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Ann Sloan Devlin

Connecticut College, asdev@conncoll.edu

Jack L. Nasar

Ohio State University

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Recommended Citation

Devlin, A. S., & Nasar, J. L. (2012). Impressions of psychotherapists' offices: Do therapists and clients agree? *Professional Psychology: Research & Practice*, 43, 118-122. doi:10.1037/a0027292

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Keywords

aesthetics, environmental meaning, person perception, therapists' offices, therapists' perceptions

Comments

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<http://dx.doi.org/10.1037/a0027292>

Running head: JUDGMENTS OF CLINICAL OFFICES

Impressions of Psychotherapists' Offices: Do Therapists and Clients Agree?

Ann Sloan Devlin

Connecticut College

Jack L. Nasar

The Ohio State University

ANN SLOAN DEVLIN received her PhD in psychology from the University of Michigan. She is the May Buckley Sadowski '19 Professor of Psychology at Connecticut College. Her current areas of research include the role of architecture in healthcare outcomes, perceived control as a mediator of stress in healthcare settings, and perceptions of therapists' offices.

JACK L. NASAR received his Ph.D. in Man-Environment Relations from Pennsylvania State University. He is a Professor of City & Regional Planning at The Ohio State University. His research deals with human responses (perception, evaluation, meaning, and behavior) to the physical environment.

We want to thank Saul Robbins for the use of his photographs.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Ann Sloan Devlin, Department of Psychology, Connecticut College, 270 Mohegan Avenue, New London, CT 06320. E-mail: asdev@conncoll.edu

Abstract

Do therapists and potential clients similarly evaluate offices of practicing clinicians?

Furnishings in a therapist's office can create a welcoming environment, yet little research examines perceptions of such furnishings, leading to the focus of this research. In a previous study with 30 color photographs of psychotherapists' offices, students favored clinical settings that were soft, personalized, and orderly (Nasar & Devlin, 2011). Using the same 30 photographs, the present studies had 32 licensed psychotherapists evaluate the quality of care, comfort in the setting, and therapist qualities they expected clients to experience in each office. The judgments that therapists thought clients would make had high correlations with the earlier judgments of students; each group's composite evaluation improved significantly as the office became softer and more orderly. This brief report concludes by recommending the features likely to create a welcoming therapeutic office.

Key words: therapists' perceptions, therapists' offices, aesthetics, environmental meaning, person perception

Impressions of Psychotherapists' Offices: Do Therapists and Clients Agree?

In his introduction to Engelman's (1976) book of photographs taken of Freud's office in Vienna, Peter Gay argues that Freud tried to create a comfortable therapeutic environment for himself and his patients, providing heat in the tile stove positioned at the end of the analytic couch and throws and pillows covering the surface of the couch. The therapeutic environment represents a healing setting (Frank & Frank, 1991, 2004). Through a process of interpersonal influence (Strong, 1968, 1987; Strong & Dixon, 1971; Strong & Schmidt, 1970), perceived characteristics of the therapist, each of which may relate to the physical environment of the office, may affect clients' experience (Chaikin, Derlega, & Miller, 1976). Although distal (Sue & Zane, 1987), the appearance of the office is a therapeutic variable that many practitioners can control. Admittedly practitioners in private practice have more ability to control the appearance of their office than do practitioners who work in organizations and institutions, but even in those settings the therapist may have some degree of choice and personal expression. Knowing the likely impressions on clients and the degree to which therapists accurately gauge those impressions could offer guidelines for office appearance.

Regrettably, although research has documented influences of the physical environment on human well-being, particularly for healthcare settings (e.g., Arneill & Devlin, 2002; Devlin, 2008), it has given less attention to the therapist's office. Within the broader literature on offices, two physical characteristics of offices have been identified that may affect the client experience: softness/personalization and order. An office with softness has many comfortable surfaces and textures (e.g., upholstered cushioned chair, carpeting), among other features. Personalization refers to the degree to which the office displays personal mementos, certificates, etc. Orderliness refers to how neat and tidy the office is. Soft or muted lighting and soft personalized offices have favorable effects (Chaikin et al., 1976; Miwa & Hanyu, 2006; Nasar & Devlin, 2011). Some psychotherapists may object to

personalization, believing that the display of personal memorabilia interferes with the therapeutic process (Scharff, 2004). However, personalization that creates a comfortable environment for the counselor may enhance clinical effectiveness (Pressly & Heesacker, 2001). People judge therapists who display a large number of credentials as more qualified and energetic than therapists who do not (Devlin et al., 2009). Further, students judged counselors in an office having diplomas and awards visible as more expert than they did counselors in an office lacking them (Heppner & Pew, 1977).

With respect to order, people like orderly and well-kept places (Kaplan & Kaplan, 1989; Nasar, 1998; Robinson, Lawton, Taylor, & Perkins, 2003) and respond more favorably to neat offices than to less tidy ones (Campbell, 1979; McElroy, Morrow, & Wall, 1983; Morrow & McElroy, 1981). Orderliness may relate to the perceived formality of the office; clients have greater confidence in a therapist when an interview is held in a formal than in a less formal setting (Amira & Abramowitz, 1979). In sum, the formality and order of the therapist's office might affect impressions of the office and of the therapist.

The present research extends earlier studies involving student perceptions of 30 offices. In those studies, students rated 1) the qualities likely to be exhibited by a therapist in the office, 2) the degree of comfort (i.e., affording contentment) and the quality of care that the student expected to feel and receive, respectively (Nasar & Devlin, 2011). The earlier studies found favorable impressions associated with softness/personalization and orderliness, and evidence that the results might apply to clients in therapy, people of different gender, age, geographical region, and city size. Would the results also apply to therapists? Based on the findings of large and consistent similarities in responses to environments across many demographic groups (Stamps, 1999), we hypothesized that therapists' assessments of the offices would accurately reflect the student assessments. Further, there is a convergence in

response to psychotherapists' offices across respondents varying in many socio-demographic characteristics (e.g., Backhaus, 2008; Nasar & Devlin, 2011).

Shared Method

Settings Studied

The two new studies used 30 digital color photographs of psychotherapists' offices in Manhattan (these photographs are available as Supplemental Material on the web at <http://>); 5 are home offices. The kinds of clients served and their presenting problems were unknown both to us and to the photographer, Saul Robbins (Green, 2008). Each photograph shows a controlled view of the therapist's chair from the vantage point of the client. This point of view and focus on the chair is appropriate. When asked to describe the physical environment of the therapy setting in detail (Backhaus, 2008), more than 90% of therapists and clients mentioned furnishings such as a chair or couch, and when asked to rate the importance of such items, they rated the chair as the most important. In the current studies, participants saw and responded to the color photos of the offices on-line on Survey Monkey. Each study used four different orders of the offices to mitigate order effects.

Setting Characteristics

To keep the independent and dependent variables separate, we obtained ratings of the physical attributes of offices separately from ratings of the evaluations of the offices and likely therapist. Thus, the earlier studies obtained judgments from 12 graduate students who used 7-point scales to rate seven attributes of each office: Simple-Complex (the number of different objects in the office), Spacious-Cramped, Orderly-Disorderly, Neat-Messy, Modern style-Traditional style, Hard office-Soft office, and Impersonal-Personalized (see Nasar & Devlin, 2011 for details). Each scale had a high inter-observer reliability ($\alpha > .77$). A principal component analysis found that two components explained most of the variance (72.5%).

We reversed and labeled the first component “orderly.” Four scales had high loadings on it: disorderly, complex, messy, and cramped. We labeled the second component “soft/personalized.” Two variables had high loadings on it: personalized and soft office. For subsequent analyses, we combined the attributes with high loadings on each component into two summary variables, which have a low and statistically insignificant correlation with one another.

Studies 1 and 2: Therapist Data

The new data gathered for studies 1 and 2 had three purposes. Both studies looked at therapists’ perceptions of clients with regard to the target variables of the studies. Study 1 investigated whether soft office/personalization and order were associated with the therapists’ assessments of the perceived quality of care and comfort they would expect clients to experience in the office. Study 2 examined whether the same two variables were associated with the therapists’ assessment of the clients’ likely perceptions of the therapist’s qualifications, boldness, and friendliness. The words qualified and friendly have their normal connotations; boldness is used to suggest lack of shyness. Each study then compared the therapist responses to those reported earlier from students (Nasar & Devlin, 2011).

Method

Sample. The participants were therapists who are part of the Anthem Blue/Cross Blue Shield network of Connecticut. Six hundred sixty-eight Clinical/Independent Psychologists listed within the Century Preferred Health Plan, under the category of Behavioral Health, who practiced within 50 miles of three cities spread across the state, were sent letters to solicit participation. In addition, e-mail requests for participation were sent to 7 clinicians in group practice in southeastern Connecticut and 20 clinicians in group practice in the Pioneer Valley area of Massachusetts: 55 responded, yielding a response rate of 7.9%. Each solicitation contained one of the SurveyMonkey URLs, distributed roughly equally across the

number of letters sent. Nineteen of the 55 therapists (9 men and 10 women; age, $M = 55.8$ years, $SD = 9.5$ years) participated in Study 1. Although the sample is relatively small, the main unit of analysis is the 30 offices. Most of the participants were Caucasian (89.5%). On average, they had practiced 23.0 years. Most of them described their training or license as clinical psychologist (89.4%) and their terminal degree as a PhD (73.7%). They reported primarily seeing adults (68.4%), but they also reported no specific emphasis (15.8%), or seeing adolescents, children, or all groups (5.3% each). Most of them reported that they did individual, family, or couples therapy (78.9%); over half worked in one location (57.9%) and not in a shared office (68.4%).

Thirteen of the 55 therapists (5 men, 7 women, 1 NA; age, $M = 56.8$ years, $SD = 13.1$ years) participated in Study 2. Again, the unit of analysis is the 30 offices. All of the participants were Caucasian. On average, they had practiced for 23.9 years. Most of them described their training or license as clinical psychologist (92.5 %) and their terminal degree as a PhD (69.2%) or a PsyD (23.1%). Most of them reported primarily seeing adults (61.5%). Most of them provided individual, family, or couples therapy (92.3%), worked in one location (69.2 %), and over half did not share an office (53.8%).

The earlier student samples from Nasar and Devlin (2011) had 104 participants (52 women, 51 men, 1 NA, 76 undergraduates, 28 graduate students, mean age 22.0 years) in Study 1; and 102 students (52 women, 50 men, 75 undergraduates, 27 graduate students, mean age 21.1 years) in Study 2. Most participants in each student study were Caucasian (more than 79.0%). They were fairly evenly distributed across their year of study. Most reported that they had visited a therapist at least once (more than 53.0%; median number of visits was 12 for Study 1, and 17.5 for Study 2).

Procedure

Therapists receiving a letter of solicitation could participate either by contacting the researchers for a web link or by typing into their browser the web link in the letter. There were 16 versions of the survey (4 conditions, 2 of which are described here, each with 4 orders). As described in Nasar and Devlin (2011), students from the earlier studies, whose data are used for comparison here, were recruited from undergraduate courses in psychology at a small college in a small town in the Northeast and a graduate course in city and regional planning at a large university in a midsized city in the Midwest.

For Study 1, therapists were asked to rate how they imagined patients would react to each office (on 7-point scales from very poor to very good) for the quality of care expected and how comfortable they would feel in it. Research by Devlin (2008) indicated that these qualities could be used to significantly differentiate judgments of medical facilities. For Study 2, therapists were asked to rate the patient's expectations about the therapist in each office on three 7-point scales (Unqualified-Qualified, Timid-Bold, Friendly-Unfriendly). These three dimensions had emerged through factor analysis in earlier research on therapists' offices assessing how displaying different numbers of credentials impacted judgments of the therapist (Devlin et al., 2009).

In each study, the order of the items varied at random from office to office. Both studies then had an open-ended question asking for the characteristics of the offices that most stood out and influenced the ratings, and a list of 23 factors (such as plants, or neatness) to rate on a 5-point scale for the importance of each in affecting their judgments. These items came from the range of items (furnishings, decorations, style) and their arrangement (e.g., orderly) in the 30 photographs. The therapists were also asked to report various characteristics of themselves and their practice.

Recall that we used two scales in Study 1 and three in study 2. The unit of analysis was the mean score on each of these scales for each office. We used these mean scores on

each office to examine the reliability of judgments across participants. There was high inter-observer reliability (α 's > .80) across the therapist participants for the Comfort dimension, Quality of Care dimension, and the Qualified dimension; the Comfort, Quality of Care, and Qualified dimensions had a high inter-item reliability ($\alpha = .92$). These results suggest that therapists' responses on those three scales could be combined into a composite score for each office. The Bold and Friendly dimensions, which had low inter-observer reliability ($\alpha < .70$), were dropped from subsequent analyses.

Results

Overview

As described earlier, the analysis of perceived physical characteristics of the office revealed two aspects, orderliness and softness/personalization. In Studies 1 and 2, we examined the relationship between these two aspects of the offices and the quality of care and comfort that therapists thought patients would expect for each office (Study 1) and judgments of how qualified, bold, and friendly patients would think the therapist in each office was (Study 2). The ratio of 30 cases to two independent variables is acceptable. Due to space constraints, the paper cannot report in detail the results for the perceived importance of the various elements in the offices. However, those analyses found that: 1) the therapists ($N = 32$) gave the highest scores to elements (such as neatness) related to order, and to elements (such as chair comfort, books, paintings, windows and chair covering) related to the soft/personalization dimension; 2) the responses of the therapists correlated with those of the students ($N = 23$; $r = .88$, $p < .001$).

For impressions of quality of care and comfort (Study 1), the softness/personalization dimension and orderliness mattered. As softness/personalization and orderliness increased, the perceived quality of care and comfort that therapists thought patients would expect improved. In the multiple regression analyses, as the office became softer and more orderly

(predictor variables), the therapists' judgment of patient expected quality of care and comfort (criterion variables) improved at significant levels ($p < .01$). For quality of care, orderliness had a large effect, but the soft/personalized dimension had a small to medium sized effect. For comfort, orderliness and soft/personalized each had a medium to large sized effect.

For impressions of the likely psychotherapist (Study 2), orderliness had less relevance. As softness/personalization increased, the qualities expected for the psychotherapist improved, but changes in orderliness did not have an effect. The multiple regression analyses showed that as the office became softer/more personalized, perceived qualifications of the therapist improved, at a statistically significant level ($p < .005$). For ratings of how qualified the therapist was, the soft/personalized dimension had a large effect. For each criterion variable, orderliness had a small effect.

The means of the Student and Therapist ratings ($N = 30$) for comfort, quality of care, and qualified had statistically significant high Pearson correlations with Bonferroni adjustments for multiple comparisons ($r's > .76, p < .001$). Each of the scales – comfort, quality of care, and qualified – within and across each group had statistically significant correlations with one another, and the three scales had high inter-item reliability ($\alpha = .91$), suggesting that the items could be combined into one scale. The combined therapist and student sample also had high inter-item reliability for the three scales ($\alpha = .94$). After reporting on the role of soft/personalized and orderliness on each of the scales, we report on the composite of the means of the three items in relation to those two attributes.

For Study 1, a repeated measure analysis of variance with group (Therapist vs. Student) as a between subject variable and scale (Comfort, Quality of Care) as a within subject variable found no significant difference in response between the two groups, or group by scale interaction. For Study 2, the repeated analysis of variance with group (Therapist vs. Student) as a between subject variable and scale (Qualified) as a within subject variable

found a similar pattern of results. There was no statistically significant difference in response between the two groups. The regression of soft/personalized and orderly onto the composite scale (the means of the three scales on each office) found that as soft/personalized and orderly increased, the composite evaluation improved (soft/personalized, $\beta = .67$, $t = 5.03$, $p < .001$; orderly, $\beta = .544$, $t = 4.01$, $p < .001$).

As new clients form an impression based on a first session in one office, and as responses to fewer offices might be less consistent than responses to many, an additional analysis centered on students' responses to the first office rated. We could not do an analysis for the therapists on fewer than the first five offices because using four different presentation orders reduced the number of participants in each order, for each office. For that reason, we focused on the students. The students' responses to the first office (which varied across the four orders), confirmed high inter-observer reliability for comfort ($\alpha = .87$), quality of care ($\alpha = .79$), but a somewhat lower inter-observer reliability for how qualified the therapist was judged ($\alpha = .68$), suggesting some consistency, especially for quality of care and comfort, even when a single office is rated. In analyses for the first five offices for therapists (the number of offices large enough to calculate alphas), similar reliabilities ($> .70$ for comfort and quality of care, $\alpha = .68$ for qualified) emerged.

The degree of perceived variability in the offices might also have affected the degree of consistency that emerged. If little variability were perceived, greater consistency might result from this characteristic alone. The standard deviations across offices for the ratings on each of the five scales suggest that the therapists did perceive variability in the offices. The *SDs* ranged from 0.93-1.24 for these scales; the average differences between the minimum and maximum scores were: 4.23 (comfort expected), 4.07 (quality of care expected), 3.24 (boldness), 3.30 (friendliness), and 3.73 (qualification).

Discussion

The results reinforce the importance of comfortableness (i.e., feelings of well-being, ease) and orderliness (i.e., neatness) in affecting judgments about the office and its occupant and lend support to the generalizability of the findings from earlier research (Nasar & Devlin, 2011). The present studies suggest moderate agreement between the judgments of the offices by therapists and students. Overall, therapists were accurate in predicting how clients were likely to perceive the offices. That result is reassuring, both in terms of external validity and the generalizability of results based on student samples, and also in terms of the degree of influence of the variables highlighted in the study (softness, personalization, and orderliness). The results reinforce the role of softness/personalization in affecting the perceived quality of care and comfort, and the perceived qualifications of the therapist. The effect of orderliness, while important, is not as clear-cut for some evaluations by the therapists. For that reason, further research should examine differences in how orderliness is manifested and interpreted in terms of its weight in evaluating the physical environment. The finding that softness and orderliness are desirable in counseling settings is consistent with previous research (Chaikin et al., 1976; Gifford, 1988; McElroy, Morrow, & Wall, 1983; Morrow & McElroy, 1981). A soft and personalized office may capture the perceived social attractiveness of the therapist (Chaikin et al., 1976; Gifford, 1988; Miwa & Hanyu, 2006; Sommer, 1974) and affect the credibility of the therapist, which in turn may play a role in whether a patient remains in therapy (Amira & Abramowitz, 1979; Strong, 1987; Sue & Zane, 1987). Such an office may feel comfortable, help the setting appear safer to clients (Frank & Frank, 1991, 2004), and improve client disclosure and therapists' effectiveness with their clients (Chaikin et al., 1976; Pressly & Heesacker, 2001). In the context of the therapeutic environment, an orderly clinical setting may provide a sense of structure and predictability for the client whose own life may lack those reassuring characteristics.

The results also suggest that clinicians may have some awareness of the impact of the

physical environment for clients. Some remarks made by therapists to explain their ratings reflect an awareness of the potential impact of the physical environment. For example, one therapist commented, "Bookshelves give the impression of competence," and another stated, "Clutter gave the impression of a disorganized therapist." Still others gave a somewhat begrudging nod to the impact of the physical environment, as reflected in the following comment: "I know too many great therapists who work in messy rooms and have very satisfied clients to put much stock in the orderliness of the room or the book cases," but this therapist then went on to say, "Empty book cases may not say much about the therapist's skills, but would convey less of a sense of confidence to the client."

Although responses of the therapists agreed with those of the students, one area of divergence may be useful to consider. For perceptions of the therapist's qualifications, orderliness had a larger role in the student than in the therapist responses. Perhaps the therapists are less aware of variations in orderliness or they underestimate its effect on client evaluations. Better information is needed on what influenced therapist responses and how well their responses would generalize to ratings made while sitting in the actual offices. Further, research is needed on whether these ratings would predict therapeutic outcomes.

Limitations

Participants responded to photographs of therapists' offices and did not experience the offices in person. Although responses to the photos should generalize to responses to the offices (Nasar, 1998; Roth, 2006; Stamps, 1993; Ulrich et al., 1991), future research should test on-site evaluations by clients. Through controlled studies (e.g., using videotape clips), future research also might examine the interaction of particular characteristics of the environment (such as the degree of softness or order) and therapist (such as expressed empathy).

The studies also had a low response rate from therapists, which may restrict the findings, even though the analyses used the 30 settings as the unit of analysis. Despite the limited number of participants, our sample was similar in a number of respects (age, gender, race, kinds of clients seen) to a national sample of Psychology Health Service Providers sponsored by the APA in 2008 (<http://www.apa.org/workforce/publications/08-hsp/index.aspx>), and to a sample of full-time clinical psychologists who were members of the California Psychological Association (Sentell, Pingitore, Scheffler, Schwalm, & Haley, 2001). Future research would benefit from a larger sample of therapists.

Summary and Recommendations

In sum, the data reflect a degree of consonance between the judgments of therapists about the likely reactions of their clients and the earlier reactions of the students, most of whom had experience in therapy. Whether or not they had been in therapy, those students responded similarly to one another; those similarities also indicate the potential generalizability of the results. If clinicians knew more about the effect of the physical environment on perceived comfort and quality of care, they could use that information to improve their therapeutic environment. The low ratings of some offices in this research suggest that some clinicians might benefit from guidelines about the kinds of environments likely to be considered supportive and welcoming, contributing to our understanding of the healing setting (Frank & Frank, 1991, 2004). Therapists may want to consider the role of orderliness in their office (the appearance of neatness) as well as the degree to which the surroundings communicate softness, through their selection of furnishings and accessories. Therapists' ratings suggested that chair comfort, books, paintings, and having windows were all positive aspects of the offices. Clinicians or those who manage office appearances could use such findings to improve not only the comfort of therapeutic environments but also the quality of care that clients expect.

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