Beyond the counselling workspace: Spaces of significance in the treatment of self harm

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Abstract: This paper explores the significance of environments outside the counselling workspace\(^1\) in the treatment of self harm\(^2\). Spaces considered include a de-escalation space post counselling, an urge room in inpatient care, and a natural mind-space, adjacent to the counselling workspace and accessed only visually. The transition of spaces and planning of the spatial journey around a counselling session are also discussed. Using literature of therapeutic practice, each of these spaces are analysed to show the reasons behind their significance to individuals in treatment for self harm. Utilising the architectural science principles of examining the way buildings are used and how well they physically fit their function, this paper explores the design of the built environments delivering mental health services, and the impacts of design practice on the therapeutic efficacy and the function of these spaces. By understanding how individuals who self harm may experience a space, better design of these environments delivering mental health services may be enabled. This paper suggests a series of design initiatives for each of the spaces outlined, and suggests further research into how to evaluate and integrate these into built environments. Implications for clinical practice are discussed, to explore the relationship between the physical space and the function for which they are designed.

Keywords: Self harm; therapy; built environment; interior design.

1. Introduction

There is a considerable body of literature affirming links between mental wellbeing and good design practice. Evaluations of specific design interventions have shown that good design of clinical and treatment environments leads to better clinical outcomes and less stress for the users; both patients

\(^1\) Within this paper, the counselling workspace is defined as the space where a therapeutic/counselling session occurs. This is typically an interview room/office type space, and is inclusive of physical items such as a table, chairs, bookshelves and similar; physical aspects such as ceiling height, colour, lighting levels and similar; and other aspects such as control, personalisation, territories, interpersonal distances and similar, all forming what Stanley Law describes as ‘the therapeutic situation’. [Law, S., G (1948) The therapeutic situation, in S. G. Law (ed.), Therapy through interview, McGraw Hill, New York, 12-21.]

\(^2\) Within this paper, self harm is conceived of as the physical harming of the body without suicidal intent. This involves a physical wounding of the body tissues. More broad definitions of what may constitute self harm, such as eating disorders, tobacco smoking, alcohol abuse, or some forms of tattooing, and correlated but clinically separate conditions, such as depression, are not considered part of this research.
and staff (Ulrich et al., 2004; Marberry, 2006). When considering environments for therapy and counselling specifically, research exists which links this therapy practice with the built environment, illustrating how its design can affect therapeutic delivery and suggesting that the incorporation of spatial and built elements should form a part of therapeutic techniques (Sivadon, 1970). The counselling environment is regarded within clinical literature as having an effect on a consumer’s\(^3\) sense of wellbeing (Gross et al., 1998; Ulrich et al., 2008). Consumers’ experience of such spaces can have a highly emotional dimension (Pressly and Heesacker, 2001) which is suggestive that environment design should be investigated as a potential means to influence therapeutic efficacy. Further, individuals have differing abilities to censor or suppress their environments (Dijkstra et al., 2008) and a stressed patient has reduced capacity to exclude environmental distractions (Samuelson and Lindauer, 1976), suggesting the environment of a counselling room may have more impact for these individuals who often arrive in a distressed state. Research exists linking the design of counselling workspaces to communication and patient self-disclosure. This highlights the potential significance of the physical design of built environments which are delivering mental health services.

2. Methodology

The above discussion serves to emphasise the importance of spatial encounters within counselling and therapeutic practice, as defined in the literature. As outlined in this paper, the author has conducted interviews with consumers in treatment for self harm to further understand and analyse the linkages between space and therapy. Many counselling theorists and practitioners assert that there is a link between counselling environment design and therapeutic outcomes (Pressly and Heesacker, 2001). However there is also an acknowledged lack of research in this area (Pressly and Heesacker, 2001), further, many existing studies which examine the impact of the designed environment on counselling practice have focused on the public areas, such as common rooms in in-patient psychiatric facilities, rather than more private spaces, such as counselling rooms (Corey et al., 1984). A number of studies have only focused on therapist perspectives of the issue rather than interviewing patients/consumers (Pearson and Wilson, 2012). This is suggestive that consumer perceptions also need to be included in the research, and that a multi-source data collection methodology is ideal, where the counsellors, patients, and other related parties such as patient carers, are sought to provide feedback to inform the research. The design of built environments delivering mental health services affects each of these groups (Pressly and Heesacker, 2001).

Fieldwork undertaken by the author involved a series of focused interviews with consumers, therapists/counsellors, carers, architects/designers and design experts/researchers, in order to understand consumer experience of built environments delivering therapy. This data was analysed through a thematic network (Attride-Stirling, 2001) and the data re-interpreted to draw conclusions on spatial perception, and implications for the design of built environments to best support the function of therapy. Open ended questions were asked in order to facilitate participants expressing their views on the issues being investigated (Creswell, 2003). The interviews lasted from forty minutes to ninety minutes depending on interviewee’s responses to interview questions. This exploratory qualitative analysis (Attride-Stirling, 2001) was undertaken with the five respondent groups noted above, including: 12 consumers of mental health services, 12 practicing therapists/counsellors, 3 carers of loved ones with

\(^3\) The term consumer is used within this paper referring to the individuals who are clients of mental health service delivery. The terms patients and consumers are used interchangeably.
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a mental illness, 4 architects/designers who practice in the field of designing built environments for mental health; and 5 design experts/researchers who work and research in the field of design for mental health. For in depth interviews, as were undertaken, the number of interview respondents were deemed significant enough to draw substantial conclusions (Attride-Stirling, 2001).

Through this fieldwork undertaken by the author, three further environments in addition to the counselling workspace were found to be significant, which are the subject of this paper. These spaces include a de-escalation space post counselling, an urge room in inpatient care, and a natural mind-space, adjacent to the counselling workspace and accessed only visually, such as through a window to an outside courtyard. The transition of spaces and planning of the spatial journey around a counselling session was also found to be significant. Each of these spaces is discussed below, as they were reflected upon by interview participants. Each space is also presented with reference to clinical literature to better enable an understanding of why these specific spatial environments and their particular design is significant. Following this, therapeutic implications of spatial design are discussed, outlining how the physical built environment affects therapeutic delivery. Finally, a series of design initiatives are suggested in relation to each of these spaces, to better enable the activity of therapy and support this function.

2.1 De-escalation space

A space to occupy post- counselling as part of a journey of de-escalation was found to be significant to individuals who self harm, in fieldwork undertaken by the author. After the intensity of a counselling session, for individuals who self harm the transition to the outside world afterward was found to be very difficult:

“The therapy sessions are often really intense, I don’t know about other people but my sessions might go for two hours, and I’d be totally numb afterwards and have to go straight out into the world, when I feel so vulnerable and it was so frightening, sometimes I’d just get so anxious about it, I’d be self harming in my car on the way home” (Consumer, 2015, Personal communication).

Having a space to occupy alone post counselling was raised by several consumers as being of potential benefit to them:

“If you could sit on your own and self soothe and rebalance yourself before you leave; otherwise I just dissociate and I think how did I get here! I must have gotten in my car and driven home but I’ve dissociated, which I do really easily after a session, and I have no idea how I’ve gotten home, and that’s dangerous! Somewhere in private before you go, it’d stop you dissociating, and mediate between the really intense heavy session, and going home” (Consumer, 2015, Personal communication).

Consumers who were interviewed mentioned feeling very vulnerable after their counselling session and needed a space to occupy quietly and privately to rebalance themselves and move from the intensity of the counselling session to the noise and pressure of the ‘outside world’. Some mentioned that within the counselling workspace they felt shut off from the world and needed a private space to sit in and maybe have a cry and prepare themselves for moving back into the world they had felt shut off from moments before. One consumer noted that even knowing that a private room was available for
A practicing therapist also reflects and supports the idea of a de-escalation space for consumers after a counselling session:

“Emerging straight into the world is confronting; I would liken it to getting up in the morning, and you have been in another state like sleep, and you need to adjust and bring yourself back to the world outside and bringing yourself back to whatever that might need to be. So, I think you are at a different rate, whether it be consciousness, or reengaging back into where you were previously, I think that can take time, and it can also take an awareness of how you can bring yourself back to that space” (Therapist, 2015, Personal communication).

One practicing therapist also discusses the notion of a de-escalation space for consumers to occupy post counselling, revolving around bodily movement:

“Possibly beyond that [counselling space] a space for someone to take a short walk, like a small hallway, for someone who the way they gather themselves... [is to] take a short walk back and forth... the physicality of walking is calming... it does offer the opportunity for your mind to go to find the answer. The rhythmic nature is also important” (Therapist, 2015, Personal communication).

This is suggestive that the transition between a counselling session and the world beyond is difficult and needs to be supported by environment and design, such as through a de-escalation space.

It seems the suggestion of a de-escalation space post counselling is strongly related to dissociation; this dissociation is prominent in individuals who self harm and the de-escalation space would be beneficial to help manage this, aiding reconnection with the self and re-integration with the ‘outside world’. Self injury is synonymous with stronger dissociative traits (Zlotnik et al., 1999), particularly during an episode of self harm (Low et al., 2000). Further, dissociation means that the experience is not remembered, which is confronting. This perhaps indicates why such a space is significant in individuals who self harm.

2.2 Urge room

The notion of an urge room in inpatient care was brought up in interviews with individuals who self harm. This is essentially a space where they might go when confronted with the urge to self harm, and this space would help to quell these desires through its design. This is described thus:

“Bright coloured pods, a confined space, where I could go would help - I blast the senses to occupy myself, to bring me back to the present. A sensory stimulus pod! That can rock! To soothe yourself. I mean, that’s why I watch a movie really loud [when I have the urge to self harm], or play my music real loud, to bring me back and stop distress. Rocking - it's relaxing, and it’s disabling, it’s rhythmic and brings you back to your body” (Consumer, 2015, Personal communication).

High sensory stimulation is paramount in this room to quell dissociative traits and enable the individual to remain present. Music is also noted as useful in this endeavour: “[Music] would be great for soothing, to be more present, it’s a good distraction and coping strategy. Music is good for escapism, it can transport you” (consumer, 2015, Personal communication).
Within clinical literature it is noted that individuals who practice self harm are commonly also afflicted by symptoms known as ‘high sensation seeking’ (Leibenluft et al., 1987). There is a close relationship between the practice of self harm and the sensations of the body (Huband and Tantam, 2009); the harming procedures serve to elicit sensory response as an emotional release, or aim to reconnect with the body, when anxiety or emotional distress has served to disengage the individual’s perceptions of their body, its boundaries and their environment (Juzwin, 2004). The high need for sensation is also attributed to maintaining arousal states in self harming individuals (Jones, 1982), essentially used to feel “something…more tangible” (Huband and Tantam, 2009) and provide important evidence that one is still alive. High sensation seeking is directly related to both mental wellbeing/function and the individual’s wider environment. There is an inference in existing research that high sensation seeking individuals have very particular perceptions to and needs from their environments (Hebb, 1958). Some require very strong stimuli in order to experience optimally strong emotions and support appropriate mental functioning (Zaleski, 1983). Experiences of high stimulation and arousal may help the individual to bypass the urge to self injure (Bresin et al., 2013). This is suggestive that an urge room would be useful in aiding individuals to quell dissociation and urges to self harm.

2.3 Natural mind-space

A view through a window to a natural landscape adjacent to the counselling workspaces was found to be very significant for individuals who self harm, in fieldwork undertaken by the author.

“Having that view out to a landscape, it’s been important through my whole stages of treatment, yeah the whole way, but I didn’t realise until I didn’t have that safe view from a window, and I think that is probably part of the reason I didn’t continue in some ways, because as I said it was so confrontational, I had nowhere to look, I felt totally judged and I just didn’t feel safe” (Consumer, 2015, Personal communication).

It seems that this landscape is not important to occupy physically, and that visual access provides the sense of escapism or mental respite which is desired:

“I would look out the window and even in the counselling I would need a window to feel safe, to “Oh, there’s a world out there!” You know? There’s a world out there and I might not feel safe in the physical area I am in, but it’s OK. It gives me a psychological connection to a bigger space, to a world outside what I am dealing with” (Consumer, 2015, Personal communication).

This window, alongside escapism, also promotes a sense of control, which is commonly lacking in individuals who self harm (Briggs et al., 2008):

“I’d like a big window where I could focus on everything. Otherwise [if the window is too small] it’s like you are just looking through a tunnel, you are not seeing what both sides are, what the big picture is, if I had a bigger window, I could see a bigger picture… It’s more relaxing, it allows me to be free, it allows me my freedom and my control, not anyone else’s” (Consumer, 2015, Personal communication).

The counselling space itself can be a smaller space, whilst still providing this visual access to a landscape space:
"I prefer smaller, smaller around me, but visual access to something larger, like a landscape, ideally" (Consumer, 2015, Personal communication).

However, it seems that a large expansive view to an unframed landscape, with no boundaries, is not preferable:

"I think if it’s too big, yeah I don’t think I’d feel safe, I don’t know why. No, if it’s too big I don’t think I’d feel safe" (Consumer, 2015, Personal communication).

The notion of a framed landscape as providing greater sense of freedom and comfort simultaneously is echoed by several consumers, who discuss how connection to nature in a contained way allows them to maintain a sense of protection and control through the borders or framing of the natural space.

Self harm is also associated with notions of control, which may explain why an unbounded landscape is threatening, as it may be more difficult to ‘come back from’, and this is confronting to individuals who already feel a lack of sense of control. Clinical literature and accounts of self harm describe how self injury is often a means by which an individual aims to reassert a sense of control and to quell anxiety. A perceived lack of control as occurs in self harm is closely linked with increased anxiety, and further “chronic self-injurers are often significantly less able to cope with emotional stress” (Huband and Tantam, 2009). The purpose of self harm is to reduce anxiety. The accounts of self harm also allude to notions of control when discussing boundary. These individuals seek experiences of high sensation in order to root themselves in a sense of stability (Levitt et al., 2004), in order to feel and explore the extent of their body (Huband and Tantam, 2009), and to feel in control (Briggs et al., 2008).

Practicing therapists also acknowledge that “landscapes and views to nature allows you [the consumer] a sense of escapism” (Therapist, 2015, Personal communication) and yet “a vast expanse is going to allow you to go too far, and might be threatening” (Therapist, 2015, Personal communication). Access to nature provides tranquillity and “it did have that enclosed space to it, and that offered me a lot of comfort” (Consumer, 2015, Personal communication). Thus, “the closed space does make sense to be able to bring someone back” (Therapist, 2015, Personal communication). It is noted by another practicing therapist how a sense of boundedness might also afford a psychological kind of privacy, which is important to therapeutic processes:

“The containment [around a natural space] demarcates that this is a sacred kind of space, and it respects people’s privacy, so what we are talking about here is just between us, and I think if it was just in the middle of a field it might feel unsafe... [it is important to have containment] when a client is talking about things that might make them feel vulnerable or exposed. Having an uncontained landscape would just exacerbate that feeling of vulnerability, I think it really could” (Therapist, 2015, Personal communication).

It also seems that the window offering views to nature should be on the ground floor or lower levels of a building for therapeutic reasons. As one practicing therapist explains, “being in a high building and having a view out might not be so grounding” (Therapist, 2015, Personal communication) which can be problematic therapeutically. Another therapist echoes this notion, explaining how high elevation in a built environment can be destabilising, and this can interrupt the therapeutic processes of the counselling session.

Theoretical research in this area explains that nature containing elements and content will reduce stress (Ulrich, 1999). Studies in healthcare environments generate strong evidence of the stress-reducing benefits of real or simulated views of nature or natural elements, and this manifests in positive
emotional, psychological and physiological changes (Hartig et al., 1995). This relates to how visual access to nature may allow individuals who self harm a sense of safety, as nature helps to reduce stress and anxiety and thus promotes a sense of comfort. Literature discusses user control in relation to territories and boundaries; as Goffman explains, we utilise boundary markers to distinguish territories and exert a sense of control (Goffman, 1971). This perhaps explains why a bounded landscape, accessed visually and occupied only by the mind, is calming, whereas an unbounded landscape is threatening.

2.4 Spatial journey

The notion of a linear spatial journey was also raised as being significant by individuals in treatment for self harm. As one explains: “It's kind of yucky to walk out the same way you came in if you are distressed. There should be a distressed door [an exit to use when feeling distressed after a counselling session], where you can’t be seen, and can leave that's different to the entry. Yeah a linear journey, I like that idea” (Consumer, 2015, Personal communication). It seems there is a metaphor of progress made spatially, and to backtrack and repeat earlier steps is not conducive to or representative of therapeutic development, and reminds the consumers of how they felt prior to the session, which to the consumers feels as though they are not making positive progress. A practicing therapist reflects on this:

“So you step out of the counselling space and if it is somewhere where you have just been, it doesn’t totally make sense [to reverse your journey] and I can see why someone could feel like it is a little bit of a backtrack, and you are just back where you started... if a certain behaviour environment represents something to someone, we need to listen to that and understand that it is really beneficial” (Therapist, 2015, Personal communication).

Another practicing therapist reflects on the metaphorical journey of a counselling session:

“Perhaps they [the consumers] are somewhat mentally preparing for a session and what to mention to their counsellors and it might be the space that triggers a lot of that thinking, and perhaps then having a space that you could then leave through would associate more with letting go of the session, and creating that mental boundary or that mental break between what just happened in the session and resuming your day to day daily life” (Therapist, 2015, Personal communication).

The importance of metaphors, such as the physical journey around counselling, may be of particular significance to individuals who self harm. To express emotional or physical pain to another, individuals who self harm “often rely upon metaphor. Self-mutilation is generally an unspoken expression of an internal and intangible experience” (Hitchcock Scott, 1999). Here self harm is a significant metaphor. Perhaps this is an indication of why the metaphor of a journey through physical space is of particular significance to individuals who self harm, who are already operating with strong use of metaphors, and find much comfort and calm in this.

3. Therapeutic implications of spatial design

Each of the spaces discussed above suggest a relationship between the physical design of the built environment delivering mental health services, and the therapy taking place. A de-escalation space may better enable a consumer to re-engage post counselling, reduce stress and anxiety, and minimise dissociation, which in turn promotes re-connection with the self. An urge room, by offering high sensory stimulation, may quell dissociative traits and urges to self injure, allowing the consumer to
remain present and more readily engage in therapy. A natural mind-space reduces stress and anxiety, offers escapism and a sense of control, which aligns with key aims of therapeutic treatments. A journey manifested spatially reinforces notions of progress and development, which supports empowerment in the consumer. These therapeutic implications of spatial design highlight the significance of the physical environment in supporting delivery of mental health services.

4. Design initiatives

Following the initial literature review, and the analysis of interviews conducted by the author, potential design initiatives suggested to architects were developed in relation to the design of counselling practices, relative to the three spaces beyond the counselling workspace outlined in this paper (see Table 1). Further research is suggested into these suggested initiatives, through a careful post occupancy evaluation and control studies, to better understand their applicability and therapeutic effects.

Table 1: Design initiatives

<table>
<thead>
<tr>
<th>De-Escalation Space:</th>
<th>Therapeutic effects discussed</th>
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<tbody>
<tr>
<td>Layout to permit movement (walking/pacing) as well as sitting</td>
<td>De-stress;</td>
</tr>
<tr>
<td>Visual and audial privacy must be afforded (consider lines of sight, access, soundproofing)</td>
<td>Reduce dissociation, remain present; Progress metaphor.</td>
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<tr>
<td>Rich material palate promoting sensory stimulation</td>
<td></td>
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<tr>
<td>Connection to nature ideal (artificial means include artwork posters with nature content, sound recordings of nature; other means include pot-plants, views to nature/courtyard, sand trays/rock garden to engage with)</td>
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<tr>
<td>Exit must not link back to the point of entry; circulation must be a linear journey</td>
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<tr>
<td>Urge Room:</td>
<td></td>
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<tr>
<td>Rich material palate promoting sensory stimulation</td>
<td>Reduce dissociation, remain present; Foster sense of agency.</td>
</tr>
<tr>
<td>Ability to play music – user controlled</td>
<td></td>
</tr>
<tr>
<td>Bright colour in interior furnishings and wall colouring</td>
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<tr>
<td>Small interior dimensions – the space needs to feel tight in order to quell anxiety (do not use high ceilings, spacious interior)</td>
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<tr>
<td>Tactile wall treatments beneficial</td>
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<tr>
<td>Natural Mind-Space:</td>
<td></td>
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<tr>
<td>View to nature is privileged – natural space must be directly adjacent to the counselling workspace</td>
<td>Escapism; Provide safety and privacy; De-stress; Remain present/grounded.</td>
</tr>
<tr>
<td>Nature area is framed or bordered (such as an enclosed courtyard, an open area with a surrounding hedge, tree-lined (evergreen) to block further sight, consider clear spatial boundaries)</td>
<td></td>
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<tr>
<td>Nature area cannot be accessed (the area must be enclosed an private to allow it to be occupied by the mind – ensure entry points are not seen from the counselling workspace)</td>
<td></td>
</tr>
<tr>
<td>Large windows to allow access to this nature area from the interior of the counselling workspace</td>
<td></td>
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<tr>
<td>Counselling workspace is on the ground floor or lower levels of the building</td>
<td></td>
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<tr>
<td>Visual access to ground and sky is permitted at all times (consider lines of sight and window positioning)</td>
<td></td>
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<tr>
<td>Interior area of counselling workspace may be smaller if nature area is larger</td>
<td></td>
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<tr>
<td>Spatial Journey</td>
<td></td>
</tr>
<tr>
<td>Linear circulation from entry, though counselling workspace, to exit</td>
<td>De-stress;</td>
</tr>
</tbody>
</table>
5. Conclusion

Self injury is acknowledged by the literature as a growing health concern (Klonsky and Glenn, 2008). In addition, self injury is correlated with many types of psychopathology, and personality disorders, including the borderline, dependent, schizotypal and avoidant personality disorders (Klonsky et al., 2003). This paper has addressed therapeutic interventions for individuals in treatment for self harm through the vehicle of the design of the built environment. This paper found the importance of a de-escalation space post counselling, to quell dissociative traits; an urge room to keep individuals grounded in the present and help quell urges to self injure; the inclusion of a natural mind-space adjacent to the counselling workspace; and the journey of counselling manifest in physical space is significant for remaining present and quelling dissociative traits. The findings suggest a need for these proposed spaces, but further research is needed to prove the need and efficacy of the suggested design initiatives.

This reinforces the importance of the physical environment in relation to therapeutic outcomes, and a consideration of how buildings are used and how well they physically fit their function of delivering mental health services. Further research is recommended into how the spaces discussed in this paper may be manifest and integrated into the development of care. The findings in this paper emphasize the importance of consumer consultation, to best understand the perception of these spaces by individuals in treatment for self harm. Finally, consideration should be given to further research into the specificity of how to design and integrate these spaces, through careful post occupancy evaluation and control studies, to enable the built environment to best support therapeutic delivery and mental wellbeing.

References


