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Good-Enough Therapeutic Space Design: A Literature Review
and Considerations for Expressive Arts Therapy

Capstone Thesis

Lesley University

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Expressive Arts Therapy

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Abstract

This thesis investigates the role of therapeutic space in expressive arts therapy through an interdisciplinary and international literature review. Definitions of therapeutic space and therapeutic space design are explored. This paper is theoretically grounded in the notion of good-enough therapeutic space, which is adapted from Winnicott's (as cited in Davis & Wallbridge, 2004/1981) concept of a good-enough holding environment and Moskowitz-Corrois's (2018) understanding of therapeutic space. Personal internship experiences of not-good-enough therapeutic space and a personal arts-based inquiry conceptualizing good-enough therapeutic space are discussed. Research from non-therapeutic and therapeutic settings, for both general and specific populations, are surveyed. The literature establishes the positive impact that therapeutic space design can have on the therapeutic relationship. A checklist of good-enough therapeutic space design considerations for the expressive arts therapist, inspired by Liddicoat (2018), is drafted and presented. These considerations are accessible, adaptable, and applicable to the expressive arts. The roles of the therapist and client in the design process, limitations of this paper, and directions for further research are identified.

Keywords: therapeutic space design, expressive arts therapy, mental health counseling, good-enough therapy, literature review

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Introduction

Since my graduate program in expressive arts therapy at Lesley University began, I have had a persistent interest in how the built environment impacts the psyche and relates to therapy. During my time studying at Union Theological Seminary in New York City, I wrote a depth psychology paper exploring how our external environment can help or hinder us in accessing our inner safe space (Kreshak, 2014). In my own journey of healing, I have been nourished by various interior spaces: church sanctuaries, bedroom nooks, library stacks, and dinner tables.

In this paper, I investigate the impact of therapeutic space on the therapeutic relationship between therapist and client as it relates to expressive arts therapy. I define *therapeutic space* as the interior built environment in which expressive arts therapy, mental health counseling, psychotherapy, and/or other mental health services take place. I define therapeutic space design as the process of creating this environment. While the term *therapeutic space design* seems to have been first used by Cotton and Geraty (1984) regarding the design of an inpatient psychiatric unit, their research had no bearing on my use of the term in this paper.

This literature review is interdisciplinary as I summarize research from within and beyond mental health disciplines. I gather insights from design, architecture, and hospitality as well as from settings in which expressive arts therapists and related professionals work. The fields of design and architecture inform how to construct space. The field of hospitality informs how to create a sense of welcome in the constructed space.

My value of hospitality as it relates to therapy is informed by my experience in the Episcopal Christian Church. In the Episcopal Church, hospitality is a key theological tenet

embodied by the declaration that “All are welcome” in a church’s social and physical spaces. The idea that “All are welcome” translates to therapy in which all clients and all emotions are welcomed. In my review of hospitality literature, I investigate which therapeutic space design features support welcome in the therapeutic relationship.

Regarding research from within mental health disciplines, I survey literature about therapeutic space design for both general populations, including mixed-setting and private-practice counseling spaces as well as in-home settings and hospitals. I also survey literature about therapeutic space design for specific populations, including high schoolers, individuals being treated for self-harm, elders with dementia, veterans in inpatient psychiatric treatment, children and adolescents in inpatient psychiatric and other medical treatment, and women affected by trauma and substance misuse.

This literature review is international as I survey research from the United States, Israel, Japan, Turkey, Vietnam, Australia, Portugal, New Zealand, and Taiwan. The international scope of the literature suggests the widespread value of therapeutic space design as an area of inquiry. The United States has much to learn from other countries about therapeutic space design. The International Expressive Arts Therapy Association (IEATA), the professional organization of expressive arts therapy with an international board of directors, could provide a rich forum to exchange ideas regarding culturally informed therapeutic space design (“Who we are,” n.d.).

In my discussion, I establish the positive impact of therapeutic space design on the therapeutic relationship between client and therapist. Given this impact, I create and present a draft of a checklist of design considerations for good-enough therapeutic space (see Appendix B). This checklist, inspired by Liddicoat (2018), begins the process of identifying categories of

therapeutic space design features that are accessible, adaptable, and applicable to the expressive arts. I also address the roles of the therapist and client in the design process.

Key Limitations of this Paper

I enter this investigation with a bias towards the value of therapeutic space design. My research discusses a variety of therapeutic spaces, which gives my investigation breadth but not depth into design considerations for any one population. Additionally, I do not address the selection of expressive arts materials to have in a therapeutic space.

Good-Enough Therapeutic Space: A Theoretical Approach

My approach to this investigation is informed by the theoretical frameworks of psychologist D.W. Winnicott and the clinical reflections of my thesis consultant Laurie Moskowitz-Corrois. Moskowitz-Corrois is a registered expressive arts therapist and licensed clinical mental health counselor in Massachusetts who specializes in therapeutic space design.

In this paper, I conceptualize therapeutic space that positively impacts the therapeutic relationship as *good-enough therapeutic space*, a notion derived from Winnicott's (as cited in Davis & Wallbridge, 2004/1981) concept of the *good-enough mother* or primary caregiver. According to Winnicott, the good-enough mother provides *holding* to meet the infant's developmental needs. Winnicott used the term *good-enough* to account for the reality that an ideal mother, while aspirational, does not exist. While this ideal mother may not exist, a good-enough mother is capable and essential for the infant to develop properly. I use the term *good-enough* in describing therapeutic space to convey the idea that there is no space that perfectly meets the varied needs of all clients and that an imperfect space can still serve the work.

Winnicott (as cited in Davis & Wallbridge, 2004/1981) related the therapist's role to that of the mother's as the therapist works to provide an environment that supports the client's

psychosocial development. Winnicott discussed the relational space existing between client and therapist and raised the question of how the built therapeutic space might support the holding of this relational space.

According to Moskowitz-Corrois (2018), therapeutic space is “designed and created with intention and purpose... [and] supports the well-being of those utilizing the space” (para. 3). I would add that in good-enough therapeutic space, this intention and purpose serve therapeutic goals that support the psychosocial well-being of the clients.

Not-Good-Enough Therapeutic Space: Examples from the Field

My internships through Lesley confirmed the value of good-enough therapeutic space. The office I worked in last year at my placement at a public high school inhibited my therapeutic work. The office was small and dusty with a tiled floor warped from water damage, a radiator that overheated the room, a door without a doorknob, and floor-to-ceiling storage boxes. Students had to choose between comfort and privacy, between being uncomfortably hot or keeping the door ajar. Keeping the door closed was not a safeguard of confidentiality given the missing doorknob.

Last year, I also interned at a public middle school that was affiliated with the high school. At this school, human service workers, including me, did not have designated office space and needed to vie for one to meet with students. The school did not have a formal reservation process for its limited spaces. I would attempt to reserve a room by posting a sign on the door, but this effort did not guarantee my use of the room. Instead, I would often walk around the school, searching for any available room. As an itinerant therapist-in-training, I carried bags of supplies (e.g., arts materials, games) to create therapeutic space.

At my internship this past year, an affordable housing complex for elders, comfort and privacy were improved—compared to the schools—but were still concerns. The three interns, including me, shared office space with two permanent staff members. On a day when everyone was in the office, meeting privately with residents in that space was challenging. Alternative meeting spaces existed but were not guaranteed to be available. Our office did not have windows and was uncomfortably hot given that its closet housed the computer server, which generated a lot of heat. Like at the high school, keeping the office door closed compromised comfort, yet keeping the door open compromised privacy. At this site, I also co-led an arts group with my co-intern in a community room. For this group, like at the middle school, we used bags to carry art supplies from our office to this room.

At my internship sites, I found that the lack of a consistent and comfortable space drained my physical and emotional energy, hindering my capacity to attend to my clients. However, I also found that using bags was a helpful way to work with limited resources and inconsistent space, which I will discuss more thoroughly later in this paper.

Conceptualizing Good-Enough Therapeutic Space: An Arts-Based Inquiry

To inform my literature review, I engaged in an arts-based inquiry. I made a collage to explore my personal conceptualization of good-enough therapeutic space. In taking stock of the images I chose, I identified three broad categories of images: nature, arts, and hospitality. I coded the images for ease of analysis (see Appendix A). Not all the images represent features that are appropriate or feasible in a working therapeutic space. My collage came to represent what I find to be comforting in any space. Still, this exercise was fruitful in identifying what constitutes my “felt sense” (Moskowitz-Corrois, 2018, para. 7) of an aspirational therapeutic space.

In the category of nature, my collage included images of thresholds to nature (images 1, 3, 6, 18), people engaging in outdoor activities (images 2, 6, 13, 14, 17), as well as natural materials and views (images 16, 20). In the category of arts, my collage included images of arts activities (images 5, 13) as well as arts materials and products (images 8, 12, 18, 19). In the category of hospitality, my collage included images of beverages (images 7, 11), sitting with crossed legs (images 10, 13), and other amenities (images 4, 9, 15). All my images were pasted atop a blue green circle.

Literature Review

In the first part of this literature review, I summarize research from non-therapeutic settings that inform therapeutic space design. From this research, I gather insights about the use of sensory information in design, the role of attention in architecture, and the integration of nature-based design in hospitality.

Insights from Non-Therapeutic Settings

The use of sensory information in design. Sadar (2018) described graduate student projects that investigated the role of *atmospheric quasi-materials*, such as light, sound, temperature, and humidity, in the built environment. These projects were a part of an environmental technology course at Parsons School of Design in New York.

Sadar (2018) drew heavily on Böhme's definition of *atmosphere*: "an intermediary haze that sits in between the actively-perceiving subject and the quality-effusing object" (as cited in Sadar, p. 52). For Böhme, atmosphere is "[felt] . . . with all of our senses" (as cited in Sadar, p. 51). Böhme's definition of atmosphere is akin to Winnicott's (1971/2005) notion of *transitional phenomena*, which Winnicott defined as a "designation of the intermediate area of experience [between inner and outer reality]" (pp. 3-4). Both atmosphere and transitional phenomena

emerge in the encounter of internal and external reality, suggesting the impact of the built environment on the psyche.

In Sadar's (2018) study, graduate students measured and created environments with quasi-materials, including light, air movement (wind), sound, heat, humidity, and odor. One group of students used clay to measure sound, creating a "topography . . . that suggested a possible interior spatial strategy" (p. 57). Another group of students created an environment using air movement by suspending a polyethylene film sheet in a public staircase, which waved in response to air. These student projects demonstrated ways by which quasi-materials can be used in space design.

Sadar (2018) established that quasi-materials can be used in space design, especially to create a desired atmosphere. However, his study did not address the emotional impact of these phenomena. Further research could, for example, investigate the affective responses of folks who walk past the film sheet. Given that Sadar's (2018) focus was non-therapeutic design, he did not address how sensory information in a therapeutic space needs to be used differently depending on the population. Later in this paper, my review of Tsai and Hong (2019) and Bobier et al. (2015) will attend to sensory therapeutic space design considerations for elders with dementia in day services and children and adolescents in inpatient psychiatric care, respectively.

The role of attention in architecture. Peri Bader (2015), an architecture scholar at Tel Aviv University in Israel, offered a model to guide the design of interior spaces: the Lived Experience of the Built Environment (LEBEN). The LEBEN model conceptualizes how folks perceive their environment. According to the model, folks can perceive an environment's *theme*, *context*, and *margins*. Theme refers to "the subject's ability to act" (p. 251) in an environment based on the environment's *affordances*. Affordances, a term by Gibson, are physical features

that indicate possibilities for bodily action in a space (e.g., staircases, doors, etc.) (as cited in Peri Bader). Context refers to an environment's *depth* and *edge*, or the boundaries within which "the theme operates" (p. 251) or within which folks act in a space. Margins refer to the notion of atmosphere, a concept explored in Sadar (2018). For Peri Bader (2015), atmosphere is an "immediate, pre-conceptual [and affective] sense of place" (p. 251).

In the process of formulating her model, Peri Bader (2015) conducted a workshop in which she asked participants to report their experiences of four familiar locations. Among her findings, Peri Bader discovered that the "physical-aesthetic qualities" (p. 252) of a space influenced the extent to which the space's affordances invited action. Inviting qualities included openness, warmth, and sunlight. Ultimately, Peri Bader concluded that folks do not pay direct attention to their environment when they are comfortable in it/when it is meeting their needs. However, Peri Bader found that folks do maintain awareness of how their environment makes them feel and the actions they take within it.

While Peri Bader's (2015) discussion of her workshop research was limited, she offered critical insight for therapeutic space design. In a good-enough therapeutic space, the built environment may be ignored as it accommodates the actions that folks expect to take in the space. Moreover, openness, warmth, and sunlight are important design considerations that create a nurturing atmosphere, though Peri Bader did not give clear examples of these features.

L. Moskowitz-Corrois corroborated the role of awareness in designing therapeutic space (personal communication, February 12, 2020). According to Moskowitz-Corrois, therapists exercise awareness, both self-awareness and attention to detail, to design intentional therapeutic space. Moskowitz-Corrois furthers that clients are largely unaware of intentional therapeutic space. This inattention to the built environment allows clients to focus on the therapeutic process.

Peri Bader's (2015) finding of openness as an inviting quality does not apply to all therapeutic settings. According to Weinberger, Butler, McGee, Schumacher, and Brown (2017), openness—more specifically, open space—is an important feature for hospital playrooms for children as it encourages exploration in the space. In contrast, according to Platt, Bosch, and Kim (2017), open space is problematic in inpatient psychiatric units for U.S. veterans. In this setting, “open clinical areas [can] increase patient, family, and staff interaction” (p. 39). If not implemented well, this openness can also make staff feel unsafe. One solution, negotiating openness and safety, is experimenting with “a variety of partition heights and counter depths [at staff workstations]” (Mural, as cited in Platt et al., p. 38).

Peri Bader's (2015) notion of inattention does not apply to the treatment of populations who use sensory environments. Tsai and Hong (2019) outlined a strategy for designing a multisensory environment for elders with dementia. This environment has the therapeutic intention of bringing attention to the built space by providing elders with sensory stimulation to connect them to their past and ground them in their present. Similarly, Bobier et al. (2015) explored the design of a sensory room for children and adolescents in an inpatient psychiatric unit. In Bobier et al.'s study, direct engagement with the sensory room's items was key to its therapeutic functions, including emotional regulation.

The integration of nature-based design in hospitality. Lee (2019) explored the impact of “introducing *biophilic design* to a hotel's physical environment” (p. 141). Biophilic design involves “[using] natural systems and processes in the design of the built environment” (Kellert et al., as cited in Lee, p. 141). Lee's study aimed to test the effects of three biophilic design elements—plants, water, and natural light—on “[U.S. hotel] guest emotion, quality perception, attitude, and behavior” (p. 144). Lee tested these effects by showing each participant a photo of a

hotel lobby that incorporated one of these three biophilic design elements or none of them. Then, each participant filled out a questionnaire about the photo they observed.

Lee (2019) found that the hotels with the biophilic design elements “elicited stronger positive emotional responses [from participants] than the [hotels with the] non-biophilic design [elements]” (p. 148). Participants reported a more “favorable attitude” (p. 148) towards the hotels with the biophilic design elements, including a perception that these hotels were “superior in quality” (p. 148). Participants also reported “stronger positive behavioral responses” (p. 148) (e.g., wanting to stay longer) at the hotels with the biophilic design elements, especially those with plants and natural light.

Applying Lee’s (2019) findings to therapeutic space is limited due to the different intentions and purposes between the hotel industry and mental health care. In her discussion of positive behavioral responses, Lee (2019) mentioned that one desired response was for guests to “spend more money in biophilic environments” (p. 148). Certainly, the core intention of using biophilic design in a therapeutic space is not for the therapist to make a profit but rather to cultivate a supportive space for the client. Still, Lee suggested that biophilic design improves one’s perception of a space. Biophilic elements in therapeutic space design may improve a client’s impression of the therapist as well as their comfort in the space, helping to strengthen the therapeutic relationship.

Therapeutic Space Design in Various Settings

In the next part of this literature review, I summarize research that explores therapeutic space design in a variety of settings in which expressive arts therapists and other human service professionals work. I categorize these spaces by those designed for general populations and those designed for specific populations.

Therapeutic spaces for general populations. The following research explores therapeutic spaces for general populations, including mixed-setting and private-practice counseling spaces, in-home settings, and hospitals. By the term *mixed-setting counseling spaces*, I refer to rooms and offices in a variety of contexts, including private practice, inpatient and outpatient settings, as well as residential treatment.

Mixed-setting counseling spaces. Miwa and Hanyu (2006) “[investigated the] effects of the interior design of a counseling room on participants’ self-disclosure and impressions of a counselor [in Japan]” (p. 484). Miwa and Hanyu created a counseling room in which they tested the impact of lighting and “home-like decorations” (p. 484). Interviews of psychology undergraduate students were conducted in this room under different design conditions (i.e. bright/dim lighting and with/without home-like decorations).

The bright lighting condition was created with fluorescent ceiling lamps, and the dim lighting condition was created with incandescent lamps (Miwa & Hanyu, 2006). Sunlight did not contribute to the lighting as the room had no windows. The decorations included a beige carpet, a beige tablecloth, stuffed dolls, framed pictures (of flowers and a bridge), and artificial flowers in a vase. Miwa and Hanyu found that students reported more favorable impressions of the room and interviewer and were more likely to self-disclose under dim lighting. The decorations did not have a significant impact.

Perhaps Miwa and Hanyu’s (2006) study was unable to identify the impact of decorations because there were too many variables among the decorations (e.g., color, texture, imagery). Because the counselor was a young graduate student, it is worth noting how closeness in age and similarity of interest may have influenced the affinity between participants (from a psychology class) and the counselor. Given that the participants in Miwa and Hanyu’s study were young

adults, it is also worth wondering how successful dim lighting would be with other ages and abilities. Platt et al. (2017) prescribed lighting that supports the staff and patient's circadian rhythms in inpatient psychiatric units for U.S. veterans (p. 42). Thus, in this setting, dim lighting would only be appropriate at certain times.

Devlin, Nasar, and Cubucku (2014) explored how the interior design of a psychotherapist's office impacts clients' impressions of the psychotherapist. This study expanded on Miwa and Hanyu (2006) by exploring cultural differences in these impressions. In the study conducted by Devlin et al. (2014), undergraduate and graduate students from the United States, Turkey, and Vietnam reported their appraisals of "digital color photos of 30 psychotherapists' offices in Manhattan" (p. 954). Because the psychotherapists had backgrounds in psychology, social work, medicine, nursing, and education, the settings of their offices were unclear and likely mixed (e.g., private practice, outpatient, inpatient, etc.).

Participants evaluated the spaces using seven Likert scales: simple-complex, spacious-cramped, orderly-disorderly, neat-messy, modern style-traditional style, hard office-soft office, and impersonal-personalized (Devlin et al., 2014). The study found that the U.S. students, Turkish students, and Vietnamese students all reported softness/personalization and orderliness as contributing to the clients' "composite evaluation of comfort and quality of care [in the psychotherapy office]" (p. 960).

While Devlin et al.'s (2014) study had culturally diverse participants, the therapists' offices were not regionally diverse, all located in New York City. Devlin et al. were aware that their metric for ranking the offices "may have unintentionally defined what [they] measured... from a Western or etic perspective" (p. 964). Still, Devlin et al.'s study brings attention to cultural differences in both design and the perception of mental health.

Devlin et al. (2014) did not do a thorough job of explaining they meant by softness/personalization and orderliness as well as the exact process by which these qualities were translated from the Likert scales. However, they do identify “personalizing features... as plants, sculptures, a blanket, or article of clothing” (p. 956).

Fenner (2011), an art therapist and professor at La Trobe University in Australia, explored the impact of place on the therapeutic relationship in art therapy. Fenner, in both client and therapist roles, as well as five client/art therapist pairs made art in response to being in a therapy room. The therapy rooms were located within private practice, community outpatient services, and a residential program for women treated for substance misuse.

Fenner (2011) facilitated dialogues with the images created by the clients and therapists as well as identified common themes that emerged in these dialogues. Through this data, Fenner established five key findings. The first finding was that clients and therapists developed an affinity for “certain objects and zones [in the therapy room]” (p. 854). For example, one client identified the chair in which she sat during sessions as being “for me” (p. 855). The second finding was that clients and therapists enjoyed window views of nature. The third through fifth findings were iterations of the notion that the room and its contents served the goals of therapy.

Fenner (2011) established that the therapy room serves as “an extension of the therapist” (p. 854) and that space is an undeniable part of the therapeutic relationship. This idea is like L. Moskowitz-Corrois’s understanding that the therapy room can serve as a “mirror [of the therapist]” (personal communication, February 12, 2020). According to Moskowitz-Corrois, this mirroring is why therapist self-awareness is key in designing an effective therapeutic space.

Private-practice counseling rooms. Jones (2018) interviewed U.S. social workers in private practice about their offices where they meet with clients. An analysis of the interviews

revealed three common themes of how the offices were used: for care, for communication, and as a tool for direct practice. The theme of care involved considerations for the clients' physical comfort, considerations for the clients' other preferences and needs, and considerations for the therapists' self-care. The offices provided for the clients' comfort by, for example, having natural and/or lamp light (versus overhead lighting), pillows, a couch, no clutter, a space heater and/or fan, a sound machine, throw blankets, and natural elements (e.g., plants, seashells, flowers). The offices provided for the clients' other preferences and needs by, for example, keeping a client's favorite chair in the room as well as supplying pens, tissues, and beverage coasters. The offices provided for the therapists' self-care by, for example, being conveniently located to the therapist.

The theme of communication involved relaying therapeutic messages and revealing/concealing the personality of the therapist (Jones, 2018). Therapeutic messages were conveyed using color (e.g., blue green) or wall art. Jones shared the example of a social worker who displayed wall art that encouraged clients that "it's okay to go dark... go deep" (p. 44). The social workers in Jones's (2018) study were all intentional yet different regarding the extent to which they revealed their personality in their offices through photos, favorite decorations, etc.

The theme of the office as a tool for direct practice involved furnishing offices with items that facilitated connection and discussion with the clients. The ways by which the clients engaged with the spaces and the spaces' contents informed the therapists' clinical interpretations. Moreover, the layouts of the spaces were designed to support the therapists' work (e.g., the distance between the therapist's seat and the client's seat).

While Jones (2018) did not directly study the responses of clients to design considerations, which Jones admitted was a limitation, this study was valuable in taking stock of how social workers relate to and use their offices. Because the respondents were in private

practice, they may have had more freedom in designing their spaces than respondents working in other settings. Still, Jones's discussion of care and comfort confirmed the value of hospitality in the therapeutic space.

In-home settings. Graham, Gosling, and Travis (2015) made the case that the home was a worthwhile area of psychology research. According to Graham et al., homes "are consequential real-world settings in which basic psychological processes are regularly played out" (p. 347). Some of these processes are relationship building and identity building (personally and culturally), emotion regulation, and development. To support their argument, Graham et al. distributed an online survey to inventory the ambiances that people try to cultivate in their "ideal home" (p. 350). For 18 different spaces in the home, the survey asked folks to choose two ambiances, from a list of 29, that they try to cultivate in each space.

Graham et al. (2015) found that the top three ambiances for all rooms, from most popular to least popular, were inviting, organization, and relaxation. According to Graham et al., "the distributions of ambiances varied substantially across the rooms" (p. 350). While the choices of ambiances were influenced by respondent preferences, the choices did tend to correspond with the function of the rooms. For example, over half of respondents indicated inviting as a desired ambiance in their entryway.

Graham et al.'s (2015) study was limited as the survey was designed with a western (i.e. white, Euro/Americentric) home in mind. Moreover, the respondents were architectural clients of Travis, one of the study's authors. Although the study was based on an imagined ideal home, the respondents still had the financial means to purchase and design a new home. The study's formulation of a list of ambiances is useful for thinking about the desired ambiance of a therapeutic space, especially for in-home clinicians. While these clinicians may not have much

ability to change the design of the home space in which they are working, this study may make them think more critically about which spaces within the home might support their work. This study gives context to “home-like decorations” mentioned by Miwa and Hanyu (2006) and to-be-reviewed articles Platt et al. (2017) and Goelitz and Stewart-Kahn (2006).

Hospitals. Andrade, Lima, Devlin, and Hernández (2016) conducted two studies in Portugal to investigate the relationship between physical environment, social environment, and the perceived quality of care in hospitals. Andrade et al. investigated the general hospital environment, not focusing on any one population of hospital user. Later in this paper, I cover research on inpatient psychiatric units for veterans (Platt et al., 2017), inpatient psychiatric units for children and adolescents (Bobier et al., 2015), and hospital playrooms for children (Weinberger et al., 2017).

In the first study conducted by Andrade et al. (2016), participants were either shown a photo of an inadequate, neutral, or good hospital physical environment or given a story about a negative, neutral, or positive hospital social environment. Participants were then asked questions about how they perceived the quality of these physical and social environments, as well as their expected well-being in these spaces/scenarios. In the second study, participants were shown a photo and a given a story simultaneously before being asked questions.

The photos aimed to capture spaces involved in each participant’s experience before and after their appointment, including the waiting room, the reception desk, the door to their doctor’s office, etc. (Andrade et al., 2016). Participants rated the quality of the physical environment on spatial-physical comfort, orientation, quietness, and views and lighting. Participants rated the quality of the social environment on care for social and organizational relationships and privacy as well as measured expected well-being in terms of satisfaction and affective state.

Andrade et al. (2016) found that the perceived qualities of the physical and social environments were positively correlated with expected well-being, with social environment having a greater impact than physical environment on expected well-being. Andrade et al. discovered “that expected well-being tends to increase when the physical environment improves from ‘inadequate’ to ‘neutral,’ and to become stable when the physical environment improves from ‘neutral’ to ‘good’” (p. 318). Andrade et al. supported the notion of a good-enough therapeutic space, confirming the “inability of the physical environment to improve [patient/client] satisfaction when the environment is better than ‘good enough’” (p. 318).

While Andrade et al. (2016) did not directly address the work of therapists, their study is informative for therapists working in hospitals. Compared to Devlin et al.’s study (2014), Andrade et al.’s (2016) study was limited as it used photographs, rather than in-person presence, to capture the respondents’ felt sense of the hospitals. Still, Andrade et al. affirmed the value of a good-enough therapeutic space while highlighting the equal, if not greater, value of the person of the therapist in cultivating an effective therapeutic relationship.

Therapeutic spaces for specific populations. The following research explores therapeutic spaces designed for specific populations including a counseling room for high school students, spaces for individuals who self-harm, inpatient psychiatric units for veterans, inpatient psychiatric units for children and adolescents, a day services facility for elders with dementia, hospital playrooms for children, and an outpatient counseling waiting room for women affected by trauma and substance misuse.

Counseling room for high school students. Cook and Malloy (2014) investigated the impact of re-designing a school counselor’s (Malloy’s) office at a high school in the United States. This investigation was inspired by Malloy’s observation that students seemed more

comfortable to share of themselves in the school's group-counseling room than in her office. The group-counseling room had neutral colors, including off-white walls and a tan carpet, a window view of trees, and was a larger space to allow students to sit in different places within the room. In contrast, Malloy's office was green and yellow and a small space. Gutheil's concepts of *fixed-feature space* versus *semifixed-feature space* shaped the office's transformation process (as cited in Cook & Malloy). Fixed-feature space includes the "immovable elements of space such as buildings, walls, and doors" (p. 438). Semifixed-feature space includes more customizable elements such as "furniture, accessories... binders, books, files, and filing cabinets" (p. 438).

Cook and Malloy (2014) were able to transform the school counselor's office despite an inability to change fixed features, namely of which was a built-in wall cabinet. They reduced clutter, switched the color scheme of the room to blue green, and rearranged furniture to maximize open space. Students gave positive feedback about the changes, and Malloy became more at ease in her new space.

A key insight of Cook and Malloy's (2014) study was Malloy's discovery that a counselor's personal design preferences, while important to consider, come "secondary to the comfort of the clients and the importance of the work to be done in the office" (p. 442). Malloy developed this awareness after adding black and white decorative elements to the space (e.g., her favorite stuffed panda bears). Malloy found, on further research, that black and white combined with the preexisting yellow in the space could convey danger and tension (Wagner, as cited in Cook & Malloy).

Cook and Malloy's (2014) study is especially valuable because it was conducted using a real, working space rather than a simulated, counseling space (e.g., Miwa & Hanyu, 2006).

While Malloy's observations were subjective, her perspective gave insight into how a counselor is impacted by therapeutic space.

Spaces for individuals who self-harm. Liddicoat (2018) conducted a study in Australia to discern how folks being treated for self-harm perceived the therapeutic space. Informed by Peri Bader (2015), Liddicoat's (2018) study interviewed clients, therapists, caregivers, designers, and design researchers. Liddicoat found that clients who self-harm tended to value a *natural mind-space* and a *uni-directional metaphor* in a therapeutic space as well as tended to perceive and dislike *traces of inhabitation* in the space. Liddicoat's term *natural mind-space* refers to having a window view of a natural landscape. Liddicoat noted that clients did not need to be outside, and in fact, benefitted from the window offering containment of the landscape.

A client in Liddicoat's (2018) study preferred what Liddicoat calls a *uni-directional spatial journey* whereby the client was able to leave the space using a different door than the one by which they entered the space. According to Liddicoat, differentiating a space's entrance and exit supports a "metaphor of [therapeutic] progress" (p. 100). This metaphor allows clients to not feel as if they are undoing their therapeutic work.

Liddicoat (2018) found that clients who self-harm did not want to perceive any traces of inhabitation, or indicators that previous clients used the space. Examples of traces are signs of violence (e.g., punched holes in the walls), general dirtiness, the wear-and-tear of furniture, and certain smells. Traces can be negatively activating, inhibiting a feeling of safety in the space.

Liddicoat (2018) concluded her article with a table of design suggestions for therapeutic spaces serving clients who self-harm. These suggestions elaborated on how to cultivate a natural mind-space, create spatial metaphor, and manage trace. These suggestions included reducing the use of materials often found in clinical settings (e.g., plastic curtains, linoleum), using sensory

information (e.g., light, sound) to support uni-directional spatiality, and choosing furnishings that can withstand weathering (e.g., no carpets). Liddicoat's (2018) table inspired my own draft of a checklist of design considerations to be discussed later in this paper (see Appendix B).

Inpatient psychiatric units for veterans. Platt et al. (2017) conducted a literature review and analyzed three case studies to develop a framework for designing inpatient psychiatric units for veterans. Their case studies were three Veteran's Administration (VA) sites in the United States. At these sites, Platt et al. interviewed VA staff and former and current patients to inventory the design principles in place and identify aspirational interior design elements. Through this process, Platt et al. developed a framework with six domains of design strategy: Involve, Protect, Engage, Comfort, Personalize, and Sustain.

The design strategy of Involve was reflected in Platt et al.'s (2017) study as patients and staff were called to participate in the therapeutic design process. According to Platt et al., this involvement is "key to creating person-centered environments of care" (p. 33). The design strategy of Protect refers to creating a physically safe space for both patients and staff by including design elements that "reduce environmental hazards, minimize the risks of suicide, optimize staff-to-patient visibility, provide appropriate acoustical privacy, and protect patients' dignity" (p. 38). An important consideration regarding minimizing the risks of suicide is ensuring the space does not contain anything that could be used as a weapon.

The design strategy of Engage refers to design considerations that allow patients and staff to be alone or to socialize (Platt et al., 2017). Allowing for patient privacy provides space for as well as reduces the risk for seclusion (Van der Schaaf, Dusseldorp, Keuning, Janssen, and Noorthoorn, as cited in Platt et al.). Engage also elaborates on how to provide successful patient-to-staff and patient-to-patient interactions.

According to Platt et al. (2017), the design strategy of Comfort creates a “home-like” (p. 42) and non-institutional environment, including comfortable yet safe seating, lighting that supports circadian rhythms, and natural elements, such as nature-based artwork and aquariums. The design strategy of Personalize refers to the client’s ability to customize their space, and the design strategy of Sustain refers to cultivating a salubrious ambiance by regulating sound levels and improving air quality, among other efforts.

The core contribution of Platt et al. (2017) is their presentation of a person-centered and evidence-based framework for designing inpatient psychiatric units for veterans. Their study highlighted a key question in therapeutic space design: the extent to which clients play an active role in the design process, which I will discuss later in this paper.

Inpatient psychiatric units for children and adolescents. Bobier et al. (2015) conducted a study to test the usefulness and impact of a sensory modulation room in a psychiatric inpatient unit for children and adolescents (ages 18 and under) in a hospital in New Zealand. Their study involved training staff about sensory modulation, constructing a sensory modulation room, and having staff record their use of the room. Bobier et al. defined sensory modulation as “the ability to regulate sensory input” (p. 385). Sutton and Nicolson described the benefits of sensory modulation in psychiatric units as “promoting calm, promoting trust between service users and staff members, and facilitating the development of self-awareness, as well as the ability to manage and regulate emotions” (as cited in Bobier et al., p. 387).

Features of the sensory room included an air ventilation system, a window (with blinds and curtains), two doors for entering/exiting the room with one opening to a courtyard, a wall mural of a landscape, sensory equipment (e.g., weighted objects, stress balls), an audio player, and other features for comfort, including pillows and blankets (Bobier et al., 2015).

To record the use and impact of the sensory room, patients and accompanying staff signed in and out of a guestbook before entering and exiting the space (Bobier et al., 2015). Among other information, the guestbook recorded who used the room and when, the sensory items used, and the arousal levels of clients. In analyzing the data from the guestbook, Bobier et al. found that “Both patients and staff members reported significant improvements in mood and energy levels following use of the room, whether it was intended for activation or deactivation” (p. 396). Moreover, they found that “episodes of seclusion and full restraint were reduced in the six months during and following the study period” (p. 397). Thus, the sensory room had a positive impact on both patients and staff.

Bobier et al. (2015) are helpful in educating about the value of a sensory room for children and adolescents in an inpatient setting. From the sensory room’s design, therapists can learn what features they might incorporate in their own spaces to support clients with sensory regulation needs. Bobier et al. mentioned how, in addition to a sensory room, the unit had a “portable sensory kit” (p. 398) that patients could use outside of the sensory room (e.g., common areas, bedrooms). While the kit’s contents are not described, the concept of a kit is especially useful in contexts where the resources to create a sensory room do not exist. Later in this paper, I discuss the helpfulness of kits in settings that constantly change or cannot be changed.

Day services facility for elders with dementia. Tsai and Hong (2019) outlined a strategy for designing a multisensory simulation environment for elders (ages 65 and older) with dementia in Taiwan. They developed their strategy by reviewing literature and holding symposiums of experts in medicine, functional therapy, architecture, interior design, and social work. Tsai and Hong’s suggestions for design can be applied to a single sensory room or integrated throughout an entire day services facility.

Tsai and Hong (2019) established five key characteristics of “sensory stimulation indoor environment planning” (p. 1743). These characteristics are accessibility, safety, interactivity, autonomy, and gameplay. Tsai and Hong recommended that the environment integrate natural elements (e.g., natural light) and cultural elements to connect the clients to their life experiences. They also recommended that the space contain mostly movable, or semi-fixed, furniture, as well as adjustable sensory stimulation, based on the clients’ needs.

Hospital playrooms for children. Weinberger et al. (2017) explored good hospital playroom design. Their study asked child life specialists in the United States to evaluate photos of real hospital playrooms. Using Likert scales and open-ended responses, specialists evaluated the playrooms based on each room’s capacity to support “[themes from] the CLC’s (Child Life Council’s) mission and goals statement” (p. 77). These themes included safety, coping, normalizing, social interaction, mastery, and play.

Weinberger et al. (2017) found that the “child life specialists [favored] playrooms with specific design features and playrooms that [supported] the values [or themes] of the child life profession” (p. 80). The top three preferred design features, as indicated in the open-ended responses, from most preferred to least preferred, were biophilic elements, “appealing [color and décor]” (p. 80), and open space. Respondents mentioned daylight and windows as important biophilic design features. The use of color in the playrooms connects to biophilic design as Weinberger et al. recommended “using a variety of color from the full palette found in nature” (p. 85). The playrooms also included décor that encouraged play (e.g., castles). Open space allowed freedom of movement in play.

Other preferred design features included play options and storage and organization (Weinberger et al., 2017). Play options refer to the playroom’s provisions for pretend play and

sensory-motor play. Storage and organization allowed the play materials to be accessible to the children and for the room to not cause sensory overload.

Weinberger et al. (2017) also discussed design requirements of a playroom, including safety, cleanliness, and accessibility. A critical safety feature was maneuverability or the ability for children using wheelchairs and/or IV poles to move around the space. While respondents did not list these required features as preferred features in the highest rated rooms, these features did exist in these rooms.

While Weinberger et al.'s (2017) study did not directly address the work of therapists, the study did discuss the work of human services professionals (child life specialists). Therapists who work in hospital settings, especially those who use play therapy, may make use of playrooms for their sessions.

Outpatient waiting room for women affected by trauma and substance misuse. Goelitz and Stewart-Kahn (2006/2007) redesigned the waiting room of an outpatient counseling facility for women affected by trauma and substance misuse. Goelitz, who interned at the facility, led the project. She redesigned the space based on Arneill and Devlin's seven questions, which inquire into a client's initial view upon entering the space, the comfort of the chairs, the quality of light, and more (as cited in Goelitz & Stewart-Kahn). The redesign aimed to cultivate a "home-like atmosphere" (p. 41) by including magazines and toys for distraction, dried flowers for aroma, pillows and water/tea for comfort, as well as window curtains and wall art. Clients gave positive written feedback about the new space, and staff noticed an increase in interaction among clients.

The value of Goelitz and Stewart-Kahn's (2006) study, like Cook and Malloy's (2014) study, is that they experimented with a real, working space rather than with a simulated space (Miwa & Hanyu, 2006) or with photos of a counseling space (Devlin et al, 2014). Goelitz and

Stewart-Kahn (2006) demonstrated that positive changes can be made with a limited budget of \$400. A major limitation of Goelitz and Stewart-Kahn's study is the fact that the redesign was of a waiting room rather than a counseling room. Still, the waiting room serves outpatient counseling and highlights the importance of a waiting room in supporting therapeutic space.

Discussion

The literature review reveals that therapeutic space design has the capacity to improve client self-disclosure (Cook & Malloy, 2014; Miwa & Hanyu, 2006) and clients' impressions of the therapist and/or quality of care (Andrade et al., 2016; Devlin et al., 2014; Miwa & Hanyu, 2006). Therapeutic space design has the capacity to serve therapeutic goals and activities (Bobier et al., 2015; Fenner, 2011; Liddicoat, 2018; Tsai & Hong, 2019; Weinberger et al., 2017) and contribute to the comfort and care of the client and therapist (Goelitz & Stewart-Kahn, 2006/2007; Graham et al., 2015; Jones, 2018; Liddicoat, 2018; Platt et al., 2017).

Good-Enough Therapeutic Space Design Considerations

Given the positive impact therapeutic space design can have on the therapeutic relationship, I began to develop a checklist of design considerations for the good-enough therapeutic space (see Appendix B). This checklist, inspired by Liddicoat (2018), is intended to be used by the expressive arts therapist or related professional in any setting.

I started to identify common categories of therapeutic space design considerations: the layout of the space, the use of sensory information, provisions for hospitality, provisions for biophilic design, and provisions for expressive arts therapy. The layout category includes safety and privacy considerations. This category also includes attention to thresholds (e.g., entrance/exit, windows) and taking stock of the fixed and semi-fixed features in a space. The sensory information category includes considerations of light, color, tactility, and sound.

Provisions for hospitality include cleanliness, comfort, organization, and home-like features. Provisions for biophilic design involve the integration of natural elements in the space (e.g., wall art, photos, and/or windows displaying natural views; plants; water features). The value of these last two categories were confirmed by my therapeutic space collage, which identified nature, arts, and hospitality as categories of good-enough therapeutic space design (see Appendix A). Furthermore, the considerations of privacy and comfort were confirmed by my experiences of not-good-enough therapeutic space at my internships.

The checklist's categories are interconnected. For example, the light consideration under sensory information connects with biophilic design (when discussing natural lighting) as well as thresholds (when discussing windows). Moreover, comfort under hospitality connects to the regulation of sensory information. Depending on the population, certain categories may take precedence over other categories. For example, while carpets may contribute to a sense of home and comfort (Cook & Malloy, 2014; Miwa & Hanyu, 2006), they also may present a cleanliness issue (Liddicoat, 2018).

The need for accessibility and adaptability. Through my investigation, I discovered that accessibility and adaptability are guiding principles of good-enough therapeutic space design. Accessibility, for which I did not create a separate category in my checklist, is a global consideration that needs to be integrated in the entire checklist. An accessible therapeutic space responds to the needs of the specific population using the space. To account for a variety of client needs, my checklist lists questions under categories to defer to the expertise of therapists to serve their clients. For example, under safety I ask, "Is open space appropriate?" given different client responses to open space, as discussed in my review of Peri Bader (2015).

Financial limitations for the therapist and/or agency, which I mentioned in my summary of Jones (2018), is another global consideration for the checklist. Only therapeutic space design considerations that are financially feasible can be implemented. Goelitz and Stewart-Kahn (2006) executed a successful redesign on a budget. The reality of limited finances is why I appreciate the term *good-enough* to describe therapeutic space design. To reference Moskowitz-Corrois (2018), therapeutic space “designed with intention” (para. 3) to client needs and therapeutic goals, regardless of the budget of the therapist and/or agency, makes a difference.

To accommodate the diversity of client needs between and within populations, good-enough therapeutic space must be adaptable. In their investigation of multisensory environments for elders with dementia, Tsai and Hong (2019) recommended that the therapeutic space contain mostly movable, or semi-fixed, furniture, as well as adjustable sensory stimulation. This recommendation is worthwhile for any therapeutic space. Multipurpose spaces are especially helpful for agencies and/or therapists on a budget as they can use the same room for different activities and functions. L. Moskowitz-Corrois agreed with Tsai and Hong (2019) that a therapeutic space is ideally “transformable and multipurpose” (personal communication, February 10, 2020).

When working in spaces that cannot be changed or that are constantly changing, whether due to limited financial resources or unhelpful fixed features, creating what I will call *portable therapeutic space* is an alternative. By portable space, I refer to Bobier et al.’s (2015) sensory kits and my experiences at my internships of carrying expressive arts supplies in bags. Portable space is especially helpful to expressive arts therapists and related professionals in inpatient hospital settings. At Boston Children’s Hospital in Massachusetts, child life specialists use an

Art Cart to bring visual arts activities (e.g., painting, collage, sculpture) “to the bedside of patients who cannot leave their rooms” (“Art Cart,” n.d., para. 3).

Although my checklist is primarily created for built therapeutic space, it can still inform features to include in portable space. At my internship sites, my bags included art supplies, an audio player, games, a “Do not disturb” sign, and an electric kettle with tea bags. While the contents of a therapist’s supply bag would change depending on the needs of clients, items that could be included in this bag are fidget toys (for sensory regulation) as well as hand sanitizer and tissues (for cleanliness).

While portable space must contain materials to meet the clients’ needs, it must also support the therapists’ self-care. When using bags at my internship at the school, I often had back pain after a day of carrying supplies. In this regard, I recommend, when possible, using portable space that is easy to carry whether it be a bag on wheels or a bag that is kept lightweight through organization and minimalism.

Applicability to expressive arts therapy. Of the literature I reviewed, only Fenner (2011) discussed expressive therapy (i.e. art therapy) as it relates to therapeutic space design. My checklist accounts for considerations specific to expressive arts therapy by including certain questions within the checklist’s categories.

A good-enough therapeutic space for expressive arts therapy would have provisions for keeping the space clean, especially after artmaking, as well as for maintaining the cleanliness and quality of the arts materials. These provisions might include ensuring a sink is in or near the space, having cleaning supplies, and placing a covering on the surface where art is made. Cleanliness would help to reduce the trace of other clients, facilitating a client’s connection to the space during their session (Liddicoat, 2018). Keeping arts materials organized and accessible

would also help to reduce trace as well as support the creative process of the clients. An expressive arts therapist who uses dance/movement would want to consider how the space might adapt to provide open space for range of movement.

According to L. Moskowitz-Corrois, artwork made by clients in the expressive arts process ought not to be displayed and is ideally kept/held/owned by clients (personal communication, February 12, 2020). Storage of arts products is a confidentiality concern negotiated at the beginning of the therapeutic relationship. If the therapist agrees to store client artwork until the end of treatment or dispose of client artwork, the therapeutic space needs to accommodate for organized storage and/or discreet disposal. L. Moskowitz-Corrois furthers that wall art can be used in service of therapeutic goals or “metaphors” (personal communication, February 12, 2020). Moskowitz-Corrois prefers displaying photographs of nature. For example, a therapeutic space might have a wall photo of a bridge to encourage the client to make connections internally and externally. As previously mentioned, Jones (2018) included an example of a social worker using wall art to encourage clients into deep therapeutic work. The wall art is not part of an expressive arts intervention but does contribute to a space’s atmosphere.

The roles of the therapist and client. The fact that therapeutic space design is a creative process inspires my interest in this investigation. In my arts practice, I make decorative art and enjoy interior design. However, a critical distinction between therapeutic space design and my personal creative processes is that therapeutic space design is guided, first and foremost, by the therapeutic needs and goals of the client, as noted by Cook and Malloy (2014). This literature review did not discover a single or clear approach regarding therapist design preferences. For example, in Jones (2018), the social workers revealed/concealed aspects of their personality to varying extents. I would suggest that beyond putting client needs first, the decision to

reveal/conceal connects to the therapist's approach to their work. Moreover, as addressed by Fenner (2011) and Jones (2018), therapist needs must be considered as these needs apply to their capacity to do their work well.

Furthermore, this literature review gave multiple prescriptions for the role of clients in the design process. As previously mentioned, for Platt et al. (2017), client involvement is key to the therapeutic space design of inpatient psychiatric units for U.S. veterans. For L. Moskowitz-Corrois, who works with grieving children, teens, and families in a community outpatient setting, clients are not actively involved (personal communication, February 12, 2020). Receiving client feedback is a value of every article I reviewed. Different levels of involvement are likely best for different populations and settings. Because the veterans live for extended periods of time in the psychiatric unit, their control of their environment, via involvement in the design process, is perhaps key to creating a sense of home. Since Moskowitz-Corrois aims to cultivate, like Peri Bader (2015), client inattention to the space, not directly collecting client input makes sense.

Conclusion

The aim of this interdisciplinary and international literature review was to investigate the role of therapeutic space design on the therapeutic relationship between client and therapist, with a focus on expressive arts therapy. I surveyed research from non-therapeutic settings, including design, architecture, and hospitality, as well as therapeutic settings for general and specific populations. The therapeutic settings for general populations were mixed-setting counseling spaces, private-practice counseling spaces, in-home settings, and hospitals. The therapeutic settings for specific populations were designed for high schoolers, individuals being treated for self-harm, veterans in inpatient psychiatric treatment, children and adolescents in inpatient

psychiatric treatment and other medical treatment, elders with dementia, and women affected by trauma and substance misuse.

Through my literature review, I established that good-enough therapeutic space positively impacts the therapeutic relationship. Good-enough therapeutic space design for the expressive arts therapist considers the layout of the space, the use of sensory information, provisions for hospitality, and provisions for biophilic design. These considerations are evaluated by their accessibility, adaptability, and applicability to expressive arts therapy.

Perhaps the most important qualities a therapist can possess in creating good-enough therapeutic space are intentionality—mentioned in Moskowitz-Corrois's (2018) definition of therapeutic space—and resourcefulness. The therapist must be intentional about meeting the needs of their clients and their own self-care needs. This intentionality creates a hospitable space. The therapist must also be resourceful with the space and materials they have (or do not have) to meet these needs.

Further research is needed to expand as well as test the efficacy of my checklist. Researching a single population in depth may reveal additional considerations to include in my checklist. Further research could also explore the relational space created between client and therapist, the role of time in creating therapeutic space, and the impact of built versus portable therapeutic space on the therapeutic relationship.

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Appendix A

Good-Enough Therapeutic Space Collage



I created this collage on November 24, 2019 in my Research and Evaluation course at Lesley University. This collage represents my personal conceptualization of good-enough therapeutic space. On February 19, 2020, I coded the images for ease of analysis. Through this process, I identified three broad categories of images: nature, arts, and hospitality.

Appendix B

Good-Enough Therapeutic Space Design Considerations for the Expressive Arts Therapist

<p>1. The Layout of the Space</p> <p>A. Safety (Cook & Malloy, 2014; Peri Bader, 2015; Platt et al., 2017)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Is open space appropriate? Is it needed for dance/movement and/or accessibility? <input type="checkbox"/> Which items should not be in the space for the well-being of the client and therapist? <p>B. Privacy (Platt et al., 2017)</p> <ul style="list-style-type: none"> <input type="checkbox"/> How does the space support the confidentiality of the work? <p>C. Thresholds (Bobier et al., 2015; Fenner, 2011; Liddicoat, 2018)</p> <ul style="list-style-type: none"> <input type="checkbox"/> How might the entrance/exit be accessible and support the work? <input type="checkbox"/> How can you emphasize the window(s)? Or compensate for the lack of a window? <p>D. Fixed v. Semi-fixed Features (Cook & Malloy, 2014)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Which features in the space cannot be changed? <input type="checkbox"/> Which features in the space can be changed? <input type="checkbox"/> What financial resources do you have to re-design the space?
<p>2. The Use of Sensory Information</p> <p>A. Light (Bobier et al., 2015; Jones, 2018; Miwa & Hanyu, 2006; Peri Bader, 2015)</p> <ul style="list-style-type: none"> <input type="checkbox"/> How might you incorporate natural lighting? <input type="checkbox"/> Is dim (or warm) lighting appropriate? <p>B. Color (Cook & Malloy, 2014; Jones, 2018; Miwa & Hanyu, 2006; Weinberger et al., 2017)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Which natural colors will you use? (e.g., blue green, neutral tones) <p>C. Tactility (Bobier et al., 2015; Platt et al., 2017)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Are sensory-regulating items needed? <p>D. Sound (Andrade et al., 2016; Sadar, 2018)</p> <ul style="list-style-type: none"> <input type="checkbox"/> How can sound be used for privacy? <input type="checkbox"/> How can sound be used to support therapeutic goals (e.g., relaxation)? <p>E. Other (Sadar, 2018)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Do you need to regulate other sensory information, such as temperature, air quality, humidity, and odor?
<p>3. Provisions for Hospitality</p> <p>A. Cleanliness (Jones, 2018; Liddicoat, 2018)</p> <ul style="list-style-type: none"> <input type="checkbox"/> How can the space reduce the trace of other clients? <input type="checkbox"/> What can support cleaning after artmaking and the maintenance of arts materials? <p>B. Comfort (Andrade et al., 2016; Bobier et al., 2015; Jones, 2018; Peri Bader, 2015)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Are the seating options comfortable? <input type="checkbox"/> How can the sensory information support the comfort of the space? <p>C. Organization (Devlin et al., 2014)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Are materials, such as expressive arts supplies, orderly? <p>D. Home-like Features (Goelitz & Stewart-Kahn, 2006; Graham et al., 2015)</p> <ul style="list-style-type: none"> <input type="checkbox"/> What home-like features might be included to support the work?
<p>4. Provisions for Biophilic Design</p> <p>A. Décor (Andrade et al., 2014; Bobier et al., 2015; L. Moskowitz-Corrois, personal communication, February 12, 2020; Lee, 2019; Platt et al., 2017)</p> <ul style="list-style-type: none"> <input type="checkbox"/> How might you include natural scenes on the walls via art, photos, or windows? <input type="checkbox"/> Are you willing to take care of plants, flowers, and/or water features (e.g., aquarium or fountain)? <input type="checkbox"/> What other natural elements might be included (e.g., seashells, stones)?

Inspired by Liddicoat (2018), I created this checklist to synthesize my literature review and begin to identify categories of therapeutic space design features that are accessible, adaptable, and applicable to the expressive arts.

THESIS APPROVAL FORM

**Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Expressive Arts Therapy, MA**

Student's Name: _____ Rebecca Kreshak _____

Type of Project: Thesis

Title: ____ Good-Enough Therapeutic Space Design: A Literature Review and Considerations for Expressive Arts Therapy _____

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: _____ Dr. Ara Parker _____