THE EFFECT OF THE THERAPY ROOM ENVIRONMENT ON EXPECTATIONS REGARDING PSYCHOTHERAPY

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YEDITEPE UNIVERSITY

GRADUATE SCHOOL OF SOCIAL SCIENCES

ISTANBUL, 2023

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SUBMITTED TO GRADUATE SCHOOL OF SOCIAL SCIENCES

IN PARTIAL FULFILLMENT

OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

IN

CLINICAL PSYCHOLOGY

YEDITEPE UNIVERSITY

ISTANBUL, 2023

PLAGIARISM STATEMENT

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ABSTRACT

Clients' expectations of psychotherapy are important because they can actually affect the process and outcome of therapy. Not only therapists' behavior but also the characteristics of their therapy room could potentially influence clients' expectations. This study aimed to investigate the effects of therapy room interior designs on the formation of expectations of psychotherapy. Three photographs of typical therapy rooms were prepared, representing variations in seating arrangement and furniture: A) home-style furniture and egalitarian seating arrangement, B) classic Freudian-couch arrangement, and C) office-type furniture and desk-between seating arrangement. Participants consisted of those who have a prior experience of psychotherapy as a client (*n*=81) and those who have no experience (*n*=81). They were shown three rooms in a counterbalanced sequence and asked to complete the Milwaukee Psychotherapy Expectations Questionnaire each time. They were also asked open-ended questions: what element of the rooms attracted their attention, and what they liked/disliked about the rooms. The result indicated that psychotherapy-related expectations differed based on the room characteristics. The participants' expectations were the highest in Room A and the lowest in the Room C, regardless of their therapy experience. Thematic analysis of the responses to the open-ended questions revealed three themes regarding seating arrangement, *Sincerity, Power Dynamics,* and *Feeling of Security,* and two themes concerning furnishing, *Simplicity, and Homeyness.* The room that looks like a manager's office, which is common in Turkey, was received most negatively by both groups. Given the results, paying careful attention to the choice of furniture and seating arrangement when designing therapy rooms was recommended.

Keywords: therapy room, psychotherapy expectations, interior design, seating arrangement, furniture type

ÖZET

Danışanların psikoterapiye dair beklentileri önemlidir çünkü bu beklentiler terapi süreci ve sonucunu etkileyebilirler. Sadece terapistlerin kendi davranışı değil, terapi yaptıkları odanın özellikleri de danışanların terapi ile ilgili beklentilerini etkileyebilir. Bu çalışmanın amacı, terapi odası iç tasarımlarının, bireylerin psikoterapiye dair beklentilerinin oluşmasındaki etkisini araştırmaktır. Oturma düzeni ve mobilya tipi çeşitliklerini temsil eden üç tipik terapi oda fotoğrafı hazırlanmıştır. Oda koşulları: A) ev tipi mobilya ve eşitlikçi oturma düzeni, B) klasik Freudyen kanepeli düzen, ve C) terapistin çalışma masası karşısında oturduğu ofis tipi şeklindedir. Araştırmanın örneklemi, daha önce danışan olarak terapi deneyimi olan (*s*=81) ve deneyimi olmayan (*s*=81) kişilerden oluşmuştur. Katılımcılar karşıt dengelemeli bir sıralamayla sunulan üç çeşit oda fotoğrafına bakarak Milwaukee Psikoterapi Beklentileri Ölçeği'ni doldurmuştur, ardından odalarda neler dikkat çektiğine ve neler sevdiği/sevmediğine dair iki açık uçlu soruyu yanıtlamaları istenmiştir. Terapi beklentisi, odaların özelliklerine göre farklılık göstermiştir. Hem terapi deneyimli grubun hem de terapi deneyimsiz grubun psikoterapi beklentileri Oda-A'da en yüksek ve Oda-C'de en düşük çıkmıştır. Açık uçlu sorular için yapılan tema analizi sonucunda oturma düzeni ile ilgili olan üç tema, *Samimiyet, Güç Dinamikleri* ve *Güven Hissi*, ortaya çıkmıştır. Mobilya ile ilgili ise iki adet tema, *Sadelik* ve *Ev Havası,* ortaya çıkmıştır. Türkiye'de yaygın olan müdür ofisi benzeri oda her iki grup tarafından en olumsuz karşılanmıştır. Bu araştırmanın sonucundan yola çıkarak, terapi odası tasarlanırken mobilya seçimi ve oturma düzenine dikkat edilmesi önerilmektedir.

Anahtar Kelimeler: terapi odası, psikoterapi beklentisi, iç tasarım, oturma düzeni, mobilya tipi

To my beloved cat Ponçik

Even though you could not be with me when I finished my thesis,

I am grateful to you for always being right by my side throughout my academic life.

ACKNOWLEDGEMENTS

I would like express my deepest gratitude to my thesis advisor Dr. Mari Ito-Alptürer, who has always supported and guided me patiently with her wisdom since the day I started my research. I am happy and proud to have done this project with her.

I would also like to thank architect Selin Bingöl, who took the time to prepare the visual simulations of rooms for the research.

I could not have undertaken this journey without Umut Ulaş Tarhan, whose endless love gives me strength and Begüm Atakan, who is my companion in facing every challenge in life.

Last but not least, I am grateful to my beautiful family, Bekir, Esra and Nihan, for their years of boundless love and trust.

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1 INTRODUCTION

1.1 Psychotherapy and the Physical Environment

Psychological therapies, or collectively psychotherapy, can be a source of support when we are not well mentally, when we want to understand or change something about ourselves, and when we cannot cope with emotional difficulties on our own. The goal of psychotherapy can range from reducing physical symptoms caused by psychological distress to having a more integrated sense of self, improving personal relationships, and gaining new emotional capacities (Horowitz & APA, 2019). Each individual has a unique therapy process, which is to be discovered together with the therapist. It is a remarkable process where one can observe and gain a deeper understanding of human nature which may not be easily observable except in an interaction between the therapist and the client (Stiles, 2007).

Before psychological therapies and biomedical treatments for psychiatric disorders were established in the 20th century, the mentally disturbed were commonly put under the custody of mental institutions. A number of specialized hospitals called "asylums" existed in many countries, where the main method of treatment was social isolation. At the end of the 19th century, however, new developments in both psychiatry and psychology made outpatient psychological treatments optional. In 1886, Sigmund Freud opened his first private office where he gradually developed his treatment methods of psychoanalysis whose main technique was free association (Quinodoz, 2016). In typical Freudian psychoanalysis, patients visited a psychoanalyst's private office where they were asked to lie down on a couch with no eye contact with the therapist who sat

behind them. The room with a couch played an important role in creating a secure and intimate environment that encouraged the patient to freely talk about what comes to their mind. By the 1930-40s, psychoanalysis earned widespread popularity among the public, especially in the US (Schultz & Schultz, 2008). With the emergence of psychoanalysis, people with emotional and mental health issues, except severe cases of psychosis, can seek out personal “talking” therapy as an alternative to inpatient treatment in psychiatric hospitals.

Around the same time, a new development occurred in the field of psychology as well. Lightner Witmer opened the world’s first psychological clinic at the University of Pennsylvania in 1896, which marked a start of a new field he called clinical psychology. His practice resembled school psychological counseling, assessing and treating schoolchildren’s behavioral and learning problems. After Witmer’s original model of the psychological clinic, Freud’s ideas slowly but significantly influenced the advancement of clinical psychology and the practice of psychotherapy (Schultz & Schultz, 2008). Psychodynamic psychotherapy, for example, has its roots in Freud’s psychoanalytic theory (Mitchell & Black, 2016). Another theorist who has made important contributions to contemporary psychotherapy practices with his humanistic approach is American psychologist Carl Rogers. His method of psychotherapy is referred to as client-centered therapy (also person-centered therapy) (Rogers, 1965). Rogers’ emphasis was on the ‘client’ where the therapist strives focusing on client’s experience rather than theory and technique (Wilkins, 2016). His approach signifies the equality and value of the client in the therapeutic processes. There are now many other approaches to psychotherapy such as cognitive-behavioral therapy (CBT), existential therapy, and so on. Although the theoretical background and techniques vary, there are common factors in all therapies,

such as therapeutic alliance, the client's hope and expression of emotions, therapist empathy, and feedback (Stamoulos et al., 2016). They all carry a mutual goal to help and improve the mental health of the clients. The demand for psychotherapists increased dramatically during and after World War II due to the need to treat emotionally disturbed veterans of war (Schultz & Schultz, 2008). Psychotherapy started to be offered widely in private practice, as well as in different settings such as medical centers, clinics, schools, and agencies. All that is needed for the practice of psychotherapy is a therapist, a client, and a therapy room.

In general, the physical environment of psychotherapy has not been considered to have any particularly important role in the therapeutic process and outcome. For instance, Anthony and Watkins in 2002 reported that they could found no information at all about the design of psychotherapists' or counselors' offices as a result of their extensive literature search. It is a common belief that any space can be turned into a therapy room. In many institutional settings like hospitals and schools, therapy rooms are often found in such a compromised location as the dark basement with no windows, with a hodgepodge of furniture collected from other offices. However, some researchers have recognized the potential effect of therapy room conditions (e.g., Pressly & Heesacker, 2001; Anthony and Watkins, 2002). The interaction between the client and the physical environment is potentially as important as the interaction between the client and the therapist in psychotherapy, and both should be examined (Fenner, 2011). For instance, research demonstrated that symbolic meanings derived from the therapy room could affect the client's impression of the therapist and the quality of therapy (Nasar & Devlin, 2011; Ito-Alpturer, 2016; Miwa & Hanyu, 2006).

1.2 Psychiatric Hospital Research and Its Implications

The physical environment of health care is an important factor that influences the experience of the patients during treatment and their well-being (Devlin & Arneill, 2003; Ulrich, 1991). However, psychiatric hospitals used to be prison-like custodial institutions. They were cold and inhuman rather than safe and comfortable healing places for patients. In the 1950s, a British psychiatrist Humphry Osmond, who was working in Canada, initiated collaborative efforts between psychiatrists, architects, and psychologists to improve the conditions of psychiatric hospitals and other hospitals (Osmond, 1957; Sommer & Osmond, 1960). This collaboration marks the beginning of what we call environmental psychology today. Inspired by Osmond's work, William Ittelson and Harold Proshansky's (as cited in Bonnes & Secchiaroli, 1995) research group at the City University of New York started studying how the ambient of a psychiatric hospital affected the patients' behaviors in 1958.

Researchers continued to work on and learn more about the spatial needs of people and to improve the conditions in psychiatric hospitals. Their findings not only demonstrated the relationship between the psychiatric patients' behaviors and the environmental conditions of the hospital but also highlighted the fundamental principle of human-environment interaction. One of the most important premises of environmental psychology is that people are not only influenced by their physical surroundings but also actively interact with and make sense of their surroundings. Through this interaction, a neutral space transforms into a meaningful place as individuals ascribe personal meanings to it. These meanings, which can either be positive or negative, and strong or weak, in turn, influence their actions in that place (Canter, 1977; Donald, 2022; Gifford, 2014a).

The early development of environmental psychology has been strongly inspired by Robert Sommer's (1983) idea of "social design" which emphasizes user need analysis and user involvement in the design process. Having worked with Osmond in the mental hospital improvement project, Sommer went on to become a pioneering environmental psychologist. His social design approach has contributed to the design improvement of not only hospitals but also prisons, nursing homes, offices, and many other facilities (Gifford, 2014ab).

The quality and comfort of the physical environment are also a crucial influence on the social interactions that occur there (Andrade et al, 2016). For example, in the study of the hospital environment, Osmond (1959, as cited in Sommer, 1969) discussed that seating arrangement and other interior design elements could either encourage or discourage social interaction. He coined the term "sociopetal" for the former type of setting and "sociofugal" for the latter type of setting. A study of the geriatric ward by Sommer and Ross (1958) demonstrated that the interaction between elderly female patients could be increased by changing the furniture arrangement of the room to the sociopetal one. Baker, Sivadon, and Davis (1960, as cited in Chrysikou, 2014), two doctors and an architect from France and the UK, jointly published "Psychiatric services and architecture" for WHO, suggesting that hospitals should not be like prisons, rather they should be as similar to the domestic environments as possible. The "domestic" here refers to the home environment as opposed to the institutional environment. Home is generally considered a secure retreat from the outside world (Altman & Werner, 1985), where people feel most comfortable, relaxed, and familiar (Sixthsmith, 1986). What Americans call "homeyness" (i.e., homelikeness, homeliness) includes characteristics such as small-scale, private, personal, reminding the past memory (e.g. childhood),

friendly and welcoming, not too neat, and having culturally shared aesthetics (McCracken, 1989). Having some of the characteristics of home is considered important for good environmental design not limited to the hospital design. The advantages of soft, homelike design, as opposed to hard, institutional designs have been discussed by environmental psychologists (e.g., Sommer, 1974; Sommer & Olsen, 1980). For example, the use of soft furnishing (fabric-covered bench seats, curtains, carpet etc.) in the classroom was found to have a long-term positive effects on students' participation and classroom behaviors (Wong et al., 1992). The therapy room is supposed to be a private, healing space that provides safety to the clients, so that they can express themselves freely (Frank, 1985). Therefore, the homey design elements that are likely to promote a sense of security are considered important.

1.3 The Potential Role of Therapy Room Designs from the Environmental Psychology Perspective

Psychological therapies generally take place in a one-on-one room setting occupied by the therapist and the client. The therapy room is an important, shared component in all kinds of therapies. Cumulative work in environmental psychology (Donald, 2022; Gifford, 2014ab) teaches us that physical surroundings have a substantial influence on individuals. Thus, the therapy room can also have either positive or negative impacts on clients' ideas and behavior. It can potentially play an important role in the psychotherapy process and outcome, just as what the hospital environment does to patients' treatment process and outcome. For example, the softness and homeyness of therapy room design may help clients feel more comfortable and relaxed, whereas sociopetal seating arrangement may encourage the communication between the client and therapist.

The physical environment has symbolic functions as well. Rooms can talk about the owner. Research demonstrated that the physical characteristics of a person's room have an impact on what others think of the person in the process of impression formation (Canter et al., 1974). Furthermore, these impressions can be quite realistic. Gosling and colleagues (2002) found that people who had recently examined someone's office and bedroom, usually have coherent and accurate impressions of the person. Given that, therapy rooms can also influence clients' first impressions of therapists. Indeed, a preliminary study by Ito-Alpturer (2016) showed that the judgment of counselor quality was affected by the furniture type and seating arrangement of counseling rooms. These room characteristics could be used as environmental cues to judge the therapist who works in the room. Thus, how the therapy room is designed is important. Therapy rooms possibly affect clients' expectations about the therapy as well. Supporting evidence for this hypothesis comes from the study of waiting rooms in a medical clinic. Arneill and Devlin (2002) found that furnishings in a doctor's waiting room affected patients' expectations about the quality of care they would receive. Higher expectations were found in waiting rooms that are nicely furnished with artwork and lighting which appeared warm. Their finding findings imply that furnishings in the therapy room can also affect clients' expectations about the quality of psychotherapy they would receive. Therefore, the therapy room cannot be seen as an element discrete from the therapy process.

One of the primary goals of environmental psychology is to create better physical environments that are more fitting to the user's needs (Gifford, 2014ab). Individuals' well-being can be affected by good or bad environmental design. From the social design (Sommer, 1983; Gifford, 2014ab) perspective, where the user needs analysis is the central

pillar, it would be beneficial if therapy rooms are designed based on the analysis of clients' needs. Research oriented by the social design approach has provided some important clues to designing more suitable places for users' needs, such as the location of psychological counseling offices on the university campus (Ito-Alpturer & Uslu, 2010). In the field of clinical psychology, however, the subject of inquiry is more commonly the contents, techniques, and process of psychotherapy itself. Therefore, very little attention has been paid to the effect of the physical environment where the therapy takes place (Fenner, 2011). The needs and opinions of clients are rarely researched when therapy rooms are prepared and used by clinical psychologists. Although psychotherapists do not always have control over the structural features of the building/room where they will practice psychotherapy, they can at least alter the interior design considering client needs.

1.4 Research on the Therapeutic Environment of Counseling and Psychotherapy

The therapeutic environment is a physical setting where therapy takes place. Ideally, the setting itself should also have a therapeutic effect, thus supporting and promoting the therapy process (Canter & Canter, 1979). In Sweden, Ulrich's (1991) theory of supportive design suggests that healthcare facilities such as hospitals should promote coping with stress by providing a sense of control to patients, increasing accessibility to social support, and using positive distractions. Like other healthcare facilities, the physical environment of psychotherapy should also be therapeutic. The first step to creating a "therapeutic" therapy room is to understand and provide a physical setting where the psychological needs of the clients are met. The needs during the therapy can be, for instance, having a sense of control, establishing the roles of therapist and client, feeling safe and secure, guarding privacy, ensuring order, and feeling comfortable (Watkins &

Anthony, 2007). Carefully designed psychotherapy rooms based on clients' needs would help the client in the psychotherapy process. For example, an orderly therapy room might provide feelings of consistency and structure which might be something that the clients lack in their lives.

So, what elements of the therapeutic environment are important for clients? Nasar and Devlin (2011), using 30 photographs of real psychotherapists' offices, indeed found that the orderliness, as well as soft/personalized style, of psychotherapists' offices were important and these attributes of the offices positively influenced the expectation of therapist quality, care, and comfort. Devlin and colleagues (2014) conducted the same study with samples from Vietnam and Turkey, and found that there was a high correlation between the responses of participants from different countries.

As discussed before, hospital research points towards soft and home-like design as opposed to hard, institutional design. In Turkey, Başkaya and colleagues (2005) indicate that it is possible to reduce the negative effects of spending time in hospital waiting areas with a well-designed environment and ensure the psychological comfort of the patients. They found that patients considered metal chairs uncomfortable and did not prefer such chairs in waiting halls. On the other hand, patients in another unit appreciated the soft, more comfortable chairs made of rubber. Patients felt more comfortable and stress-free in environments where aesthetic objects were used and they could feel the warmth of home (Sungur Ergenoğlu & Tanrıtanır, 2013). Noble and Devlin (2021) also found in their study that the most preferred waiting rooms were the ones that had quality décor, cozy furniture, and natural ambiance which the clients would prefer to use in their homes. "Homey" environments are the ones that give the feeling of a home or a sense of domesticity, and possess properties such as being embracing, informal and authentic

(McCracken, 1989). Thus, it is important to design warm, homelike environments for the well-being of patients. The positive impact of the environment on patient health is an issue that attracts more and more attention in healthcare facilities. However, a very limited number of studies exist in Turkey when it comes to designing a setting for psychotherapy.

Counseling room research also looked into the effect of soft design and homelike décor. Chaikin et al. (1976) found that clients are more likely to share private information in a counseling room with soft furniture compared to a room with hard furniture, because they felt more relaxed in the soft counseling room. Miwa and Hanyu (2006) also demonstrated that clients were affected by the physical environment of the room when it comes to talking about themselves. They found dim lighting had a positive impact on the participants' feelings, the impression of the counselor, and self-disclosure but no effect of home-like decoration. Ito-Alpturer et al. (2012) studied the preference for counseling room designs among students who were users of university counseling services. The results revealed that the five most liked rooms were all homey rooms with soft furnishing while the five most disliked rooms were institutional office-type settings with a desk and hard chairs. As regards unfavorable room types, Sinclair (2020) found that both clients and therapists significantly disfavored rooms with a medical/clinical appearance. Turkish students also expressed their dislike of "hospital-like" counseling facilities (Ito-Alpturer & Uslu, 2010).

Two decades ago, literature reviews by Pressly and Heesacker (2001) and Anthony and Watkins (2002) indicated that, although the design of counseling rooms and psychotherapist's offices was a potentially important subject for counselors and psychotherapists, only a small number of architects, environmental psychologists, and

psychological counselors looked into this subject. Since their reviews, there has been an increase in research on the physical environment of counseling and psychotherapy. Yet, studies are still limited and their implications are scattered. Existing research has examined the counseling or psychotherapy environment focusing on one or two variables chosen by researchers, for example, lighting and homelike décor (Miwa & Hanyu, 2006), type of artwork in the room (Devlin et al., 2013), style (soft/personalized) and orderliness of the office (Nasar & Devlin, 2011), and seating arrangement (Rickard et al., 2020). However, as Sinclair (2020) points out, not enough research has been done on which features of the rooms are more important than others for users, and how the client, the therapist, and the psychotherapy process and outcome, are affected by various components of the therapy room. More information should be gathered in order to have a clearer understanding of what aspects of the room are important, especially what clients, as users of the room, need and want.

1.5 Seating Arrangement and Furniture Type

Research showed that a certain seating arrangement influences the impressions of occupants more positively. Becker's (1983) study of seating arrangements in the office environment indicated that sitting behind a desk was perceived to be more authoritative and formal whereas more friendly and nurturing when there was no desk in between. Similarly, Zweigenhaft's (1976) study showed that faculty members who did not place a desk between themselves and a visiting student in their office was evaluated more positively by the students compared to those who sit behind the desk. Widgery and Stackpole (1972) found that less anxious people who were being interviewed perceived the interviewer to be more credible when there was a desk in between the two. On the

other hand, the highly anxious group of participants perceived the interviewer as more credible when there was no desk in between the two. This condition seems to apply in the counseling and psychotherapy environment as well. Considering that people seeking therapy are more likely to be anxious, it would be more suitable not to place a desk between the therapist and the client in the therapy room. Clients may also find a therapist sitting behind the desk very authoritarian. More recently, Lattimore's (2013) study of counseling settings confirmed that clients perceived their therapists as more empathetic when there was no desk between them during sessions. Eye contact is influenced by seating arrangement. A study of therapists' nonverbal behavior (Dowell & Berman, 2013) showed that therapists were considered more trustworthy and empathetic when they make eye contact more. Rickard and colleagues (2020) analyzed the formation of therapeutic alliance in terms of three important themes of seating arrangement, which are eye contact, proxemics (personal space, therapist-client distance), and perceived power dynamics. They found the face-to-face seating arrangement, which provides an appropriate distance and facilitates eye contact, to be the best for the development of a good therapeutic alliance.

A qualitative study of counseling room design by Pearson and Wilson (2012) revealed that seating arrangement and its effect is the most powerful theme in their research and that clients preferred cozy seating which can be moved around freely if desired. Another qualitative study by Sanders and Lehmann (2019) found that people tended to prefer a casual seating arrangement that resembles an informal meeting with friends. Based on their therapeutic alliance research, Rickard and colleagues (2020) suggest that seating arrangement gives a message about power dynamics between the client and the therapist and that clients felt more comfortable with a face-to-face

egalitarian seating arrangement in therapy sessions to talk about personal issues. One of the core values of humanistic counseling listed by Cooper (2009) is the maintenance of a non-hierarchical, democratic relationship between the therapist and the client. Emotional comfort provided by furniture such as armchairs is preferred by clients because it advances more easygoing, honest communication (Sanders & Lehmann, 2019). Therefore, clients' preference for face-to-face seating is in line with this idea. In Turkey, Ito-Alpturer et al. (2012) asked users of university counseling services to sort a set of room photographs into five groups, from the most liked to the most disliked. The content analyses of verbal explanations and Multidimensional Scalogram Analysis of preference sorting data both indicated that "seating arrangement" and "the type of room and furnishing" were the two most important criteria for evaluating counseling rooms. The users of counseling services preferred a counseling room where identical chairs for the therapist and the client were placed face to face without a desk/table dividing them. They also preferred soft, homelike rooms and furniture to hard, office-type rooms and furniture. In summary, the review of hospital research (Section 1.2) and the review of research on offices and counseling/psychotherapy rooms in this section both point toward the benefit of seating arrangement, furnishing, and overall décor that have a more informal, homelike appearance for clients to feel familiar and safe, compared to a formal, medical/clinical, office-like appearance.

In addition, Rickard et al. (2020) looked into the room arrangement with the Freudian couch, along with face-to-face and side-by-side arrangements. They found that all participants had a negative perception of the Freudian-couch arrangement. The seating arrangement in Freud's room can be perceived as sociofugal (Gifford, 2014a). The position of the client is interesting in Freud's office, where he sees, although not fully, the

client on the couch but not the other way around; In this way, he was able to listen to his patients silently and effectively, without interrupting their associations (Subotincic, 1999, as cited in Anthony &Watkins, 2002). Clinical professor of psychiatry and analyst David D. Olds (2006) reports that some critics of psychoanalysis emphasize that the couch is a damaging factor to the therapeutic relationship because it deprives the clients of the nonverbal communication cues in therapeutic interaction. In other words, it can be thought that some elements of communication between the therapist and the client are left out due to this seating arrangement. Rickard et al. (2020) suggest that it might be beneficial for the therapist to first form a therapeutic alliance with the client and then move on to the couch. It can be speculated that clients who are familiar with psychoanalysis will have a more favorable attitude toward the Freudian arrangement. However, empirical research on the effect of the Freudian couch is very rare.

1.6 Therapy Rooms in Media

Therapies and therapy rooms have also been frequently depicted in the media. Anthony (1998, as cited in Anthony & Watkins, 2002) analyzed the therapist rooms in *Good Will Hunting*, one of the classic films dealing with psychological issues. Here, the main character, who goes to therapy for a psychological problem, visits three different therapists' offices. The first office has a more somber and dark design. The main character sits in an armchair and the therapist sits behind the desk. The therapist in this office is also more serious and formal. In the second room, the character lies on a couch and the therapist tries to practice hypnosis by standing next to him. Again a rather cold environment is displayed there. The third room, on the other hand, gives the feeling of a more intimate, lived place. The therapist in this room is more sincere in harmony with the

design of the room and eventually succeeds in establishing a therapeutic relationship with the main character.

In recent years, there has been an increase in Turkish TV series' display of psychological therapies. One example of this is *Kırmızı Oda* (Karcı, 2020). In this series, we see a psychiatrist's office, where the therapist sits behind a desk. Dark-wood furniture covered with red fabric are used. The therapist's chair is different from visitor's chairs. The furniture and seating arrangement in *Kırmızı Oda* (Karcı, 2020) represent the typical psychiatrist's office in Turkey (See Figure 1). However the participants of Ito-Alpturer et al's (2012) counseling room evaluation study interpreted the counselor sitting across a desk as distancing from the client, and the desk as an obstacle to communication. Furthermore, the counselor sitting on a different type of chair (taller, larger, more luxurious etc.) than the clients chair was interpreted as a symbol of hierarchy and non-egalitarian relationship by the participants (Ito-Alpturer et al., 2012). Therefore, the seating arrangement in this therapy room portrays the therapist in a superior position. This room may leave an impression that the therapist is an authority who imposes a hierarchical relationship in therapy, although, in most cases of psychotherapy, the therapeutic relationship and the therapy process are something that the therapist and client will explore together. The therapist in this series is also the one that does many ethical violations such as boundary violations where she makes physical contact with clients and sometimes sees them outside the office. This kind of portrayal of the therapist and the therapy room can cause false expectations about the therapy process and the nature of the therapeutic relationship.

Another series that was discussed widely in psychological communities is called *Bir Başkadır* (Oya, 2020). Therapy in this series takes place in a state hospital. As there

are no curtains or carpet, it is not a soft, homelike design. It has an institutional appearance with hard furniture. The client’s chair that is made of steel pipes and wooden panels resembles a student’s chair in a classroom. The therapist again sits behind a desk on a taller office chair and the client sits on a hard, smaller chair on the other side (See Figure 2). As discussed before, the clients would find this seating arrangement non-egalitarian (Ito-Alpturer et al., 2012).

The other TV show where psychotherapy is depicted is *Çocuklar Duymasın* (Tekay, 2017). This room resembles a living room at home, where the therapist and the client can sit face to face in a cozy atmosphere. (See Figure 3). However, a large coffee table in the middle can set a distance between them. This type of the room was not particularly preferred by the participants of Ito-Alpturer et al. (2012) either.

These portrayals of therapy environments and therapists are important because they are influential on society's view of therapies, especially for people who are not very familiar with therapy. It is quite common for people with no previous therapy experience to have unrealistic expectations about the therapist’s behavior and the process of therapy when they first come to therapy.

Figure 1

Therapy room depicted in the Turkish TV series "Kırmızı Oda" (Karcı, 2020)

Figure 2

Therapy room depicted in the Turkish TV series "Bir Başkadır" (Oya, 2020)

Figure 3

Therapy room depicted in the Turkish TV series "Çocuklar Duymasın" (Tekay, 2017)

1.7 Psychotherapy Expectations

All psychotherapy methods are intended to help clients overcome some of the problems they are experiencing and/or learn new ways to cope with them. It is common for individuals to have ideas and expectations about what kind of therapy they will receive before they begin. These naturally occurring assumptions can both be about the therapist and the therapy itself. At the starting point of therapy, clients may make assumptions about their therapist, such as the credibility of the therapist, their competence, and how much the therapist can help them (Wampold, 2015). A client's expectation is an important predictor of whether they will continue their treatment or not. It is most appropriate to measure expectations before starting treatment since these expectations are anticipatory ideas (Dew & Bickman, 2005). If the reasons why some clients discontinue

their therapy are better understood, it can be possible to improve procedures to help them continue therapy and have better treatment results (Norberg et al., 2011).

Glass (2001) defines two major types of expectancies in psychotherapy, one of which is about the therapy process and the other one about therapy outcome. Expectations about the therapy process are related to what kinds of roles the therapist and the client will have during the process. Outcome expectations are about how much the client thinks the therapy will help them. Constantino (2012) also distinguishes psychotherapy expectations of clients into two types: during treatment and treatment outcome expectations and found that clients with higher outcome expectations were more likely to have adaptive outcomes. As for process expectations, clients' anticipation of what the behaviors of therapists and their own will be during the therapy is crucial, because it is likely that they will be more involved in the early collaboration if the expectation is positive. Thus, clients' expectations about therapy at the beginning play an important role in both the process and prognosis of psychotherapy.

There is a body of evidence showing that the clients' expectations do influence the actual outcome of psychotherapy (e.g., Constantino et al., 2011; Goldstein & Shipman, 1961; Greenberg et al., 2006). Thus, expectations are an important factor for the course of therapy. In the literature, expectations are generally defined as cognitive processes that occur naturally, and research focuses more on how these expectations affect the therapy itself (Greenberg et al., 2006). Although the number is limited, some studies have focused on determinants or predictors of early expectations for psychotherapy. Constantino and colleagues (2017) conducted a study in order to expand this knowledge. In their study with socially anxious participants, they found that having positive beliefs about psychotherapy, being psychologically minded (higher capacity to think about and

interpret one's own feelings and behaviors), and having prior therapy experience were associated with higher outcome expectations. Swift and colleagues (2012) found that higher levels of hope were positively correlated with positive outcome expectations; on the other hand, participants with higher levels of distress had decreased levels of expectations toward treatment. Some studies found that demographics played a role in outcome expectations. For example, being female (Vîslă et al., 2019) and being older (Tsai et al., 2014) were correlated with having higher outcome expectations.

The aforementioned studies were all concerned with internal factors. It is easy to speculate that one's expectations about psychotherapy are influenced by the client's prior knowledge about the nature of psychotherapy. This knowledge may come from one's past experience with psychotherapy. However, some information about psychotherapy can be acquired from their environment. Morrison and colleagues (2021), for example, conducted qualitative research with students who had no prior therapy experiences. Without the prior knowledge gained through past experience with psychotherapy, the researchers could examine other determinants of outcome expectations. As a result, they found that the students' expectations of psychotherapy outcome were influenced by external factors such as media, psychology coursework, and experiences of friends and family. These factors either positively or negatively influenced outcome expectations depending on how they were construed. However, they also found that coursework was more likely to have a positive impact, while incorrect information gained from other sources was more likely to produce a negative impact on the outcome expectations.

Given the evidence of the relationship between psychotherapy expectations and the actual therapeutic outcome, the clients' expectations should be taken seriously in the initial stages of the therapeutic encounter. If the expectations are better understood before

starting the therapy, the psychotherapist can approach the client accordingly. As discussed, existing research on the determinants/predictors of therapy expectation mainly investigated internal factors, namely, focusing on clients' characteristics. Only Morrison and colleagues (2021) identified environmental factors. As I discussed in the previous section, what clients saw in media may be an important source of information that influences expectations. Morrison and colleagues' (2021) research did find the influence of media on the expectations of people without prior therapy. On the other hand, research also suggests that, on the first visit to the therapist, the client may observe the environment (e.g., therapist's behavior, attire, and objects in their room) and interpret some meanings (Devlin et al., 2009; Devlin et al., 2013, Kerr & Dell, 1976). Based on the evidence of environmental inference in different types of rooms (e.g., Arneill & Devlin, 2002; Canter et al., 1974; Gosling et al., 2002), the design of therapy rooms (e.g., the choice and arrangement of furniture) is also expected to be observed by the client and used to infer meanings. However, no research so far investigated the effect of the setting of psychotherapy (i.e. an external factor) on expectations for psychotherapy. The present study was aimed at filling this gap in research.

1.8 Research Questions and Hypotheses

Research questions of the present study were:

1) if the interior design of therapy rooms (i.e., seating arrangement and furniture type) had an effect on the clients' expectations of psychotherapy, and also
2) if a person's prior experience of psychotherapy sessions made a difference in the formation of therapy-related expectations based on the room design.

The purpose of the study was to investigate the effect of three therapy room types on expectations about psychotherapy using a quasi-experimental design, where the participants' therapy-related expectations were measured after presenting different types of therapy rooms to them. The room types to be examined represent typical interior designs of therapy rooms in use in Turkey. Each room type represents a different combination of furniture types (i.e., (a) soft home-like, (b) classic Freudian couch, or (c) hard office-type) and one of the seating arrangements (i.e., (a) egalitarian, face-to-face without a desk, (b) psychoanalytical, therapist behind a couch, or c) hierarchical, face-to-face with a desk between). Namely, Room A (See Figure 4) harbors egalitarian seating where the therapist and the client are sitting in identical home-like chairs, and there is no desk between them. Room B (See Figure 5) features a Freudian couch, where the therapist's chair is behind the couch and unseen by the client, with home-like furnishing. Lastly, Room C (See Figure 6) has an appearance like a doctor's office, where the therapist sits in a bigger chair and there is a desk between the therapist and client, representing a more hierarchical relationship. The reason why the proposed study uses a general typology of therapy rooms, rather than focusing on a more specific environmental stimulus is that the study aims to deal with what environmental psychologists called "the molar physical environment" (Craik, 1970; Ward & Russell, 1981), rather than an artificially manipulated environmental condition of low ecological validity. Two subgroups of participants, those with therapy experience (i.e., who have visited therapy room as a client and experienced psychotherapy session) and those with no experience (i.e., who have never visited a therapy room as a client and never experienced any psychotherapy session), were included in the study considering whether having a therapy experience or not could affect perceptions of the therapy environment.

Based on the literature review and rationale presented below, two hypotheses were formulated. The primary hypothesis (H1) was about the effects of room types. In addition, the secondary hypothesis (H2) was about the interaction of psychotherapy experience and room type on the formation of psychotherapy-related expectations.

H1. The participants' mean scores of psychotherapy-related expectation would differ depending on the room they saw and the mean expectation score of Room A will be the highest of all.

Rationale: Research by Ito-Alpturer et al. (2012) in Turkey found that university students, who were users of counseling services, most preferred homelike counseling rooms with two identical chairs and no desk between them. As the Room-A type is generally perceived positively, it was predicted that positively perceived Room A would produce the highest therapy-related expectation.

H2. Differences between those with a prior psychotherapy experience and those without prior experience would be found in their therapy-related expectation mean scores of Rooms B and C, in that the therapy-experienced group would have a higher mean expectation for Room B, while the no-experience group would have a higher mean expectation score for Room C.

Rationale: Constantino and colleagues (2017) found that having prior therapy experience was associated with higher outcome expectations. Although Rickard et al. (2020) found that the Freudian-couch arrangement was negatively perceived by

their participants, those who have a prior experience of psychotherapy sessions as a client may be more familiar with the idea of psychoanalysis and the Freudian-couch room and therefore may have a more favorable expectation of Room B. On the other hand, Morrison and colleagues' (2021) research found media's influence on the psychotherapy-related expectations of people without prior therapy experience. The Room-C like therapy rooms are the most frequently displayed on the Turkish media. Therefore, it was predicted that the participants without therapy experience would have higher expectations for Room C due to familiarity, compared to unfamiliar Room B.

2 METHOD

2.1 Participants

The participants were 162 adult volunteers in the age range of 19-58 (M = 28.42, SD = 7.53). They were recruited online via social media using a convenience sampling method. The sample size was determined using G*Power 3.1 (Faul et al., 2007), by setting the power (1- β) at .80 and the alpha (α) at .05, with the expectation of a small effect size (η^2_p = .01). The 162 participants were composed of two subgroups: 81 with no experience and 81 individuals with therapy experience. A summary table of the two subgroups' demographics can be found in Appendix A.

The mean age of the no-therapy-experienced subgroup was 29.44 (SD = 7.98). Participants in the no-experience subgroup identified as female (55.6%), male (43.2%), and other (1.2%). The subgroup included university students (Bachelor's, Master's, and Doctorate programs combined) (35.8%), university graduates (Bachelor's, Master's, and Doctorate degrees combined) (60.5%), high school graduates (2.5%), and middle school graduates (1.2%). On the other hand, the mean age of the therapy-experienced subgroup was 27.40 (SD = 6.94). Participants in the experienced subgroup identified as female (72.8%), and male (27.2). The subgroup included university students (Bachelor's, Master's, and Doctorate levels combined) (43.2%), university graduates (Bachelor's, Master's, and Doctorate levels combined) (55.6%), and high school graduates (1.2%).

Types of therapy experienced by the latter group of 81 participants were made up of general psychological counseling (n = 27, 33.3%), cognitive behavioral therapy (CBT, n = 21, 25.9%), psychodynamic psychotherapy (n = 14, 17.3%), psychoanalysis (n = 4, 5.0%), EMDR Therapy (n = 4, 5.0%), and others (n = 11, 13.6%). As for the duration of

therapy, 35 out of 81(43.2%) answered less than 1 year. 34 (42.0%) said 1-5 years, four of them (4.9%) reported more than 5 years, and eight of them (9.9%) selected “other”.

2.2 Visual Simulations of Therapy Rooms

Three types of therapy rooms were prepared as realistic images (See Figures 4 – 6). Firstly, three-dimensional room simulations were created with architectural design software called Kuula (Kuula, n.d.). After that, the finest images with the right angle clearly displaying the variations in terms of furniture and seating arrangement were taken. As explained earlier in Section 1.8, these three room conditions represent realistic combinations of different choices of furniture and seating arrangements. Care was taken to create cultural authenticity of the rooms by using some Turkish-style décor such as a carpet. Room A features a room with homelike furniture and an egalitarian seating arrangement with two identical soft chairs and without a table or desk dividing them (Figure 4). Room B is a classical Freudian-couch room where the therapist and client cannot see each other (Figure 5). Room C represents hard, office-type furniture with a desk between the therapist and client which looks like a typical doctor’s office in Turkey (Figure 6). Care was taken to create cultural authenticity of the rooms by using some Turkish-style décor such as a carpet. The three visual simulations of therapy rooms were presented to the participants.

Figure 4

Room A: Homelike Furniture, Egalitarian Seating Arrangement, Face-to-Face

Figure 5

Room B: Classical Freudian-couch room, Therapist behind, Not Face-to-Face

Figure 6

Room C: Hard, Office Furniture, Hierarchical Seating, Therapist behind the Desk

2.3 Measurement of Therapeutic Expectations

A Turkish version of the Milwaukee Psychotherapy Expectations Questionnaire (MPEQ-TR, Çetinkaya & Güler, 2020) was used to measure the participants' expectations of the process and outcome of psychotherapy. Milwaukee Psychotherapy Expectations Questionnaire (MPEQ) was originally developed by Norberg and colleagues (2011) in the U.S. and it is a self-report measure. It is a 13-item scale that measures expectations about psychotherapy on an 11-point Likert-type scale from 0 *(not at all)* to 10 *(very much)*. The scale measures expectations about process and outcome in two subscales and a total score can be calculated. It includes items such as "I expect my therapist will provide support" and "My therapist will provide me with feedback" regarding the therapist's role expectations. It also consists of items such as "I will be able to express my true thoughts and feelings" and "I will feel comfortable with my therapist" in relation to the client roles. A higher composite score means a higher expectation. Cronbach's alpha coefficient of the original scale was α = .90 and the test-retest correlation was .83 (Norberg et al., 2011). According to Çetinkaya & Güler (2020), the psychometric quality of the Turkish version of (MPEQ-TR) is suitable. Cronbach alpha for the process expectations subscale was *α* = .84 and for the outcome expectations subscale was *α* = .88. Factor loadings varied between .48 and 74 for the process expectations, and for the outcome expectations it ranged between .74 and .87. The test-retest reliability coefficients for the process expectations and for the outcome expectations were .82 and .76 respectively (Çetinkaya & Güler, 2020).

The Cronbach's alpha coefficients for the two subscales and the total scale according to the data of present study are shown in Table 1. They were all above .95. As a

minimum Cronbach alpha of .80 and .90 for applied science is considered acceptable for internal consistency (Nunnally, 1967), the internal consistency of the scale was excellent.

Table 1

Reliability Statistics of Milwaukee Psychotherapy Expectations Questionnaire (MPEQ-TR)

Measures	*n* of items	Cronbach's α
MPEQ-TR Process Subscale	9	.957
MPEQ-TR Outcome Subscale	4	.956
MPEQ-TR Total	13	.969

2.4 Research Design

The present quasi-experimental research was based on a 2 x 3 mixed factorial design. Two subgroups of participants, one group having therapy experience and the other not having therapy experience, were compared (i.e., 2-level between-subjects factor). The participants were not assigned to one of the three room conditions. Instead, they all went through three room conditions in one of counterbalanced orders, and psychotherapy expectation was measured under each room condition (i.e., 3-level within-subjects factor).

2.5 Procedure

The online questionnaire was prepared using Qualtrics. A link to the Qualtrics online questionnaire was posted on social media. The participants who clicked the link were asked to fill in the online questionnaire. It started with an informed consent form (See Appendix B). The participants proceeded to the next section of the questionnaire if they agreed to the informed consent form. The first question following the consent page was a question: "Have you found yourself in a psychotherapist's/counselor's office before as a client?" (See the original Turkish question and answer choices for Appendix C). In the next section, one of three room images (Figures 2, 3, & 4) appeared with an instruction:

> Please inspect the image of a therapy room. Imagine you visited there to see a psychotherapist. What your psychotherapy experience would be like? Please answer the questionnaire below according to your expectations. [*Lütfen görseldeki terapi odasını inceleyiniz. Buraya bir psikoterapist ile görüşmeye gittiğinizi hayal ediniz. Burada nasıl psikoterapi deneyimleriniz olabilir? Beklentinize göre aşağıdaki anketi doldurunuz.*]

The MPEQ-TR items (See Appendix D) followed immediately after that. The participants were asked to report their therapy expectations on the provided scale based on the room they just saw. All three rooms appeared one by one with the same instruction each time paired with MPEQ-TR items. The order of appearance of the three therapy rooms was automatically counterbalanced by Qualtrics to control order effects. Each participant was randomly assigned to one of the six possible room sequences (ABC, ACB, BAC, BCA, CAB, CBA).

Then followed were two open-ended questions (See Appendix E) asking what attracted their attention in the rooms and what they liked and disliked about the rooms. In the last

part, the demographic form (See Appendix F) collected data on participants' age, gender, place of residency and educational status. Only for those who answered "yes" to the first question (Appendix C), the type of therapy they received and its duration were asked. The questionnaire ended with a debriefing form (See Appendix G), giving additional information about the research and thanking the participant.

The participants were automatically sorted into two subgroups based on their answer to the first question (Appendix C). A quota of 81 respondents was preset for both the "Yes (therapy experienced)" group and the "No (therapy inexperienced)" group. Those who answered "Online only" ($n = 6$) were excluded from the main data set. Qualtrics allowed the respondents to the questionnaire until the quota was filled.

2.6 Research Ethics

Ethical approval was obtained from Yeditepe University Human and Social Research Ethics Committee (No. E.50532705-302.14.01-1321) (Appendix H). Informed consent was obtained from all participants prior to the study.

3 RESULTS

3.1 Descriptive Statistics of the Data

Table 2 shows the descriptive summary of the participants' responses to the Milwaukee Psychotherapy Expectations Questionnaire. Before the analysis, the distribution was controlled for each of the 18 cells of the design, namely 2 subgroups (with or without therapy experience) x 3 room types x 3 scales (the process subscale, the outcome subscale, and the total scale of MPEQ-TR). Kolmogorov-Smirnov test initially suggested non-normality of seven out of 18 distributions, although examination of histograms, box-plots, skewness and kurtosis proved otherwise. Skewness was in the range between 0.993 and 0.092 ($SE = .267$) and kurtosis was between -1.058 and 0.744. ($SE = .529$). Both were within the range of ±2, which is generally considered to be normal (George & Mallery, 2010). Z scores for skewness and kurtosis were also checked according to Kim's (2013) criterion of $Z = \pm 3.29$ for $N > 50$. Judging comprehensively, the data was deemed to satisfy the normality assumption.

The interscale correlations between the process expectation and the outcome expectation subscales were in the range between .80 and .88. Typical correlations between subscales are said to be in the range of .30 and .60 (Vickers, 2004). The extremely high interscale correlations indicate low discriminant validity of the subscales, meaning that there is too much overlap between what the two subscales were measuring (Lyons-Thomas, 2014). Therefore, rather than using the two separate subscales, the composite, total expectation scores were used for the analysis.

Table 2

Summary Statistics Table for Scores on Milwaukee Psychotherapy Expectations Questionnaire

With Therapy Experience [a]	*M*	*SD*	*Min*	*Max*	Skewness [b]	Kurtosis [c]
MPEQ-TR Process Subscale						
Room A	7.12	1.90	1.00	10.00	-.993	.744
Room B	5.41	2.16	1.00	10.00	-.282	-.554
Room C	4.69	2.36	0.00	9.44	-.168	-.884
MPEQ-TR Outcome Subscale						
Room A	6.68	2.09	1.00	10.00	-.514	-.414
Room B	5.51	2.28	0.00	10.00	-.308	-.438
Room C	4.65	2.51	0.00	10.00	-.058	-.736
MPEQ-TR Total						
Room A	13,80	3,77	2.00	20.00	-.755	.351
Room B	10,92	4,26	1.11	20.00	-.324	-.401
Room C	9,34	4,77	0.00	19.44	-.118	-.801
With No Therapy Experience [a]	*M*	*SD*	*Min*	*Max*	Skewness [b]	Kurtosis [c]
MPEQ-TR Process Subscale						
Room A	6.31	2.21	0.89	10.00	-0.668	-0.109
Room B	5.33	2.20	1.00	10.00	-0.266	-0.897
Room C	4.53	2.48	0.00	10.00	0.092	-0.920
MPEQ-TR Outcome Subscale						
Room A	5.85	2.51	0.00	10.00	-0.568	-0.191
Room B	5.21	2.63	0.00	10.00	-0.398	-0.858
Room C	4.44	2.69	0.00	10.00	0.022	-1.058
MPEQ-TR Total						
Room A	12,17	4,52	1.39	20.00	-0.646	0.032
Room B	10,55	4,54	1.67	20.00	-0.309	-0.936
Room C	8,97	4,96	0.00	20.00	0.020	-0.862

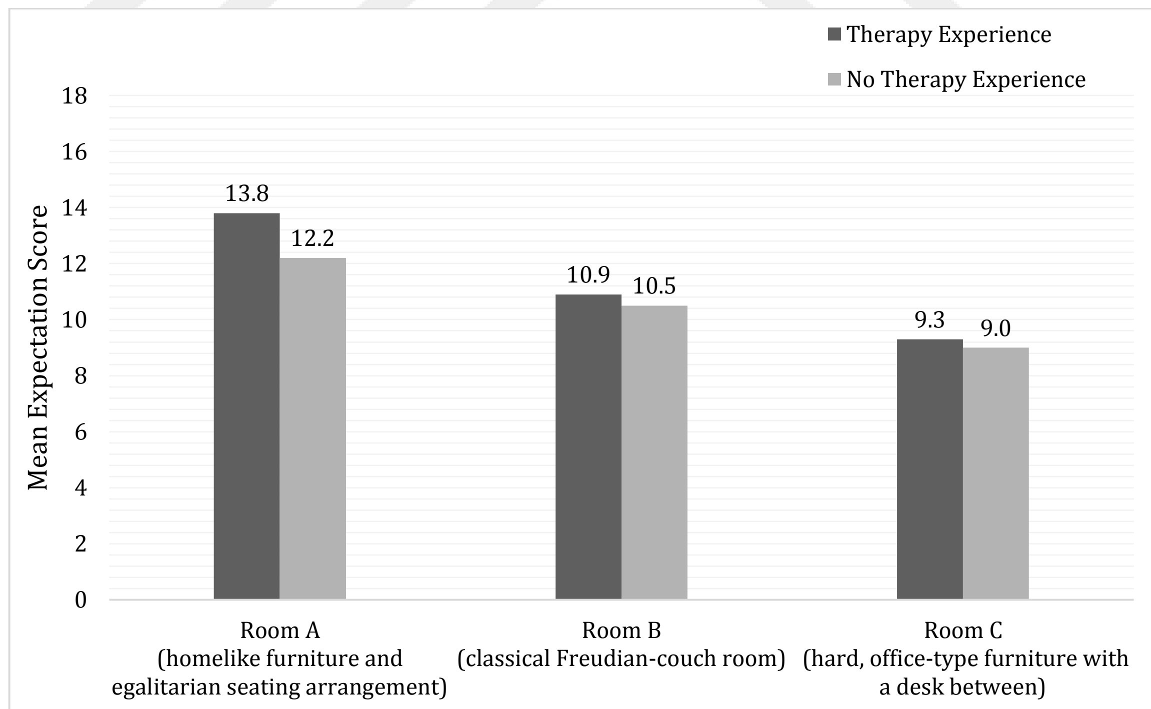
a. *n*=81, b. *SE* =.129, c. *SE*=.257.

3.2 Hypothesis-Testing Analyses

Figure 7 indicates the estimated marginal means of total expectation scores of two subgroups across the three rooms. To test if the differences between the mean expectation scores of three rooms conditions (A, B, & C) and those of the two subgroups (with or without therapy experience) were statistically significant, a 2 x 3 factorial ANOVA, with one between-subjects factor and one within-subjects factor was performed. Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = .546$, $p = .761$.

Figure 7

Estimated Marginal Means of Milwaukee Psychotherapy Expectations Total Scores by Room and Psychotherapy Experience



Multivariate tests of within-subjects effects showed that there was no significant interaction between therapy experience and room type, Wilks' Lambda = .976, F (2,159) = 1.967, p = .143, η^2_p = .024. A significant large main effect was found for room type, Wilks' Lambda = .583, F (2,159) = 56.953, $p < .001$, η^2_p = .417, with the highest expectation score for Room A (M = 13.0, SE = 0.32) followed by Room B (M = 10.7, SE = 0.35), and Room C (M = 9.2, SE = 0.38). Pairwise comparisons of rooms with Bonferroni adjustment (at an α of .05) found that the differences between three pairs of rooms were all significant ($p < .001$). Thus, therapy expectations clearly differed by room conditions and the highest expectation was derived from Room A, thus supporting the primary hypothesis of this research.

Table 3 presents the sphericity-assumed results of univariate tests of between-subjects effects together with the tests of within-subjects effects from the 2 x 3 mixed factorial ANOVA. The between-subjects tests found no main effect of therapy experience. Thus, therapy experience did not make a difference in participants' psychotherapy expectations. The within-subject test found a significant main effect of room conditions, while the interaction between therapy experience and room conditions was not significant. Overall, psychotherapy experience did not change the participants' therapy-related expectations of the three rooms. The two subgroups' mean expectation scores for each room were at very similar levels (See Figure 7). Regardless of their therapy experience, the highest expectation was derived from Room A, while the lowest expectation was from Room C. Since there was no significant difference between the two subgroups, the secondary hypotheses was rejected.

Table 3

Analysis of Variance (ANOVA) Results for Psychotherapy Expectation as a Function of Room and Psychotherapy Experience

Source	*SS*	*df*	*MS*	*F*	*p*	η^2_p
Between-subjects effects						
Experience	76.29	1	76.29	1.911	.169	.012
Error	6387.70	160	39.92			
Within-subjects effects						
Room	1.197.28	2	598.64	58.72	<.001	.268
Room x Experience	42.65	2	21.33	2.09	.125	.013
Error	3262.60	320	10.20			

3.3 Post hoc Analysis of the Effect of Experienced Therapy Type

An additional analysis was conducted to compare the participants who had previously experienced different types of therapy. Only those who experienced either psychoanalysis or psychodynamic therapy (n = 18) and those who had an experience with CBT (n = 21) were selected for this analysis. In order to make the first group, the participants who had experienced psychoanalysis (n = 4) and those who had experienced psychodynamic therapy (n = 14) were combined, thus making a total of 18. The participants who experienced general psychological counseling, other types of therapy, or those who had experienced more than one therapy type were excluded.

Figure 8

Estimated Marginal Means of the Milwaukee Psychotherapy Expectations Questionnaire Total Scores by Room and Experienced Psychotherapy Type

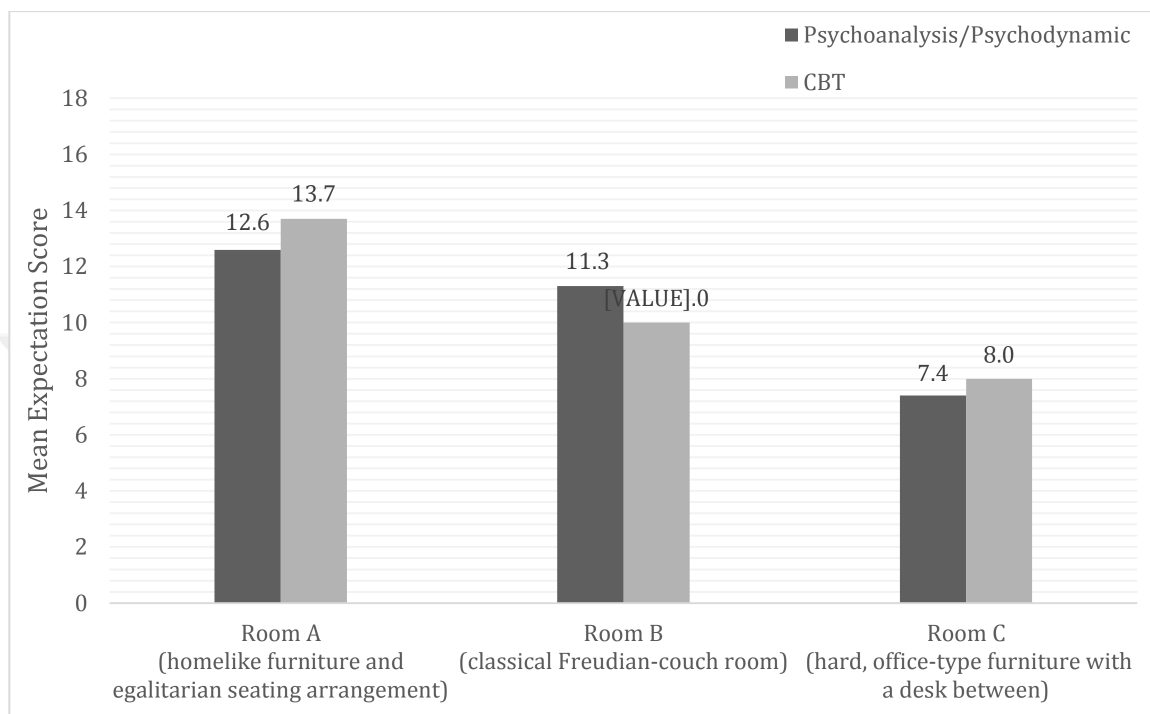


Figure 8 shows the difference between the mean expectation scores of the psychoanalysis/psychodynamic therapy group and those of the CBT group separately for each room. For Room A and Room C, the CBT group's expectation scores were slightly higher than the psychoanalysis/psychodynamic group. As for the expectation scores of Room B, the reverse pattern was found, where the psychoanalysis/psychodynamic group's mean expectation score was a little higher than the CBT group's expectation. To check if the difference between the groups across the three rooms was statistically significant and if the type of therapy the participants experienced influence their room-based expectations therapy type, a 2 (therapy types) x 3 (room conditions) mixed factorial ANOVA was conducted. Mauchly's Test of Sphericity indicated that the assumption of

sphericity had not been violated, $\chi^2(2) = 1.230$, $p = .541$. Multivariate tests of within-subjects effects showed that there was no significant interaction between the two therapy types and room conditions, Wilks' Lambda = .902, F (2,36) = 1.958, $p = .156$, $\eta^2_p = .098$. However, the main effect of room conditions was highly significant. Wilks' Lambda = .468, F (2,36) = 20.499, $p < .001$, $\eta^2_p = .532$, with the highest expectation score for Room A (M = 13.2, SE = 0.67) followed by Room B (M = 10.7, SE = 0.64), and Room C (M = 8.1, SE = 0.75). Pairwise comparisons of rooms with Bonferroni adjustment (using an α of .05) found that the differences between three pairs of rooms were all significant ($p < .01$).

Table 4 presents the sphericity-assumed results of univariate tests of between-subjects effects together with the tests of within-subjects effects from the 2x3 mixed factorial ANOVA. The main effect of therapy type was not significant. The interaction between therapy type and the room conditions was not significant, either. Thus, the between-group differences observed in Figure 8 were non-significant ones. Namely, therapy type did not make a statistically meaningful difference in participants' psychotherapy expectations. Only the main effect of room conditions was statistically evident.

Table 4

Analysis of Variance (ANOVA) Results for Psychotherapy Expectation as a Function of Room and Psychotherapy Type

Source	*SS*	*df*	*MS*	*F*	*p*	η^2_p
Between-subjects effects						
Therapy Type	5.749	1	5.749	.172	.681	.005
Error	1235.30	37	33.387			
Within-subjects effects						
Room	495.982	2	247.991	22.599	.000	.379
Room x Therapy Type	40.615	2	20.307	1.851	.164	.048
Error	812.026	74	10.973			

3.4 Theme Analysis of Responses to Open-Ended Questions

There were two open-ended questions in the questionnaire: “What in these rooms attracted your attention? [*Bu odalarda neler dikkatinizi çekti?*]*”* and “What in these rooms did you like or dislike? [*Bu odalarda sevdiğiniz/sevmediğiniz neler oldu?*]*”*. 140 participants (86.4 %) answered the first question and 142 participants (87.7 %) answered the second question, of which 137 participants (84.6%) answered both questions. With respect to the contents, 101 participants (62.3%) talked about seating arrangements, and 67 participants (41.4%) commented on furnishing. Answers to these questions were analyzed via thematic analysis (Braun & Clarke, 2006), only focusing on the statements concerned with seating arrangement and furnishing. The aim of the analysis was to gain a deeper understanding of what elements in these therapy rooms were important for the participants and what they meant to them. The researcher read answers carefully and

came up with several recurring themes. Five major themes emerged in total as relevant descriptive data was collated. Three themes were regarding seating arrangement: *Sincerity, Power Dynamics*, and *Feeling of Security.* The other two themes were concerning furnishing, which were *Simplicity* and *Homeyness.*

3.4.1 Seating Arrangement Theme 1– Sincerity

One of the themes that the participants cared about very much was sincerity ("*samimiyet"* in Turkish). This Turkish word also implies intimacy and warmth. It played an important role in how they felt about the therapy and the therapist. They stated that sincerity is important in the therapy process and that the seating arrangement and furniture affect their feelings on this issue. In this context, the most favored room was Room A (homelike furniture, egalitarian seating arrangement, face to face).

> I need to make eye contact with the therapist so that I can realize how well they can listen and understand me, how much I can express myself, and achieve sincerity. [*Terapist ile göz teması kurmalıyım ki beni ne derece dinleyip anlayabiliyor, ben ne kadar kendimi anlatabiliyorum onu fark edeyim, samimiyet kurabileyim.*] (Participant No. 65, Age 30, No counseling experience)

> The room with two armchairs facing each other made me feel more sincere and more comfortable. I thought I could be more open in that room. [*Karşılıklı iki koltuğun bulunduğu oda bana daha samimi ve daha rahat hissettirdi. O odada daha açık olabileceğimi düşündüm.*] (Participant No. 6, Age 26, Experience)

> I thought that I would feel more sincere and comfortable, especially where we look face to face. [*Özellikle yüzyüze baktığımız kısımlarda daha samimi ve rahat hissedeceğimi düşündüm.*] (Participant No. 26, Age 21, No counseling experience)

3.4.2 Seating Arrangement Theme 2– Power Dynamics

Participants felt that the seating arrangement carried a message about the relationship between the therapist and the client. Most of the participants thought of Room C (hard, office-type furniture, desk between the therapist and client) as hierarchical and that it would not feel like therapy under such circumstances.

> In the room with a desk in between, I felt myself in a tense situation in front of the doctor. [*Masalı olan fotoğrafta kendimi doktor karşısında gergin bir durumda hissetmeme sebep oldu.*] (Participant No. 30, Age 25, No counseling experience)

> I think that having the therapist behind the desk in the last room creates a cold environment, which I didn't like. [*Son odada terapistin masanın arkasında olmasının soğuk bir hava kattığını düşünüyorum bunu sevmedim*.] (Participant No. 40, Age 24, No counseling experience)

> I do not believe that, in the room where a table is in the middle and a hierarchical relationship is clearly displayed, the relationship between the therapist and the client will be established as it should be. [*Bir masanın ortada bulunduğu ve hiyerarşik bir ilişkinin açıkça sergilendiği odada terapist-danışan arasındaki*

ilişkinin olması gerektiği gibi kurulacağına inanmıyorum.] (Participant No. 25, Age 22, No counseling experience)

I felt like I was in a job interview in the room where the therapist was behind the desk. [*Terapistin masanın arkasında olduğu odada kendimi mülakatta gibi hissettim.*] (Participant No. 9, Age 30, No counseling experience)

Participants had opposing opinions and ambivalent feelings about Room B (classical Freudian-couch room). While some thought it would be comfortable to lie on a couch and talk about themselves, others thought not being able to see and check the therapist's behavior would be uncomfortable.

I liked the couch in the room for the expression of real feelings and thoughts. [*İkinci odada gerçek duygu ve düşüncelerin ifadesi açısından divanı sevdim*.] (Participant No. 68, Age 35, No counseling experience)

It doesn't make me feel comfortable having the therapist sitting behind me while I'm lying down. Sitting face-to-face creates a more comfortable situation and gives the feeling of being more equal with the other side. [*Ben yatarken terapistin arkamda oturması beni rahat hissettirmez. Karşılıklı koltukta oturmak daha rahat bir ortam yaratıyor ve karşı tarafla daha eşit olma hissi veriyor.*] (Participant No. 13, Age 25, No counseling experience)

> Although the lack of eye contact in the first room (Room B) may make it easier to speak, I won't be able to see if the therapist is listening. [*İlk odada göz teması olmaması daha rahat konuşmayı sağlama ihtimali bulunsa da psikoloğun dinleyip dinlemediğini göremeyeceğim.*] (Participant No. 50, Age, 27, No counseling experience)

Power dynamics is about who has control over the other. Not being able to see what the therapist is doing means a lack of control on the client's side.

3.4.3 Seating Arrangement Theme 3 – Feeling of Security

Another important theme for the participants was if they could feel safe and secure. The type of room presented affected their feelings of security and comfort. In this regard, the most reassuring room was Room A.

> The third room (Room A), I think, was the room I saw closest to myself and where I felt most comfortable and safe." [*Üçüncü oda sanırım kendime en yakın gördüğüm ve kendimi en rahat ve güvende hissedeceğim oda oldu.*] (Participant No. 8, Age 25, Experience)

> Being face to face with my therapist makes me feel safer. [*Terapistimle yüz yüze olmak bana daha güvende hissettirir*.] (Participant No. 49, Age 24, Experience)

> Going through therapy without eye contact and feeling of security would make an already difficult process even more difficult. [*Göz temasından ve güvenden uzak*

bir şekilde terapi almak, zaten zor olan bir süreci daha da zorlaştırırdı.] (Participant No. 7, Age 27, Experience)

3.4.4 Furnishing Theme 1 – Simplicity

Participants tended to prefer a simple therapy room in terms of colors and objects used in the room. The main reason for this is that it does not cause distraction. Many participants stated that they would like a less busy, less cluttered room with plain colors. In this respect, many commented on the carpet being too multi-patterned and colorful and thus distracting. Some suggested that a more modest one with neutral colors and patterns could be used. Others expressed an opinion that it was too oriental and that it was inappropriate for a therapy room.

> In general, the simplicity of the rooms is beneficial in terms of not being distracted. [*Genel olarak odaların sadeliği dikkat dağınıklığı olmaması açısından faydalı*.] (Participant No. 65, Age 30, No counseling experience)

> The carpet in the room caught my attention too much and I thought it might distract me during therapy. [*Odadaki halı çok fazla dikkatimi çekti ve terapi sırasında dikkatimi dağıtabileceğini düşündüm*.] (Participant No. 26, Age 21, No counseling experience)

> Ethnic patterned carpet can be tiring as it makes the room look a bit crowded. [*Etnik desenli halı biraz odayı kalabalık gösterdiği için yorucu olabilir.*] (Participant No. 7, Age 25, No counseling experience)

> I think a more elegant carpet with a plain color should be used. [*Bence düz renk daha elegant bir halı olmalı.*] (Participant No. 62, Age 19, No counseling experience)

3.4.5 Furnishing Theme 2 – Homeyness

The other factor that the participants cared about was if the rooms felt like home. They stated that the feeling of being at home made them feel comfortable and pleased. In this context, the carpet was liked, but it was also suggested that a more modest one with neutral colors and patterns could be used.

> It is intimate, the color of the walls are pleasant, the carpet gives feeling of being at home. [*Samimi, duvarların rengi içi açıcı, halı sanki evdeymiş hissiyatı veriyor*.] (Participant No. 38, Age 22, Experience)

> The pattern of the carpet caught my attention. It has an authentic texture, it felt like a living room at home. [*Halının deseni dikkatimi çekti. Otantik bir dokusu var, evdeki salon hissi uyandırdı.*] (Participant No. 52, Age 23, Experience)

3.5 Theme Analysis Summary

The identified themes indicate what meanings they infer from the conditions of therapy rooms. The “sincerity” theme points to the importance that clients give to the relationship they will establish with their therapist. The “power dynamics” theme and the “feeling of security” theme are again about the client’s relationship with the therapist. The “feeling of security” theme suggests that varying patterns of seating arrangement also gives a message about whether the therapy room is a secure place or not. These themes also represent what elements clients value in the therapy rooms. In terms of furnishing, the participants expressed their preference for therapy room furniture that is comfortable and cozy, just like the one that could be used at home. At the same time, the participants expressed their idea that plain furnishing is more suitable for the therapy.

4 DISCUSSION

4.1 Overview of the Results

This study was conducted in order to examine the effect of three therapy room types on expectations about the psychotherapy process and its outcome. The result clearly indicated that the participants' expectations about psychotherapy differed by the type of therapy room they saw. Having therapy experience or not did not affect the levels of expectations that were associated with the three room types. Firstly, the different types of rooms produced differing levels of expectation about psychotherapy. Furthermore, regardless of having therapy experience or not, both subgroups' expectations about psychotherapy were the highest when based on the therapy room with home-style furniture and egalitarian seating arrangement (Room condition A). Thus, the primary hypothesis was fully supported. Secondly, with respect to the participants' expectations based on the three rooms, the differences between the therapy-experienced subgroup and the no-therapy-experience subgroups were statistically non-significant. No significant interaction was found between therapy experience and the rooms, either. Thus, the secondary hypothesis was not retained. The room-based expectations were in the same order (i.e. Room A > Room B > Room C) for both therapy-experienced and no-therapy-experienced subgroups. The findings showed that the therapy room with home furniture and an egalitarian seating arrangement led to higher expectations than any other rooms. Room resembling a doctor's or manager's office led to the lowest expectation.

4.2 Environmental Inference in the Therapy Room

Judging from the high expectation associated with Room A and comments made by the participants to the open-ended questions, positive meanings (e.g. intimacy, warmth, comfort, safety, security, feeling at home) were inferred from this room where the client and the therapist sit on the same type of soft chairs facing each other. This result is in line with previous research (e.g., Sanders & Lehmann, 2019; Ito-Alpturer et al., 2012; Watkins & Anthony, 2007). On the other hand, judging from the lowest expectation scores for Room C and comments made by respondents to open-ended questions, negative meanings (e.g. cold, tense, hierarchical) were inferred from the room with hard office-type furniture where the therapist sit behind a large desk. This result supports the previous study conducted in Turkey on the users' evaluation of counseling room samples (Ito-Alpturer et al., 2012), where the most negatively evaluated rooms were of this type.

The results of the present study suggest that the participants were able to infer positive or negative meanings from the physical characteristics of therapy rooms and, based on the inferred meanings, they could form different expectations. Furthermore, the present research confirmed that this kind of environmental inference does not necessarily require prior experience of visiting the therapy room. Devlin and colleagues (2013) also found that clients' perceptions of a therapist based on artworks present in the therapy room were unrelated to their therapy experience. This means that clients without prior experience with psychotherapy can easily form expectations based on the room appearance, in the same way as those with therapy experience do. The appearance of the therapy room can be a useful source of information especially for first-time clients' initial expectations about therapy.

4.3 Seating Arrangement and the Type of Furnishing

The seating arrangement and the type of furniture used are important clues for clients to form some ideas about the therapy, the therapist, and the therapeutic relationship. Qualitative analysis reveals that clients are able to infer different meanings by observing the furnishing and arrangement of a therapy room. By means of theme analysis focusing on the descriptions of furnishing and seating arrangement, themes that are important for the participants were revealed. In terms of furnishing, simplicity (non-distraction) and homeyness (comfortable like home) were appreciated by the participants. What clients value with respect to seating arrangement were sincerity ("*samimiyet*" – also meaning intimacy and warmth), and a feeling of security (feeling safe and protected). The seating arrangement was also used to infer a kind of power dynamics (who has control?) in the therapeutic relationship. These findings parallel the findings of previous research by Becker (1983), Ito-Alpturer et al. (2012), Pearson and Wilson (2012), Lattimore (2013), Sanders & Lehmann (2019), and Rickard and colleagues (2020).

For example, Rickard and colleagues' (2020) research also found that the seating arrangement gave a certain message to clients about the relationship between therapist and client. However, a difference between their study and the present study was that their participants negatively judged the Freudian couch as hierarchical, while, in this study, the room with the couch (Room B) was considered not so hierarchical and judged relatively less negatively compared to the room where the therapist sits behind the desk (Room C). The Freudian couch seemed to invoke mixed feelings among the participants. Some find it intimate and the most suitable arrangement to talk about private matters. Others found it uncomfortable due to the lack of eye contact with the therapist who is sitting behind the

client. One said that it is impossible to check if the therapist is listening or not. The discomfort they felt about Freudian-couch room seems to originate from the lack of control felt by the clients' side. The sense of control was one of the essential elements of the supportive healthcare environment in Ulrich's (1991) theory as well.

Research on office seating arrangements in the past suggested that sitting behind a desk frequently results in negative impressions. Becker (1983) found that the seating behind the desk was perceived to be authoritative. Lattimore's study (2013) suggested that not having a desk between the therapist and the client during therapy sessions might increase the perceptions of the positive client-therapist rapport. The results of the present study support these previous findings.

4.4 Clinical and Design Implications

One of the strengths of this research is that it deals with a topic that has received very little attention in the field of clinical psychology in Turkey. Although there is some research in Turkey regarding the design of healthcare facilities to meet the needs of patients, research specific to the psychotherapy or psychological counseling setting is almost non-existent. Therefore very little information exists when it comes to what psychotherapy clients in Turkey need and want, and how they are affected by the design of therapy rooms. The present study filled this gap in the literature by investigating the effect of room designs with the Turkish sample, especially focusing on the formation of psychotherapy-related expectations.

Increasing research points to the necessity of designing therapy rooms where the needs and desires of the clients are prioritized. Although it may be quite difficult to find a

design solution that fits everyone, the proper user need analysis can help create some room designs that are preferred by most people.

The present study provided research evidence for the importance of egalitarian seating arrangement and homelike furnishing for Turkish clients. It is important that clinical psychologists become more aware of these design themes. The findings of the present study can be applied when designing the actual therapy room or counseling offices. The clients' needs in therapy rooms should be taken into account in the decision-making process. For example, counseling offices resembling Room C, where the therapist and the client sit across the desk, are most commonly used in schools, universities, hospitals, municipalities, and other public institutions in Turkey. However, given the negative meanings ascribed by Turkish participants in the present study and also the previous study (Ito-Alpturer, 2012), it is advisable to reconsider the use of this type of room. A homey room like Room A, where the therapist and the client sit without a desk dividing them, may be more appropriate for the therapy room environment because it is of at most importance that the clients feel at home and comfortable.

When designing the therapy room, therapists should be aware of the messages it can carry to the clients. Taking into account clients' needs and wants can help them create a more client-centered and effective therapy room. The therapy room should be extra carefully prepared for the client's first visit, as a caution against the formation of wrong first impressions and expectations. The therapist should not forget that the therapy room can lead to some therapy-related expectations, and according to research evidence (e.g., Constantino et al., 2011; Goldstein & Shipman, 1961; Greenberg et al., 2006), expectations do influence the actual outcome of therapy. Therefore, instead of a hit-and-miss method of designing, which is commonly used by many psychotherapists, graduate programs in Clinical Psychology can teach future clinicians about the

significant aspects of designing a therapy room (Watkins & Anthony, 2007). It is strongly recommended to pay attention to the choice of furniture and seating arrangement while arranging the therapy room.

4.5 Methodological Strengths

Methodologically, the present study is one of its kind. Firstly, the expectation of psychotherapy, in terms of both the process and the outcome, was measured as a dependent variable of the therapy room design. As discussed in Section 1.7, the determinants/predictors of psychotherapy-related expectations have not been sufficiently studied. Especially, we know little about how external factors influence expectations about psychotherapy. No known study investigated the effect of therapy room design on psychotherapy-related expectations. Studying the effect of the therapy room on the perception of a therapist and the psychotherapy process is methodologically difficult because measurement of these can be done only after they interacted with the therapist and have the actual experience of therapy in the real therapy room. Scales to measure the quality and effectiveness of a psychotherapist or psychotherapy usually require real experiences as well. Therefore, the present study focusing on the expectation of psychotherapy instead of the perception of psychotherapy was a good solution for this methodological difficulty. The difference between expectation and perception is that expectation is the anticipation of the future while perception is the current understanding of something. Therefore expectations can be measured before the clients start the real sessions. Measuring the expectation that is influenced by the environment was theoretically relevant and methodologically innovative since it can be done without

simulating the therapy sessions. Instead, it was possible to use visual simulations of different rooms to examine the participants' anticipation of the imagined therapy.

Secondly, the present study focused on the combination of seating arrangement and furniture type, the two factors that had previously been proved important in the analysis of Turkish users' evaluation of counseling rooms (Ito-Alpturer et al., 2012), not just using factors prescribed by the researcher. These factors were evidence-based, culturally valid constructs of counseling rooms. Research in the past often used photographic room simulations of poor quality. In the present study, very realistic simulations of three therapy rooms were created using 3D architectural design software. Thus, the ecological validity of room simulation is assumed to be high. Each room represented a different combination of seating arrangements and furniture types that were commonly found in Turkey. It is one of the first empirical research that looked into the effect of therapy rooms on people's expectations of psychotherapy. Gathering qualitative data with open-ended questions in addition to standard quantitative data from a rating scale was beneficial to have a better understanding of what the participants actually wanted. This study has practical implications. The findings can be useful when designing therapy rooms.

Another strength is that the study used a community sample, not limited to the student sample. The age and occupational diversity of the participants can increase the generalizability of the results. Furthermore, the inclusion of the therapy-experienced group and the no-therapy-experienced group for comparison was useful in resolving the issue of whether or not therapy experience matters in therapy room evaluation.

4.6 Limitations and Future Research

While the study demonstrated how the therapy room environment affects expectations regarding psychotherapy, there are some limitations to take into account. Firstly, as a self-report measure was used in this study, answers given by the participants may be affected by various biases such as social desirability biases. Participants may feel the need to give the desired answers, or they might give overscores or underscores if they are hesitant to share thoughts and feelings, they feel, are private. Secondly, since participants in a within-subjects, repeated-measure research design are forced to compare three different rooms, they might feel pressured to give differentiated answers for each room. Also, they might get bored from filling out the same scale three times and might give thoughtless answers. Lastly, although past research endorses that a person can make an inference about a situation by looking at a visual image, being in a real room and drawing conclusions about it via simulated media are two different experiences (Scott & Canter, 1997; Ulrich, 1991; Devlin et al., 2013).

Another issue is that the participants who do not have therapy experience may not be so naïve in their opinions about psychotherapy as there are other environmental factors that influence their ideas and beliefs about therapy (e.g. media, experiences of friends and family etc.). The reason why there was no difference found between those with therapy experience and those without may be the common exposure to therapy rooms depicted in media. Therapy rooms may have become a familiar place for viewers of TV series such as *Kırmızı Oda* and *Bir Başkadır.* Further research can focus on the influence of media. Future research may also focus more on the cultural elements that affect the clients' perceptions regarding therapy rooms, since representing a more Western-style or

contemporary design versus a more traditional design is likely to create different effects on different sub-groups in a socioculturally diverse country like Turkey.

In addition, no significant difference was found between psychoanalysis and CBT groups in the present study. However, the number of participants in each group was very small. Future research can focus on the experience-related differences and use a larger sample for each group. For example, future research can investigate the effects of room designs by using ANCOVA to control the effect of possible confounding variables such as age, prior experience of a specific type of therapy, therapy experiences of someone close, or level of exposure to media depicting psychotherapy. Moreover, future research can conduct phenomenological interviews where participants come to different rooms and have a lived experience, reflecting on their thoughts and feelings afterward. A problem with psychotherapy research is that it is private and confidential in nature. However, session-like trials may help gather more information.

4.7 Conclusion

Psychological therapies are becoming increasingly common. Yet, clinical psychologists have paid little attention to the places in which they practice psychotherapy. There is a lack of research, especially in Turkey. The present study aimed to investigate how the physical environment of a psychotherapy room affected clients' expectations of psychotherapy by focusing on seating arrangement and furniture type. Findings indicated that clients are influenced by the seating arrangement and furnishing of the room regardless of having prior therapy experience or not. Participants in this study presented the highest expectations for the room where the therapist and client sit facing each other on the same home-style chairs, with no desk dividing them. The study suggests that how a

psychologist designs their room can alter the clients' expectations substantially. Therefore, having a better understanding of clients' needs when designing a therapy room is crucial. Since the therapy room is what makes the first impression prior to the start of psychotherapy, clinical psychologists and psychological counselors should pay attention to how they design their rooms.

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APPENDIX A

Demographic Characteristics of Participants

	No Therapy Experience				Therapy Experience			
	n	%	*M*	*SD*	*n*	%	*M*	*SD*
Age	81		29.44	7.97	81		27.40	6.94
19-29	54	66.7			63	77.6		
30-39	18	22.1			12	14.8		
40-49	6	7.3			4	4.8		
50-59	3	3.6			2	2.4		
Gender								
Female	45	55.6			59	72.8		
Male	35	43.2			22	27.2		
Other	1	1.2			0	0.0		
Education								
Middle school graduates	1	1.2			0	0.0		
High shool graduates	2	2.5			1	1.2		
Unversity students (Bachelor and higher degrees)	29	35.8			35	43.2		
University Graduates (Bachelor and higher degrees)	49	60.5			45	55.6		
Place of residence								
İstanbul	50	61.7			65	80.2		
Ankara	7	8.6			5	6.2		
İzmir	4	4.9			2	2.5		
Other places in Turkey	15	18.3			3	3.6		
Other places in foreign countries	3	3.6			6	7.3		

APPENDIX B

Informed Consent

Değerli Katılımcı,

Bu araştırma T.C. Yeditepe Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi İrem Soytürk tarafından Dr. Öğr. Üyesi Mari İto Alptürer danışmanlığında yürütülmektedir. Araştırmanın amacı bireylerin terapi odasından yola çıkarak terapiye dair edindikleri beklentiler konularını incelemektir. Araştırmayı yürütmek için gerekli izinler T.C. Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurulu'ndan alınmıştır.

Sırayla 3 farklı terapi odasını göreceksiniz. Sizden, her odayı inceledikten sonra bazı duygu ve düşüncelerinize yönelik soruları yanıtlamanız istenecektir. Lütfen odaları dikkatlice inceleyerek yönergeyi dikkatle okuyunuz ve sorulara sizin duygularınızı ve düşüncelerimizi en iyi şekilde ifade eden cevabı işaretlemeye çalışınız. Araştırmanın geçerli ve güvenilir bir sonuç elde edebilmesi için cevapların dürüst olması ve tüm sorulara cevap verilmesi çok önemlidir. Anketin diğer bölümünde bazı demografik bilgiler vermeniz istenecektir. Bu prosedürün yaklaşık 10-15 dakika sürmesi beklenmektedir.

Araştırmaya katılım tamamen gönüllülük esasına dayanmaktadır. Ankette genel olarak rahatsızlık verecek sorular yer almamaktadır. Ancak, herhangi bir noktada bir rahatsızlık hissederseniz cevaplamayı bırakıp araştırmadan ayrılabilirsiniz. Böyle bir durumda araştırmacıya aşağıdaki e-posta adresinden ulaşabilirsiniz.

Araştırmada kimlik bilgilerinizi açık edecek hiçbir bilgi istenmemektedir. Cevaplarınız kesinlikle gizli tutulacak ve sadece araştırmacı tarafından değerlendirilecektir. Elde edilecek bilgiler yalnızca bilimsel ve eğitim amaçları ile kullanılacaktır. Çalışma hakkında daha fazla bilgi almak isterseniz araştırmacı ile iletişime geçebilirsiniz:

İrem Soytürk
Yeditepe Üniversitesi Psikoloji Bölümü

Araştırmaya katılmayı onaylıyorsanız, lütfen aşağıdaki ifadeyi işaretleyip, sonraki sayfaya devam ediniz.

○ Bu bilgilendirilmiş onam belgesini okudum ve anladım. Bu araştırmaya katılmayı hür irademle kabul ediyorum.

APPENDIX C

The First Question about Psychotherapy Experience in the Questionnaire

Daha önce bir psikoterapi/psikolojik danışmanlık almak için terapi odasında bulundunuz mu?

- ○ Hayır, hiç bulunmadım
- ○ Evet, bulundum
- ○ Sadece çevrimiçi terapi ortamında bulundum

APPENDIX D

Milwaukee Psikoterapi Beklentileri Ölçeği

Aşağıda, psikoterapi ile ilgili olası beklentilerinizi açıklayan ifadeler listelenmiştir. Bu ifadeler terapideki davranışlarınızı, gelecekteki terapistinizi ve terapi süreci ile ilgili beklentilerinizi kapsamaktadır. Daha önce bir psikoterapi deneyiminiz olmayabilir veya olası beklentileri daha önce düşünmemiş olabilirsiniz lakin şimdi bunlarla alakalı düşünmenizi istiyoruz. Her bir ifadeyi dikkatlice okuyup, ifade edilen durumla ilgili ne düzeyde beklenti içerisinde olduğunuzu gösteren rakamı işaretleyiniz.

	Hiç değil (0)	(1)	(2)	(3)	(4)	Biraz (5)	(6)	(7)	(8)	(9)	Çok fazla (10)
1. Terapistimin bana destek vermesini beklerim.	○	○	○	○	○	○	○	○	○	○	○
2. Terapistim bana geri bildirim verecektir.	○	○	○	○	○	○	○	○	○	○	○
3. Terapide gerçek düşünce ve hislerimi ifade edebileceğim.	○	○	○	○	○	○	○	○	○	○	○
4. Terapistimleyken kendimi rahat hissedeceğim.	○	○	○	○	○	○	○	○	○	○	○
5. Terapistim samimi/içten olacaktır.	○	○	○	○	○	○	○	○	○	○	○
6. Terapistim söyleyeceğim şeylere ilgi duyacaktır.	○	○	○	○	○	○	○	○	○	○	○
7. Terapistim sempatik olacaktır.	○	○	○	○	○	○	○	○	○	○	○

8. Her terapi randevuma gideceğimi düşünüyorum.	○	○	○	○	○	○	○	○	○	○	○
9. Terapi kendime olan saygımın artmasını sağlayacaktır.	○	○	○	○	○	○	○	○	○	○	○
10. Terapiden sonra, gelecekte yaşayabileceğim sıkıntılı hislerden kaçınmak için gerekli güce sahip olacağım.	○	○	○	○	○	○	○	○	○	○	○
11. Terapi neticesinde daha iyi bir insan olmayı umuyorum.	○	○	○	○	○	○	○	○	○	○	○
12. Terapiden sonra çok daha iyimser olacağım.	○	○	○	○	○	○	○	○	○	○	○
13. Terapi ile alakalı endişelerim olduğunda bunu terapistime söyleyeceğimi düşünüyorum.	○	○	○	○	○	○	○	○	○	○	○

APPENDIX E

Open-ended questions about the rooms

Bu odalarda neler dikkatinizi çekti?

____

Bu odalarda sevdiğiniz/sevmediğiniz neler oldu?

____

APPENDIX F

Demographic Information Form

Cinsiyetiniz

- ○ Kadın (1)
- ○ Erkek (2)
- ○ Diğer (3)

Yaşınız (Lütfen sayı ile belirtiniz)

____

Yaşadığınız şehir

- ○ İstanbul (1)
- ○ Ankara (2)
- ○ İzmir (3)
- ○ Diğer (Lütfen belirtiniz) (4)

____

Eğitim durumunuz nedir?

- ○ İlkokul mezunu (1)
- ○ Ortaokul mezunu (2)
- ○ Lise mezunu (3)
- ○ Liseye devam ediyorum (4)
- ○ Üniversiteye devam ediyorum (Lisans/Yüksek Lisans/Doktora) (5)
- ○ Üniversite mezunu (Lisans/Yüksek Lisans/Doktora) (6)

Hangi bölümde okuyorsunuz/okudunuz?

____

Daha önce bir psikoterapi/psikolojik danışmanlık için terapi odasında bulundunuz mu?

- ○ Hayır, hiç bulunmadım (1)
- ○ Evet, bulundum (2)
- ○ Sadece çevrimiçi terapi ortamında bulundum (3)

Bir psikoterapi/psikolojik danışmanlık deneyiminiz olduysa ne kadar sürdü?

- ○ Psikoterapi deneyimim hiç olmadı (1)
- ○ 1 yıldan az (2)
- ○ 1-5 yıl (3)
- ○ 5 yıldan fazla (4)
- ○ Diğer (Lütfen belirtiniz) (6)

____

Hangi psikoterapi yönelimi ile terapi tecrübeniz oldu?

- ◯ Psikodinamik Psikoterapi (1)
- ◯ Psikanaliz (2)
- ◯ Bilişsel Davranışçı Terapi (3)
- ◯ Varoluşçu Terapi (4)
- ◯ EMDR Terapisi (5)
- ◯ Genel psikolojik danışmanlık (6)
- ◯ Diğer (Lütfen belirtiniz) (7) ____

APPENDIX G

Debriefing Form

Çalışma sona ermiştir. Katılımınız için teşekkür ederiz. Bu çalışmada terapi ortamının/odasının fiziksel koşullarının bireylerin terapiye dair oluşabilecek süreç beklentilerine etkisini araştırmayı hedefledik. Bu çalışmanın, terapistlerin danışanların tercihlerine göre terapiye daha uyumlu ortamlar sağlamaları yönünde katkı sağlayacağını düşünmekteyiz. Çalışma kapsamında sağladığınız veriler ve çalışma sonuçları bilimsel ve mesleki etik ilkeleri çerçevesinde korunacak, sonuçlar toplu olarak yorumlanıp yalnızca bilimsel yayın amacıyla toplu bilgiler halinde paylaşılacaktır. İzlediğimiz prosedürün katılımcılarda bir rahatsızlık yaratmayacağı düşünülmektedir. Ancak katılımınızla ilgili bir problem yaşarsanız veya çalışmaya dair herhangi bir sorunuz olursa araştırmacıya aşağıdaki e-posta adresinden ulaşabilirsiniz. Çalışmanın sağlıklı ilerleyebilmesi için çalışmaya katılacağını bildiğiniz diğer kişilerle çalışma ile ilgili detaylı bilgi paylaşımında bulunmamanızı dileriz.

Katılımınız için tekrar çok teşekkür ederiz.

İrem Soytürk

APPENDIX H

Ethics Approval by Yeditepe University Human and Social Research Ethics Committee

T.C.
YEDİTEPE ÜNİVERSİTESİ REKTÖRLÜĞÜ

06.07.2022

Sayı : E.50532705-302.14.01-1321
Konu : İrem Soytürk Kurul Onayı

İLGİLİ MAKAMA

Üniversitemiz Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans Öğrencisi İrem Soytürk'ün, Dr. Ögr. Üyesi Mari Ito Alptürer danışmanlığında gerçekleştireceği "The Effect of the Therapy Room Environment on the Expectation of Psychotherapy Process and Outcome" başlıklı araştırmasının Beşeri Bilimler etik standartlarına uygunluğuna ilişkin Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurulu Onayı ekte sunulmuştur.

Gerekli iznin verilmesi hususunu bilgilerinize arz ve rica ederim.

İmza
Prof. Dr. Fatma Yeşim EKİNCİ
Rektör a.
Rektör Yardımcısı

Ek: Etik Kurul Onayı.pdf

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YEDİTEPE ÜNİVERSİTESİ BEŞERİ VE SOSYAL BİLİMLER ETİK KURULU KOMİSYONU

25.03.2022 TARİHLİ
28/2022 No'lu TOPLANTI KARARLARI

21) Yeditepe Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Yüksek Lisans Öğrencilerinden İrem Soytürk'ün, Dr. Ögr. Üyesi Mari Ito Alptürer danışmanlığında gerçekleştireceği "The Effect of the Therapy Room Environment on the Expectation of Psychotherapy Process and Outcome" başlıklı araştırmasının Beşeri Bilimler etik standartlarına uygunluğu Yeditepe Üniversitesi Beşeri ve Sosyal Araştırmalar Etik Kurulu tarafından değerlendirilmiş ve onaylanmıştır.