Impressions of Psychotherapists’ Offices

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For counseling settings, research suggests that softness, personalization, and order might affect the experience and the perceived expertise, trustworthiness, and social attractiveness of the therapist. This article discusses exploratory studies on college students’ perception of the counseling office environment and whether the likely client experience was associated with the softness/personalization and order of the office. As stimuli, the studies used 30 color photographs of psychotherapists’ offices viewed from the client’s perspective. After obtaining ratings of the characteristics of each office, we obtained ratings from different groups of students of the quality of care and comfort expected in each office (Study 1) and how qualified, bold, and friendly the therapist in the office would be (Study 2). Additional studies examined the likelihood of choosing a therapist based on the office, and the first thought or feeling that came to mind about the office, the therapist, and the patient experience. There were strong correlations in response between groups (by whether they had experienced therapy; their level in school; their gender; and their major, location, and school size). The quality of care, comfort, therapist boldness, qualifications of the therapist, and the likelihood that one would choose a therapist based on the office improved with increases in the office’s softness/personalization and order. Friendliness improved with increases in softness/personalization. The office choices, open-ended responses, and reported reasons for the ratings confirmed the importance of softness (comfort) and order. Research should test longer term exposure and behavior.

Keywords: aesthetics, environmental meaning, person perception, therapists’ offices

Supplemental materials: http://dx.doi.org/10.1037/a0023887.supp

Eight years I was on a couch, and five years I was allowed to sit up and face them and chat. —Woody Allen (1971)

People visit psychotherapists for many reasons, from elimination of phobias to reduction of existential anxiety, and the duration of that relationship can vary from a single intake session to years. The number of people in outpatient therapy is not insignificant, with an estimate of that number in 1997 of 9.69 million, or 3.59% of the U.S. population (Olfson, Marcus, Druss, & Pincus, 2002). Americans also spend a considerable amount of money and time on outpatient psychotherapy. In 1997, 5.7 billion dollars were spent by 9.7 million Americans on these visits, with 10.3% of those visiting a therapist having more than 20 visits, and just over one third with only 1–2 visits (Olfson et al., 2002).

Many college students visit psychotherapists. Between 12% and 18% of college students suffer from a diagnosable mental illness, indicating that mental health is a major issue on college campuses (Mowbray et al., 2006). In the 2003 National Survey of Counseling Center Directors, 81% of college counseling center counselors reported seeing more students with serious psychological problems than they did 5 years before (Gallagher, Zhang, & Taylor, 2003), and examination of archival data over 13 years indicated increases among college students in 14 of 19 problem areas, including personality disorders, suicidal ideation, and sexual assault (Benton, Robertson, Tseng, Newton, & Benton, 2003). Mental health problems have been described as both prevalent and persistent among college students (Zivin, Eisenberg, Gollust, & Golberstein, 2009). An article summarizing a variety of national surveys also points to an increasing demand for mental health services among college students (Schwartz & Kay, 2009). Beyond the psychological benefits to be derived from therapy, undergoing counseling is associated with student retention in college (Lee, Olson, Locke, Michelson, & Odes, 2009).

Among the factors judged to play a role in the therapeutic process is a healing setting, specifically one that increases the prestige of the therapist and in so doing elevates the expectation of benefit on the part of the patient (Frank & Frank, 2004). More broadly, the physical environment, ranging from houses to medical facilities, creates impressions about its residents and inhabitants (e.g., Becker, 1977; Cooper Marcus, 1995; A. S. Devlin, 2008; Nasar, 1989; Sadalla, Verschure, & Burroughs, 1987). The topic has a long history. In sociology, more than 50 years ago Goffman (1959) discussed how we manage our appearance to create an impression and whether the likely client experience was associated with the softness/personalization and order of the office.
Devlin et al., 2009; McElroy, Morrow, & Ackerman, 1983), and responses to offices do not vary much with the individual (Backhaus, 2008). Impressions of the therapist and therapy from the office might affect the likelihood that clients would want to undertake therapy and continue in it as well as the communications that take place. Thus, it is worth considering the impressions of the office on student clients’ perceptions of the practitioner and the therapy, as those impressions may be related to client outcomes and may generalize well to other populations.

The present research can be situated within a social psychological approach to counseling psychology in which factors such as the perceived expertise, trustworthiness, and social attractiveness of the therapist may affect counseling through the process of interpersonal influence (Strong, 1968, 1987; Strong & Dixon, 1971; Strong & Schmidt, 1970). Although factors such as the therapist’s credibility may be distal to therapeutic outcomes, they are nevertheless necessary to consider (Sue & Zane, 1987) because such credibility may influence whether a client remains in therapy. Beliefs about credibility, the “client’s perception of the therapist as an effective and trustworthy helper,” may influence the therapeutic outcome (Sue & Zane, 1987, p. 40). Fostering a belief in the ability of the therapist to help the client address his or her difficulties in living may be influenced by a variety of variables, including the client’s knowledge of the therapist’s specialized training, the ability of the therapist to present convincing arguments about the benefits of behavior change, and the therapist’s reputation in the broader community (Dorn, 1984).

With regard to aspects of the physical environment, which are the foci in this research, responses to aspects of offices and their importance do not vary with the person’s education, age, gender, type of therapy, or how long the individual has been in therapy (Backhaus, 2008). However, the display of awards and credentials has been shown to impact the perception of the counselor’s competence at the beginning of the therapeutic relationship (Heppner & Pew, 1977; Pressly & Heesacker, 2001; Siegel, 1980; Siegel & Sell, 1978; Strong & Dixon, 1971). For example, the display of five diplomas resulted in higher perceived expertise in a counseling situation, in contrast to the absence of such credentials (Heppner & Pew, 1977), and displays of a large number of credentials have a positive impact on judgments of therapists’ qualifications and energy (A. S. Devlin et al., 2009).

The credibility of the therapist has also been examined within the context of office décor, specifically the degree of formality in the office (e.g., Amira & Abramowitz, 1979; Bloom, Weigel, & Trautt, 1977). In research by Amira and Abramowitz (1979), higher ratings of the therapist’s competence emerged in response to a videotaped interview done by the therapist in a more formal room (with diplomas) than in a less formal room (with sensitivity posters and a wall rug). Thus, the physical environment can serve as a mode of interpersonal influence in the counseling process. Formality may relate to the human preference for order, neatness, and good upkeep (Kaplan & Kaplan, 1989; Nasar, 1998; Robinson, Lawton, Taylor, & Perkins, 2003). Research shows favorable impressions associated with some neatness (Campbell, 1979; McElroy, Morrow, & Wall, 1983; Morrow & McElroy, 1981), though in one exception, a study found that people evaluated the occupant of an office with a messy desk as more kind, creative, and warm, but less calm, than the occupant of an office with a neat desk (Sitton, 1984). However, in this exception, the neat desk condition may have been confounded by its lack of any cues suggesting that it was occupied. The desk looked empty, displaying only a blotter, pen, and piece of paper, as if it were on display in a store. Although the messy desk was messy, it looked in use, which was not apparent from the neat desk.

With regard to social attractiveness, an office’s perceived comfort may be important. One study found that approximately two thirds of therapists sampled designed their own office, and many of them wanted to elicit a feeling of acceptance, comfort, or welcoming (Backhaus, 2008). These aims may also relate to the therapist’s desire for clients to feel free to disclose personal information about themselves. Creating an environment of safety is one of the two therapeutic functions of a healing setting mentioned by Frank and Frank (2004) in their discussion of common elements of psychotherapy. Researchers often measure the client’s degree of disclosure as a dependent variable, and properties of the office that might affect disclosure include softness, display of credentials, or—more broadly—personalization, formality, and style. Thus, McElroy, Morrow, and Ackerman (1983) saw personal items, such as personal memorabilia, as a subtle form of therapist self-disclosure, which through a reciprocal process might lead the client to disclose more. In office settings, personalization, the display of personal items such as family photographs or indications of sports participation, is associated with affiliation but also with personal well-being and creativity (Wells, 2000; Wells, Thelen, & Ruark, 2007). Others have endorsed a “soft” room—one with plants, art posters, a decorative rug, and a padded armchair—to increase disclosure (Chaikin, Derlega, & Miller, 1976; Gifford, 1988), and one soft room property, muted lighting, has been shown to have more positive effects than has bright lighting (Miwa & Hanyu, 2006). Research shows that soft rooms are perceived as socially attractive. For example, people judged soft living and dining rooms (comfortable, looked “lived in”) as “warmer” than hard (sparsely furnished modern, geometric) rooms, which people judged as cold (Ritterfeld & Cupchik, 1996). In comparison with hard (cool) rooms, soft (warm) rooms had higher scores for involvement, personally relevant memories, warmer episodes remembered, familiarity, and details standing out (Cupchik, Hilscher, & Buttu, 2010). Beyond the perceived softness of the setting, people also notice differences in style—particularly high versus traditional or popular styles—and their preference for traditional or perceived historic styles over modern styles (K. Devlin & Nasar, 1989; Nasar, 1998; Nasar & Devlin, 2000) might affect impressions of the office and therapist.

In four exploratory studies, we sought to discover the meanings conveyed by counseling offices to likely clients and the characteristics of the offices that underlie those meanings. Research examining the effect of the counseling office environment on clients’ perceptions and/or degree of disclosure has often taken an experimental approach, varying the characteristics or displays in a given office (e.g., Chaikin et al., 1976; A. S. Devlin et al., 2009; Miwa & Hanyu, 2006). This approach may test variables that people do not notice in real offices or may exaggerate effects of the test variables. The present research uses an approach advocated by Brunswik (1955) to achieve ecological validity, and in this regard, it can add results from naturally occurring characteristics in a large sample of real offices. We sampled real environments: 30 offices used by psychotherapists. Although sacrificing aspects of experimental control, the evaluation of a large number of offices used in
practice (as opposed to recreations of offices) provides the opportunity to better understand the relation between naturally occurring characteristics of such offices and the messages they convey about therapists and therapy. Each study assessed likely client responses to the offices. One study obtained ratings of the feeling of comfort and the quality of care one would expect in each office. A second study obtained ratings of how qualified, friendly, and bold the therapist would likely be. Two additional studies assessed (a) which therapist the respondent would most likely choose and which therapist the respondent would least likely choose if asked to make a choice based on the offices and (b) open-ended responses about the first feeling or thought that came to mind about the office, the client’s experience in it, and the therapist in it. We expected each kind of assessment to relate to the office characteristics (their softness/personalization and order), such that improvements in the assessments would be associated with increases in softness/personalization and order.

**Shared Method**

**Settings Studied**

All of the studies used 30 digital color photographs of psychotherapists’ offices (see Figure 1), five of which are home offices. Independent of the present research, the photographer Saul Robbins had obtained access to 30 psychotherapists’ offices in Manhattan and had taken the photos to show a controlled view of each office and the therapist’s chair from the viewpoint of the client. Neither he nor we knew the kinds of clients the therapists treated or the reasons five of them had home offices, though with the high real estate costs in Manhattan, perhaps they chose a home office as a way to control costs. Seeing nine of the photos reprinted in The New York Times (Green, 2008), we contacted the photographer to ask whether he had more and whether he would permit their use for our research. He agreed.

*Figure 1.* The 30 color photographs of psychotherapists’ offices used in the studies. (The five home offices are by row from the left: first row, first and fourth; second row, fifth; fourth row, third; fifth row, first.) A color version of this figure is available in the online supplemental materials.
For impressions of the office, the chair is important. When asked to describe the physical environment of the therapy setting in detail, open ended responses to offices by therapists and clients found that 90% of them described furnishings such as a chair or a couch, and ratings of importance of items found the chair as most important, more important than couches, tables, coffee tables, or desks in the office (Backhaus, 2008). For all studies here, participants saw and responded to the color photos of the offices online on Survey Monkey. Each study used four different orders of the offices to mitigate order effects.

Characteristics of the Settings

The characteristics of the offices varied. Twelve graduate students at a land-grant university in the Midwest judged the characteristics of each office on five 7-point rating scales: Simple—Complex (the number of different objects in the office), Spacious—Cramped, Orderly—Disorderly, Neat—Messy, and Modern Style—Traditional Style. An additional 12 such graduate students rated the offices on two additional 7-point rating scales, accompanied by instructions for each scale. For Hard Office—Soft Office, the instructions stated the following:

A soft office has lots of soft surfaces and textures—a soft upholstered chair, wall paper, curtains, thick carpeting, a throw rug, plants, table lamps, and movable furniture. A hard office has hard smooth surfaces (floor, wall, furniture) throughout and bright lighting.

For Impersonal—Personalized, the instructions stated the following:

A personalized office has mementos and personal signs of the occupant, such as pictures of family members, photographs, sculptures, knickknacks, plants, diplomas/certificates of achievement, books, and personal items like a blanket or article of clothing. An impersonal one lacks such mementos or personal signs.

Each scale had high interobserver reliability ($\alpha > .77$). In real settings, attributes may covary with one another. To find naturally occurring groups of attributes in the offices, we conducted a principal component analysis. It revealed a two-components solution. With eigenvalues greater than 1.0 (principal component analysis. It revealed a two-components solution. With eigenvalues greater than 1.0, the two components explained most of the variance (72.5%). Thus, we combined the attributes that had high loadings on each component into two summary variables. The first component, accounting for 50.1% of the variance, had four scales—Disorderly, Messy, Cramped, and Complex—with high loadings on it (each loading > .84). The second component, accounting for 22.4% of the variance, had two scales—Personalized Office and Soft Office—with high loadings on it (each loading > .70). We labeled the new variable for the first component “orderly.” It was the mean of the values of the four scales loaded on it, subtracted from eight to reverse the scale such that orderly had the higher score. We labeled the new variable for the second component “soft/personalized.” It consisted of the mean of the two scales loading on it. The judged characteristics of the offices varied on seven items. For composite orderly, the mean was 3.38 ($SD = 0.96$), and for composite soft/personalized, the mean was 4.25 ($SD = 0.96$). They did not have a statistically significant Pearson correlation between them ($r = .27, p = .15$).

Studies 1 and 2

Study 1 sought to find out whether perceived quality of care and comfort in the office were associated with soft office/personalization and order. Study 2 sought to find out whether perceptions of the likely therapist were associated with soft office/personalization and order. Also, in light of previous findings of broad consistency in environmental evaluations, we expected to find consistency in the evaluations across gender, age, geography, and whether the participant had visited a therapist.

Method

Participants. Study 1 had two groups of participants. Seventy-six undergraduate students (42 women and 34 men; mean age = 20.2 years) taking a course in psychology at a small private college in a small town in the Northeast volunteered to participate in this study. Most people in the undergraduate sample were Caucasian (86.8%) and in their first or second year of college (73.1%), and most of them (62.7%) reported that they had seen a therapist. Of those who reported seeing a therapist, 30.4% reported more than 20 visits, and 21.7% reported 1–2 visits ($Mdn = 11$ visits).

A study of a diverse sample of 153 participants who had experienced therapy (20 men, 133 women) found that evaluations of therapists and ratings of the importance of characteristics of their offices did not differ with age, education, gender, or income of the respondent (Backhaus, 2008). Similarly, a meta-analysis of more than 19,000 people evaluating more than 3,200 environments found high correlations in responses between students and adults, between men and women, and across cultural groups (Stamps, 1999). Although undergraduate students are important on their own as users of therapy, the findings suggest that their responses should generalize well to other groups. Nevertheless, we added a different sample to allow a test of generality.

This sample had 28 participants (10 women, 17 men, 1 non-report; mean age = 26.8 years) taking a graduate level course in city and regional planning at a large urban land-grant university in the Midwest. Most of them were Caucasian (60.7%) and in their first or second year of graduate school (88.9%). Fewer of them (28.6%) than the undergraduates reported that they had seen a therapist, and those who reported seeing a therapist had fewer visits than the undergraduates; 25% reported more than 15 visits, and 12.5% reported 1–2 visits ($Mdn = 7.5$ visits).

Study 2 also had two groups of participants. Seventy-five undergraduate students (41 women and 34 men; mean age = 20.4 years) taking a course in psychology at the small private college in a small town in the Northeast volunteered to participate in this study. Most were Caucasian (81.3%) and in their first or second year of college (57.7%), and most of them (60.0%) reported that they had seen a therapist. Of those who reported seeing a therapist, 41.3% reported more than 20 visits, and 8.7% reported 1–2 visits ($Mdn = 20$ visits).

Twenty-seven students (11 women and 16 men; mean age = 26.0 years) in a graduate course in city and regional planning at a large land-grant urban university in the Midwest volunteered to

1 For Personalized, we dropped three judges to increase $\alpha$ to .78, and we used the remaining judges in subsequent calculations.
participate in the study. Most were Caucasian (74.1%) and in their first or second year of graduate school (66.7%). Fewer of them (37.0%) than the undergraduates reported that they had seen a therapist, and those who reported seeing a therapist reported fewer visits than the undergraduates. Forty percent reported 20 or more visits, and 20% reported 1–2 visits (Mdn = 13.5 visits).

Procedure. At the small Northeastern college, we recruited students through posting a request for volunteers on the research participation board. At the Midwestern university, we recruited students by an e-mail to the class. Students who volunteered to participate received one of the eight URLs (four for Study 1 and four for Study 2, each set of four having a different randomized order of the photos). Each study had the same introductory material. The first page had the informed consent and a box to check if they agreed to participate. If they checked the box, they were to go to the next page, which informed them that they would see pictures of 30 real offices that focused on the therapist’s chair. In responding to the images they were to imagine visiting the therapist for advice about an emotional problem. For Study 1, they were asked to give their honest opinions about the individual whose office was viewed. They were asked to rate each office for the quality of care expected and how comfortable they would feel in it (on 7-point scales ranging from very poor to very good). We selected these items based on a study finding them as important in judgments of care (A. S. Devlin, 2008). For Study 2, they were asked to rate the expected therapist in each office on three 7-point scales (Unqualified–Qualified, Timid–Bold, Friendly–Unfriendly). We selected these items based on a study that found that judgments by 227 participants of the characteristics of the therapists from the office grouped into three factors: qualifications, energy (timid–bold), and friendliness (A. S. Devlin et al., 2009). In each study, the order of the items varied at random from office to office. For the analyses, we reversed the coding on friendly–unfriendly to become unfriendly–friendly. Both studies then had an open-ended question asking for the characteristics of the offices that stood out and influenced the ratings, followed by a list of 23 factors (such as size, plants, and neatness) to rate on a 5-point scale for the importance of each in affecting their judgments. The survey concluded with questions on the participant’s background, experience with therapy, and a debriefing statement.

Results

Recall that the analysis of perceived physical characteristics of the office revealed two components: orderly and soft/personalized. We examined the relationship of these two aspects of the offices to the quality of care and the comfort that participants expected for each office (Study 1), and judgments of how qualified, bold, and friendly the therapist in each office was (Study 2). The ratio of 30 cases to two independent variables is acceptable. The analyses found that as softness/personalization and order improved, the expected quality of care, comfort, and boldness and qualifications of the therapist improved. For friendliness, only softness mattered. The multiple regression analyses with orderly and soft/personalized as predictor variables and with quality of care expected, comfort expected, boldness, qualified, or friendly as the criterion variable found that as the office became softer and more orderly, the expected quality of care, comfort, boldness, and qualifications of the therapist improved; however, for friendly, as the office became softer/more personalized, judgments of the friendliness of the therapist improved (see Table 1). Soft/personalized had a large effect on comfort and friendly and a medium-to-large effect on quality of care, bold, and qualified. Orderly had a medium effect on qualified, a small-to-medium effect on quality of care, and a small effect on comfort and bold. The Pearson correlations with soft office were $r = .45$ (quality of care), $r = .55$

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<th>Effect</th>
<th>Coefficient</th>
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<th>β</th>
<th>Tolerance</th>
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<th>p</th>
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(comfort), \( r = .40 \) (bold), \( r = .46 \) (qualified), and \( r = .71 \) (friendly), and with orderly, the Pearson correlations were \( r = .32 \) (quality of care), \( r = .25 \) (comfort), \( r = .15 \) (bold), \( r = .39 \) (qualified), and \( r = .21 \) (friendly). Moderator analyses, with the sample (graduate students in a city and regional planning course at a large Midwestern land-grant university in an urban area vs. undergraduate students in a psychology course at a small Northeastern private college in a small town) dummy coded as a moderator of each association, found no statistically significant effect of moderation on any of the scales (\( ps > .50 \); except quality of care, \( p = .10 \)). Figures 2, 3, and 4 (available in the online supplemental materials) show offices that had high scores and low scores on the scales. Tests of the degree to which ratings on each scale were consistent across participants by whether they had experienced therapy, year in school, location/city size, race/ethnicity, and gender found strong commonalities in response across each group (see Table 2 for Pearson correlations), with all but three comparisons explaining more than 50% of the variance (\( rs > .70 \)). Friendly by race/ethnicity, and comfort by location and by gender each had lower \( rs \).

Four of the five scales had high Pearson correlations with one another (see Table 3), and an item analysis revealed high interitem agreement between those four scales—comfort, quality of care, qualified, and bold (\( \alpha = .91 \)). A multiple regression of orderly and soft/personalized onto a composite of the four scales found that as soft/personalized and orderly increased, overall evaluation improved—soft/personalized, \( p = .0001 \); orderly, \( p = .002 \); \( R^2 = .50 \), adj. \( R^2 = .46 \), \( F(2, 27) = 13.50, p = .0001 \)—with a large effect for soft/personalized and a small one for orderly. Composite score had Pearson correlations of \( r = .52 \) (soft/personalized), and \( r = .32 \) (orderly), respectively.

**Discussion**

Studies 1 and 2 found similar patterns of response in relation to ratings that assessed feelings about the office and the therapist. As perceptions of softness/personalization and order increased, so did expectations about quality of care, comfort, boldness, and qualifications of the therapist. Perceived friendliness increased with increases in softness/personalization. For all five scales, softness/personalization had larger effects than did order. Moreover, none of these responses were differentially related to gender, race/ethnicity, class year, or experience visiting a therapist, suggesting a broadly generalized response. In addition, the findings showed similarity in responses between undergraduate students (more of whom were women) taking a course in psychology at a small private college in a small town in the Northeast and older graduate students (more of whom were men) in a city and regional planning course at a large urban land-grant university in the Midwest.

As the four studies share enough similarity in method that questions about internal and external validity and future research are similar, we hold such discussion for the conclusions after Study 4. For now, we ask the question that led to Studies 3 and 4: Would similar findings emerge for the decision about choosing a psychotherapist based on the appearance of the office, and would similar findings emerge for open-ended questions about the office, the therapist, and therapy experience in each office?

**Additional Findings**

Study 3 sought to find out whether the choice of therapist based on the appearance of the office was associated with soft office/personalization and order. Study 4 sought to find out whether open-ended responses about the office, the patient’s likely experience in it, and the therapist in it were associated with soft office/personalization and order. Both studies recruited undergraduate students taking a course in psychology at the same small Northeastern college and in the same way we recruited them for Studies 1 and 2. The therapist choice study had a sample of 47 undergraduate students (37 women and 10 men; mean age = 19.9 years). Most of them were Caucasian (80.8%) and in their first or second year of college (78.8%), and most of them (52.2%) reported that they had seen a therapist. Of those who reported visiting a therapist, 37.5% reported more than 20 visits, and 33.3% reported 1–2 visits (\( Mdn = 15.0 \)). This study presented participants all 30 offices at once in one of four random orders. The instructions asked them what they would do if they had to choose a psychotherapist based on his/her office, and then indicate which office they would most likely choose and which office they would least likely choose.

The study of open-ended responses had a sample of 48 undergraduate students (36 women, 11 men, 1 not reporting; mean age = 19.8 years). Most were Caucasian (78%) and in their first or second year of college (74%), and many of them (46.8%) reported that they had seen a therapist. Of those who reported seeing a therapist, 13.6% reported more than 20 visits, and 22.7% reported 1–2 visits (\( Mdn = 5.0 \) visits). This study had four randomized orders of offices. For each office, participants were asked to write the first thought or feeling that came to mind about the following: a patient’s likely experience in the office they would most likely choose and which office they would least likely choose.

### Table 2

**Pearson Correlations Between Ratings by Various Groups (\( N = 30 \))**

<table>
<thead>
<tr>
<th>Group</th>
<th>Study 1</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy experience: Some vs. none</td>
<td>.90</td>
<td>.87</td>
</tr>
<tr>
<td>School year: 1st or 2nd year vs. upper level or graduate student</td>
<td>.82</td>
<td>.83</td>
</tr>
<tr>
<td>Size/location: Small Northeast private college vs. large Midwestern state university</td>
<td>.59</td>
<td>.82</td>
</tr>
<tr>
<td>Gender: Men vs. women</td>
<td>.61</td>
<td>.82</td>
</tr>
<tr>
<td>Race/ethnicity: Caucasian vs. other</td>
<td>.82</td>
<td>.79</td>
</tr>
</tbody>
</table>

*Note.  \( ps < .001 \).  
*** \( p = .006 \).*
For the choice of offices, we created a composite choice score by subtracting the frequency for least likely choice from the frequency for most likely choice for each office. The resulting scores had statistically significant Bonferroni-adjusted correlations with independently rated comfort, quality of care, qualified, and boldness ($r > .60$, $ps < .01$). For least likely choice, 40.4% of the sample picked one office, and 14.9% picked each of two other offices; and for most likely choice, 14.9% of the sample picked one office, and 8.5% of the sample picked each of two other offices. Figure 5 (available in the online supplemental materials) shows the least likely choices (top row) and most likely choices (bottom row). The multiple regression analysis of soft/personalized and orderly onto the composite choice score revealed that as the offices became more soft/personalized, the composite choice score improved (see Table 4). Soft/personalized had a medium-to-large effect, and orderly had a small and nonsignificant effect. Composite choice had Pearson correlations of $r = .49$ (soft/personalized), and $r = .09$ (orderly), respectively.

The open-ended comments also pointed to the importance of softness and order. From the results of the three previous studies, we calculated the average of the scores on each office across the five evaluative dimensions and the composite choice score to construct a list of offices of those offices receiving the most favorable to least favorable scores. Then, we compared the comments for the five offices with the best overall scores to the comments for the five offices with the worst overall scores. Focusing on both ends of the favorability spectrum provides an opportunity to more clearly understand the characteristics that influenced respondents’ judgments. Of the 240 possible sets of responses to most liked offices (5 offices × 48 participants) or least liked offices (5 × 48) and for each question (office, therapist expected, patient experience), most participants (between 78% and 84.5%) had one comment for a most liked office, and most participants (between 70.8% and 80.8%) had one comment for a least liked office. We then conducted content analyses on the reasons given. For this, we moved the reasons into an Excel file. If a participant gave more than one reason, we moved the additional reasons to new columns. We edited out extraneous words (such as “a” or “the”) and eliminated a reason if it was cited by the same observer more than once; we then sorted the reasons, grouped similar words (such as comfort and comfortable, ordered and organized, open and spacious), and made a tally.

For the top five offices, participants most frequently described the office as comfortable, nice, clean, warm, inviting, and professional, whereas they most frequently described the bottom five offices as cluttered, cramped, messy, uncomfortable, and unprofessional. Two-way comparisons between the top and bottom offices and opposite pairs of descriptors show that the participants mentioned cramped, cluttered, uncomfortable, and unprofessional, and unwelcoming more often for the bottom five offices and open, comfortable, organized, and welcoming more often for the top five offices (see Table 5 in the online supplemental materials). Each of these comparisons achieved statistical significance.

For the expectations about the therapist who occupies the office, two-way comparisons between the top and bottom offices and opposite pairs of descriptors (such as professional and unprofessional) revealed that participants mentioned organized, professional, man, friendly, easy-going, old, and experienced more often for the top five offices and disorganized, unprofessional, woman, unfriendly, busy, and inexperienced more often for the bottom five offices. Each of these comparisons achieved statistical significance. For patient experience expected, two-way comparisons between the top and bottom offices and opposite pairs of descriptors revealed that the participants mentioned comfort, good, and supportive of disclosure more often for the top five offices and uncomfortable, bad, and discouraging disclosure more often for the bottom five offices.

Table 3
*Pearson Correlations Between Five Rating Scales*

<table>
<thead>
<tr>
<th>Scale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Offices ($n = 30$)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Friendly</td>
<td>—</td>
<td>.03</td>
<td>.11</td>
<td>.56</td>
<td>.30</td>
<td></td>
</tr>
<tr>
<td>2. Bold</td>
<td>—</td>
<td>.77**</td>
<td>.50</td>
<td>.57**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Qualified</td>
<td>—</td>
<td>—</td>
<td>.70**</td>
<td>.87**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Comfort</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.90**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality of Care</td>
<td>4.39/0.43</td>
<td>4.21/0.50</td>
<td>4.37/0.73</td>
<td>4.35/0.72</td>
<td>4.54/0.64</td>
<td></td>
</tr>
</tbody>
</table>

*Based on ratings of the 30 offices in Studies 1 and 2.

* $p < .05$. ** $p < .01$. 

Table 4
*Regression of Soft/Personalized and Orderly Onto Composite Choice (N = 25)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE</th>
<th>$B$</th>
<th>Tolerance</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>7.82</td>
<td>4.70</td>
<td>.00</td>
<td>—1.66</td>
<td>.110</td>
<td></td>
</tr>
<tr>
<td>Soft/Personalized</td>
<td>2.59</td>
<td>.91</td>
<td>.53</td>
<td>0.97</td>
<td>2.86</td>
<td>.009</td>
</tr>
<tr>
<td>Orderly</td>
<td>0.94</td>
<td>.94</td>
<td>.81</td>
<td>0.97</td>
<td>0.99</td>
<td>.330</td>
</tr>
</tbody>
</table>

*Note.* For Personalized, we dropped three judges to increase $n$ to .78, and we used the remaining judges in subsequent calculations. Because five offices were neither selected as most liked nor least liked they did not receive a score. $R^2 = .28$; Adj. $R^2 = .21$ ($p = .03$).
Results From All Studies

Each of the four studies had the same questions about what characteristics of the offices most stood out and influenced respondents’ ratings and the importance of each of 23 factors influencing their judgments. We combined those data from the four studies for analyses. The combined sample had 242 participants (177 women and 65 men; mean age = 20.6 years). Most were Caucasian (76.7%) and in their first or second year of college (52.3%). Compared with the national average (Olfsen et al., 2002), the sample had more people who reported that they had seen a therapist (60.4% vs. 3.59% nationally), and of those, it had a higher percentage reporting more than 20 visits (43.2% vs. 10.3% nationally) and a lower percentage reporting only 1–2 visits (21.1% vs. just over one third nationally).

The results suggest that participants differentiate among offices when thinking about the therapist they are more or less likely to choose, reflected in the appearance of the office. The office choices were consistent with the character of offices associated with comfort, quality of care, and qualities of the therapist as qualified or bold. The rated importance of each of 23 factors confirmed the importance of order and softness (see Table 5 in the online supplemental materials). There was a statistically significant difference in the rated importance of the attributes, $F(22, 4004) = 57.08, p < .0001$. Neatness and chair comfort were rated as most important, followed by order, space, style, and color. The first two items were judged significantly more important than were the rest. Order was judged as significantly more important than 16 other attributes, and space, style, and color were judged as significantly more important than 10 other attributes. Examination of the ranking of the five home offices on the composite score revealed that ratings of them did not distinguish them from the other offices. In addition, comparisons of the importance scores for the 23 attributes by groups found high Pearson correlations by school ($r = .93, p < .0001$), gender ($r = .97, p < .0001$), race (Caucasians vs. African Americans; $r = .91, p < .0001$), and year in school (lower level vs. upper level and graduate students; $r = .97, p < .0001$).

Open-ended responses to what attributes stood out and influenced participant decisions also pointed to the importance of soft/personalized offices and order. We did a content analysis of the open-ended responses. The analysis followed the same procedure we used in the earlier content analysis. Although the chair (and its appearance, location, look, materials, quality, size, style, type) was frequently cited ($n = 61$), order (or clean, clutter, neatness, organization) was cited most frequently ($n = 68$), followed by comfort ($n = 45$), and items (such as decorations, art, plant, rugs, and diplomas) related to personalization ($n = 43$), lighting ($n = 38$), books ($n = 29$), color ($n = 26$), and space (size, openness; $n = 17$), which at least in the judged attributes of the office related to order.

General Discussion

The four studies reveal consistency about what aspects of the appearance of psychotherapists’ office are important. These consistencies held across different groups of participants by gender, race/ethnicity, year in school, major, location, city size, type, and size of school, and whether the participant had experience with therapy. They also held for fixed and open-ended ratings of qualities of the office, likely therapist, and therapy experience. The perceived desirability of the office as a setting for therapy, therapist, and experience of therapy improved with the softness/personalization and order/neatness of the office, and these findings agree with findings on the desirability of softness/personalization and neatness in counseling settings (Chaikin et al., 1976; Gifford, 1988; McElroy, Morrow, & Wall, 1983; Morrow & McElroy, 1981), and with findings on human preferences for orderly, well-kept, and spacious settings over chaotic, poorly kept, and cramped ones (Kaplan & Kaplan, 1989; Nasar, 1998; Robinson et al., 2003).

There is an ecological interdependence between behavior and the physical environment (Barker, 1968), and the physical characteristics of settings—that is, what they afford—may support certain kinds of behavior (Gibson, 1979). Order/neatness and softness/personalization may well affect perceptions related to personal influence and whether a patient remains in therapy (Strong, 1987; Sue & Zane, 1987), and perceived credibility, trustworthiness, and expertise of a therapist may relate to office order/neatness (Amira & Abramowitz, 1979; Gosling et al., 2002). Further, perceived social attractiveness may relate to soft/personalized designs—which use soft surfaces and textures, wallpaper, curtains, thick carpeting, throw rugs, plants, table lamps, and movable furniture—and cues to personal identity (Chaikin et al., 1976; Gifford, 1988; Miwa & Hanyu, 2006; Sommer, 1974). Therapists who create a comfortable environment for themselves by including pleasing accessories may be more satisfied with their working environment, which may improve their effectiveness in working with their clients (Pressly & Heesacker, 2001). Soft/personalized, neat/orderly offices might encourage greater disclosure from clients (Chaikin et al., 1976). Furthermore, in line with the work of Frank and Frank (1991, 2004) on the healing setting as one of the common elements of psychotherapy, a soft/personalized office may provide an environment of safety, and an orderly/neat office may communicate that the therapist is someone from whom the patient has an expectation of benefit.

Although there was less agreement about which particular office the respondents would most likely choose for therapy, there was more agreement about which office the respondents would least likely choose. Once a minimum set of design criteria is satisfied, the role of style comes into play, and with it the range of choices expands (Simon, 1970). There may be greater agreement about conditions that violate the desired criteria, and thus suggest a possible risk and less safety, than about conditions that conform to the desired criteria, and suggest a possible benefit (A. S. Devlin, 1995; Kahneman & Tversky, 1979). For the practice of psychotherapy, one of the lessons from this study may be to avoid chaotic and cramped offices (with papers piled haphazardly, chairs in disarray, and lots of wires) and hard impersonal offices, as these may decrease the perception of safety and the expectation of benefit. Although five of the 30 offices in our studies were home offices, this did not appear to differentiate their scores, suggesting that such offices were not perceived significantly differently as office environments.

The office perceptions contribute to first impressions. Although initially important, such impressions may be ephemeral in the actual client perceptions of their therapist and the quality of therapy. In spite of similarities between responses to photographs of settings and to the actual settings (Nasar, 1998; Roth, 2006;
This emphasis on first impressions suggests a need for tests of longer term experience and whether characteristics of the therapist (such as gender), kind of visit, location of office (e.g., clinic vs. private office) affect the results, and whether the character of the office affects the kind and quality of interaction in it and counseling outcomes.

The findings derive from naturalistic and correlational studies. To establish causality, future work should disentangle order from neatness and softness from personalization and test them by systematically manipulating offices and testing responses to those conditions in a true experimental design. The studies centered on responses by college students. Although the participants were college students, more than half of them reported at least one visit to a psychotherapist, with many having multiple visits. Whether the findings generalize to other populations—such as adult or child clients, clients visiting a therapist in dyads or in larger groups, or for different kinds of therapy—would require additional study. However, research suggests minor effects of individual differences (Stamps, 1999) or of variations in education, age, gender, income, length, or type of therapy on clients’ ratings of the importance of attributes of the office or of the therapist’s attractiveness, expertise, and trustworthiness (Backhaus, 2008). Our studies also found strong correlations in responses across year in school, gender, location/major/age and whether the participant had experienced therapy. Although Studies 3 and 4 had few men in the sample, the findings were consistent with Studies 1 and 2, which had more men, and the results for the graduate samples, which had more men than women, were similar to those for the undergraduate sample, which had more women than men. Taken together, these results suggest that (a) it is unlikely that the gender balance in Studies 3 and 4 distorted the results and (b) there is a likely broader applicability of the findings to various kinds of clients in therapy.

In theory, counselors are aware of the attributes that counseling facilities should possess; for example, directors of counseling services favored indirect lighting and carpeting (Iwai, Churchill, & Cummings, 1983). However, there is sometimes a disconnection between theory and practice, as reflected in a number of the poorly rated offices photographed for the current studies. Therapists can glean tentative guidelines for the appearance and furnishing of their office from our findings. Our research suggests two sets of characteristics of the office to consider: comfort/personalization and order/neatness/spaciousness.

Further, to find out more about the messages conveyed by the appearance of the office, therapists might gauge client reactions, see whether the changes worked as expected. Although the therapist’s chair was the focus of the photo that respondents viewed, viewers may well make inferences about the provision of seating for themselves based on what the therapist chose for him/herself. If the therapist is perceived to be comfortable, respondents may expect themselves to be. For therapists and clients alike, chairs are central to the therapeutic setting (Backhaus, 2008), and client seating could be the focus of future study. Therapists might try to offer seating that looks (and presumably is) comfortable (i.e., with soft cushions, rounded corners, and throw pillows). They could also add other touches of comfort and personalization to their office, but at the same time they should keep it neat, orderly, and uncluttered. Ultimately, the character of the setting can make a place more appealing and may subtly affect outcomes. Such changes have the potential to improve the therapeutic aspects of the healing setting (Frank & Frank, 1991, 2004) for the client.

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Received November 3, 2010
Revision received April 4, 2011
Accepted April 7, 2011

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