wilson (2012) found that softer natural light was preferred, as opposed to fluorescent lighting, in their study of therapists' views of therapy rooms. A number of participants in this study also felt that a window with a view to outside world, providing natural light, helped to create a comfortable and effective workspace. Similarly, Watkins and Anthony (2007) also found that therapists preferred natural light and that fluorescent lighting was viewed as unhelpful, due to increasing client anxiety and discomfort.

Colour

A significant amount of research into the effect of wall colour on individuals within non-therapy settings exists (Küller et al., 2006; Norman & Scott, 1952; Read et al., 1999), with research consistently showing that colour can have a significant effect on the mood, behaviour and performance of children and adults. Pearson and Wilson (2012) found that therapists highlighted the role of the colour of a room, in its ability to create a comfortable and calm atmosphere, although no specific colour was favoured.

In assessing the ideal therapy room colour, Liu et al. (2014) found that green and blue were the preferred colours in their experimental research involving 75 client participants, recruited at a psychological clinic. Watkins and Anthony (2007) found that therapists favoured neutral colours for their workspace, believing that they provided a calming effect. Dalke and Matheson (2007) argue that a search for the 'perfect' colour for healthcare environments is misguided, as other contextual variables such as lighting, and the type of building can affect how the colour is perceived. When deciding which colours to use in decorating a therapy room, Pressly and Heesacker (2001) suggest that therapists should consider the sex and age of their client group. They also highlight the

importance of therapists being satisfied with the colour of the rooms that they work in, where possible, as they will spend a lot of time in the room(s).

Sound and Privacy

Confidentiality is a key aspect of the physical environment in talking therapies and poor soundproofing can result in breaches of confidentiality. In addressing the issue of soundproofing, Pressly and Heesacker (2001) suggest that music or water sounds could be used within settings, to prevent therapeutic conversations from being overheard and increase a client's feeling of privacy. Venolia (1988) pointed out that individuals vary in their sound tolerance. The perception of the sound, relationship to the listener and the perceived ability to control the sound, all contribute to this. Furthermore, Pressly and Heesacker (2001) point out that high sound levels can have a hindering effect on conversation and introspection; both of which are essential to therapy.

In considering particular client groups, individuals with Post Traumatic Stress Disorder (PTSD) often have an increased startle response (Shalev et al., 2000) and sensitivity to particular noises; this could also be an issue in noisy therapy settings. Therapist participants within my previous research (Sinclair, 2021) described clients presenting with trauma, as having great difficulty in engaging with the therapy when the therapy rooms were in a noisy setting. The therapists described the noise of the heavy doors closing within the building (a secondary care mental health services building that housed many different teams) and the general 'corridor noise' of people talking outside, as both startling clients and hindering the process of trauma therapy, particularly during the 'reliving' phase (Foa & Rothbaum, 2001) of processing a particular trauma, whilst using a cognitive behavioural approach.

Accessories and artwork

Plants in office settings have been researched and Larsen et al., (1998) found that plants had a significant positive influence on participants' rating of the attractiveness of an office. In terms of the therapy room, Pressly and Heesacker (2001) describe plants as representing life, renewal and growth, all significant themes within therapy.

In terms of accessories, clients, and therapists in Backhaus' (2009) study reported clocks, plants, and artwork as being the most important accessories in therapy rooms. Watkins and Anthony (2007) found that the psychologists they surveyed believed that views of nature through a window, plants and landscape paintings in their offices helped to reduce stress and facilitate therapeutic conversations with clients. Artwork has been researched within physical healthcare in-patient settings (Carpman & Grant, 1984), with findings that patients preferred natural scenes such as landscapes, as opposed to abstract artwork which was ambiguous or confusing. Therapists working in private practice settings often have more control over the artwork or other accessories on display in their rooms, however McElroy et al., (1983) argue that personal items can serve as a form of self-disclosure.

Control over the environment

Hewitt (2007) suggests that giving clients control over the environment in the form of choice over factors such as temperature and ventilation, can communicate care, attentiveness, and valuing of the client, as well as offering ownership of the therapeutic space. In hospital settings, a lack of control over aspects of the environment such as bright lighting, irregular noise levels and a lack of privacy can increase stress and also increase patient's feelings of helplessness (Steptoe & Appels, 1989; Ulrich, 1992).

The waiting room

Although not strictly part of the individual therapy room, clients in many NHS and other services will have to sit in or walk through a waiting room, prior to entering the therapy room and very little research attention has been given to this. Arneil and Devlin's study (2002), whereby participants were shown pictures of physicians waiting rooms and asked to rate the type of care they thought they would receive from the physician, found that the perceived level of care was better for waiting rooms that were warm in appearance, contained artwork and were well lit, in comparison to those that were cold in appearance and had no artwork.

Liddicoat's study (2020) looking at twelve clients' and twelve therapists' experiences of waiting rooms found a close relationship between a client's experience of waiting rooms and the 'emotional and psychological state' of the client. She also asserted that "aspects of built environments could provoke powerful emotional reactions, manifest negative stigma, signal erosion of agency and empowerment, exacerbate power imbalances, and violate psychological privacy" (Liddicoat, 2020, p. 115).

The appearance and design of the room and the relationship to the therapeutic dyad and process of therapy

Where studies into the therapy room have been done, they have usually involved looking at individual variables of the room, as opposed to considering the more complex relationships between different 'ingredients' of the room, its inhabitants, and the therapeutic relationship and process in a more systemic way. The issue of whether a room is actually a designated therapy room, used solely for the purpose of therapy will have an impact upon how the room is designed and set up. McLeod and Machin (1998) assert that the layout of the therapy room, conveys expectations to the client, about what will take place within a room.

Watkins and Anthony (2007), in a qualitative study involving 10 psychologists delivering psychotherapy, found that the psychologists wanted the therapy room to communicate ‘appropriate social scripts’. They further noted that the modality of the therapist affected the way that therapists chose to set up rooms; some therapists deliberately aimed to communicate a collaborative, ‘team’ approach with the client, through their choice of furniture and layout.

Nasar and Devlin’s (2011) study, which involved psychology students observing photographs of therapy rooms, found that soft and personalised rooms with soft lighting, soft furniture and pictures on the wall were preferred. Similarly, Backhaus’ (2009), mixed methods study involving one hundred and fifty-three actual clients and seventy- three therapists, found that clients preferred rooms with a more ‘homely’ feel, whereas therapists felt more comfortable in rooms that were furnished and accessorised in ways that fitted their individual personalities. ‘Furnishings’ were described by Pressly and Heesacker (2001, p.151) as having the ability to convey the “personality of the space” and this can help to create a more homely, as opposed to clinical appearance.

In terms of how a ‘softer’ room may influence clients, Chaikin et al. (1976), in their study that examined self-disclosure within a counselling analogue, also found that subjects disclosed significantly more in a ‘soft’ room. Smalley (2014), in her quantitative research which involved 220 women looking at photographs of messy, intermediately neat or neat therapy rooms, along with those considered ‘cold’ or ‘warm’ and then rating the therapist qualities that they would expect to receive in that room, found that the intermediately neat and warm room condition was correlated with the most positive therapist characteristics.

The importance of the wider organisation or culture that the therapy is provided within, was recognised by McLeod and Machin (1998), who explain that many counselling agencies operate within larger organisations, such as university counselling services. This can influence the goals or values of the service, as well as the physical space of the therapy rooms that are provided and may not be under the control of the actual counselling agency. This is often the case in the NHS, when individual services are often allocated or directed to use certain rooms that are also often shared spaces or multi-use rooms.

In terms of the therapy room and any influence on the process of therapy, Pressly and Heesacker (2001), in their review of the literature regarding the physical space of therapy rooms outlined the need for an environment that is facilitative of therapy processes such as developing rapport, exploration and self-disclosure. Pressly and Heesacker (2001) also focus their overview of the current literature on specific physical elements that either detract from or enhance the therapy process. Benton and Overtree (2012) noted the importance of therapy rooms being culturally sensitive and inclusive.

Backhaus (2009) found that the physical environment had a significant effect on clients and therapists' ability to form a therapeutic relationship and that the lighting of the room was significantly correlated with the client's perception of their therapist's trustworthiness, expertness, and attractiveness. Furthermore, she reported that clients described furnishings, lighting, and accessories in the therapy room, as playing a part in enhancing or distracting from the process of therapy. She also found that the physical environment of therapy rooms can give rise to feelings of safety, comfort, and relaxation and that there was a significant association in the quantitative data, between client retention and a 'welcoming environment' (as perceived by clients). In further considering

the therapeutic process, a study looking at client's experiences of art therapy was undertaken by Fenner (2011), and she found that clients formed deep attachments to particular objects and areas of the art therapy room; this also had a facilitative effect on the therapeutic process. Furthermore, Pearson and Wilson, (2012) in their qualitative study involving thirty-four counsellors, suggest that therapy spaces that are 'emotionally safe' and user-friendly could have a positive impact on outcomes.

My previous study, Sinclair (2021); found that clients and therapists reported that feeling physically comfortable and safe in a room, enabled a greater engagement with the therapy process and the majority of clients and therapists agreed that the physical environment of the therapy room was important for encouraging an effective therapeutic relationship and therapy outcomes. Rooms with a 'clinical' appearance were described negatively, by both groups, as unhelpful. This is of relevance to the present study, as the NHS often uses rooms within primary and secondary care, which have more of a 'clinical' appearance.

Within the NHS, therapy rooms often reflect a 'medical model' of distress, with psychiatric wards, particularly, reflecting a medicalised environment (McKellar, 2015). McKellar (2015) argues that psychiatric wards are not surgical and there is therefore no need for them to continue to be 'medicalised.' However, within many buildings used to deliver NHS mental health services, stark institutional settings with a clinical feel (in the medical sense of the word) persist.

The room as a symbol

Waldburg (2012) asserts that the therapy room is permeated with psycho-symbolic meaning and suggests that the room acts as a symbolic container for the contents of the client's mind. In her chapter regarding

preparing a therapy room for work with children or young people, she also suggests that it is important that therapists consider the symbolic significance of the space to clients at both a conscious and unconscious level. The present study will pay particular attention to the meaning that clients make of the room and be attentive to psycho-symbolic significance.

The environment of the therapy room and particular client issues/presentations

Liddicoat (2018) carried out a recent three-phase piece of qualitative research that explored the experiences of therapy rooms, of clients who self-harm. Through interviews with twelve clients, twelve counsellors, three carers, and design experts and architects, she determined that the design, layout, and contents of a therapy room were particularly important for clients who self-harm, as they could help contain anxiety and mitigate potential dissociation. It is important to consider whether specific client groups would be more likely to find similar features about rooms unhelpful, due to the nature of the issues they are dealing with and cognitive and emotional salience or interplay with the room/room features. The present study will allow for this question to be considered, as clients will be able to describe any interplay between their issues and the therapy room. In my previous research (Sinclair, 2021), a survey participant had given a short-written description of distress that she had been caused as a client, through having to use a kitchen as a make-shift therapy room, whilst receiving talking therapy for an eating disorder, as all the other therapy rooms were occupied. There were also instances described by therapists, of having to counsel a rape survivor in a GP clinic room, where instruments for cervical smear tests were on full view and counselling students who were struggling at school, in the head teacher's office (where students were usually disciplined). Within that study, there had not been the scope to further explore these experiences, the meanings the clients had made of these experiences and the impact on the client,

therapeutic relationship, and outcome of therapy. The present study, will however, be able to explore first person accounts of experiences of therapy rooms and the meanings attached to them, therefore building on my previous study, as further outlined below.

The importance of the 'healing environment' within the NHS

Within the National Health Service (NHS), initiatives such as the King's fund 'Enhancing the Healing Environment' (Department of Health, 2008) have highlighted the need to explore the relationship and interaction between the healthcare environment and service users. This project, which initially encompassed forty-eight NHS primary and secondary care sites, identified the importance of the physical environment of healthcare settings (physical and mental health) and collaborated with service users and staff to make improvements to the 'healing environment' (Department of Health, 2008). The study, which expanded to include 250 health and social care organisations, was described as a 'catalyst' for the NHS in terms of considering the impact of the environment in which care is delivered. As a result, many practical changes to healthcare environments were made, these changes however, were to communal and outside areas and not clinical rooms.

The client's experience

Little has been written about the overall meaning and experience of the therapy room from the client's point of view. In determining what is therapeutic and healing to clients, it is important to ask clients for their actual viewpoints; surprisingly, very little research has been done on actual clients' viewpoints of the overall experience of the therapy room. My previous research (Sinclair, 2021), which did ask clients for their viewpoints, highlighted the importance of gaining feedback about rooms from the client's point of view. When client participants were asked about

advice that they would give to therapists and therapy providers about the physical environment of the therapy room, they emphasised the importance of therapists and therapy providers considering things from the client viewpoint and asking clients about their experience of the physical environment of the room.

Minton et al., (2008) conducted a small-scale piece of research within their workplace, which sought to explore adult clients with eating disorders' experiences of changing therapy rooms, whilst being seen within an NHS psychological therapies service. This study came about as a result of a team meeting, where there were conflicting viewpoints on the need for a consistent therapeutic setting. Findings from the qualitative questionnaires of the six participants were that changing therapy rooms can affect clients, in terms of feeling safe, feeling valued, feeling equal and finding comfort. Clients reported that changing therapy rooms could have a negative effect on them and their progress in terms of the work, but that this could also be
'buffered' by the therapeutic relationship; when there was a good quality relationship, the feeling of safety with the therapist remained.

How this differs from and will build upon my previous research

My previous study (Sinclair, 2021) was a mixed methods study that involved therapist and client participants and was firstly seeking to generally explore whether the environment of a room did seem to be important to clients and therapists and then, specifically sought to identify which individual components/features (such as lighting and seating) were rated as most important to clients and therapists. This study compared client and therapist responses and focussed on individual components of rooms and how those affected the client/therapist and process of therapy. The present study will be different from my previous study, as it will only

involve client participants, not therapists, it will also be a fully qualitative study and will specifically explore client's lived experiences of NHS therapy rooms. Instead of focusing on specific variables of rooms, the present study will seek to give voice to and understand the entirety of the lived experience of the physical environment of therapy rooms, at a deeper and more complex level and will specifically explore the meaning that clients make of those rooms and their experiences. This will enable an exploration of the psycho-symbolic potential of the room to 'mean' different things to different clients and will provide unique, in-depth, 'storied' experiences of client's experiences in rooms (something that my previous studies did not do). In my previous study (Sinclair, 2021), as noted above, there were instances, where clients had written brief survey responses, describing significantly positive and negative experiences of aspects of a therapy room, however there was not the scope within that study, to further explore the client's story of their experience and what this had meant to them. This study will build on and develop the previous study, by specifically focusing on and allowing for a full voicing of those client experiences of rooms and exploring the individual meanings attached to those experiences. It will also allow a consideration of any interplay between a client's presenting issue and the room, as clients will be asked a question around this (without needing to go into details about their previous therapy/issues); my previous studies did not explore this.

Research rationale, aims and questions

Research rationale

The present study has significant advantages:

- Actual clients are being used as participants, instead of non-clients. As therapy is a particular experience involving significant emotional and psychological experiences and reactions, this differs from other reasons for being in rooms; it is therefore important that actual clients are used.

- A qualitative approach will allow for the capturing of the emotional experience of therapy rooms and a storied experience of rooms, as well as more generally providing a 'thick' description of the experiencing of rooms, by the participants.
- The design of the study will enable clients to be 'given voice' about NHS therapy rooms.
- The use of Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009) will enable the participant's experience of rooms to be seen within the wider context of their lives and experiences and enable an understanding of the meaning that they make of their experiences of NHS therapy rooms.
- The design of this study has built upon data from the author's previous research in in this area and the interview questions were developed from the service user's/client's responses to prior research (Sinclair, 2021); thus, incorporating service user voice into the design of the present study.
-

Research questions

- How do clients experience the therapy room?
- How does the therapy room impact upon the therapeutic process?
- What are the perceived effects of the room upon the therapeutic relationship?
- What interplay can there be between client issues and the therapy room?

The present study – aims and objectives.

Aims and objectives

Aim

-To explore client's lived experiences of the physical environment of therapy rooms, used for talking therapies in the NHS.

Objectives

-Understand more about the meaning that clients can make about their experiences of the therapy room, including the psycho-symbolic meaning of therapy rooms and the impact of this upon the therapy /therapeutic relationship and process of therapy.

-Explore any interplay between the client's issue/client group and the room.

Methodology

Philosophical underpinnings and theoretical frameworks

It is important that a researcher considers the epistemological and ontological stance of a study and that the design of a study and methods used are in fitting with the philosophical underpinnings. Ontological positions (views on the nature of reality) can be considered to sit on a continuum between realism, which holds that there is an independent reality out there, and relativism, which holds that there are multiple 'realities', which are created by human interpretation and knowledge (Braun & Clarke, 2013). Epistemological positions (views on the nature of what constitutes knowledge) can be considered to sit on a continuum between positivism, which would employ rigorous empirical testing to pursue knowledge or 'truths,' and social constructivism, which would view knowledge as being subjective and very much influenced by language, culture, and power. For this study, a critical realist approach to ontology was chosen and a phenomenological approach to epistemology taken; this is due to a personal 'fit'

with the theory and it being an appropriate ontology and epistemology for a study of this type. This will be further elaborated below.

Critical realism

In terms of ontology, critical realism widely attributed to Bhaskar (1975), takes a realist position, as it maintains that there is a reality out there, independent of human experience. However, critical realism also maintains that our ability to 'see' that reality will be obscured by other factors; therefore, acknowledging contextual factors when pursuing 'reality.' In terms of epistemology, critical realism rejects positivism and takes a relativist approach, thereby acknowledging the impact of the researcher upon the research, as well as the impact of theory. Bhaskar (2008) suggested that critical realism is best understood as a stratified concept comprising of three levels; the empirical (which can be observed), the actual (which is known, but cannot be directly observed) and the real (underlying mechanisms which represent that which is real). These aspects will impact what we can 'see,' and it is therefore important to acknowledge this when taking a critical realist approach.

Rationale for choosing a critical realist approach

A critical realist approach fitted with the qualitative design of the study and allowed for the complexity of client's experiences of therapy rooms to be explored. The critical realist underpinning of the study also gave more power to the participants, as it allowed for a study design that gave space to clients describing their experiences in their own words, allowing the context to be seen. The study was not seeking to uncover a 'truth' or definitive reality, as would have been the case if a positivist approach to epistemology had been chosen. A critical realist approach was therefore a good fit for this study, as the context of client's answers to the questions regarding their experience of therapy rooms was important to understand. Through pursuing an exploration of client's phenomenological experiences of therapy rooms and using the double hermeneutic of IPA (see below), further context to client's answers to questions could be examined, throwing light on how and why they experienced rooms in the way that they did.

Phenomenology

The phenomenological paradigm is particularly concerned with experience and people's lived experience of the world and their subjective experience, (Willig, 2013) is therefore prized. As this study was looking at client's individual experiences of therapy rooms and the meaning that they make of these, a phenomenological approach was appropriate. A phenomenological focus is also highly compatible with and relevant to counselling psychology, which is concerned with understanding people's inner worlds and prioritises subjective knowledge (Woolfe et al., 2010). A potential critique of a phenomenological approach being *entirely* compatible with counselling psychology, is that people may not be aware of all of their experience, as some things may exist outside of an individual's awareness; a solely phenomenological approach may therefore not capture this. So, for instance, a client may not be aware that a particular therapy room reminded them of a room from early childhood (either positively or negatively) and this could affect their experience of the current room, without them realising. The overarching critical realist approach taken to the study would allow for this, with the recognition that as researchers, we can only ever gain an 'obscured' and not total view of 'reality.' However, in pursuing further context, again in keeping with the critical realist underpinnings of the study, the semi-structured interview approach allowed for further questions to be asked, to allow the participants to further reflect on their experience and potentially allow such 'out-of-immediate-awareness' experiences to arise. Time was also given at the end of the interview for participants to reflect on the entire process and how they had found it. A follow-up interview could also have been done to give space for further experience (this is often done within an IPA approach); however, this was not possible within the time constraints of this study.

The study was designed to be a qualitative study. This approach was chosen as, the physical space of therapy rooms, in terms of how clients experience it and subsequent interaction with the therapeutic relationship, therapy process or outcome is a complex area and one which a qualitative approach would serve

well. A qualitative design using in-depth interviews enabled the gathering of data, which provided rich, 'thick' descriptions of individual's first-hand experience and also allowed for the emotional experience of rooms to be captured, which is important in exploring client's experiences of the built environment (McKellar, 2015). Interpretative Phenomenological Analysis (IPA) was chosen as the method of analysing the data, as it is an appropriate method of analysis for a study that is seeking to understand the lived conscious experiences of people (Smith et al., 2009).

Epistemology of IPA

IPA (Smith et al., 2009) is an approach to research which has a central focus on phenomenology. Phenomenology is how people experience the world around them within particular contexts and times (Willig, 2013). Central to IPA are phenomenology, ideography, and hermeneutics. An IPA study is not concerned with making generalisations, but instead exploring the ideographic and giving particular attention to meaning making, both of the participants and the researcher. It is also however "possible to think about theoretical transferability rather than empirical generalisability" (Smith et al., 2009, p. 51), whereby the reader of an IPA study can make links between the study, their own personal or professional experience, and the wider existing literature. Central to IPA is the concept of the 'double hermeneutic,' (Smith & Osborn, 2003), whereby the researcher is trying to make meaning and sense of the participant's meaning and sense-making of their experiences. Therefore,

> "Although the primary concern of IPA is the lived experience of the participant and the meaning which the participant makes of that lived experience, the end result is always an account of how the analyst thinks the participant is thinking" (Smith et al., 2009, p. 80.)

Another double hermeneutic put into operation when taking an IPA approach, is that of “a hermeneutics of empathy with a hermeneutics of questioning” (Smith et al., 2009, p. 36). Taking both an empathic and a questioning approach, an IPA approach will seek to gain the ‘insider perspective’ (Conrad, 1987), whilst also asking questions and ‘puzzling’ over what the participants have said.

IPA is particularly concerned with how people make sense of experiences in their lives. It allows participants to explore their own narrative and sense-making of their experiences and it has the advantage of allowing for an in-depth, rich, and detailed study of phenomena. As this study intended to explore the lived experiences of clients and sought to understand more about the meaning that clients make of their experiences of rooms, with a specific set of people (clients who have experienced NHS therapy rooms), IPA was a justified and sensible choice of data-analysis.

Central to IPA is the interpretative aspect of this form of analysis. The researcher is acknowledged as bringing their own understandings, experiences and ways of seeing the world to the process. As such, in line with many other qualitative approaches, the researcher taking a reflexive approach is important. See below for a further explanation of the reflexive approach taken within this study.

Other research designs and methods considered for the study

Quantitative and experimental designs were not considered appropriate for this study, firstly as the research questions and subject area required a research design that could enable participants to give detailed responses, and also because experimental designs would not be able to easily capture first-hand experiences of *actual* therapy rooms that had been used for *actual* therapy sessions. When rooms are used for therapy, the room can become an active ingredient within the therapy and experimental designs (unless very

complex and resourced) would struggle to capture this. Likewise, they would also not capture the reality of the types of rooms that are used within the NHS, including the wider buildings in which they are located.

In terms of data analysis, thematic analysis was considered as an alternative method for analysing the data, however as this study sought to gather in-depth lived experiences of therapy rooms that were routed within and contextualised by the participant's wider experiences and subjective accounts, as opposed a wider more 'broad-brush' picture, IPA was considered more suitable.

Questionnaires asking open ended questions were also considered as a means of collecting data, alongside the interviews. However, these were rejected as it was felt that interviews would be enough to capture the data needed to address the research questions and questionnaires would not be likely to enable richer data to be gathered. The opportunity to be able to ask further questions to contextualise the participants responses was important in terms of the critical realist underpinnings of the study and the phenomenological focus of IPA; interviews were sufficient to enable this.

Reflexive statement

Reflexivity in qualitative research involves a "critical reflection on the research process and on one's own role as researcher" (Braun & Clarke, 2013, p. 10). In recognising the importance of this, a research journal was kept throughout the process of the research, in order to reflect upon and critically consider my role and relationship to the study. This was important in identifying my own feelings and thoughts about the research topic, which I was then able to reflect upon and 'bracket' off when necessary. This bracketing took two forms, as outlined by Fischer (2009). Firstly, identifying and setting aside my own assumptions about the data, which was also an ongoing process throughout all stages of the study

and secondly, an on-going bracketing with regards to the evolving findings and my own understanding of them.

I am a female, qualified psychotherapist, of white ethnic origin, with experience of working within the NHS within primary and secondary services, as well as many other non-NHS settings. I first developed an interest in the physical environment of therapy rooms during my degree, when I came across a quantitative study looking at therapy rooms. Critiquing this article led me to think about my own experiences of therapy rooms as a therapist and client, both positive and negative and I was surprised to see how little research there was into this common factor of therapies of all modalities. My own experience as a client and therapist had shown me that aspects of the therapy room, such as pictures or noise in the corridor could be distracting and hinder the process of therapy. Within my own therapy, my therapist had been receptive to my experiences of the various rooms that we used and sought to make changes where possible or use a preferred room (of mine), however I was aware that this isn't always the case and had experienced other therapists who had not. Whilst working as a therapist in primary care, I would also at times be given informal feedback from clients about rooms, however, there didn't seem to be any place for this feedback to 'go', and it also made me wonder whether other clients (and therapists) had things to say about rooms, but perhaps weren't being given the opportunity to feed back their experiences.

In terms of my own experience of therapy rooms as a therapist outside the NHS, I have had experience of working within a secondary school and using offices designated for staff members to see students (often for disciplinary reasons) to do counselling sessions with students and found this a very different experience, to working within a university counselling service, where the rooms where designated counselling rooms, with a lot of thought put into their design and layout. Similarly, I have also worked in some third sector settings, where

therapy rooms were multi-use rooms that often were not soundproofed and found this a different experience to other third sector rooms, where the therapy rooms were designed for and designated solely as therapy rooms. Within the NHS, I have encountered a range of rooms in primary and secondary care, whilst delivering therapy both on a 1:1 and group basis and have found the variance in rooms and usability (from a therapist viewpoint) to be vast, ranging from makeshift multi-use rooms in hospitals, to rooms belonging to a supermarket and more generic rooms in between. My initial thoughts, based on my own experiences of rooms as a therapist and seeing second-hand some of the impact of the rooms upon clients (e.g., students in the school-setting would often behave as though in a classroom and relate to me as a teacher, often calling me 'miss'), led me to think that clients would probably have some negative stories to tell about rooms that weren't designated therapy rooms. I was careful however to reflect on this and bracket this off, not presuming this to be the case when both designing the study and analysing the data.

My experience of a job within a local mental health trust, which involved increasing service user involvement in research, led me to think further about how service users and therapists could be given voice in a meaningful way about therapy rooms that they use, within research or service evaluations. Aware that quantitative methods don't always capture the entirety of service user voices, I decided to design a mixed methods study for my master's research, in order to provide voice about therapy rooms and start to build an evidence base in this area, in terms of what aspects of rooms work or don't work for clients and therapists. Doing that study helped me to see that client's experiences of rooms were often based within more storied accounts of their previous experiences, or the issues that they were bringing to the therapy room, and I realised that the design of the research did not allow the space for these wider stories to be heard, along with a space for client participants to make meaning of their experiences of rooms. I therefore decided to design this present study, in order to allow for those voices and storied accounts of rooms.

In approaching this study, I was initially aware of feeling the strong need to 'bracket off' my previous experiences of therapy room research, so that I did not influence the study with my prior research and other experience, however in considering this further with my research supervisor, I was able to see that, a more mindful and flexible approach was needed. My previous research experience in this area could be both an advantage and a disadvantage. I was aware of the need, both to learn from and allow my previous research to feed into this study and at other times, lay my previous findings aside in order to allow for an inductive approach. In designing the study, my previous experience of what has worked/not worked in researching this area, and also my ability to be able to bring service user voice (from my previous study) in designing the interviews were aspects that I was able to embrace, acknowledging the active role that the researcher plays in qualitative research. However, although I had experienced the physical environment of the therapy room to be important, both as a client and therapist, I was careful not to presume this would be the case for others.

When it came to the data analysis, particularly in the initial coding stages, I made a concerted effort to approach the transcripts with 'fresh eyes,' seeking only to capture the participant's lived experiences as they described them and develop the themes from each case inductively. When I was developing the superordinate themes, I also tried to bracket off the previous themes from my previous research and allow the themes to be constructed inductively, from the data. In doing this however, I am aware that I will have brought my own person and experience to this process and was mindful to reflectively consider this throughout the process, through the use of a research journal. Overall, in line with the role of the researcher in qualitative research, I recognise my role as researcher in interacting with and making *'a,'* rather than '*the*' sense of the data.

Method

Participants were initially sent the demographics form (Appendix A) by email to complete. This form enabled data on their age, gender and number/setting of

therapy rooms to be captured, in order to give more context to their experiences, in line with a critical realist approach. The remaining data were collected through six x 60-minute (approx.) semi- structured interviews, conducted via Skype, which were audio recorded using a Dictaphone and transcribed. Although it was originally intended that participants could choose to engage in the interviews either face-to-face or using Skype, as a result of the Covid-19 pandemic, all interviews were conducted via video (Skype). Skype is an effective and valid method for collecting research data, which can provide similar benefits of face-to-face interviews, whilst also allowing for convenience (Hanna, 2012). Interviews were chosen, as they are a good method to use for research questions that involve exploring experience (Braun & Clarke, 2013) and allowed for an in-depth view. IPA requires the use of 'rich' data, where "participants have been given the opportunity to tell their stories, speak freely and reflectively, and to develop their ideas and express their concerns at some length" (Smith et al., 2009); the semi-structured interviews used in this study allowed for this.

Interviews were also an effective way to capture data on the emotional experience of the physical environment of therapy rooms. Semi-structured interviews, using open-ended questions were chosen, as they enabled participants to give more depth to their answers and allowed them to voice more, outside the confines of a more structured quantitative approach. Interview questions (Appendix B) were informed by Sinclair (2021) and focussed on client's experiences of the therapy room (*not* client issues).

Six interviews have been suggested as sufficient for a qualitative professional doctoral study, using IPA (Smith et al., 2009). The interviews lasted around an hour and open-ended questions, were posed to interviewees; these were developed from the findings of Backhaus (2009), Liddicoat (2018) and Sinclair (2021). These were piloted on colleagues and adjusted for ease of understanding and relevance. Questions included:

-How would you describe the room/rooms?

-How did you feel in the room and in relation to the room?

-What did the room represent for you/mean to you? (If anything)

-What was helpful/unhelpful about the room? -What role (if anything) do you think the room plays in the therapeutic relationship / the process of therapy / the outcome of therapy?

-Would you say that the issues that took you to therapy affected your experience of the room in any way? (How?)

-Could you describe what you think an ideal therapy room would look like/be like?

Participants and sampling

All clients were over 18 years old. The exclusion criteria for client participants were that they were not currently receiving therapy in rooms they were talking about; this was to avoid any interaction with therapy and avoid potential distress to clients still within a therapy process. The participants were therefore former clients, who had finished 1:1 therapy in an NHS therapy room at least two months ago. Two months seemed a reasonable time, to put distance between the course of therapy and the research and to allow time for the person to reflect on their experience. Participants had received a 1:1 talking therapy, in at least one therapy room, in an NHS setting (primary or secondary care). Service providers providing NHS services on an any qualified provider (AQP) basis were included within the definition of 'NHS services.' Therapists/trainee therapists were excluded from the study, as their training and experience as a practitioner could have affected their responses. Participants were recruited using voluntary and snowball sampling techniques.

An IPA study should aim for a 'reasonably homogenous sample,' however the extent of the homogeneity will vary from study (Smith et al., 2009). Participants for an IPA study are included, as they offer access to a 'particular perspective,' or experience of the phenomenon that is being explored (Smith et al., 2009).

Within this study, participants based in the UK who had had experience of NHS therapy rooms as a client were chosen. All had experienced sessions of talking therapy within an NHS service and had finished the sessions. Whilst more homogeneity could have been sought through restricting the study to groups with particular presentations, such as clients presenting with trauma, it was important to this study that participants were able to participate in the study without having to speak about the reasons for having the therapy. This was due to the design of the study and the fact that it was taking place outside of any particular service, meaning that provision for any distress caused by the study would have been limited, without any further follow up. Furthermore, limiting the study to participants with experience of either primary care or secondary care services would have been problematic for recruitment, both in terms of recruiting adequate numbers of participants (particularly as recruitment was not take place within or through the NHS), but also as many clients had experienced both primary and secondary care and some NHS sites use rooms for both. As this study was one of the first studies to look at NHS client's experiences, it also seemed pragmatic to allow for less homogeneity and treat it as a type of pilot study, whilst making suggestions for further studies into individual groups of clients/presentations below.

Recruitment

Recruitment of participants mainly took place using online channels of communication. Adverts (Appendix C) were placed on Facebook and posted to WhatsApp groups, furthermore, personal networks of the researcher and colleagues were used to spread message of the study through word of mouth. It had been intended to distribute hard copy posters to local counselling agencies, however due to the Covid-19 pandemic, this was not possible. Recruitment of participants did not take place within the NHS, due to a desire to complete this study independently, as this could allow participants to speak more freely about their experiences. Previous clients of the researcher were also not recruited to the study, for ethical reasons. Participants were offered the opportunity to be entered into a 'thank you' prize draw for a £20 Amazon voucher.

It transpired that one of the initial participants had only experienced therapy rooms for psychoeducational courses and not 1:1 therapy. The data from this participant was therefore not included in the analysis as they did not fit the inclusion criteria for the study. Another participant who had experienced NHS therapy rooms in 1:1 therapy was instead found.

Table 1: Participant demographics information

Participant Pseudonym	**Demographic Information**	**Therapy Room Information**
Andy	Male White-British Age:55-64	Primary care -rooms in a GP surgery -other rooms used by IAPT No. of sessions: 6 No. of rooms: 3
Brianna	Female White-British Age:25-34	Primary care -rooms in a hospital -rooms in community buildings No. of sessions: 56 No. of rooms: 6
Carys	Female White-British Age:55-64	Primary care -rooms in a health centre No. of sessions:3 No. of rooms:1
Dina	Female White-British Age:55-64	Primary care -rooms in a GP surgery No. of sessions: 6 No. of rooms: 1

Erin	Female White-British Age:25-34	Secondary care -rooms in a community hospital -rooms in a building used by a psychological therapies service. -rooms in a general hospital -outpatients centre No. of session: 100+ No of rooms 10+
Finlay	Male White-British Age:35-44	Primary care -rooms in a GP surgery No of sessions: 3 No. of rooms:1

Further demographical information for the group as a whole

Two of the participants identified as being disabled, four as non-disabled. Four participants considered themselves to have no class category, with one identifying as working class and another identifying as currently lower middle class, but having grown up as working class. Four participants were employed or self-employed, one was not working, and one was retired.

Transcription

The researcher transcribed the interviews shortly after they took place. Oliver et al. (2005, p. 127), suggest that “transcription can powerfully affect the way participants are understood, the information they share, and the conclusions drawn”. A naturalised approach to transcription was chosen for this study as it was in keeping with the qualitative and IPA design of the study. Naturalism in transcription, involves noting non-verbal information such as gestures and

pauses in speech (as well as speech), in recognition that nonverbal communication can powerfully contribute to what is being communicated. In aiming to give a high amount of contextual detail, the transcripts, in keeping with the critical realist approach were more likely to closely reflect the reality of the participants' experience. In recognising that punctuation can alter the meaning of what is said, punctuation was omitted from the transcripts, apart from question marks to indicate questions. In some places, to differentiate between two different excerpts of speech, three full stops were used. Italics were used to denote any emphasis the interviewee made on particular words. All identifying information, such as names of places and services was omitted from the transcripts and square brackets were used in places, to denote such information having been removed, in order to ensure participant's anonymity.

Analysis

The data was analysed using Interpretative Phenomenological Analysis (IPA) (Smith, et al., 2009). Smith et als., (2009) steps for conducting an IPA were followed; an overview of these is shown below:

- For each transcript, the following process was undertaken: the transcript was read numerous times and the tape recording listened to at least twice in order to gain a feel for the client's voice, as well as listen to the content.
- The transcript was then copied into a table with three columns, on a word document. The verbatim transcript formed the central column, with a column for exploratory comments on the right and a column for emergent themes on the left. Excerpts for parts of the process, as outlined below, are shown in Appendix D.

- The transcript was then read line-by-line and initial notings on the content, use of language, preliminary interpretations and other observations were added to the exploratory comments column.
- Emerging theme titles were then noted in the left-hand column, with the aim of capturing the essence of what was found in the text. This was completed for the whole transcript.
- The emergent themes were listed on a separate sheet of paper and the researcher looked for connections between them. This then led to a more analytical ordering, as the researcher noticed clustering of themes. These clusters were then checked back with the transcript.
- A table of themes was then created that captured most strongly the participants' views. These clusters were labelled into 2-4 super-ordinate themes. Themes were omitted if they were not rich in evidence within the transcript.
- This process was repeated with each of the transcripts. Every transcript was treated separately throughout this process and ideas from prior analyses were 'bracketed' off, in fitting with IPA's idiographic approach
- Following this process, all the tables of superordinate themes were combined, and a final table of super-ordinate themes was compiled, referring back to the original transcripts, to ensure a richness of evidence for each theme.
- Themes were then compiled and explained in the write-up of this research, with extracts of participant's interviews given to both evidence and contextualise the themes.

The findings were written up within separate analysis of findings and discussion sections, in order to clarify and distinguish between the participant's verbatim account and the researcher's interpretation. Links to existing literature were also made within the analysis of findings and discussion sections.

The themes are evidenced by sections of the relevant text from the participant's transcripts. It is important to note that whilst the themes are

distinct, they are not considered wholly independent from one another, and they share commonalities. The excerpts also demonstrate some of the interrelation across themes.

The key themes identified are incorporated into a final discussion below, related to the research questions. This allows for a greater understanding of client's experiences, what it is like to experience these, and the meanings clients make of their experiences. Although findings from this study are not generalisable, potential implications for practice will be suggested below. This data could also be used in future studies, to develop guidance for therapy providers about best practice for therapy rooms and to highlight the importance of gaining client feedback about therapy rooms.

Ethical considerations

Ethical approval for the study was granted by the appropriate University of the West of England (UWE) faculty research ethics committee (FREC) for this study (Appendix E) and the researcher adhered to the British Psychological Society ethical guidelines for conducting research (Oates et al., 2021). In terms of informed consent, participants needed to read an information sheet (Appendix F) which gave information about the study and outlined their right to withdraw from the study, prior to being asked to sign a consent form (Appendix G), in order to take part. Participants were also able to email the researcher to ask further questions. Additional verbal consent was obtained from the participants immediately prior to interview, to allow tape recording of the interviews using an Olympus Dictaphone. Participants were briefed on the information sheet regarding their right to withdraw. The information sheet also informed interview participants that they would have the option of viewing and amending typed transcripts prior to them being used for analysis. Transcripts were emailed in password protected files, with all identifying information removed. All data was promptly anonymised and identifying data was removed. Participants were

offered the opportunity to receive a copy of the write-up of the final research report.

Data was handled and processed in line with the Data Protection Act (2018), with data anonymised and held securely on the UWE server, in line with the General Data Protection Regulation requirement (GDPR) (2018). A data management plan was completed and uploaded to the university online system. Data will be held on the server for a period of three years after the research has been written up; after which all data will be destroyed. This is so that the research can subsequently be submitted for publication in a professional journal; counselling and psychotherapy journals often require data to be held for three years.

Additionally, consideration was given to the risk of client distress through participating in the research. The researcher is a qualified counsellor and had carefully considered the risk of distress to participants taking part in this study. As the researcher is a qualified counsellor with significant research interview experience, this provided additional safety, as well-developed listening and containment skills and a good understanding of the differences between therapy and research interviews, helped to mitigate against participant distress. Participants were former clients only, who had completed their therapy at least two months prior to the present research; this was to avoid potential distress or conflict related to any current therapy. Interviewees were not asked to give any specific details about their previous therapy. All interviewees were verbally briefed and debriefed prior to recording.

It was not thought that participants would suffer any distress through taking part in this study, however participants would have been signposted to a free counselling agency if they had been left with any unresolved issues after having taken part in the study (details of how to access this were outlined on the information sheet). All participants were also offered the option of contacting the

research supervisor at any time, in order to discuss any concerns or complaints about the research; this was outlined in the participant information sheet.

Analysis

(Participant pseudonyms are used throughout, to preserve anonymity).

Three super-ordinate themes were identified, as shown in the table below (Table two). These were 'the hospitality of the room,' 'the journey to the room' and 'cure or space to explore.' These three super-ordinate themes, along with their sub themes will be discussed, with reference to the research questions for the present study and existing literature.

Table two: super-ordinate themes and sub-themes.

Super-ordinate Theme 1 The journey to the room	**Sub-theme 1a:** Physical journey to the room
	Sub-theme 1b: Psychological journey to the room
Super-ordinate Theme 2 Hospitality of the room	**Sub-theme 2a:** Provision of the room
	Sub-theme 2b: Permission within the room
Super-ordinate Theme 3 Cure or space to explore	**Sub-theme 3a:** Medical rooms
	Sub-theme 3b: Space to be/explore

Super-ordinate Theme 1: The journey to the room

The first theme of 'the journey to the room' related to the physical and psychological journey that clients took to enter therapy rooms. This theme

incorporated the things that the participants said about the wider buildings that therapy rooms were situated in, the journey to those rooms and buildings, as well as the first impressions of the room and service and the psychological aspects of these impressions.

Subtheme 1a: The physical journey to the room.

This theme related to the actual physical journey that clients took to get into a therapy room, where the building was located and how they accessed the rooms in the building.

Often the journey through the building was experienced negatively and formed part of the first impressions of the service or what the person might receive from the service. Four of the participants mentioned first impressions of the therapy space and wider building as being important, particularly in terms of reducing anxiety and enabling engagement. One client spoke of how important those first impressions were and how he wanted to leave the session/service as a result of his negative experience in a room situated in a primary care health centre:

> "I think when one turns up (pause) for the first time (pause) not knowing at all, probably having been more courageous than ever before in one's life…and if one is presented with something which is… What on earth is this… what on earth is this? Where am I now? Why am I at the end of a corridor… why am I being pushed down a cul-de-sac…why is there not any fresh air…why…what on earth are those posters doing there? And now we've got to sit facing each other across a…what on earth is going on? It kind of made me want to get up and walk out really (Andy)".
>
> He further elaborated on his experience of the journey to the room down the corridor and what it meant to him:
>
> I think the space was inappropriate…follow me down and sit in a waiting room…. you then get called…you're (pause)… I think the first time I was

> pushed down the corridor… because the counsellor was behind me… I think the second time I was led down a corridor…there wasn't… there wasn't room in the corridor to walk side-by side…I think it was a cul-de-sac…and I haven't come to stay in a cul-de-sac (laughs)…I've come to get out of here (Andy).

This journey to the room also formed part of this participant's first experience of the therapist, in either feeling 'pushed' or 'led,' as opposed to being able to walk side-by-side. Interestingly, there was also the psycho-symbolism of the journey to the room being like walking into a 'cul-de-sac'; something that the participant said he was trying to get out of, in his own therapy journey. This participant would have preferred a separate way in and out of the service:

> "Well I think…I think I would prefer to go in one door and go out of another… so that you're not going back out of the door you came in…cause you're meant to be leaving things behind." (Andy).

Another participant spoke of how the physical journey through a 'warren' of corridors could increase anxiety, that then was brought into the therapy room:

> "If you're constantly worried that you're gonna trip over your own feet… and there's ledges everywhere and you don't know where the toilet is and it looks scary as heck and the corridors look all kind of same-y and you know you're gonna get lost even just trying to get out… and all of that…you bring that in to that space as you've been led through this warren of a space" (Erin).

Two other participants mentioned issues to do with entering/exiting the building that the therapy room was in being an issue, with one clearly describing the felt risk of 'being seen' by others and the potential for stigma, as a result:

> "In [place name] they've actually got a psychiatric unit and if you were then sent to that for the counselling you'd very much stigmatise yourself

> …but also people would see you going in and out and that would add to what you are doing… so I think where it is *is* important" (Carys).

The experience of being in or walking through a waiting room, such as that found in GP surgeries within buildings used by IAPT services, was also mentioned by three clients as being unhelpful and anxiety-inducing:

> "The state you're in… you don't want anybody looking at you… you sort of felt uncomfortable because it was the first counselling session I'd ever had…so you've got stigma attached because you've got depression…and you felt like all eyes were on you…and so you just wanted to get in there so you could get out" (Dina).

In further looking at the physical journey to the room, the accessibility of the room was mentioned by one participant, who noted the inaccessibility of buildings that she had experienced or knows of, that are used by the NHS for talking therapies:

> "So [building name] was incredibly inaccessible…like there were steps going into it…there were loads of little ledges that you could trip over everywhere… all of the corridors were about as wide as me…really like…truly like a little warren" (Erin).

She went on to articulate how important it was that therapy rooms and the buildings that they were situated in were universally accessible, both for those who are disabled, but also for older-age adults and those with temporary impairments:

> "I think that all therapy spaces absolutely 100% have to be as accessible as humanly possible... I definitely don't understand today how you can think about having a space that isn't accessible to everybody and obviously not only for disabled people…but also everybody has different challenges at different times in their lives and thinking about somebody going skiing and breaking their leg and thinking about someone being at a later stage in life and their accessibility changes…accessibility needs

> change…I don't…I think that that's still hugely problematic and exclusionary…like many things are in our society... we live in an ableist society…but I think that when you're thinking about the importance of mental health care…and if we're wanting to truly make sure that everyone can access appropriate mental health spaces and they want to bring with them…you know…some of the different experiences that they have in society of the different challenges and then one of the challenges is they can't even get into the room…I mean that's base level" (Erin).

This participant, who herself identified as disabled, articulated accessibility as 'base level' and was surprised that NHS premises providing talking therapies services were not universally accessible. This will be discussed further below.

Finally, one participant noted that the journey to the room in its entirety should be thought through, in terms of practicalities, by all service providers:

> "I think it begins with how you arrive at the place…I don't think it's just… a Tardis that you end up…I think it's much more about… how you're gonna get there…if you're driving…where are you gonna park… is it well signposted? Does one have to…does one have to sit in public waiting for someone to come and call you?" (Andy).

<u>Subtheme 1b: The psychological journey to the room/ the baggage carried to the room:</u>

This subtheme related to the prior life and therapy experiences and expectations of therapy rooms that participants brought with them, that directly linked to how they experienced the room. One client, talked about how when she heard the grand sounding name of the (NHS) building that she would be going to, to access talking therapy in secondary care, she formed a very grand and 'whimsical' mental image of the place, which was in direct contrast to the 'dilapidated' and worn building she was greeted with for her first appointment. This experience was disappointing and an important first impression of the service she would receive there:

> "When I knew I was going there I was like thinking it was this grand…huge listed building…beautiful place…it was going to be all whimsical and it was a house that was truly kind of falling down in the middle of the city centre…it was very...it felt very used" (Erin).

This first impression or appearance of the place was linked to and formed a psychological representation of issues/process that was going on for this participant at the time:

> "And sort of the crumbling state of it…I think really kind of represented some of the things around like trust and um some of my…some of my institutionalisation that I was trying to deal with in those spaces wasn't helped by how institutional and dilapidated and crumbling (laughs) the foundations felt about the place" (Erin).

For this same client, her experience of being institutionalised and now being seen in rooms that were 'crumbling' and 'worn,' only added to her anger and frustration, again making her want to leave the rooms:

> "I wanted to leave… I constantly wanted to leave…. I didn't connect with any… I didn't have any good sense of those rooms… I went in angry… I went in so angry…so frustrated… um they used plastic chairs and they had shiny floors and I would… I was so annoying… I would like tap my foot or like bang my ring on the plastic and I would just… I would be humming with frustration and I *don't* want to be here…just like a child in a class and they're acting up because they don't want to be there…they have no idea why they're there…it's not what they wanna do… it's not where they wanna be… and that was my feeling in those rooms" (Erin).

One participant spoke of how for a one-off session, the room that they received therapy in (from an IAPT service) was within the grounds of a

psychiatric hospital and whilst traveling there, he became very anxious about why he had been asked to come to the place and whether he might be kept there:

> "The only time the counsellor could see me was if I went to that space… which was strange…in a hospital setting… for people with um psychiatric issues…so that was really unhelpful…Shit are they…why am I driving in here?...Shit… am I staying? Is this why they've brought me here… am I gonna stay? And all that sort of… again a complete lack of care really…only interested in themselves…" (Andy).

This led him to conclude that the service only 'cared' about themselves and not the anxiety or difficulties that clients might go through in trying to access the service. This same participant also talked about the expectations that he had of the therapy room, prior to entering it:

> "I was expecting to be able to enter a space that was going to be part of the events rather than four walls of a room keeping the event (pause) very tight" (Andy).

This space felt like it was laid out as a confrontational space: "it was laid out as a confrontational space… rather than a space to engage" (Andy).

The issues that the participants had been bringing to the room at times interacted with their first impressions of the room and the therapist. One participant spoke of how her severe anxiety had led her to get therapy, but that she also felt 'paranoid' and suspicious about the setting and the therapist, fearing she had been sent to the 'nut house;' this wasn't helped by the layout of the room, which exacerbated her anxiety:

> "But for me I've been sent to the nut house as far as I felt at the time…I was feeling I'd gone a bit crazy…which you do feel like that when you've

> got anxiety…you are not in control of everything…you are just scared the whole time when you've got no control and everything" (Carys).

Her initial experience of the room and the layout only exacerbated her concerns about the therapy, leading to her to be suspicious of the therapist and his motives:

> "Well I was very anxious and that was the reason I was having counselling because of these terrible anxiety attacks and things…for me…it was uncomfortable because he had a desk and I wasn't sure if he was recording me… I suppose I was a bit paranoid really… I was a bit scared I would be recorded… So that actual layout of room wasn't helpful for that" (Carys).

Super-ordinate Theme 2: The Hospitality of the room

A second significant theme that arose from the data was that of the 'hospitality' of the room. This theme included client's experiences of how they were 'catered' for they were within the room and how they felt in relation to the space and the therapist.

Subtheme 2a: The Provision of the Room.

This subtheme incorporated how clients were accommodated in the room, both in terms of access and the structure and contents of the room. Participants had experienced a range of different rooms, from both primary and secondary care and four of the participants also went on to compare their experiences of the provision of the NHS rooms, with their subsequent experiences of private therapists/counselling agency rooms. Overall, the majority of participants experienced the NHS rooms as negative, with many describing 'unwelcoming' rooms that were not designed with the intention of delivering talking therapies. Within primary care, the rooms were doctor's surgery rooms, often with poor soundproofing, where participants described the experience of rooms not 'designed' for talking therapy:

> “Well there was nothing there that was sort of felt like it was designed for the therapy… so it seemed like it was in the wrong place…that was a room that was made for a different purpose to the one that I was there for… so there was nothing there to help me relax… so things like the lighting was very bright…it was quite cold there were no pictures on the walls…the seating wasn't very comfortable so yeah there was nothing there that seemed like it was made or designed for helping me relax and talk about issues” (Finlay).

> “Too small…too hot…too cramped…uncaring… clearly not conducive to the counselling setting…very little fresh air…dark…uncomfortable chair” (Andy).

These rooms were experienced as ‘formal,’ ‘plain,’ ‘uninviting’ and ‘generic,’ with some participants also noting the lack of maintenance. One participant (Erin) who had experienced rooms in secondary care, described the rooms and facilities as being worn and unmaintained:

> “Although I was going in there to do some work… it felt like work had been happening in this space for a really long time… er… lots of magazines that were 20 years out of date and just urgh frayed carpet… and the seats were just *so* uncomfortable… The windows looked gross and the net curtains were yellowing” (Erin).

The participants all stated a preference for rooms with a ‘homely,’ cosy or warmer feel, with accessories such as cushions and some colour to lessen the formal, bland appearance and improve the sound quality; this was in keeping with the findings of my previous research (Sinclair, 2021) and Nasar and Devlin’s findings regarding a preference for ‘soft’ rooms (Nasar & Devlin, 2011). One participant articulated this:

> “I would have preferred to have some sort of dim lighting in there… maybe carpet on the floor to make it feel a bit warmer…I would say pictures on the walls…something to focus on…a lack of medical equipment in there cause there was like a bed in there… like a medical bad and that wasn’t helpful” (Finlay).

Likewise, two other participants described their version of their preferred therapy room:

> “Perhaps a coffee table on the angle…so not quite between you but perhaps with some flowers on it so you’ve not got that exposed feeling and a comfortable room that feels perhaps like a living room…neutral pictures” (Carys).

> “I’m just thinking if you’ve got carpets or softer floors and you’ve got soft furnishings and you’ve got pictures and things you soften the sound…you don’t get this echoey sort of circumstances…that creation of furnishings closes in the noise as well as…psychologically it sort of gives this cosy feeling” (Carys).

These were descriptions of more ‘homely’ rooms. One participant did however note that it was important that it was not too informal. Two of the participants contrasted these ‘homely,’ softer rooms with their experiences of ‘formal’ (Brianna) or ‘confrontational’ (Andy) rooms:

> “It was laid out as a confrontational space…rather than a space to engage” (Andy).

> “The rooms were formal and uninviting…not homely or anything like that” (Brianna).

Three of them also linked being able to relax with ‘opening up’ more; something which seemed an important task of therapy for them:

> “Things like comfortable chairs… carpet… pictures on the walls…so I think all those would enable me to relax and talk more freely without being bothered by the negative things in the room” (Finlay).

> “Comfy things…so that you can sit down and get relaxed that way and if you're relaxed then you might be able to open up a little bit more” (Brianna).

The room playing a key role in that process of being able to relax, ‘open up’ and ‘confide’ in the therapist was highlighted by one participant, with ‘unsafe’ feeling rooms or room variables hindering that process:

> “You need to reach a point where you feel like you are confiding in somebody…that you’ve really got that level of confidence and I think the room is really important…when I felt that perhaps someone could be recording or somebody could be outside the window you won’t open up… because you won’t concentrate…you won’t really think about where you are” (Carys).

This participant also spoke of the business-like formal appearance of the room as being like a barrier that prevented her therapist from enabling her to open up:

> “It felt more like a businessy sort of arrangement…that sort of thing…and you think if it had have been more sofas and chairs and a little bit more homely feeling…whether he would have been able to cross those barriers” (Carys).

Another participant also linked the room not being ‘inviting’ with hindering her process of opening up:

> “I think it depends on the individual…but with my experience…as I said I didn't find it very inviting so I didn't… it took longer to open up” (Brianna).

The lighting of the room was mentioned by four of the participants, with bright artificial lighting being described negatively, by all apart from one. Dimmer lighting or natural lighting was mentioned by four of the participants, either in the context of what they would have preferred, or in their answer of what an ideal therapy room would look like:

> “I think a dimmed lighting would be helpful…not so dim that you can’t see people clearly…but yes..taking the bright lights off so that people feel relaxed” (Carys).

One participant also described spotlights as being unhelpful:

> “And well-lit… definitely… no spotlights…ever…no spotlights *ever*.” (Erin).

One client also described the importance of having things for clients to fidget or play with in the room, noting that this was particularly important for clients feeling anxious or distressed:

> “Having things to fidget with I think is really really important…if you don’t give someone something to fidget with when they’re talking about stuff that is really hard…they will pull apart your chair or they will like…you know…tap their foot…or they will try and fray their own jumper…or whatever it is…give people…it doesn’t have to be complicated…just *blocks* …whatever you want” (Erin).

Although not strictly about the room itself, three of the participants also would have liked the provision of tea/coffee facilities within the therapy room:

> “I think it would have been good to have had some(pause) form of hospitality facilities…whether it's hot or cold... a beverage of some description... cold water is always helpful”. (Andy).

The same participant also explained that if tea and coffee facilities could not be provided in the therapy room, the therapist could suggest that clients brought their own refreshments:

> “Take your own flask…and if you want to bring cake…bring cake and bring your own mug…because this is about hunkering down and being with yourself” (Andy).

In terms of the bricks and mortar of the physical environment of the room, having views of nature was also mentioned as important by three of the participants, particularly in terms of helping them to relax. One of them also alluded to the psycho-symbolism of it:

> “Connections with nature from the outside…really big windows…really big windows” (Erin).

> “I would prefer something that was looking onto a garden… which is well tended…I think it needs to be something which shows…um…growth and fruit…and not just a blank wall with nothing on it” (Erin).

The overall appearance of the room could also influence how the participants saw their therapists. This is in agreement with Nasar and Devlin’s (2011) findings that the room can affect the perception of the therapist. Two of the participants spoke of seeing their therapist in a particular way because of the room:

> “In the way that these rooms felt worn and used and tired and dilapidated and crumbling…the psychiatrist and the therapist that I worked with…the psychiatrist was obviously…I think was doing his best…but obviously had way too many cases and was exhausted and exasperated beyond all measure and was trying his best” (Erin).

The participants often concluded that the reason for the rooms/building being sub-standard and not suitable was due to a lack of money and resources within the NHS:

> “It was not an accessible place or a friendly place or a welcoming place… or an anything place… It was probably the cheapest place (laughs) that the local authority could hire” (Erin).

One participant (Andy), contrasted the NHS rooms that he had found to be unhelpful, with his subsequent experience of a private therapist’s rooms and felt that a lack of money was not the only issue:

> “Well the NHS could offer the same thing as private…if they chose to invest their money wisely...managers who don’t understand what’s going on…only want to get the numbers in the books” (Andy).

Two participants spoke of how their negative experience of the room caused them to terminate therapy early, with one explaining:

> “When I had a what I deemed a bad room… the medical room… I don’t think I don’t think I had any good any positive outcomes from that therapy and I cut it short and finished that therapy after I think two or three sessions because it wasn't working” (Finlay).

Subtheme 2b: The Permission of the Room.

This theme related to the way that participants felt they were given permission in the room, in terms of being given ownership of the space and being 'allowed' to be how they needed to be in the space. Issues related to permission in the room, were mentioned by four participants. Being given choice in the room was an important aspect of the permission of the room and was linked to being able to relax and open up:

> "I would have liked to have had an option to change the lighting or the seating or the temperature in there…I think if I was able to do that it might have helped me to feel more relaxed and more like I am somewhere I should be" (Finlay).

Being allowed to 'be' how you needed to be in the space was mentioned in one participant's (Erin) idea of what would make an ideal therapy room. She felt being able to give clients autonomy about the space and using the space would be 'revolutionary.' She further explained that being able to move in the space was important for her and this had helped, especially at times when she felt nervous in talking about something:

> "So feeling like I had space to *move* (laughs)…I think is important… especially if I'm bringing a *lot* and I'm nervous about talking about something…. I think giving clients a bit of autonomy about the space and how they want to use the space… I think would be kind of revolutionary" (Erin).

The ability to be able to move around when talking links in with the modality of 'walk and talk' therapy; this is discussed further below.

Being able to talk about the space was also linked with giving clients autonomy in the space/room and allowing the client to feel some ownership of the space:

“Have open conversations about that space and to give people a little bit of autonomy just like ‘okay…yes…you have entered where I work but this is *your* space too where you are working on some stuff that is going to be tricky for you at times…What can I do to make this space feel a bit more like yours?’” (Erin).

Super-ordinate Theme 3: Cure or space to explore.

This theme is related to the appearance of the room and the ‘message’ that it gives clients about the origin and maintenance of their issues and the purposes of talking therapy. This related to the participant’s descriptions of rooms that were either more in keeping with a medical model of mental health, with spaces having a medicalized appearance where they go to receive help from an ‘expert,’ or a more informal, facilitative and growthful space, in line with humanistic theory, where the therapy room and wider setting allowed for ‘space to explore’ collaboratively, whatever the client wanted to bring. Furthermore, participants described the confusion and disappointment that arose when they had come for: a ‘space to explore’ and when the environment instead gave cues and seemed set up for it being a place to come for a ‘cure’ for physical health issues.

<u>Subtheme 3a: Medical rooms.</u>

Five of the participants talked about the medical appearance of the NHS therapy rooms that they had used and all of them spoke about the medical appearance in negative terms. Within primary care, the rooms were doctor’s surgery rooms, often with poor soundproofing, where participants described the experience of rooms not ‘designed’ for talking therapy: Participant descriptions ranged from it being experienced as ‘uninviting,’ (Brianna) to ‘cold and clinical’ (Dina):

“Because it’s in a doctor’s surgery…and it was one of the rooms that they use for a doctor or for the nurse...it was just cold and clinical really” (Dina).

Some of the participants also felt that it heightened their experience of anxiety, with one participant particularly, focusing on this:

> "It was a medical environment it was a medical surgery and being in that made me feel anxious…I think it was like waiting for waiting for surgery or waiting for some kind of medical procedure and that made it difficult to relax and that…so I felt quite anxious…there were medical things going on in other rooms that I could hear so I felt quite uptight…I couldn't…I couldn't relax or really focus on the therapy" (Finlay).

This participant also spoke of how this felt incongruent to the talking therapy that he was receiving and how the medical appearance and setting of the room imbued a medical model understanding of mental health, that he didn't find helpful.

> "Because I was in in a medical room so I felt like there was something wrong with me…that I needed a doctor for...that was sort of the dynamic I guess…I find that an unhelpful way to think about what I was experiencing and the reasons why I was really there ...I know some people do find that helpful... but you know I was struggling with issues in my life... I don't really find it helpful to think that I've got an illness that I need to see a doctor for" (Finlay).

This medical appearance also impacted upon the felt practicality of the room for talking therapies, for the same participant:

> "(It) was a room that was made for a different purpose to the one that I was there for... so there was nothing there to help me relax... so things like the lighting was very bright... it was quite cold...there were no pictures on the walls and the seating wasn't very comfortable so yeah there was nothing there that that seemed like it was it was made or

designed for helping me relax and talk about issues that I was having" (Finlay).

Another participant also spoke about his similar experience of a medical environment and the incongruence to talking therapy, when accessing an IAPT service in primary care:

> "This was a multi-purpose room and their users… the professional users were not taking into account how well the room presented itself...there were posters up about STDs and various things which had absolutely no relevance to what I was doing" (Andy).

He also felt that the medical environment was not conducive to engaging in talking therapy and hindered his process of being able to 'open up' within the therapy:

> "And this space was in the doctor's surgery…but it wasn't conducive to a positive experience... And that created a tightening of um...instead of being able to blossom into the space... I felt that my flower buds (laughs) were being tightened and shut...rather than being encouraged to open" (Andy).

One participant described the doctor's room that had been used by her therapist within an IAPT service, as 'authoritarian,' indicating the room conveying a power dynamic.

> "It felt authoritarian because it belonged to a doctor." (Dina).

Another spoke of the desk as a 'barrier' and the impression she had of the therapist as a result:

> "It was a barrier…it did leave him as the professional on the other side of a desk and didn't leave that open…friendly sort of feeling that you might have come away with" (Carys).

One participant who was seen in another clinical environment also described the table as acting as a ‘barrier’ in the room and seeming out of place:

> “The table seemed to be the important thing…it was like a barrier in the middle of the room…I'm not sure that one needs to have a conference table in a counselling…in a meditative space” (Andy).

For this participant, the space was meant to be a ‘meditative space,’ a concept that clearly charred with the furniture with which he was presented. It is interesting to consider here McLeod and Machin’s (1998) suggestion that the layout room can convey the expectations of the activity that will take place in a space; this participant seemed to be getting a mixed message here.

One other participant spoke about desks as being unhelpful, as they reminded the client that the therapist was just doing a job and could be distracting; she therefore advocated for a desk free space when doing therapy:

> “So if possible… any kind of like desk and computer space I think needs to be either covered or just not kind of there if at all possible” (Erin).

Another issue with medical rooms that was articulated by two of the participants were that there was a risk of interruptions in these types of rooms, as staff such as nurses were used to entering the room when patients and the GP were in there. One participant who had experienced one such interruption described them as ‘awful’ and explained the impact it had:

> “It breaks the privacy…and in some ways it can break your trust” (Dina)

Similarly, the medical rooms in surgeries were also described as not being soundproof by two of the participants, with one participant explaining the negative impact this had on her, in terms of feeling free to speak:

> “When you sit in doctor’s waiting rooms… I think there’s six or seven doctors’ rooms now and if they’re a bit louder in the room you can hear muffled noises...I think it adds to the stigma and the self-consciousness…so then you sort of feel like you’re holding back” (Dina).

Subtheme 3b: Space to explore.

This theme related to the type of ‘ideal’ space that the participants described as having wanted for therapy; a space that allowed the process of therapy to occur and facilitated exploration and preferences or flexibility for things such as varied postural position (siting, standing, walking) within the room.

One participant, outlined this need for flexible space, where clients could have a choice over the type of chair that they sat in and also ‘be’ how they needed to be in the space:

> “A choice of different chair in the space…but also a space where if you wanted to…you could lie down…If you wanted to…you could stand on something…if you wanted to…So give people the choice of how they want to *be* in the room” (Erin).

This participant also went further, with the need for the room to also accommodate the client moving around:

> “There should be enough space so that if people want to walk around or wheel around or *run around* then there is space to move… that has to be *absolutely crucial*” (Erin).

Another participant explained this concept of it being about exploration, rather than being ‘pushed’ through a process and the psycho-symbolism of being given options in the space and how this could create freedom in the therapy process:

> “It’s not about being pushed through something…it’s about… yeah…so you’ve come along to explore yourself...maybe I can show you where some of the doors and the windows are… you might choose to go

> through them or not… but if I can show you… where you might find them…that might be helpful" (Andy).

One participant (Finlay) compared his experience of NHS therapy rooms (in a GP surgery), which he terminated early, due to a dislike of the setting, with his experience of 'wild therapy' (therapy that takes place outdoors) that he engaged in, with a therapist working privately... Within the wild therapy, he found this much more helpful than being in a room with a medical appearance:

> "I've actually had had so much more successful therapy outside…it's called wild therapy and I found that actually much better than even a good room that I've been in…cause I did have a much better room with that same therapist for the first session and it was really…. I found it really really positive the room… but then we also went outside and that was even better" (Finlay).

While a discussion of wild therapy is beyond the scope of this paper, this participant found the freedom of not being confined in a room helpful and a welcome contrast to the anxiety-inducing room with a medical appearance that he experienced in the NHS therapy. He also emphasised the choice and control that he was given in this therapy outside the room, in direct contrast to the lack of choice that there was in the NHS room:

> "I was encouraged to go to whichever spot I wanted to or just to keep walking around ...I was encouraged to take ownership of where on the piece of land our therapy was gonna take place... it also gave control over how I was interacting with the therapist…because you know always facing each other might sometimes be comfortable...so just walking alongside each other instead...so I could take control of when I wanted to do that" (Finlay).

This illustrates not just the importance of the flexibility of the room, but also the ownership, that having choice over the therapy gave him.

Another participant spoke of how her ideal therapy room would be designed like a hospice, in terms of choice, flexibility and a comfortable and non-clinical appearance:

> "Hospices are… so many of them are *amazing*… they have *so* many windows on the outside… there's loads of access to the garden really easily from every single room… loads of air… loads of light and they're usually beautiful grounds… lovely…lovely…also connections with nature are really easy" (Erin).

This is interesting, as modern hospices usually have a homely, relaxed, and comfortable feel, far different to that of a general hospital and while medical care forms a part of what they offer patients, the focus is on a holistic approach, catering to the whole person. This approach seems to encompass much of what the participants said they looked for in a room, particularly within this subtheme, when they were often articulating wider needs relating to growth, as opposed to going to somewhere to be 'cured'.

Discussion

The themes will now be analysed and discussed in further depth, with reference to relevant literature. Following that, the findings will be discussed in relation to the research questions, with further reference to the relevant literature and the strengths and limitations of the study will also be discussed. Consideration of the findings, with reference to current issues and debates in counselling psychology will also be made. Finally, implications for practice will be suggested.

The journey to the room

This is an aspect that was spoken about by all the participants, and yet interestingly is absent from much of the research literature into therapy rooms.

Many of the participants spoke of the anxiety-heightening experience of having to wait in a waiting room in a GP surgery, where they feared being ‘seen’ by others, or of having to be ‘led’ or ‘pushed’ down a warren of corridors, before finally getting to the therapy room they were going to be using. It seemed that this was a problem found in both primary and secondary care settings within the NHS. It seems as though service providers have often not considered the ‘journey’ to the room on a practical or psychological/emotional basis and one participant described the way that a secondary care building was wholly inaccessible to those with mobility issues. This is another area where issues are particular to an individual service and an area that highlights the need for consulting with service users and carers about the wider buildings that are used for talking therapies and asking for feedback on how buildings ‘work’ for service users and carers. Accessibility to buildings is an issue that is still clearly problematic and NHS services that are not based in hospitals can often not be universally accessible. Interestingly one participant pointed out that lots of private therapist’s rooms and buildings are also inaccessible (e.g., upstairs with no lifts) and it is clear from a quick look at many online therapy directory searches that this is the case. This participant felt that it should be a requirement of a therapist’s professional registration that they provide accessible premises, and it is interesting that no professional body appears to have required this (despite a focus on inclusion in other areas). Counselling psychologists are expected to provide safe environments for practice (HCPC, 2015) and be inclusive, it therefore seems particularly important that counselling therapists working in the NHS or privately consider this issue of accessibility with regards to their practice. This will be discussed further below. Furthermore, accessibility in the widest context should arguably also be considered, regarding the whole physical journey to the room, including parking, the way that clients enter the building, signage to the room, the journey through the building, provision within the room and accessibility of information.

The psychological journey to the room was also a factor, in terms of the expectations that clients brought to the rooms about what the therapy room would look or feel like and also in terms of their life experiences and identity. One participant (Erin) spoke of the expectation of a beautiful and 'whimsical' place that the building name conjured for her, and then explained the disappointment she felt when she encountered the dilapidated building. How might this have affected her expectation of the therapy/help that she would receive in that place? It was interesting to note that she described seeing the psychiatrist in the same way that she saw the buildings; 'worn and tired' and although feeling like she 'belonged' there because she had been so institutionalised, she also felt that she constantly wanted to escape both the therapy and the rooms/building. This participant's consideration of her experience of therapy rooms in terms of her institutionalisation was interesting to consider. When someone has experienced lots of medical/therapy rooms starting from early childhood; when does another room become just another room where you are going to be 'studied,' 'done therapy on,' or sit feeling frustrated when the 'cure' you were hoping for does not materialise? For this participant, she also considered her experience of not feeling that she 'belonged' in the beautiful and 'middle-class' rooms of her private therapist, through the lens of class, in that coming from a working-class upbringing, she did not feel that she belonged in those spaces, despite the fact that said she would probably be considered middle class now. This is interesting to consider, in terms of other clients and how class and other identity factors could either lead to and intersect with a person feeling they did/did not 'belong' in a space or therapy room.

The hospitality of the room

The participants spoke of preferring rooms that had a 'homely' feel. They often gave examples of soft furnishings and accessories as helping to provide this 'homely' feel. A room having a homely feel was linked with being able to 'relax' and 'open up' more with the therapist. Four of the participants had also had

experience of private therapist's/agency therapy rooms and they all compared their NHS therapy rooms experience with the different experience of those rooms; with the private therapy rooms being experienced more positively in every case. The private therapy rooms were described as more comfortable and conducive to being able to relax. Interestingly, the private therapy rooms were almost always described as the therapist's space, however the participants described how therapists could enable clients to feel that it could be their space for the duration of the session, particularly through offering choice over aspects of the room.

The provision of a comfortable-feeling space was interestingly linked with 'care,' both in terms of the room feeling 'cared for,' but this could also seep into the client feeling cared about. The room being linked to the therapist was also a finding of my previous research (Sinclair, 2021) and is in line with a wealth of evidence from the wider psychology literature, showing that people are often perceived according to the environment that they are in (Gosling et al., 2002; Maslow & Mintz, 1956). The offering of choice in the room, such as a choice of chairs, was also seen as both practical (in terms of ergonomics and inclusion), but also in a deeper way, as a way of welcoming clients into the space.

The choice of the word 'hospitality' in the title for this superordinate theme was a deliberate one, that encompassed the sense of both the service and the therapist welcoming clients into their therapy rooms, in the way that someone might welcome a guest into their homes. This was something that the majority of the participants described that they would have wanted or envisaged there being, in an 'ideal' therapy room, but also explained that they didn't receive in their experiences of NHS therapy rooms. It is understandable that many NHS services share rooms, and it wouldn't be possible or practical to always have 'softer' rooms, however, this sense of welcome seemed to go beyond the vases of flowers and other 'soft room' accessories, to the way that the therapist

interacted with the space, in order to welcome the client and offer some ownership of the space, for the duration of the session.

Ownership of the space also linked into the second subtheme of the permission of the room, in that permission-giving was also linked to a subtle shifting of the power dynamic, whereby clients could be how they needed to be in the room, rather than having to be in a particular way as dictated by the layout of the room or the lack of therapist permission-giving, as one participant parodied: “You sit here, you will *glance* (laughs) at this beautiful painting, here is the stunning view, you will be heated from behind” (Erin). This participant said she thought it would be ‘revolutionary’ for clients to be given autonomy in the space and how they use the space. It is interesting to consider why this might not happen. She linked it to therapist’s defensiveness about *their* space (from her experience of private therapy rooms) and this may be the case in private therapist’s rooms, where they may have put effort into a particular room layout, however in the NHS, the therapist often does not have the same influence over contents or the layout of the room. Some therapists, particularly those from a psychodynamic background will be concerned about the ‘frame’ of therapy and keen for it not to change, however another participant (Andy) also pointed out the time and resource constraints that NHS therapists often have. A therapist in an NHS setting may not have much time in between clients, in order to move furniture about, in order to offer more options and may be working in multi-use rooms, where it can be frowned upon to move things around. It is also interesting to consider the practitioner’s and service provider’s viewpoint about therapy too, in that if it is the therapy that brings the ‘cure,’ then it does not necessarily matter where the therapy is taking place, as the concern is more about the therapist ‘delivering’ an evidence-based therapy. All these things and more could be factors in why clients in NHS therapy rooms might not often get the same experience of choice and ownership of the space that clients of private therapist’s report getting. The fact that four participants in this study had experience of both NHS and private/agency therapy rooms offered a helpful insight into this.

Permission to use the space as needed and the room layout/size providing an opportunity for this was also an aspect of 'hospitality' of the room. The ability to be able to move around when talking, links in with the modality of 'walk and talk' therapy. However, some therapists, particularly those working with very distressed clients in secondary care might have sessions where clients may get up and walk around, or even when the therapy is effectively taken into a corridor or outside in an unplanned and spontaneous way. This was reported in my previous research (Sinclair, 2021) and could be helpful for a therapist to suggest or allow, when clients are particularly triggered by something in the room or too distressed to contain things in a seated position. Such spontaneous taking of the therapy outside the room is different to the planned 'walk and talk' or 'wild therapy' mentioned by one of the participants, however it is interesting to consider the possible increased sense of collaboration or shifting in the power dynamic that could occur when this happens. On a practical note, it could also be a possible solution (whilst also giving careful attention to the frame and confidentiality etc.) for times when rooms are not working for the client, particularly in busy NHS services, without the luxury of alternative therapy rooms or seating choices etc. Indeed, the British psychological Society (BPS) recently published a document on taking therapy outdoors, (BPS, 2020 p.2) that outlined that it could promote "access and equity of care for clients who find an indoor therapy room encounter too uncomfortable (e.g., its perceived pressure and formality, feeling trapped or pathologised, experiencing difficulties with cognitive and attentional capacity)".

Cure or space to explore

Rooms with a medical appearance were unanimously experienced and described in negative terms. From being 'uninviting' to 'cold,' participants also linked the feel of these medical rooms with making it harder for them to relax and open up, and for one participant, with actually making him feel more anxious and discontinuing the therapy. Clients not liking rooms with a medical

or ‘clinical’ appearance was a key finding in my previous research (Sinclair, 2021) that I wanted to explore further, to see whether it re-occurred and also to understand more about client’s experiences in medical rooms/rooms with a clinical appearance. Two participants spoke of the confusing message it gave to them, when they started talking therapy in medical rooms. For both of these participants it was their first experience of talking therapy and neither of them had expected the environment to be a medicalised environment. This was also confusing for them as neither of them framed their problems in a medical way (i.e., they did not hold a medical model of mental health) and so the setting seemed even more incongruous and confusing. It is interesting to consider the message that delivering talking therapies within a medical building sends, with regards to the understanding of the origin and maintenance of people’s problems. For those who do hold a medical model of mental health, it could perhaps be helpful; in fact, one participant (Brianna) described feeling ‘safe’ in the rooms of a hospital (even though she didn’t like the rooms). It is also important to consider that some therapists, such as psychologists within the NHS work within multi-disciplinary teams (MDTs) and work with clients with physical health issues (such as burns patients or patients undergoing bariatric surgery). For these clients, it could perhaps be helpful to see a therapist in a medical room, as it could minimise the stigma attached to ‘mental health’ and make it seem more like just another professional related to the procedure/condition the person is facing. However, for those that hold more of a ‘problems in living’ (Szasz, 1961) understanding, it could be very unhelpful as was the case for the aforementioned two participants in this study. These participants had been expecting more of a space that would be conducive to relaxing, opening up and exploring their issues, as was reflected in the ‘space to explore’ title of the sub-theme and as these two participants received when they then went on to a private therapist.

Many people are not able to afford private therapy and will have to access talking therapies through the NHS. A parallel can be drawn with private healthcare for physical health issues, in that it appears that if someone is able

to pay, then they can receive the choice, comfort and hospitality that a private therapy room might offer, whereas NHS clients will not have the luxury of that choice. It is also interesting to note that many private therapists put photographs or a description of their therapy room on their website, perhaps as a selling point, or as a way of giving a 'feel' for the type of service that they are providing. Private clients can then have the luxury of looking for the kind of room that they would prefer or imagine themselves in; NHS clients do not get that luxury. These issues will be discussed further below, with attention given to the wider issues of inequality and social justice.

Consideration of the research questions

This study aimed to gain a greater understanding of clients' experiences of rooms used for talking therapy in the NHS. The research questions were: How do clients experience NHS therapy rooms? How does the therapy room impact the therapeutic process? What are the perceived effects of the room upon the therapeutic relationship? What interplay can there be between client issues and the therapy room? The research questions will now be addressed. The first two research questions will be discussed together, as they were very much linked in the way that clients spoke about them and naturally lead from one into the other.

In terms of how clients experienced NHS therapy rooms (RQ1) and the effect that the therapy room had upon the therapeutic process (RQ2). Common overarching experiences were of the room being medical or formal, 'office-like' and stark in appearance and not conducive to relaxing and being able to 'open up' (talk to the therapist). Interestingly, many of the participants inherently considered the process of relaxing and 'opening up,' as especially important in therapy and this was despite none of the interview questions specifically asking about this. Four of them talked directly about their own experiences of not being able to 'open up' and talk in the therapy and linked this directly to the room or

general environment of the building that the rooms were in. One participant (Erin) spoke of how she ‘could not get to a place of trust in those rooms’ (in a secondary care service) and also how she constantly wanted to leave or escape the rooms, whilst feeling huge amounts of anger and frustration. For this participant, her prior experience of many therapy rooms, feeling of institutionalisation and the dashed hopes of imagining a grand and whimsical building where she would receive what she needed, very much seemed to influence her experience of those particular rooms at that time. This illustrates the complexity of client’s experiences of rooms and how they can carry past experiences of rooms and therapy into rooms, as well as the issues that they are bringing. This illustrates why research into therapy rooms needs to be designed in such a way that can capture the complexity and emotion of this experience and could fall short if it consists of showing photographs of rooms, or simply asking clients or potential clients what type of rooms they might prefer.

In this study, participants unanimously expressed a preference for therapy rooms with a ‘homely’ feel, as opposed to medical-type rooms and felt that feeling more comfortable (both physically and psychologically) in a room helped them to relax and then ‘open up’ to their therapist. This is in agreement with my previous findings (Sinclair, 2021), where clients also voiced a dislike for rooms with a clinical appearance and linked their physical comfort in the room, with being able to relax and open up to the therapist. Rooms with a medical appearance or neutral office appearance were experienced by the participants as unhelpful, and for some, heightened their anxiety and led to them terminating therapy early. Paraphernalia associated with medical rooms, such as medical posters on the walls and medical equipment were also experienced as confusing for clients who did not hold a medical model of mental health, leading to them wondering why they were being seen within a physical health setting, or becoming suspicious about whether they might be about to be sectioned.

It was also the case that participants often spoke about how aspects such as furniture or the layout of the room were interpreted, or felt by them, usually in emotional terms. For instance, the participant who said: “it was laid out as a confrontational space, rather than a space to engage” (Andy). Clearly here, the participant was experiencing the feel of the room as ‘confrontational’ and linked this to the way that the room has been laid out. Interestingly, this participant also articulated that the rooms were presented in a ‘lazy’ way and linked this aspect of the rooms not being cared for, to a wider sense of a lack of ‘caring’: “it just felt that it wasn't (pause) a space that somebody cared about... it didn't have... it didn't have a sense of caring.” This links in with Devlin’s research (2008) regarding the perceived care that patients might receive in a healthcare building, as judged by its appearance, and my previous research (Sinclair, 2021) showing that the room can communicate a message to clients, either explicitly or implicitly. The ability of the room to communicate a valuing or not valuing of the client (Sinclair, 2021) is one aspect of this and one which was present in one participant’s recall of his therapy room experience: “oh he's coming in…so we need to have some space so that it can be private...this room will do” (Andy). He went on to conclude that there was “a complete lack of care really…only interested in themselves” (Andy). One participant also said that she had been ‘too much of a mess’ to notice the room and that for her, the fact that the therapist had been so good mitigated any of the difficulties that she had with the room. It is interesting that even though she said she had not really noticed the room as she was too distressed at the time, when asked further about her experiences, she was able to recount some aspects that she had not found helpful about the room. The issue of a ‘good’ therapist mitigating room issues will be explored further below.

Within the literature, the concept of ‘stimulus screening ability’ (Mehrabian, 1977) is found, whereby some people (high screeners) are more able to reduce the complexity of an environment and ‘screen out’ difficulties with the environment than others (low screeners). It is also noted that people who are physically unwell,

or with high levels of anxiety might struggle more with being able to screen out difficulties (Dijkstra et al., 2008). Many people who access therapy are struggling with high levels of distress, and so this is interesting to consider in with relation to ‘problematic’ therapy rooms.

The concept of ‘first impressions’ counting was also an important feature of the participant’s experiences of therapy rooms. It was seen as particularly important that the first experience of a service or indeed of therapy was positive: “for anyone for the first time…it should be a warm comforting environment” (Dina).

For participants such as Andy, for whom it had been their first experience of therapy, they seemed to describe a sense of feeling especially let down: **“**I had two sessions in there, and my second session kind of confirmed my first, which was…this person isn’t really bothered…this is a tick box exercise…as I said I was new to the whole adventure of counselling at that point” (Andy)

Three of the participants talked about the room in terms of it not ‘catering’ for them or not being suitable for the task of therapy. All of the participants spoke about the room or the journey through the building to the room as heightening or inducing anxiety. The medical appearance in itself, was enough to trigger anxiety and early termination of therapy for one participant. For other participants, it seemed to be more of a general feel of the place that they linked to a ‘restriction’ or ‘tightening’ (not being able to speak). It seems important that therapists and therapy providers give attention to the issue of how their service can be seen through the building that they are using and also whether aspects of the environment might be hindering any of the important tasks of therapy.

The wider journey to the room and the building that the therapy room was in was an issue which nearly all the participants spoke about, with waiting rooms within doctors’ surgeries, or long walks down a network of corridors being described as heightening or inducing anxiety. Considering the whole of the client journey through the building as Liddicoat’s research (2018) suggests,

feels important here and seems like something that does not often happen, with therapists and service providers often not giving attention to this. If a client struggles to access the room, due to accessibility issues not being considered, or has sat in a waiting room that led to them feeling more anxious prior to entering the room, then this will likely have an effect on how they turn up feeling at the therapy room door. A journey to a therapy room that increases anxiety could be counteractive to the therapy process and even the process of developing trust and a relationship with the therapist. Furthermore, it is also apparent from this study that many therapy settings, including those within the NHS are still not universally accessible to people with physical disabilities, despite the Equality Act (2010) and legislation requiring organisations to ensure equality of access. The rise of online therapies could provide an alternative means of access to clients who might otherwise struggle with access, however it is important that service providers and individual therapists within the NHS, consider whether the rooms and buildings that they use are accessible to people with a range of impairments, so as to provide equality of access and meet the requirements of professional bodies. Individual therapists must recognise their own professional responsibility here to flag up accessibility issues and find ways within their service of providing alternatives, as opposed to leaving the responsibility for a lack of accessibility to the service provider. Further attention will be given to this issue below.

In summary, in addressing research questions one and two, therapy rooms are experienced in a range of different ways by different clients and a client's previous experiences of therapy rooms, or indeed other non-therapy rooms can influence how they experience a therapy room. Furthermore, a client's experience of the therapy room and journey through a building to the room, can also have an effect on the process of therapy, either hindering, enhancing or, when a client terminates therapy because of the room, curtailing the process. Frank and Frank (1993) spoke of the 'healing setting' and this research has shown that what could be a 'healing setting' for one client may not necessarily be so for another client, as there are several factors to consider. Within a

practice setting, it therefore seems important that therapists dialogue with their clients to find out how the clients are experiencing the room and setting that they are working in.

In considering how the therapy room might impact the therapeutic relationship (RQ3), the findings suggest that participants often viewed the therapist in light of their surroundings; in agreement with previous research showing that people are perceived differently according to their surroundings (Gosling et al., 2002; Maslow & Mintz, 1956). This is also in line with previous findings that the room can affect the perception of the therapist (Nasar & Devlin, 2011). For instance, the participant (Erin) who had therapy in a crumbling, worn out building, viewed and described her therapist in the same terms; likewise, another participant (Andy) described his therapist as 'uncaring' and lazy, in accordance with his assessment and experience of the room as being "a lazy presentation of the room." Furthermore, participants spoke of how a poor environment, which did not feel comfortable and allow them to relax, made it harder to establish a good, trusting relationship with their therapist, or in one case (Finlay), didn't allow it to develop. Contrastingly, when the therapeutic space was experienced in a positive way, this was perceived as helping the therapeutic relationship to develop, such as when Finlay spoke of his experience of 'wild therapy' and when other participants described their subsequent experiences of private therapy rooms and the positive relationships that they were able to develop with their therapist in those rooms.

The effect on the therapeutic relationship was seen as a part of the process of building trust with the therapist by one participant: "And it can take years…or just ages…to build up trust with the person…but the space does become a part of that" (Erin). For the participant (Finlay) who terminated NHS therapy early and then had one session in a private therapy room, before going on to have wild therapy outside the room, he linked less-tangible aspects of the room,

more the choice and control in the room, as helping to develop a ‘positive relationship’:

> “I didn’t develop positive relationships with the therapist in the NHS room and I did develop a positive relationship with the guy in wild therapy… so I think because it was so collaborative… because of their control I was given over things… I think that for me enabled a much more positive relationship to develop” (Finlay).

One participant (Dina) did however say that for her the therapist was so good that they were able to transcend the difficulties with the room. It is interesting though to consider, whether therapists working in poor or less helpful therapy rooms might have to work harder to build up a trusting therapeutic relationship, particularly where there are interruptions such as nurses walking into therapy rooms, as this participant encountered and which she felt could break the privacy and, in some ways, could “break your trust” (Dina).

In considering the final research question of the potential interplay between client issues and the room, three participants spoke of experiencing an interaction between their presenting issues and the room or wider building that the room was situated in. This could be directly or indirectly. For example, one participant (Carys) who had been in a controlling relationship and who had presented to an NHS service with anxiety, described her experience of a therapy room where a therapist sat behind a big desk as provoking further anxiety and fear that she might be being recorded from behind the desk by the therapist; playing into her anxiety that she could be seen as an ‘unfit mother’. In another example, Brianna described feeling ‘judged’ already (prior to entering therapy) and linked the impact of the ‘formal’ and ‘uninviting’ room to making her feel more judged.

As an example of an indirect interplay between client issues and the room, the participant (Erin) who had been institutionalised through her lifelong

experience of NHS services (mainly for physical health reasons), described the crumbling and worn-out rooms she experienced in secondary care mental health services, as amplifying her anger and frustration with the system and dashing her hopes that psychotherapy could help her. Erin recognised and described her experience of bringing her prior experience of being institutionalised with her into the therapy rooms in secondary care and then further feeling trapped and wanting to escape from the worn and crumbling rooms in the dilapidated building, that made her feel that she had always belonged or been there. That people will bring their experiences of previous rooms into therapy and that there could be a psycho-symbolic interplay between client issues and the room, would be of no surprise to therapists who have an understanding of psycho-symbolism or transference. Drawing from psychodynamic theory, the concept of transference could be applied to rooms, in the way that it is to people and situations; whereby people bring and transfer their thoughts and feelings from previous rooms into the current rooms that they are in. In behavioural psychology terms, the stimulus (such as layout or colour of the room) provokes the same or similar response to when that stimulus was encountered before. This has clear implications for therapists to consider, particularly when working with certain presentations such as trauma/PTSD and anxiety, whereby clients could be triggered by aspects of the room or wider building that the room is located in. Liddicoat (2018) noted the importance of various aspects to consider when working with clients who self-harm and it seems important that therapists and service providers consider the individual needs of the client groups that they work with, as there may well be aspects specifically salient for different presentations/client groups.

It seems however that therapists often don't incorporate a psycho-symbolic understanding into their practice, in terms of considering the room as an active ingredient and talking about this with their clients. Obviously, given that private-practice therapists will usually have more control over the therapy rooms that they use then NHS therapists, they might well design/lay out the room in the best way that they consider would help to provide a consistent 'container' for the

client and what they bring, however this doesn't necessarily mean that they then consider the impact of the room for particular clients with particular presentations or talk about their client's experience of the therapy room with them. In cases where rooms have been designed or laid out as designated therapy rooms, the fact that a therapist or service also 'designed' or chose a room, could also create a potential blindness as to how the room might not be helpful for some clients and a defensiveness around perceived 'criticism' about the room, as experienced by Erin. Furthermore, clients may not always be consciously aware of feeling triggered by a certain room/room aspect or such a 'transference' type of reaction and it therefore seems important that therapists are alert to this potential dynamic and communicate about the room, to check out how clients are feeling in it and in relation to it. All of the participants in the study said that they had not talked about the NHS therapy room with their therapist, other than one who said that the therapist had briefly apologised about the room. One participant (Erin) who had also experienced private therapy had talked much more about the room with her therapist, which she had found helpful, particularly in processing and understanding changes to the room that she had found uncomfortable (such as a new rug). Even with this participant however, it was she who initiated the conversation. Clients and therapists not communicating about rooms was an issue that arose in my previous research (Sinclair, 2021) and it appears particularly to be the case in NHS therapy rooms. Perhaps time issues, or the fact that many NHS therapists don't have much choice about the rooms that they use are factors in this. However, participants from this study (Erin, Andy and Finlay) and my previous study indicated that it was helpful to be able to talk about the therapy room, particularly when it was problematic in some way. Indeed, although sometimes it may be obvious that a client was having some difficulty with the environment, at other times, it could be difficult to know how a client might be experiencing a room without talking to them about it. Talking about the room could also communicate 'care' and consideration for the client, as opposed to the experience of lack of care and consideration that Andy had described feeling.

Two participants specifically spoke of the importance of therapists and service providers talking about the rooms with their clients and consulting with them as to how they could be improved. Service providers could consider and consult with the service users that they provide for in terms of their therapy room provision and this could be done both on an individual client basis and through other means, such as focus groups or feedback forms. Minton et al's., (2008) study within their service for clients with eating disorders is a good example of such practice-based research. Talking therapies are delivered by many different teams, in many different settings within the NHS, and it is important that individual services think about the characteristics, needs and potential preferences of clients that they work with. This is a particular area where service user and carer involvement could be employed to good effect, to consult with room users about rooms and implement changes where needed. Talking to service users about helpful changes to the environment and evaluating them at a service level basis, as they do when utilising a PIE model (Keats et al., 2012) would seem appropriate. Not doing so, risks a potentially negative effect on the process and outcome of therapy for some clients, many of whom will perhaps not return to the service, to give reasons for their early termination of therapy (as happened with Finlay).

The relation of the findings to current narratives and debates in counselling psychology

Social justice, inequality, inclusion and the addressing of power issues are key aspects of counselling psychology and the findings of this study have important implications in terms of a number of different aspects in this area. This research has identified the importance of not ignoring the therapy room. The link between social and economic inequality and poor mental health has been well established (Macintyre et al., 2018). NHS clients do not usually have the luxury of choosing the therapy room that they will have therapy in, whereas privately paying clients can (either through seeing the room beforehand on a website, or switching therapists if they don't like the room). If therapy rooms can

potentially enhance or hinder the therapeutic relationship and the process and outcome of therapy (as the findings of this and other studies suggest), then it is important that those clients who cannot afford to pay for private therapy are also able to access therapy rooms which can meet their needs. If this does not happen, then those without the means to pay will likely be disproportionally impacted, by receiving therapy in unhelpful or inappropriate therapy rooms.

Counselling psychologists are required to address issues of power, with regards to working with clients (BPS, 2006). Clients having to use rooms where they do not feel comfortable, feel disempowered, confused by the room/building signalling a medical model of distress or have difficulty accessing the room in the first place, are all examples of where a power dynamic can exist in this area. Counselling psychologists working in the NHS are well-placed to highlight and address such power dynamics where they exist. One way of ensuring that rooms are meeting needs would be to consult with individual clients or groups of clients to gain feedback and make improvements, to ensure that rooms are appropriate. Counselling psychologists working within NHS services could take the lead in encouraging and facilitating this process within the services that they work within.

This study has highlighted the ongoing problem of the inaccessibility of therapy rooms for disabled clients, or those with temporary or age-related impairments. Rooms that are not universally accessible are not in keeping with the ethos of counselling psychology's commitment and focus on inclusion and equality of access, and yet many counselling psychologists currently work in the NHS and other settings, where inaccessible rooms can be the norm. A recent search of an online directory looking for therapists (counsellors, psychologists and psychotherapists) working with common mental health issues that offered wheelchair access, showed that less than a quarter of therapists were able to offer access (Jackson, 2022). Wheelchair access is also only one form of access issue, clients with a range of other impairments, including hearing and

visual impairments also often struggling to access talking therapy (Jackson, 2022). Disabled clients are also less likely to be in a position to be able to pay for private therapy, due to being disproportionally impacted by poverty and so may well be more likely to need therapy through the NHS, making this more of a pressing issue.

Ableism continues to exist within our society and many individual practitioners working in large settings can perhaps ignore, not recognise, or become blind to access issues, perhaps partly through a lack of felt direct responsibility. It is also important to remember that accessibility does not relate solely to physically getting into a building, however, also encompasses aspects such as accessibility of information (e.g., letters and leaflets) and clear information about the venue, for people with impairments to plan the visit. Counselling psychologists who work in the NHS or other settings where rooms and services are not universally accessible have a professional responsibility to identify access issues (particularly through engagement with service users, carers and grassroots organisations), voice access issues to the therapy provider and make alternative arrangements where possible. In doing so, they will help to ensure that counselling psychology is accessible to all, and not those just those who are non-impaired. This is important, as otherwise the voices of those who cannot access rooms may well go unheard and many disabled clients may continue to disproportionately have to go without access to therapy. Whilst the growth of online therapy may be a solution in some cases of access problems, disabled and otherwise-impaired people should be given the same choice of face-to-face therapy that other people have, where at all possible.

The findings of the study relating to clients experiencing rooms with a clinical appearance to be unhelpful, and medical models of mental health potentially being reinforced through using therapy rooms with a clinical appearance, is one which is also related to a current debate and tension within counselling psychology. Counselling psychology within the UK has resisted a medical

model of understanding human distress (Woolfe et al., 2010), however continues to grapple today with issues such as whether as to allow practitioner psychologist prescribing. The full rollout of the IAPT programme within the UK has made talking therapies more accessible to many, however the framework for delivering this has often been within the existing network of GP surgeries, which have a primary purpose of delivering physical healthcare. Some would argue that rooms designed for physical healthcare are not in fitting with talking therapies that have a humanistic or non-medical model understanding of human distress and this issue is therefore particularly pertinent to the profession of counselling psychology. The findings of this study show that clients who do not hold a medical model understanding of their issues can be confused by receiving talking therapy in a room with a primarily medical purpose. It seems important therefore, that counselling psychologists working in the NHS reflect on how their practice 'sits' within the rooms that they use and whether there are conflicts between their approach and the environmental cues of the rooms that they work in, that could also be confusing to clients. Again, it is interesting to consider that few private therapists would choose to set up their therapy room with a medical appearance akin to a GP's clinic room (beyond the psychoanalytical couch) and yet many counselling psychologists and other therapists will work in rooms with a medical appearance within hospitals and other settings, simply because there is nowhere else to go. This could be another opportunity for counselling psychologists to speak up, in situations where the rooms provided are not appropriate for engaging in talking therapies.

In summary

This research has provided rich accounts of some of the different ways that NHS therapy rooms can be experienced by different clients at different times and the possibility for there to be a bi-directional interaction between the therapy issues and the clients experience of the therapy room. Although the data shows preferences for comfortable, more 'homely' rooms and certain other factors such as accessibility are "base level" the search for the 'perfect' therapy

room, particularly, as a research endeavour, appears to be a red herring. People's preferences, past experiences, issues, upbringing, and culture will all influence how a client experiences a therapy room (as it will how they experience the therapist) and potentially influence how helpful or effective the 'container' of the therapy room is. What is more important than searching for 'perfect' therapy rooms is that individual therapists consider the setting of the therapy as an active ingredient and allow clients to give voice to their experience of the room, whilst considering making changes that are possible, when needed.

The Covid-19 pandemic has meant that individual teams and therapists within the NHS have had to rethink the way that they deliver services and look at alternative ways of delivering them. As restrictions lift and face-to-face therapy becomes possible once again, this has prompted a wider conversation for therapists about which services will continue to be delivered remotely and which are better suited to face-to-face delivery. It could therefore be argued that it is also an ideal time for therapists and service providers to reconsider therapy environments more generally, so that when face-to-face therapy is offered, it is in premises and rooms that are facilitative of the therapy process and comfortable and accessible for all.

The strengths and limitations of the study

The strengths of this study are that the participants were actual clients of NHS talking therapies who had been in actual therapy rooms; this differs from many other studies, where psychology students or other non-client participants were used. The study design was an effective way of addressing the research questions. The study design enabled the participants to give voice to their experiences of the therapy room; this is important, both in terms of prioritising first person experience (which counselling psychologists are directed to do) and as it enabled service user's voices to be heard. The qualitative design, using

semi-structured interviews allowed for a wider experience of rooms to be shared and the emotional experience of the room to be explored. The use of IPA also enabled an exploration of the meaning that clients made of their experiences and a more storied account of their experiences. As opposed to an experimental approach, assuming a linear causal affect between an individual and groups of room features, the study design allowed for the complexity of the interaction between clients as room users and the built environment of the therapy room to be looked at.

The limitations of the study are that participants who had had particularly positive or negative experiences of therapy rooms, or who viewed the therapy room as important could have been more likely to participate, due to the sampling methods used. As all of the (self-selecting sample) of participants were white British, this also limited an exploration of factors related to culture and ethnicity, as voices from other backgrounds and identities were not represented.

A potential critique of this study (and indeed much of the research related to human experience) is how much participants were fully and consciously aware of their experience, either at the time of the experiences being researched or in the present, when recounting it to a researcher in studies such as IPA studies. It is important to note that in line with the critical realist approach taken by this study, that uncovering and exploring the 'reality' of the participant's experiences, is subject to limitations such as that of conscious awareness, the psychological aspects of the research encounter and memory. A way of attempting to address this within this study could have been to interview participants on several occasions, to allow further material to surface and more time for them to reflect on their experiences. This is common to the approach of IPA; however, this was not possible within the time and resource constraints of this study and particularly within the context of the global covid-19 pandemic that was occurring at the time of the research taking place.

Implications for practice

Although this study has not sought to generate findings that would be generalisable, the following implications for practice are suggested:

- The journey through the wider building to the therapy room should be considered by therapists and service providers. The accessibility of the building and room, as well as the potential for waiting rooms to heighten anxiety needs to be considered.
- Avoiding the use of rooms with a medical appearance when seeing clients within general mental health settings services. Where this is not possible, then discussing the impact of this with the client and being aware of the need to protect against interruptions by other staff members, when using rooms, particularly within GP surgeries.
- Rooms with a softer and more 'homely' appearance can be preferred by clients and could help clients to feel more relaxed and comfortable in talking to the therapist.
- Talking to the client about the room and their level of both physical and psychological comfort within the room; making adjustments where possible to meet the client's needs, particularly where there are accessibility needs
- Considering the needs of the types of clients that the service/therapist usually sees and how this might affect how they experience the room. E.g., certain presentations such as PTSD, may result in people being more sensitive to environmental factors.
- Consider the possibility of moving the therapy to an alternative place, or using a different delivery modality, such as utilising walk and talk therapy outside, if the client is struggling with the therapy room, particularly if they are very distressed or would struggle in the room due to other access issues, such as physical disability, neurodiversity and sensory issues.
- Recognise that the room and layout of the room can influence how a client might view the therapist, therapy and the service and also have an effect upon the power dynamics within the room and therapy relationship.

- For NHS therapists to consider individual client's previous experiences with the NHS and therapy rooms. For clients who have experienced a lot of NHS buildings and services for physical health issues or who have been institutionalised as a result of their use of services, their experience of rooms and services could well be affected by this previous experience.

Further research

Further research into therapy rooms is needed and specifically more opportunity for clients to be able to give voice to their experience of therapy rooms. Further research with minority clients in particular, is needed, as those from different backgrounds or cultures may experience therapy rooms in very different ways, which would be important to capture. Practice-based research such as Minton

et al's. (2008) could be undertaken, in order to design studies relevant to the individual service/client group. Within the NHS, service evaluations could be a relatively easy and effective way of capturing these experiences, which could vary according to the type of clients, types of issues and rooms being used. This information could then be used to make improvements to the rooms/wider building environment, which could both improve the therapy experience for clients and therapists and potentially improve retention and outcomes. Focus groups of service users and carers could also be used to give input into the design and layout of rooms within services, particularly when services are moving into new premises or having to share rooms with other services.

In terms of research with an experimental design, it could also be possible to develop a suite of therapy rooms with differing décor, size and lighting which could then be used to gather feedback and outcome measures from clients and/or therapists. Factors such as the medical appearance of a room or being allocated to a different room during the course of therapy could be tested out in such a room. A drawback of his study design would be the resources needed to conduct this type of study and it is unlikely that this type of study would be

feasible for most NHS talking therapies services, however any findings from other studies outside the NHS could potentially also be relevant to NHS clients.

Conclusion

In conclusion, this study has shown that the physical environment of rooms used for talking therapies in the NHS is an important area to consider and that a client's experiences of these rooms can have a significant effect upon their ability to be able to form a positive therapeutic relationship and engage with the therapy. This study provides an important insight into some of the ways that rooms can be experienced and the impact that this can have, and the study design has enabled clients to express this in their own words. Clients experience rooms in a range of different ways and it is important for practitioners and service users to recognise and engage with a client's experience of rooms and make adjustments and improvements, where possible. Engaging with clients in this area and making appropriate adjustments will help counselling psychologists and other practitioners working within the NHS (and elsewhere) to 'establish safe environments of practice' (HCPC, 2015) and ensure that clients experience a therapy environment that is physically and psychologically safe, inclusive and universally accessible.

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Appendix A

Demographic form/survey v1 16/12/19

Client's lived experiences of NHS rooms used for talking therapies

Some questions about you

In order for me to learn about the range of people taking part in this research, I would be grateful if you could answer the following questions. All information provided is anonymous.

Please either write your answer in the space provided, or mark an **X** next to the answer, or answers, that best apply to you.

1	How old are you?	18-24 25-34 35-44 45-54 55-64 65+		
2	I am: **(mark an X)**	Male	Female	Other
3	I am:	Full-time employed	Part-time employed	Full-time student
		Part-time student	Other: _____	
3a	If you work, what is your occupation?			
4	How would you describe your racial/ethnic background? (e.g., White; Black; White Jewish; Asian Muslim) Prefer not to say	_____		

5	How would you describe your social class? (e.g., working class; middle class; no class category)	_____	
6	Do you consider yourself to be disabled? (Please delete, tick/cross, as appropriate)	Yes	No
7	Do you have any children?	Yes	No
8	How many sessions of therapy did you have (approx.)		
9	How many different rooms did you experience?		
10	How long ago did you finish therapy?		
11	Was this in primary care (IAPT/GP surgery) or secondary care? (Mark an X)	Primary care	Secondary care
12	What kind of building were the rooms in? (e.g., hospital, GP surgery, community building).		

Appendix B

Interview Questions

- How would you describe the room/rooms (any particular words, adjectives)?
- How did you feel in the room?...How did you feel in relation to the room?
- What did the room represent for you/mean to you? (If anything)
- What was helpful about the room?
- What was unhelpful about the room?
- What (if anything) would you like to have changed?
- Did you have any experience of changing therapy rooms (e.g., for a session)?
- Was there any interaction between the issues you were bringing and the room? (No need to give details of issues) …how did you find that?
- What did you feel (if anything) about the ownership of the room? How much did it feel like your space?
- Could you describe what you think an ideal therapy room would look/be like? -How do you think a therapy room should be? Any thoughts on the lighting of therapy rooms? Seating?
- How important do you think the room is in terms of therapeutic outcomes?
- What role (if any) do you think the room plays in -the therapy process? -or in encouraging an effective therapeutic relationship?
- Any experience of talking about the room, with your therapist?
- Is there anything else that you would like to say about the room/s?

Debrief

How has it been for you, talking about the room?

Appendix C

Have YOU ever had counselling, CBT or any other type of 1:1 talking therapy in the NHS?

How did you experience the room/s?

This study is looking to give voice to and explore client's experiences of NHS therapy rooms (primary and secondary care).

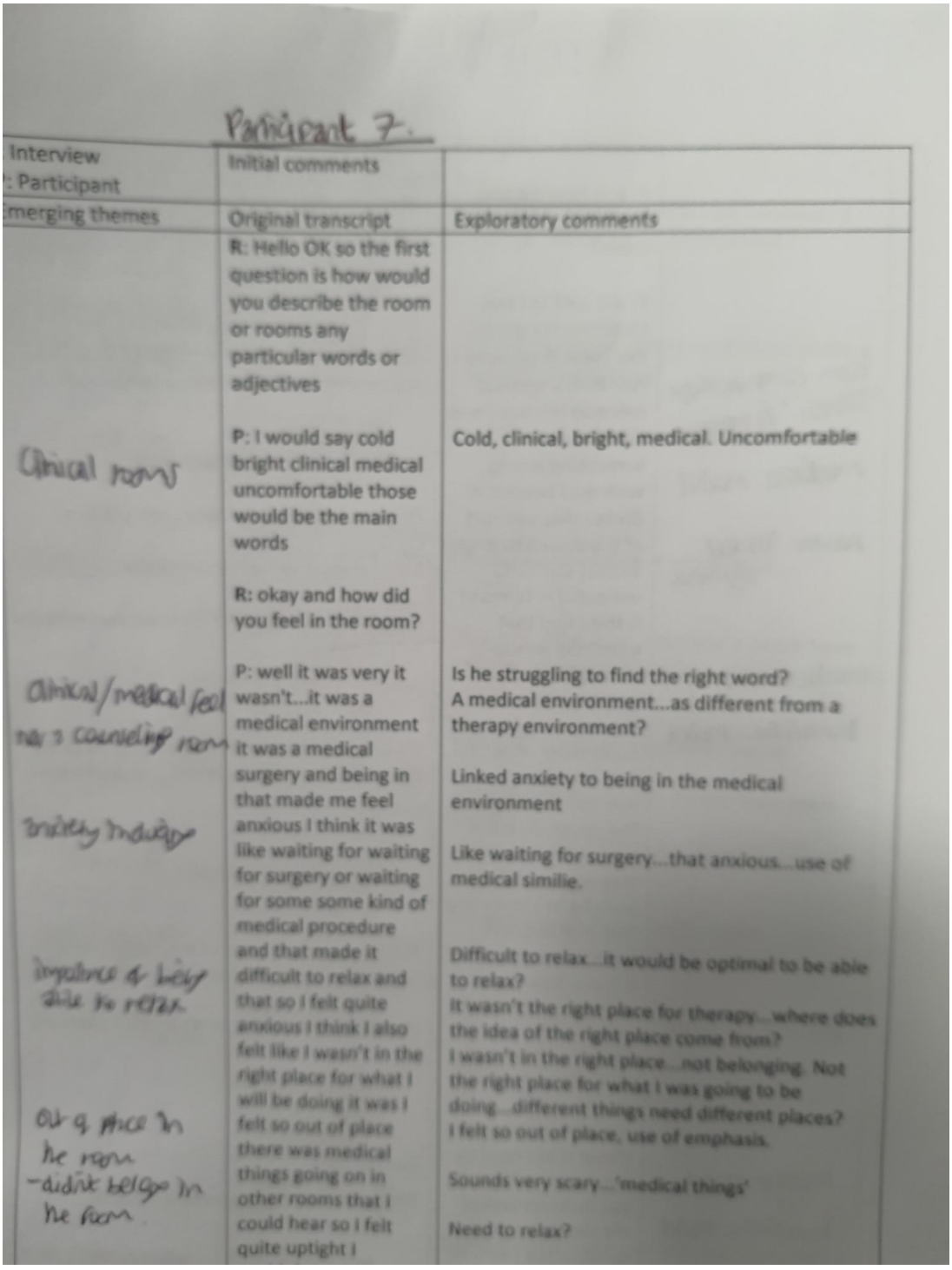
How you can get involved:

By taking part in a 50-minute approx. interview about your past experience of therapy rooms (you must have finished counselling/therapy at least 2 months ago and not be a trained counsellor/therapist) **you won't be asked for any details about the counselling/therapy**; I'm just interested in your experience of the room. All participants will be entered into a 'Thank You' prize draw for a £20 Amazon voucher.

To take part, or for any questions, please contact: [redacted]

Appendix D

Excerpt of a grid for the analysis of a single participant's transcript, showing exploratory comments and emerging themes



Participant 7.

Interview : Participant	Initial comments	
merging themes	Original transcript	Exploratory comments
	R: Hello OK so the first question is how would you describe the room or rooms any particular words or adjectives	
Clinical room	P: I would say cold bright clinical medical uncomfortable those would be the main words	Cold, clinical, bright, medical. Uncomfortable
	R: okay and how did you feel in the room?	
Clinical/medical feel not a counseling room	P: well it was very it wasn't...it was a medical environment it was a medical surgery and being in that made me feel anxious I think it was like waiting for waiting for surgery or waiting for some some kind of medical procedure	Is he struggling to find the right word? A medical environment...as different from a therapy environment? Linked anxiety to being in the medical environment Like waiting for surgery...that anxious...use of medical similie.
Anxiety inducing		
Importance of being able to relax.	and that made it difficult to relax and that so I felt quite anxious I think I also felt like I wasn't in the right place for what I will be doing it was I	Difficult to relax...it would be optimal to be able to relax? It wasn't the right place for therapy...where does the idea of the right place come from? I wasn't in the right place...not belonging. Not the right place for what I was going to be doing...different things need different places?
Out of place in the room -didn't belong in the room	felt so out of place there was medical things going on in other rooms that I could hear so I felt quite uptight I	I felt so out of place, use of emphasis. Sounds very scary...'medical things' Need to relax?

Excerpt of a noting-down of all the emerging themes for the same participant as above

(REMOVED TO ENSURE ANONYMITY)

The overall map of all the emerging themes, for all the participants.

(REMOVED TO ENSURE ANONYMITY)

The next process of distilling themes into superordinate themes, with some amalgamated and some discarded, after rechecking for prominence and frequency amongst all the participants. The themes were then refined further, using the same process, to achieve the final themes.

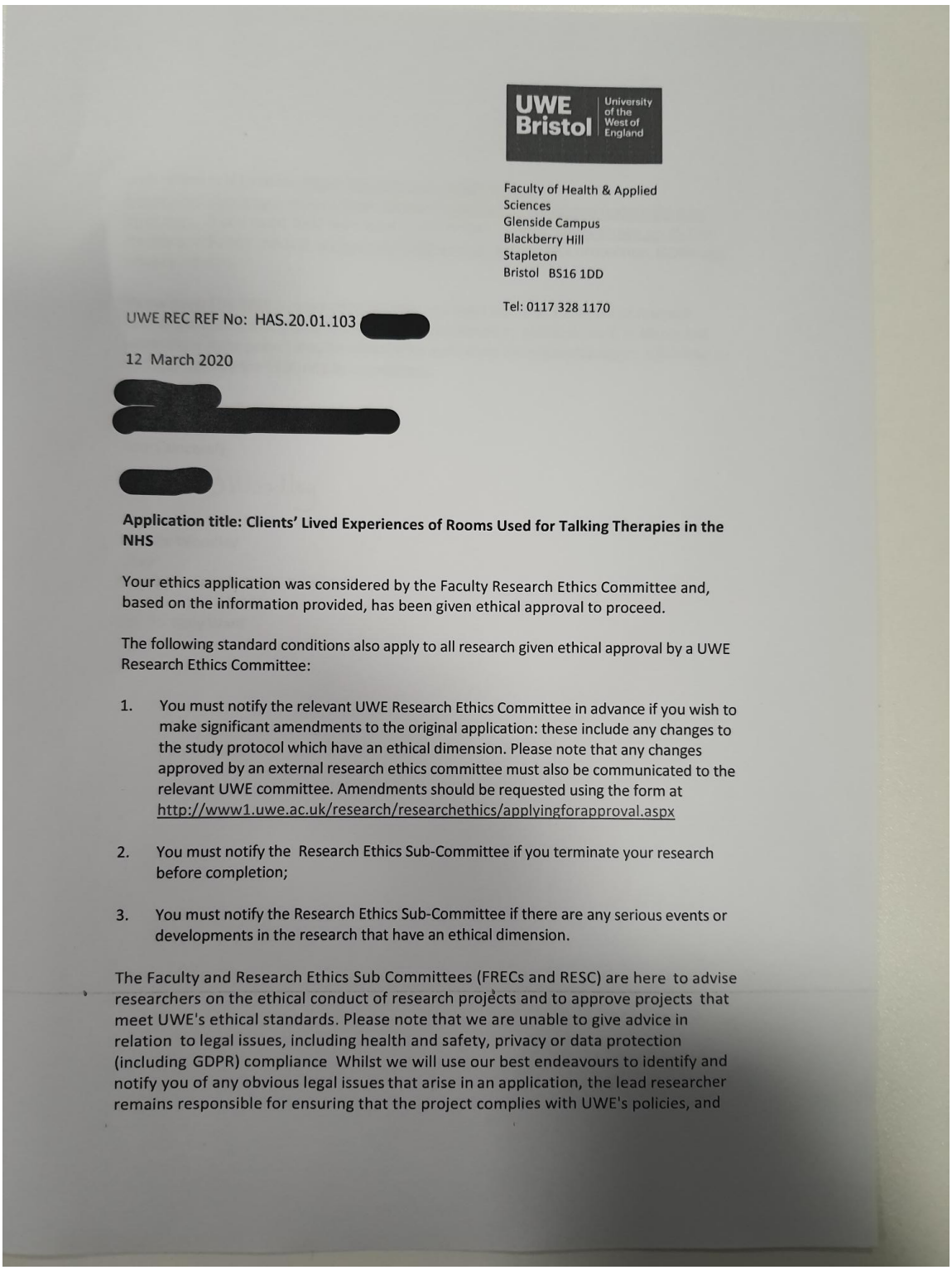
(REMOVED TO ENSURE ANONYMITY).

Final Thematic Table

Super-ordinate Theme 1 The journey to the room	**Sub-theme 1a:** Physical journey to the room
	Sub-theme 1b: Psychological journey to the room
Super-ordinate Theme 2 Hospitality of the room	**Sub-theme 2a:** Provision of the room
	Sub-theme 2b: Permission within the room
Super-ordinate Theme 3 Cure or space to explore	**Sub-theme 3a:** Medical rooms _____ **Sub-theme 3b:** Space to be/explore

Appendix E

Ethical Approval for the study



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UWE REC REF No: HAS.20.01.103 [redacted]

12 March 2020

[redacted]

Application title: Clients' Lived Experiences of Rooms Used for Talking Therapies in the NHS

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed.

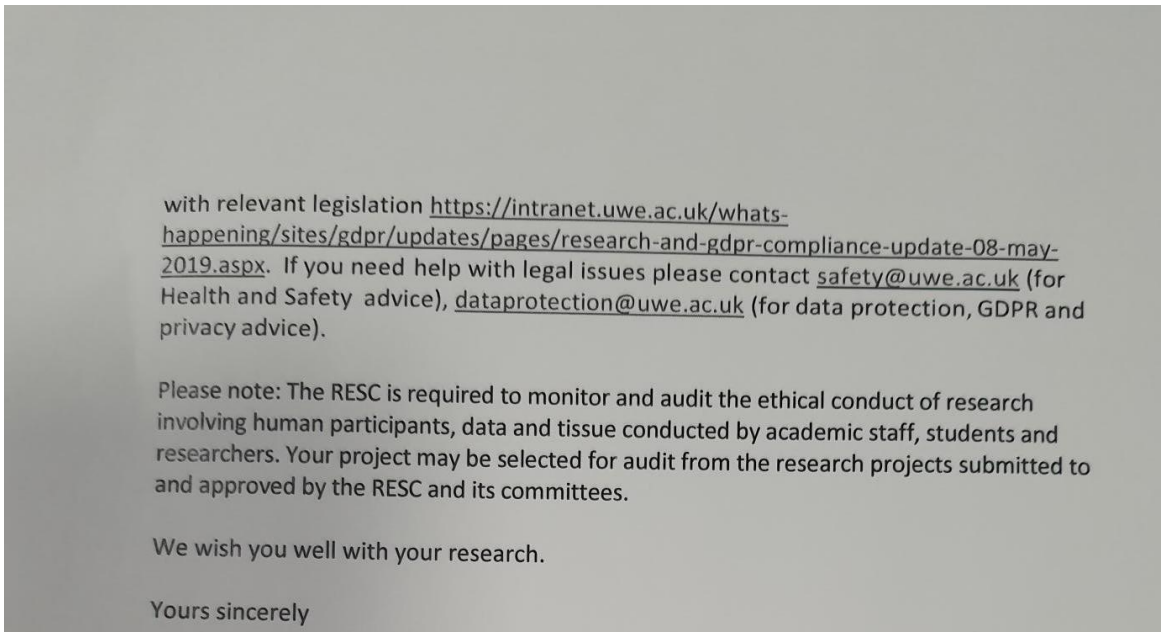
The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee. Amendments should be requested using the form at http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx

2. You must notify the Research Ethics Sub-Committee if you terminate your research before completion;

3. You must notify the Research Ethics Sub-Committee if there are any serious events or developments in the research that have an ethical dimension.

The Faculty and Research Ethics Sub Committees (FRECs and RESC) are here to advise researchers on the ethical conduct of research projects and to approve projects that meet UWE's ethical standards. Please note that we are unable to give advice in relation to legal issues, including health and safety, privacy or data protection (including GDPR) compliance Whilst we will use our best endeavours to identify and notify you of any obvious legal issues that arise in an application, the lead researcher remains responsible for ensuring that the project complies with UWE's policies, and



with relevant legislation https://intranet.uwe.ac.uk/whats-happening/sites/gdpr/updates/pages/research-and-gdpr-compliance-update-08-may-2019.aspx. If you need help with legal issues please contact safety@uwe.ac.uk (for Health and Safety advice), dataprotection@uwe.ac.uk (for data protection, GDPR and privacy advice).

Please note: The RESC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the RESC and its committees.

We wish you well with your research.

Yours sincerely

Appendix F

Participant Information Sheet

Participant information form v 1 16/12/19

Participant Information Sheet

Clients' Lived Experiences of Rooms Used for Talking Therapies in the NHS

You are invited to take part in research taking place at the University of the West of England, Bristol. Before you decide whether to take part, it is important for you to understand why the study is being done and what it will involve. Please read the following information carefully and if you have any queries or would like more information, please contact [redacted]

Who is organising and funding the research?

Thank you for your interest in this research. This study is looking at client's experiences of NHS therapy rooms (rooms used for counselling and psychotherapy). This study aims to give voice to and learn about client's experiences of rooms. This is important as there has been little research done in this area and clients are not often given the opportunity to talk about or give feedback about therapy rooms.

I am a psychology postgraduate student in the Department of Health and Social Sciences, University of the West of England, Bristol. I am completing this research for my thesis project. My research is supervised by Dr Tony Ward (see below for contact details).

What is the aim of the research?

The research is looking at clients' experiences of rooms used for counselling and psychotherapy in the NHS. Our research questions are: How do clients experience NHS therapy rooms and what sense do they make of their experience? How do clients experience any relationship between the issues that they are speaking about and the room? In order to answer these questions,

I will be conducting interviews. The aim of the interviews will be to collect information, that will be made anonymous.

The anonymised results of our study will be analysed and used in a report made available on the University of the West of England's open-access repository. The anonymised results may also be used in conference papers and peer reviewed academic papers.

Why have I been invited to take part?

As a counselling psychology student, I am interested in gaining information about your experience of therapy rooms, so the interview will ask you about these things. I will not be asking any questions about specific details of the content of your therapy sessions. The purpose of the questions will be to gain information about your experience of the rooms.

Do I have to take part?

You do not have to take part in this research. It is up to you to decide whether or not you want to be involved. If you do decide to take part, you will be given a copy of this information sheet to keep and will be asked to sign a consent form. If you do decide to take part, you are able to withdraw from the research without giving a reason up until a month after completing the interview. This date will be given to you at interview, should you choose to take part. If you want to withdraw from the study within this period, please write to [redacted] Deciding not to take part or to withdraw from the study does not have any penalty.

What will happen to me if I take part and what do I have to do?

If you agree to take part, you will be asked to sign a consent form and then given a short form to collect some demographic information (e.g., age, how many therapy rooms you experienced). You will then be asked to take part in a conversation (research interview) about your experience of NHS therapy rooms. This will be conducted by me. I am experienced in the subject matter and am sensitive to issues it may raise. This will take approximately 50 minutes. The interview can take place over Skype or at UWE (University of the West of England), in a quiet room, at a mutually convenient pre-arranged time.

The subject and focus of the discussion will be on your experiences of NHS therapy rooms and the effect this had on you. Your answers will be fully anonymised. You will not be asked for specific details about the content of your counselling/therapy sessions.

Your interview will be recorded on a voice recorder. but the recording will not contain your name. A unique identifier will be used to re-identify you if you choose to withdraw from the study within the period. Your data will be anonymised when it is written up and will be analysed with interview data from other anonymised participants. You will be given the opportunity to see the anonymised typed- up transcript before it is mixed with the other participants data for analysis.

What are the benefits of taking part?

If you take part, you will be helping us to gain a better understanding of client's experiences of rooms and this can then inform practitioners and service managers about the types of rooms that can be helpful or hindering to counselling and psychotherapy.

What are the possible risks of taking part?

I do not foresee or anticipate any significant risk to you in taking part in this study. If, however, you feel uncomfortable or upset at any time you can ask for the interview to stop. If you need any support during or after the interviews, then I will be able to put you in touch with suitable support and counselling agencies. I am experienced in conducting research interviews and am sensitive to the subject area. The interviews have been designed with these considerations in mind. If you feel that taking part in this study may cause you to feel distressed, please do not take part.

What will happen to your information?

All the information we receive from you will be treated in strictest confidence. All the information that you give will be kept confidential and anonymised at the point of writing up transcripts. This study may use a UWE approved transcription service, with whom the university has a data protection agreement,

but no identifying details, such as names will be given to the service. Data will be managed as confidential data, stored on the university's secure system, according to the University's and the Data Protection Act 2018 and General Data Protection Regulation requirement (GDPR) (2018). Voice recordings will be destroyed securely after transcription. Your anonymised data will be analysed together with other interview and file data, and we will ensure that there is no possibility of identification or re-identification from this point. The anonymised transcripts and coded demographic forms (using pseudonyms) will be held by Dr Tony Ward in a locked filing cabinet at UWE, for three years after the viva and all amendments are made and the award has been made; this is to fulfil the requirements of some journals to hold the data for some time after publishing. After this time, these documents will be disposed of as confidential waste. Any anonymised data written into the final report will be kept and published in the UWE repository and as journal articles in professional journals.

Where will the results of the research study be published?

A Report will be written containing our research findings. All information in this report will be anonymised. This Report will be available on the University of the West of England's open-access Research Repository and may be published in professional journals.

A hard copy of the Report will be made available to all research participants, if you would like to see it. Key findings (using anonymised information) will also be shared both within and outside the University of the West of England, in hard copy and through presentations and this may involve dissemination to NHS service providers/practitioners. Anonymous and non-identifying direct quotes may be used for publication and presentation purposes.

Who has ethically approved this research?

The project has been reviewed and approved by Health and Applied Sciences Faculty and the University of the West of England University Research Ethics Committee. Any comments, questions, or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at: Researchethics@uwe.ac.uk

What if something goes wrong?

Any concerns, queries and/or complaints can be made to the researcher [redacted] the researcher's supervisor [redacted] or the research ethics committee (above).

What if I have more questions or do not understand something?

If you would like any further information about the research, please contact me the first instance: [redacted] University of the West of England, Frenchay Campus, Bristol.BS16 1QY

Thank you for agreeing to take part in this study. You will be given a copy of this Participant Information Sheet and your signed Consent Form to keep.

Appendix G

Participant Consent Form

Thank you for agreeing to take part in this research into client's experiences of NHS therapy rooms

I am a psychology postgraduate student in the Department of Health and Social Sciences, University of the West of England, Bristol. I am collecting this data collection for my thesis. My research is supervised by Dr Tony Ward. He can be contacted at the Department of Health and Applied Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY. Tel: [redacted] Email: [redacted] if you have any queries about the research.

Before we begin, I would like to emphasize that:

- your participation is entirely voluntary
- you are free to refuse to answer any question
- you are free to withdraw at any time until one month after the interview.

You are also the 'expert.' There are no right or wrong answers; I am interested in everything you have to say about your experience of therapy rooms.

Please sign this form to show that you have read the contents of this form and of the participant information sheet and that you consent to participate in the research:

_____ (Signed) _____ (Date)

Please return the signed copy of this form to me.

This research has been approved by the Faculty Research Ethics Committee (FREC)

The personal information collected in this research project (e.g., on any form/questionnaire/survey) will be processed by the University in accordance with the terms and conditions of the 1998 Data Protection Act. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on the participant information sheet.

Appendix H

Journal Article.

Client's lived experiences of rooms used for talking therapies in the NHS.

Abstract

Background: There has been little research into how clients experience rooms that are used for talking therapies within the National Health Service (NHS), despite the NHS being the single largest provider of talking therapies in the UK. This study used a qualitative approach to explore how clients experience the physical space of the therapy room.

Aims: This qualitative study aimed to explore client's lived experiences of the physical environment of therapy rooms, used for talking therapies in the NHS.

Methods: Qualitative data were gathered through semi-structured interviews with six participants who had received a 1:1 talking therapy, in at least one therapy room, in an NHS setting (primary or secondary care). The data were analysed using Interpretative Phenomenological Analysis (IPA) to develop themes that were then discussed, with reference to existing literature and in terms of implications for practice.

Findings: Three superordinate themes were developed. 'The hospitality of the room' encompassed client's experiences of how they were 'catered' for they were within the room and how they felt in relation to the space and the therapist. The second superordinate theme of 'the journey to the room' related to the physical and psychological journey that clients took to enter therapy rooms, encompassing accessibility, attention to the wider building and previous experience of therapy rooms. The final superordinate theme of 'cure or space to explore' related to the appearance of the room and the 'message' that gave the participants about the origin and maintenance of their issues and the purposes of talking therapy.

Conclusion: The findings have implications for individual therapists and service providers within the NHS. Client's experiences of rooms can impact upon their ability to engage with the therapy and the therapist. Practitioners and service providers need to consider the impact of the therapy rooms that they use, including the wider setting that the rooms are situated in and consult with individual clients, to ensure that the rooms are meeting their needs.

Introduction and rationale

Although most face-to face talking therapy within the NHS (all forms of counselling and psychotherapy) takes place in a room, little research attention has been given to client's experience of the physical environment of the therapy room and the meaning that clients make of the room and their experiences. The Covid-19 pandemic has seen a significant change to the way that many therapy sessions are delivered, with video and telephone sessions being increasingly utilised, however there are still many clients who would prefer to have face-to face sessions within a therapy room. Furthermore, for certain therapies such as trauma therapy, or therapy with very distressed clients, where there can be increased risk, it can provide additional safety to be in the same room when delivering the therapy.

The therapy setting is often considered an important part of the 'frame' (Gray, 2013) of therapy. There are important questions regarding whether the therapeutic space can influence client motivation, trust in the working alliance and client outcomes (Pearson & Wilson, 2012). Increasingly, within services such as Increasing access to Psychological Therapies (IAPT), a variety of different rooms are used for talking therapies, including GP surgeries and rooms in the community, however, it is not clear how clients experience these rooms and what, if any effect, using these dual-purpose rooms might have on the client, process and outcome of therapy.

For the purposes of this paper, the terms 'talking therapies' or 'therapy' will be used to encompass all forms of counselling and psychotherapy, the term 'therapist' to describe the counsellor, psychotherapist, psychologist, or

practitioner delivering the therapy and the term ‘therapy room’ to denote the room where therapy takes place.

Environmental psychology and evidence-based design

Within the wider field of environmental psychology, research has consistently shown that physical settings can have an impact upon the people within them (Maslow & Mintz, 1956; Rice et al., 1980; Ulrich, 1984). The physical environment can also affect the impressions that people have, of individuals inhabiting a particular setting (Devlin et al., 2009; Gosling et al., 2002; Maslow & Mintz, 1956).

Psychologically informed environments

The concept of ‘psychologically informed environments’ (PIE) (Keats et al., 2012), includes a recognition of the importance of the physical environment when working with people with complex needs. Within this approach, how psychologically safe clients feel within the spaces is considered important and the quality of the space, in terms of whether it allows the kinds of interactions that are needed, is also attended to.

The client’s experience

Very little has been written about the overall meaning and experience of the therapy room from the client’s point of view. Altringer, (2010), in discussing psychiatric ward design, also noted that the interaction between the ‘emotional experience of healthcare’ and health facility design is an under-researched area that warrants further research, particularly in terms of patient outcomes. She also suggested that service providers often prioritise ‘functional efficiency,’ over all else; often to the detriment of providing an environment that is experienced as therapeutic and ‘healing’ to service users.

The importance of the ‘healing environment’ within the NHS

Within the National Health Service (NHS), initiatives such as the King’s fund ‘Enhancing the Healing Environment’ (Department of Health, 2008) have highlighted the need to explore the relationship and interaction between the healthcare environment and service users. The study which expanded to

include 250 health and social care organisations was described as a ‘catalyst’ for the NHS, in terms of considering the impact of the environment in which care is delivered. As a result, many practical changes to healthcare environments were made, these changes however, were to communal and outside areas and not clinical rooms.

The individual aspects, or ‘ingredients’ of rooms

A mixed methods pilot study into the physical space of the therapy room (Sinclair, 2021), involving twenty-four clients and twenty-one therapists and looking particularly at individual components/features of rooms, found that comfortable seating, position of the seating, temperature, soundproofing, and accessibility of the room, were identified by clients and therapists as the most important features. Both groups reported that feeling physically comfortable and safe in a room, enabled a greater engagement with the therapy process and the majority of clients and therapists agreed that the physical environment of the therapy room was important for encouraging an effective therapeutic relationship and therapy outcomes.

The room as a symbol

Waldburg (2012) asserts that the therapy room is permeated with psycho-symbolic meaning and suggests that the room acts as a symbolic container for the contents of the client’s mind. The present study will pay particular attention to the meaning that clients make of the room and of their own experiences.

The appearance and design of the room and relationship to the therapeutic dyad and process of therapy

Where studies into the therapy room using have been done, these have usually involved looking at individual variables of the room, as opposed to considering the more complex relationships between different ‘ingredients’ of the room, its inhabitants and the therapeutic relationship and process in a more systemic way. Nasar and Devlin’s (2011) study, which involved psychology students observing photographs of therapy rooms, found that soft and personalised rooms with soft lighting, soft furniture and pictures on the wall were preferred. Similarly, Backhaus (2009) found that clients preferred rooms with a more

‘homely’ feel, whereas therapists felt more comfortable in rooms that were furnished and accessorised in ways that fitted their individual personalities. ‘Furnishings’ were described by Pressly and Heesacker (2001, p. 151) as having the ability to convey the “personality of the space” and this can help to create a more homely, as opposed to clinical appearance.

In terms of the therapy room and any influence on the process of therapy, Pressly and Heesacker (2001), in their review of the literature regarding the physical space of therapy rooms outlined the need for an environment that is facilitative of therapy processes such as developing rapport, exploration and self-disclosure. Benton and Overtree (2012) noted the importance of therapy rooms being culturally sensitive and inclusive.

Backhaus (2009) found that the physical environment had a significant effect on clients and therapists’ ability to form a therapeutic relationship and that the lighting of the room was significantly correlated with the client’s perception of their therapist’s trustworthiness, expertness, and attractiveness.

Medical appearance

Within the NHS, therapy rooms often reflect a ‘medical model’ of distress, with psychiatric wards, particularly, reflecting a medicalised environment (McKellar, 2015). Previous research has shown that therapy rooms with a medical appearance have been described negatively and as being ‘unhelpful,’ by both clients and therapists (Sinclair, 2021). This is of relevance to the present study, as the NHS often uses rooms within primary and secondary care, which have more of a ‘clinical’ appearance.

The environment of the therapy room and particular client issues/presentations

Liddicoat (2018), an architect, carried out a recent three-phase piece of qualitative research that explored the experiences of therapy rooms, of clients who self-harm. She determined that the design, layout, and contents of a therapy room were particularly important for clients who self-harm, as they could help contain anxiety and mitigate potential dissociation.

Aims and objectives

Aim

-To explore client's lived experiences of the physical environment of therapy rooms, used for talking therapies in the NHS.

Objectives

-Understand more about the meaning that clients can make about their experiences of the therapy room, including the psycho-symbolic meaning of therapy rooms and the impact of this upon the therapy /therapeutic relationship and process of therapy.

-Explore any interplay between the client's issue/client group and the room.

Methodology

Design

The study was a qualitative study. This approach was chosen as, the physical space of therapy rooms, in terms of how clients experience it and subsequent interaction with the therapeutic relationship, therapy process or outcome is a complex area and one which a qualitative approach would serve well. Interpretative Phenomenological Analysis (IPA) was chosen as the method of analysing the data, as it is an appropriate method of analysis for a study that is seeking to understand the lived experiences of people (Smith et al.,).

Reflexive statement

I am a female, qualified counsellor, of mixed white ethnic origin, with experience of working within the NHS. My interest in this area initially developed as a result of a number of negative and positive experiences of therapy rooms, both as a client and therapist. My previous MSc research showed me that there was a need for research designed in such a way as to allow service users to fully voice their experiences of therapy rooms in a more in-depth way. I therefore

decided to design this present study in order to allow for those voices and storied accounts of rooms.

Method

Participants were initially sent a demographics form by email to complete. This form enabled data on their age, gender, and number/setting of therapy rooms to be captured.

The remaining data were collected through six 60-minute semi-structured interviews, conducted via Skype, which were audio recorded using a Dictaphone and transcribed. Although it was originally intended that participants could choose to engage in the interviews either face-to-face or using Skype, as a result of the Covid-19 pandemic, all interviews were conducted via video.

Interviews were chosen, as they are a good method to use for research questions that involve exploring experience (Braun & Clarke, 2013) and allowed for an in-depth view. IPA requires the use of 'rich' data, where "participants have been given the opportunity to tell their stories, speak freely and reflectively, and to develop their ideas and express their concerns at some length" (Smith et al., 2009); the semi-structured interviews used in this study allowed for that.

The interviews lasted around an hour and nine open-ended questions were posed to interviewees; these were developed from the findings of Backhaus (2009), Liddicoat (2018) and Sinclair (2021). Questions included:

-How would you describe the room/rooms?

-How did you feel in the room and in relation to the room? -What

did the room represent for you/mean to you? (If anything)

-What was helpful/unhelpful about the room?

-Would you say that the issues that took you to therapy affected your experience of the room in any way? (How?)

Participants and sampling

All clients were over 18 years old. The exclusion criteria for client participants were that they were not currently receiving therapy in rooms they were talking about; this was to avoid any interaction with therapy and avoid potential distress to clients still within a therapy process.

The participants were former clients, who had finished therapy in an NHS therapy room at least two months ago. Two months seemed a reasonable time, to put distance between the course of therapy and the research and to allow time for the person to reflect on their experience. Participants had received a 1:1 talking therapy, in at least one therapy room, in an NHS setting (primary or secondary care). Service providers providing NHS services on an any qualified provider (AQP)basis were included within the definition of 'NHS services.' Therapists/trainee therapists were excluded from the study, as their training and experience as a practitioner could have affected their responses. Participants were recruited using voluntary and snowball sampling techniques. Adverts were placed on Facebook and posted to WhatsApp groups

Table 1: Participant demographics information

Participant Pseudonym	**Demographic Information**	**Therapy Room Information**
Andy	Male White-British Age: 55-64	Primary care -rooms in a GP surgery -other rooms used by IAPT No. of sessions: 6 No. of rooms: 3
Brianna	Female White British Age:25-34	Primary care -rooms in a hospital -rooms in community buildings

		No. of session: 56 No. of rooms: 6
Carys	Female White-British Age: 55-64	Primary care -rooms in a health centre No. of sessions:3 No. of rooms:1
Dina	Female White-British Age:55-64	Primary care -rooms in a GP surgery No. of sessions: 6 No. of rooms: 1
Erin	Female White British Age:25-34	Secondary care -rooms in a community hospital -rooms in a building used by a psychological therapies service. -rooms in a general hospital -outpatients centre No. of session: 100+ No of rooms 10+

Finlay	Male White British	Primary care -rooms in a GP surgery
	Age 35-44	No of sessions: 3 No. of rooms:1

Analysis

The data was analysed using Interpretative Phenomenological Analysis (IPA) (Smith, et al., 2009). Smith et al's., (2009) steps for conducting an IPA were followed. Super-ordinate themes were developed and will be discussed below. The themes will be evidenced by sections of the relevant text from the participant's transcripts. It is important to note that whilst the themes are distinct, they are not considered wholly independent from one another, and they share commonalities.

Ethical considerations

Ethical approval for the study was granted by the appropriate University of the West of England (UWE) faculty research ethics committee (FREC) and the researcher adhered to the British Psychological Society ethical guidelines for conducting research (Oates et al., 2021).

Analysis

Three super-ordinate themes were identified, as shown in the table below (Table two). These were 'the hospitality of the room,' 'the journey to the room' and 'cure or space to explore.' These three super-ordinate themes, along with their sub themes will be discussed, with reference to the research questions for the present study and existing literature.

Table two: super-ordinate themes and sub-themes.

Super-ordinate Theme 1 The journey to the room	**Sub-theme 1a:** Physical journey to the room
	Sub-theme 1b: Psychological journey to the room
Super-ordinate Theme 2 Hospitality of the room	**Sub-theme 2a:** Provision of the room
	Sub-theme 2b: Permission within the room
Super-ordinate Theme 3 Cure or space to explore	**Sub-theme 3a:** Medical rooms _____ **Sub-theme 3b:** Space to be/explore

Super-ordinate Theme 1: The journey to the room

The first theme of 'the journey to the room,' related to the physical and psychological journey that clients took to enter therapy rooms. This theme incorporated the things that the participants said about the wider buildings that therapy rooms were situated in, the journey to those rooms and buildings as well as the first impressions of the room and service.

Subtheme 1a: The physical journey to the room.

The first sub-theme, related to the actual physical journey that clients took to get into a therapy room, where the building was located and how they accessed the room/s in the building.

Often the journey through the building was experienced negatively and formed part of the first impressions of the service or what the person might receive from the service. Four of the participants mentioned first impressions of the therapy space and wider building as being important, particularly in terms of reducing anxiety and enabling engagement. One client spoke of how important those first impressions are and how he wanted to leave the session/service as a result of his negative experience in a room situated in a primary care health centre:

> "I think when one turns up (pause) for the first time (pause) not knowing at all, probably having been more courageous than ever before in one's life…and if one is presented with something which is… It kind of made me want to get up and walk out really (Andy)".

This journey to the room also formed part of this participant's first experience of the therapist, in either feeling 'pushed' or 'led,' down a corridor, as opposed to being able to walk side-by-side. Interestingly, there was also the psycho-symbolism of the journey to the room being like walking into a 'cul-de-sac'; something that the participant said he was trying to get out of, in his own therapy journey. This participant would have preferred a separate way in and out of the service.

Another participant spoke of how the journey through a 'maze' of corridors could increase anxiety, that then was brought into the therapy room:

> "If you're constantly worried that you're gonna trip over your own feet… and there's ledges everywhere and you don't know where the toilet is and it looks scary as heck and the corridors look all kind of same-y…you bring that into that space as you've been led through this warren of a space" (Erin).

Two other participants mentioned issues to do with entering/exiting the building that the therapy room was in being an issue, with one (Carys) clearly describing the felt risk of 'being seen' by others and the potential for stigma, as a result.

The experience of being in or walking through a waiting room, such as that found in GP surgeries within buildings used by IAPT services, was also mentioned by three clients as being unhelpful and anxiety-inducing:

> "The state you're in, you don't want anybody looking at you… you sort of felt uncomfortable because it was the first counselling session I'd ever had… so you've got stigma attached because you've got depression and you felt like all eyes were on you and so you just wanted to get in there so you could get out" (Dina).

In further looking at the physical journey to the room, the accessibility of the room was mentioned in particular by one participant, who noted the inaccessibility of buildings that she had experienced or knows of that are used by the NHS for talking therapies:

> "So [building name] was incredibly inaccessible…like there were steps going into it…there were loads of little ledges that you could trip over everywhere…all of the corridors were about as wide as me... really like… truly like a little warren" (Erin).

She went on to articulate how important it was that therapy rooms and the buildings that they were situated in were universally accessible, both for those who are disabled, but also for older age adults and those with temporary impairments:

> "I think that all therapy spaces absolutely 100% have to be as accessible as humanly possible... I definitely don't understand today how you can think about having a space that isn't accessible to everybody and obviously not only for disabled people but also everybody has different challenges at different times in their lives …I mean that's base level" (Erin).

Subtheme 1b: The psychological journey to the room.

This subtheme related to the prior life and therapy experiences and expectations of therapy rooms that participants brought with them that directly linked to how they experienced the room. One client, talked about how when she heard the grand sounding name of the (NHS) building that she would be going to access talking therapy in secondary care, she formed a very grand and 'whimsical' mental image of the place, which was in direct contrast to the 'dilapidated' and worn building she was greeted with for her first appointment. This experience was disappointing and an important first impression of the service she would receive there:

> "When I knew I was going there I was like thinking it was this grand… huge listed building… beautiful place… it was going to be all whimsical and it was a house that was truly kind of falling down in the middle of the city centre…it was very...it felt very used" (Erin).

This first impression or appearance of the place was linked to and formed a psychological representation of issues/process that was going on for this participant at the time:

> "And sort of the crumbling state of it, I think really kind of represented some of the things around like trust and um some of my…some of my institutionalisation that I was trying to deal with in those spaces wasn't helped by how institutional and dilapidated and crumbling (laughs) the foundations felt about the place" (Erin).

For this same client, her experience of being institutionalised and now being seen in rooms that were 'crumbling' and 'worn' only added to her anger and frustration, again making her want to leave the rooms:

> “I wanted to leave. I constantly wanted to leave. I didn’t connect with any…I didn’t have any good sense of those rooms.”

One participant spoke of how for a one-off session, the room that they received therapy in (from an IAPT service) was within the grounds of a psychiatric hospital and whilst traveling there, he became very anxious about why he had been asked to come to the place and whether he might be kept there:

> “The only time the counsellor could see me was if I went to that space, which was strange…in a hospital setting…for people with um psychiatric issues…so that was really unhelpful…shit are they…why am I driving in here?..shit, am I staying? Is this why they’ve brought me here, am I gonna stay? And all that sort of…again a complete lack of care really…only interested in themselves…” (Andy).

This led him to conclude that the service only ‘cared’ about themselves and not the anxiety or difficulties that clients might go through in trying to access the service.

The issues that the participants had been bringing to the room at times interacted with their first impressions of the room and the therapist. One participant spoke of how her severe anxiety had led her to get therapy, but that she also felt ‘paranoid’ and suspicious about the setting and the therapist, fearing she had been sent to the ‘nut house’; this wasn’t helped by the layout of the room, which exacerbated her anxiety, leading to her to be suspicious of the therapist and his motives:

> "I was very anxious and that was the reason I was having counselling because of these terrible anxiety attacks and things. For me…it was uncomfortable because he had a desk and I wasn't sure if he was recording me…I suppose I was a bit paranoid really…so that actual layout of room wasn't helpful for that" (Carys).

Super-ordinate Theme 2: The Hospitality of the room

The second significant theme that arose from the data was that of the 'hospitality' of the room. This theme included client's experiences of how they were 'catered' for they were within the room and how they felt in relation to the space and the therapist.

Subtheme 2a: The Provision of the Room.

This subtheme incorporated how clients were accommodated in the room, both in terms of access and the structure and contents of the room. Participants had experienced a range of different rooms, from both primary and secondary care and four of the participants also went on to compare their experiences of the provision of the NHS rooms, with their subsequent experiences of private therapists/counselling agency rooms. Overall, the majority of participants experienced the NHS rooms as negative, with many describing 'unwelcoming' rooms that were not designed with the intention of delivering talking therapies. Within primary care, the rooms were doctor's surgery rooms, often with poor soundproofing, where participants described the experience of rooms not 'designed' for talking therapy:

> "There was nothing there that was sort of felt like it was designed for the therapy…so it seemed like it was in the wrong place…that was a room that was made for a different purpose to the one that I was there for… so there was nothing there to help me relax…the lighting was very bright…it was quite cold

> there were no pictures on the walls…the seating wasn't very comfortable" (Finlay).

> "Too small, too hot, too cramped, uncaring… clearly not conducive to the counselling setting, very little fresh air, dark, uncomfortable chair" (Andy).

These rooms were experienced as 'formal,' 'plain,' 'uninviting' and 'generic,' with some participants also noting the lack of maintenance. One participant (Erin) who had experienced rooms in a variety of settings, described the rooms and facilities she had experienced in a secondary care service as being worn and unmaintained:

> "Although I was going in there to do some work…it felt like work had been happening in this space for a really long time… urgh, lots of magazines or ER that were 20 years out of date and just urgh frayed carpet and the seats were just SO uncomfortable." (Erin).

Subtheme 2b: The Permission of the Room.

This theme related to the way that participants felt they were given permission in the room, in terms of being given ownership of the space and being 'allowed' to be how they needed to be in the space. Issues related to permission in the room, were mentioned by four participants. Being given choice in the room was an important aspect of the permission of the room and was linked to being able to relax and open up:

> "I would have liked to have had an option to change the lighting or the seating or who are the temperature in their think if I was

> able to do that it might have helped me to feel more relaxed and more like I am somewhere I should be" (Finlay).

Being allowed to 'be' how you needed to be in the space was mentioned in one participant's idea of what would make an ideal therapy room by Erin. She found being able to move in the space was important for her and this helped especially at times when she felt nervous in talking about something:

> "So feeling like I had space to MOVE (laughs) I think is important, especially if I'm bringing a LOT and I'm nervous about talking about something. I think giving clients a bit of autonomy about the space and how they want to use the space, I think would be kind of revolutionary" (Erin).

The ability to be able to move around when talking links in with the modality of 'walk and talk' therapy. However, some therapists, particularly those working with very distressed clients in secondary care might have ordinary sessions where clients may get up and walk or even when the therapy is effectively taken into a corridor or outside in an unplanned and spontaneous way. This was reported in my previous research (Sinclair, 2021) and could be particularly helpful when clients are particularly triggered by something in the room or too distressed to contain things in a seated position. On a practical note, it could also be a possible solution (whilst giving careful attention to the frame and confidentiality etc.) for times when rooms are not working for the client. Indeed, the British psychological Society (BPS) recently published a document on taking therapy outdoors, (British Psychological Society, 2020 p. 2) that outlined that it could promote "access and equity of care for clients who find an indoor therapy room encounter too uncomfortable".

Being able to talk about the space was also linked with giving clients autonomy in the space/room and allowing the client to feel some ownership of the space.

Super-ordinate Theme 3: Cure or space to explore

This theme is related to the appearance of the room and the 'message' that that gives clients about the origin and maintenance of their issues and the purposes of talking therapy. This encompassed the participants' descriptions of rooms, that were either more in fitting with a medical model of mental health, with spaces having a medicalized appearance where they go to receive help from an 'expert,' or a more informal, facilitative and growthful space, in line with humanistic theory, where the therapy room and wider setting allowed for 'space to explore' collaboratively, whatever issue the client had brought.

Subtheme 3a: Medical rooms.

Five of the participants talked about the medical appearance of the NHS therapy rooms that they had used and all of them spoke about the medical appearance in negative terms. Within primary care, the rooms were doctor's surgery rooms, often with poor soundproofing, where participants described the experience of rooms not 'designed' for talking therapy: Participant descriptions ranged from it being experienced as 'uninviting,' (Brianna) to 'cold and clinical' (Dina):

> "Because it's in a doctor's surgery, and it was one of the rooms that they use for a doctor or for the nurse... it was just cold and clinical really" (Dina).

Some of the participants also felt that it heightened their experience of anxiety, with one particularly, focusing on this:

> "It was a medical surgery and being in that made me feel anxious I think it was like waiting for waiting for surgery or waiting for some kind of medical procedure …I couldn't relax or really focus on the therapy" (Finlay).

This participant also spoke of how this felt incongruent to the talking therapy that he was receiving and how the medical appearance and setting of the room imbued a medical model understanding of mental health, that he did not find helpful:

> “Because I was in in a medical room so I felt like there was something wrong with me, that I needed a doctor for...that was sort of the dynamic I guess. I find that an unhelpful way to think about what I was experiencing” (Finlay).

Another participant also spoke about his similar experience of a medical environment and the incongruence to talking therapy, when accessing an IAPT service in primary care:

> “This was a multi-purpose room and their uses… the professional users were not taken into account how will the room presented itself...so clearly they were posters up there about STDs and various things which had absolutely no relevance to what I was doing” (Andy).

He also felt that the medical environment was not conducive to engaging in talking therapy and hindered his process of being able to ‘open up’ within the therapy:

> “And this space was in the doctor's surgery…and that created a tightening of um...instead of being able to blossom into the space...I felt that my flower buds (laughs) were being tightened and shut...rather than being encouraged to open” (Andy).

One participant described the doctor’s room that had been used by her therapist within an IAPT service, as ‘authoritarian,’ indicating the room conveying a power dynamic.

> “It felt authoritarian because it belonged to a doctor” (Dina).

Another issue with medical rooms that was articulated by two of the participants were that there was a risk of interruptions in these types of rooms, as staff such as nurses were used to entering the room when patients and the GP were in there. One participant who had experienced one such interruption described them as ‘awful’ and explained the impact it had:

> “It breaks the privacy, and in some ways, it can break your trust” (Dina).

Similarly, the medical rooms in surgeries also were described as not being soundproof by two of the participants, with one participant explaining the negative impact this had on her, in terms of feeling free to speak:

> “When you sit in doctor’s waiting rooms…if they’re a bit louder in the room you can hear muffled noises...I think it adds to the stigma and the self-consciousness…So then you sort of feel like you’re holding back” (Dina).

Subtheme 3b: Space to explore

This theme related to the type of ‘ideal’ space that the participants described having wanted for therapy; a space that allowed the process of therapy to occur and facilitated exploration and preferences or flexibility for things such as postural position (siting, standing, walking) within the room.

One participant, outlined this need for flexible space where clients could have choice over the type of chair that they sat in and also ‘be’ how they needed to be in the space:

> “A choice of different chair in the space, but also a space where if you wanted to…you could lie down…If you wanted to…you could stand on something… if you wanted to…So give people the choice of how they want to *be* in the room” (Erin).

This participant also went further with the need for the room to also accommodate the client moving around:

> "There should be enough space so that if people want to walk around or wheel around or *run around*…then there is space to move…that has to be *absolutely crucial*" (Erin).

Another participant (Andy) explained this concept of it being about exploration, rather than being 'pushed' through a process and the psycho-symbolism of being given options in the space and how this could create freedom in the therapy process.

One participant (Finlay) compared his experience of NHS therapy rooms (in a GP surgery), which he terminated early, due to a dislike of the setting, with his experience of 'wild therapy' (therapy that takes place outdoors) that he engaged in with a therapist working privately... Within the wild therapy, he found this much more helpful than being in a room with a medial appearance.

While a discussion of wild therapy is beyond the scope of this paper, this participant found the freedom of not being confined in a room helpful and a welcome contrast to the anxiety inducing room with a medical appearance that he experienced in the NHS therapy. He also emphasised the choice and control that he was given in this therapy outside the room, in direct contrast to the lack of choice that there was in the NHS room.

Another participant spoke of how her ideal therapy room would be designed like a hospice, in terms of choice, flexibility and a comfortable and non-clinical appearance:

> "Hospices are, so many of them are *amazing*. They have *so* many windows on the outside…there's loads of access to garden really easily from every single room…Loads of air…loads of light and they're usually beautiful grounds… lovely...lovely connections with nature are really easy" (Erin).

Conclusion

In conclusion, this study has shown that the physical environment of rooms used for talking therapies in the NHS is an important area to consider and that client's experiences of these rooms can have a significant effect upon their ability to be able to form a positive therapeutic relationship and engage with the therapy. Clients experience rooms in a range of different ways and it is important for practitioners and service users to recognise and engage with client's experiences of rooms and make adjustments and improvements, where possible. Engaging with clients in this area and making appropriate adjustments, will help counselling psychologists and other practitioners working within the NHS (and elsewhere) to 'establish safe environments of practice' (Health and Care Professions Council, 2015) and ensure that clients experience a therapy environment that is both physically and psychologically safe.

The strengths and limitations of the study

The strengths of this study are that the participants were actual clients of NHS talking therapies who had been in actual therapy rooms; this differs from other studies, where psychology students or other non-client participants were used. The study design was an effective way of addressing the research questions and enabled the participants to give voice to their experiences of the therapy room using semi-structured interviews, which allowed for a wider experience of rooms to be shared and the emotional experience of the room to be explored.

The limitations of the study are that participants who had had particularly positive or negative experiences of therapy rooms, or who viewed the therapy room as important could have been more likely to put themselves forward to participate, due to the sampling methods used. As all the (self-selecting sample) of participants were white British, this also limited an exploration of factors related to culture and ethnicity, as voices from other backgrounds and identities were not represented.

Further research

Further research into therapy rooms is needed and specifically more opportunity for clients to be able to give voice to their experience of therapy rooms. Further research with minority clients in particular, is needed, as those from different backgrounds or cultures may experience therapy rooms in very different ways, which would be important to capture. Within the NHS, service evaluations could be a relatively easy and effective way of capturing these experiences, which will often vary according to the type of clients, types of issues and rooms being used. This information could then be used to make improvements to the rooms/wider building environment, which could both improve the therapy experience for clients and potentially improve retention and outcomes. Focus groups of service users and carers could also be used to give input into the design and layout of rooms within particular services, particularly when services are moving into new premises or having to share rooms with other services.

Implications for practice

Although this study has not sought to generate findings that would be generalisable, the following implications for practice are suggested:

The journey through the wider building to the therapy room should be considered by therapists and service providers. The accessibility of the building and room, as well as the potential for waiting rooms to heighten anxiety needs to be considered.

Avoiding the use of rooms with a medical appearance. Where this is not possible, then discussing the impact of this with the client and being aware of the need to protect against interruptions by other staff members, when using rooms within GP surgeries.

Talking to the client about the room and their level of both physical and psychological comfort within the room; making adjustments where possible to meet the client's needs.

Considering the needs of the types of clients that the service/therapist usually sees and how this might affect how they experience the room.

Consider the possibility of moving the therapy to an alternative place, or modality, such as utilising walk and talk therapy outside, if the client is struggling with the therapy room.

Recognise that the room and layout of the room can influence how a client might view the therapist, therapy and the service and also have an effect upon the power dynamics within the room and therapy relationship.

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