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**Walk and Talk therapy: A pluralistic inquiry into practice,
perceptions and client experiences in the UK.**

by

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**Thesis submitted
for the Degree of Doctor of Philosophy**

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Abstract

There has been increasing interest in recent years in the possibilities arising from conducting psychotherapy in outdoor settings. Walk and talk is a therapeutic activity that utilises the interactional effects of physical movement within in outdoor settings from the context of an intentional therapeutic relationship (Doucette, 2004; McKinney, 2011; Revell & McLeod, 2016, 2017). Research exploring the benefits and utility of walk and talk therapy is in its infancy, despite the growing number of therapists choosing to integrate this activity into their professional practice.

The main aim of this research, is to explore the practice of walk and talk therapy from three different perspectives within a UK context. First, to explore experiences of therapists who integrate walk and talk into their professional practice. Second, to explore the perceptions of walk and talk held by potential clients of therapy. Third, to explore a client's experience of participating in walk and talk. Methodological pluralism is employed to explore these multiple perspectives.

Findings from therapists who participate in walk and talk with their clients, highlight some of the interactional mechanisms that are present within this therapeutic activity. Findings from the study of potential clients, contributes valuable understanding of potential barriers that may prevent individuals taking part in walk and talk therapy. Furthermore, findings indicate that individuals who have a strong environmental identity or who hold positive beliefs and attitudes about walking in outdoor environments, may be more likely to consider walk and talk as a useful therapeutic activity. Findings from a client's experience shows how walk and talk can offer an opportunity for different types of therapeutic exploration that may be suited to individuals who respond to engaging in psychological processes through bodily movement or who prefer to be in outdoor settings. Recommendations for future research that would build upon these findings are suggested.

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List of publications

The following articles have been published or submitted for publication from studies 1, 2 and 3.

Revell, S., & McLeod, J. (2016). Experiences of therapists who integrate walk and talk into their professional practice. *Counselling and Psychotherapy Research*, 16(1), 35-43. doi: 10.1002/capr.12042.

Revell, S. (2017). Walk and talk therapy: Potential client perceptions. *SCOPE (Health and Wellbeing)*, 24-34.

Revell, S., & McLeod, J. (2017). Therapists' experience of walk and talk therapy: A descriptive phenomenological study. *European Journal of Psychotherapy & Counselling*, 1-23. doi.org/10.1080/13642537.2017.1348377.

Revell, S., & Hinds, J. (2019). *Predicting participation in walk and talk therapy: the role of environmental identity and therapy preferences*. Manuscript submitted for publication.

Chapter 1: Introduction

Interest in the combining of outdoor settings within counselling and psychotherapy has been steadily developing in recent years. Various terms are used to characterise a variety of therapeutic practices that intentionally integrate an outdoor setting within the processes of therapy, such as: nature therapy (Berger & McLeod, 2006), nature-guided therapy (Burns, 1998); Eco therapy (Buzzell & Chalquist, 2009); wilderness therapy (Davis-Berman & Berman, 2008); adventure therapy (Gass, Gillis & Russell, 2012); bush adventure therapy (Pryor, Carpenter & Townsend, 2005) and outdoor therapy (Jordan, 2015; Revell, Duncan & Cooper, 2014). Whilst there are significant differences in how each variant is applied in practice, it can also be seen that there are two broad aspects in common. First, there is intentionality associated with the outdoor setting within which the therapy takes place, thus linking the ultimate aims and anticipated outcomes of the intervention (i.e. the use of 'remote' geographical locations for wilderness therapy programmes). Second, the presence of some sort of physical activity during the therapy (i.e. participating on a high ropes course as part of an adventure therapy intervention or building a sculpture during a nature therapy session). However, much of the research focus centred on outdoor based therapies tends to emphasise the role of the outdoor setting and/or the activity itself as being the main conduit of therapeutic benefit or change (Davis-Berman & Berman, 2008; Gass, Gillis & Russell, 2012). To date, few studies have explored other aspects such as, the different dynamics of the therapeutic relationship in outdoor settings (Jordan, 2014) or the nuances relating to bodily processes that are activated through therapy in outdoor settings involving movement (Corazon, Schilhab & Stigsdotter, 2011).

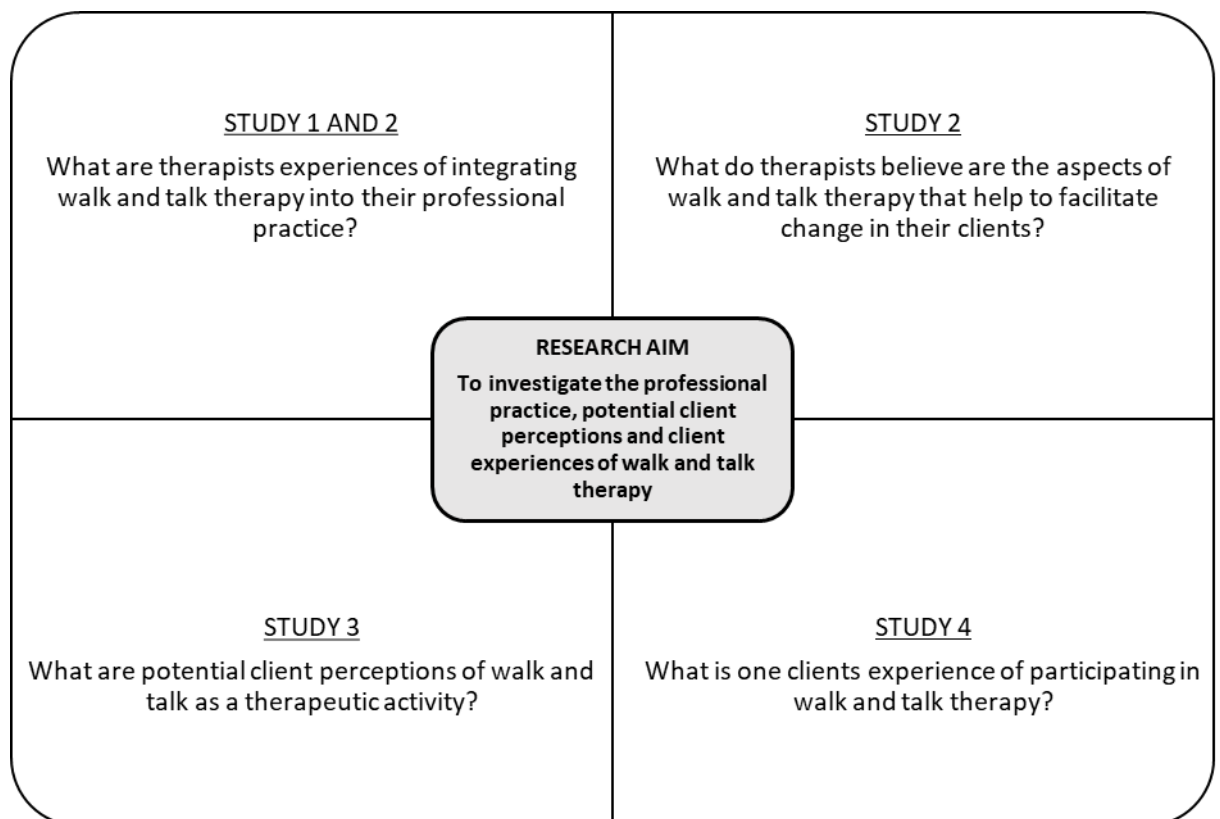
Walk and talk is an intentional therapeutic activity that is conducted within the context of a psychotherapeutic relationship. The interactional benefits of walking and being in an outdoor setting are harnessed, in order to facilitate or maintain physical/psychological health and wellbeing. Broad support for the rationale of walk and talk is found through the considerable evidence that walking has numerous physical and psychological benefits (i.e. Barton, Hine & Pretty, 2009; Hays, 1999; Pickett, Yardley & Kendrick, 2012) in conjunction with research that identifies benefits from spending time in outdoor settings (i.e. Hartig et al., 2003; Jordan, 2015; Kaplan, 1995). Walk and talk therapy therefore, is described as a therapeutic activity where the therapist and client walk together outdoors during the therapy session (Doucette, 2004; Hays, 1999). The use of walk and talk as a therapeutic intervention appears to be increasing despite research being limited and a lack of a theoretical underpinning or best practice guidelines to inform this therapeutic activity. To date, only two known qualitative studies have investigated the specific practice of walk and talk (Doucette, 2004; McKinney, 2011). This research can therefore be considered to be practice based and exploratory. A further aim is to contribute to existing research through exploration of walk and talk from three different perspectives.

Aims of the study

There is a need for research that investigates walk and talk as a therapeutic activity in order to understand more about the benefits and limitations associated with this approach. The main aim of this research therefore, is to explore the practice of walk and talk therapy from three different perspectives from within a UK context. Firstly, to explore experiences of therapists who integrate the use of walk and talk into their professional practice. Secondly, to explore the perceptions of walk and talk held by potential clients of therapy. Thirdly, to explore a client's experience of participating in walk and talk as part of their therapy experience.

The overall research aim and questions associated with each of the four studies are detailed in Figure 1.1.

Figure 1.1: Research aim and research questions for each study.



Structure of the thesis

Chapter two presents a review of the literature from related fields that are relevant to walk and talk therapy. Walk and talk as a specific therapeutic activity, has a very limited research base with two known studies to date. This chapter begins with a review of existing walk and talk literature before broadening out to other related bodies of literature which serve to provide a theoretical rationale from which the practice of walk and talk can be understood. The chapter will explore areas such as nature and wellbeing and walking and wellbeing, before moving on to a discussion of supporting concepts from counselling and psychotherapy literature.

Chapter three presents the ontological and epistemological assumptions that this research is based upon. Methodological pluralism will be introduced as the theoretical position that has been adopted for this research. Pragmatism and phenomenology are identified as underpinning philosophical approaches which have guided an understanding of the data, the process of analysis and choices made about presentation of the findings. The exploratory research design is introduced along with a description of general methods and materials utilised. A description of approaches to data analysis is given, with justifications of choices made in how this was approached. Ethical considerations and a summary of research questions for each study conclude this chapter.

Chapter four introduces the first of four empirical studies that were conducted for this research. This chapter firstly presents a summary of walk and talk as a therapeutic activity and goes on to identify the benefits of studies of professional knowledge in counselling and psychotherapy. This study focuses on therapists' experiences of integrating walk and talk into their professional practice as a way of setting the scene for subsequent studies. The method of conducting this on-line mixed method study is presented, followed by the findings. Descriptive statistics of the quantitative data are presented, followed by thematic analysis of qualitative data. A discussion of the findings, limitations of the study, implications for practice and a concluding comment completes this chapter.

Chapter five presents the second empirical study for this research, which followed on from study 1. Study 2 as presented in this chapter, investigates therapists experiences of integrating walk and talk into their professional practice through employing a qualitative interview method in order to elicit rich, in-depth descriptions of walk and talk practice. An introduction to relevant literature begins this chapter, with a specific focus on change processes in therapy whilst further identifying some of the interactional mechanisms present in outdoor based therapy experiences. A descriptive phenomenological analysis of the results is presented, followed by a discussion of the findings. Limitations of this study along with implications for practice are acknowledged, with a concluding comment completing this chapter.

Chapter six presents the third empirical study which was informed by the previous two studies. The third study sought to identify potential client's perceptions of walk and talk as a therapeutic activity. This on-line mixed methods study presents a description of the three existing quantitative survey measures which were used to investigate how help seeking behaviour, client preferences for therapy and environmental identity might predict likelihood of engaging in walk and talk. Main findings are presented which offer an understanding of the factors which potential clients of walk and talk may take into account, before deciding to take part in this therapeutic activity. Limitations of this study along with implications for practice are acknowledged, with a concluding comment completing this chapter.

Chapter seven presents the fourth and final study within this research. A narrative case study of one client's experience of participating in walk and talk is explored through the use of a mobile method of interview called the walking interview. The narrative approach and the use of narrative case studies within counselling and psychotherapy is discussed. The walking interview as a method is introduced and justifications for employing this method are detailed. The findings from this study are presented in stanza form with photographs obtained from the walking interview to support the overall narrative. The explicit intention in this chapter is provide a rich and storied account of a client's experience of walk and talk therapy, and at the same time to incorporate a reflexive stance of the researcher as a way of illustrating the co-constructed nature of the walking interview process. Limitations of this study, along with implications for practice are acknowledged. A concluding comment completes this chapter.

Chapter eight begins with a discussion on how findings from all four empirical studies can be understood as a 'whole' through the identification of four themes that link the studies together. Implications of these overall findings are presented, with a discussion on how the findings have relevance for both therapists who might wish to develop their practice to incorporate the activity of walk and talk, and also potential clients of walk and talk. Finally, this chapter identifies limitations of this research and presents concluding comments on recommendations for future studies that could serve to add to the understanding of walk and talk that supports both the practice and theoretical underpinning of this therapeutic activity.

Researcher Reflexivity

My motivation for conducting this research, arose from a longstanding interest in working with people in a developmental and therapeutic capacity in outdoor settings. Prior to training as a counsellor, I worked for several years in the field of development training and would notice the way some people appeared to experience different parts of themselves when engaging in activities in outdoor settings that facilitated new personal learning. I also noticed several limitations of the programmes I was involved in, such as the focus on adventure activities and perceived risk that was assumed to elicit change and be of inherent benefit to participants. I wondered about the exclusivity of these programmes and the long term benefits from these ‘one off’ experiences.

After completing my counsellor training and having a small number of varied opportunities to integrate outdoor settings into my therapeutic work, I began to develop a curiosity about the different ways people responded to being in outdoor settings and the ways this was assimilated into the therapeutic session. My first experiences of walking and talking with clients also provoked a curiosity and a realisation that there was ‘something different’ about moving through a landscape while engaged in a therapeutic conversation. I noticed I had to learn a different style of listening and responding skills that did not rely on face to face cues, and I also noticed how the state of my own physicality could intrude into the session. As the client group I was working with at that time were young people, it seemed the informal setting of walking outdoors while talking provided a relaxed less pressured atmosphere for their therapy. I began to wonder how other client groups (i.e. adults) might respond to walking and talking and in what ways could this therapeutic activity be useful or helpful, particularly for those who might not otherwise access counselling.

My own relationship with physical activity in outdoor settings stemmed from a young age growing up in New Zealand. As a young child through to late teens I spent a lot of time outside, riding my bike, horse riding and going on walks at local parks and at beaches. Looking back, I think to a large extent, the amount of time I would spend outdoors was driven largely by my desire to ‘be on the move’ and be busy doing something, and less about any conscious desire to ‘engage with nature’. A highlight of my secondary schooling were the outdoor pursuit camps and field trips that took place at the base of the local mountain, Mt Taranaki. These opportunities provided a chance to engage in a different, more bodily way of interacting and learning about myself in the world. Consequences were immediate and outcomes could be unpredictable. I thrived on the variety of activities on offer and even if I had no particular aptitude or skill for that particular exercise, it felt less problematic to remain engaged and participating in some capacity. Whether it was the activities, the various outdoor settings, or a

combination of the two, I can recall many significant moments of feeling a deep inner ‘settledness’ during these experiences.

My passion for being outdoors and ‘having a go’ at whatever activity was on offer, characterised my first two years at University. At the end of my second year, I had an accident that significantly affected my physical mobility for a period of time, which led to developing a different relationship with physical activity in the outdoors. The carefree jaunts I was accustomed to, became planned and controlled short walks on flat pavements, where various ‘escape routes’ were identified in advance, should I not be able to make it the full way. I came to be more aware of my body with its new limitations, and a heightened appreciation of sensations that came with being outside – my senses awakening with the fresh air, gentle winds, sights and smells as I moved carefully and slowly along the local urban streets. My focus became centred on maintaining a balance of physically activity that would support my rehabilitation, and at the same time challenging myself. I also became critically aware just how important maintaining a good level of physical activity was for my mental health and overall wellbeing. It was through this experience in particular, that I came to realise that ‘everyday’ physical activity in both urban and nature based settings could also be beneficial.

In my early 20’s I left New Zealand for the UK, where I ended up living for the next 18 years. I continued my passion for outdoor activity and held various jobs that allowed majestic settings of lakes and mountains to be the backdrop to my working day. Before and during my counsellor training I remained actively interested in the field of outdoor therapies and in particular developments that were arising within the UK context. At the same time I developed a clearer understanding of my own position regarding outdoor settings and nature and the role of physical activity within that. I realised that my passion lay with working with others individually on a one to one basis within the ‘usual’ therapeutic hour. It was also important for me to integrate the physical movement of walking within the therapy, and this could take place in any appropriate outdoor setting (whether it be urban park or countryside fells) where no extra equipment or access to adventure activities was required. I was also conscious of not assuming that this would be a way of working that would fit all people’s preferences, or needs.

I approached this research with a curiosity of how walk and talk as a therapeutic activity is understood both within the counselling and psychotherapy profession and also more broadly within a UK cultural context. I was conscious of the potential for an activity such as walk and talk to not be seen as ‘real therapy’ or sitting outside the mainstream discourse of what professional counselling and psychotherapy is considered to be. My own internal sceptic also questioning the seemingly simplistic popularised refrain of ‘being in nature is inherently good

for you' which motivated me to want to explore the edges of combining walking in outdoor places during therapy, in order to develop a more nuanced understanding of this activity.

Aware of my own limited lived experience of walk and talk, I approached studies one and two with inquisitiveness to learn more about the inherent processes within walk and talk as identified through the lived experiences of therapists. Study 3 I approached with a curiosity about the barriers and concerns that people might face when deciding if walk and talk is suitable for them. I realised I was more attuned to the potential 'downsides' of this approach, than necessarily seeking to reinforce beliefs about the ways walk and talk could potentially be beneficial. The case study (study 4) was an opportunity to hear stories about a client's therapy journey in a context that felt deeply moving and energising. It was a privilege to walk through a therapy-scape that was rich with stories and meanings.

In conclusion, the findings from these studies have fostered a new understanding for me of the multi-layered complex nature of embodied experiences and how choices relating to therapy preferences, places of restoration and attitudes towards physical activity interact. I have developed a renewed appreciation for the therapists who have 'pioneered' the use of walk and talk and hope the findings of this research can further contribute to the theoretical and practical understanding of walk and talk as a therapeutic activity.

Chapter 2: Literature Review

Research focused specifically on walk and talk therapy, as a therapeutic activity, is limited. Therefore, in order to provide some contextual understanding for the rationale of walk and talk, a broader approach to the literature is required. This chapter therefore presents a review of literature that is drawn from associated fields of research, thus offering an understanding of some of the underlying interactional mechanisms which may be present in walk and talk therapy.

Concept of walk and talk therapy

The combination of walking in outdoor settings during therapy is not new. Freud was said to have analysed patients while walking with them through the streets of Vienna (Gabbard, 1995). However, as psychotherapy practice developed with a greater emphasis on how boundaries could be maintained and transference minimised, so too did the focus on therapy taking place in an indoor controlled setting (Jordan & Marshall, 2010). With increased attention being paid to health and well-being in the late 20th Century, so too came a renewed interest in developing psychotherapeutic interventions which could benefit both body and mind, and as a result challenge the notion that therapy needed to be conducted in static indoor settings (Hays, 1999; Jordan & Marshall, 2010). Integrating physical activity with therapy has been one way this has occurred. Running therapy was developed in the 1970's as the pioneering work of physician and psychiatrist Thaddeus Kostrubala (1984) who used the term 'running' to indicate "walk/jog/run" (p. 113). Kostrubala (1984) began using running as a therapeutic tool in his work with psychiatric patients based on his own experiences as a marathon runner and noticing the beneficial physiological effects from cardiovascular exercise. Kostrubala (1984) concluded that running therapy was effective in working with depression, anxiety, schizophrenia, addiction issues and promoted a decrease in prescribed medication. He proposed that psychotherapy alone focused on enclosure and control of the therapeutic environment through the configuration of seating, body position and indoor setting. Kostrubala (1984) sought to challenge the status quo through the use of running therapy which he saw as providing a less passive and restrictive form of therapy as well as fostering a therapeutic relationship that promoted equality through joint engagement in physical activity, being upright and moving forward in the same direction. Kostrubala (1984) attributed the positive outcomes to the running component of the therapy, and not to the psychotherapeutic intervention itself. However, he also acknowledged that his own passion and belief in the effectiveness of running therapy interventions influenced his views and with the lack of empirical research to support the anecdotal evidence, the efficacy of this approach remains unknown (Hays, 1999; Kostrubala 1984).

Despite attempts at promoting benefits of integrating of physical activity and therapy, such practices have remained under researched and on the periphery of therapeutic interventions. Recent government initiatives acknowledge the relationship between mental health, physical activity and wellbeing, thus prompting renewed emphasis on therapeutic interventions which adopt a holistic approach that incorporates factors such as physical activity and spending time in outdoor settings (Department of Health, 2014). Walk and talk therapy is one approach that aims to harness the interactional beneficial effects of physical movement and an outdoor setting within the context of an intentional therapeutic relationship. Walk and talk describes a specific therapeutic activity where the counsellor and client walk together outdoors during the therapy session (Doucette, 2004; Hays, 1999). Walk and talk therapy is not linked to any specific counselling or psychotherapy theory, and is seen to be utilised flexibly, in some instances forming the basis for all therapeutic work with a client, and in other cases operating as an alternative to office-based meetings (McKinney, 2011). To date, there is no identified framework for practice, nor a commonly shared theoretical underpinning that informs this therapeutic activity (McKinney, 2011).

Whilst it can be seen that there is a growing interest in walk and talk as a therapeutic activity (see Chapter 4) research exploring the practice and benefits of walk and talk is in its infancy. To date, two known studies have been conducted, one exploring the benefits of walk and talk as experienced by clients (Doucette, 2004) and the other, investigating therapists experiences of participating in walk and talk therapy (McKinney, 2011).

Doucette (2004) investigated a school-based six week programme for eight behaviourally challenged youths that was specifically designed to integrate a counselling intervention, eco-psychology principles and facilitate physiological benefits. The programme as a whole was underpinned by attachment theory which intended to maximise opportunities for connections between participants and therapist and participants and the outdoor setting whilst raising overall self-efficacy of the participants. The counselling intervention utilised solution focused brief therapy model that aimed to help participants highlight their strengths as well as identify positive strategies for problem solving. The eco-psychology aspect of the intervention aimed to increase individual connections to the natural environment, while the physiological benefits were assumed to be achieved through the physical activity of walking during the counselling sessions. Doucette (2004) reported that the impact of therapy was enhanced by being outdoors and engaging in exercise, and that the walking component allowed for physical release and aided problem-solving. Further findings indicate the participants reported greater feelings of self-efficacy and overall wellbeing. Whilst there are limitations associated with this study (i.e. small sample, participants that were chosen and only positive findings reported) there are also important implications to acknowledge. First, this study supports the idea that some client

groups may benefit from a counselling intervention which is not restricted to an indoor, seated context. Second, the opportunity to walk in an outdoor setting whilst talking about difficult things could be a useful way of engaging youth. Third, walk and talk as a therapeutic activity may be well suited to complementing other existing interventions as a way of potentially enhancing positive outcomes.

In the second known study to explore walk and talk specifically, McKinney (2011) interviewed eleven walk and talk therapists in the USA with the intention of producing a theory for the practice of walk and talk therapy. McKinney (2011) reported consistency regarding the general definition of walk and talk as described by Doucette (2004), which is therapy that occurs while walking in an outdoor setting. Additionally, there was consensus between McKinney (2011) and Doucette (2004) regarding the interactional ingredients of walk and talk (i.e. intentional therapy, outdoor setting and physiological benefits). McKinney (2011) further reported that walk and talk was considered by her participants as an informal approach to therapy due to walking, as well as the altered physicality of being side by side (thus minimal eye contact). Other main findings indicate walk and talk therapy as being conducted in conjunction with a range of therapeutic modalities and therapists tailored their practice to suit their specific location and client need.

In answer to what motivated therapists to develop their walk and talk practice, McKinney (2011) reported: a desire to offer choice to clients; personal beliefs and experience of walking; awareness of research from related fields; the desire to increase physical activity in their therapy practice and a belief in the restorative connection with nature. McKinney (2011) further reported that it was younger therapists who appeared more willing to broaden the boundaries of their therapeutic work by developing alternative therapeutic activities such as walk and talk. Positive client outcomes observed by the practitioners in this study included a greater degree of equality in the relationship and client experiential processing being enhanced through walking side by side. A number of therapists indicated they felt clients got to their issues quicker through walk and talk. Findings from this study further report that both therapists and clients benefit from walk and talk in several ways, such as: physical health through walking, benefits to mental health through improvement in mood, developing connection to nature and the opportunity to develop self-care strategies (different for therapists and clients). A number of limitations of walk and talk methods were also described: inclement weather which could limit participation; a lack of professional support opportunities (i.e. training, supervision) and many of the therapists indicated a lack of clients willing to try walk and talk. It was further acknowledged that walk and talk was not suitable for all client groups (i.e. families, couples and some presentations of trauma) which was identified as a limitation of potential client participation. Whilst this study is important due to providing the first known research to

investigate the practice of walk and talk from therapist's perspective, there are also limitations. First, this study only reports therapist perceptions and therefore is subject to positive bias supporting this approach. Second, client benefits experienced through walk and talk need to be verified with further research that includes clients and measurable outcomes. Third, this study is based in the USA, therefore attitudes to walking and conducting therapy outdoors while walking may have also influenced the findings. It is possible therefore, that different cultural contexts could interpret and experience walk and talk in very different ways.

As previously acknowledged, research into walk and talk therapy is in its infancy which means there are limited ways to situate this study within an established body of existing knowledge. Therefore, this study draws upon the related fields of nature and wellbeing, walking and wellbeing and psychotherapeutic literature to provide a broader context for the rationale of walk and talk therapy.

Nature and wellbeing

Nature is a term that means different things, to different people, in different contexts and within the literature is applied both broadly and specifically (Ginn & Demeritt, 2009; Kaplan & Kaplan, 1989). The term 'nature' in this section adopts the position of Kaplan and Kaplan (1989) to refer to a range of outdoor settings from ones that are largely untouched by humans to local parks, streets and gardens. "We are referring to places near and far, common and unusual, managed and unkempt, big, small, and in-between, where plants grow by human design or even despite it" (Kaplan & Kaplan, 1989, p.2).

People are spending less time in natural environments due to a trend in global urbanisation (Skár & Krogh, 2009; Turner, Nakamura, & Dinetti, 2004). This decline in contact with nature has been linked to an increase in mental health problems and negative effects on psychological functioning (Bratman, Hamilton & Daily, 2012; Caracci, 2008; Patel, Flisher, Hetrick, & McGorry, 2007). Exposure to natural environments in contrast to urban ones, has been linked to a range of beneficial outcomes, such as: supporting healthy stress responses (Brown, Barton & Gladwell, 2013); increasing positive emotions and decreasing negative ones (Hartig, Mang & Evans, 1991, Hartig et al., 2003; van den Berg, Jorgensen & Wilson, 2014); increasing levels of subjective wellbeing (Bowler et al., 2010; MacKerron & Mourato, 2013; Mayer et al., 2009); aiding reflection (Herzog et al., 1997; Kaplan & Kaplan, 1989) supporting the regulation of emotions (Johnsen & Rydstedt, 2013); and providing restoration (Beyer et al., 2014; Bowler, et al., 2010; Bratman, et al., 2015, Kaplan, 1995; Ulrich, 1979). However, despite this growing substantial body of knowledge, there remains questions concerning the type of outdoor setting, and under what circumstances, are most beneficial for whom (Bowler et al., 2010).

Within the literature, 'exposure' to nature is operationalised broadly and has been investigated in several different ways. Research has explored the effects of nature whilst physically situated in the outdoor setting (e.g. Berman, Jonides & Kaplan, 2008; Hartig et al., 2003), or viewing pictures or films of natural scenes (e.g. Berto, 2005; van den Berg, Jorgensen & Wilson, 2014) or viewing nature through a window (Ulrich, 1979). Whilst it can generally be seen that some exposure to nature can be beneficial, findings are inconclusive as to the specific amount or type of nature that is needed in order for the benefits to be experienced (Berto, 2005).

The beneficial effects of natural environments has most commonly been linked to restoration in cognitive and affective domains. There are two main theoretical frameworks that are commonly utilised when considering restorative environments. Attention Restoration Theory (ART; Kaplan & Kaplan, 1989) and Stress Reduction Theory (SRT; Ulrich, 1979, 1993) both offer explanations as to how natural environments offer the potential for restoration when in a depleted state.

Attention Restoration Theory (ART).

Attention Restoration Theory focuses on the cognitive capacities of attention, as distinguished by two types: involuntary attention, which is activated due to intrinsically interesting or significant stimuli, and voluntary or directed attention, where attention is activated through cognitive processes (Kaplan & Kaplan, 1989; Kaplan, 1995). Directed attention is seen to be central to effective emotional and cognitive abilities and it is also susceptible to becoming depleted and fatigued. Therefore, ART proposes there is limited capacity for focused directed attention tasks which requires both concentration along with the ability to withstand distractions. When directed attention is depleted, mistakes are made on tasks that require concentration. Spending time in an environment that does not require the function of directed attention, therefore offers respite for the inhibitory processes upon which directed attention depends and the capacity for directed attention can be re-established (Kaplan & Kaplan, 1989; Kaplan, 1995). ART contends there are four components of restorative settings. These are: an environment which offers different stimuli than usual and gives the sense of 'being away'; a setting that has sufficient 'extent' in both content and structure which can engage the mind and allow directed attention to rest; a setting which provides the opportunity for effortless attention, referred to as 'fascination'; and a degree of 'compatibility' between what the environment offers and a person's intentions (Herzog, Maguire & Nebel, 2003).

A further assumption that ART rests upon is the causal link between an individual's preferences for nature over urban settings when in a state of attentional fatigue. ART proposes that the perception that a particular setting (i.e. nature) will provide directed attention restoration results in a person seeking that setting out in order to restore their attentional

capacities (Herzog, Maguire & Nebel, 2003; van den Berg et al., 2014; Staats & Hartig, 2004). Preferences for settings, within ART, is often assessed based on likable characteristics or the degree of attractiveness of a particular setting when urban and nature environments are compared (Herzog, Maguire & Nebel, 2003; Staats & Hartig, 2004; White & Gatersleben, 2001).

However, there remains a lack of consensus regarding the relationship between preferences and type of setting that is sought when in need of attention restoration. Wilkie and Stavridou (2013) argue that the nature vs urban dichotomy is too narrow and instead propose the expectation of restoration and environment includes place-identity preferences, which incorporates both nature and urban settings. While Staats and Hartig (2004) propose there are social factors that are part of the decision making process and state: “ART looks to the physical environment to provide support, but remains silent as to whether and how people have a role in this process” (p. 200). Despite there being a considerable body of research that supports general principles of ART (i.e. natural settings have the capacity to support cognitive functioning), it is less clear as to the interactional processes involved in individual preferences and decision making that influence behaviour when seeking restoration.

Stress Reduction Theory (SRT)

SRT (Ulrich, 1993) is a psycho-evolutionary theory which proposes natural settings can support a reduction in physiological arousal following a stressful encounter. Natural environments are seen to be superior to urban ones, as they possess certain adaptive qualities which support stress recovery. The qualities can include aesthetic aspects, such as attractive elements of a setting or be semantic, such as the absence of threat and availability of resources which were important for evolutionary survival (Ulrich, 1983, 1993). Ulrich’s (1983) initial work was concerned primarily with visual responses to natural settings that was justified by the assertion that sight is the most important of the five senses. Affect within SRT is used synonymously with emotion and takes the position that affect precedes cognition. Furthermore, affect as evoked by natural environments is seen to exist in relationship with cognition, physiological arousal and behaviour, as aesthetic and affective responses cannot be understood in isolation from associated human systems. SRT holds that different settings can evoke different affective and physiological responses which are automatic and not necessarily given into conscious awareness. For example, people living in densely populated urban areas may not be consciously aware of stress related responses being experienced in their bodies and affecting their cognitive capacities. SRT describes stress responses as including psychological (i.e. evaluation of a situation, emotions such as fear, sadness, anger), physiological (i.e. bodily responses being activated to help deal with a situation such as cardiovascular, skeletomuscular

and neuroendocrine) and often including behavioural components (i.e. avoidance behaviours or reduction of performance on cognitive tasks such as proof reading), which can be evoked when a situation is experienced as challenging or threatening to well-being (Ulrich et al., 1991). Recovery and/or restoration from stressful situations can include recovery from situations that are characterised by levels of over as well as under stimulation and exceptionally high/low arousal (Ulrich, 1981, 1983). Therefore, recovery from a range of stress responses is characterised by positive changes in psychological, physiological and behaviours or levels of functioning (Ulrich et al., 1991). SRT further contends that as humans have evolved in nature based settings there is an inherent capacity to notice and positively respond to natural settings which support survival and well-being, such as having access to water, vegetation, expansive views etc. (Ulrich, 1983). Therefore, exposure to such natural environments are said to bring about unconscious positive effects such as increased positive emotion, reduced negative emotion, reduced physiological arousal and decreased stress response (Ulrich, 1993).

As with ART, much of the empirical research has compared urban or built environments with natural settings using simulations (i.e. viewing videos of natural scenes; Ulrich et al., 1991) and less so with participants who are physically situated within natural setting (i.e. Lee et al., 2009). Findings suggest that both simulations and real exposure to nature are effective at producing lower rates of physiological arousal, lower negative affect and increased positive affect in comparison to urban settings (Hartig et al., 2003; Lee et al., 2013). However, real exposure to nature produces greater positive benefits for well-being than artificial forms (Mayer et al., 2009).

Whilst there is a significant emphasis on restorative and recovery aspects of nature present in the literature, there is more to be understood from a wider theoretical position about the ways nature can be beneficial (Mayer et al., 2009). Furthermore, whilst there exists a compelling amount of evidence that supports the idea that contact with nature is beneficial, people don't always seek out contact with nature when in need of cognitive or emotional restoration (Eriksson & Nordlund, 2013; Herzog, Maguire & Nebel, 2003). This indicates the presence of other interacting factors which influence the relationship people have with nature.

Health geographers have examined the ways certain places and wellbeing are connected (Phillips, Evans & Muirhead, 2015). Recently, the focus has been shifting from identifying characteristics within a setting that contribute to wellbeing and moving toward an understanding of wellbeing and place that emphasises the role of relationships (Conradson, 2005). Atkinson (2013) promotes conceptualising wellbeing as a process and not an outcome. The implications of adopting a relational stance, situates wellbeing within the broader context of connections between people and places, and as something fluid that is subject to change over time and from

experiences. This view has particular relevance for the practice of walk and talk, as the therapeutic relationship underpins what takes place within the therapy. Therefore, it is the complex and multi-dimensional relational interactions that occur in a particular setting from which meaning is made (Conradson, 2005). It is from this relational stance that explores processes and practices that the realisation of place to support wellbeing can be achieved (Phillips, Evans & Muirhead, 2015). Understanding the altered dynamics associated with taking therapy into outdoor places therefore, calls for the acknowledgement of context and subjective experience, which includes all aspects of place.

Walking and wellbeing

Literature citing the physiological and psychological health benefits of physical activity is well established (Reiner et al., 2013; Warburton, Nicol & Bredin, 2006). Traditionally, mental health treatments were approached from a dualist stance of the mind and body being separate (Mutrie, 2000). More recently however, the connection between mental and physical health has been established, and greater attention has been paid to investigating the ways physical activity can support treatment of mental health, as well as how physical activity can enhance wellbeing in the general population (Fox, 1999). Studies suggest a positive relationship between levels of physical activity and improved mental health, with indications that management of mild to moderate depression and anxiety may be supported through various types of physical activity (Paluska & Schwenk, 2000). However, results remain inconclusive with regard to the type and intensity of different types of activity which are considered to be most effective for different types of mental health conditions (Barton & Pretty, 2010; Mutrie, 2000).

Walking, is one form of physical activity that is recognised as being simple to integrate into a daily routine, does not carry stigma, can be undertaken by all age groups and abilities, with low risk of injury (Barton, Hine & Pretty, 2009; Ettema & Smajic, 2015; Parkkari et al., 2000; Priest, 2007; Soroush et al., 2013). Physiological benefits of walking have been comprehensively investigated, and evidence shows walking can aid the prevention of obesity and type II diabetes (Smith et al., 2007), cardiovascular disease (Soroush et al., 2013) and positively impact on blood pressure levels (Chan, Ryan & Tudor-Locke, 2004). Furthermore, regular walking can benefit aerobic capacities, positively affect bodily composition and contribute to trunk muscle endurance (Parkkari et al., 2000).

Psychological benefits gained through walking is also well documented. These cited benefits include enhanced psychological processing and ability to problem solve (Boutcher, 2000; Corazon, Schilhab & Stigsdotter, 2011; Hays, 1999); enhancing creativity (Oppezzo & Schwartz, 2014); alleviation of depressive symptoms (Pickett, Yardley & Kendrick, 2012; Robertson et al., 2012), reduction in anxiety (Biddle, 1995; Fox, 1999); improved self-esteem

and mood (Barton, Hine & Pretty, 2009; Biddle, 2000; Ekkekakis et al., 2008; MIND, 2007; Scully et al., 1998); decreased negative emotions and increased positive affect (Berman, Jonides & Kaplan, 2008; Hartig, Mang & Evans, 1991, Hartig et al., 2003; Olsson et al., 2013).

However, psychological benefits of walking are not gained in isolation from other contextual aspects. Studies show that individual factors (Fox, 1999), and the activity of walking itself, along with environmental and social factors (Priest, 2007) can influence the level of psychological benefits that are gained. Individual beliefs and attitudes towards walking have been identified as either facilitating or hindering participation. In one study Darker et al., (2007) identified various positive beliefs that UK adults associated with walking. These included walking as being beneficial for stress relief, promoting health and fitness and providing an opportunity to benefit from being outdoors (i.e. fresh air, scenery). Barriers to participation were identified as inclement weather and a lack of time. Overall however, walking was considered an acceptable form of physical activity across the different demographics within the study. These results indicate the potentially broad appeal of walking, as well as highlight the value in understanding personal beliefs and attitudes an individual might hold which could subsequently influence participation.

Environmental and social factors can also influence the extent to which beneficial effects from walking can be gained. Literature suggests that walking in outdoor natural environments can lead to a greater increase in self-esteem and improved mood compared to indoor walking (MIND, 2007). Furthermore, walking in 'greenspace' areas (ranging from wilderness settings to domestic gardens and allotments) is said to harness the interactional benefits of exposure to nature and physical exercise, resulting in improvement in mood and self-esteem (Barton, Hine & Pretty, 2009; Barton & Pretty, 2010). Further studies report that walking in outdoor settings can decrease negative emotions and increase positive ones (Berman, et al., 2012; Hartig, Mang & Evans, 1991, Hartig et al., 2003) and natural environments in comparison to urban settings can enhance affective and attentional capacities (Berman, Jonides & Kaplan, 2008; Hartig et al., 2003).

Social factors can play an important role in the potential benefits gained from outdoor walking. Social benefits such as reducing isolation and increasing connections to others and the outside setting whilst taking a walk has important implications for mental health and wellbeing (Darker et al., 2007; Priest, 2007). Furthermore, walking in the company of others is seen to encourage walking behaviour, with some studies suggesting people prefer group walking more than walking alone (Johansson, Hartig & Staats, 2011; Plante et al., 2007).

Taken together, this body of literature demonstrates the wide ranging holistic health benefits that can be gained from walking. Given that both sedentary lifestyles and mental ill-health are

significant public health issue worldwide (World Health Organisation, 2018), walk and talk is one therapeutic activity that could support public health initiatives through offering an intervention that benefits both mental and physical wellbeing.

The therapeutic context

There is a lack of understanding around the impact outdoor settings have on the therapeutic alliance, and the specific change processes that are activated when participating in outdoor based therapy. Whilst the therapeutic alliance can be seen to underpin therapy regardless of the particular setting, it is possible that different aspects of the alliance are activated and relied upon when in an outdoor context. The therapeutic alliance has been defined as “the collaborative aspect of the therapeutic relationship, in which the client and therapist together negotiate the focus and depth of the relationship” (Levitt & Williams, 2010. p.337). Along with an emotional bond, and agreement around goals and tasks, responsiveness and synchrony have also been identified as components that contribute to the development of the therapeutic alliance (Stiles, Honos-Webb & Surko, 1998; Tschacher, Rees & Ramseyer, 2014).

A responsive stance promotes the therapeutic relationship as dynamic, bidirectional in influence and constantly in an emergent state. As a result, appropriately responsive therapeutic activities will evolve within the context of therapy based on relevance to the therapeutic process and the state of the client (Stiles, Honos-Webb & Surko, 1998). This is in line with a pluralistic view that clients benefit from different things at different stages in their therapy (Cooper & McLeod, 2011); by maintaining a responsive position within therapy, therapists are able to work flexibly with clients to achieve their therapeutic goals (Stiles, Honos-Webb & Surko, 1998).

Synchrony, on the other hand, refers to embodied aspects of therapeutic processes that acknowledge the connection between bodily aspects such as facial expression, gestures, bodily movement and cognitive processes (Tschacher, Rees & Ramseyer, 2014). McKinney (2011) reported that therapists offered the activity of walk and talk in a highly collaborative way. Therefore, it seems possible that the demands of conducting therapy in an outdoor environment, may not only require a collaborative stance, but also an awareness of how responsiveness and synchrony can contribute to the building of an effective therapeutic alliance.

There is a paucity of literature examining the mechanisms of change identified in outdoor therapy programmes (Harper, 2009; Tucker & Rheingold, 2010). This can be attributed to several factors such as a lack of consensus surrounding terminology of outdoor based programmes (Annerstedt & Währborg, 2011), the absence of clearly defined programme aims and objectives, and methodological limitations of studies (Newes, 2001; Tucker & Rheingold, 2010). However, despite these factors, one area of general agreement is that different natural environments can positively influence therapeutic processes (Annerstedt & Währborg, 2011).

This is despite a lack of understanding around ‘why’ and ‘how’ this occurs (Beringer, 2004). Rutko and Gillespie (2013) refer to this as a ‘paradox’ in terms of a specific outdoor environment being fundamental to the way a programme is run, yet without the explicit clarity around the function the environment is assumed to play within the overall therapeutic process. The degree to which the outdoor setting is identified as being an explicit part of the therapeutic process appears to depend on what aspects are identified as essential to the change process. For example, Adventure Therapy emphasises the therapeutic activities themselves as promoting change (Gillis & Ringer, 1999, Norton et al., 2014), whereas Wilderness Therapy proposes a combination of helpful factors, such as having the opportunity to experience ‘unique’ relationships with peers and therapist, solo time to reflect on life, and overcoming challenges (Russell & Phillips-Miller, 2002). There is growing criticism of an anthropocentric view that tends to overlook the role of the setting (nature and environment) within outdoor therapy experiences, where the focus rests solely on human factors that are conceptualised as being detached from the physical setting which includes more-than-human aspects (Beringer & Martin, 2003; Jordan, 2014; Rutko & Gillespie, 2013).

Approaches such as nature therapy, nature based therapy, eco-therapy and eco psychology position the natural environment as a fundamental component of the therapeutic process. With nature therapy the dynamic interplay between therapist, client and the natural setting are seen to help facilitate change for clients through the use of metaphor, ritual and the natural environment which evokes internal processes for clients (Berger, 2006; Berger & McLeod, 2006). Similarly, nature based therapy utilises therapeutic horticulture in conjunction with formal therapeutic interventions, and argues it is the interaction between the physical environment and human behaviour that helps create the environment for change (Corazon et al., 2010). Ecopsychology and Eco therapy concentrate on explicitly healing the separation between the human psyche and the natural world – maintaining that through repairing this divide a greater level of wellbeing and mental health is possible (Buzzell & Chalquist, 2009). In a UK study of therapists who work outdoors in natural settings, Jordan (2014) reported that therapists sought to challenge the normative practice of therapy and this included the desire to make more explicit the relationship between emotional wellbeing and the environment from an ecological position. Through this, clients could be supported in cultivating an ecological identity that would ultimately support their psychological wellbeing.

Therapy in outdoor places allows for the inclusion of creative therapeutic tools such as metaphor, symbolism and rituals (Burns, 1998). Metaphors and symbols can be seen as components of narratives that offer a way of expressing meaning making through description and thoughts and feeling attached to an event (Lewis & Langer, 1994; Sims, 2003). The use of metaphor and symbols within therapy is considered beneficial in a variety of ways such

reinforcing the therapeutic relationship through the development of a common language that can be continued during the course of the therapeutic relationship, increase empathic the connection between therapist and client, enhance the clients feeling of being understood and offers a way of creatively approaching problematic issues (Babits, 2001; Lewis & Langer, 1994; Sims, 2003). Rituals can be used to modify behaviour or as a vehicle for working with spirituality within therapy, as a means of facilitating change and increasing personal empowerment through acknowledgement of a 'higher power' (Cole, 2003).

Metaphors are defined as "understanding and experiencing one kind of thing in terms of another" (Lakoff & Johnson, 1980, p. 5). Symbolism is defined as "an imaginative act wherein two different items of experience are linked in a way that one comes to represent the other; an item... becomes a symbol only when it is mentally cast to stand for something else which it is not" (Lewis & Langer, 1994, p. 231). Rituals can be described as intentional behaviour that arouses emotions and is representational of particular thoughts and feelings (Al-Krenawi, 1999). Therapeutic rituals have been used in a range of therapy contexts such as family therapy (Imber-Black, Roberts & Whiting, 2003); grief and bereavement (Rando, 1985); and couple counselling (Winek & Craven, 2003). These creative therapeutic tools can draw upon both unconscious and conscious processes which can be beneficial to developing new insights of how individuals make sense of themselves in the world (Cole, 2003; Lewis & Langer, 1994; Sims, 2003).

Outdoor based therapies work with metaphor, symbolism and ritual in a way that encompasses embodied, experiential factors that acknowledge place related aspects. Using metaphor as an example, Burns (1998) proposes a four step experiential metaphor model. The steps include setting of goals, journeying in a natural setting, giving sufficient time for experiences to occur and sense to be activated, a focus on the relationship between the individual and the environment and anticipation of change that can be taken into the future to maintain wellbeing. This model is extensive and unapologetic in its promotion of the role of nature and embodied processes in the creation of the experiential metaphor.

Berger's (2007) Nature therapy model is another example of therapy in an outdoor place that utilises symbolism, ritual and metaphor. Nature therapy seeks to broaden the concept of therapy as a static endeavour and promotes a dynamic therapeutic environment that is experiential and where nature is considered a 'live' partner in the therapy process (Berger & McLeod, 2006). Drawing from drama therapy concepts, narrative and use of metaphor is employed along with rituals that serve different functions from therapeutic learning, safety and consistency within group process, to developing confidence (Berger, 2007). From a transpersonal perspective, Jordan (2015) promotes using rituals in outdoor based therapy as a

way of facilitating connection with something larger than ourselves (i.e. nature, universe), therefore decreasing personal isolation and increasing potential for therapeutic change.

In sum, whilst there are no unified and accepted components of change within the broad field of outdoor therapy practice it would appear that existing literature suggests it is the therapeutic relationship and interaction between several factors such as the context, setting, client group and underpinning theoretical basis of the outdoor therapy experience (Rutko & Gillespie, 2013).

Chapter 3: Methodology

Introduction

This chapter will present the ontological and epistemological assumptions this research is based upon. It will also identify the purpose of the overall research inquiry, rationale for methods used, general materials and procedures employed. In addition, the general data collection and analysis methods are described as well as ethical considerations to ensure integrity of the research process.

Purpose

The purpose of this thesis is to explore the practice of ‘walk and talk therapy’ from multiple and interrelated perspectives. A main goal of conducting a series of studies was to obtain rich, multi-perspective information that would elucidate the emergent practice of walk and talk therapy. Through exploring walk and talk therapy from different perspectives, my intention was to produce an understanding of walk and talk therapy that would have implications for both psychotherapeutic practitioners and potential clients of this therapeutic activity.

Psychotherapeutic practitioners would be able to understand more fully the considerations and implications for working in this way with clients, by drawing upon the professional knowledge of participants in the first study. Additionally, an understanding of perceptions that potential clients might hold about walk and talk, from the third study, could serve to inform how practitioners offer walk and talk to clients they work with. Both therapists and potential clients of walk and talk therapy could understand more about this therapeutic activity through hearing a clients experience, which will be the focus of the fourth study.

Ontological Assumptions

Ontology defined by Crotty (1998) is “the study of being. It is concerned with ‘what is’ with the nature of existence, with the structure of reality...” (p. 10). Guba and Lincoln (1994) pose the ontological question as being concerned with “the form and nature of reality and, therefore, what is there that can be known about it?” (p. 108).

My understanding of the ontological situation for this research is that of multiple realities. Because of this view, I have chosen methodological pluralism as an expression of how plurality of experience is understood.

Epistemological Assumptions

Epistemology is “a way of understanding and explaining how we know what we know” (Crotty, 1998, p. 3). Epistemology is also “concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both

adequate and legitimate” (Maynard, 1994; as cited in Crotty, 1998, p. 8). The epistemological stance in this research is pragmatic. A pragmatic epistemology rejects the imposed choices between positivism/post-positivism and constructionism, instead advocating the use of both perspectives to inform epistemology within a research project (Teddlie & Tashakkori, 2009). Therefore, a pragmatic position adopts both subjective and objective stances, dependent upon “the current statement of the research questions and the ongoing phase of the inductive-deductive research cycle” (Teddlie & Tashakkori, 2009, p. 87). The subjective view is identified through constructionism. Constructionism, defined by Crotty (1998) is:

“Trust, or meaning, comes into existence in and out of our engagement with the realities of the world. There is no meaning without a mind. Meaning is not discovered, but constructed” (p. 8).

Within a constructionist stance, it is understood that the knower and the known are not separate, and that different people construct meaning in different ways, thus resulting in multiple constructed realities (Teddlie & Tashakkori, 2009). In contrast, the objective view is identified through a positivist/post-positivist stance. A positivistic stance contends that “objects in the world have meaning prior to, and independently of, any consciousness of them” (Crotty, 1998, p. 27). In other words, positivism seeks an objective view based on scientific findings through which claims about what constitutes truth and knowledge can be made (Cohen, Manion & Morrison, 2011; Crotty, 1998). A post-positivist stance, is considered a ‘milder’ version of positivism, whereby claims regarding what is considered valid, are tentative, and tempered (Willis, 2007). The world is seen as changeable and plural. Whilst reasoning for an objective reality, a post-positivist stance acknowledges multiple, coexisting realities rather than a single reality (Cohen, Manion & Morrison, 2011). As such, this research is aligned with a post-positivist epistemological position.

Theoretical Stance

In the following section I identify and discuss key theorists who have influenced the methodological approach taken in each of the following studies, and the specific philosophical underpinnings which constitute the methodological pluralism frame for the purpose of this research; namely pragmatism and phenomenology. I will also detail the mixed methods approach which has been employed as an expression of how I have utilised methodological pluralism within this study.

Methodological Pluralism

Walk and talk is an emergent therapeutic practice and is yet to develop a theoretical base. In order to develop a broad understanding of the practice of walk and talk, different aspects of this

therapeutic activity need to be explored in different ways. This therefore calls for a diversity of methods to be employed. Methodological pluralism is a framework that argues for the legitimacy of different methods to be employed to investigate and understand a particular subject, even though the methods may have different underlying philosophical assumptions (Barker, Pistrang, & Elliott, 2002; Moss & Haertel, 2016; Slife & Gantt, 1999).

Methodological pluralism holds a fundamental view that knowledge can be accrued from a range of sources in a number of different ways (Barker & Pistrang, 2005). This can be taken to include a pluralism of underpinning philosophies as well as methods and measures used within a study (Slife & Gantt, 1999).

Methodological pluralism has been defined as

“...the belief that no single approach to research is best overall, rather, what is important is that the methods be appropriate for the questions under investigation. No single research method is inherently superior to any other: all methods have their relative advantages and disadvantages” (Barker, Pistrang, & Elliott, 2002, p. 245).

Historically there has been some debate as to the “incommensurability of paradigms” (Slife & Gantt, 1999, p. 1460) between qualitative and quantitative methods and their related epistemologies. Quantitative methods are commonly associated with a post positivist stance which contends that only those things which are directly observable or which can be measured can be reliably known. This view seeks to quantify experiences through the use of numbers and strives to uncover universal truths that are constant across time and space. This view also supports the deterministic view of naturalism, which presumes that human behaviour is not influenced by free will or choice (Creswell, 2015; Slife & Gantt, 1999).

Qualitative methods on the other hand are underpinned by different assumptions. First, that all experiences provide valid ways of knowing. Ways of developing an understanding about experiences come from individual experience and meanings made from experience are varied and multiple. A qualitative stance promotes the value of context in understanding meaning made from experience. Universality is not sought, however it is recognised that some aspects of experiences can be generalised. Essentially, humans are viewed as having meaning in their lives and it is through understanding what meanings are attached to experiences that knowledge is generated (Creswell, 2015).

After Kuhn (1970) this study focuses on areas of useful comparison and possible relationships between the quantitative and qualitative approaches employed. Adopting this stance is a way of appreciating the different philosophical underpinnings that guide each approach as well as

utilising the differences between the two, in order to investigate walk and talk therapy from various positions.

Supporting this stance, Slife and Gantt (1999) state:

“In the case of methodological pluralism we would argue that this incommensurable difference is precisely what pluralism is all about: It is the use of different measuring sticks, different methods, to understand a particular subject under consideration” (p. 1461).

Furthermore, different stances and points of view can be valued for their individual qualities and by adopting a collaborative, comparative stance, rich mutual learning and connections can be produced (Barker & Pistrang, 2005; Keating & della Porta, 2009). Adopting a complementary position between methods and philosophies brings with it greater scope for freedom and creativity through the implementation of alternative assumptions thus inviting the potential for new possibilities to be explored (Mohamedunni, 2014; Moss et al., 2009; Moss & Haertel, 2015).

A robust and trustworthy application of methodological pluralism requires choosing methods that are appropriate to the overall aim of the research. Thus, the research questions are positioned at the forefront of the inquiry, not methods (Barker & Pistrang, 2005). Additionally, theoretical positions and context of the study are made explicit and clearly detailed so that the relevance and purpose of the study can be ascertained by the reader. This also situates the researcher’s interpretations of their findings so that it can be made sense of and the procedures undertaken during the research are open for evaluation (Barker & Pistrang, 2005).

“A pluralistic framework cannot work unless method philosophies have some meaningful relation i.e. have some coherence. Otherwise, there is no basis for comparison and no way to know when one method philosophy is to be used over another” (Slife & Gantt, 1999, p. 1460).

Pragmatism

A pluralistic stance finds support from the pragmatist position (Teddlie & Johnson, 2009). Pragmatism can be described as a philosophical method which is centred on psychological understanding of experience (Barbalet, 2004). There are several different stances that are taken within a pragmatist view (Bourgeois & Rosenthal, 1979). This study is informed by the pragmatist position of William James (1907).

James (1907) asserted, experiences are both subjective and objective. One experiences experience and within experiences there are also experiential objects. This then transforms into

a multifaceted view of the world and of self-experiencing the world (Burch, 2010). Experiences are considered diverse: 'plural'. This is in direct contrast to forms of monism.

“In fact the immediate deliverance of experience is that the world is a vast plurality of things that are related to one another... but not unified into one substance. In the experiences, the relations among things are as fully given as the things themselves. Thus relations are as real as the things related, and they are as diverse as, or even more diverse than, the things related” (Burch, 2010, p. 755).

For James (1907), it was important that experiences in life have meaning and be meaningful. He emphasised tentativeness, imperfection and inconclusiveness of all enquiry (Burch, 2010). A pragmatist's view of reality is firstly that there is an external reality that exists independently from our minds. Second, the truth regarding reality cannot be known. Therefore, it is not possible for one view of reality to be privileged over another (Teddle & Tashakkori, 2009). In a view that acknowledges diversity of experience and legitimate knowledge, a range of approaches are employed to represent a 'plurality' of voices, perspectives and experiences. This offers a mirroring of the multiplicity and 'pluralism' within society. “What experience directly gives us is a pluralistic but still genuinely interconnected universe” (Burch, 2010, p. 768). A pragmatic position is further concerned with practical issues and real world problems, therefore maintaining a distinction between other worldviews that align with more rigid measures of how knowledge is produced (Shaw, Connelly & Zecevic, 2010). It is for these reasons that a pragmatist position is well suited to practice based research (Creswell & Plano-Clark, 2011).

Drawing upon these stands of pragmatism, this research assumes the position that different people start at different places and the conclusions reached may also be varied and different. There is no single starting point, junction or end point that will suit everyone. Different and varying results from inquiries therefore, are in some way, to be expected and embraced (Burch, 2010). This research further harnesses the pragmatic stance which encourages full exploration of a phenomena, plurality of experiences and the subsequent multiple meanings that result (Crotty, 1998).

Phenomenology

Phenomenology and pragmatism are distinct philosophical traditions which rest upon different assumptions (Bourgeois, 2002). Whilst they are mostly known for their specific stances, it is also argued that there are similarities between their positions (Ferrarello, 2010). Some critics believe these traditions are mutually exclusive, whilst in recent times, others have argued for an approach of “interarticulation” (Bourgeois, 2002, p. 569) which takes a broad view of each perspective without sacrificing fundamental aspects or attempts to reduce one to fit within the

other (Bourgeois, 2002; Rosenthal & Bourgeois, 1980). It is further asserted that these two differing views can form a common context, thus broadening possibilities and increasing clarity in relation to the other, without compromising fundamental premise of either.

“The potential of these two movements to illuminate, expand and refine the focus of the other can be developed in a way that maintains the tradition, integrity and insights in each” (Bourgeois, 2002, p. 569).

In the methodological choices I made in this research I chose to employ pragmatism and phenomenology together. I consider these methodologies in their own right and utilise them in a way that broadens what is possible within this research, thus not being limited by either approach alone. A fundamental feature of this research is aligning with the non-dualistic view of lived experience. Phenomenology therefore furnishes us with the tools of a world view to understand and conduct research of individual lived experience which is not separate from the world.

Phenomenology can be described as the pursuit to depict lived experience and the meanings that are made from those experiences (Finlay, 2011). A main focus of phenomenology is to go “back to the things themselves” (Husserl, 1970/1900, p. 252. as cited in Giorgi, 1985, p. 8). Phenomenology seeks “a rigorous description of human life as it is lived and reflected upon in all of its first-person concreteness, urgency and ambiguity” (Pollio et al., 1997, p. 5). A phenomenological stance takes a broad view of experience and meaning can come from bodily, visceral, intuitive, emotional and transpersonal dimensions. In depth, generalizable meanings, structures and patterns of a phenomena come from a particular instance of a real world situation (Seamon, 2000).

In the choice and application of methodology for this research, I have been informed by phenomenology in two main areas. First, conscious lived experience and meanings; Second, in my theorisations around place.

Conscious lived experience

Husserl (1913/1962) sought to promote an alternative stance to positivistic scientific inquiry. He argued that different types of knowledge needed to be approached in ways that are consistent with the line of inquiry – in other words, philosophical questions cannot be answered by empirical science (D’Amico, 1999). Husserl (1913/1962) further focuses on “consciousness as it is given (i.e. how it appears) in experience: ‘to the things themselves’ (*zu den Sachen selbst*)” (Finlay, 2011, p. 44). Subjective perceptions arising from experience are therefore considered “the truest form of experience one can have “(Husserl, translated by Boyce-Gibson,

1962, p. 3) and this enables experiences to be examined as they are initially given to consciousness (Husserl, translated by Boyce-Gibson, 1962).

A challenge in phenomenology is to portray the person-world connection in a manner that avoids the subject-object dualism. Intentionality is a concept that has been developed to address this dichotomy, via the assumption that consciousness is intentional and constantly focused towards something (Finlay, 2011; Wertz, 2005). Intentionality then, is the assertion that “human experience and consciousness necessarily involve some aspect of the world as their object, which, reciprocally, provides the context for the meaning of experience and consciousness” (Seamon, 2000, p. 4). Phenomenological reflection therefore allows for both the ways in which we are aware and the *objects* of our awareness to be explored as we experience them (Finlay, 2011).

Bracketing is a fundamental part of investigating the essence of conscious experience (Finlay, 2011). This is also referred to as adopting an attitude of ‘phenomenological reduction’ which requires setting aside (‘bracketing off’) preconceived assumptions in order to encounter ‘what is given’ as “things as they are in themselves” (Husserl, translated by Boyce-Gibson, 1962, p. 3; Finlay, 2011).

However, not all who undertake phenomenological research agree with the concept of bracketing as originally proposed by Husserl (Tufford & Newman, 2012). Considerable debate has eschewed, which has subsequently led to a lack of consistency in how bracketing is interpreted and applied within the research process (Tufford & Newman, 2012). Those with opposing views contend that bracketing is neither possible nor necessary and argue for the legitimacy of preconceptions to be a valid contribution to context and the overall validity of the research process (Gearing, 2004). This stance however, has been criticised for misunderstanding the intent of bracketing, seen to arise largely from the lack of a clear and consistent definition and process through which bracketing can be conducted (Gearing, 2004; Kohák, 1978).

This research follows Giorgi (2009) who posits that bracketing is concerned with suspending prior knowledge during the process of investigating a particular phenomenon so that the past does not influence the present as it is being experienced. Giorgi (2009) further contends that the attitude of phenomenological reduction requires increasing an attitude of being fully present to the unfolding experience, and not focusing on denying all past knowledge and experience.

Aspects of two typologies of bracketing as compiled by Gearing (2004), have informed this research. First, a descriptive (eidetic) approach, which concentrates on setting aside past experience and preconceived ideas in order to directly experience the phenomenon as it is presented, in an unbiased way. Generalisations are not generally sought, rather the focus is on

describing specific instances. It is also understood that bracketing off all social and cultural aspects of the world may not always be possible, therefore these aspects may influence how the phenomena is experienced and understood. Second, a reflexive bracketing typology informs this study through the inclusion of researcher reflexivity. This requires the researcher's personal values, ideas and suppositions to be made transparent and obvious within the research process, with attempts made to bracket these. There is an acceptance that complete bracketing of all personal opinions, culture and past experience may not be possible, however through reflexivity, researcher influence can be identified and potentially reduced.

This research has drawn upon aspects of these two typologies in the following ways. Bracketing has been employed with the intention of approaching each study in an open and responsive way. As such, whilst later studies are informed by the studies that preceded them, there remained the intent to bracket off previous knowledge in order to encounter each research question openly. Researcher reflexivity has also been utilised, as a way of locating myself within the research and making explicit the ways in which my own influence and experiences may have influenced research processes.

Place

A phenomenological view of place focuses on subjective embodied experience of 'being in the world' (Creswell, 2004). The 'essence' of this view is the recognition that being human and being in a place are inextricably linked, therefore place is understood through the way we experience the world (Relph, 1976).

"Place is also a way of seeing, knowing and understanding the world. When we look at the world as a world of places we see different things. We see attachments and connections between people and place. We see worlds of meaning and experience"
(Creswell, 2004, p. 11)

A focus on place serves to provide a framework of understanding how human life and events are bound together through physical, spatial and environmental aspects (Seamon, 2000). It is due to the embodied nature of our existence, that the concept of place represents a core feature of 'being in the world', for "to be, is to be in place..." (Casey, 1993, p. 15).

From a phenomenological stance, place goes beyond location. Drawing upon previously discussed concepts of 'consciousness' and 'intentionality', "consciousness constructs a relation between self and the world" (Creswell, 2004, p. 22). Relph (1976) develops this further, by saying consciousness is being conscious of something in place and place influences our experience.

For this research, place offers an avenue to explore the nuanced ways therapy in the outdoors may be understood. Specifically, a phenomenological view of place adopted in this study supports a non-dualistic view of mind-body and promotes an intentional acknowledgement of the role place has within therapeutic encounters. The combination of these aspects avoids dualisms (of mind-body split) and at the same time highlights the often overlooked role of place within therapeutic encounters.

Mixed Methods

Mixed methods research intentionally employs different methods for the purpose of gathering different kinds of information. Mixed methods can be understood at both methodology and method levels (Creswell & Plano-Clark, 2011). As a methodology, philosophical assumptions direct the collection and analysis of data. As a method, quantitative and qualitative methods are used within a single study (Creswell & Plano-Clark, 2011).

“The underlying rationale for mixed-method inquiry is to understand more fully, to generate deeper and broader insights, to develop important knowledge claims that respect a wider range of interests and perspectives” (Greene & Caracelli, 1997, p. 7)

This research utilises a mixed methods approach which specifically refers to:

“the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process of research” (Creswell et al., 2003, p. 212).

An advantage of using two methods within a single study, allows for both generalisations and an in depth understanding of the topic of inquiry to be generated (Hanson et al., 2005). Further justification for the use of mixed methods, is that multiple methods enable a diverse and multi-layered way of knowing different social phenomena, thus mirroring the complex social world we live in (Greene & Caracelli, 1997). For this research, using a mixture of both qualitative (exploratory) and quantitative (confirmatory) methods was deemed an appropriate way of producing a more comprehensive understanding of the practice of walk and talk than either question type could elicit alone (Bryman, 2006; Johnson & Onwuegbuzie, 2004; Teddlie & Tashakkori, 2009).

There are several paradigms that are associated with a mixed methods approach and which subsequently influence the design of the study (Hanson et al., 2005; Tashakkori & Teddlie, 2003). This study is aligned with a pragmatic position which is a stance that is commonly associated with a mixed method approach to research (Biesta, 2010; Hanson et al., 2005; Johnson & Onwuegbuzie, 2004; Tashakkori & Teddlie, 2003). A pragmatist position argues for

the legitimacy of incorporating both methods within a single study, thus using ‘what works’ in an appropriate and meaningful way which respects both objective and subjective forms of knowledge (Cherryholmes, 1992; Greene & Hall, 2010; Hanson et al., 2005). Pragmatism aims to find middle ground between conflicting paradigms, that involves practical solutions as an alternative to dualisms or ‘either or’ choices (Johnson & Onweugbuzie, 2004). Furthermore, Shaw, Connelly and Zecevic (2010) contend that pragmatism offers a practical fit for practice based research as it approaches research from an unconstrained, less rigid stance than paradigms which are considered more traditional. Given the strong practice based focus of this research, pragmatism was therefore considered a compatible worldview.

In promoting an approach to research that offers greater flexibility, pragmatism refutes the incompatibility stance and utilises research questions as the guiding factor as to which methods are employed. This serves to emphasise a focus on practical applications of methodological decision making throughout the research process (Greene, 2007; Maxcy, 2003; Plano-Clark & Badiee, 2010). A key justification when conducting mixed method studies, is to demonstrate a rationale for combining both forms of data and being explicit with the process of analysis (Greene, Caracelli & Graham, 1989; Hanson et al., 2005).

This research considered a pragmatically informed mixed method approach to be the most effective method for responding to the various research questions. Following Creswell et al.’s (2003) framework for mixed methods research, this research integrated resultant quantitative and qualitative data at two stages of the research process. Firstly, the research question stage, where hypotheses were presented that related to the quantitative instrument items and open ended exploratory questions were asked, that related to the qualitative questions. Secondly, at the interpretation stage, both qualitative and quantitative data were appraised and areas of convergence were identified.

Research Design

This research is practice based and exploratory as there are only two known studies investigating the practice of walk and talk therapy. Doucette (2004) explored experiences of youth who took part in a 6 week walk and talk therapy intervention. McKinney (2011) explored therapists’ experience of conducting walk and talk therapy with clients. This research therefore, sought to extend and develop upon this initial research by investigating walk and talk therapy from multiple perspectives.

Four studies were conducted to address the overall research aim of this thesis. Each study utilises different research designs and jointly contribute to the overall understanding of the analysis. The first study has a mixed-methods design, the second study is qualitative, the third study has a mixed method design and the fourth study employs a narrative single case study

method. The overall research design therefore was emergent and flexible, with the results from each study informing the design of subsequent studies.

Table 3.1: Summary of research methods used to collect data in the four studies.

	Study 1	Study 2	Study 3	Study 4
Participants	Walk and talk practitioners	Walk and talk practitioners	Students (as potential clients of walk and talk)	A client of walk and talk therapy
Number of participants	32	7	147	1
Method	On-line questionnaire	Semi-structured interviews	On-line questionnaire	Single narrative case study
Analysis	Quantitative data: Descriptive Statistics Qualitative data: Thematic analysis	Descriptive Phenomenological approach	Quantitative Data: Inferential statistics (e.g. regression) Qualitative Data: Thematic analysis	Narrative case study and stanza analysis

General Methods

The primary overall research purpose for the four studies was to investigate the professional practice, potential user perceptions and client experiences of walk and talk therapy. Each study was guided by a main research question and sub-questions which are presented at the beginning of each empirical study chapter. The following section will discuss the general research methods employed across all studies, including participants, materials, analysis and ethics.

Participants:

This research sought participation from three different populations. Studies one and two focused on therapists who advertised as offering walk and talk therapy sessions to clients within their private practice. Study 3 sought participation from University students, as potential clients

of walk and talk therapy, and study 4 focused on an individual who had taken part in walk and talk in the past, as a client.

Recruitment for all studies was conducted via on-line mediums. Emails inviting participation along with details of the scope of the study were sent directly to therapists (study 1 and 2). Emails inviting participation and with details of the scope of the study were sent to professional colleagues along with a request to pass on to relevant students were sent for study 3. Again, drawing upon professional networks, emails inviting participation and details of the scope of the study were sent to therapists who offer walk and talk, along with a request to pass details of the study on to any clients who may wish to take part. For all four studies, notices inviting participation were also placed on web based forums, such as the British Association of Counselling and Psychotherapy (BACP) research notice board.

Materials

Web-based Surveys

Two internet based survey platforms were used for this research. Study 1 employed Bristol Online Survey (BOS) while study 3 utilised Qualtrics. The use of two different web-based survey platforms was required due to a transfer between institutions thus deciding to adopt the survey platform associated with the institution at the time of each of the studies being conducted.

The decision to use web-based survey platforms was considered the most appropriate method for studies 1 and 3. Benefits of conducting web-based surveys include; reaching sample populations who are distributed across a wide geographical area, the ability to generate a large number of responses; time and cost effectiveness, and immediate access to data (Gray, 2004; Wright, 2006). Furthermore, web based surveys can be more user friendly and attractive than either postal or email varieties which can enhance response rates (Madge & O'Conner, 2002). A criticism of web-based methods concerns the reliance on potential participants to have internet access and adequate computer skills, thus potentially limiting participation and/or introducing bias in the sample (Wright, 2006). Further limitations include potential non-completion rates and a lack of control over the sample which can affect the reliability of the data (Jansen, Corley & Jansen, 2007). For this research, the benefits of using a web-based questionnaire were considered on balance with potential limitations. As the therapists in study 1 were identified via on-line methods (a web search) it was assumed this participant group had adequate internet access and would be sufficiently skilled in navigating the survey. Similarly, with study 3's population being students and knowing that much of University teaching is now delivered via on-line mediums, it was also assumed that they would have the required levels of internet access and computer skills to take part.

Surveys

The surveys which were utilised in this research comprised of a combination of unique items alongside the use of existing measures which were modified to fit the context of this research. Unique items were generated from relevant literature and linked to the research questions of that particular study. Each of these measures are outlined below.

Helpful Aspects of Therapy (HAT) Form

Study 1 was largely informed by the Helpful Aspects of Therapy (HAT) form originally developed by Llewelyn (1988) and subsequently modified slightly by Elliott (1993). This research utilised Elliott's (1993) version. The HAT form is a client self-report measure designed to elicit descriptions of helpful and hindering aspects of therapy sessions. The design of items within the HAT form allows respondents to use their own words in identifying aspects of a therapy session that were considered helpful/hindering and then to rate this on a five-point scale (1 = Neutral, 5 = Greatly helpful/hindering). The function of the rating scale allows for a level of comparison between identified helpful/hindering aspects of therapy, thus enhancing the richness of the data (Elliott, 2010).

Investigating helpful/hindering aspects of therapy has been identified as one valid line of inquiry toward supporting evidence based practice (Elliott, 2010). Furthermore, helpful/hindering research supports the endeavour to identify particular aspects of therapy which are important in understanding more about therapy processes (Castonguay et al., 2010). The HAT form is primarily a qualitative instrument, and as such cannot be assessed using quantitatively oriented validity or reliability criteria. However, the HAT form has been utilised in several process-oriented studies and can be seen to be regarded as a suitably robust instrument in identifying helpful/hindering aspects of therapy (e.g. Castonguay et al., 2010; Cooper et al., 2015; Elliott, 2010; McLeod, 2013).

Given the limited amount of existing research on the practice of walk and talk therapy, utilising the question formation of the HAT form with slight modification to fit the current context (i.e. walk and talk) was deemed to fit the investigative aims of this research. For further detailed information on how the HAT form was utilised, see Chapter 4.

Study 3 utilised either original or modified versions of three standardised quantitative measures to investigate general help seeking, client preferences and environmental identity.

General Help Seeking Questionnaire (GHSQ)

The General Help Seeking Questionnaire (GHSQ; Wilson et al., 2005) is one tool that has been developed to explore help seeking intentions. This measure, originally designed for a young person demographic, is informed by the theory of planned behaviour which argues that

intentions can be predictive of actual future behaviour (Ajzen, 1991; Wilson et al., 2005). The GHSQ identifies both formal and informal sources of support, and these have been supported in subsequent studies (Ciarrochi et al., 2002; Ciarrochi et al., 2003). Furthermore, the matrix format of the GHSQ offers the possibility of modification to fit the context of a specific study without compromising the robustness of the measure (Wilson et al., 2005). The GHSQ is one of the few help-seeking oriented measures that has published reports on the psychometric properties of the questionnaire. In a study designed to test the reliability and validity of the GHSQ, Wilson et al., (2005) reported convergent and divergent validity, along with evidence to support the predictive and construct validity of the instrument.

The original version of the GHSQ asks two main questions. Question 1 relates to personal or emotional problems and question 2 relates to suicidal ideation. Both questions ask participants to rate the likelihood to seeking help from nine listed sources on a 7 point Likert-type scale (1 = very unlikely, 7 = very likely). There is an option for participants to list and rate any source of support they would use which is not listed. This research utilised question 1 only, which asked participants to consider if they were experiencing emotional or personal problems, to rate the likelihood of seeking help from the listed sources. The question concerning suicidal ideation was not included as it was deemed outside the scope and focus of this research.

Psychotherapy Preferences and Experiences Questionnaire (PEX-P1, v3.3)

The Psychotherapy Preferences and Experiences Questionnaire (PEX-P1, v3.3) (Clinton & Sandell, 2011) was also utilised in study 3. This 25-item measure asks respondents to rate, on a 6-point scale, to what extent they considered various non-specific features of therapy would be helpful for them, if they were to seek counselling (1 = not at all, 6 = completely). The non-specific features were organised into the following five sub-scales which were generated from research on helpfulness beliefs (Sandell, et al., 2011): *Outward Orientation* (i.e. ‘training in practical problem solving’ and ‘working towards concrete goals’); *Inward Orientation* (e.g. ‘putting feelings into words’ and ‘working on understanding relationships with others’); *Affect Suppression* (e.g. ‘working to keep anxieties out of mind’ and ‘keeping feelings under control’); *Affect Expression* (e.g. ‘sharing bottled up emotions’ and ‘talking about painful memories’); *Support* (e.g. being taught how to cope with problems’ and ‘working with an active initiative therapist’). Factor analyses has supported the use of subscales.

For the purposes of this research, the PEX-P1 was reduced from a 25-item measure, to 15 items. Three items were taken randomly from each sub-scale to generate the adapted measure. Two further questions designed for the purpose of this research were included in this measure. The first added question sought to capture preferences relating to the walking aspect of walk and talk, through the statement “Having the opportunity to walk outdoors while talking with a

counsellor”. The second added question sought to capture preferences relating to the location aspect of walk and talk, through the statement “Having a choice of being indoors or outdoors for the counselling session”. For a further description of this adapted measure, see Chapter 6.

Environmental Identity Scale (EIS)

The final measure utilised in Study 3 was the Environmental Identity Scale (EIS) (Clayton, 2003). EIS was constructed using identity theory as the framework for understanding the relationship between self and nature (Clayton, 2003). Environmental identity as a variable is considered difficult to assess in terms of reliability and validity (Olivos & Aragonés, 2011). Clayton & Opatow (2003) argue against the application of a rigid definition, instead promoting a broad conceptualisation which acknowledges multiple theoretical influences and disciplines which subsequently determine how the terms ‘environment’ and ‘identity’ are subsequently understood. Furthermore, identity is considered to be a construct which is dynamic and changeable (Clayton & Opatow, 2003).

EIS consists of 24 items that are rated on a 7 point scale (1 = not at all true of me, 7 = completely true of me) and constructed around five concept clusters: i) the salience of identity, as relating to the degree and significance of an individual’s interaction with nature (e.g. “I spend a lot of time in natural settings”); ii) identifying one’s self as a member of a group, which relates to the way in which nature is part of the group within which someone identifies with (e.g. “I think of myself as a part of nature, not separate from it”); iii) personal belief systems, as relating to the level of support for environmental issues and sustainable lifestyle (e.g. “Behaving responsibly toward the earth – living a sustainable lifestyle- is part of my moral code”); iv) experiencing positive emotions, as relating to the level of enjoyment found in nature through satisfaction and aesthetic appreciation (e.g. “I would rather live in a small room or house with a nice view than a bigger room or house with a view of other buildings”); v) and experiences in nature, as relating to personal historical accounts of memories based on interacting with nature (i.e. I spent a lot of my childhood playing outside”) (Clayton, 2003).

The EIS is reported to have good internal reliability with Cronbach’s alpha 0.90 or above for the full 24 item scale (Clayton, 2003; Olivos & Aragonés, 2011). Clayton (2003) further reports that “factor analyses suggest that a single factor accounts for much of the variance... and is relatively free from floor or ceiling effects” (p. 53). A noted limitation of this measure is that it is informed by a North American social and cultural perspective which potentially limits its applicability for other cultures whose meanings relating to nature and environmental issues are based on different social and cultural assumptions (Clayton, 2003).

For the purpose of this research a shortened version (10 items) of the EIS was constructed, consisting of ‘Salience of Identity’ and ‘Identification of self as a group member’ items. These

two clusters were chosen based on the relevance of the items within each cluster for this research. It was not anticipated that shortening the scale would adversely affect the reliability or validity of the measure as all items load on a single factor (Clayton, 2014 personal communication).

Interviews

Interviews constituted the primary source of data, which were combined with quantitative results from surveys in order to gather full accounts utilising different data types. This research is fundamentally exploratory, therefore interviews were deemed an appropriate method of data collection, to capture rich, in-depth accounts of individual experiences. Interviews can serve several purposes such as; eliciting data relating to experiences with and perceptions of a phenomena; distinguishing relationships between variables, and as a supplement to other research methods in order to provide more in depth and nuanced information (Gray, 2004). Interviews were further understood in this research as a relational co-construction between the interviewer and interviewee (Etherington, 2007). Conceptualising qualitative interviews as a co-construction, requires researchers to make themselves visible within the research process. This serves to attend to the trustworthiness, transparency and accountability within the research, by acknowledging and identifying the ways in which researcher subjectivity has influenced how the data is produced, and analysed (Finlay, 2002). This research attends to these requirements through the inclusion of an overall researcher reflexivity statement in the introduction, as well as through the inclusion of interview dialogue between interviewer and interviewee and interviewer reflexive statements in study 4.

Two different interview strategies were employed in this research. In studies two and four, a semi structured interview method was used. This method allowed a balance to be struck between offering a level of consistency regarding the questions being asked of each participant as well as providing a way for subjective meanings of each interviewee to be investigated (Gray, 2004). Study 4 utilised a mobile method of interviewing, referred to as the 'walking interview' (Moles, 2008). Walking interviews allow for the rich contextual understanding of the interaction between people and place to be a prominent part of the interview process. In order to maximise contextually based exploration, the walking interview was approached in a non-directive way, thus inviting the participant to walk wherever they wished to do so at the location, and talk freely about their experiences. Using this approach to interviews requires active listening by the interviewer, clarifying meanings and checking for accuracy of understanding (Gray, 2004).

Analysis

Quantitative data

Quantitative data in this study were utilised to describe and identify the potential relationship between variables (e.g. Field, 2013). This included inferential analysis to allow for interpretations that could be generalised (Creswell et al., 2003).

Qualitative data

Qualitative data were produced across all four studies and varied in terms of quantity and depth, dependant on the research aims and questions of each study. Therefore the data were approached with types of analysis considered most fitting in each context. For each study, NVivo software was used to store, organise and support the data analysis process. Software such as NVivo, carries the benefit of supporting a wide range of methodologies through utilising different tools within the software programme, as well as a supporting the application of a rigorous analysis procedure (Bazeley & Jackson, 2013).

Thematic Analysis

Thematic analysis (TA) is a flexible approach to qualitative data analysis which can be employed across different theoretical and epistemological approaches (Braun & Clarke, 2006). TA aims to systematically identify, analyse, interpret and describe salient patterns from engaging with the data (Boyatzis, 1998; Braun, Clarke & Terry, 2015; Smith & Firth, 2011). A strength of TA is seen to be in the accessibility and flexibility of its application (Braun & Clarke, 2012).

Braun, Clarke and Terry (2015) advocate for researchers to make active, transparent choices of four main areas when using TA in order to demonstrate rigour of the research process. First, for researchers to situate their research within ontological and epistemological frameworks, thus serving to identify how the use of TA will be informed. Second, to identify the specific theories underpinning how TA will be utilised (i.e. phenomenological etc.). Third, to identify how the coding and analysis is approached, utilising either an inductive or deductive approach. Lastly, to consider if the codes will be used to identify semantic or latent meanings.

This research employed TA in studies 1 and 3 for data resulting from short answer survey questions. TA was considered an appropriate method of analysis, as it enabled patterns to be identified from participant responses. As walk and talk is an under researched area, identifying patterns and semantic meanings provided information upon which subsequent research can be based. This research approached the use of TA with an ontological assumption of multiple realities. The epistemological assumption was pragmatism, which advocates the use of both

constructionist and post-positivist views. The data were approached with a phenomenological perspective. Coding and analysis was conducted inductively, and semantic meanings identified.

Descriptive Phenomenological Approach

A phenomenological approach to research focuses on “the way things appear ...through experience or...consciousness where the...aim is to provide a rich textured description of lived experience” (Finlay, 2008, p. 1). A fundamental focus of phenomenology therefore is to “go back to the things themselves” (Husserl, 1970 as cited in Giorgi, 1985, p. 8).

There are several types of phenomenological approaches which are based upon variants in philosophical values, theoretical underpinnings and methodological processes (Finlay, 2008). A descriptive phenomenological approach aims to describe the essence or structure of a phenomena as it is directly experienced in consciousness. Descriptions are directly attached to the data, without interpretation or external theory being applied (Finlay, 2011). The origins of the descriptive phenomenological approach can be found in the philosophies of Husserl, and later developed by Giorgi (1985). Giorgi (1985) presents four features of the descriptive phenomenological approach: there is an emphasis on rigorous descriptions; phenomenological reductions are employed; the intentional relationship between individuals and their situations are explored; and imaginative variation allows for the essences of meanings connected to experiences to be elucidated.

Giorgi (1985) insists that a descriptive phenomenological approach be approached with scientific rigour, whilst at the same time maintaining a ‘certain openness and flexibility’ (Finlay, 2011). There is further emphasis on adopting a position of ‘phenomenological reduction’ which is approaching the data in a way that bypasses pre-existing beliefs, values and cultural assumptions. This is in order to engage with the phenomenon directly as it appears, thus “putting aside how things supposedly are, focusing instead on how they are experienced” (Finlay, 2008, p. 2).

This research utilised a descriptive phenomenological method as this allowed the ‘essential structures’ (Giorgi, 1985) of walk and talk to be explored in a way that elucidated the essential features, as they are experienced and understood by participants. Furthermore, this approach provided an opportunity to produce rich textured descriptions of the experience of participating in walk and talk, which has not been researched before.

Narrative Case Study

Case study methods have long been used in psychology and related disciplines as a viable approach to exploring, describing, explaining and evaluating various situations (Yin, 2014).

Case studies can take various forms: single subject (i.e. n=1); theory building; pragmatic, hermeneutic single case efficacy designs and narrative approaches (McLeod, 2010).

Although considered an empirical method of inquiry, case studies have struggled to be accepted as a reliable and valid tool in social science research practices. Gerring (2004) refers to case studies as surviving in a “curious methodological limbo” (p. 341) due to the relative lack of procedural framework for researchers to follow (Thomas, 2011). Case studies have also been criticised for their limitations concerning generalisability, potential lack of rigour and presence of bias (McLeod, 2002; 2010; Yin, 2014). In response, advocates of case studies (i.e. Gerring, 2004; McLeod, 2002; 2010; Yin, 2014) promote an approach to case study research which is systematic, informed and justified. Furthermore, case studies have been identified as an effective way of exploring the complexities of people’s experiences that survey and experiments would not be able to do (Yin, 1994).

This research justifies employing a case study approach (study 4) as an appropriate way of producing practical, context-dependent knowledge (Flyvbjerg, 2006). To mitigate against hidden potential bias, researcher reflexivity is evident within the presentation of the findings (McLeod, 2010). The use of a case study did not seek to produce generalisations or broad conclusions regarding all clients’ experiences of walk and talk. Rather, this research sought to elucidate practice based principles which could contribute to the understanding of interactional mechanisms present in walk and talk therapy.

This research utilised a narrative case study design (study 4). The aim of narrative case studies are to produce storied accounts of experience with a particular focus on articulating the meanings relating to the experience (McLeod, 2010). The presentation of narrative case studies does not fall within one set of methodological principles (McLeod, 2010). For the purpose of this research, an experience-centred approach was utilised for the analysis that was presented in an adapted stanza style (after Gee, 1991). Experience-centred narrative is informed by a phenomenological view that stories provide a way for experiences to become consciously known (Squire, 2013). Analysis was therefore conducted using Squire’s (2013) assumptions in experience-centred narrative analysis. Firstly, narratives have meaning and are sequential and are integral to the meaning-making process. Secondly, narratives are human centred and located within a social context that requires a teller and a listener. Thirdly, narratives ‘represent’ experiences that are reconstructed and expressed across time and place, producing changeable and multiple stories that are influenced by different social contexts. Lastly, narratives show change.

Excerpts of the interview conversation were produced in an adapted stanza form (after Gee, 1991). Utilising poetic stanza structure for the presentation of narratives allowed for the

participants own language to be used, represented as authentically as possible, with the meaning and structure of the narrative clearly depicted (Etherington, 2004; McLeod & Lynch, 2000).

Ethics

Ethical approval from University ethics panels was granted for each study. Studies 1 and 2 were granted ethical approval from Glasgow Caledonian University, as this was the institution where I was registered as a student at the time of conducting the research. Studies 3 and 4 were granted ethical approval from Canterbury Christ Church University as this was the institution where I was registered as a student at the time of conducting the research.

Trustworthiness

Guba and Lincoln (1994) propose that trustworthiness of studies can be assessed through the four components of *confirmability*, *dependability*, *transferability* and *credibility*.

To ensure *confirmability*, I have presented clear descriptions of research methods, interpretation and analysis procedures, along with underlying theoretical assumptions of this research. My intention therefore, is to demonstrate transparency of the research process from which the reader can ascertain the quality of this study.

The component of *dependability* relates to the degree within which the process within the research have been systematically applied and open to scrutiny of peer or participants. I have demonstrated dependability through having qualitative transcripts reviewed by either an independent researcher (study 2; study 4) or by the research participant (study 4) from which discussions around emergent themes and interpretations were had. Several discussions on findings and interpretations of both qualitative and quantitative data were had with my supervisor's which further added to dependability of the research process.

Transferability refers to the degree of which the findings from a study can be applied to the similar contexts at a different time. To demonstrate this, I have aimed to provide comprehensive descriptions of all findings and related these to prior research in the discussion chapter.

Finally, *credibility* relates to whether the findings are considered believable and acceptable to readers or participants (Bryman, 2004). This is evidenced through having four publications in peer reviewed journals relating to studies one, two, and 3. Additionally, the analysis of the interviews in study 4 were sent to the participant for review and they confirmed the depiction was an accurate representation of what occurred.

In summary, the methodology chosen for this research is responsive to the multiple research questions I have chosen. The methodology has also allowed me to effectively research the

practice of walk and talk therapy from multiple perspectives. The research questions for each study, are listed below in Figure 3.2.

Figure 3.2: Research questions for each of the four studies.

Study 1:

What are therapist's experiences of integrating walk and talk therapy into their professional practice?

Study 2:

What do therapists believe are the aspects of walk and talk therapy that help to facilitate change in their clients?

Study 3:

What are potential client perceptions of walk and talk as a therapeutic activity?

Study 4:

What is one client's experience of participating in walk and talk therapy?

Chapter 4: Study 1

Introduction

The aim of study 1 presented in this chapter was to explore therapists experiences of integrating walk and talk into their professional therapy practice (the research question and sub-questions are outlined in Figure 4.1 below). This preliminary study aimed to understand both practice related aspects and theoretical elements of walk and talk therapy in practice. To date, no known study conducted in the UK has been conducted that investigates the practice of walk and talk by therapists who work in this way.

Figure 4.1. Study 1 research question and sub-questions

<p>Study 1</p> <p>Research question: What are therapist’s experiences of integrating walk and talk therapy into their professional practice?</p> <p>Sub-questions:</p> <ol style="list-style-type: none">1: What is the current provision of walk and talk therapy practice within the UK?2: What constitutes walk and talk therapy practice?3: What are the theoretical underpinnings that inform the practice of walk and talk therapy?4: What are the therapeutic processes inherent in walk and talk therapy experiences?

The use of outdoor spaces in counselling and psychotherapy has been steadily developing in recent years (Jordan & Hinds, 2016). Practices such as nature therapy (Berger & McLeod, 2006), ecotherapy (Buzzell & Chalquist, 2009), outdoor therapy (Jordan, 2015; Revell, Duncan & Cooper, 2014), wilderness therapy (Davis-Berman & Berman, 2008) and adventure therapy (Gass, Gillis & Russell, 2012) have raised awareness of how the outdoor environment can aid both physical and psychological wellbeing. The benefits and challenges of therapy in outdoor-based settings have been reviewed by Jordan and Marshall (2010). ‘Walk and talk’ describes a type of counselling where the counsellor and client walk together outdoors during therapy sessions (Doucette, 2004; Hays, 1999). Walk and talk offers an accessible means of integrating nature and physical activity within routine therapy practice, and does not attract costs associated with other variants of outdoor based therapy (such as wilderness and adventure therapy).

General support for the concept of walk and talk can be found in the literature on walking and wellbeing. There is considerable evidence that walking has numerous benefits, including enhanced psychological processing and ability to problem solve (Hays, 1999), alleviation of depressive symptoms (Pickett, Yardley & Kendrick, 2012), and improved self-esteem and mood

(Barton, Hine & Pretty, 2009). Further support for walk and talk can be identified in research into the inherent benefits that can be gained through spending time in nature (Jordan, 2015). Spending time in natural environments is linked to positive outcomes such as a decrease in symptoms of depression and anxiety (MIND, 2007), alleviation of stress (Pretty et al., 2007), and increased overall well-being (Mayer et al., 2009). Furthermore, it is suggested that bodily movement within natural environment settings produces positive impacts on cognitive processes (Corazon, Schilhab & Stigsdotter, 2011).

Walk and talk is not linked to any specific therapy theory, and is utilised flexibly, in some instances forming the basis for all therapeutic work with a client, and in other cases operating as an adjunct to office-based meetings. Walk and talk therapy is an approach that aims to harness the interactional beneficial effects of physical movement and outdoor setting within the context of an intentional therapeutic relationship. To date, there is no identified framework for practice, nor a commonly shared philosophical underpinning that informs this therapeutic activity (McKinney, 2011; Revell & McLeod, 2016). Research exploring the benefits of walk and talk as a therapeutic activity is in its infancy.

Studies of professional knowledge, in which practitioners report on their experience in relation to a specific area of work, represents a valuable research strategy in emerging areas of practice (Chartas, & Culbreth, 2001; Christianson, & Everall, 2009; Fox, 2011; Karakurt, et al., 2013; van Rooij, et al., 2012). Råbu and McLeod (2018) describe professional knowledge as;

“...a particularly important area for therapeutic knowing. Professional knowledge consists of the mix of personal experience and critical incident, conceptual understanding and practical skills and strategies that have arisen from the process of conducting therapy” (p. 3).

Benefits of professional knowledge being documented and disseminated offer valuable opportunities for sharing both practical experiences and learning that other professionals have gained through working in a particular way or with certain client groups (Råbu and McLeod, 2018). As walk and talk is a relatively new therapeutic activity, there is a lot that can be learned from exploring the experiences of therapists who have pioneered this approach. To date, one professional knowledge study (McKinney, 2011) that relates specifically to the practice of walk and talk has been conducted (see Chapter 2 for a review of this study).

The aim of the present study was to document the professional knowledge of walk and talk practitioners in the UK. For the purposes of this study, walk and talk was defined as “individual counselling/psychotherapy where some or all of the contracted sessions have taken place in an out-of-doors setting where both client and therapist walk during the therapeutic session” (Revell & McLeod, 2016).

Method

This study was conducted in two phases. Phase 1 consisted of a desk based study that was intended to inform both the method and content of subsequent phases of the inquiry. Phase 2 utilised an on-line anonymous questionnaire that contained both quantitative items and short answer response questions.

Phase 1 – Desk based study

A desk based scoping study was conducted as the initial phase of this research. Main aims of the scoping study were to identify the number of practitioners within the UK who advertised as offering ‘walk and talk’ therapy to individual clients along with identifying aspects of walk and talk practice. Due to a lack of recognised terminology associated with outdoor based therapy, a range of search terms were employed. The following search terms were used: ‘walk and talk therapy UK’; ‘outdoor therapy’; ‘ecotherapy’; ‘nature therapy’; ‘outdoor counselling’; ‘walking therapy’. Particular attention was paid to the descriptions offered on practitioner websites, to ascertain the type of outdoor therapy experience that was being offered in order to keep the focus of this study centred on walking during the therapeutic session and not branching out into other variants of outdoor therapy practice (i.e. adventure based therapy, horticulture therapy).

The desk based research revealed that practitioners who advertised as offering outdoor walking sessions most often used the term ‘walk and talk’ therapy or close variants of this (i.e. walking talking therapy, walking therapy). Also identified during this phase was a high degree of consistency between practitioners in how walk and talk sessions were described. The initial desk based research identified 32 therapists who advertised as offering walk and talk therapy sessions.

Phase 2 – On-line questionnaire

This study utilized a mixed methods approach (Creswell & Plano-Clark, 2011; Tashakkori & Teddlie, 2003; 2010) to collect standard information from a sample of practitioners, while at the same time making it possible for each participant to report on his or her own individual experience through employing short answer questions.

Recruitment

An objective of the study was to gather views of all practitioners within the UK who advertised as offering ‘walk and talk’ therapy sessions to individual clients. Potential participants identified through the desk based phase were emailed directly and invited to take part in the anonymous on-line questionnaire. Those contacted were also asked if they would consider passing details of this study onto other relevant and/or interested parties (i.e. colleagues offering walk and talk). This utilised a snowball sampling technique in order to maximise the number of

respondents. A link to access the on-line questionnaire was included within the invitation email. Notices were also placed on relevant on-line research forums such as British Association of Counselling and Psychotherapy (BACP) and LinkedIn, inviting participation from practitioners who self-identified as employing this approach in their therapeutic work.

It had initially been intended to conduct concurrent questionnaires investigating both therapist and client experiences of walk and talk. A separate link to a client focused on-line questionnaire was provided within the introductory email to therapists. Therapists were asked to consider passing the details and survey link on to any suitable clients. The client focus of this study failed to recruit any participants. This will be further discussed in the limitations section of this chapter.

Data collection

An on-line questionnaire was constructed and hosted by Bristol Online Surveys (BOS). The questionnaire contained 24 questions that were constructed to enable both qualitative and quantitative responses. The first twelve questions included demographic information; professional qualifications, affiliations and both participants experience as a counsellor/psychotherapist and of offering walk and talk. Additional questions sought information about reasons for incorporating walk and talk into practice, and length and location of walk and talk sessions. These questions were informed by existing literature and information gained from phase 1, desk based study.

The latter part of the survey invited respondents to use a 5-point scale to rate a series of statements concerning helpful and hindering aspects of walking and being outdoors. The statements used in these items were compiled from existing literature and from walk and talk practitioner websites accessed during phase 1 of this study. Participants were then invited to indicate, on a 9-point scale, the overall extent that offering walk and talk therapy had been helpful or hindering for them as a therapist. The wording of those items which related to helpful and hindering factors was based on the Helpful Aspects of Therapy form (Llewelyn, 1988; Elliott, 1993). Participants were invited to rate their responses of each statement on the following scale: Neutral, slightly helpful/hindering, moderately helpful/hindering, greatly helpful/hindering, and extremely helpful/hindering.

The survey concluded with open-ended items intended to elicit personal accounts of walk and talk therapy. In separate questions participants were invited to record in their own words, what they found to be helpful / hindering about the outdoor and walking elements of walk and talk. A text box was provided for respondents to record their answers (see Appendix 3 for a full copy of the survey).

Pilot

The on-line questionnaire was piloted for content and face validity, on a number of colleagues known to the researcher. They received a link to the questionnaire and were invited to offer feedback on the questions contained within the questionnaire. Although the Helpful and Hindering ratings were primarily designed to allow analysis of responses to specific items, a reliability analysis was also conducted on data collected within the study, to explore the extent of inter-item consistency. Cronbach alphas of .88 were recorded for the Helpful items and .91 for Hindering items, indicating a satisfactory degree of internal reliability.

Ethical procedure

The study focused on professional's experiences of offering walk and talk, and did not seek sensitive information on participants work with their clients. All participants were required to read two information pages prior to taking part. Explicit consent was gained by participants ticking an 'I agree' option before being able to access the questionnaire. Participants could withdraw at any time. Participants completed the questionnaire anonymously unless they chose to leave their contact details indicating their willingness to be contacted for a follow up interview. Participants were informed this would compromise the anonymity of their participation. All participant identifying information was stored securely for the duration of the research project. All results are presented anonymously. Ethical permission was received from the Research Ethics Committee at Glasgow Caledonian University (see appendix 1 & 2).

Analysis

Quantitative data was in the form of ranked interval scale questions which produced descriptive statistics (e.g., means, SD). Qualitative data were analysed using thematic analysis (Braun & Clarke, 2006). All participants responded to the open-ended questions with responses ranging from a short sentence to small paragraph in length. In the first instance, themes were identified by the researcher. These themes were subsequently discussed and agreed upon with an independent colleague who was an experienced qualitative researcher and who read the data independently.

Results

A total of 32 therapists were located, who described themselves as offering walk and talk therapy sessions. Five practitioners contacted the researcher expressing an interest in the study but stating that they did not feel they fit the criteria for participation due to a lack of client uptake of walk and talk sessions. Completed questionnaires were eventually received from 18 participants, 11 (61.1%) female and 7 (38.9%) male, the majority aged between 46-60 (72.2%, n=13). Respondents tended to be experienced psychotherapeutic practitioners with more than

five years of post-qualification experience (61.1%, n=11) and had been integrating walk and talk into their practice for 1-2 years. The two main psychotherapeutic approaches that were identified as being most utilised in informing the walk and talk practice of participants were person-centred and integrative. Other therapy orientations that were used by participants included CBT, mindfulness-based CBT, Gestalt, psychodynamic, eco-psychology, eco-systemic, and humanistic.

The findings of the study are presented in three sections: (i) characteristics of walk and talk practice; (ii) rating scale data on participants' perceptions of helpful/hindering aspects, and (iii) thematic analysis of open-ended qualitative sections of the questionnaire.

Characteristics of walk and talk practice

The duration of walk and talk sessions were generally indicated to be either up to one hour (61.1%; n=11) or between 1-2 hours in length (33.3%; n=6). Locations that walk and talk sessions are held in varied – with forest/woodland and countryside being reported as the two most common environments. City and town streets, mountains and seaside settings were the least common settings encountered.

Practitioner evaluation of walk and talk practice

Therapist personal beliefs about the outdoors and/or walking were the main reason that had led to them offering walk and talk sessions (16 participants; 88.8%). The second most common reason was therapists desire to offer a variety of methods in their therapy (14; 77.7%). Twelve participants (66%) mentioned that they had read research supporting the use of walk and talk within therapy.

Participants' perceptions of the relative helpfulness of various elements of walk and talk practice is presented in Tables 4.2 and 4.3. Ratings were made using a 5-point scale, with a high score indicating the strongest level of agreement. Participants regarded the outdoor element as slightly more helpful than the walking element within walk and talk sessions. In general, participants indicated no difference between how hindering either the walking or outdoor aspects of walk and talk sessions were, with both elements on average being ranked between the 'not at all and slightly hindering' scale points. Overall, respondents reported that offering walk and talk had been a positive experience for them, with a mean of 7.8 (SD = 1.1), between the points on the scale labelled moderately helpful and greatly helpful on the 9 point scale used in this section of the survey.

The two statements where participants indicated the highest levels of agreement were that walking and talking can shift 'stuckness' in clients and that walk and talk strengthens the connection between body and mind. In addition, practitioners indicated that the experience of

walking side by side helped clients to open up, as well as enhancing overall wellbeing and that walk and talk promoted a holistic approach for clients' self-discovery. On the whole, respondents did not agree that clients resolved issues quicker through walk and talk compared with indoor therapy.

Results indicate that practitioners showed a high degree of agreement that offering a variety of experiences (such as walk and talk) is useful to clients. Respondents also indicated that they felt invigorated when doing walk and talk and that they generally had no trouble being focused on their clients during walk and talk sessions. On the whole respondents did not agree that walk and talk was mentally demanding or that they were distracted by things happening in the environment during walk and talk sessions.

Table 4.2: Perceived benefits of walk and talk therapy for clients

Perceived benefits of walk and talk	MEAN	S.D.
Walking and talking during a therapy session helps clients to get 'unstuck'	4.1	0.6
Walk and talk therapy strengthens clients connection between body and mind	4.1	0.9
Walking side by side with a client's helps them to open up	4.0	0.8
Clients achieve a greater sense of overall wellbeing through walk and talk therapy	4.0	0.8
The process of clients self-discovery is promoted in a more holistic way through walk and talk therapy	4.0	0.9
Walking together during walk and talk therapy promotes equality in the therapeutic relationship	3.9	0.8
Being outdoors during a therapy session enhances the therapeutic process	3.9	0.9
Walk and talk therapy encourages deeper ways of thinking	3.9	0.9
Walk and talk therapy is less intimidating for clients compared to indoor seated therapy	3.8	0.8
Through walk and talk therapy the overall counselling process is enhanced	3.7	0.8
Lack of eye contact is more comfortable for the client	3.7	0.8
Walk and talk therapy improves physical fitness of the client	3.6	0.8
Clients resolve issues quicker through walk and talk therapy compared to indoor seated therapy	2.9	0.8

Table 4.3: Therapists' experiences of walk and talk therapy

Therapists experiences of walk and talk	MEAN	SD
I believe that offering a variety of therapeutic experiences (such as walk and talk) is useful to clients	4.5	0.6
I generally feel invigorated when doing walk and talk therapy sessions	4.3	0.5
I generally have no trouble being focused on my client during walk and talk therapy sessions	4.3	0.8
I generally have clear thought processes during walk and talk sessions	4.1	0.8
Offering walk and talk therapy has been beneficial for my professional development	4.1	0.7
I believe that walk and talk therapy offers mutual benefits to both client and therapist	4.1	0.8
Offering walk and talk therapy has reduced my own stress levels	3.8	1.0
I do some of the best therapeutic work during walk and talk sessions	3.6	0.8
I am physically fitter since starting walk and talk sessions with clients	3.4	1.0
I sometimes get distracted by things happening in the environment during walk and talk sessions	2.9	1.0
I find walk and talk mentally demanding to do with my clients	2.7	1.1

Thematic analysis

Eight themes emerged from analysis of participant qualitative statements in response to open-ended items that invited views on helpful and hindering aspects of walk and talk therapy sessions.

Helpful aspects of walk and talk

Participants described a number of ways in which they believed that conducting walk and talk therapy had been beneficial. Each of the helpfulness themes outlined below were reported by at least half of the participants in the study.

Facilitating collaborative engagement. Walk and talk sessions were seen as promoting equality within the therapeutic relationship as both therapist and client shared the experience together and this ‘tangible’ aspect was seen to enhance the therapeutic alliance. Additionally, equality was further facilitated through clients being able to choose whether or not to walk, where to walk and what pace to walk at. A sense of informality was identified as being present throughout walk and talk sessions and this was seen to be helpful as it was experienced as informal and less intimidating:

Opportunity to work as team - gates/stiles/traffic warnings/slippery ground, helps to build relationship. Working together to find pace which suits both.

More equal power dynamic on neutral territory and without 'expert' props of a carefully constructed counselling room. Informality, more casual tone.

Encountering different relational embodiment: The change in physicality between client and therapist from seated face to face to standing and walking side by side was identified as helpful during a walk and talk session. It was suggested that these benefits were gained through lack of eye contact, therefore easing tension for some clients. Additionally it encouraged an ease and informality within a session while at the same time offering a physical representation of ‘being alongside’ clients:

While you are walking side by side, rather than sitting face to face, some clients find it easier to express difficult and painful emotions or events in their lives.

Gaining new insights through moving. The act of movement was viewed as an important helpful aspect in walk and talk as the bodily movement forwards was seen to facilitate a mirrored internal process (i.e. develop new awareness and have greater ability to problem solve). The physical rhythm was also identified as bringing energy to the session which was helpful for the overall therapeutic process. The release of endorphins through movement was also identified as a helpful ‘feel good’ factor on a physiological level.

It allows the client to take control of the pace and exercise raises the endorphin levels so the client will feel naturally lifted and therefore more open

My clients have mentioned they feel the gentle exercise is also beneficial to their overall sense of well-being.

The physical movement heightens positive energy and clarity of thought often creating a psychological state more open to therapeutic movement and change.

Exercise helps to encourage clients to get 'out of their heads' and 'into their bodies' ...and helps them to reconnect with their capacity for joy and living.

Experiencing the outdoor environment: Outdoor and nature based settings were considered to offer healing and restoration through a sense of freedom, space, and openness. The multisensory aspect of outdoors was helpful in that it allowed metaphorical connections that aided psychological process and also added an authenticity to the sessions. The opportunity to journey through and be in an outdoor environment allowed a sense of connection to develop between self and nature:

Being in touch with nature enhances creativity and freedom to speak...

Being outdoors helps the client to get in touch with them self as the path is always going forward and unconsciously they can see natural growth all around

Being outdoors allows for space in therapy, physically and mentally.

Hindering aspects of walk and talk

Five (27.7%) participants reported there was nothing hindering about walk and talk sessions. The remaining thirteen responses indicated that hindering aspects were generally related to the practicalities associated with walk and talk sessions.

Working with uncertainty: The weather was a main hindering aspect that was identified. This included rain, cold and windy conditions – all experienced as negatively affecting the session in some way. Walking on an unfamiliar route was also seen as hindering as this could affect how long a session lasted for, thus causing challenges with holding the boundary of time. The potential for encountering other walkers and dogs were also acknowledged as hindering aspects of walk and talk as these interruptions could interfere with the flow of the conversation.

Attending to the therapeutic process: The development of new skills to hold the therapeutic process while walking was identified. Aspects such as not having eye contact with clients relied on other ways of making and maintaining contact with clients during the session. Additionally, the physicality of walking side by side, sometimes resulted in not hearing clients clearly, therefore had the potential to disrupt the therapeutic process. Both clients and therapists attention could potentially be drawn towards things in the environment (i.e. a nice view) and this was also seen to raise the potential for the therapeutic process to be interrupted. The outdoor environment was conceptualised as a space and place for reflection, with the potential for this to develop into ‘philosophical’ mode (i.e. the focus of the conversation moving from the client’s specific situation into broader issues). Therapists indicated a need to be aware of the potential for this to occur and thus requiring developing strategies for keeping the conversation ‘on track’.

Focus can sometimes be 'pulled' by a view, a hill and so forth

It took time to learn how to hold my therapeutic perspective while negotiating the practicalities of walking

Maintaining boundaries: Aspects such as timing of session and the potential for seeing people that were known to either therapist or client were raised. The potential to be overheard during the session was also acknowledged. Additionally, clients who did not come prepared with adequate or appropriate footwear/clothing was also seen as a hindering aspect as this raised questions relating to the broader aspect of responsibility within the therapeutic relationship.

Because you are walking 'alongside' the client in an open and public environment, holding professional boundaries can be more challenging than when working inside in a confidential, less dynamic, safer and more neutral space.

I have concerns regarding confidentiality for clients. Being outdoors walking in parks anyone can hear the conversation, which at times can alter the therapeutic alliance, stop a client talking for a few moments.

Working within certain restrictions: It was acknowledged that while walking and talking offered certain freedom, it also brought with it restrictions. These restrictions related to not being able to engage in additional creative therapeutic exercises during a walk and talk session and that there was not additional information on hand should it be required. For example:

I also like to work with clients through sitting on the floor and using large pieces of paper as I feel this adds to the sessions however this is not possible when doing walk and talk sessions.

The limitations of only being able to talk and not being able to do any experiential work due to the public nature of the outdoor space.

Discussion

The results from this preliminary study of professional knowledge suggest that walk and talk is an emergent psychotherapeutic approach, characterised by a substantial degree of consensus across walk and talk practitioners regarding the rationale for this type of intervention and the facilitative processes that are supported by it. A key finding is the extent to which practitioners regard it as an effective means of ‘unsticking’ therapy processes. This finding supports the existing call for further exploration into the relationship between bodily movement, cognition and psychological processes within outdoor settings so that more can be understood about how the components of walk and talk interact and contribute to therapeutic change (Corazon, Schilhab & Stigsdotter, 2011).

In addition, there appears to be an inherent degree of ‘not knowing’ about what might occur during a walk and talk session, with some aspects of the activity that were identified as being helpful also described as hindering. For example, lack of eye contact was reported as useful for some clients, while also being experienced as hindering for the therapist when trying to gauge what is happening for a client. Similarly, walking side by side could promote equality in the therapeutic relationship and offer a tangible sense of support and journeying together yet could also mean it is difficult to hear what the client is saying. Jordan and Marshall (2010) refer to aspects of unpredictability as challenges to the traditional ‘frame’ of the therapeutic encounter. They argue that therapists themselves need to be able to tolerate the uncertainty in order to negotiate outdoor spaces with their clients. Furthermore, Jordan and Marshall (2010) recommend that a fluid and dynamic approach to contracting and maintaining professional boundaries represents an integral part of therapeutic practice in the outdoors.

The helpful and hindering factors identified by this present study, are similar to those reported in previous studies (McKinney, 2011; Doucette, 2004). However, as with previous studies, helpful factors relating to client benefits need to be interpreted with caution as clients

themselves have not been the participants in these studies. There were two main differences in the findings from this study and those of McKinney (2011). First, the findings from this study suggest that walk and talk therapists in the UK tend to be experienced psychotherapeutic practitioners, in contrast to the findings of McKinney (2011) who reported younger and less experienced therapists were more likely to incorporate walk and talk methods in their therapeutic work. Second, respondents in this study did not agree that clients resolved issues quicker through walk and talk compared with indoor therapy.

Limitations

It is important to acknowledge the limitations of the present study. The data reported in this study reflects the experiences and beliefs of therapy practitioners who can be regarded as public “advocates” and pioneers in the use of this approach. It seems certain that other practitioners, for example those who may have tried walk and talk and decided that it was not appropriate for their therapeutic goals or style, would contribute different perceptions and themes. The use of an on-line questionnaire restricted the richness of information provided by participants. Although the open-ended, qualitative items in the survey questionnaire generated valuable insights, these were derived from a small sample of therapists. On the other hand, the design of the study explicitly sought to identify all relevant informants in the UK. It therefore seems likely that the sample obtained in the present study reflects the limited nature of this community of practice in the UK at this time. A further limitation was that the rating items on the questionnaire were generally framed in a manner that favoured positive aspects of walk and talk therapy. However, qualitative questions explicitly invited participants to highlight hindering factors. Further research utilising the questionnaire should include hindering statements. This study failed to recruit clients as participants. It is not possible to know the reasons as to why this happened. Future research seeking client participation would need to consider appropriate ways of approaching clients directly, thus removing the need to rely on third parties to pass information on.

Implications

The results of the present study can be regarded as having a range of implications for practice. There appear to be a growing number of practitioners who are offering walk and talk despite a lack of “best practice guidelines”. Given the variety of factors present in walk and talk that can be experienced as either helpful or hindering, consideration by the therapist needs to be given to how these factors might be managed before venturing out with a client. It would be valuable to develop research-informed guidelines and training opportunities to support safe and effective practice in this area of work. Given that practitioners tended to combine walk and talk with a range of office-based therapy models, it is necessary for future research and training to consider

not only the issues associated with walk and talk as a stand-alone practice, but to investigate the challenges of combining it with other modes of therapeutic work.

Conclusion

It is clear that further research into walk and talk methods is warranted, using a range of methodologies, including controlled outcome studies, client experience research, and systematic single-case analyses. It would be valuable if further research into professional knowledge of walk and talk practitioners made use of in-depth interviews that generated a more nuanced understanding of the themes identified in the present study.

Chapter 5: Study 2

Introduction

Study 2 was designed as a follow-on from study 1 in order to elicit greater understanding of therapists' experiences of integrating walk and talk therapy into their professional practice.

Study 1 provided preliminary information regarding the professional practice of walk and talk in the UK through the use of an on-line questionnaire. Study 2 therefore, aimed to extend upon these preliminary findings, through the use of qualitative interviews, in order to gather rich, in-depth descriptions of therapists' lived-experience of taking part in walk and talk therapy sessions with their clients. Therefore, the aims of this study were two-fold. Firstly, to explore therapists' beliefs of the helpful and hindering aspects of walk and talk, and secondly, to identify what aspects of walk and talk therapists believe help facilitate change for their clients (research question and sub-questions are outlined in Figure 5.1 below).

Figure 5.1. Study 2 research question and sub-questions

Study 2

Research question: **What do therapists believe are the aspects of walk and talk therapy that help to facilitate change in their clients?**

- 1: What is the current provision of walk and talk therapy practice within the UK?
- 2: What constitutes walk and talk therapy practice?
- 3: What are the theoretical underpinnings that inform the practice of walk and talk therapy practice?
- 4: What are the therapeutic processes inherent in walk and talk therapy practice?
- 5: What aspects of walk and talk therapy help facilitate change in clients?

There is a lack of consensus regarding what mechanisms can predict client change in therapy, however it is thought to be a combination of client and therapist factors (Mander et al., 2013; Duff & Bedi, 2010). The therapeutic alliance has been identified as one of the 'common factors' that is consistently associated with constructive therapeutic change across theoretical orientations (Mander et al., 2013; Orlinsky, 2009; Norcross & Lambert, 2011). Further research has identified that it is specifically the strength of the therapeutic alliance which predicts the degree of therapeutic change that is possible (Bordin, 1979; Duff & Bedi, 2010; Mander et al., 2013; Levitt & Williams, 2010; Martin, Garske & Davis, 2000; Horvath & Symonds, 1991). The therapeutic alliance has been defined as "the collaborative aspect of the therapeutic

relationship, in which the client and therapist together negotiate the focus and depth of the relationship” (Levitt & Williams, 2010. p. 337).

There is a paucity of literature examining the mechanisms of change identified in outdoor therapy programmes (Harper, 2009; Tucker & Rheingold, 2010). This can be attributed to several factors such as a lack of consensus surrounding terminology of outdoor based programmes (Annerstedt & Währborg, 2011), the absence of clearly defined programme aims and objectives, and weak methodological robustness of studies, thus limiting identification of specific change agents (Tucker & Rheingold, 2010; Newes, 2001). However, despite these factors, one area of general agreement is that different outdoor settings can positively influence therapeutic processes (Annerstedt & Währborg, 2011). This is despite a lack of understanding around ‘why’ and ‘how’ this occurs (Beringer, 2004). Rutko and Gillespie (2013) refer to this as a ‘paradox’ in terms of a specific outdoor setting being fundamental to the way a programme is run, yet without the explicit clarity around the function the setting is assumed to play within the overall therapeutic process. There is growing criticism of an anthropocentric view that tends to overlook the role of the setting (nature and environment) within outdoor therapy experiences, where the focus rests solely on human factors that are conceptualised as being detached from the physical setting which includes more-than-human aspects (Jordan, 2014). Calls are being made to address this gap in the literature (Beringer & Martin, 2003; Rutko & Gillespie, 2013). Whilst there are no unified and accepted components of change within the broad field of outdoor therapy practice, it would appear that existing literature suggests it is the relationship and interplay between several factors such as the context, setting, client group and underpinning theoretical basis of the outdoor therapy experience (Rutko & Gillespie, 2013).

As a means of identifying possible therapeutic processes and relationship factors that are active in walk and talk therapy, it is necessary to gain a more comprehensive understanding of how both therapists and client experience and make sense of this form of therapeutic activity. Qualitative research into the experience of walk and talk therapy makes it possible for subsequent, studies, with larger samples, to be grounded in authentic description of key phenomena. In the light of such considerations, the aim of this preliminary, exploratory study was to investigate the lived experience of therapists within the UK who participate in walk and talk therapy sessions with their clients.

Method

Participants

From the sample of eighteen therapists that took part in study 1, ten therapists indicated their willingness to take part in a follow-up interview (study 2). Seven interviews were eventually conducted; three respondents withdrew due to family and time pressure commitments.

Participants were four male and three female counsellors/psychotherapists from various regions of the UK. Five participants were in the age range 46-60, while two were in the age range 31-45. Participants had been qualified from 1 to more than 10 years and had been offering walk and talk therapy from 4 months to over 10 years. Frequency of walk and talk sessions were mixed. One participant participated in walk and talk sessions weekly, whereas the remaining participants experienced 'walk and talk' irregularly, dependent on the clients they were working with. Therapists theoretical orientations included person centred, integrative (including humanistic, solution focused and transactional analysis), CBT and contact related pre-therapy. Reasons for offering walk and talk were varied, with all participants stating it was influenced by their personal beliefs about walking and being outdoors. Other main motivations included responding to requests by clients, the desire to offer a variety of methods and having read research. Walk and talk sessions were conducted in a variety of outdoor environments, ranging from semi remote wild areas and countryside to urban parks.

Data Collection

Semi structured interviews were conducted via Skype or telephone and lasted between 40-60 minutes. An interview schedule was designed to prompt participant accounts around areas of therapy practice relevant to the aims of the study, while allowing space for elaboration of personal experience. The interviews focused on what participants identified as the helpful and/or hindering aspects of walk and talk therapy; what processes they felt helped to facilitate the change process for clients; theories that informed their practice and their overall experience of offering walk and talk. Open questions were used to prompt discussion of these broad areas, whilst also allowing the flexibility to explore specific themes as relevant to participants. Interviews were audio recorded and transcribed (see appendix 6 for a list of questions contained in the interview schedule).

Ethical Procedure

Once participants had indicated a willingness to take part in the interview, they were emailed an information sheet and consent form (see appendix 4 & 5). Consent was given by all participants to audio record the interview. Participants were advised of their right to withdraw at any point and of their editing rights should they wish something to be removed from the

recording during the interview. Names and contact details of academic supervisors along with details of University ethical approval was given and participants were invited to ask any questions at the beginning and end of the interview. The focus of the interview was on participants' lived experiences of offering walk and talk and did not pursue any sensitive information pertaining to themselves or their clients. The interviews were transcribed and anonymised.

Data Analysis

Data were analysed utilising a descriptive phenomenological approach (Giorgi, 1985; 2009). This approach is underpinned by the philosophy of Husserl and Merleau-Ponty and seeks to offer a description of consciously lived experience (Finlay, 2011; Giorgi, 1985).

A descriptive phenomenological approach was deemed appropriate given the aim of exploring from therapists' point of view their lived experience of conducting walk and talk with clients and what meanings they attach to this therapeutic activity. The aims and focus of phenomenological research as described by Finlay (2011) are:

- (1) A focus on lived experience and meanings;
- (2) The use of rigorous, rich, resonant description;
- (3) A concern with existential issues
- (4) The assumption that body and world are intertwined
- (5) The application of the 'phenomenological attitude' and bracketing
- (6) A potentially transformative relational approach

(p. 15-16)

Phenomenology is one approach that honours the relational stance of lived experience and encourages exploration in a manner that was deemed particularly fitting for the phenomenon that is walk and talk. The analysis process required a phenomenological attitude to be adopted which meant the data was approached sensitively, with past knowledge and assumptions put aside in order to engage with the data 'freshly' (Finlay, 2011).

The procedural steps of Giorgi (1985; 2009) were used to guide the analysis. Four systematic stages were followed: (i) transcripts were read through to gain a sense of the overall experience; (ii) in-depth re-reading of the descriptions and further reflection identified themes that were pertinent to therapists' experiences of walk and talk. A theme statement conveyed an aspect of meaning that relates to a specific, recurring aspect of the overall experience of participating in walk and talk; (iii) emergent themes were integrated into an exhaustive 'condensation'

(summary representation) that reflected therapist experience as a whole. The stages of analysis were reviewed between an external academic supervisor and myself, and while consensus is not an essential requirement of this method, intersubjective agreement can be a valuable way of challenging or clarifying any assumptions that may have arisen during the analysis process (Giorgi, 1985).

Results

In accordance with standard practice in descriptive phenomenological inquiry, the findings of the study are presented in two parts. First, a phenomenological summary representation of the lived experience of engaging in walk and talk therapy is offered, as a means of providing an account of the overall lived experience of research participants. Second, an analysis of emergent themes is provided, as a basis for subsequent discussion and comparison with published theory and research.

Summary representation

Evident in the provision of walk and talk therapy is the experience of revitalisation of professional roles and experiencing self in relation to client differently. The essence of this experience is revealed through the rejuvenation, renewal and re-definition of professional selves. A deeply held belief in the restorative and curative potential of this therapeutic activity is embodied by these therapists.

To offer 'walk and talk' therapy is to embrace a collaborative stance in relation to clients and engage in a therapeutic process that is fluid, emergent and integrative. 'Walk and talk' arises from responsiveness to client's therapeutic needs and goals and enables choice within a spectrum of possible activities to enhance the therapeutic potential of the therapy. The capacity to be adaptable and the ability to tolerate uncertainty is a key characteristic of these therapists.

Walking and talking invites a different relationship to emerge from the physicality of walking side by side, thus altering the relational dynamics and inviting a freer, less inhibited connection to potentially develop. The therapeutic space therefore collaboratively emerges, is constantly negotiated and is unique with each client. Walk and talk is an activity situated within the context of a therapeutic relationship and actively supports empowerment, equality and client preferences to be explicitly negotiated and incorporated into the therapeutic relationship.

To 'walk and talk' is to harness an interplay between physical movement and therapeutic conversation in the outdoors that results in an integration of place and embodied experiencing. This offers a 'tangible' lived experience that is rich in useful metaphorical associations that are naturally and spontaneously made. Walking forward and being in motion symbolises an integration and connection with internal processes to enable a loosening from 'stuck' places and

helping to facilitate the movement of therapy in a tangible and constructive way. Walk and talk as a therapeutic activity is co-constructed and co-created in the 'here and now' and offers a therapeutic process that encourages freedom, movement and creative ways of processing.

The outdoors as a therapeutic space is employed in a variety of ways from being incorporated as an active ingredient within the therapeutic process, to representing a backdrop to the therapeutic relationship which is journeyed through. The environment offers a paradox between freedom – space to explore new or difficult ideas – and containment – the holding and support of the therapeutic process.

Walk and talk represents an alternative therapeutic activity with limitations. Weather, location, confidentiality, timing and client fitness levels are approached pragmatically which is supported through the contracting process, allowing for explicit dialogue to occur where potential uncertainties are explored and negotiated within the therapeutic alliance.

To offer 'walk and talk' is to feel a sense of professional 'difference' due to offering a therapeutic activity that disrupts a commonly held perception of where and how therapy is offered. Thus a reliance on professional and personal knowledge in order to shape and construct the development of this therapeutic activity is utilised. A deeply held belief that this therapeutic activity could be of benefit to more clients than who currently participate in walk and talk is felt. This leaves a sense of questioning around how to communicate the potential benefits in relevant ways in order to increase awareness and understanding for both potential clients and funding organisations.

Themes

Four themes emerged from the analysis: Making use of different therapeutic processes that arise through altered physicality in an outdoor environment; Enhancing the potentiality of the therapist; Promoting a collaborative stance that invites clients to express and act on their preferences and choices; Taking account of professional issues.

Theme 1. Making use of different therapeutic processes that arise through altered physicality in an outdoor environment

Several participants described an altered physicality (i.e., a style of embodied relating that allows greater possibilities for nonverbal synchrony and communication, compared to sedentary office-based interaction) and talked about ways in which working in an outdoor environment allowed for something useful to emerge within the therapy that otherwise would not be possible.

...you are engaging in moment to moment life more fully out there than you are in a room... you get access to more parts of the person or they get access to more parts of themselves while journeying and experiencing and being in nature... (participant 7)

Through these aspects, all participants identified how different therapeutic opportunities could emerge through engaging in 'walk and talk' with particular clients.

All participants saw the interconnected and interrelated relationship between physical movement, the natural environment and underpinning therapeutic relationship that allowed for a holistic response to the therapeutic process.

I guess a lot of my clients tend to come and they are split off. They have got stuff going on in their head, stuff going on in their body and they don't integrate the two. When we are doing the walking and talking, their mind and body are integrating... (participant 4)

Moving can also represent a visual representation of therapeutic process. *...and I'll say 'Have you noticed?... you're taking positive steps forward, literally taking positive steps forward!' ...they can always see there is a path forward as well as a path back... it gives them a different coping strategy as well I think. (participant 4)*

Several respondents indicated how altering the space within which the therapy takes place changes how the therapeutic relationship is experienced in ways that are clearly felt, yet difficult to articulate.

Different qualities to the therapeutic relationship become amplified within the context of walk and talk. This was conceptualised in various ways. One participant identified this as a quality of realness.

... you know I get to journey with somebody in a way that feels much more real... (participant 7)

Other participants referred to a greater sense of equality that is fostered through the walk and talk sessions.

...they do have much more autonomy, there is more equal-ness there – I think that influences the change because the relationship is generally more equal and certainly moves to be more equal as each session goes on. (participant 6)

While the activity of walk and talk was experienced as a unified whole, it was acknowledged that each component brought something distinctive to the therapeutic process. Physical movement allowed for a different energy to emerge between therapist and client. Physical movement was also experienced as a conduit for internal shifts that bring about a loosening and freeing of internal processes.

And it just changes the dynamics completely. If they are stuck in something I just find that walking forwards and being in motion helps. (participant 4)

One participant described how movement allows for a bodily felt sense way of connecting, helping to facilitate presence, attunement and an empathic connection with clients.

I find that you can get an empathetic connection with someone through walking with them actually – it's because you are tuning in to the rhythm of their movements– so it's a physical sort of empathy... (participant 1)

All participants described the richness of the environment in terms of providing variety and allowing for the spontaneous use of metaphor to facilitate connections with nature and psychological process.

I've been down the beach with a client walking along and they just stopped and looked out because the sea was particularly rough... I left them looking and then they were like 'Well that's just exactly how I feel – all mushed up and churning...that's how I feel- just churned and churned and churned, and I'm just constantly going around in circles'' (participant 4)

Several participants related to the natural environment as a 'live' component of the therapy and offered support and holding of psychological distress.

“...it's almost like, if it's really big, let's go outdoors and talk about it – because if you've got lots of emotion... it might be more healing to talk about this outside with nature present”.
(participant 6)

All participants described the significance of the physicality of being side by side. This was experienced in various ways from inviting a different experience of eye contact which could potentially lessen anxiety for clients who otherwise might feel intimidated by sitting in a room face to face.

...naturally stuff comes out I think when you are walking because you are more mentally and physically in tune. Whereas when you are sitting down the pressure is on you as the client to do something, to say something. (participant 5)

Walk and talk built upon common experiences of walking and being outdoors, therefore enhancing what is already familiar to the client and lessening some of the ‘unknowns’ that might exist around therapy.

Theme 2. Realising the potential of the therapist

Several participants experienced how walking and talking with clients enriched their experience of the therapeutic relationship.

I think it has enhanced my relationships with the clients I have taken on the walks, without a doubt. And that obviously enhances, deepens, broadens, whatever the work you are doing with them which is rewarding for me as it is I hope for them. (participant 1)

Therapists described how they experienced themselves differently in relation to their clients with a different quality to the connection experienced.

Being outdoors allowed participants to flourish in ways that did not feel possible within indoor based work.

“I feel less free when I am indoors doing counselling than when I am outdoors...it just feels like it is something quite different that I haven’t brought to the counselling room”. (participant 7)

All therapists identified that offering walk and talk allowed them to make visible other parts of themselves within their professional role.

I suppose its felt... very congruent for me to do this... because it’s me. I am sharing a little bit of myself with a client without inappropriate disclosures – so it feels like being true to myself when I go for a walk with a client ...and it’s good to share it and sometimes I think that’s helpful in itself. (participant 1)

Engaging in walk and talk was also associated with a loosening of internalised constraints associated with the therapeutic role in general. *“because it’s made a different relationship with the clients I have done it with - I find I have a different relationship with all my clients as far as I am more open. ... I think it’s because I am freer to offer it”. (participant 4)*

Commonly participants experienced how the outdoor environment provided support of the therapeutic process, lessening their embodied sense of responsibility.

It offers an additional dimension and in some way for me personally it feels like it takes some of the responsibility off me – so as a therapist working in nature I feel less weighed down by the responsibility for being helpful – something feels different. (participant 7)

One participant experienced how specifically the physical movement provided a buffer from taking on the residue of client's material.

For me certainly physical benefits of walking – I feel after I have had a walk and talk client compared to a therapy room client I feel... less burdened if you like... just lighter because I have had that physical movement ... it's like it hasn't left me with their feelings that sometimes I feel like I get left with in a therapy room. (participant 3)

All participants identified a reciprocity of potential benefits gained through being able to offer walk and talk.

“...we are both out the room! We are both in the trees and we are both enjoying the sound of the river, the sound of the rain and the feeling of the rain on your face - we are both getting nurtured...” (participant 7)

Participants described how developing practice to include offering walk and talk evoked a sense of possibility by adapting therapeutic activities to assist the client in their process. From this emerged a way of holding the traditional therapeutic composition more lightly and flexing the normative boundaries by offering a variety of settings and activities within therapeutic practice.

I am a creative person so ultimately what I am experiencing with walk and talk therapy it's giving me a window of possibility... I know I am getting back to some sort of balanced approach to my work – and walking is something that is me. (participant 2)

A common experience was shared of how offering walk and talk enabled a preserving of the professional role. Personally restorative benefits were gained from being in nature and moving.

This was also expressed as a protective element to not becoming diminished or burnt out.

“So its created longevity maybe – because you also get to engage in the pace that nature offers then it also is a much more natural pace for me so I can be in it longer...” (participant 7)

Engaging in walk and talk with clients allowed for a re-configuration of the therapists sense of professional self. One therapist experienced this as providing both self-nurturing and a degree of validation of their skills and abilities.

“I think it has given me faith in my ability; faith in the fact the therapy as a whole can happen literally anywhere... it's given me a lot of confidence just in the fact that I can offer this...” (participant 2)

An overall sense of rejuvenation was commonly expressed through offering walk and talk that fuelled an enthusiasm and desire to develop this therapeutic practice further.

Theme 3. Promoting a collaborative stance that invites clients to express and act on their preferences and choices

Collaboration was fundamental to the practice of walk and talk. The invitation to walk and talk inspired clients to take an active role in their therapy - literally. Through collaborative dialogue, the therapeutic potential of walk and talk was explored with client preference and autonomy at the heart of this process. There was a realism associated with expectations of outcome and the activity was offered with a belief of its therapeutic value and at the same time acknowledgement that it was not relevant, possible or appropriate in all cases.

“I think it’s got to be, is it right for this client, and at what point is it right for this client and does this client want it? How can it enhance what is going on? I don’t think it’s something that I would want to do all the time with every client – that would be very false.” (participant 1)

The practicalities of walking and talking such as location, speed, route and overall choice of participation were constantly negotiated. A reiterative, collaborative and co-constructed contracting process was adopted. As familiarity with walk and talk developed, so too did the balance of roles enacted within the therapeutic alliance.

they have much more autonomy... they do take more ownership of it... that changes the dynamic of the session quite a lot because that means that if they choose where we go physically they also choose where we go psychologically – that’s the link. (participant 7)

Theme 4. Taking account of professional issues

All of the participants in the study emphasised that walk and talk therapy was conducted within the context of a professional, intentional therapeutic relationship. Professional and ethical considerations were adapted to fit the outdoor and walking context. A stance of creative problem solving was evoked and issues of safety and acceptability were approached pragmatically. The intention was not to remove unpredictable aspects from the therapeutic encounter. Rather, they were acknowledged as part of the richness and diversity inherent in this therapeutic context.

Participants were responsive to their local geography and what was considered an appropriate location for sessions. For some, only rural areas were fitting. *“it wouldn’t work for me walking*

around an urban environment – wouldn't be suitable because you wouldn't get the quiet and the privacy that you would require for this kind of work". (participant 1) Whereas for others based in populated areas, adaptations were made. "...there are slightly more issues around confidentiality because you get a lot of [people] walking along. But so far it's never been an issue because you are walking and you are not talking loudly... so it's being aware sometimes if a group is passing, you might just keep quiet and then you continue speaking once they have passed". (participant 5)

The absence of an existing theoretical base for walk and talk demanded a response of intuitive professional sensibilities with boundaries being re-defined. *"I considered the safety... the boundaries are no longer my therapy room; my boundaries are as far as I can see... so from there, to there, to there, to there – those are my boundaries that I am working in..." (participant 3)*

Participants also talked about underlying professional issues, such as developing their walk and talk practice without an existing structure or recognised framework. Informal learning channels were therefore utilised in order to fill gaps in knowledge. There was a sense that what they were doing represented an emergent and unique activity within the UK counselling and psychotherapy profession. Reactions from professional colleagues between the participants had been mixed – for one participant this has been problematic:

"Oh professionals are the worst! My supervisor – I have to convince my supervisor that it is ok! I have to sell it to everyone... I have a peer supervision group that I am in and everyone says 'oh, I am not sure if that is counselling... what if 'this and that'. There is a lot of fear and lack of knowledge around what it is and what might be the potential benefits" (participant 6)

Whereas for others, a more dispassionate response had been felt:

...people are kind of interested. They are kind of interested but they don't ask a lot... They say 'oh really? You do walk and talk do you' but they won't necessarily want to go 'where do you do it, how do you do it...' (participant 3)

Participants expressed cautious optimism regarding the future development of walk and talk. For some, there was sense of frustration over how to 'move forward' and facilitate change with how walk and talk could be viewed and understood within the counselling and psychotherapy profession. For other participants, they indicated looking toward a professional body to support and help raise the profile of walk and talk. For one participant, a source of frustration was linked to funding challenges which meant they were not able to develop their practice in ways they would like to. All participants acknowledged the absence of an existing evidence based practice for walk and talk and indicated this was a main reason for being involved in this study.

All participants indicated they had considered strategies for increasing client awareness and participation in walk and talk therapy.

“I feel like I want to make that movement go forwards but it’s not a very tangible movement of outdoor practitioners... I have kind of lost my way with that. So at the minute I am just on the edge of it... So how to make it more of a business option? I wouldn’t mind helping with that – but at the moment I am just a one man band just trying to survive...” (participant 7)

“Something that feels isolating because... there isn’t a network of people who are doing it that share... the hindering bit has been the feeling of aloneness with the experiences that I have had” (participant 8)

Discussion

This study utilised descriptive phenomenology to explore therapists’ experiences of participating in walk and talk sessions with clients. The main findings of the study were that therapists regarded the outdoor environment as enabling a wider range of helping processes to occur that were beneficial to clients. The capacity to draw on embodied awareness and synchrony emerged as a key process in walk and talk therapy sessions. Therapists also viewed walk and talk practice as enabling them to draw on personal values and life experience in ways that renewed their levels of motivation and commitment, and allowed them to do their best work. In addition, research participants highlighted challenges associated with the maintenance of a therapeutic relationship in outdoor based work, and a range of professional and ethical issues that they had encountered. Taken as a whole, the findings of the study point to essential similarities between walk and talk therapy and other forms of therapy, alongside some distinctive features.

The findings of the study reinforce the view that the therapeutic relationship offers a contextual base from which the benefits of engaging in walk and talk therapy can be achieved (Lambert & Barley, 2001). Duff and Bedi (2010) argue that ‘physical attending skills’ such as eye contact, sitting still and facing the client among others, are crucial to the formation and development of the therapeutic alliance. Findings from this study however suggest there are alternative ways to demonstrate ‘physical attending skills’ which do not rely solely on being seated and positioned face to face. The altered physicality of being side by side whilst moving during walk and talk therapy necessitates the development of additional competencies and abilities in order to maintain attending skills during a therapeutic session. Findings from this study indicate therapists have developed alternative strategies that serve to communicate attention non-verbally to clients. This finding is in accordance with literature that suggests synchronised motor activity can increase the level of co-operation and affiliation that is experienced between two parties (Hove & Risen, 2009; Wiltermuth & Heath, 2009). Furthermore, it is suggested that

‘in tune’ bodily movement can increase positive affect which in turn contributes positively to the emotional quality of the therapeutic relationship (Tschacher, Rees & Ramseyer, 2014).

Whilst the strength of the therapeutic alliance in relation to outcome is widely acknowledged (Duff & Bedi, 2010; Horvath & Symonds, 1991; Levitt & Williams, 2010; Mander et al., 2013; Martin, Garske & Davis, 2000;) attention has also been paid to ‘person of the therapist’ factors which are seen to contribute in a fundamental way (Aveline, 2005). Literature suggests that within therapist professional development a high degree of integration occurs between how the professional and personal self is experienced (Rønnestad & Skovholt, 2003). It is proposed that when therapists experience increases, so too does the desire to actively seek out working environments that are congruent with who they see themselves to be. With this, comes a greater awareness of the importance of robust therapeutic relationships and the implementation of therapeutic methods that are offered intuitively and flexibly (Rønnestad & Skovholt, 2003). Findings from this study would seem to demonstrate this process to be true for these participants in terms of how the opportunity to offer walk and talk therapy connects with deeply held beliefs and values. This serves to support the assertion of therapists seeking out opportunities within their professional development process that support the integration of professional and personal selves (Aveline, 2005).

The motivations of therapists utilising walk and talk is in contrast to Jordan’s (2014) findings, where the participants in his study were largely motivated to develop clients “ecological self” (p. 367). This difference could be due to the different sample of participants within each study as well as the specific focus of this study (i.e. ‘walk and talk’) in contrast to the focus of Jordan’s (2014) study being a broader comment on developing professional practice in response to an ecological crisis.

Collaboration is a significant component of the therapeutic alliance for these walk and talk therapists. This finding is in accordance with McKinney’s (2011) study that found the neutral space of the outdoor environment and the shared physical activity of walking supported the collaborative stance of therapy. Research shows that when therapy is offered collaboratively, clients can share their views on the type of activities they consider might be helpful during their therapy, therefore increasing positive client outcomes and lowering dropout rates (Swift & Callaghan, 2009). It would seem this finding indicates that walk and talk is a therapeutic activity that lends itself to being offered collaboratively, where it is supported by both the neutral setting and activity of walking during the therapeutic session.

The other main finding of this study indicated the relationship between physical movement and psychological processes within therapy. Embodied cognition proposes that bodily experiences (such as movement and sensation) play a role in the formulation of understanding abstract

concepts (Barsalou, 2008; Niedenthal et al., 2005). This has important implications of the application of creative problem solving abilities (Leung et al., 2012; Oppezzo & Schwartz, 2014). Furthermore, it is suggested that moving freely (for example walking outdoors) can activate and increase thought processes that can prevail over a state of fixed thinking, thus providing the opportunity for new connections to be made between different concepts (Leung et al., 2012; Oppezzo & Schwartz, 2014). This has particular relevance in understanding how walk and talk could be supportive of therapeutic conversations that support clients change process from a state of rigidity to fluidity; allowing access to potential solutions not previously considered.

Limitations

It is important to acknowledge the limitations of this study. The focus was solely on the experiences of therapists: future research could address this imbalance by exploring client experiences of walk and talk. This would serve to offer an alternative view that would contribute to the development of this therapeutic activity and identify potential applications that could be beneficial for particular clients at specific stages of their therapy. Additionally, future research could explore potential client's perceptions of walk and talk as a way of understanding client's interest in participating in this activity as part of their therapy. The therapists interviewed in this study were highly positive about the benefits of walk and talk therapy. Despite being explicitly invited in the interviews to talk about the 'downsides' of the approach, they had little to say on this topic. It would be important for further research to find ways to investigate the circumstances (e.g., client characteristics and goals) in which walk and talk practice is not beneficial.

Implications

The results of this study can be regarded as having implications for practice. The in-depth description of the therapists' practice of walk and talk contributes to the domain of professional knowledge studies within the field of counselling and psychotherapy. Therapists who may be wanting to develop their own practice to incorporate walk and talk can therefore draw upon the lived experiences and practical knowledge detailed in this study. In addition, the findings of this research could serve to raise the profile of walk and talk as a potentially beneficial therapeutic activity, which may in turn increase client participation.

Conclusion

Findings from this study provide in-depth information on therapists' lived experience of participating in walk and talk therapy with their clients. This study further provides a starting point for developing an understanding some of the underpinning, interactional mechanisms

which are present in this therapeutic activity. It would be valuable if future research included potential client perceptions of walk and talk, as a way of understanding why clients may be reluctant to have this as part of their therapy.

Chapter 6: Study 3

Introduction

The design of study 3 was influenced by the findings from studies one and two. A main finding across both previous studies indicated therapists were curious about the lack of uptake by clients for walk and talk therapy. Therapists expressed a desire to integrate walk and talk more frequently into their practice and in order to do so, recognised that more needed to be understood about perceptions potential clients may hold about walk and talk, which could ultimately influence their participation in this therapeutic activity.

Therefore, the main aim of study 3 was to identify potential clients' perceptions of walk and talk therapy (research question and sub-questions are outlined in Figure 6.1 below). This research question was approached in two main ways. Firstly, to identify predictors associated with potential clients likelihood of engaging in walk and talk therapy. Secondly, to explore potential client's perceptions of walk and talk as understood by appealing and unappealing factors.

Figure 6.1. Study 3 research question and sub-questions

Study 3

Research question: What are potential client perceptions of walk and talk as a therapeutic activity?

- 1: What are the predictors of individuals perceived likelihood of engaging in walk and talk therapy?
- 2: What are potential client's perceptions of walk and talk as a possible therapeutic intervention?
- 3: What do individuals identify as the appealing aspects of walk and talk?
- 4: What do individuals identify as the least appealing aspects of walk and talk therapy?

The present study utilised three existing measures to investigate how the concepts of environmental identity, client therapy preferences and help seeking behaviour might predict participation in walk and talk therapy. Understanding a client's environmental identity may identify how relevant the option for walk and talk therapy might be for some clients. Client's preferences for therapy and help seeking behaviours include factors such as; the ingredients clients wish to have as part of their therapy, and preferences related to whom to seek help from that may also inform the provision of walk and talk. In addition, short answer responses were

also sought to elicit participant's perceptions of appealing and least appealing aspects of a written description of walk and talk therapy. Insights from both quantitative and qualitative data can serve to guide therapists in responding optimally to these preferences and what aspects of walk and talk may be considered barriers to participation for clients.

Environmental Identity

Environmental Identity is a complex concept that emerges from a dynamic interaction between social and environmental influences (Clayton & Opatow, 2003). Theories of 'identity' have commonly overlooked the role the natural environment might play in shaping "who we think we are" (Gottschalk, 2001, p. 246). In response to this, Clayton (2003) proposes that environmental identity "is one part of the way in which people form their self-concept: a sense of connection to some part of the nonhuman natural environment, based on history, emotional attachment, and/or similarity, that affects the ways in which we perceive and act towards the world..." (p. 46).

Clayton (2003) further proposes that Environmental Identity results from interaction with natural environments in a socially constructed context which will change dependent on culture, religion and world view. These experiences are emotionally meaningful and can ultimately influence the way people see themselves and others. Natural environments can facilitate identity development in the following ways. The setting itself can provide straightforward information on personal abilities and competencies that serve to contribute to self-knowledge, through a clear relationship between behaviour and consequence (i.e being under prepared for changes to weather) (Clayton, 2003). Furthermore, interactions with non-human entities (such as that which is possible in natural environments) can offer a greater sense of perspective (i.e. through being a part of a larger functioning system) and contribute to an understanding of what it is to be human in contrast to 'other' (Myers & Russell, 2003).

Natural settings are also seen to facilitate ways of processing that can contribute to identity development. A study conducted by Herzog et al. (1997) identified 'ordinary natural settings' as allowing for beneficial effects of attention restoration and also the capacity for reflection. It is through the process of reflection that greater self-awareness can be gained, leading to a more refined understanding of self in the world (Clayton, 2003). Therefore, it can be seen that interaction with natural environments provides unique and diverse ways of fostering an understanding self, which includes identity.

Client Preferences

Client preferences relate to those aspects that clients' want or seek to have as part of their therapy experience (McLeod, 2012; Swift et al., 2013; 2018). Client preferences are generally

seen to fall into three categories. First, *activity preferences* denote activities (including behaviours and roles) that clients desire to have as part of their therapy (i.e. therapeutic activities such as homework, or therapist role to offer advice, challenge or ask questions). Second, *treatment preferences* refer to the type of therapy clients wish to receive (i.e. CBT, person centred, medication). Third, *therapist preferences* are those characteristics which the client would like the therapist to have (i.e. age, gender, ethnicity, personality) (Swift et al., 2013; 2018).

Understanding client preferences both before and during therapy has important implications for therapy process and outcome. Research indicates that when clients have preferences relating to their therapy, and subsequently receive the type of therapy that matches this, greater satisfaction and participation in the therapeutic process can result. This further contributes to an increased likelihood of a positive therapy outcome (Glass, Arnkoff, & Shapiro, 2001; Lindhiem et al., 2014; Swift, Callahan, & Vollmer, 2011; Swift et al., 2018).

Little is known about what specific factors contribute to client's preferences for therapy. Generally, it is conceptualised as a multi-layered process of decision making that is not necessarily static and can be susceptible to change over time (Swift & Callaghan, 2010; Swift et al., 2013). Possible factors such as previous experiences and motivation to engage in therapy have been suggested to inform preferences (Leykin et al., 2007). Two meta-analysis studies found that potential clients of psychotherapy show a greater preference for relational (i.e. strong therapeutic relationship) over scientific credibility (i.e. empirical efficacy) aspects (Swan & Heesacker, 2013; Swift & Callaghan, 2010). In a subsequent study, Farrell and Deacon (2016) further developed these findings and reported that preferences were also influenced by the type and acuteness of the presenting problem. Levy Berg, Sandahl & Clinton (2008) further suggest that personal coping styles may influence preferences, with individuals seeking treatments that compliment these.

Although benefits for incorporating client preferences in therapy is consistently strong in the literature, it is not known to what degree this happens in practice (Cooper & Norcross, 2016; McLeod, 2015). Furthermore, some argue it cannot be assumed that all clients will choose to state their preferences, or even know what their preferences are until they have experienced either what works for them or not (Cooper & Norcross, 2016; McLeod, 2015).

While these latter factors cannot be disregarded, there remains a compelling argument for implementing a client preference informed approach to therapy. Such a stance can increase the strength of the therapeutic relationship as well as promoting successful outcomes of therapy (Frankl, Phillips & Wennberg, 2014; McLeod, 2015; Sandell et al., 2011). Additionally, highlighting early any disparity between what the client wants and what the therapist is

offering, can help uncover any mistaken beliefs the client might hold about the therapy process (Cooper & Norcross, 2016). Ultimately, offering clear explanations about the therapy being offered increases the clients' capacity to make an informed choice (Glass, Arnkoff & Shapiro, 2001). These factors emphasise the practice based benefits to be gained through initiating client preferences, particularly in the context of 'new' therapeutic activities such as walk and talk in order to facilitate informed choice of participation.

Help Seeking

Historically, research has highlighted substantial differences between professional and public beliefs concerning useful treatments of psychological problems such as depression and schizophrenia (Jorm et al., 2000). More recently however, research suggests there is greater public awareness of mental health issues and potentially helpful interventions along with a reduction in the view that mental health issues are best managed alone (Jorm, Christensen & Griffiths, 2005; Schomerus, Matschinger, Angermeyer, 2012).

Despite this, it is argued that a significantly smaller number of people access therapy than those who could potentially benefit from it (Meadows & Burgess, 2009; Swan & Heesacker, 2013). Whilst the reasons for this are not clear, possible contributory factors include: how descriptions of psychotherapy are presented to potential client groups (Swan & Heesacker, 2013); individual views of how helpful a specific intervention is thought to be (Rickwood & Braithwaite, 1994); previous experiences of therapy (Cusack et al., 2006) and personal belief systems (Jorm et al., 2000).

Young adulthood is identified as a life stage when there is increased likelihood of experiencing mental health problems (Reavley & Jorm, 2010; Stallman, 2010). The impact of problems experienced at this developmental stage can have significant long term influence on educational and employment abilities and negative effects on social functioning (Eisenberg, Golberstein & Gollust, 2007; Vanheusden et al., 2009). Studies show that adolescents and young adults tend to seek informal sources of help before formal ones (Boldero & Fallon, 1995; Thomas, Caputi, & Wilson, 2014; Tuliao & Velasquez, 2014); and females are generally more likely to seek professional help than males (Addis & Mahalik, 2003; Möller-Leimkühler, 2002; Rickwood & Braithwaite, 1994).

Helpfulness Beliefs

It is generally assumed that clients enter therapy with ideas about what could be useful for them in dealing with and managing their difficulties (McLeod, 2012; Sandell, et al., 2011). Within the literature, various terms are used interchangeably to explore client focussed concepts such as attitudes, beliefs, expectations, treatment credibility, acceptability and helpfulness beliefs

(Bragesjö, Clinton & Sandell, 2004; Duncan & Miller, 2000; Iselin & Addis, 2003; Joyce & Piper, 1998; Kazdin, 1980; McLeod, 2012; Sandell et al., 2011).

Of particular relevance to the present study, are the concepts of helpfulness beliefs and acceptability. Helpfulness beliefs are influenced by how well pre-existing ideas about the nature of the issue(s) and the potential ways of addressing it are matched (Duncan & Millar, 2000; Iselin & Addis, 2003). Helpfulness beliefs are further shaped by the degree of existing knowledge or familiarity about a certain intervention; the type of issue that help is being sought for; and past experiences of a particular intervention (Frövenholt et al., 2007; Sandell et al., 2011). Interventions for particular issues are judged as acceptable when they are perceived as being fair, reasonable, appropriate and non-intrusive (Kazdin, 1980). Therefore, interventions that are perceived as potentially being helpful and deemed acceptable are more likely to be implemented, engaged with and ultimately successful (Iselin & Addis, 2003; Kazdin, 1980).

Walk and talk is an emergent therapeutic practice and little is known about how this is perceived by potential clients in terms of offering a 'fit' between activity and desired therapeutic outcome. Therefore, understanding how helpful and/or acceptable the idea of walk and talk is, can serve to inform the development, provision and potential success of this emergent therapeutic activity.

Place

Historically, the physical setting in counselling/psychotherapy has received relatively scant attention in psychotherapeutic literature (Backhaus, 2008; Berger, 2007; Fenner, 2011). Of the studies that have been conducted, the focus has been largely on client and therapist components, thus overlooking how the physical environment might influence various processes within the therapeutic encounter (Backhaus, 2008; Fenner, 2011; Pressly & Heesacker, 2001). Despite this, the awareness that therapy processes and outcomes are subject to influences by the setting of the therapy, is not new (Gross et al., 1988; Pressly & Heesacker, 2001). Recent studies have sought to promote the interconnectedness between therapist-client-physical environment factors as dynamic influences within the therapy encounter, thus challenging the privileging of human influences on the therapeutic process (Backhaus, 2008; Berger, 2007). Backhaus (2008) argues that investigations of the therapeutic process need to explicitly acknowledge the potential influence of the physical environment as it is an interconnected part of the overall therapeutic encounter.

Taking the view that therapy occurs between two people in the context of 'somewhere', literature on 'place' offers a useful framework for exploring this further. 'Place' is a term used to describe meanings that are attached to locations (Vanclay, 2008). Creswell (2004) describes place as "...a way of seeing, knowing and understanding the world. When we look at the world

as a world of places we see different things. We see attachments and connections between people and place. We see worlds of meaning and experience” (p. 11). Place is approached from various positions that are both distinct and interconnected. A humanistic view of place emphasises human experiences in the world (Creswell, 2008). Experiences, therefore, are informed by both feeling and thought from which meaning can be made from past experiences and projections into the future (Tuan, 1977). From within a humanistic position, a phenomenological interpretation focuses on subjective experiences gained through ‘being in the world’ (Creswell, 2004). The ‘essence’ of a phenomenological view on place is the recognition that being human and being in place are inextricably linked, therefore place is understood through the way we experience the world (Relph, 1976). This stance promotes ‘place’ as a construct that goes beyond location, and argues that human experience of place is influenced by a conscious relationship between the self and the world (Creswell, 2004).

This present study sought to investigate one of the existing gaps in literature, namely what potential clients perceive as the usefulness of this therapeutic activity. It was hypothesised, based on the literature review above, that Environmental Identity, having a Walk and Talk Option and Therapist Support would be significant and positive predictors of the likelihood to engage in walk and talk therapy. An additional analysis was conducted to determine if gender and age of participants indicated any differences in choosing walk and talk therapy for these variables.

Method

The survey contained both qualitative and quantitative items, thus employing a mixed methods approach (Hanson et al., 2005). Quantitative measures sought to identify the predictors of the likelihood of choosing to participate in walk and talk. Qualitative data was gained through short answer responses that sought to elicit participants’ perceptions of appealing and least appealing aspects of a written description of walk and talk therapy. This survey was administered on-line via the survey platform Qualtrics.

Participants

A convenience sampling approach was employed. Participation was sought from current students aged 18 years or over who were students at UK Universities/colleges. Lecturers working across five UK Universities who were known to the researcher were contacted with details of this study. Requests were made for the details of the study to be passed on to their students. In addition, information was placed on internet based research forums and other informal networks.

A total of 212 people indicated their consent to access the survey. Twenty six people (12.2%) left the survey completely blank. Twenty two people (10%) did not answer beyond some initial questions. 164 (77%) participants responded to the majority of the survey which consisted of the three quantitative measures. Participation for the final question requiring a short answer dropped to 147 (69%) participants. Therefore, all quantitative analyses were conducted on 164 responses and qualitative analysis on 147 responses. Table 6.1 below presents participant demographics indicating more female respondents (79%) than males (21%) and the greatest number of respondents were in the 18-25 (55%) age bracket. The majority of participants (70%) indicated they were studying Psychology or Counselling related courses at either undergraduate or postgraduate levels.

Table 6.1. Overview of respondents
(N=164)

Categories		%	<i>n</i>
Gender			
	Male	21	34
	Female	79	130
Age			
	18-25	55	90
	26-35	20	33
	36-45	12	21
	46-55	8	13
	56-65	4	7
Courses studied			
	P/G Counselling & Psychology	27	45
	U/G & Diploma Counselling	8	14
	U/G Psychology & allied disciplines	35	57
	Other	8	14
	Unreported	22	34

Note: There is some missing data on demographic items, therefore some totals do not reach 100%

Ethical Procedure

All participants were requested to read the information pages prior to gaining access to the survey. Participants indicated their explicit consent to participate in the study by selecting the 'I agree' option, which would grant access to the survey once ticked. Participants could withdraw at any time by exiting the survey. No sensitive information pertaining to individual therapy was sought and all responses were anonymous. Ethical permission was received from the Research Ethics Committee at Canterbury Christ Church University (see appendix 7).

Description of measures

The survey contained two information pages that contained the purpose of the study, intended participants, consent information and standard demographic questions. Three existing measures provided the framework for the remainder of the survey, with the addition of a specific question pertaining to their likelihood of participating in walk and talk to conclude the survey. All responses were recorded on seven-point Likert-type scales (response scale end points are indicated in parentheses) unless otherwise indicated. Reverse coding of variables was carried out where appropriate. Operational measures were determined by calculating the mean average of each. All reported reliability statistics (Cronbach's alpha) are for the computed variables for this study. A full copy of the survey can be found in Appendix 8.

Materials

Environmental Identity Scale (EIS)

The environmental identity scale utilises identity theory as the framework of understanding the relationship between self and nature (Clayton, 2003). An adapted ten item version ($\alpha = .94$) of the Environmental Identity Scale (EIS; Clayton, 2003) was used. The original full EIS measure consists of 24 items within five domains. For the purpose of this study, two domains were chosen for inclusion on the basis of having the most relevance for the purpose of this study (making sure this was also possible in terms of reliability and validity of the measure which it was as all items load on a single factor). The two relevant domains consisting of five items each were: 'Salience of identity', which explores the extent and importance of an individual's interactions with nature (e.g. "I would feel an important part of my life was missing if I was not able to get out and enjoy nature from time to time"); and 'Identification of self as a group member' which items explore the way nature contributes to the group which an individual identifies with (e.g. "I think of myself as part of nature, not separate from it").

Participants were asked to indicate the extent to which each statement described their behaviours/beliefs about nature on a 6 point Likert scale (1 = *Not at all true of me* - 6 = *Completely true of me*).

Psychotherapy Preferences and Experiences Questionnaire (PEX-P1)

The Psychotherapy Preferences and Experiences Questionnaire (PEX-P1; Clinton & Sandell, 2011) was adapted for the purpose of this study. The PEX-P1 questionnaire is a 25 item self-report measure that evaluates preliminary beliefs about various therapeutic activities and therapist attributes. Respondents are required to imagine they are about to begin counselling/psychotherapy and asked to rate on a 6-point Likert scale the degree to which they believe they would be helped by different ingredients within therapy. The PEX-P1 subscales

have satisfactory internal consistency (Cronbach's α 's = 0.78–0.86), and concurrent and predictive validity is evident (Sandell et al., 2011). The adapted version of the PEX-P1 used for this study utilised 16 items that captured five subscales: Outwardly oriented (therapist contributions that are directive and aimed at problem solving); inwardly oriented (therapeutic activities based on reflection and increasing self-awareness); affect expression (therapeutic activities aimed at expressing emotions); affect suppression (therapeutic activities aimed at suppressing emotions); and support (therapist contributions that are supportive and encouraging).

An additional two questions were added to the 16 PEX-P1 items, that measured preferences for walk & talk ($r = .70, p < .001$); "Having a choice of being indoors or outdoors for the counselling session" and "Having the opportunity to walk outdoors while talking with a counsellor". For all questions participants rated each statement along a 6-point Likert scale according to the extent each statement would be important for them if they were starting counselling/psychotherapy (1= *Not at all* – 6= *Completely*).

General Help Seeking Questionnaire (GHSQ)

As an additional measure, the General Help Seeking Questionnaire ($\alpha = .71$; Wilson, et al., 2005) was employed in this current study to investigate help seeking in the form of formal and informal sources of support, which is considered particularly relevant for both non-Western cultures and a young adult demographic (Ciarrochi et al., 2003; Rickwood et al., 2005; Tuliao & Velasquez, 2014). In addition, the GHSQ is one of the few help seeking measures that have demonstrated an acceptable level of reliability and validity (Wilson et al., 2005). Participants were asked to imagine they were having a personal or emotional problem and to rate the likelihood of seeking help from a list of ten possible sources of support including both formal (e.g. G.P, Counsellor) and informal (e.g. partner, friend, relative) sources (1 = Very unlikely - 7 = Very likely).

Walk and Talk

In line with other studies seeking perceptions of counselling/psychotherapy interventions (eg. Sandell et al., 2011) a written description of walk and talk was given. Respondents were asked to imagine they were about to enter counselling/psychotherapy sessions. In addition to indoor based counselling, they would also be offered the opportunity to try 'walk and talk therapy'. A description of walk and talk was given as follows:

Figure 6.2. Description of Walk and Talk.

A type of counselling that takes place in an outdoor setting. You and your counsellor/psychotherapist walk outdoors together during the session while you discuss your issues. Sessions are usually around 50-60 minutes long. Common locations that are used include parks, woodlands, beaches and riverside paths. Walk and talk therapy is not be intended to be a workout or a physically strenuous exercise session and is adapted to suit individual physical needs. Some people find the combination of movement and being outdoors helpful for reasons such as: becoming 'unstuck' when exploring difficult issues; improvement in mood due to physical activity; feeling more relaxed; and being in a natural setting can have the effect of increasing overall well-being.

Respondents were then asked to describe in the text box provided, those aspects of walk and talk they considered appealing and which aspects were considered least appealing.

One final question offered a description of 'walk and talk' therapy and asked participants to consider if they were in a position to seek counselling/psychotherapy and were offered walk and talk therapy how likely or unlikely they would be to participate in this type of counselling activity (1= *Very unlikely* – 7= *Very likely*) and this acted as the outcome variable for the regression analysis.

Results

Quantitative

Means, standard deviations and inter-correlations for the research variables are presented (see Table 6.3). A hierarchical regression was carried out of participant's likelihood of engaging in Walk and Talk on PEX: Support (step 1), Walk & Talk Option (step 2), and Environmental Identity (step 3). The model was a significant predictor of Walk and Talk: $R^2 = 0.28$, $F(2, 153) = 30.26$, $p < 0.001$. Results show that there were significant percentage changes in the variance explained by the inclusion of Walk & Talk Option: $F_{\text{change}} = 33.14$, $p < .001$ and Environmental Identity: $F_{\text{change}} = 22.71$, $p < .001$. There was no significant incremental contribution to the model from PEX: Support.

Final beta values show significant independent predictive effects for Walk & Talk Option ($\beta = 0.22$, $p = .007$) and Environmental Identity ($\beta = 0.38$, $p < .001$) but not for PEX: Support.

Overall, 69% (n=108) of respondents indicated a likelihood of taking part in walk and talk if offered as part of their counselling/psychotherapy.

Further tests were conducted to determine age and gender differences for likelihood of choosing walk and talk. A one-way ANOVA with 5 levels for each age category (18-25; 26-35; 36-45; 46-55; 56-65) was completed indicating no differences for likelihood of choosing walk and talk for age $F(4, 151) = 1.89, p = .12$. Similarly, a T-Test for likelihood of choosing walk and talk ($t[153] = 1.08, p = .28$) revealed no differences for Gender.

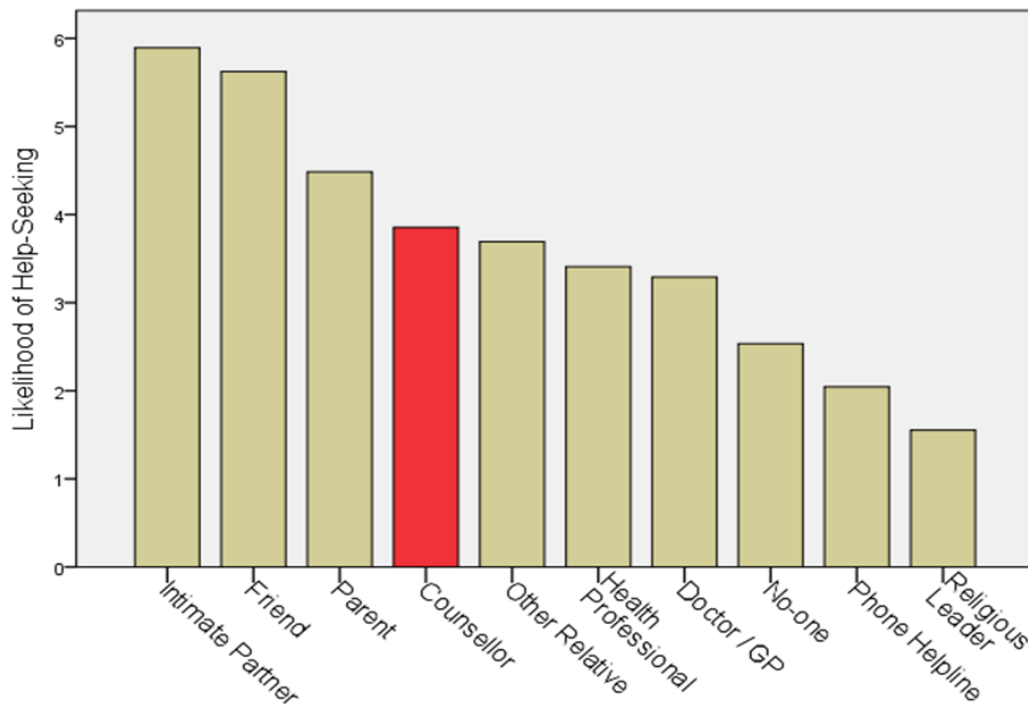
In addition, sources of Help Seeking (see Figure 6.1) were examined using simple frequencies, which indicated the most likely sources of informal support that would be sought were intimate partners, friends and parents. Of the formal sources of support, counsellors were rated most likely to be sought. There were gender differences for Help Seeking in that Females ($M = 4.10, SD = 0.88$) compared with Males ($M = 3.38, SD = 1.20$) had a greater propensity for Help Seeking $t(42.79) = -3.28, p = .002$.

Table 6.2. Inter-correlations for the research variable

Variables	1	2	3	4	5	6	7	8	9	10	11	M	SD
1. Gender	-	.03	-.07	.20*	.09	.17*	.10	-.16*	-.02	.30***	-.09	-	-
2. Age		-	.26***	.21**	-.29***	.27**	-.37***	.01	.04	-.05	.02	-	-
3. Environmental Identity			-	.12	-.02	.22**	-.01	.14	.52***	.08	.50***	3.68	1.20
4. PEX: Affect Expression				-	.25***	.52***	.30***	.19*	.01	.35***	.10	4.48	1.02
5. PEX: Outward Orientation					-	.08	.74***	.18*	.24**	.20**	.07	4.17	1.13
6. PEX: Inward Orientation						-	.22**	.08	.10	.20**	.04	3.21	1.02
7. PEX: Support							-	.12	.21**	.23**	.15	2.88	1.47
8. PEX: Affect Suppression								-	.26***	-.37***	.19*	3.95	0.99
9. Outdoor Option									-	-.02	.42***	4.95	1.85
10. Help Seeking										-	.07	4.42	1.54
11. Choosing Walk & Talk											-	4.15	0.97

* $p < .05$; ** $p < .01$; *** $p < .001$

Figure 6.3. Mean ratings for help seeking sources



Qualitative

Qualitative data were analysed using a six phase thematic analysis process, as described by Braun and Clarke (2006). The intention of utilising thematic analysis was to provide an overall account of the themes, reflecting the data in full. Adopting this approach inevitably results in a level of depth and complexity being lost (Braun & Clarke, 2006). However, given this inquiry is investigating an under-researched area and seeking views that are not known, this approach was considered appropriate and sufficient (Braun & Clarke, 2006). The phases of analysis were conducted systematically yet in a flexible manner that involved moving back and forward between the phases in a responsive fashion, based on the data of the interviews. As Braun, Clarke and Terry (2015) state:

“It should be evident that the process of TA (Thematic Analysis) is far from a rigid or mechanical application of a set of processes or formulae to data... instead... it is an organic and fluid, yet systematic process and it requires an engaged, intuitive and reflexive researcher (p. 107).

The phases of analysis involved familiarisation with the data; producing preliminary codes; identifying themes; re-evaluation of themes; refining core themes and identifying core narratives; generating an account of themes overall (Braun & Clarke, 2006). The data analysis was independently checked by a colleague of the author and no major discrepancies were found.

Three main themes; 'being outdoors'; 'engaging in movement'; and 'therapy processes' were identified through analysis. Appealing and less appealing aspects were integrated within each theme, in order to present a fuller account of how walk and talk as a therapeutic activity is perceived. A summary of the full analysis is presented below in table 6.3.

Table 6.3. Thematic analysis themes and sub-themes

BEING OUTDOORS		ENGAGING IN MOVEMENT		ASPECTS AFFECTING THE CONTEXT OF THERAPY	
<i>The open space</i>	Lacks therapeutic containment	<i>Being in motion</i>	Supports engagement with therapeutic process	<i>Effects on therapy processes</i>	Having a shared experience
	Feels emotionally unsafe		Encourages overall wellbeing		Having flexibility and choice
	Opportunity to be overheard		Increases integration of mind/body processes		Challenging ideas of professionalism
	Enhances affect		Limits use of other therapeutic activities		
	Adds therapeutic benefits		Impractical when physically limited		
<i>Varying weather conditions</i>	Negatively impacting upon mood	<i>Walking side by side</i>	Lowering intensity of therapy session	<i>Having distractions</i>	As a helpful therapeutic tool
	Disruptive to focus of session		Creating barriers to developing therapeutic connection		As something that gets in the way
	Invigorating				
<i>A different setting</i>	Offers contrast to being indoors				
	Allows for different connections				

Being outdoors

In the main theme ‘being outdoors’ participants identified that being in an open space would offer an opportunity for enhanced positive affect through an improvement in mood, and the development of an overall ‘feel good’ factor. There were also associations made between personal relaxation and outdoor settings. One participant expressed this as: *Feeling an increase in overall well-being; an uplift in mood; a general relaxation in tension and anxieties.*

Therapeutic benefits to being in open space was articulated as: *being outside can help me to clear things I have on my mind*” and where *“being able to be outdoors in a relaxing setting and just talk... would be considered helpful.*

However, open space was not always conceptualised in such positive ways. A lack of containment in the physical environment highlighted the ways privacy could be compromised through *the fact that you are out in the open with other people.* The potential for being overheard was related to feeling inhibited and uncomfortable:

“Perhaps the feeling that other individuals can hear private conversation and may make me feel uneasy about who is around listening and making judgements about my experiences and thoughts”

These factors appeared to evoke feelings of being ‘exposed’. This seemed to stem from not being in a specifically identified place for the therapy. This could be understood as linked to a sense of being emotionally unsafe. For example, *“If you’re outdoors I wouldn’t feel completely safe talking about certain things”* and *“I would find it difficult to talk about deep things in an open space”*.

Varying weather conditions was also identified as potentially impacting upon the therapy. References to weather highlighted the ways it could impact upon mood and the tone of the session. For example, *“the fact that one would be subjected to mood swings due to changing weather”* and *“it would feel moderately uncomfortable of the weather wasn’t great, it may make me tense up and not want to talk about anything”*. However, the weather was also identified as a factor that could be experienced as *“refreshing and stimulating positive emotions”*. References to *“being in the fresh air, being able to breathe deeply, feeling the wind”* were associated with clarity of thought and facilitative of therapeutic exploration.

Being outdoors fundamentally alters the setting of the therapy. This contrast was perceived as offering ‘something else’, for example *“more positive than looking at four walls, less formal, more comfortable sharing feelings”*. An outdoor setting was also seen to be helpful as *“the problem wouldn’t be so concentrated, and I would feel more free if the session was outdoors”*, similarly expressed as *“not being stuck in a small room with difficult feelings”*. A reduction in

stigma associated with being a client in therapy was also commented on as well as less “...rigidity involved with clinic based working”. Being in an out-of-doors setting presented possible connections from “being able to use nature as an avenue through which to talk about myself” to “being outside, ... being able to see a bigger picture [and] foster greater connectedness with the world”.

Engaging in movement

The second main theme identified, was ‘Engaging in Movement’. Being in motion through walking was described as supporting overall wellbeing. For example:

“I really like the moving around aspect. I find energy levels drop when I am sat still, I also like the feeling of my body moving, it gives me a much better sense of wellbeing”

Walking was also identified as being “good for stress” and having “positive physical and emotional effects”. There were strong links made between walking and thinking/problem solving that indicated this being supportive of strategies, such as, “I will often go for a walk when feeling overwhelmed or upset as I find it helpful for thinking and problem solving”. Being able to move during a therapy session was seen as facilitative of therapeutic engagement as “...struggling to ask for help or talk about something very painful... going for a walk could be a good way of engaging me”. Walking could also make talking easier, as “sitting down talking about difficult issues can be hard at times. Talking usually comes easier to me when walking outside anyway”.

However, walking was also identified as a potentially limiting factor in therapy. Constraints were linked to not being able to meet spontaneous needs, such as not having the option to sit if desired or access to creative materials. For example “I also feel that walking at the same time wouldn’t allow for drawing and mapping things out”. Walking during therapy is not always possible or desirable when managing physical limitations. Particularly, the physical effort was described as being counterproductive to therapeutic aims, such as “it could be physically draining, considering my physical health is poor...” While, existing medical conditions could make walking and talking challenging. “I have cerebral palsy so walking and talking would be potentially difficult”.

Walking side by side with a therapist was viewed as both potentially beneficial and problematic. The change in dynamic of being physically alongside as opposed to ‘face to face’ was thought to be “much easier for sharing difficult things when you’re not also having to maintain eye contact”. This also could offer the opportunity for “avoiding eye contact if I wanted to without it being awkward or obvious, lifting the ‘pressure’ of the situation”.

However, not being able to see a therapist’s face could also be a limiting factor.

“I would miss the face-to-face nature of a traditional therapy paradigm... I might feel that my therapist wasn't ‘seeing’ me if we were walking and talking”

Therapy processes

‘Therapy Processes’ was the third theme identified. Having a shared experience of client and therapist walking together was identified as potentially fostering a collaborative therapeutic relationship and facilitative of rapport building. *“It would also create a sense of trust... much faster”*. The neutrality of the place (i.e. not ‘owned’ by either party) was also identified as being useful in building a therapeutic relationship.

Flexibility and choice could be gained through choice on location, pace and direction the walk could take. *“The fact that I can choose when to walk and when to stop, and perhaps even where to go”*. Choice also referred to having *“the opportunity to try something new”* and *“liking the creativity of the idea”*.

The concept of ‘walk and talk’ was also identified as challenging notions of professionalism, representing unclear boundaries.

“I would feel worried about going for a walk with a therapist I didn't know and would feel... that the boundaries of the session would be less clear”.

The informality associated with walk and talk *“would not feel like it was professional. Would just be like talking to a friend and if I went to a session I would want a client/counsellor relationship”*.

Experiencing distractions through the activity of walk and talk had the potential to bring something useful to the therapy by *“feel[ing] like there is more flow to the session and you could talk and walk for a long time to work out solutions or express emotions as the...environment distracts you”*. Distractions were also seen to offer physical representation of psychological space from difficult material.

“Being able to talk openly and frankly whilst being engaged in a task of ‘walking’ to provide a slight distance between the things being discussed”

On the other hand, the potential for distraction through the environment and walking was identified as something that could be experienced adversely.

“Having to focus on taking in my surroundings and on the walking, rather than being able to think solely on problems – too much multi-tasking”

The variation inherent in outdoor settings – through sight or sounds - was identified as potentially increasing the potential for attention being drawn away from the focus of the

therapy. A consequence of this could be “*allowing avoidance of more direct immediate contact*” or result in “*not discussing all of your feelings*”.

Discussion

The quantitative findings of this study support the hypothesis that Environmental Identity and having a Walk and Talk Option would be significant and positive predictors of willingness to engage in walk and talk therapy. However, the hypothesis was not supported for PEX: Support. Furthermore, there were no effects of age or gender on these choices.

Quantitative analysis shows that individuals whose scores on the EIS indicated a strong environmental identity are positively associated with the likelihood of participating in walk and talk therapy. This finding makes sense through existing literature, that suggests judgements about different types of therapy are related to pre-existing attitudes and beliefs (Jorm et al., 2000) and that people are motivated to seek the types of support that fit with personal coping styles (Levy Berg, Sandhal & Clinton, 2008). Furthermore, this finding supports existing literature which demonstrates a relationship between preferences for outdoor settings and how restorative or beneficial that setting is perceived to be (Berto, 2005; Hartig, Kaiser & Bowler, 2001; Hartig, Kaiser & Strumse, 2007). Therefore, it is likely that individuals who report strong links to the environment, have established coping strategies and preferences that include spending time in outdoor environments, thus there will be a subjective ‘fit’ between the setting and desired goals or needs (Berto, 2005).

Having the option for walk and talk was also positively related to the likelihood of choosing walk and talk. It would seem the important aspect of this finding is the element of having ‘choice’. This is consistent with existing literature which suggests clients appreciate the opportunity to be actively involved in the decision making process about their counselling and being offered choice can potentially bring about a range of positive effects such as; increased motivation during counselling, increased client satisfaction; better outcomes through symptom reduction (Handelzalts & Keinan, 2010; Lindhiem et al, 2014; Manthei, 2006).

Preference for the Support sub-scale of the PEX was not a predictor for the likelihood of choosing walk and talk therapy. This finding is in contrast to existing studies which utilising similar measures to the PEX, suggest a supportive therapist role is preferred (Cooper & Norcross, 2015; Hatchett, 2015). A possible explanation for this finding is that this study did not utilise the full PEX: Support subscale that consists of five items. Only the items “being taught how to cope with problems”; “working with an active initiative taking therapist”; and “being encouraged” were used. Therefore, this may have affected the results. Alternatively, this finding could indicate that individuals who may be inclined to participate in walk and talk, may hold other preferences relating to their therapy that are not captured by the PEX. For example,

clients may hold stronger preferences for particular outdoor settings or routes undertaken during a walk and talk session, than those aspects related to therapists roles. As the practice of walk and talk is still relatively new, it could also be possible that clients (or potential clients) may not be able to articulate or know what their preferences are in relation to walk and talk therapy. Further research is needed in order to understand more clearly the underlying features of walk and talk therapy client preferences.

Quantitative results regarding help seeking behaviour are generally consistent with previous findings that indicate young adults tend to seek informal sources of support before formal ones (Boldero & Fallon, 1995; Thomas, Caputi, & Wilson, 2014; Tuliao & Velasquez, 2014) with the exception in this instance of counsellors being ranked above the option of 'other relative'. Counsellors were also the most likely formal help source which is in contrast with previous studies that rated doctors as the most likely formal source of help (Wilson et al., 2005). These two differences in findings could be explained by the majority of participants in this present study being students on counselling/psychology related courses and therefore more open toward counselling as well as more familiar with counselling as a relevant source of support. Findings from this study also show females to have a higher likelihood of seeking all variants of support than males, which is consistent with existing literature (Rickwood & Braithwaite, 1994).

The overall likelihood response rate of 69% (n=108) implies walk and talk is considered a potentially helpful and/or acceptable therapeutic activity. With no difference by age or gender found, this further suggests a potentially broad appeal base. This finding can be understood in different ways. Darker et al. (2007) reports that UK adults are more likely to engage in walking as an activity when there are positive beliefs held as to the benefits for health, stress management and being in the fresh air. Furthermore, intended engagement in physical activity depends on how positively it is viewed based on past experiences (Darker, Larkin & French, 2007; Focht, 2009). With helpfulness beliefs being influenced by personal beliefs and past experiences (Frövenholt et al., 2007; Sandell et al., 2011) it seems reasonable to suggest that individuals who hold positive beliefs and attitudes about walking in outdoor environments and whose established coping strategies include walking and being outdoors, are more likely to consider walk and talk as a helpful therapeutic activity. However, further investigation is warranted to understand the nuances of these results, such as in existing literature that examines moderators associated with preferences and helpfulness beliefs which are based on severity and type of presenting issues, and other contextual factors (Farrell & Deacon, 2016). Exploration into other relevant moderators that affect participation in outdoor walking such as weather and environmental factors (i.e. accessibility) is also needed (Darker et al., 2007; Giles-Corti & Donovan, 2002).

Qualitative findings suggest potential clients can identify a number of benefits that could be gained from participating in walk and talk. Whilst drawbacks were also identified, there was generally a positive response for walk and talk as a potential therapeutic activity. As the first known study to explore potential client's attitudes towards walk and talk, this offers an optimistic start from which further inquiry can be developed. This study further highlights place related issues and concerns that arise when taking counselling into outdoor settings, as the move from indoor to outdoor is perceived to add something and also potentially detract from the therapeutic encounter. This finding lends support to Conradson's (2005) assertion that people can see outdoor settings as both helpful and problematic at the same time, therefore challenging the assumption that natural settings are "intrinsically therapeutic" (p.338). The varied responses to walk and talk are indicative of perceptions based on past experiences, thus supporting Tuan's (1977) assertion that meaning is made from a dynamic interplay between past experiences and anticipations into the future. Furthermore, results from this study show perceptions of walk and talk as being inextricably linked with place, as appraised through responses to the outdoor environment. This further serves to demonstrate the multi-dimensional and complex relationships between people, place and experience and the different meanings that arise from these (Creswell, 2008).

A high degree of similarity between appealing and least appealing aspects suggest a dissonance in how the purpose and intent of walk and talk is perceived to fit therapy in an outdoor setting. Herzog, Maguire and Nebel (2003) report that potentially restorative environments can be both well-suited and ill-suited to the individual's intent and goals. They further suggest it is a degree of compatibility (i.e. to what extent the environment meets the needs of a situation) that is seen to mediate the potential for restoration. These findings support the importance of helpfulness beliefs that clients enter therapy with, thus suggesting those more favourable to walk and talk can see the ways this could be beneficial to them (Duncan & Miller, 2000; Iselin & Addis, 2003).

The maintenance of appropriate professional boundaries was of concern to participants in this study. There is an unpredictability inherent in outdoor environments with limited human control over the setting, therefore therapy will in some way or another be affected by variations in the environment. Jordan (2014) highlights the need for therapists to be accountable for the holding of the 'therapeutic frame' when working in outdoor settings, and attend to professional aspects such as confidentiality and boundaries. In a study of therapists who offer walk and talk within their therapy practice, therapists described how walk and talk was offered in an informed, collaborative and planned manner. They emphasised the importance of a therapeutic rationale for moving from indoors to outdoors, acknowledging unpredictable aspects and involving the client in the decision making process (Revell & McLeod, 2017). This suggests

that therapists who offer walk and talk are familiar with managing professional boundaries in an unpredictable environment and have developed the skills to work with these in a way that is constructive for the client's therapeutic benefit.

The participants in this study demonstrated a high level of awareness regarding the physical and emotional benefits to be gained from walking and being in outdoor environments. Walk and talk could therefore provide an opportunity that harnesses existing levels of awareness and at the same time serve to support a wider public health agenda through increasing physical activity levels of clients and beneficial effects of spending time in outdoor environments, enhancing overall wellbeing (Mayer et al., 2009; Pryor et al., 2006).

Limitations

There are limitations associated with this study. The sample in the present study was comprised of University students with gender and age related biases – they tended to be younger and female and therefore do not represent a stratified section of the general population. However, research shows that females can be more likely to seek counselling support than males, therefore it could be argued that the sample is reasonably representative of counselling clientele (Ang et al., 2004; Morgan, Ness & Robinson, 2003). While the specific walk and talk questions utilised a Likert scale and the term 'likelihood' in order to capture 'intentions' in accordance with the theory of planned behaviour (Ajzen, 1991; Wilson et al., 2005), it cannot be known for certain that participants indication of choosing walk and talk would translate into actual participation, if offered. Furthermore, participants in this study were not necessarily potential clients of counselling, therefore it cannot be assumed that these findings reflect attitudes or intentions of individuals at the point of seeking counselling support. Clients of therapy (who are not studying counselling/psychology related courses) may also have different reactions to walk and talk and fewer or different concerns relating to the maintenance of the therapeutic relationship.

Utilising an on-line questionnaire was practical in terms of accessing large cohorts of potential participants however, the depth and richness of the data is subsequently limited by use of quantitative measures and short answer responses. As the practice of walk and talk therapy has not been widely investigated, the findings from this study nonetheless offer a useful platform from which to base further in-depth qualitative investigations upon.

Implications

The findings from this study have implications for walk and talk therapy practice. Firstly, useful insight has been gained into the reasons that potential clients may choose or not choose to take part in walk and talk, if offered. Thus, understanding both factors that increase client

participation (such as matching preferences with intervention) and barriers in help seeking can enable practitioners to develop their way of working that attends to this, therefore potentially enhancing participation in therapy for those clients that might otherwise be unmotivated to seek support (Levy Berg, Sandhal & Clinton, 2008).

Secondly, there are indications that having the option of walk and talk could be considered helpful for some clients and there is a moderate level of interest in walk and talk as a therapeutic activity. This is a heartening result for practitioners wishing to promote this therapeutic activity in their practice, and could offer a useful starting point for understanding potentially relevant precursors for which individuals might be more willing to engage in this therapeutic activity. As is suggested in literature, the greater the match between what clients believe will be helpful and the therapy being offered, can serve to promote a collaborative therapeutic alliance and credibility of the intervention (Frankl, Phillips & Wennberg, 2014; Sandell et al., 2011).

Conclusion

Findings from this study offer an insight into potential client's perceptions of walk and talk, as well as possible ways of identifying characteristics of clients who may be more inclined to participate in walk and talk therapy. However, further research is needed in order to develop a more nuanced understanding of how walk and talk could benefit certain client groups and be of value to specific types of presenting issues. Research exploring a client's experience of participating in walk and talk is also needed, in order to further inform the development of this therapeutic activity.

Chapter 7: Study 4

Introduction

The aim of study 4 is to present a narrative case study of one client's experience of participating in walk and talk therapy (the main question and sub-questions are outlined in Figure 7.1 below). Previous studies within this research, have explored therapist experiences of participating in walk and talk therapy utilising both an on-line questionnaire and in-depth qualitative interviews. Potential client perspectives of walk and talk were explored utilising an on-line mixed methods questionnaire. Therefore, investigating an actual client experience of participating in walk and talk therapy through qualitative interviews, provides the remaining view for this multi-perspective research.

Figure 7.1. Study 4 research questions and sub questions.

<p>Study 4</p> <p>Research question: What is one client's experience of participating in walk and talk therapy?</p> <p>1: What meaning has this client made from their experience of participating in walk and talk therapy?</p> <p>2: What helpful processes are part of this client's experience of walk and talk therapy?</p> <p>3: What un-helpful processes are part of this client's experience of walk and talk therapy?</p> <p>4: How can the practice of walk and talk therapy be informed through this client's experience?</p>
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To date, there is only one known study where clients experience of walk and talk therapy has been explored. Doucette (2004) evaluated a multimodal walk and talk intervention for school aged youth (9-13 years) as part of an 8 week behavioural intervention within a school setting. There is no known study to date that has investigated adult client participants of walk and talk therapy. This study will employ a narrative, single case study approach to collect and analyse a full account of one client's experience of walk and talk therapy and the meaning that was made from that experience. A mobile method in the form of a walking interview will be used in order to produce contextual understanding of the relationship between place, walk and talk therapy and a client's experience.

Narrative

‘Narrative’ is a term that can represent different things across a range of contexts and is often used interchangeably with ‘story’ (Riessman, 2008). McLeod (1997) proposes a distinction between how story and narrative are understood, whereby a story concerns a single occurrence, whilst a narrative can include (but is not limited to) a “story-based account of happenings” (p.31). Therefore, narrative can be understood as a story (or stories) where sequence and meaning is conveyed through a variety of mediums (i.e. oral, textual and visual) (Riessman, 2008). A narrative approach is underpinned by an assumption that stories are inherently a human social act, which are constructed from experience and utilised to express meaning (Mishler, 1986; Ricoeur, 1991). Polkinghorne (1995) writes, “Stories are concerned with human attempts to progress to a solution, clarification, or unravelling of an incomplete situation” (p.7).

The telling of personal stories therefore, can be seen as an integral part of what happens in therapy, as clients seek to answer questions of “‘who I am’, ‘what I want to be’, or ‘what troubles me’” (McLeod, 1997. p. 2). Whilst the focus in therapy is often on individual stories, it is also acknowledged that personal stories and meaning-making sit within the context of culture as an individual seeks to position their personal experience alongside their cultural experiences (Bruner, 1990; McLeod, 1997).

Case studies

Case studies are a viable way of contributing to the evidence base for counselling and psychotherapy practice, as well as for exploring developments of new ways of working (McLeod, 2002; McLeod & Elliott, 2011). Case study approaches have not achieved a high profile in process and outcome research due to limitations of generalisability and difficulty in ascertaining the robustness or truthfulness of the study when it relies solely on therapists reporting of the therapy (McLeod, 2002). However, despite these limitations, case studies can provide research findings that are relevant and useful for developing psychotherapeutic practice (Fishman, 1999).

Single case studies seek to highlight both specifics and uniqueness of an individual’s lived experience (Simons, 2009). Single case studies can also be useful for generating professional practice knowledge in various ways, such as; illustrating a particular way of working, understanding what a client gained from their therapy experience, or determining possible relationships between a particular intervention and subsequent outcome (McLeod, 2002). In this way, case a study can therefore be understood as providing potential learning with the opportunity to see some aspects of therapy practice in a new way (McLeod, 2016).

Case studies can be approached in a variety of ways. A narrative case study seeks to ‘tell the story’ of a client’s experience of therapy from the client’s point of view and the meaning they subsequently made from their experience (McLeod, 2010). A methodological challenge with presenting a narrative case study is that it is not linked with any one approach and as such there is no established framework to be followed (McLeod, 2010). However, despite the lack of an established framework, Riessman and Speedy (2007) propose that trustworthy case study research needs to account for several factors such as sequence and context within the analysis, justified and explicit methodology and a transparent research process. Furthermore, McLeod (2002) suggests gathering material from different sources (i.e. autobiographical; artifacts; diary or journal entries etc.); utilising multiple readers to generate different perspectives; systematic description of the steps in analysis and offering contextual information can enhance trustworthiness of a narrative case study.

Within narrative research, the use of researcher reflexivity is explicitly shown and utilised as a core component in the gathering, interpreting and presentation of the clients story (Simons, 2009). The use of reflexivity recognises the generation of knowledge is influenced by contextual aspects of lived experience such as, history, culture, language and understanding (Etherington, 2004). Furthermore, reflexive research aims to show how knowledge gained through interviews is co-constructed in both *what* is learned as well as *how* (Etherington, 2000).

Walk and talk therapy

Whilst different therapy practices that take place in outdoor settings can be varied, there are also a number of broad commonalities that underpin these practices such as, activation of the senses through embodied engagement, use of creative therapeutic tools (i.e. metaphor, symbols and rituals), and fostering a connection with the outdoor environment (Berger, 2006; Jordan, 2015).

Bodily movement in outdoor environments, where sensory systems are activated at the same time as intentional therapeutic conversations occurring, offers a unique opportunity for personal learning. The theory of embodied cognition proposes that “the mind must be understood in the context of its relationship to a physical body that interacts with the world” (Wilson, 2002, p.625). Furthermore, it is suggested that greater understanding of emotional material is possible when there is synchronicity between a person’s bodily and psychological states (Ghane & Sweeny, 2013). An embodied view draws upon the belief that affect (thoughts, feelings, behaviours) is linked to sensory experiences and positions of the body (Barsalou, 2008; Corazon, Schilhab and Stigsdotter, 2011; Niedenthal et al., 2005). Furthermore, research suggests that implicit processes (i.e. unconscious or sub-conscious) linked to sensory motor systems can facilitate explicit learning, which is learning that is available to our consciousness and includes conceptual, symbolic and discursive learning (Barsalou, 2008; Barsalou et al.,

2003; Schilhab, 2007). Research further suggests that direct bodily experiences play a useful role in how abstract concepts (i.e. friendship, values, self and love) are understood (Anderson, 2003; Barsalou, 2008; Corazon, Schilhab & Stigsdotter, 2011; Williams, Huang & Bargh, 2009).

These findings have useful implications for understanding some of the learning and potential change processes that might be present in walk and talk especially as conversations in therapy are often concerned with explicit learning such as change, personal development, setting of goals and understanding problem life issues (Corazon, Schilhab & Stigsdotter, 2011). Further research is needed however, to understand more fully the links between bodily related processes and embodied cognition as a means of contributing to the therapeutic potential of therapies that take place in outdoor settings (Corazon, Schilhab and Stigsdotter, 2011).

Whilst there are many differences between the variants of outdoor based therapy practices, the use of metaphor is one therapeutic tool which is considered a common ingredient (Berger, 2006; Jordan, 2015). It is maintained that outdoor settings provide rich material that facilitate a link between embodied experiencing and therapeutic process (Bacon, 1983; Santostefano, 2008). It is further suggested from the cognitive science field that embodied experiences can invigorate language and allow for articulation of metaphorical connections from within an affective domain that may not otherwise have been possible to express (Gibbs et al., 2004). These factors therefore, suggest that the use of metaphor may have important implications for therapeutic change which are supported by the rich and varied nature of the outdoor setting as experienced during walk and talk sessions. These examples offer useful alternatives for understanding some of the different therapeutic processes that are present in outdoor therapy practices and could potentially serve as a starting point for understanding some of the underpinning mechanisms that are present in walk and talk therapy.

In conclusion, the aim of this chapter is to present a narrative case study of one client's experience of walk and talk therapy. The meaning the client made from their experience of walk and talk is a central focus of this investigation. This study makes a novel contribution to the field of counselling and psychotherapy research, through being the first of its kind that is known to explore an adult's client's experience of participating in walk and talk therapy through the use of a walking interview.

Method

Procedure

The overall aim in this narrative case study is to 'tell the story' (McLeod, 2010) of one clients experience of walk and talk therapy. A multi-method approach was used (Etherington, 2000;

McLeod, 2010), evidenced in the following ways: two methods of interviews, one of which generated pictures linking narrative to place and offering contextual information of the location of the walk and talk therapy experience; artefacts (in the form of poems) which were created at the time of their therapy experience were included in the analysis; the participant wrote a summary statement of their experience of walk and talk several months after both interviews had been conducted. Furthermore, place related aspects were responded to through the employment of a walking interview.

Interviews

Two interview methods were used and conducted in two stages. Data from both interviews will be presented in the findings. The first interview method consisted of a semi-structured phone interview that lasted approximately 80 minutes and was audio recorded and aimed to address research questions 1-4 (see appendix 12 for a list of interview questions). The aim of the phone interview was to gain a full account of walk and talk therapy from the point of view of the participant. The use of questions as general prompts was balanced with engaging in a dialogical process which meant letting the conversation develop in directions that were initiated by the participant. General prompt questions included inviting the participant to describe their life at the start of therapy, what their expectations were and what they considered helpful/hindering about walking and/or being outdoor during their therapy experience. Further questions invited discussion on any changes that had occurred as a result of their therapy and how walk and talk therapy was experienced overall. When the conversation had drawn to a natural conclusion, I offered a summary statement to the participant based on what I had learned from the interview conversation and invited them to add or change anything that had not been understood correctly. The participant indicated their agreement of the summary statement and the interview was concluded.

The rationale for extending the interview method to include a walking interview, was to have an opportunity to more deeply understand the case (i.e. participant experience of walk and talk) as well as the setting, thus increasing the trustworthiness of this narrative case study by providing greater contextual information (McLeod, 2002). Furthermore, the decision to conduct the second interview in a largely unstructured manner supported the narrative stance of this research. It was anticipated that through active conversation, an extended narrative of the participants experience of walk and talk could be gained, thus adding to the richness of the data. Mishler (1986) states: “We are more likely to find stories reported in studies using relatively unstructured interviews where respondents are invited to speak in their own voices, allowed to control the introduction and flow of topics, and encouraged to extend their responses” (p.69). The walking interview was therefore conducted with research question 1 in mind.

The walking interview took place approximately one month after the phone interview at an outdoor location where the participant had taken part in walk and talk therapy. The walking interview lasted for approximately 2 hours. Prior to meeting for the interview, I discussed with the participant the intended format and purpose of our follow up conversation. Specifically, that our time together was an opportunity for them to take the lead in terms of where we walked and what parts of the location they wished to show me/tell me about. I expressed that I would be interested in hearing about the meaning of the location they had chosen and if there was anything in particular that happened there or that they and their therapist did. I reiterated the unstructured nature of the conversation, thus reinforcing their autonomy and control during the walking interview.

The walking interview was audio recorded and photographs were taken of specific places during the interview that held significance for the participant. The participant carried the audio recorder on a strap around their neck during the walk to record our conversation, while I carried the camera and took photos to capture the place related aspects of the walking interview.

Walking Interview

Walking interviews are an emergent form of mobile methods that can be described as a qualitative approach which aims to generate rich contextual understandings of the interaction between people and place (Moles, 2008). "...the mobility of walking within particular environments allows for the creation of meaning. By walking people are able to connect times and places through the grounded experience of their material environment" (Moles, 2008, p. 1.4) Walking interviews disrupt the safe and controlled interview environment that is commonly associated with research and instead, engages with the unpredictability and uncertainty inherent in uncontrolled environments (Jones et al., 2008). The use of a walking interview was particularly fitting for the context of this study, as it mimics the salient features of walk and talk therapy (i.e. walking and talking in an outdoor environment). McKinney's (2011) findings offer a description of brief visits to some walk and talk locations of her participants that were undertaken either on her own or in the company of the therapist. However, there did not appear to be a specific rationale for this beyond an opportunity to offer general descriptions of the types of settings therapists might choose for walk and talk sessions. Therefore, it is anticipated that this study is the first study on walk and talk that has intentionally utilised a walking methodology with the purpose of capturing place related aspects. Furthermore, the utilisation of this method, offers an opportunity to gain unique, rich, multi-layered, place specific data that would otherwise not be possible in a seated, indoor interview setting.

However, there are specific technological challenges with linking narratives to place in mobile methods research (Jones et al., 2008). Managing multiple forms of technology whilst walking and talking can be disruptive of both the interview process and result in data that is confusing and unusable (Jones et al., 2008; Pink, 2007). On the other hand, mobile methods that do not capture a place related context of the interview have been criticised as not making the most of what the method can elicit in terms of rich, multi-layered accounts (Jones et al., 2008). Therefore, this study sought to attend to place related contexts through the analysis being presented with photographs and attention paid to place related components. In attending to the need to provide data that was usable and relevant to the overall aims of the study, a collaborative approach was taken. The participant carried the voice recorder on a strap around their neck that hung freely, midway down their torso, therefore requiring minimal holding (just occasional steadying when negotiating uneven terrain). Other than occasional visual checking of the device to ensure the weather (rain and sleet) was not impairing its functioning, the recorder did not require any further attention after it had been set to record. It was decided that I would carry the camera and would be responsible for taking pictures during the walking interview of the setting that related to the participants narrative. In these ways we shared responsibility for the technology in the hope that the potential for disruption to the interview was minimised for us both.

The pseudonym 'Cathy' is used throughout the analysis to protect the identity of the participant.

Recruitment

Participation was sought from clients of UK based therapists who had taken part in walk and talk therapy. A purposeful sampling approach was employed where therapists known to the researcher as offering walk and talk therapy were contacted. Written information of the study's aim and scope was emailed to six therapists. Given the ethical considerations associated with conducting research with current therapy clients, it was stipulated that participation was sought from past clients only (i.e. individuals no longer in therapy). This caveat however, also brought ethical considerations associated with therapists contacting past clients after the therapy has ended. This was addressed by asking therapists to keep the study in mind if they were anticipating ending with a walk and talk therapy client in the near future and within the anticipated timescale of the study. Notices inviting participation by clients of walk and talk therapy were also posted on on-line notice boards (i.e. BACP). One ex-client of walk and talk expressed interest in participating in the study. Whilst having only one participant was not intended, it was decided that by adopting a narrative single case study method, this would be acceptable for the purposes of this inquiry to be conducted as further efforts to recruit participants had not been successful.

Ethics

Ethical permission was granted by Canterbury Christ Church University (UK) research ethics committee (see appendix 9 & 9a). Prior to both the telephone and walking interviews, the participant was sent information on the purpose and aim of the study and the voluntary nature of their participation (see appendix 10). Details were given as to how material gained from the interviews would be used and measures taken to preserve anonymity. Informed consent forms were sent to the participant prior to each of the interviews taking place (see appendix 11). As the data from this study was to be used as a case study, particular attention was paid to how the case would be presented and any potentially identifying information removed. Any identifying data was stored securely. The participant was offered several opportunities to edit information contained in the case study and to withdraw their involvement at any time.

Analysis

Audio recordings from both interviews were professionally and fully transcribed. Anonymity of the participant was maintained through no identifying data being present on the audio recording. A confidentiality agreement was agreed with the transcriber. The process of analysis was informed by an experience-centred position on narrative, which takes the phenomenological view that stories provide a way for experiences to become consciously known (Squire, 2013). There are four main assumptions of an experience-centred approach to narrative as detailed by Squire (2008).

Firstly, narratives have meaning, are sequential and integral to the meaning-making process. This meant during the reading and re-reading of the transcript, I paid attention to events within the narrative that seemed to be highly meaningful. Furthermore, as an experience-centred approach considers items that are produced outside the context of the interview to be a legitimate part of the overall narrative, I was able to integrate into the analysis, segments from poems that the participant had written during the time of their therapy.

The second assumption of an experience-centred approach is that narratives are a human centred way of making sense of experience through sequential temporal organisation. This meant I looked for instances within the participants narrative that showed how sense was made from their experience of walk and talk therapy, where sequence and temporality was evident.

Thirdly, narratives ‘re-present’ experiences that are reconstructed and expressed across time and place, producing changeable and multiple stories that are influenced by different social contexts. This meant I aimed to show in the narrative co-constructed aspects by including dialogue between myself and the participant. The analysis was further conducted with the assumption that more than one interpretation is possible, thus accepting there are “multiple

valid interpretations and multiple narrative ‘truths’” (Freeman, 2003 as cited in Squire, 2013 p.57). Representations of narratives therefore, can only ever be partial and incomplete, as meanings are contextual and fluid, arising from interactions between people (Riessman, 1993).

Lastly, narratives from an experience-centred stance, show change or transformation. This meant I was interested in the change that occurred for the participant as a result of her walk and talk therapy experience.

After several close readings of the transcripts and following completion of an initial analysis, both the full transcripts and analysis were sent to an external supervisor and a conversation had whereby individual understandings were compared and discussed. The initial analysis was also sent to the participant and they were invited to comment or change any aspect they felt did not represent their recollection of the interviews or their experience.

This narrative case study is presented using the general structure of Riessman (2008), which begins with the context of the case, followed by descriptions of events and appraisals, and is completed with a coda. The descriptions of events and appraisals were presented in an adapted stanza form (after Gee, 1991). A stanza presentation allowed for the participants experience to be represented as authentically as possible, with the meaning and structure of the narrative clearly depicted (Etherington, 2004; McLeod & Lynch, 2000).

An additional aspect of this narrative case study is the presentation of researcher reflexivity within the analysis. Simons (2009) argues that the researcher is an integral part of the research process from the gathering, interpreting and through to re-presenting the narratives. Therefore, this calls for the bidirectional influence between the context and relationship between interview participants be made evident in the production of narratives (DeFina, 2009).

This overall aim of this narrative analysis therefore, is to present the story of and stories within Cathy’s experience of therapy. Utilising the structure of Riessman (2008) (as discussed above), three main sections are presented. The first section provides context for the case, through an introductory biographical statement containing general information on why Cathy entered therapy; Cathy’s expectations of therapy and the location of the walk and talk sessions.

The next section of the analysis presents descriptions of events and appraisals in four ways and will be discussed in the order of how they are encountered. Firstly, there is an overarching narration of the walking interview. This is to situate the conversation in place and to add to the environmental context of the interview (Anderson, 2004). The overarching narration is in plain font and occurs both at the beginning of each theme, as well as certain points throughout the theme.

Secondly, four main themes are presented which offer a representation of the richest accounts from Cathy's narrative. Mostly, the themes are presented sequentially as events occurred during the walking interview. Other themes contain more disparate events which were encountered during the walking interview, but that cannot be presented sequentially. Within the themes, segments of Cathy's speech in her own words is presented in an adapted stanza form (after Gee, 1991). This includes instances of dialogue between Cathy and myself which makes transparent the dialogical co-construction of the walking interview in line with a narrative stance that offer context to 'what' was learned as well as 'how' (Etherington, 2000; Riessman & Speedy, 2007). Cathy's speech is italicised and situated on the left hand side of the page. Moments of dialogue that include my speech is also italicised and situated on the right of the page.

Thirdly, the photographs taken during the walking interview and presented in the stanza analysis, reflect the conversations which occurred in place. The use of these pictures aims to deepen the understanding of the case setting, thus making explicit connections between the place and narrative (Anderson, 2004; Lynch & Manion, 2016).

Fourthly, segments of poems that Cathy wrote during the course of her therapy and which are connected to the conversations in specific places are included within the themes. These are non-italicised segments that are indented from the left hand side of the margin, and labelled to aid clarity.

Lastly, each theme section concludes with a reflective researcher statement that is contained in a text box, as a way of situating myself explicitly within the analysis process (DeFina, 2009; Simons, 2009).

The final section of the analysis constitutes a summary statement (coda) of the case as a whole that offers further analytic interpretation of Cathy's experience of walk and talk therapy. This section concludes with a final reflective researcher statement on taking part in a walking interview process.

Results

Case study introduction statement

Cathy was a female in her 50's nearing the end of a 25 year long profession when she entered therapy. Cathy had four years of 'walk and talk' therapy with the same therapist. When I met Cathy it was 7 months after her counselling had finished and she was newly retired. We spoke on two occasions. The first occasion was a phone interview, and the second was a 'walking interview' where Cathy and I walked around a location she had 'walked and talked' with her

therapist for the latter 2 years of her therapy. The case summary is informed largely from the phone interview, while the themes were largely produced from the walking interview.

Biography

As a child Cathy spent a lot of time in outdoor environments, these times evoke happy memories and she described herself as a “feral, free range child”. It was also a time in her life when she remembered feeling confident and happy at the level of control she had over her own life. Being outside with her animals was a place that “made sense”.

Cathy had been to therapy at various times in her life and experienced a range of different therapeutic approaches. Her help seeking process was strongly influenced by her past experiences and she considered herself ‘well informed’ about the type of therapy that would fit her aims – “I knew what I was drawn to and what I didn’t want”. During the time of considering returning to therapy, Cathy was told about a therapist that offered ‘walk and talk’. Instinctually she knew this was the type of therapy that she wanted and made contact with the therapist to find they had space on an afternoon that she did not work. “Serendipity upon serendipity, I practically raced her [the therapist] to the chosen outdoor location... thus began my five year journey inside out”.

Cathy described how she had always been particularly drawn to ways of expressing herself that had tangible elements and where movement is incorporated for exploration of personal process. Her background framed a strong attraction for engaging with a kinaesthetic approach to storytelling and personal expression.

Starting therapy

Cathy entered therapy highly motivated, committed to therapeutic exploration and determined to “get to the roots” of her issues. Cathy described her life at the time of entering therapy as being in grief, feeling confused and in a state of “befuddlement”. Her confidence had suffered through breakdown of a relationship and she wanted to “get herself back together again - back on an even keel”. Within this was the opportunity to “reclaim and regain effective strategies and tools” through exploration of relationship patterns within a professional context. Counselling was seen as an investment in herself – at what was emerging to be a pivotal time in her life in several significant areas.

Expectations of therapy

The expectations associated with seeking outdoor counselling was that it would ultimately feel more “comfortable”. This was both in terms of being in an outdoor environment and the opportunity to be physically moving while engaging with emotional material. Walking offered a means of “clearing the cobwebs” and “clearing a space” where problems could potentially be

accessed and solved quicker. There were also the anticipated physical benefits associated with walking – such as getting a “boost”. It was expected that being outdoors would also provide opportunities of metaphorical connection that would support psychological processing and from that richer layers of meaning could be achieved.

Cathy was clear that along with the option of having ‘walk and talk’ therapy, there needed to also be a high degree of challenge within the therapeutic relationship. This was explicitly requested by Cathy during the contracting process. Through challenge, Cathy felt it would be possible to get to the “nitty gritty” stuff.

Location of walk and talk

Cathy had participated in ‘walk and talk’ in two different locations over a four year period of time. The location of the walking interview was a place where ‘walk and talk’ sessions had occurred for the latter two years. This location was described as “wilder” than the first one and was symbolic for Cathy of going to the “wilder places within”. This location provided an opportunity for “reclaiming freedoms” and processing significant life events within the geography and setting.

Stanza presentation of Walking Interview

We met at a road-end on a bleak and cold morning. The low mist clung stubbornly to the hills and the bare trees dripped from wet sleet showers. Despite the surly and frigid weather, I sensed a lightness in Cathy’s brisk and purposeful step as we (Cathy, her friend’s dog and myself) embarked on our explorative journey of her special and familiar landscape.

Theme 1: Therapy in an outdoor place – opportunities for pauses, perspectives and reflections

*It’s all part of the therapy for me really
that lovely drive here, the lovely drive back
I just feel myself go weeeeeee!
bit of a mini holiday really
definitely space
just expands the whole system
somehow
very organic*



We turned off the main path, crossing a small footbridge over a swollen stream.

We paused at a cluster of trees that at one time had offered a place of sheltered refuge.

There were deaths

it felt very soothing to be outside

it felt right

it felt very holding

much more holding

much less sterile, organic



to be in the rain

to be part of something much more ethereal ...

and natural

to be talking about somebody

who passed away

to be able to cry and just

do that all outside...

much more freeing

We continued our journey, winding our way over snow covered mushy ground, gently climbing toward a craggy lookout in the distance. Cathy spoke of a recognisable internal change that was evoked from being in an outdoor environment.



*Well... it's very existential
and it ... I think
the primary thing for me ...
it's like standing next to a mountain or
next to the sea
it's so much bigger than us*

*it creates such perspective on ...
in the regulation of the body
and how I know I go
from being 'all about me' to
'huh'
it just takes it - it draws me out
to a much more spiritual place
I think*

*yes - a very egocentric place
to a much more spiritual place*

yes, it's huge

*coming here is part of that
getting up here is an embodiment
of perspective, climbing higher
getting a better view
looking back to where you have been
when you turn around
it's pretty ...
it's pretty amazing*



so starting off with the 'all about me' or 'what about me?'

and seeing your place within the whole?



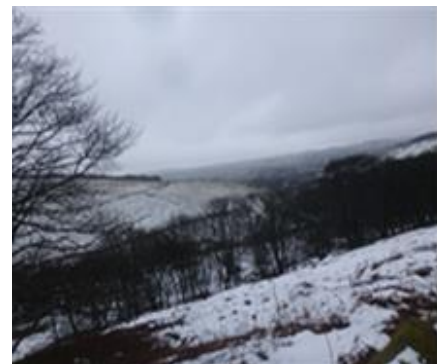
Slightly breathless, we arrived at the top of the hill. There was a small rocky lookout that offered a sweeping view of the basin and hills beyond; we paused.

From this exposed ledge at the lookout, the weather performed a lively dance of blustery wind gusts and sleet showers around us.

*It is such a huge presence
a room doesn't breathe like this
a room doesn't have weather and seasons
it doesn't throw
this much happy chance at you
no room can do this...*



*I think it's
a very useful metaphor
of the way landscape holds
stories – people - events - emotions*



*you don't have to make
a big song and dance about it
it is not going to judge you
it is just going to carry on being what it is...
that is a great lesson to be reminded of...
to carry on
and keep on being...*

We stood, each taking a quiet moment to soak in the view amidst the persistently tempestuous weather, the hills in the distance offering space and expanse, invoking a feeling of endless reflections and possibilities.

*Going up a hill I once quipped
I didn't feel the need to look backward
to which my therapist replied
'it's good to pause sometimes
to see where you've come from'*



We stood on the lookout as Cathy recounted a time when she had read a poem to her therapist.

*It was all about getting out - being freed
it was a great release
because I had been holding on to it [the poem]
that release
of standing here
giving it into the space
was like saying thank you
really powerful for me*



*Mmmm... and was that thank you to the space here as well as
...?*

*Yes!
the poem is 'You are'
and you can read it
as the landscape AND and the therapist....
it just kind of morphs..!*

“... You are the uphill breathy slog
The sun kissed sky views
The natural highs, the opening gate,
The stile to another somewhere
The downhill sigh of another story exhaled.
You are my guide, my mentor, my nurturer, my healer
Holding, holding, holding all-...
Dancing my spirit back to the wild...
You free me...

You are my guide, my mentor,
holding, holding, holding all-
this untamed, tangled find, this raging cage
this rush of human animal
still straining at the leash
dancing my spirit back to the wild
you free me.”

(excerpt of poem 'Wilder-Ness' written by Cathy)

From meeting Cathy at the start of the route, I was struck by her energy and delight at being outdoors, despite the inclement weather. During the initial stages of the walking interview, I was aware of my own sense of tentativeness in approaching the interview with Cathy. To literally walk through another person's therapy-scape is a unique and intimate experience. Cathy seemed very comfortable in taking the lead – both in where we walked, when we paused and what was spoken about. I felt this helped to relax us both into the conversation.

I started to get a clearer sense of how the outdoor setting had been utilised in various ways, from allowing sheltered pauses when needed, to providing a different perspective on issues. The landscape a holding space for her stories that could be re-visited and reflected upon.

Cathy's interaction with the outdoor environment spoke of an attitude that was both pragmatic (i.e. embracing variations in the weather, and things being 'what they are') and explorative (i.e. using the space in varied and creative ways). I saw underpinning this was the sense of safety and belonging that Cathy held towards the outdoors. I could see that for someone who had an established relationship with outdoor environments it made a certain amount of sense that this would be a potentially useful environment for therapy.

Theme 2: Therapy that makes use of physical energy – huddling, stomping and exploring

We continued on our journey, winding our way along a muddy narrow path beside a swollen stream. Cathy spoke of how places in the landscape offered different ways of engaging with therapeutic material.

*We would usually come up here
for something that felt much
more energetic ...
something I needed to wrestle with
mentally
and then I get that kind of
physical engagement as well*

*I know when we used to get
really deep into stuff
we would always stop
and huddle
at the beginning and end
we would be stomping more
interesting*

*on the longer routes
it was probably things that
needed more untangling
a little bit more knotty*



sometimes

if I had something very frustrating

but not as deep

I just needed to let it all out down there

'I am just going to dump it here

now and not move actually...

I just need to get this out now!

I am not waiting

until we get up there!'



We dropped down from the high point, following a drystone wall that meandered across the hillside.

... it sounds as if it's very easy for you to know what you need and how that can be physically supported ... ?

I know it now Steff

I am not sure

I could have articulated it at the time.

on some organic level

I can see now

that's what happened



Ahh.. OK, so it wasn't necessarily conscious in the moment ... ?

Not necessarily

*I think sometimes I would get
myself rooted
in something*

that energy would just be 'I need to be here ...

and this is grrrr... '.

so a very different energy

the way the energy plays out here

is just so powerful

it is so powerful...

So ...

that is my thinking through of it now...

We carried on our journey. The path became uneven and slippery underfoot. Walking in single file was the only option. Our conversation lapsed into a companionable silence. Physically we became more spread out as we navigated the uneven terrain at different speeds. Wind was whipping the sleet around the hood of our jackets as we picked our way along the path, jumping over boggy dips that would suddenly appear. Talking became impractical as our focus was drawn to negotiating the terrain.

*I noticed in that section, it wouldn't be possible to
continue to walk side by side.*

No

*So during your therapy... what did you feel happened
during those more challenging path moments...?*



I think it's every woman for herself!...
I need to pick my own way
make sure I feel ok about it
I am a skier as well ...
I know how easy it is to just go over,
so ... I think about being responsible
for myself
picking my own course



As Cathy described the rhythm and responsiveness of her therapy sessions, I was intrigued with how Cathy and her therapist negotiated and integrated the 'right' geographical space that provided a 'fit' with her internal needs. Was it explicit and intentional? Did it just unfold naturally? Who decided? How was it named? Would the process of acknowledging physicality needs within the therapy session disrupt the focus on the client's narrative? Walk and talk has is described as being highly collaborative – this seemed to offer a good example of the types of collaboration that might take place and would be useful for therapists to think about before doing walk and talk.

After the exchange where Cathy indicated the fit of bodily movement and psychological processing wasn't necessarily an explicit decision – this showed me that Cathy's story as I was hearing it that day, was a mixture of poignant memories and new understandings that had developed in hindsight. I have long been interested in the dual process between thinking and bodily movement and maybe there is an element to this that happens intuitively (in everyday life) and it is in hindsight that a different sense can be made of it?

Experiencing the variations in physicality during the interview was interesting. For myself not being familiar with the terrain and not knowing what was coming next, there was an element of not being prepared. The concentration required to focus on footing and holding the camera at a certain muddy section meant that I felt I lost physical and psychological contact with Cathy. I became curious about how this might be experienced in the therapy session – could there be a danger of retreating into separate worlds? Or was psychological contact in this situation more like a large elastic band that would stretch and contract in response to the terrain?

Theme 3: Therapy of possibilities – how incorporating metaphor and rituals brings new understanding

*Somewhere up here
there is a heart carved in a tree
we always seemed to acknowledge it
when we went past...*

*it has always meant a great deal to me
because it seemed to be symbolic
of starting outdoor therapy
and recovering love...
in all its different shades*



*a sort of naturalness
of being outdoors
and getting back to...
'me'
yes - so I always like going past that*

From the open field, we headed towards a small bridge that straddled the banks of a swollen stream that tumbled and gurgled down through the valley.

We stood silently on the newly repaired bridge leaning over the single rail, mesmerised by the constant volume of water that loudly made its way under the bridge and beyond.

*So this is a lovely spot....
for some reason
I think of this as a very female place
I mean - it kind of
has hips, and groin
and all of that going on*



*this was falling apart [the bridge]
towards the end of me coming
but we would cross it anyway
we felt it was safe enough
It was never
as roaring as this*



The stream that gurgled and swept its way beneath us on the bridge, also offered an adventurous up- stream scramble, enticing and beckoning with the promise of ‘off the beaten track’ discoveries.

We moved off the bridge and made our way into a nearby clearing at the side of the stream.

Cathy went on to describe a powerful ritual that she and her therapist had enacted as part of the ending process.

*I went off and did a little solo time...I came down here
I came underneath the bridge
I deliberately didn't go over the bridge
I climbed up here*

*it was a wonderful little journey
because if you go
further up there
there is a big tree across a ravine
there was lots of lichen and...
I climbed up as high as I could
to the wire fence
then I came back down*



*I was contemplating the different direction,
stages of life
seasons
very powerful*

*was it your decision to use this
stream...?*

Yes

*because of the significance that it had
for you?*

Yes

*it was a very personal decision
we hadn't walked that together
I felt drawn to make my own
little expedition...
as I was approaching the end
of my time here
it seemed important to do that*

*What did that
represent?*

Me

*going out on my own
going back to myself
without coming here
saying goodbye
journeying on to newer ground
yes - definitely*

*it was lovely ...
a good personification for me
a good embodiment of me
getting back to me
and all of that stuff
deliberately not crossing
the man-made bridge*



Gently balance foot by
Foot my reflections smeared in
stretching currents suddenly a
flat pool landing a
Huge tree across her I
Scrape my wet arsed
trousers across her mossy
trunk balancing less well than the girl I
Was..."

(excerpt from poem 'Upstream' written by Cathy)

We turned our attention away from the stream and moved toward a majestic bare oak tree that stood proud among a cluster of trees.

*So here is the mother fucker tree
that is quite some tree*

how is it significant to you?

*Well, I have
a very troubled relationship
with my mother and I think
just the idea of it
being strong and old
kind of edgy
a little bit scary*

*there is an element to it
that is scary
but also monumental
it has been around a long time ...
you really have to be right up close
underneath
to see its power
walking around in the landscape
it kind of gets lost
but once you are here – it's a mighty tree...*



*so what was it like, coming here on subsequent
sessions, and knowing that the tree was here?*

I just feel great affection for it

*like it was a physical part of the
therapy?*

Yes

the tree is going to go on

the tree doesn't give a fuck

that is nice

I like that about the tree



I was struck by the powerful metaphors and imagery that connected Cathy to these places in the landscape.

As I looked over the rails of the small footbridge, I thought about Cathy's adventurous up stream scramble as part of the ending rituals she had participated in. That Cathy had chosen to explore the stream in this way, spoke to me of her ability and willingness to respond intuitively and bodily in her therapeutic exploration. It made me consider client engagement and participation in therapy in a new light – that clients have more options available in choosing the level and type of engagement in their therapy that no longer sits only within the linguistic domain.

The tree that represented Cathy's mother had a rough gnarled trunk that implied a lifetime of growing in the changeable and exposed landscape. I was immediately struck by the powerful symbolic association this had for Cathy and became curious as to the impact it held once it had been 'named'. Perhaps this came from my own imagining of what it would be like to name and locate a 'problematic relationship' in the landscape – would I necessarily want it there to remind me in future sessions, or could it provide a useful touchstone for seeing the distance travelled in resolution of difficulties?

Theme 4: Therapy as an opportunity to experience an expansive relationship

I remember my first therapy relationship

it felt very clunky

mechanical

I didn't really feel any deep empathy

warmth

I felt invited to be

very mechanical in what I put into it

I suppose

During our journeying, Cathy had made several references to the depth of relationship she shared with her therapist. Experiencing their vulnerability. Their realness.

She fell

long before I did

a number of times

fell or slipped

the first time it happened

I remember...

I saw her as my mother

falling over ...

I remember feeling very tearful

afterwards

talking it through with her

saying 'it is like,

it reminds me of being with

my falling-over mother



*her not being there for me
being afraid she wouldn't be there for me
because she was always having
terrible things happen
to her
prone to all sorts of chaos
and that was
very helpful
really helpful*

*it sounds as if it really challenges the trust that
you can develop in a therapeutic relationship, seeing
[your therapist] as a physical being that might trip ...?*

*Yes
it is
their own vulnerability ...*

Cathy described a transparency within their therapeutic relationship of roles and expectations.

*although we did have
a conversation about
'why does the therapist need to lead everything?'
'well she doesn't!'
'well, come on then' [she would say]
what are we doing?'*

*definitely she was the person
doing the holding...
I was paying for her
to look after me
and be my therapist*

*which meant a lot for me
as a busy professional woman
it is just so lovely
to be held like that*

As we picked our way across the snow- covered ground, heading towards where our walk would end, our conversation turned toward the ending of the therapy.

*It was all very ...
a very lovely ending
it taught me ...
how lovely endings
can be
when really consciously co-created*

*although it was very moving
it didn't feel painful
I have a history of painful endings
difficult, unresolved endings*

*I felt it was a great gift
I know it is part of the therapy
but it doesn't always work
like that*

*on the last day
I read the last poem
then we got to somewhere around here
she just said
'right I am going to leave you to do the crossing on your own'
which I wasn't expecting*



she said

'I will be down at the other side when you are ready'.

I thought it was lovely ...

I became very aware that she had created

a very flexible space

for this to happen

again I thought, a great gift

so I just sort of had

some time on my own,

just standing here

looking around and thinking about my time here

how important it had been

I felt ready

I just had a feeling of readiness

I had a feather, a swan feather

because I watch swans near where I live

so I had brought a swan feather

I took it to the bridge

and this is a little ritual I do

it is like pooh sticks

I had done it in memory of a friend in San Francisco who had died

I threw the feather

over the bridge

it blew upstream!

it just made me laugh...

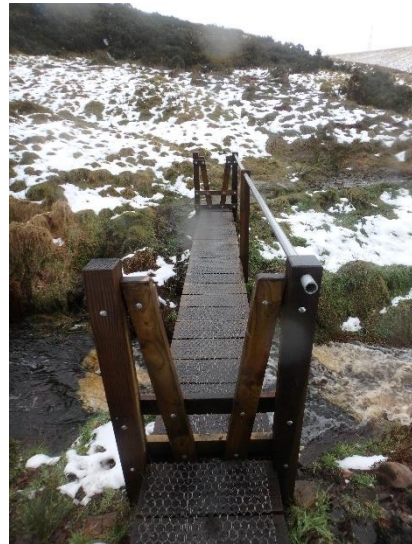
It didn't go down like a pooh stick at all!

it flew upstream

so I was laughing as I crossed over...



*its nature doing what it does
not doing what you want or
predict it to do...
we have a relationship with it
an impact on it
it will do its own thing too
which is great!
it's relationships!*



We had reached the end of our journey together. There was a relaxed rhythm to our pace as we meandered along the path that would lead us to our cars.

What has it been like for you to walk around here and talk about your therapy?

*It is very therapeutic again
on another level
it is very empowering
it is like - this is still
a really powerful place
for me*

*I feel
great affection for it
great affection for it
it could be done anywhere
this is the particular place
where I came*



In the short time I had had with Cathy, my experience of her was one of a competent and capable woman, who was used to being self-sufficient and self-reliant. I could see in this outdoor landscape that there had been multiple 'tangible' opportunities to enact different therapeutic activities and roles. I could hear from Cathy's response that the opportunity to be held and at the same time to be prompted into taking ownership of the therapeutic process (by 'leading') had been a significant and useful part of the therapy.

Cathy's experience of the therapeutic relationship was very positive and one that expanded relational possibilities (such as positive endings). While there were other ingredients of her walk and talk therapy experience that were powerful and poignant, I understood that it was the therapeutic relationship which underpinned those experiences and made exploration possible. This is something that again speaks to me of the entwined processes that are at play in walk and talk, and that viewing it holistically offers a more useful sense of what it is than identifying and attempting to quantify specific factors.

I felt very privileged and grateful at being invited to share the private world of Cathy's place of therapy and for our journey through her stories that are embedded and entwined within the landscape.

Summary Statement

At the start of the walking interview, Cathy was invited to tell me about the place and any particular events that happened there during her therapy which were significant or meaningful. It can be seen that Cathy responded to this invitation with several stories that were embedded in the landscape. Overall, Cathy's story is one of successful therapy. It is a story of multiple stories that were structured in a way that showcased both artifacts in the environment as well as descriptions of experiences that took place. Cathy described how she responded to variations in the landscape (such as trees, bridges, streams, hills, lookouts etc.) creatively for therapeutic benefit, constructing profound relationships with both her therapist and place. Cathy also structured her story in such a way as to make it clear that the outdoor environment was one in which she felt most at home in, an environment that provided her with variety and unpredictability as well as safety and security for deep and varied exploration.

It is possible to hear Cathy's story in several ways. It is a positive walk and talk therapy story, characterised by energetic and motivated exploration. It is a story of movement (both physical and psychological) and change. It is a story of reconnection to self, made possible through the external environment. It is a story of meaningful relationships. Other readings of Cathy's story are also possible.

It is possible to identify within Cathy's narrative, an implicit story of 'being a motivated client' which influences how her story is told. Cathy's motivation to engage in therapy is evident from the beginning of her narrative when she describes the intentional process to find a therapist that 'fit' both her goals of being challenged and having therapy outdoors. Cathy used her knowledge and past experience of therapy to choose a therapy orientation that she knew would enable 'going deep to the roots'. The successful outcome of therapy indicates a personal goal being achieved.

It is also possible to identify another implicit parallel story that relates to Cathy's identity. It is evident through Cathy's narrative that she identifies herself as being 'an outdoorsy person' which has significant links back to her childhood and her 'free range' child days. Early life experience of outdoor spaces 'making sense' are held in contrast to the indoor environment response of feeling 'confusing' for her. It therefore makes sense that Cathy would seek a safe environment (i.e. an outdoor one) for therapeutic exploration.

Within Cathy's narrative, it is possible to see the outdoor environment is conceptualised as an entity in its own right that is non-judgemental and having motion and life force that is independent of human influence. For Cathy, bringing her stories to be held in this landscape and context provided something important in her therapy.

Having therapy in an outdoor place provided Cathy the capacity to move and pause, being responsive in the moment. Cathy's narrative describes pauses as being physical representations of moments of significance within her therapy. Pauses were experienced as spontaneous bodily responses to emotional material. The outdoor environment provoked two different experiences of perspective for Cathy. There was the opportunity to 'get things into perspective' through a process of attention that moved from being internally focussed to a more expansive, outward view. This in turn, activated a 'different perspective' which brought clarity and new understanding to emotional material.

Being on the move during therapy sessions was a fundamental ingredient of Cathy's therapy experience. Movement allowed for synchronicity between internal processing and bodily movement, thus making integration of experiencing possible. Cathy's narrative described an embodied understanding of 'self-in-the-world' where assimilation of physicality and place was an intentional part of the work.

It is evident in Cathy's story that the opportunities to respond bodily to internal feelings and work these through in an active way was physically and psychologically satisfying. Cathy presents as very bodily aware and describes how different 'energies' brought to therapy sessions contributed to the rhythm that was spontaneously responded to. From this, a physical-emotional synchronicity unfolded and formed that was responsive, emergent in-the-moment and intricate.

Cathy clearly articulates the importance of being offered possibilities for enactment in the outdoor environment which provided valuable ways of exploring complex layers of personal material. It was through these embodied therapeutic rituals that Cathy experienced a way of fully expressing herself.

It is possible to identify the use of metaphor and symbolism as another salient ingredient of Cathy's walk and talk therapy experiences. For Cathy, the environment offered an additional dimension to connect with – weather could mirror or evoke emotions; features in the environment provoking a responsiveness that generated greater exploration of personal material, artefacts provided spontaneous symbolic connections. Having artefacts situated in the environment of the therapy contributes to an emotional tie to place, demonstrated by Cathy's 'affection' for it.

Cathy's narrative describes a deep and fulfilling therapeutic relationship that was characterised by several crucial elements such as 'having choice'; being able to trust and therefore risk exposing self through therapeutic activities; being led and being able to lead; being an active co-creative agent in the therapy. For Cathy freedom came from being in the role of 'client' and

provided a valid avenue to develop own voice and ask for what was needed (i.e. challenge, being outdoors).

A high level of intimacy developed between Cathy and her therapist through walking side by side and physically depending on each other. A profound and challenging moment for Cathy was acknowledging her therapist had ‘vulnerabilities’ that could be seen and evidenced. For Cathy this allowed for a real relationship that was physically represented through ‘equal footing’. This provided the solid base for a therapeutic relationship to develop where experimental and potentially exposing therapeutic activities could be negotiated and experienced.

It is possible to identify in Cathy’s narrative the significance of the ending of her therapy relationship and as a vital part of the overall success of her therapy. Cathy articulates how the ending had been intentionally planned between her and her therapist. The characteristics of time and collaboration are evident, which produced an alternative experience of potentially painful life events (i.e. endings) and which was experienced by Cathy as a ‘great gift’ that paid tribute to the therapeutic relationship.

In a statement written several months after the walking interview, Cathy summed up her walk and talk therapy experience:

“With an outdoor therapist as a guide, this process condensed and multiplied, for now I had a mentor to reflect and question me as I walked on the wild side. And I had nature to join in. I quickly felt safe to return to a kind of Free Child exploration of my history, present challenges and future aspirations...”

The opportunity to participate in a walking interview with Cathy allowed for a joint visceral, embodied exploration of her therapy-scape. Like a new guest being shown through rooms of a house, I was tentative and careful with my steps. The frigid weather did not invite lingering in any one place and our canine companion (who was less protected from the elements than we were) employed persuasive barking that urged us to remain on the move.

Journeying with Cathy through this uncontrolled setting required balancing connection with Cathy through mobile physicality, maintaining conversation and capturing significant moments through photographs. In this way, the camera became an extension of my experience and represented part of my engagement with the setting. I was aware photographs could only be partial and incomplete in capturing the fullness of place, however through the accompanying situated narrative, meaning making becomes apparent.

Approaching the walking interview without any pre prepared questions or thoughts about the desired direction of the conversation was liberating. It was the setting itself that provoked memories for Cathy and from that stories emerged as we journeyed together through her therapy-scape. For me, being led by Cathy over unfamiliar terrain offered a representation of research participant becoming guide, from which emerges a different engagement and reflexive space. This experience for me can be summed up through the words of Solint (2001) who writes;

“the rhythm of walking generates a rhythm of thinking, and the passage through a landscape echoes or stimulates the passage through a series of thoughts. This creates an odd consonance between the internal and the external passage, one that suggests that the mind is also a landscape of sorts and that walking is one way to traverse it. A new thought often seems like a feature of the landscape that was there all along, as though thinking were travelling rather than making” (p.5).

Discussion

This study utilised a narrative case study approach to present one client’s experience of walk and talk therapy and the meaning they made from their experience. Furthermore, a mobile method of a walking interview was employed as a novel way to understand a clients lived experience of walk and talk within the context of place. Whilst narrative case studies are useful in producing rich in-depth accounts of lived experience, they are limited in other ways that prevent generalisations and statements of representativeness of experiences from being made (Etherington & Bridges, 2011). However, McLeod (2016) proposes narrative case studies can

be valuable sources of potential learning and provide an opportunity to appreciate the work of therapy in a new way. The possible learnings from this study are twofold. Firstly, for therapists who wish to incorporate walk and talk into their therapy practice and secondly, for potential clients of walk and talk who may wish to experience this type of therapeutic activity.

A main feature of Cathy's experience of walk and talk therapy can be understood through the context of embodied lived experience in place. Cathy's experience of walk and talk depicts a multi layered, complex relational dynamic that interchanges between herself, place and therapist. While these aspects of Cathy's experience have been presented discretely above (see results section), it can also be seen that each of these components do not exist in isolation from the others. Cathy's lived experience of her therapy describes bodily encounters with place and bodily encounters that were shared with her therapist. This aligns with a phenomenological view of embodiment that proposes an individual's experience of their own internal world and their shared social world are mediated through the body (Hydén, 2013). Furthermore, walk and talk challenges the notion that the individual is 'separate' from the context of the therapy setting and that the therapeutic relationship can only be understood through the dualistic client-therapist frame (Fenner, 2011). This suggests therefore, that walk and talk draws upon the traditional professional relationship dynamics between therapist and client, whilst also provoking relational responses that are situated in broader dimensions (i.e. phenomenological responses to place).

The importance of the quality of the therapeutic alliance on successful therapy outcomes has been extensively explored in counselling/psychotherapy literature (eg. Bordin, 1979, 1994; Horvath, 2005; Horvath & Bedi, 2002; Horvath et al., 2011; Lambert & Barley, 2001; Lambert & Simon, 2008; Martin, Garske & Davis, 2000; Norcross & Wampold, 2011; Wampold et al., 1997). Specifically, an affective bond and consensus between tasks and goals of therapy are generally considered to be essential ingredients of an effective therapeutic relationship (Martin, Garske & Davis, 2000). Findings from this study indicate a high degree of affective bond and agreement between Cathy and her therapist regarding the tasks and goals of her therapy. It is reasonable to assume therefore, that these factors contributed to the successful therapeutic alliance as described by Cathy. However, the relationship between Cathy and her therapist did not exist in isolation from the contextual surroundings of the outdoor setting. Fenner (2011) highlights that the physical material world within which therapy takes place has been largely overlooked within therapeutic relationship literature and argues for "relationship in therapy... to be expanded to include aspects of the material environment and place" (p.852). Furthermore, the shared ownership of the therapeutic environment as a space that is neither owned nor controlled by therapist or client, also is seen as contributing to the different relational dynamics that can emerge from therapy in the outdoors (Berger, 2007).

Evident in Cathy's narrative is the tri-fold relationship between self, therapist and place that situates her walk and talk therapy experience and provides a solid base from which her therapy process evolved. This supports existing research that suggests there are different relational dynamics that exist when therapy is taken into outdoor settings and further research is needed to understand how this altered dynamic influences therapy processes and outcomes (Backhaus, 2008; Jordan, 2015; Revell & McLeod, 2016, 2017). These relational aspects of Cathy's experience of walk and talk provide an example of how a successful therapeutic relationship was experienced in an outdoor setting that included expansive relationships with place and her therapist. Possible learning from this finding, highlights the value in place (i.e. location) of walk and talk therapy sessions being explicitly negotiated and considered as part of the therapy contracting process, as different clients may respond to different settings which may ultimately impact upon therapy process and outcome.

There are several other areas of learning that are possible from Cathy's story of her experience of walk and talk therapy. Firstly, Cathy's experience denotes a successful therapy experience, characterised by a high degree of client motivation and therapy preferences being met. Cathy entered therapy with preferences that link to categories as detailed in preferences literature (i.e. therapist characteristics, preferred type of therapy and roles and behaviours enacted during therapy) (Swift et al., 2013). Her preferences emerged from both positive and negative past experiences, which is consistent with literature which suggests preferences can become known once individuals have experienced either what works for them or not (Cooper & Norcross, 2016; McLeod, 2015). Also evident in Cathy's narrative is her experience of walk and talk meeting her preferences. Studies of client preferences suggests when clients experience a match between their preferences and the therapy they receive, greater satisfaction and participation in the therapy as well as greater likelihood of a positive outcome can result (Glass, Arnkoff & Shapiro, 2001; Lindhiem et al., 2014; Swift, Callahan & Vollmer, 2011). Cathy's experience could be seen as an example of the benefits of a client's therapy preferences being met and promotes the utility of therapists engaging with clients preferences.

Throughout Cathy's narrative, her sense of identity is clearly linked to the outdoor environment and offers an example of how interactions with the natural environment can shape "who we think we are" (Gottschalk, 2001, p. 246). Cathy's descriptions of feeling more at home within outdoor environments which subsequently made reconnection with parts of herself possible, lends further support to the idea that self-concept and environmental identity are linked through connections and emotional attachments to the natural environment (Clayton, 2003).

Another area of potential learning relates to movement during the therapy sessions. Cathy was able to bring her physical energy to therapy and make use of this constructively and flexibly.

Cathy described how different physical responses to emotional material could result in different therapeutic effects being experienced, such as; walking up a hill when there was something to wrestle with mentally could help facilitate problem solving; when holding deep sorrow or feeling ‘rooted’ in something, huddling offered the opportunity to be with that emotion in a less mobile way. Cathy’s narrative therefore, offers an example of how walk and talk offers an opportunity for thoughts, feelings and behaviours to be expressed in an embodied way, thus making use of sensory experiences and various bodily states as part of a meaning making process. This is in line with existing literature that supports the stance of embodied cognition, which proposes embodied experiencing and cognitive processing are linked and can serve to produce knowledge and new ideas (Corazon, Schilab & Stigsdotter, 2011; Leung, 2012; Meier et al., 2012).

The use of nature based metaphors, symbolism and rituals played a significant role in Cathy’s walk and talk therapy experience, which allowed for new understanding to emerge. Cathy’s narrative demonstrated the presence of metaphoric description of the landscape holding stories, the heart carving on the tree symbolising recovering love and the journey upstream as an example of an ending ritual. These examples demonstrate the experiential and embodied elements of how metaphors, symbols and rituals were located in place and emerged in a synergistic manner. This finding aligns with existing literature, that identifies the ways different types of enactment can support exploration of psychological difficulties through utilisation of the diversity and richness of the outdoor environment (Berger, 2006; Davis-Berman & Berman, 2008; Gass, Gillis & Russell, 2012; Jordan, 2015; McKinney, 2011) Furthermore, Cathy’s stories of how various therapeutic processes were linked to place concur with study 2 (see Chapter 5) findings that therapists utilise creative ways of processing which incorporates embodied, spontaneous responses that are linked and embedded within the environment.

Limitations

The limitations of this study need to be acknowledged. A single case study does not lend itself to generalisations or act as a representative example of walk and talk therapy. However, employing a narrative focus in this study allows for a rich and storied account of one client’s experience of this emergent therapeutic activity from which learning for both therapists wishing to offer this in their therapeutic work and potential clients of therapy can be gained. Because stories are jointly shaped by both the storyteller and listener, it is recognised that the data is a result of this coexistent process. For example, Cathy might have emphasised positive aspects of walk and talk only, and left out instances that may have given a negative impression of this activity as she may have not wanted to appear as though she was not supportive of walk and

talk therapy. Future research would benefit from exploring experiences of walk and talk that were not experienced as positive by clients, as a way of developing understanding of the limitations of this approach. Walking through a client's therapy-scape is a unique act and it is evident the place of her therapy had emotional connections for Cathy. This may have also influenced what stories were told in the walking interview, for reasons of protecting the specialness of the therapeutic space. Cathy was a motivated client and had experienced therapy in the past. Future studies would benefit from exploring 'novice' clients experience of walk and talk and clients for whom the decision to enter therapy may have been more conflicted. This would enable broadening and deepening the understanding of the potential beneficial contexts of walk and talk. Further research that explores several clients' experiences of walk and talk would be beneficial as a way of broadening the research base of this therapeutic activity.

Implications

This case study offers a rich description of walk and talk therapy. Cathy represented one client who responded positively to walk and talk and for whom being in an outdoor environment was pivotal to their overall successful therapy experience. This finding has useful implications for identifying types of clients that may be inclined to participate in walk and talk. Further research is needed however, in order to understand for which clients might walk and talk be supportive of their overall therapeutic aims.

Cathy's narrative of her walk and talk experience could also be seen as an example of Burns' (1998) experiential metaphor model and offers useful learning in highlighting a different model of understanding how metaphor can be experienced in an outdoor experiential therapy. Importantly, by drawing upon a model of metaphor that acknowledges the experiential features of walk and talk, an understanding of the therapeutic processes present in this therapeutic activity can also begin to be developed. Furthermore, therapists wishing to develop this way of working with clients, may find it useful to consider how they might best respond to the various types of creative therapeutic processes that can be produced through walk and talk.

Conclusion

To my knowledge this is the first study of an adult client's experience of walk and talk therapy. This is also the first study of its kind to utilise a situated understanding of the lived experience of walk and talk through the use of a walking interview. This study has made a further contribution to the body of existing research utilising mobile methods by demonstrating how a walking interview can provide a novel opportunity to learn new things about walk and talk from a client's perspective.

This study sought to combine specific elements of narrative case study and walking interview in place as a way of interrogating the relationship between walk and talk therapy and place as the location of therapy is often overlooked in counselling/psychotherapy literature (see study 2, chapter 5). Furthermore, this study makes an initial contribution towards understanding the various interactional processes that can be part of a walk and talk therapy experience.

Chapter 8: Discussion

This chapter will discuss findings from all four studies. The focus of the discussion will be on how the findings address the overall research aim, which was to investigate the professional practice of walk and talk therapy from three different perspectives. The three perspectives entailed investigating experiences of both therapists and clients who had taken part in walk and talk sessions, along with potential client perceptions of this therapeutic activity. This chapter organises a discussion of the main results based on four common themes across the studies. The four themes are: setting; walking; therapeutic relationship; therapist factors. A summary table of main findings within each theme is presented below (see Table 8.1). A summary statement of each theme will be presented, followed by a discussion of each theme, where links to existing literature will be made. Implications from this research are identified and limitations discussed. The chapter ends with recommendations for future research and concluding remarks.

Table 8.1. Summary table of main findings

Theme	Key Findings
Setting	<ul style="list-style-type: none"> • Dynamic, multi-sensory and fundamental ingredient of the therapeutic activity • Influences what is experienced and possible • Setting cannot be considered separate from the therapy • Outdoor setting associated with sense of freedom, space and openness • Outdoor setting can provoke concerns relating to maintenance of professional boundaries • Offers flexibility in use of metaphor, symbols and rituals
Walking	<ul style="list-style-type: none"> • Beneficial for psychological and physiological wellbeing • Supportive of psychological processing and internal states

	<ul style="list-style-type: none"> • Supportive of overall wellbeing • Increases mind/body connection • Could be a barrier to focusing on therapy • Alters relational dynamics through change in physicality • Side by side perceived to foster a more relaxed, informal atmosphere • Reduced eye contact when walking side by side was perceived as both an appealing and non-appealing aspect of walk and talk
Therapeutic Relationship	<ul style="list-style-type: none"> • Fundamental to supporting walk and talk • Inherently collaborative • Encourages clients to actively participate in their therapy • Different qualities within therapeutic relationship experienced • Metaphorical connections spontaneously integrated into sessions arising from both outdoor setting and walking • Informal and could potentially be helpful for clients • Could challenge what is considered an appropriate 'professional' therapeutic relationship
Therapist Factors	<ul style="list-style-type: none"> • Strong personal beliefs regarding the usefulness of walk and talk from those therapists who offer it to clients • Therapists have a common desire to offer alternative methods to clients • Revitalising for therapists to have way of increasing physical activity and spending time outside during working day • Therapists demonstrate capacity to tolerate the areas of uncertainty inherent in walk and talk • Desire to work with more clients in this way

Theme Summary: Setting

The setting within which walk and talk takes place is dynamic, multi-sensory and a fundamental ingredient of this therapeutic activity. The setting influences what is experienced and what will be possible during the therapeutic session. The setting also influences what potential participants of walk and talk consider appealing or unappealing about this therapeutic activity. Unlike indoor forms of therapy, the act of walk and talk cannot be considered contextually separate from the outdoor setting it takes place in.

There appears to be a high level of commonality between all studies, concerning the ways being in an outdoor setting is considered beneficial for walk and talk. For participants of walk and talk (studies 1, 2 and 4) the outdoor setting was associated with a sense of freedom, space and inviting openness of therapeutic exploration. Participants in study 3 who had not experienced walk and talk therapy also perceived the outdoor setting in similar types of ways, with participants across all studies citing belief in the restorative components of outdoor spaces. There were commonalities also between studies 1, 2 and 3 in the ways the outdoor setting would not be supportive of therapeutic aims. Mostly, this amounted to concerns over the psychological safety and maintaining confidentiality of clients through being in an open, public space, and the lack of possible 'containment' in the event of psychological distress. Studies 1, 2 and 4 offered ways of managing these aspects.

The outdoor setting was also identified across all studies as offering a high degree of flexibility and creativity through multisensory features of outdoor settings, allowing for use of metaphor, and different possibilities in terms of therapeutic activities and rituals. Ultimately, the outdoor setting was conceptualised as changeable, emergent and non-static which promoted an active embodied response to the therapeutic setting.

Theme Summary: Walking

There was general consensus across all studies, that walking is an activity beneficial for physical and psychological wellbeing. Therefore, it was identified that walk and talk therapy could offer broader holistic benefits to overall wellbeing than seated, indoor therapy alone. Walking was described by those who had participated in walk and talk (studies 1, 2 and 4) as energy generating which could then be useful for psychological processing. Study 4 further described how different styles of walking could mirror internal states, thus supporting therapeutic processes. Study 3 findings were also in line with the view that walking could support stress management and facilitate a greater sense of wellbeing.

Walking was also generally identified as being a useful activity to engage in whilst trying to problem solve or 'move on' from an issue through increasing the 'mind/body' connection.

Bodily movement was identified across all studies as being a useful ingredient for facilitating loosening of internal material and a way of engaging with difficult and challenging emotions in a manageable way (i.e. not getting overwhelmed by them). However, whilst findings from study 3 indicated ways bodily movement could be supportive of therapeutic processes, findings from this study also indicated that walking was perceived as an activity which could potentially get in the way of focusing on the purpose of the therapy. Findings further indicate that walk and talk is not accessible to all and there are some physical limitations which make walk and talk impractical.

Findings from across all studies indicate a level of consensus concerning the relational impact of the change in physicality between therapist and client when walking side by side. Walking side by side, as opposed to sitting face to face, was described as altering relational dynamics in terms of reducing potential anxiety associated with the therapy and feeling less intimidating. Therapists in studies 1 and 2 considered being side by side particularly beneficial for clients who may be intimidated by the idea of traditional therapy. Findings from study 3 of potential clients concurred with this idea, perceiving that walking side by side would be associated with a more relaxed and informal atmosphere. Study 3 further clarified ways in which walking during therapy was not perceived to be beneficial, which mostly related to concerns about the lack of eye contact, resulting in uncertainty over how to ascertain where the focus and attention of the therapist would be.

Theme Summary: Therapeutic Relationship

The therapeutic relationship underpins the activity of walk and talk. Studies 1, 2, and 4 indicate similar ways the therapeutic relationship is described and experienced as being inherently collaborative. Collaboration is evident at several stages, such as attending to practical aspects prior to the walk and talk session (i.e. location, route), and negotiating responses to unpredictable events during the walk and talk session (i.e. encountering walkers, dogs and managing interruptions). Walk and talk further requires both clients and therapists to literally demonstrate an active approach to the therapy. Fundamentally, walk and talk cannot occur unless the client is willing to physically participate. Studies 1, 2 and 4 demonstrated consistency in the practice of walk and talk in terms of the various ways therapists encourage clients to actively engage in the therapeutic activity, such as choosing locations for walk and talk, negotiating the route, and collaborating on any additional activities during the therapy sessions. In addition to being collaborative, findings from studies 1, 2 and 4 describe further characteristics of the therapeutic relationship as flexible and responsive to client needs.

There is a consistency between participants of walk and talk (studies 1, 2, 4) in how their experience of the therapeutic relationship is described. There is a quality to the therapeutic

relationship which is perceived as being different to what is experienced through indoor based work. Aspects such as authenticity, realness, lacking the usual hierarchy and shared ownership of the setting were identified across the three studies and seen to contribute to the development of a helpful therapeutic alliance. There is a strong indication in studies 1, 2 and 4 that the integration of metaphor is a significant characteristic of conversations had during walk and talk. Metaphorical connections stem from walking through the outdoor setting and are seen to invite spontaneity and an increase in connection between the client, therapist, setting, and therapeutic process.

However, study 3 offers contrasting findings in how the therapeutic relationship might also be impacted through walk and talk. On one hand it could offer clients a relationship that is less formal. Which could be useful if a person is feeling particularly anxious or unsure about entering therapy. On the other hand, findings suggest that for some people walking with a therapist challenged commonly held notions about what constitutes a professional bounded relationship, and walking outside with a therapist would not be considered acceptable within their perception of a professional therapeutic relationship.

Theme Summary: Therapist Factors

For the therapists who participated in walk and talk with their clients (studies 1 and 2) there is a strong belief in the usefulness of this therapeutic activity. This personal belief has allowed the intuitive development of the practice of walk and talk in the absence of best practice guidelines. Participating in walk and talk with their clients allows therapists to offer alternative methods in their professional practice. Being able to successfully develop ways of working that support both clients and their own wellbeing (through more movement in an outdoor setting), is seen to bring revitalisation to the professional practice of therapists.

However, there is a level of uncertainty arising from the open, shared outdoor setting of walk and talk. Studies 1 and 2 suggest therapists who walk and talk with their clients demonstrate the capacity to tolerate areas of uncertainty that are inherent in walk and talk as well as the ability to manage these in a professional and considered manner. Study 4 findings show that it is also important for a client to be prepared to engage in therapy in an outdoor setting and accepting of variables such as weather, other people and dogs. Whilst therapists in studies 1 and 2 indicated disappointment that more clients had not requested walk and talk sessions, study 3 findings suggest there is a moderate level of interest in this therapeutic activity from a potential client point of view. Findings from study 3 also shows that the idea of walk and talk raises some concerns. Understanding these concerns can serve to inform therapists what clients may wish to discuss prior to deciding if walk and talk is suitable for them.

The client experience in Study 4 suggests walk and talk can be a way of engaging in therapy that offers different possibilities and outcomes. Studies 1 and 2 demonstrate a common practitioner view that walk and talk is not assumed as being suitable for all clients, at all stages of their therapeutic process. However for some clients who may struggle to engage with more traditional forms of therapy, it is possible that walk and talk could offer a useful alternative.

Having presented a summary statement of each theme, the same themes and main findings will now be discussed, with links being made to existing literature.

Setting

Across all four studies, findings show there is a common belief in the restorative potential of being in natural outdoor settings. This can be seen to reflect recent government and public health initiatives which promote spending time in natural environments as being supportive of physical and psychological wellbeing (e.g. Bragg & Atkins, 2016, World Health Organisation, 2018). This finding is also in accordance with existing literature which shows people hold expectations that being outdoors will be more beneficial than being indoors (Ryan et al., 2010).

A main finding of this research highlights the significance of the outdoor setting in how walk and talk therapy is understood. The outdoor setting appears to have a particularly pivotal role in influencing levels of participation, therapeutic process and possibilities. Across all four studies it can be seen that walk and talk as a therapeutic activity is not (and arguably cannot be) considered separate from the outdoor setting it takes place in. Therapists who practice walk and talk (studies 1 & 2) describe the outdoor setting as dynamic, multi-sensory, and an interwoven ingredient of the therapeutic space. The client experience in study 4 further supports this view. These findings suggest that walk and talk is a therapeutic activity that is well situated to support the existing call in literature (e.g. Backhaus, 2008; Berger, 2007; Fenner, 2011; Reese & Myers, 2012) to conceptualise therapy in ways that explicitly acknowledge a therapist-client-physical environment dynamic.

Studies 1, 2 and 4 highlight relational aspects within an outdoor setting during walk and talk which were experienced as therapeutic. Commonly, the therapeutic effects were described in context of relational interactions between the client, therapist and setting. Clayton and Opotow (2003) suggest there is a re-iterative process that exists between people and the outdoor environment. They argue that people both effect and are affected through interaction with the natural world. The relationship an individual has with the natural world will influence the 'identity' it is given and individual 'identities' are subsequently influenced through the relationship. It could therefore be reasonable to expect, that those individuals who enter therapy with an identity that is already linked to the outdoor environment will be more open to experiencing a therapeutic relationship in an outdoor setting, as the setting will fit with who

they see themselves to be. Certainly the quantitative findings from study 3 that suggest individuals with a strong link to environmental identity could be more likely to participate in walk and talk implies an interesting area for future exploration.

Qualitative results from study 3 demonstrated that an outdoor location was not always perceived to be an appropriate setting for the activity of walk and talk, thus highlighting the complex and multi-dimensional ways different people respond to different places. The concerns appeared less to do with the outdoor setting *per se* and more to do with what Conradson (2005) refers to as the “relational dimensions of the self-landscape encounter” (p. 338). Herzog, Maguire and Nebel (2003) report that potentially restorative environments can be both well-suited and ill-suited to the individual’s intent and goals. They further suggest it is a degree of compatibility (i.e. to what extent the environment meets the needs of a situation) that is seen to mediate how positively the environment is experienced. Furthermore, how a person perceives a particular setting has been shown to subsequently impact their experience within that setting, and the degree to which it was considered restorative or not (Marselle, et al., 2015). The implications of this suggest that clients perception of the setting of walk and talk could ultimately affect their experience of it and limit (or potentially enhance) participation or therapeutic benefits.

A main area of concern for participants in study 3, was the perception that being in an outdoor setting for therapy could compromise confidentiality and not offer sufficient containment for emotional distress. Paulson, Everall and Stuart (2001) report that client concerns about vulnerability, and particularly concerns that confidentiality could be broken, can negatively impact all aspects of clients’ experience of therapy. Concerns such as these are likely to present as a barrier to participation in walk and talk. Findings from study 1 and 2 suggest that therapists openly acknowledge there are practicalities associated with maintaining professional boundaries and confidentiality, and approach this in a pragmatic manner, through discussing with clients and making agreement on how these are managed (i.e. pausing the conversation, choosing alternative settings for the sessions). These findings are aligned with Hays (1999) and McKinney (2011), suggesting that therapists who choose to walk and talk with clients are very conscious of the ethical considerations and make efforts to manage these responsively.

Findings across all studies indicate a variety of ways the outdoor setting can be useful within the therapeutic process. Studies 1 and 2 describe a way of working that is characterised by therapists adopting creative ways of processing which incorporates embodied, spontaneous responses that are linked to and embedded within the environment. The client experience in study 4 also depicts an experience of walk and talk that was inherently experiential and with metaphors, symbols and rituals being located in place. This finding is aligned with existing

research, which suggests therapy conducted in outdoor settings can evoke different responses when exploring psychological difficulties through the richness of the outdoor environment by integrating creative methods such as metaphor, rituals and symbolism (Berger, 2006; Jordan, 2015; McKinney, 2011).

Walking

Findings from across all studies suggest there is a strong general consensus that walking in general is beneficial for psychological and physiological wellbeing. This finding is in line with existing literature which demonstrates public health initiatives as successfully raising awareness of health benefits associated with increasing physical activity in daily lives (Cavill & Bauman, 2004). This finding can also be seen to concur with existing literature that reports UK adults consider walking to be beneficial for stress relief, increasing physical activity and as offering a chance to be in the fresh air (Darker et al., 2007). However, awareness of the benefits of increased activity have generally shown not to translate into changes in actual behaviour as people tend to be more motivated to engage in an activity if they consider it enjoyable (Cavill & Bauman, 2004, Eves, Hoppe' & McLaren, 2003; French et al., 2005; Marcus et al., 1998). Walking in the company of another person is suggested as one way to increase the enjoyment factor of walking for some people (Darker, Larkin & French, 2007). Recent reports on the efficacy of combining physical activity and a therapy intervention simultaneously, offer heartening benefits for the future potential of walk and talk. Nguyen et al., (2014) found that the implementation of psychotherapy and exercise together significantly reduced depressive symptoms. Whilst some alleviation of depressive symptoms were attributed to the physical activity aspect, they proposed that the social interaction whilst walking was also a key factor. Therefore, these findings combined point to the potential of walk and talk therapy to support broader health agendas through offering an opportunity to engage in shared physical activity, which could potentially motivate people to increase their physical activity levels and at the same time supporting the alleviation of some forms of psychological distress (i.e. depression).

Another main finding within studies 1, 2 and 4 indicate awareness of a facilitative relationship between the energy generated through physical movement and psychological processes during walk and talk therapy. This supports a holistic, embodied view of body and mind, thus rejecting the dualistic stance that views body and mind as separate and which traditional psychology has been based upon (Leitan & Murray, 2014; Shapiro, 2011). Study 1 findings identified that practitioners considered walk and talk as an effective means of 'unsticking' therapy processes. This finding was elaborated upon in study 2, with participants attributing the physical movement through walking to aid creative problem solving and allowing for new connections to be made between different cognitive concepts. Study 4 findings concurred with

studies 1 and 2, describing how not only was walking facilitative of therapeutic processes such as ‘moving on’, it could also be utilised in a way that supported psychological states (i.e. ‘stomping’ when experiencing a knotty problem; walking slowly when feeling contemplative etc.). Walking as an aid for problem solving was also cited in study 3 as a potential appealing aspect of walk and talk. The idea that walking can support different types of cognitive processing is evident in literature. Embodied cognition is underpinned by the assumption that there is a bidirectional influence between thoughts/feelings and motor behaviour (Koch, 2011). It is further proposed that bodily experiences (such as movement and sensation) play a role in the formulation of understanding abstract concepts (Barsalou, 2008; Niedenthal et al., 2005). This can lead to greater creative problem solving abilities (Leung et al., 2012). Furthermore, it is suggested that moving freely (for example walking outdoors) can activate and increase thought processes that can shift a state of fixed thinking, thus providing the opportunity for new connections to be made between different concepts (Leung et al., 2012). These findings therefore, lend support to the idea that walking during therapeutic conversations could have the potential to support clients change process from a state of rigidity to fluidity; allowing access to potential solutions not previously considered. However, there are many interconnected components that are experienced simultaneously during walk and talk, therefore further exploration is needed to understand the relationship between all aspects in order to understand how these contribute to therapeutic change (Corazon, Schilhab & Stigsdotter, 2011).

Walk and talk is a therapeutic activity which fundamentally changes the physicality between client and therapist. All studies made reference to this feature of walk and talk. Studies 1 and 2 described the altered physicality as offering something different, which generally could be useful for clients, for example lowering anxiety levels usually associated with maintaining direct eye contact. Study 4 findings further suggest that the physicality of ‘side by side’ can increase intimacy between therapist and client and offer physical representation of the therapeutic journey together. In contrast, findings from study 3 of potential clients, suggested that the lack of eye contact could however be a cause of concern for some people. This finding seems to be aligned with Duff and Bedi (2010) who argue that ‘physical attending skills’ such as eye contact, sitting still and facing the client among others, are crucial to the formation and development of the therapeutic alliance. In order to understand if the lack of eye contact can in fact hinder the development of the therapeutic alliance, further investigation is warranted. Respondents in study 3 had not experienced walk and talk, therefore it is not known if this would still be an issue for them in actuality. The experiences of those who have participated in walk and talk do not indicate the lack of eye contact is a barrier to establishing a therapeutic alliance (i.e. studies 1, 2 and 4), instead suggesting that a reliance on different types of bodily

awareness occurs thus allowing for the connection between therapist and client to be maintained.

For example, one possibility is that synchronised motor activity can increase the level of co-operation and affiliation that is experienced between two parties (Hove & Risen, 2009; Wiltermuth & Heath, 2009), and that 'in tune' bodily movement can increase positive affect which in turn contributes positively to the emotional quality of the therapeutic relationship (Tschacher, Rees & Ramseyer, 2014). Therefore, this points to an understanding of walk and talk that encourages an understanding of how the therapeutic alliance develops to be approached in ways which take into account the physicality differences inherent in walk and talk.

Therapeutic Relationship

Existing literature on the therapeutic alliance in counselling and psychotherapy generally focuses on the relational dynamic between client and therapist (Bordin, 1979, 1994; Horvath, 2005; Horvath & Bedi, 2002; Horvath et al., 2011; Lambert & Barley, 2001; Lambert & Simon, 2008; Martin, Garske & Davis, 2000; Norcross & Wampold, 2011; Wampold et al., 1997). Whilst findings from this research (studies 1, 2 and 4) also indicate the importance of a robust alliance to support the therapeutic activity of walk and talk, there are broader relational aspects that occur during walk and talk therapy, highlighting a dynamic interplay between the therapist-client relationship and interactive influences of the setting and walking.

Studies 1, 2 and 4 indicate the therapeutic relationship that develops from within a walk and talk therapy context is experienced differently in contrast to indoor based therapy. Aspects such as authenticity, realness, lacking usual hierarchy and shared ownership of the setting were identified across the three studies and were seen to contribute to the development of a helpful therapeutic alliance. These findings align with those of McKinney (2011) whose findings also suggest that the neutral setting of the therapy and change in physicality contributes to a different relational dynamic emerging from walk and talk. Other studies exploring variants of outdoor therapy also emphasise the role of the shared, outdoor setting in how the therapeutic relationship is experienced (e.g. Berger, 2007; Jordan, 2015; Revell, Duncan & Cooper, 2014).

These findings therefore lend strong support the idea that walk and talk is an activity that needs to be considered within a broader conceptual frame that goes beyond the client-therapist dynamic (Backhaus, 2008; Fenner, 2004; Jordan, 2015). The phenomenological view of Merleau-Ponty (1962) views the body-in-the-world as ambiguous, in that it is both subject and object at the same time. The body therefore, is seen "as the only object in the world that we can perceive from the inside and from the outside, the moving body is always being moved at the same time" (Koch, 2017, p.88). The implications of this view, is that the individual responds to

sensory information from both within and through relationships with others and the environment, thus embodying an experience of the world that is multi-layered and consisting of inter-relations (Koch, 2017). A phenomenological stance therefore, could offer a useful way of understanding the relationship between specific ingredients of walk and talk therapy, and respond to the identified need for further research that explores how these different dynamics interact to influence therapy processes and outcomes (Backhaus, 2008; Jordan, 2015).

Among participants of walk and talk therapy there is general consensus regarding the feature of collaboration. Studies 1, 2, and 4 detail the ways walk and talk is offered collaboratively, where clients are invited to act on their preferences and choices. Examples such as negotiating indoor or outdoor sessions, attending to practical aspects prior to the walk and talk session (i.e. location, route) and negotiating responses to unpredictable events during the walk and talk session (i.e. encountering walkers, dogs and managing interruptions) offer insight into how walk and talk is collaboratively managed. These findings support those of McKinney (2011). Collaboration in therapy is described by Berdondini, Elliott & Shearer (2012) as a deliberate and constantly evolving process that takes effort and the willingness to take risks, requiring active participation from both therapist and client in order to agree on what happens within the therapeutic encounter. Furthermore, collaboration has been consistently linked with successful therapy outcomes, irrespective of therapeutic modality (Bachelor et al, 2007). Studies further demonstrate that collaborative approaches to therapy are experienced as empowering by clients, and viewed as positively contributing to helpful outcomes of therapy (Bachelor et al, 2007; Levitt, Pomerville & Surace, 2016). Understanding the role of collaboration within the practice of walk and talk therefore offers a preliminary understanding of one of the interactional mechanisms that may underpin this therapeutic activity.

A collaborative approach includes the incorporation of client preferences into the therapeutic alliance. Findings from study 4 offers an example of how client preferences were continually integrated during the therapeutic contract, which can be seen to have contributed to the strong therapeutic alliance that was experienced, as well as the overall positive outcome of the therapy. This offers useful learning in two ways. First, the findings align with existing literature that indicates when client preferences are taken into account, clients are less likely to terminate therapy early, and are more likely to report a strong therapeutic alliance and positive outcomes (Lindhiem et al., 2014; McLeod, 2015; Swift et al., 2018). Second, it is possible that walk and talk therapy is one therapeutic activity that offers therapists an opportunity to actively and practically incorporate client preferences into their work. This can be done through communicating with clients in a transparent way about what walk and talk entails, what the therapist is offering and what clients can expect from taking part (McLeod, 2015).

Whilst studies 1, 2 and 4 offer insight into the positive features of how the therapeutic relationship can be experienced through walk and talk, study 3 offers an alternative perspective. Study 3 findings suggest that walk and talk as a therapeutic activity, could offer clients a relationship that is less formal, which was identified as potentially useful if a person felt particularly anxious or unsure about entering therapy. However, findings also indicate that for some people walking with a therapist challenged commonly held notions about what constitutes a professional relationship, and walking outside with a therapist may not offer the necessary conditions for them to engage in therapy. A main concern from findings in study 3 was the maintenance of appropriate professional boundaries within the context of an unpredictable outdoor environment (i.e. potential for interruptions, potential for being overheard or being seen in a distressed state). These findings reinforce the fact that walk and talk therapy will not fit all clients ideas of what is considered either helpful or acceptable as clients are most likely to engage in types of therapeutic activity that makes sense to them (Iselin & Addis, 2003; Kazdin, 1980; McLeod, 2012).

Findings from studies 1, 2 and 4 indicate that the integration of metaphor is a significant characteristic of conversations during walk and talk. Metaphorical connections stem from walking through the outdoor setting and are seen to invite spontaneity and increase the connections between client, therapist, setting, and the therapeutic process. This finding aligns with existing studies which report the evident use of metaphor as being a common feature between therapies which take place in an outdoor environment (Berger, 2006; Corazon et al., 2010; Jordan, 2015; McKinney, 2011). The use of metaphors is not new within the therapeutic domain. Metaphors are discussed as a (mostly) linguistic tool that can be helpful in various ways, such as communicating abstract ideas in ways that might not otherwise be possible, to make links between different ideas and to express difficult concepts in a more tangible way (Corazon, Schilhab & Stigsdotter, 2011; Hayes, Strosahl & Wilson, 2003; Minulescu, 2015; Speedy, 2000). However, a significant difference between the use of metaphor in indoor, seated therapy and walk and talk is metaphors that utilise physical movement in combination with the richness and diversity of the outdoor setting. Drawing from literature on embodied cognition and neuroscience, Corazon, Schilhab and Stigsdotter (2011) propose that the interaction of bodily activity in an outdoor setting offers a potentially useful way of enhancing explicit learning linked to a metaphor as well as broadening the context and application of the metaphor. Drawing upon the knowledge and theoretical ideas of these fields offers a useful avenue for further exploration towards understanding some of the interactional mechanisms that underpin the practice of walk and talk therapy.

Therapist Factors

For the therapists who participated in walk and talk with their clients (studies 1 and 2) there is a strong belief in the usefulness of this therapeutic activity. This personal belief has allowed the intuitive development of the practice of walk and talk in the absence of a theoretical framework or best practice guidelines. This can be seen to support the idea that therapists professional development process seeks to integrate professional and personal selves (Aveline, 2005; Rønnestad & Skovholt, 2003). Findings from studies 1 and 2 suggest that participating in walk and talk can support both client and therapist wellbeing. Therapists reported benefitting from greater level of physical activity and opportunities to be in an outdoor setting during the course of their working day, ultimately resulting in a sense of revitalisation of their professional practice, which concurs with existing research (McKinney, 2011). An important implication of this finding links to research on burnout for counselling/psychotherapy professionals.

Literature suggests that when therapists have a high degree of control over their working environment and can work in ways that increase job satisfaction and feelings of competency, this can serve as protecting factors against various form of burnout (Farber & Heifetz, 1982; Lee et al., 2011; Puig et al., 2014; Simionato & Simpson, 2018). This highlights the potential benefits for therapists in having the opportunity to develop their professional practice in ways that support their overall wellbeing and potentially reduce the risk of burnout while at the same time developing their practice in ways that align with personal beliefs and values.

Studies 1 and 2 also suggest there is a common desire for therapists to offer alternative methods in their professional practice. One potential explanation of this finding, is that it reflects current trends in the provision of psychological therapies which challenges the notion of 'one size fits all' and instead encourages practitioners to increase their therapeutic repertoire from the belief that there are multiple approaches that have value (Cooper & McLeod, 2011; Ross, 2012).

Quantitative findings from study 3 which show the different preferences people may have for their therapy, would seem to support this stance. Furthermore, findings from study 4 demonstrate the multiple ways that clients can need different things at various stages of their therapeutic process. This can be understood as an example of a pluralistic understanding of therapy process (Cooper & McLeod, 2011), and walk and talk may be one activity that fits well within this framework.

Therapists in studies 1 and 2 indicated disappointment that more clients had not requested or chose to participate in walk and talk sessions. This finding is aligned with McKinney (2011), who also reported therapists expressing challenges with finding clients willing to participate in walk and talk. Whilst McKinney (2011) offered no suggestions as to why this might be the case, this study can offer preliminary understanding of some of the concerns clients might hold

about participating in walk and talk. Understanding what concerns may be held is a useful way of identifying potential barriers of participation in walk and talk. Both quantitative and qualitative findings from study 3 indicate that some of the same aspects of walk and talk are considered both appealing and less appealing. For example, being in an open space could be facilitative of opening up and engaging in therapeutic processes and at the same time open space could raise concerns about privacy, confidentiality and managing unpredictability. Similarly, walking side by side could be facilitative of activating problem solving processes and fostering sense of wellbeing, and at the same time as getting in the way of focusing on the therapy and potentially lead to concerns about where the attention of the therapist is at.

Study 2 findings were able to offer some insight into how these different aspects are practically responded to in a way that takes professional and ethical considerations into account without negatively impacting the therapy. Furthermore, findings show that through the process of contracting with clients, a therapeutic rationale for engaging in walk and talk is collaboratively approached, which includes explicitly negotiating and agreeing how unpredictable aspects would be managed as part of the context of walk and talk therapy.

These findings can be of use in several ways. First, it would seem that a characteristic of therapists who offer walk and talk (study 1 and 2) is the ability to tolerate a level of 'not knowing' what might occur during the walk and talk session, and also be able to respond creatively to situations that might arise. This finding is in alignment with the findings of McKinney (2011) and Jordan and Marshall (2010). Second, this offers an example of how client preferences can be incorporated into therapy whilst maintaining a collaborative stance. Recent research shows that clients respond to being offered an active role in decisions making and having choice about methods of therapy being offered. Studies show that as a result, clients were more satisfied with their therapy, were less likely to drop out and overall had a more successful outcome (Swift et al., 2018).

Findings from study 4 demonstrate the importance for the client to have the ability to tolerate and accept a level of unpredictability within the walk and talk context. Whilst study 4 offers a positive example of how a client accepted these factors and was able to willingly integrate these into their experience of therapy, it is likely that not all clients would be willing or able to achieve this. Therefore, this highlights a practical way therapists can initiate a conversation about what clients could possibly expect or experience from participating in a walk and talk session, thus fostering a transparent and collaborative therapeutic relationship where clients have informed choice around participation. Taking such a stance allows for limitations of the therapeutic activity to be explicitly and openly discussed, as well as possible solutions to be found. This finding would seem to align with existing literature examples of how professional

issues are responded to and managed particularly in outdoor settings (Berger, 2006; Jordan, 2015; McKinney, 2011).

Lastly, providing clear and accessible information on walk and talk that is supported by research findings could be one way of raising the profile of this therapeutic activity. Eisenberg, Golberstein and Gollust (2007) report that raising awareness of psychological support services, may play a pivotal role in reaching client groups who may not seek counselling support, despite being in need. Barriers to accessing mental health support include, lack of knowledge about services being offered, concerns about privacy and lack of understanding concerning potential benefits (Eisenberg, Golberstein & Gollust, 2007; Tjia, Givens & Shea, 2005). Therefore, by focusing on barriers that may prevent clients taking part in walk and talk, therapists could develop ways of communicating to potential clients what they can expect, how privacy (and other concerns) is managed and potential benefits from participation. Further research on the process and outcome factors associated with walk and talk could play an important part in helping clients make an informed choice about their participation in walk and talk.

Limitations

This research aimed to explore the practice of walk and talk through investigating the experiences and perceptions of this therapeutic activity from different perspectives. There are several limitations of this research that warrant acknowledgment. Walk and talk is a therapeutic activity that introduces two new ingredients into the therapeutic relationship at the same time (i.e. an outdoor setting and the physical activity of walking). There is no way of knowing if one ingredient is more beneficial than the other or under what conditions walk and talk is most likely to be effective. Further research that focuses on the nuances of these effects is required to understand the interactional effects further.

Studies 1 and 2 reflected the experiences and beliefs of therapy practitioners who can be regarded as public “advocates” and pioneers in the use of walk and talk who were highly positive about the benefits of walk and talk therapy. It would be important for further research to find ways to investigate the circumstances (e.g., client characteristics and goals) in which walk and talk therapy is not beneficial. It seems certain that other practitioners, for example those who may have tried walk and talk and decided that it was not appropriate to their therapeutic goals or style, would contribute a different understanding of this therapeutic activity.

Studies 1 and 3 utilised on-line questionnaires which restricted the richness of information provided by participants in those studies. Although the open-ended, qualitative items in the survey questionnaire generated valuable insights, responses tended to be brief. In study 3, a

smaller number of participants chose to respond to the qualitative items, thus limiting the scope of the data further.

Whilst study 3 attempted to respond to an identified gap in the current literature, namely potential client perceptions of walk and talk therapy, the participants were comprised solely of University students with gender and age related biases. This therefore cannot be considered representative of the general population or representative of a counselling client sample. The majority of respondents were also students studying counselling/psychology related courses, therefore may have different reactions to walk and talk as a therapeutic activity compared to students studying in non-related counselling areas. Furthermore, it is likely that a different sample group (i.e. general public; young people) would contribute different attitudes or intentions about walk and talk as a therapeutic activity. However, given the lack of known research in this area, study 3 provides a base from which to develop future inquiry. Future research could also focus on perceptions of walk and talk therapy from those at the point of seeking counselling support, as it is possible intentions and perceptions may be different when in a state of psychological distress.

This research has only explored the participation of one person who has experienced walk and talk therapy as a client. A single case study does not lend itself to generalisations or act as a representative example of walk and talk therapy. Future research could address this imbalance by exploring several client's experiences of walk and talk, exploring both processes and outcomes. The client who took part in this research was very positive about this approach and their overall experience. Future research would benefit from exploring experiences of walk and talk that were not experienced as positive by clients, as a way of developing understanding of the limitations of this approach. The participant in study 4 was a motivated and experienced client. Future studies would also benefit from exploring 'novice' clients experience of walk and talk and clients for whom the decision to enter therapy may have been more conflicted. This would enable a broader and deeper understanding of the potential beneficial contexts of walk and talk that could be helpful for particular clients at specific stages of their therapy.

Despite the use of a walking interview method in study 4, little is known about the specific range of settings that walk and talk takes place within. In order to understand the ways the interactional effects of the setting act on the therapeutic process, future research would benefit in paying greater attention to this to understand if different settings result in different outcomes for clients. It is clear that further research into walk and talk methods is warranted, using a range of methodologies, such as controlled outcome studies, client experience research, and systematic single-case analyses.

Implications

This series of four connected studies has important implications for the practice of walk and talk therapy within counselling and psychotherapy contexts in two main ways. First, through contributing new knowledge and information which can serve as a starting point from which best practice guidelines can evolve. Second, it provides a further contribution of new knowledge toward developing an improved understanding of possible benefits and limitations of walk and talk therapy. Furthermore, findings from these studies offer an understanding of the scope of practice of walk and talk therapists within a UK context. For therapists who may wish to expand their therapy practice to include walk and talk, making use of the professional knowledge of those already using this approach can be a useful way of developing their own framework of practice. Clients of counselling/psychotherapy may also find it useful to know more about this approach and therefore be better positioned to make an informed choice regarding participation. These four studies provide a preliminary research base from which further empirical research can be conducted. Study 4 has also demonstrated the novel use of walking interviews within counselling and psychotherapy research. This offers further opportunities to utilise this mobile method of interviewing for future walk and talk research. With few known studies of walk and talk specifically, future research could develop more nuanced ways of investigating the specific ingredients of walk and talk and how these interact to impact process and outcomes of this therapeutic activity.

Conclusion

The four studies in this research sought to investigate the professional practice, potential client perceptions and client experiences of walk and talk therapy. Findings highlight how the activity of walking and being in an outdoor setting are harnessed in order to facilitate or maintain physical/psychological health and wellbeing. Findings from these four studies, offer new insights in how to begin to understand the practice and interactional therapeutic processes that are present in the activity of walk and talk. There are four main areas of new understanding as a result of this research.

First, this research offers insight into the professional knowledge of UK based therapists who participate in walk and talk with their clients. Findings from these studies detail the practical experience and learning that has been gained from participation in walk and talk. Therefore, a significant contribution is made towards understanding some of the interactional mechanisms that are present within a walk and talk therapy context. The findings can further serve to inform other therapists who may wish to work in in this way of the intricacies associated with this approach, highlighting areas for consideration before taking clients to walk and talk.

Second, in the first known study of its kind, potential clients have indicated their perceptions of the most and least appealing aspects of walk and talk therapy which contributes valuable understanding of potential barriers that may prevent individuals taking part in walk and talk therapy. Findings further indicate that those individuals who have a strong environmental identity or who hold positive beliefs and attitudes about walking in outdoor environments, where established coping strategies include walking and being outdoors, may be more likely to consider walk and talk as a useful therapeutic activity. These two findings are considered particularly relevant to therapists in terms of informing clients as to the potential benefits of walk and talk, as well indicating specific areas for collaborative consideration (i.e. practicalities and managing unpredictable aspects). Findings from this study imply that potential clients can identify a number of benefits that could be gained from participating in walk and talk, thus suggesting there is a degree of interest in walk and talk as a useful and acceptable therapeutic activity.

Third, a further novel contribution to understanding what occurs during the therapeutic activity of walk and talk is found through the client case study. The client experience in this thesis suggests a high degree of consensus between the therapeutic mechanisms and multi-layered relational aspects that are experienced during walk and talk when compared to the therapists' accounts. These findings taken together offer an initial starting point for developing a greater understanding of the interactional mechanisms present in walk and talk, from which future inquiry can be based upon. The case study also gives one example of how walk and talk can offer an opportunity for a different type of therapeutic exploration, that may be well suited to individuals who respond well to engaging in emotional/psychological processes through bodily movement or who prefer to be in outdoor settings.

A final novel contribution to understanding the practice of walk and talk was demonstrated through the use of the walking interview method. This mobile method, conducted at a site of walk and talk therapy allowed for an in depth, place situated narrative to be co-constructed, highlighting the significance of the interplay between setting, walking and the therapeutic alliance. Furthermore, this study promotes conceptualising walk and talk therapy within a broader relational context to include both the activity and the setting. Whilst both therapists and client experience of walk and talk indicate there is a different quality to the therapeutic relationship when participating in walk and talk, further research is needed to understand more clearly what these are and how these might influence therapeutic process and outcome.

In conclusion, this research sought to explore the practice of walk and talk therapy from three different perspectives within a UK context, thus making a preliminary contribution to the research base for this therapeutic activity. Walk and talk therapy can be seen to offer an

opportunity to participate in a therapeutic activity that brings benefits to both therapist and client. Furthermore, it offers different possibilities for those clients who may find walking in an outdoor setting a more useful context for therapeutic conversations. At a time when there is greater emphasis on wellbeing that embraces a holistic stance, early indications suggest that walk and talk is one therapeutic activity well positioned to offer a dynamic and collaborative adjunct or alternative to existing psychotherapeutic interventions.

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Appendix 1: Study 1 and 2 Ethics Application



School of Life
Sciences
Department of Psychology
Application for Ethical Approval for Research

1. Category of Applicant

- Staff Research student (PhD)
 Taught postgraduate student (MSc) Undergraduate student

Title of Module

2. Applicant's Details

Researcher's name

Researcher's contact email

Supervisor (name/email)

3. Study Details

Title of study (50 words max)

Version of application (first, second, third)

Is this application for Expert/Generic approval? Yes No

Reference number of any linked application

Outline the aims and objectives of the study (400 words max)

To conduct a study that explores current practice, perceptions, change processes and outcomes inherent within walk and talk therapy experiences. Walk and talk describes a type of counselling practice where the counsellor and client walk together outdoors during the therapy session (Hays, 1999). This can include both 1:1 'walk and talk' sessions and group therapy contexts where clients have walked/run together within a group therapy session (Hays, 1999). Reported benefits include increased personal strength, sense of wellbeing, of accomplishment and greater problem solving ability (Hays, 1999; Doucette, 2004). However, the majority of evidence remains anecdotal (McKinney, 2011). The practice of walk and talk therapy is evident in the UK but there is a lack of research on how it is received by clients, perceived by other professionals and its potential value.

Specific aims and objectives of the study are as follows:

To construct and distribute an on-line survey. This survey will be distributed to clients of walk and talk and separately to counsellors/psychotherapists who offer walk and talk therapy. This study will focus on walk and talk practice within the UK only. The survey aims to fulfill the following aims. Firstly, to get an estimate of the number of practitioners who are currently offering walk and talk within their therapy practices in the UK. Secondly, to identify what these therapists believe to be the helpful and hindering aspects of a walk and talk approach. Thirdly, to ask walk and talk therapists to share their knowledge of any theories that inform/underpin their walk and talk practice. Additionally, clients who have experienced walk and talk therapy will be asked what they believe to be the helpful and hindering aspects of this approach and to identify what, if any, aspects of walk and talk therapy help facilitate change for them.

4. Research Participants and Recruitment

Indicate here the population(s) from which you intend to sample, and your proposed method of recruitment. List any inclusion and exclusion criteria. Attach copies of any materials (e.g., letter, email, poster) you plan to use to help recruit participants.

All participants for the study will be adults aged over 18 years of age.

The two focuses within this study are as follows:

Counsellors Perspectives: Initial desk research has identified approximately 30 to 50 qualified UK based counsellors who are currently offering walk and talk within their therapy practice. I am aiming for around 30 respondents from this population. Participants will be recruited from advertisements within notice board sections on Counselling and Psychotherapy organisations websites (eg British Association of Counselling and Psychotherapy (BACP), UK Council for Psychotherapy (UKCP), Person Centred Therapy Scotland etc). An advertisement in the BACP Therapy Today magazine will also be placed. (See Appendix 1). The use of counselling/psychotherapy organisations to advertise this study is chosen in order to reach a large cross section of the counselling/psychotherapy profession as possible. In addition to notices on public forums, a desk study will identify walk and talk practitioners and individual emails introducing the study and inviting participation will be sent to counsellors/psychotherapists in private practice who identify themselves as offering walk and talk therapy. (See Appendix 2). A snowballing recruitment method will also be used within the above recruitment strategies, as potential participants will be asked to forward details of the study onto other interested and relevant parties. Additionally, participants who take part in the on-line questionnaire will be invited to leave their details to be contacted for a follow up interview. Separate information and consent forms will be provided for interviews (See Appendix 3). Inclusion criteria: qualified counsellors/psychotherapists who offer individual walk and talk therapy sessions to their clients. Walk and talk will be defined as "individual counselling/psychotherapy sessions where some or all of the contracted sessions have taken place in an out-of-doors setting where both the client and counsellor walk during the therapeutic hour". Exclusion criteria: other professionals who may utilise walk and talk with their clients (i.e. occupational therapists, teachers, life coaches etc); professionals who facilitate group walk and talk sessions; individuals outside the age criteria.

Client Perspectives: Participation for this study will be sought from individuals who have experienced walk and talk therapy as a client. Participants will be recruited from advertisements within notice board sections on Counselling and Psychotherapy organisations websites (eg British Association of Counselling and Psychotherapy (BACP), UK Council for Psychotherapy (UKCP), Person Centred Therapy Scotland etc). An advertisement in the BACP Therapy Today magazine will also be placed. (See appendix 4). This recruitment strategy has been adopted as it is anticipated that there is a large number of counsellors/psychotherapists who may have experienced walk and talk therapy as a client prior to offering it within their own practice. In addition, a snowballing recruitment strategy will be used by asking counsellors/psychotherapists who offer walk and talk (as contacted in the previous study) to pass details of this study onto their clients for consideration to participate. Additionally, participants who take part in the on-line questionnaire will be invited to leave contact details to be contacted for a follow up interview. Separate information and consent forms will be provided for interviews (see Appendix 5)

5. Methodology and Procedure (400 words max.)

Provide a brief overview, and attach any relevant materials (e.g., questionnaires, electronic links).

On-Line Questionnaire

A mixed method approach will be used within this study, which will combine both qualitative and quantitative methods. The on-line questionnaires will be conducted through the 'Bristol On-line Survey' (BOS) site. The questionnaire contains 21 questions that is anticipated will take about 10 - 15 minutes to complete. The first two 'pages' of the questionnaire provide information on the title and purpose of the study, for whom the questionnaire is intended, what can be expected through participation. Potential risks/discomforts and where participants can go for further support is also described, along with details on how confidentiality will be maintained and that participants can exit at any time. The third page gives information necessary in order for participants to indicate their explicit consent in order to access the questionnaire. The questionnaire begins with general demographic questions and questions intended to provide an overview of the context and setting of walk and talk therapy sessions. Questions that relate to specific helpful and hindering aspects of walk and talk follow, with the questionnaire concluding with an invitation for respondents to leave their e-mail address to be contacted with information for further participation in a follow up interview. Once questionnaire responses are submitted, the final page thanks respondents for their participation and informs respondents that the questionnaire is complete and they can now exit the survey. Both questionnaires (client and therapist) have been piloted with colleagues of the researcher and feedback has been given. No major issues were raised through this process.

See the following links for each questionnaire:

Walk and Talk Counsellors/Psychotherapists - www.survey.bris.ac.uk/cumbria/walkandtalktherapistpilot2

Walk and Talk Clients - www.survey.bris.ac.uk/cumbria/walkandtalkclientpilot2

Follow-Up Interviews

Follow up interviews will be conducted with participants who completed the on-line survey and who voluntarily left their contact details, indicating an interest in participating in an interview. In the first instance respondents will be sent via email information on what the follow up interview will involve along with a consent form which they will indicate their verbal consent prior to the commencement of the interview (see appendix 3 & 5). It is anticipated interviews will take place via phone or Skype and will last around 30 minutes. Interviews will be audio recorded and the researcher will conduct them from their own home where confidentiality and privacy can be upheld. See appendix 11 for an example of the interview schedules for both therapist and client participants.

Check all that apply

Questionnaires (please attach copies of each in the format they will be presented to participants)

Interviews (please attach summary topics to be explored or interview schedule)

Focus Groups (attach materials and /or summary of topics to be explored)

Experimental /Laboratory (attach details)

Do you intend to use questionnaires or other materials that are copyright? Yes No

If 'Yes' has permission to use these materials been purchased/assigned? Yes No

Will participants receive any compensation, reimbursement or payment for their participation (including course credits)? Yes No

Do you require a Disclosure certificate to undertake this research?

Yes No

6. Risk

Please outline below the key ethical/ risk issues associated with this study, and indicate how these will be addressed (400 words max).

Study 1: Clients of Walk and Talk Therapy - There is a low likelihood that participating in this questionnaire and follow up interview, feelings of discomfort may be raised. Participants will be advised that they can contact a qualified counsellor, Margaret Rock (margaret.rock@cumbria.ac.uk), who will be able to assist them in accessing further appropriate support (i.e. through British Association Counselling and Psychotherapy (BACP) 'Find a Therapist' search, NHS 24 etc). This is also stated on the participant information sheet. Additionally, prior to the follow up interview, participants will be informed that the focus of the interview will be on general perceptions of walk and talk therapy and will not be focusing on on-going issues raised in their therapy sessions. Additionally, that the interview will be stopped at any point if the participant starts to show signs of distress or emotional upset. Contact details for NHS 24, Samaritans, BACP will be offered and the interview will terminate.

Study 1: Therapists offering Walk and Talk - As the questions asked in this questionnaire and follow up interview, relate to professional experiences of offering walk and talk, there is low likelihood of discomfort to participants. Participants are advised that they can contact a qualified counsellor, Margaret Rock (margaret.rock@cumbria.ac.uk) who will be able to assist them in accessing further support. Counsellors will also be advised to contact their supervisor for further support if needed.

Is there a risk of any participants experiencing either physical or psychological distress or discomfort as a result of taking part in the study?

Yes Possibly No

If 'Yes' or 'Possibly' please attach a risk assessment form.

Will researcher(s) be at any risk of sustaining either physical or psychological harm as a result of involvement in the study?

Yes Possibly No

If 'Yes' or 'Possibly' please attach a risk assessment form.

6. Ethical principles incorporated into study

Additional oral explanation for participants (please attach script)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Consent form (please attach a copy)	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Additional oral consent	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Participants offered opportunity to decline to take part	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Participants told participation is voluntary	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Participants offered opportunity to withdraw at any stage	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Expert advice available if required	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Participants informed there may be no benefit to them	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Participants guaranteed confidentiality	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Participants guaranteed anonymity	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Provisions of the Data Protection Act met	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Safe data storage secured	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

If the procedure involves deception, will explanation be offered
following participation?

Yes No N/A

If the procedure involves observation, will consent be obtained
from participants?

Yes No N/A

If the procedure involves questionnaires, will the participants be
informed that they may omit any items they do not wish to answer?

Yes No N/A

If the procedure involves interviews, will the participants be
informed that they do not have to answer, and do not have
to give an explanation for this?

Yes No N/A

7. Applications to external ethics committees

Please note that approval should normally be obtained from the Psychology Ethics Subcommittee before making applications to external committees.

Will an application be made to an external ethics subcommittee? Yes No

If 'Yes', please complete and attach the form 'Submission of a Research Proposal for External Scrutiny'.

8. Applicant's Declaration

I declare that the proposed investigation described in this application will be carried out as detailed and that if any changes to the procedures are planned, written permission will be sought from the Psychology Ethics Subcommittee.

Applicant: <u>Stephanie Revell</u>	Date: 04/04/2013
Supervisor: <u>Dr. Elaine Duncan</u>	Date: <u>4/4/2013</u>

9. Supervisor's Declaration

I declare that I have read the application carefully, including appendices, and I am satisfied that it meets the required standards.

Have you included... ?	Included	Supervisor's Initials (Approval)
Completed copies of this form		
Signatures		
Consent form		
Information sheet		
Copies of all questionnaires		
Outline of interview topics		
Stimulus materials		
Any other materials required		
Letters from organisations indicating permission has been granted to co-operate with study		

Appendix 2: Study 1 Recruitment Notice

I am a student within the Psychology department at Glasgow Caledonian University, and I am conducting this study as part fulfilment of a PhD award. I am currently conducting two studies exploring the practice of walk and talk therapy. The purpose of the first study is to identify the number of counsellors/ psychotherapists who are currently offering walk and talk therapy sessions within their therapy practice in the UK and what is seen as the helpful and hindering aspects of this approach from a practitioner perspective.

Therefore, I am looking for qualified counsellors/psychotherapists who are either currently offering or have offered walk and talk therapy sessions to individual clients to take part in this study by completing an on-line questionnaire. I would be very grateful if you would consider taking part in my study. If you are interested, please click on the link below to access further information. By clicking on the link you will be under no obligation to take part.

www.survey.bris.ac.uk/cumbria/walkandtalktherapist

The purpose of the second study is to explore client's experiences of walk and talk therapy and what clients view as the helpful and/or hindering aspects of this approach. Therefore, I am looking for individuals who have experienced walk and talk therapy as a client to take part in this study by completing an on-line questionnaire which can be accessed via the link below. Individuals do not need to be currently involved in walk and talk therapy to take part nor will they be asked to disclose personal information about the content of their therapy sessions or the identity of their therapist.

I would be grateful if you would consider passing on details of my studies to any suitable parties. The link for my second study is below:

www.survey.bris.ac.uk/cumbria/walkandtalkclient

Alternatively, you can contact me via email at Stephanie.revell@gcu.ac.uk for further information. These studies are supervised by Dr Elaine Duncan and she can be contacted at e.duncan@gcu.ac.uk. The use of email to recruit participants for this study has been approved by the Psychology Ethics Subcommittee.

Thank you,

Stephanie Revell

Appendix 3. Study 1 Online Questionnaire

Welcome!

Welcome to therapists perspectives of helpful and hindering aspects of walk and talk therapy questionnaire.

The purpose of this study is to explore therapists experiences of walk and talk therapy as part of a PhD study at Glasgow Caledonian University.

The following pages contain further information to enable you to make an informed decision about your participation in this study. Please take the time to read the information and if you are willing to take part you will be required to indicate your explicit informed consent.

We are looking for qualified counsellors/psychotherapists who have offered 'walk and talk' therapy to clients on a 1:1 basis in a counselling/psychotherapy relationship. You do not need to be currently offering 'walk and talk' sessions in order to take part.
(Please note -- this study will not be exploring experiences of walk and talk therapy from NHS-based settings as separate ethical approval is required for this.)

For the purpose of this study, the use of the term 'walk and talk therapy' will be used when referring to individual counselling/psychotherapy sessions where some or all of the contracted sessions have taken place in an out-of-doors setting where both the client and counsellor walk during the therapeutic session.

The term therapist refers to both counsellor and/or psychotherapist

The term therapy includes both counselling/psychotherapy

If the above definitions fit with your experience, please continue by clicking on the 'continue' button below. If not, thank you for your time and you can now exit this survey.

Note that once you have clicked on the CONTINUE button at the bottom of each page you can not return to review or amend that page

Further Information

If you decide to take part in this study you will be invited to answer questions relating to your general experiences of offering walk and talk therapy to clients as a therapist. You will not be asked to disclose personal or sensitive information regarding the client content within the therapy sessions. The questionnaire should take around 10-15 minutes to complete.

Questions are best completed in one sitting. You are under no obligation to fully complete the questionnaire and your participation is entirely voluntary. You can exit at any point.

The data resulting from this study may be used for other publications or studies at some point in the future, and any quotes or comments used will be anonymous with identifying information removed.

In the unlikely event feelings of discomfort are raised as a result of taking part in this survey, you can contact Margaret Rock (margaret.rock@cumbria.ac.uk) who can assist you in accessing further support.

It is anticipated that the results of this study will increase awareness of walk and talk therapy provision in the UK and enable a greater understanding of what therapists who offer this form of therapy find helpful and hindering about this approach.

If you have any questions or concerns about any aspect of this study you can contact the researcher by email at: Stephanie.revell@gcu.ac.uk or the Director of studies ~~Dr~~ Elaine Duncan at: edu@gcu.ac.uk

Consent

All information gathered will be used for research purposes only. The resultant data will be stored in accordance with the Glasgow Caledonian University's Data storage procedures.

The data which results from this study will be stored securely by the researcher for the duration of this research.

Unless you choose to submit a contact email address at the end of the questionnaire, it will not be possible for me to identify individual respondents with their responses. In the event you do choose to give your contact details, these will be kept confidential and will not be used for any purpose ~~outwith~~ this present study.

Due to the electronic nature of this questionnaire, it cannot be absolutely guaranteed that respondents are not traceable somehow, however no ISP addresses or other information will be stored from the provider of this questionnaire.

Please read the following statements to indicate your informed consent. You will be required to tick the 'I agree' option at the bottom of the page in order to gain access to this survey. If you do not wish to give your consent, thank you for your time and you can now exit this survey.

Consent

1. - I confirm that I have read and understood the welcome and further information pages

- I have had a chance to think about the information, and was able to contact the researchers for more details if I wished (even if I did not make this contact).

- I understand that my responses to this questionnaire will be included in the results, and will therefore be represented in the final report. The results may also be published elsewhere. However, it will not be possible to identify me in any way from these results.

- I understand that any information that I give that might identify me will be held securely and will not be disclosed to anyone outside of the research team.

- I am over 18 and I am aware of what participating in this study involves, including any potential risks

- I agree to take part in this study by answering some or all of the questions in this questionnaire.



I agree to take part in this study

Please answer the following questions

2. Please indicate your gender

- Male
- Female

3. Please indicate what age range you are in

- 18 - 30
- 31 - 45
- 46 - 60
- 61 +

4. Are you currently offering walk and talk therapy sessions to individual clients?

- Yes
- No

5. When was the last time you participated in a walk and talk therapy session with a client? (i.e. one week ago, two months ago)

The following questions relate to your professional background

6. Which of the following titles best describe your professional identity? (Please choose one only)

- Counsellor
- Psychotherapist
- Counselling Psychologist
- Clinical Psychologist
- Other (*please specify*):

7. How long have you been qualified in this role? (as identified in previous question)

- Less than one year
- Between 1 - 3 years
- Between 3 - 5 years
- Between 5 - 8 years
- Between 8 - 10 years
- More than 10 years
- Other (*please specify*):

8. How long have you been offering walk and talk therapy sessions to clients?

- A month or less
- Between 1 - 6 months
- Between 6 - 12 months
- Between 1 - 2 years
- Between 2 - 4 years
- More than four years
- Don't know
- Other (*please specify*):

9. Please indicate which of the following therapeutic orientations informs your work with walk and talk clients

(*select all that apply*)

Cognitive Behavioural therapy (CBT)

Transactional Analysis

Person Centred

Gestalt

Psychodynamic

Integrative

Other (please specify)

The following questions relate to your past and/or current experiences of offering walk and talk therapy

10. Generally, how long do your walk and talk sessions last for?

Up to one hour

Between 1-2 hours

Between 2-4 hours

More than 4 hours

Other (please specify):

11. Which of the following settings do you encounter during your walk and talk therapy sessions?
(select all that apply)

Forest / Woodland

Lake

Countryside

River

Urban park

- Uplands
- Mountains
- Streets (City)
- Streets (Town/Village)
- Other *(please specify)*:



12. Please indicate which of the following factors contributed toward your decision to offer walk and talk therapy sessions to clients
(select all that apply)

- A client requested walk and talk sessions
- I have experienced walk and talk therapy as a client
- My personal beliefs about the outdoors/walking
- I have read research that supports the use of walk and talk within therapy
- I wish to offer a variety of methods in my therapeutic work with clients
- I have seen other therapists advertise offering walk and talk
- Other *(please specify)*:



The following questions will focus specifically on what you find helpful or important about walking and being outdoors during your therapeutic work with clients

13. As a therapist, what do you consider to be most helpful or important about the **walking element within walk and talk therapy sessions?**

Please describe below.

14. Overall, how helpful have you found the **walking** element within walk and talk therapy sessions?

Neutral

- Slightly helpful
- Moderately helpful
- Greatly helpful
- Extremely helpful

15. As a therapist, what do you consider to be most helpful or important about the **outdoor** element within walk and talk therapy sessions?

Please describe below.

16. Overall, how helpful have you found the **outdoor** element within walk and talk therapy sessions?

Please rate on the scale below.

- Neutral
- Slightly helpful
- Moderately helpful
- Greatly helpful
- Extremely helpful

The following questions relate to any hindering aspects of walking and being outdoors that you may have encountered during your walk and talk therapy sessions

17. As a therapist, what (if anything) have you found hindering about the **walking** element within walk and talk sessions?

Please describe below.

18. Overall, how hindering have you found the **walking** element within walk and talk therapy sessions?

Please rate on the following scale.

Not at all hindering

- Slightly hindering
- Moderately hindering
- Greatly hindering
- Extremely hindering

19. As a therapist, what (if anything) have you found hindering about the **outdoor** element within walk and talk therapy sessions?

Please describe below.

20. Overall, how hindering have you found the **outdoor** element within walk and talk therapy sessions?

- Not at all hindering
- Slightly hindering
- Moderately hindering
- Greatly hindering
- Extremely hindering

21. The following statements are some of the suggested benefits of Walk and Talk therapy.

With reference to your client work, please choose a response that best indicates to what extent you agree or disagree with each statement.

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
a. Walking and talking during a therapy session helps clients to get 'unstuck'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Walk and Talk therapy encourages deeper ways of thinking	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
c. Walking side by side with a	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

client helps them to open up					
d. Lack of eye contact is more comfortable for the client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Clients resolve issues quicker through walk and talk therapy compared to indoor seated therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Walking together during Walk and Talk therapy promotes equality in the therapeutic relationship	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Walk and Talk therapy strengthens clients connection between body and mind	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Walk and Talk therapy is less intimidating for clients compared to indoor seated therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Through Walk and Talk therapy the overall counselling process is enhanced	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Walk and Talk therapy improves physical fitness of the client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Clients achieve a greater sense of overall wellbeing through Walk and Talk therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Being outdoors during a therapy session enhances the therapeutic process	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. The process of clients <u>self discovery</u> is promoted in a more holistic way through Walk and Talk therapy	<input type="radio"/>	<input type="radio"/>			

These questions relate to how you have experienced Walk and Talk therapy in your professional role as a therapist

22. The statements below indicate some common experiences of therapists who offer Walk and Talk therapy to clients

With reference to your own client work, please choose a response that best indicates to what extent you agree or disagree with each statement

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
a. I generally feel invigorated when doing Walk and Talk therapy sessions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I generally have no trouble being focused on my client during Walk and Talk sessions	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
c. Offering Walk and Talk therapy sessions has reduced my own stress levels	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I generally have clear thought processes during Walk and Talk therapy sessions	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
e. I believe that offering a variety of therapeutic experiences (such as walk and talk) is useful to clients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. I am physically fitter since starting Walk and Talk sessions with clients	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
g. Offering Walk and Talk therapy has been beneficial for my professional development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I sometimes get distracted by things happening in the environment during Walk and Talk sessions	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
i. I find Walk and Talk sessions mentally demanding to do with	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

clients					
j. I do some of my best therapeutic work during Walk and Talk sessions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. I believe that Walk and Talk therapy offers mutual benefits to both client and therapist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions

23. Overall, to what extent has offering walk and talk therapy been helpful or hindering for you as a therapist?

- Extremely hindering
- Greatly hindering
- Moderately hindering
- Slightly hindering
- Neutral
- Slightly helpful
- Moderately helpful
- Greatly helpful
- Extremely helpful

24. Do you have any further comments you would like to make about walk and talk therapy and/or your participation in this research?

Follow-Up interview

Thank you for taking part in this study. Your participation is appreciated.

I would like to follow up this questionnaire by conducting some short telephone/skype interviews that will take around 30 minutes and be conducted on a day/time that is mutually convenient. I am looking for volunteers who would be willing to discuss their experiences of offering walk and talk therapy with me in more detail.

Should you wish to consider taking part in a follow up interview, please leave a contact email address below and I will send you further details of the interview process. By leaving your contact details, you will be under no obligation to take part. You will be provided with a seperate consent form prior to the interview taking place and you will have the right to withdraw your participation at any point.

If you would prefer to contact me directly to request further information about participating in a follow-up interview, you can do so by emailing me on; stephanie.revell@gcu.ac.uk
If you do not wish to consider taking part in a follow-up interview, you can just leave this section blank.

Register interest in taking part in a follow up interview

25. By leaving a contact email address below, I am indicating an interest in being sent further information about the follow-up interviews. I understand my details will not be used for any other purpose.

Thank You!

Thank you for taking the time to participate in this study. Your contribution is valued. I would be grateful if you would consider passing the web link of this questionnaire onto other therapists you know who might be interested in taking part.

www.survey.bris.ac.uk/cumbria/walkandtalktherapist

I am also conducting a similar study, looking at helpful and hindering aspects of walk and talk from clients perspectives and am seeking volunteers to take part. Participation involves completing an on-line questionnaire and I would be grateful if you would consider forwarding the following link on to any relevant parties. For further information see;

www.survey.bris.ac.uk/cumbria/walkandtalkclient

If you require any further information or would like to discuss this study further, you can contact me on: stephanie.revell@gcu.ac.uk

Thank you.

Appendix 4: Study 2 Participant Information Sheet

TITLE OF STUDY:

Helpful and/or hindering aspects of walk and talk therapy –
Therapists perspectives

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

INVESTIGATORS:

Researcher – Stephanie Revell (PhD student)

Director of Studies – Dr. Elaine Duncan (Glasgow Caledonian University)

What is the purpose of this study?

To develop a greater understanding of the practice of walk and talk therapy within the UK and to identify the helpful and hindering aspects of this approach from therapists perspectives. This study is part of a PhD project.

Do I have to take part?

No, it is up to you to decide whether or not to take part and complete the interview. You are under no obligation to disclose any intimate or personal material. You are free to withdraw from the study at any time without having to provide a reason for doing so. In addition you will have certain editing rights during the recorded interview, for example if you wish to retract something you have just said it will be wiped from the recording.

What does taking part involve?

Taking part will involve a 30 minute telephone or Skype interview that will be recorded. The questions that will be asked in the interview relate to your own experience of taking part in walk and talk therapy sessions with clients and what you believe are the helpful and hindering aspects of this approach. You will not be asked to disclose

any personal or sensitive information relating to your clients or thecontent of your therapy sessions.

What are the possible disadvantages and risks of taking part?

There is a very small risk that through participating in this questionnaire, feelings of discomfort may be raised. If you would like support as a result of participating in this research, you can contact a qualified counsellor Margaret.rock@cumbria.ac.uk who will assist you in accessing appropriate further support.

What are the potential benefits to me of taking part?

There are no direct benefits to you from taking part. However, your views and experiences and those of others will be used to contribute to the knowledge base of this developing and emergent therapeutic practice within the UK.

Will my taking part in the study be kept confidential?

Yes. The responses that you provide will be treated in confidence. Your rights are protected under the Data Protection Act and any information that might identify you will not be shared outside of the research team (namely the researcher and their supervisory team). The resultant data will be stored securely in accordance with Glasgow Caledonian University's Data storage policy.

What will happen to the results of the research study?

The data resulting from this study will be recorded and may be used for other publications or studies at some point in the future, and any quotes or comments used will be anonymous with all identifying information removed.

Will I need to sign any documentation?

You will be asked to sign a consent form before participating in the study.

Whom should I contact if I have any further questions?

Please contact the researcher directly – Stephanie Revell at: Stephanie.revell@qcu.ac.uk or the Director of studies, Dr. Elaine Duncan at: edu@qcu.ac.uk

Appendix 5: Study 2 Participant Consent

CONSENT FORM

HELPFUL AND HINDERING ASPECTS OF WALK AND TALK THERAPY – THERAPIST’S PERSPECTIVES

Researcher: Stephanie Revell

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. I am also under no obligation to answer all questions that are asked and I do not have to give a reason for this.
3. I understand that my responses within the interview will be included in the results, and will therefore be represented in the final report. The results may also be published elsewhere. However, it will not be possible to identify me in any way from these results.
4. I understand that any information that I give that might identify me will be held securely and will not be disclosed to anyone outside of the research team.
5. I agree to take part in the above study.
6. I consent to the recording of the interview.

Name of participant

Date

Signature

Appendix 6: Study 2 Interview Questions

Interview Questions

- What are the main theoretical orientations that inform your therapy practices as a whole – and specifically, which approach/s do you use when doing Walk and Talk?
- Can you give a general summary of your experiences of offering walk and talk therapy sessions (i.e. when did you start offering them, are you currently offering them, about how many clients have you done walk and talk with, how frequent were/are the sessions, how many do you generally do in one day?)
- What has taking part in walk and talk therapy sessions with clients been like? How has it felt/did it feel to be doing it?
- What changes (if any) have you noticed in yourself as a therapist since offering walk and talk therapy?
- What aspects of walk and talk therapy do you feel contribute to the change process for clients? Have any of these changes been different from how clients seem to change in indoor sessions?
- Are there any changes in your practice that you wanted from walk and talk therapy that hasn't happened?
- What has been helpful for you as a therapist about offering walk and talk therapy? (i.e. general aspects, specific events including both what others did and what you did)
- What kinds of things about walk and talk therapy have been hindering, unhelpful, negative or disappointing for you? (e.g. specific events, general aspects)

- Have you experienced any barriers in offering/conducting walk and talk therapy? (i.e. client perceptions, other therapists perceptions, logistical issues)
- How would you describe the reactions you have had from other professionals/colleagues when talking about your W&T practice?
- Do you know/ are you in contact with any other therapists who offer walk and talk therapy?
- Are there things that have been difficult for you but still Ok or perhaps helpful in offering walk and talk?
- Do you have any suggestions about how walk and talk therapy could be offered or developed?
- Are there any specific theories that you have used to inform your walk and talk practice?
- Is there anything else that seems important to know about your experience of walk and talk?

Appendix 7: Study 3 Ethics Application



FACULTY OF SOCIAL AND APPLIED SCIENCES FACULTY RESEARCH ETHICS COMMITTEE

APPLICATION FOR FREC APPROVAL

Please type your application. Remember that applications must be printed out, authorised, and then one hard copy sent to: Roger Bone (Research Office and Graduate School) together with an emailed copy to roger.bone@canterbury.ac.uk

For Faculty Office use only
FREC Protocol No: <i>/SAS/</i> Date received:

Your application **must** comprise the following documents (please tick the boxes below to indicate that they are attached):

Peer Review Form

Application Form

Declaration Form

Risk Assessment Form

Copies of any documents to be used in the study:

Questionnaire

Introductory letter(s)

Participant Information Sheet(s)

Consent Form(s)

Data Collection Instruments

Focus Group Guidelines

Other (please give details) Study is conducted online with all relevant material (information sheet etc) attached to this site:



**FACULTY OF SOCIAL AND APPLIED SCIENCES
FACULTY RESEARCH ETHICS COMMITTEE**

APPLICATION FOR FREC APPROVAL

Please type your application. Remember that applications must be printed out, authorised, and then one hard copy sent to: Roger Bone (Research Office and Graduate School) together with an emailed copy to roger.bone@canterbury.ac.uk

Please ensure that you have answered all questions.

For Committee use only

FREC Protocol No: ***/SAS/***

Date received:

1. RESEARCHER(S) ***Stephanie Revell***

1a. LEAD RESEARCHER

Name: ***Stephanie Revell***

Department: ***Psychology***

Email: ***s.revell507@canterbury.ac.uk***

Previous experience of research on human participants:

MSc and first study related to this PhD (this is the second study)

1b. SUPERVISOR

Name: ***Dr. Joe Hinds***

Email address: ***joe.hinds@canterbury.ac.uk***

2. STUDY TITLE: ***Walk and Talk therapy – how students attitudes to help seeking behavior and preferences for therapy can inform practice.***

3. **OTHER RESEARCHERS/COLLABORATORS** *(please note their employer if they are not employees of CCCU) N/A*
4. **Intended start date: January 2015**
5. **Projected date of completion: May 2015**
6. **RESEARCH SPONSOR/OTHER ORGANISATIONS INVOLVED: N/A**
If your study involves another organisation, please provide details. Evidence that the relevant authority has given permission will be needed (i.e. a letter).
7. **OTHER ETHICS COMMITTEE APPROVAL** *(Has the proposed study been submitted to any other reviewing body? If so, please provide details). N/A*
8. **LAY SUMMARY (NO MORE than 300 words)**

Walk and talk describes a type of counselling practice where the counsellor and client walk together outdoors during the therapy session (Hays, 1999). This can include both 1:1 'walk and talk' sessions and group therapy contexts where clients have walked/run together within a group therapy session (Hays, 1999). Reported benefits include increased personal strength, sense of wellbeing, of accomplishment and greater problem solving ability (Hays, 1999; Doucette, 2004). However, the majority of evidence remains anecdotal (McKinney, 2011). There are a growing number of therapists in the UK who offer walk and talk despite relatively few clients who request it. This disparity suggests more needs to be understood about clients preferences for therapy and how therapists might respond to these.

9. PURPOSE OF THE STUDY

This study aims to explore three key areas. Firstly, to understand help seeking behavior, secondly to explore individual preferences as relating to counselling/psychotherapy and thirdly, to explore the extent to which individuals identify with the natural environment. By exploring the interconnectedness of these three key areas, it is anticipated that more can be known about how relevant the counselling activity of 'walk and talk' might be for potential clients and this in turn can inform practice development.

10. STUDY DESIGN, METHODS AND DATA ANALYSIS *(please outline in brief)*

A mixed method approach will be used within this study, which will combine both qualitative and quantitative methods. An on-line survey will be conducted and hosted by Qualtrics. The questionnaire contains 13 main questions that is anticipated will take 10-15 minutes to complete. Three validated measures have been utilized in the construction of the questionnaire and adapted for the purpose of this study. The General Help Seeking Questionnaire (GHSQ) (Rickwood, Deane, Wilson & Ciarrochi, 2005) consists of 10 items rated on a 7 point likeart scale from 1 (Extremely unlikely) to 7 (Extremely likely) and is designed to measure help seeking intentions. The adapted Psychotherapy Preferences and Experiences Questionnaire (PEX-P1) (Clinton & Sandell, 2011) consists of 17 statements expressing preferences that individuals can have at the start of counselling/psychotherapy. Participants are asked to rate to what extent each statement would apply to them using a 6 point Likert scale from 1 (Not at all like me) to 6 (Completely like me). Lastly, the Environmental Identity Scale (Clayton, 2003) contains 10 items rated on a 5 point Likert scale from 1 (strongly disagree) to 5 (strongly agree). The scale is designed to measure the extent to which individuals identify with the natural environment.

Qualitative data will be analysed using thematic analysis whilst the quantitative data will be analysed using hierarchical regression. Purposeful sampling of H.E. students across 5 UK Universities will be employed.

11. WHO ARE THE REQUIRED PARTICIPANTS FOR YOUR STUDY?

Current part-time or full-time Higher Education students in the UK aged 18 and over.

12. HOW WILL PARTICIPANTS BE RECRUITED?

Invitations to participate in this study will be sent via email - with the link attached so potential respondents can access the questionnaire on-line. The researcher will use existing networks available to access the targeted population of students. In addition, notices will be placed on various research forums such as British Association for Counselling and Psychotherapy (BACP) research notice board and the British Psychological Society research forum.

Participants from another CCCU Faculty

Will you be recruiting STAFF or STUDENTS from another Faculty? If so, which Faculty?

IMPORTANT: If you intend recruiting participants from another Faculty, this form must be copied to the Dean of the Faculty concerned, and to the Chair of that Faculty's Research Ethics Committee.

13. SELECTION CRITERIA (Inclusion and exclusion criteria)

Participation is sought from current students aged 18 years old and over based at a UK University. No other inclusion or exclusion criteria apply. Participants will self select to take part in this study.

14. CONSENT

14a. How will consent be obtained? *(attach copies of any information sheet(s) and consent forms that will be used)*

Participants will be required to read two 'screens' of information about this study and will be required to indicate their explicit consent prior to being able to access the questionnaire. *(see questionnaire)*

14b. Will the participants be from any vulnerable groups? *(Tick as appropriate)*

Those under 18

Those with any form of learning difficulties

Those who may have a particularly dependent relationship with the researcher (e.g. students)

Any other vulnerable group (please give details)

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

14c. How will you ensure that vulnerable participants are competent to consent to take part? *(Please attach any correspondence to parents, guardians, carers, keyworkers etc.)*

Participation is sought from individuals aged 18 and over. I will not specifically be targeting vulnerable groups nor asking sensitive questions. As participants will self select, it cannot be guaranteed that those with any form of learning difficulties or from other vulnerable groups will not access the study. By asking participants to indicate their explicit consent prior to taking part it has to be assumed that they are competent enough to take part.

14d. Is there anything that might make it difficult for people to refuse to take part in the study (e.g. the potential participants are students or colleagues of the Researcher)? How will you address this?

It is not anticipated that anything will make it difficult for participants to refuse to take part. Participation is voluntary and results are anonymous.

Participants have the choice to click on the link to access the questionnaire and can exit at any point.

15. PARTICIPANT'S INVOLVEMENT: RISKS, REQUIREMENTS AND BENEFITS

15a. What potential hazards, risks or adverse effects associated with the study?

In the unlikely event feelings of discomfort are raised, all participants will be directed to their HE institutions Student Support services. In addition, a web address to the British Association of Counselling and Psychotherapy's 'Find a Therapist' page will be given where they can access further appropriate support. This will be stated on both the participant information pages prior to accessing the questionnaire and on the final screen after participation.

15b. Has a full risk assessment been carried out in line with University Health & Safety procedures? If NO please explain why.

This is an on-line study and participants will take part in locations for their choice.

15c. Will group or individual interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting? If so, please list and explain how you will prevent, or respond to, volunteer discomfort.

Participants will be asked for their attitudes towards preferences for counselling/psychotherapy and for information relating to help seeking behaviours. Whilst this is asking questions associated with potentially sensitive topics – participants will not be asked to disclose any sensitive, embarrassing or distressing information.

15d Is it possible that criminal or other disclosures could be made by participants in the study that require action (e.g. evidence of professional misconduct)? What procedures will be put in place to deal with these issues?

It is not anticipated nor deemed likely that disclosures could be made by participants.

15e. Please describe any expected benefits to the research participant.

There are no identified expected benefits to the research participants.

15f What circumstances might lead to premature termination of the study in part or as a whole? Please include an explanation of how you will deal with the remaining participants in this event.

In the event the researcher is unable to continue with PhD studies, and this leading to a premature termination of this study the on-line survey will be removed and all data will be destroyed. As participants will self

select 'in the moment' there will not be any 'remaining' participants to deal with.

16. FINANCIAL INCENTIVES, EXPENSES AND COMPENSATION

16a. Is any financial or other reward (e.g. travelling expenses) to be given to participants? If yes, please give details and justification.

None

16b. Will the study result in financial payment or payment in kind to the department? Please specify, including the amounts involved.

None

17. CONFIDENTIALITY, ANONYMITY AND DATA STORAGE

17a. What steps will be taken to ensure confidentiality? Give details of the anonymisation procedures to be used, and at what stage they will be introduced.

This is an anonymous on-line questionnaire. It will not be possible to identify individual participants. Participants have full anonymity from the start of the questionnaire. It will not be possible to identify any participants from any of the quantitative data as all responses will be used together for stastical analysis purposes. Any qualitative data which might be deemed to identify an individual will be anonymized before inclusion in any report and/or dissemination. As no names or other identifying information is sought from participants, confidentiality is not applicable.

17b. Who will have access to the records and resulting data?

The researcher and supervisory team will have access to the resulting data through the on-line survey host - Qualtrics.

17c. Where, and, for how long, do you intend to store the consent forms and other records?

Consent forms are integrated within the on-line survey document and will not contain any personal information of participants. Resultant data will be stored securely on a password protected pendrive by the researcher and stored securely in a locked filing cabinet. Data will be kept for the duration of the PhD study - which is anticipated to be 4 years.

17d. How do you propose disposing of the consent forms and other records at the end of the retention period?

Data will be erased from the pen drive.

18. DISSEMINATION AND OUTPUTS

Please indicate how you will disseminate the findings from your study:

Thesis/dissertation

Journal
article

x

Monograph or chapter in book

Conference paper

x

Conference poster

Research reports to Funders

x

Other (*please give details*):



FACULTY OF SOCIAL AND APPLIED SCIENCES
FACULTY RESEARCH ETHICS COMMITTEE

DECLARATION

Project Title:

Project No: */SAS/*

- The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I undertake to conduct this research in accordance with University Research Governance procedures.
- If the research is approved, I undertake to adhere to the study protocol without deviation and to comply with any conditions set out in the letter sent by the Faculty REC notifying me of this.
- I undertake to inform the Faculty REC of any changes in the protocol and to seek their agreement and to submit annual progress reports. I am aware of my responsibility to be up to date and comply with the requirements of the law and appropriate guidelines relating to security and confidentiality of participant or other personal data, including the need to register when appropriate with the appropriate Data Protection Officer.
- I understand that research records/data may be subject to inspection for audit purposes if required in future and that research records should be kept securely for five years.

- I understand that personal data about me as a researcher in this application will be held by the REC and that this will be managed according to the principles established in the Data Protection Act.

Signature of Researcher: Stephanie Revell

Print Name: Stephanie Revell

Date: 5/01/2015

FOR STUDENT APPLICATION ONLY

I have read the research proposal and application form, and support this submission to the REC.

Signature of Supervisor: Dr Joe Hinds

Date: 03/01/2015

Print Name: Joe Hinds

Appendix 8: Study 3 Online Questionnaire

Student Survey

WELCOME!

Thank you for your interest in this survey. The following page contains further information to enable you to make an informed decision about your participation in this study. Please take the time to read this information. The purpose of this study is to explore University students' attitudes towards help seeking behaviours, beliefs about nature and preferences for counselling/psychotherapy. This study is part of a PhD at Canterbury Christ Church University. This survey is for anyone who is currently a student (either full time or part-time) at a UK University and is aged 18 years or over. If you decide to take part in this survey you will not be asked to disclose personal or sensitive information and you do not need to have experienced counselling/psychotherapy to take part. All responses are anonymous (you will not be asked for your name). The survey should take around 10 minutes to complete. It is best to complete the survey in one sitting. You are under no obligation to fully complete the survey and your participation is entirely voluntary. You can exit at any point. However, for your data to be useful for the research we do request that you try where possible to complete the survey in full. In the unlikely event feelings of discomfort are raised as a result of taking part in this study, you can contact your University student support services or the British Association of Counselling and Psychotherapy (BACP) website for general information on how to access further support in a location near to you. <http://www.itsgoodtotalk.org.uk/therapists> While there is no direct benefit to you for taking part, your participation will be a valuable addition to our research and findings could inform future developments in the provision of therapy. If you have any questions about any aspect of this study you can contact myself (the researcher) Stephanie Revell by email at: s.revell507@canterbury.ac.uk or Dr Joe Hinds (PhD Supervisor) at: joe.hinds@canterbury.ac.uk.

CONSENT

All information will be used for research purposes only. The resultant data will be stored in accordance with Canterbury Christ Church's Data storage procedures. The data which results from this study will be stored securely by the researcher for the duration of this research. Due to the electronic nature of this questionnaire it cannot be absolutely guaranteed that respondents are not traceable somehow. However, no ISP addresses or other information will be stored from the provider of this questionnaire. Please read the following statements to indicate your informed consent.

If you do not wish to give your consent, thank you for your time and you can now exit this survey.

I confirm I have read and understood information about this study.

I have had a chance to think about the information and was able to contact the researchers for more details if I wished (even if I did not make this contact).

I understand my responses will be included in the results and will be represented in the final report.

The results may also be published elsewhere. However, it will not be possible to identify me in any way from these results.

I am over 18 and I am aware of what participating in this study involves, including any potential risks.

I agree to take part in this study (1)

Q1 Are you

- Male
- Female
- Prefer not to say

Q2 Which part of the UK do you currently live in?

- England
- Wales
- Scotland
- Northern Ireland

Q3 In what type of geographical area have you lived the most?

- City/ Urban
- Suburban/ Town
- Country/ Rural
- Other (please specify) _____

Q4 Please indicate what age range you are in

- 18 - 25 years old
- 26 - 35 year old
- 36 - 45 years old
- 46 - 55 years old
- 56 - 65 years old
- 65 + years old

Q5 Are you currently enrolled as a full time or part time student at a UK University or college?

- Yes
- No

Answer If Are you currently enrolled as a full time or part time student? No Is Selected

Q6 Thank you for your interest in this survey. However, your previous response has indicated that you are not currently a student at a UK University and this survey is seeking participation from current students only. Please click the cross at the top right hand of this screen to exit this survey. Thank you.

Answer If Are you currently enrolled as a full time or part time student? Yes Is Selected

Q7 Please choose from the following which most applies to your current student status

- Full time Undergraduate (i.e. Certificate, Diploma, Degree course)
- Part-time Undergraduate (i.e. Certificate, Diploma, Degree course)
- Full time Postgraduate (i.e. Pg Cert, Pg Dip, Masters, PhD)
- Part time Postgraduate (i.e. Pg Cert, Pg Dip, Masters, PhD)
- Other (please specify) _____

Q33 What is the title or name of the course you are currently enrolled on?

	Very Unlikely (1)	Unlikely (2)	Somewhat Unlikely (3)	Undecided (4)	Somewhat Likely (5)	Likely (6)	Very Likely (7)
Intimate partner (e.g. girlfriend, boyfriend, partner, husband, wife)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Friend (not related to you)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other relative/family member	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health professional (e.g. psychologist, social worker)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Phone helpline (e.g. lifeline)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctor/GP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Minister or religious leader (e.g. Priest, Rabbi, Chaplin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Counsellor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would not seek help from anyone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would seek help from another person not listed above (please specify below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q9 Below you will find a number of statements expressing preferences that people can have when starting counselling/ psychotherapy.

Imagine that you are about to enter counselling/psychotherapy. Read each statement and consider to what extent each of the statements describes what would be important for you.

The question for you to consider is: What would help you if you were to attend counselling/ psychotherapy?

+

	Not at all	Very little	Somewhat	Quite a lot	A lot	Completely
Sharing bottled up emotions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Training in practical problem solving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sharing positive feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a choice of being indoors or outdoors for the counselling session	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exploring recurring life patterns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being taught how to cope with problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talking about painful memories	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working towards concrete goals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working with an active, initiative taking therapist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working to keep anxieties out of mind	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Putting feelings into words	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working on understanding my relationships with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keeping feelings under control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Learning practical solutions to concrete problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being encouraged	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having the opportunity to walk outdoors while talking with a counsellor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Working to keep anxieties out of mind	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q10 Please indicate the extent to which each of the following statements describes you and your ~~behaviours~~ beliefs about nature

	Not at all true of me	Not true of me	Not much true of me	Neither true nor untrue	Somewhat true of me	True of me	Completely true of me
I spend a lot of time in natural settings (woods, mountains, lakes, beach)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think of myself as part of nature, not separate from it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I am upset or stressed, I can feel better by spending some time outdoors 'communing with nature'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Living near wildlife is important to me, I would not want to live in a city all the time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have a lot in common with other species	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being a part of the ecosystem is an important part of who I am	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In general, being part of the natural world is an important part of my <u>self image</u> .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I really enjoy camping and hiking outdoors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I would feel an important part of my life was missing if I was not able to get out and enjoy nature from time to time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I take pride in the fact I could survive outdoors on my own for a few days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q11 Please read the following and answer the questions below.

Again, imagine that you are about to enter counselling/psychotherapy sessions. In addition to indoor based counselling sessions, you are also offered the opportunity to try 'walk and talk' therapy.

Walk and talk can be described as:

A type of counselling that takes place in an outdoor setting.

You (as the client) and your counsellor/psychotherapist walk outdoors together during the session while you discuss your issues.

Sessions are usually around 50-60 minutes long.

Common locations that are used include parks, woodlands, beaches and riverside paths.

Walk and talk therapy is not be intended to be a workout or a physically strenuous exercise session and is adapted to suit individual physical needs.

Some people find the combination of movement and being outdoors helpful for reasons such as: becoming 'unstuck' when exploring difficult issues, an improvement in mood, feeling more relaxed, an increase in overall well-being.

Q12 Having read the description above, how likely or unlikely you would be to choose to participate in this type of counselling activity if it was offered to you?

	Very unlikely	Unlikely	Somewhat Unlikely	Undecided	Somewhat Likely	Likely	Very Likely
Please indicate on the following scale:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q13 Considering the description of walk and talk therapy above, what aspects appeal to you?

Q14 Considering the description of walk and talk therapy above, what aspects do you find least appealing?

Q15 Thank you for taking part in this questionnaire.

Your participation is greatly appreciated. If you have any other comments you would like to make relating to this study please indicate in the space below.

If you require support through taking part in this study, please contact your University student support services or the BACP website for further general information
<http://www.itsgoodtotalk.org.uk/therapists>

If you have any questions regarding this study, please contact the research supervisor Dr. Joe Hinds via email: joe.hinds@canterbury.ac.uk

Please click on the arrow button below to submit your responses.
Thank you for your participation!

Appendix 9: Study 4 Ethics Application



For Research Office Use
Checklist No:
Date
Received:

ETHICS REVIEW CHECKLIST

Sections A and B of this checklist must be completed for every research or knowledge transfer project that involves human or animal¹ participants. These sections serve as a toolkit that will identify whether a full application for ethics approval needs to be submitted.

If the toolkit shows that there is **no need for a full ethical review**, Sections D, E and F should be completed and the checklist forwarded to the Research Governance Manager as described in Section C.

If the toolkit shows that a **full application is required**, this checklist should be set aside and an *Application for Faculty Research Ethics Committee Approval Form* – or an appropriate external application form – should be completed and submitted. **There is no need to complete both documents.**

Before completing this checklist, please refer to Ethics Policy for Research Involving Human Participants in the University Research Governance Handbook.

The principal researcher/project leader (or, where the principal researcher/project leader is a student, their supervisor) is responsible for exercising appropriate professional judgement in this review.

N.B. This checklist must be completed – and any resulting follow-up action taken – before potential participants are approached to take part in any study.

Type of Project – please mark (x) as appropriate			
Research	<input checked="" type="checkbox"/>	Knowledge Exchange	<input type="checkbox"/>

Section A: Applicant Details

A1. Name of applicant:	Stephanie <u>Revell</u>
A2. Status (please underline):	<u>Postgraduate Student</u>
A3. Email address:	s.revell507@canterbury.ac.uk
A4. Contact address:	Deer Park Lodge, <u>Johnby</u> , Penrith. CUMBRIA CA11 0UU
A5. Telephone number	07950 709438

1 Sentient animals, generally all vertebrates and certain invertebrates such as cephalopods and crustaceans

Section B: Ethics Checklist

Please answer each question by marking (X) in the appropriate box:

		Yes	No
1.	Does the study involve participants who are particularly vulnerable or unable to give informed consent (e.g. children, people with learning disabilities), or in unequal relationships (e.g. people in prison, your own staff or students)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	Will the study require the co-operation of a gatekeeper for initial access to the vulnerable groups or individuals to be recruited (e.g. students at school, members of self-help groups, residents of nursing home)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	Will it be necessary for participants to take part in the study without usual informed consent procedures having been implemented in advance (e.g. covert observation, certain ethnographic studies)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	Will the study use deliberate deception (this does not include randomly assigning participants to groups in an experimental design)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	Will the study involve discussion of, or collection of information on, sensitive topics (e.g. sexual activity, drug use)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to human or animal participants?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	Does the study involve invasive or intrusive procedures such as blood taking or muscle biopsy from human or animal participants?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	Is physiological stress, pain, or more than mild discomfort to humans or animals likely to result from the study?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	Could the study induce psychological stress or anxiety or cause harm or negative consequences in humans (including the researcher) or animals beyond the risks encountered in normal life?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	Will the study involve interaction with animals? (If you are simply observing them – e.g. in a zoo or in their natural habitat – without having any contact at all, you can answer "No")	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11.	Will the study involve prolonged or repetitive testing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12.	Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13.	Is the study a survey that involves University-wide recruitment of students from Canterbury Christ Church University?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

14.	Will the study involve recruitment of adult participants (aged 16 and over) who are unable to make decisions for themselves, i.e. lack capacity, and come under the jurisdiction of the Mental Capacity Act (2005)?	<input type="checkbox"/>	X
15.	Will the study involve recruitment of participants (excluding staff) through the NHS or the Department of Social Services of a Local Authority (e.g. Kent County Council)?	<input type="checkbox"/>	X

Now please assess outcomes and actions by referring to Section C ➡

Section C: How to Proceed

C1. If you have answered '**NO**' to **all** the questions in Section B, you should complete Sections D-F as appropriate and send the completed and signed Checklist to the Research Governance Manager in the Research Office for the record. **That is all you need to do. You will receive a letter confirming compliance with University Research Governance procedures.**

[Master's students should retain copies of the form and letter; the letter should be submitted with their research report or dissertation (bound in at the beginning). Work that is submitted without this document will be returned un-assessed.]

C2. If you have answered '**YES**' to **any** of the questions in Section B, you will need to describe more fully how you plan to deal with the ethical issues raised by your project. This does not mean that you cannot do the study, only that your proposal will need to be approved by a Research Ethics Committee. **Depending upon which questions you answered 'YES' to, you should proceed as follows**

(a) If you answered '**YES**' to any of **questions 1 – 12 ONLY** (i.e. not questions 13,14 or 15), you will have to submit an application to your Faculty Research Ethics Committee (FREC) using your Faculty's version of the **Application for Faculty Research Ethics Committee Approval Form**. This should be submitted as directed on the form. The *Application for Faculty Research Ethics Committee Approval Form* can be obtained from the Governance and Ethics pages of the Research section on the University web site.

(b) If you answered '**YES**' to **question 13** you have two options:

- (i) If you answered '**YES**' to **question 13 ONLY** you must send copies of this checklist to the Student Survey Unit. Subject to their approval you may then proceed as at C1 above

(ii) If you answered 'YES' to **question 13 PLUS any other of questions 1 – 12**, you must proceed as at C2(b)(i) above and then submit an application to your Faculty Research Ethics Committee (FREC) as at C2(a).

(c) If you answered 'YES' to **question 14** you do not need to submit an application to your Faculty Research Ethics Committee. **INSTEAD**, you **must** submit an application to the appropriate external NHS Research Ethics Committee [see C2(d) below].

(d) If you answered 'YES' to **question 15** you do not need to submit an application to your Faculty Research Ethics Committee. **INSTEAD**, you must submit an application to the appropriate external NHS Research Ethics Committee (REC) or Local Authority REC, *after* your proposal has received a satisfactory Peer Review (see *Research Governance Handbook*). Applications to an NHS REC or a Local Authority REC **must** be signed by the appropriate Faculty Director of Research or Faculty representative before they are submitted.

IMPORTANT

Please note that it is your responsibility in the conduct of your study to follow the policies and procedures set out in the University's Research Governance Handbook, and any relevant academic or professional guidelines. This includes providing appropriate information sheets and consent forms, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct over the course of the study should be notified to the **Faculty and/or other Research Ethics Committee** that received your original proposal. Depending on the nature of the changes, a new application for ethics approval may be required.

Section D: Project Details

D1. Project title:	Helpful and hindering aspects of walk and talk therapy – Client perspectives
D2. Start date	November 2015
D3. End date	March 2016
D4. Lay summary (max 300 words <i>which must include a brief description of the methodology to be used for gathering your data</i>)	<p>Walk and talk describes a type of counselling practice where the counsellor and client walk together outdoors during the therapy session (Hays, 1999). This includes both 1:1 'walk and talk' sessions and group therapy contexts where clients have walked/run together within a group therapy session (Hays, 1999). Reported benefits include increased personal strength, sense of wellbeing, of accomplishment and greater problem solving ability (Hays, 1999; Doucette, 2004). However, the majority of evidence remains anecdotal (McKinney, 2011). There are a growing number of therapists in the UK who offer walk and talk despite relatively few clients who request it. This disparity suggests more needs to be understood about client preferences and experiences of therapy as a way of informing the development of this therapeutic activity.</p> <p>This study is the third and final study within this PhD. Two previous studies have explored therapists' experiences of offering walk and talk therapy, and prospective clients perceptions of walk and talk. This study's intention is to fill the gap in understanding more about actual clients experiences of walk and talk specifically exploring the following two key areas. Firstly, to understand what clients find helpful and hindering about walk and talk sessions. Secondly, to gain client perspectives about what aspects of walk and talk therapy, if any, might have helped facilitate change for them. It is anticipated that by gaining an understanding of how clients experience walk and talk therapy this in turn can inform practice development of this approach.</p> <p>This is a qualitative study consisting of semi-structured interviews - anticipated to last between 30-45 minutes. Interviews will be audio recorded and transcribed for analysis. Questions asked in the interview are informed by the "Helpful aspects of therapy form" (Elliott, 1993) and the "Client Change Interview Protocol" (Elliott, <u>Slatick & Urman</u>, 1999). The resultant data will be <u>analysed</u> using Interpretative Phenomenological Analysis (IPA) (Smith, 2009).</p>

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Section E1: For Students Only

E1. Module name and number or course and Department:	PhD Psychology
E2. Name of Supervisor or module leader	<u>Dr. Joe Hinds</u>
E3. Email address of Supervisor or Module leader	Joe.hinds@canterbury.ac.uk
E4. Contact address:	Laud Building, Room LF17 Department of Psychology, Politics & Sociology Canterbury Christ Church University North Holmes Road Canterbury, UK CT1 1QU

Section E2: For Supervisors

Please tick the appropriate boxes. The study should not begin until all boxes are ticked:

The student has read the relevant sections of the University's Research Governance Handbook, available on University Research web pages at: http://www.canterbury.ac.uk/research/governance/index.asp	<input checked="" type="checkbox"/>
The topic merits further investigation	<input checked="" type="checkbox"/>
The student has the skills to carry out the study	<input checked="" type="checkbox"/>
The participant information sheet or leaflet is appropriate	<input checked="" type="checkbox"/>
The procedures for recruitment and obtaining informed consent are appropriate	<input checked="" type="checkbox"/>

If a CRB/VBS check is required, this has been carried out

x

Comments from supervisor: Although the participants will have been through a process of therapy at some point prior to the study, and therefore potentially vulnerable, the degree to which these people are any more or less vulnerable than any other remains debatable given their completion of a therapeutic process. Moreover, all due considerations for their health and wellbeing are in place, including signposting to the BACP, should the interview process cause distress. In addition, given Steff's own professional training and experience, she is best placed to notice and enact the best possible course of action for either terminating the interview and/or providing immediate assistance and further support.

Section F: Signatures

- I certify that the information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I certify that a risk assessment for this study has been carried out in compliance with the University's Health and Safety policy.
- I certify that any required CRB/VBS check has been carried out.
- I undertake to carry out this project under the terms specified in the Canterbury Christ Church University Research Governance Handbook.
- I undertake to inform the relevant Faculty Research Ethics Committee of any significant change in the question, design or conduct of the study over the course of the study. I understand that such changes may require a new application for ethics approval.
- I undertake to inform the Research Governance Manager in the Graduate School and Research Office when the proposed study has been completed.
- I am aware of my responsibility to comply with the requirements of the law and appropriate University guidelines relating to the security and confidentiality of participant or other personal data.
- I understand that project records/data may be subject to inspection for audit purposes if required in future and that project records should be kept securely for five years or other specified period.

- I understand that the personal data about me contained in this application will be held by the Research Office and that this will be managed according to the principles established in the Data Protection Act.

Principal Investigator	Supervisor or module leader (as appropriate)
Name: Stephanie <u>Revell</u> Date: 12/10/2015	Name: Joe Hinds (PhD) by email Date:12/10/2015

Section G: Submission

This form should be returned, as an attachment to a covering email, to the Research Governance Manager at roger.bone@canterbury.ac.uk

N.B. YOU MUST include copies of the Participant Information Sheet and Consent Form that you will be using in your study (Model versions on which to base these are appended to this checklist for your convenience). Also copies of any data gathering tools such as questionnaires.

Appendix 9a: Study 4 Ethics Application for Walking Interview



FACULTY OF SOCIAL AND APPLIED SCIENCES
FACULTY RESEARCH ETHICS COMMITTEE (FREC)

Project Amendment Form

Name of	Stephanie <u>Revell</u>
Email address:	s.revell507@canterbury.ac.uk
Title of Project:	Client experiences of "Walk and talk" therapy
Project Number:	
Study Start Date:	January 2016
Length of Study: (in original submission)	3 months until March 2016

1. Change(s) to the original protocol submitted to the ethics committee

Please detail as follows:

1.1 The nature of the change(s).

To accommodate the inclusion of 'walking and talking' interviews with clients in a location chosen by them - either one where they have walked and talked with their therapist or another suitable location.

1.2 The reason(s) for the change(s).

This study is focusing on the affect 'walking and talking' has within a therapeutic session. Therefore to include this interview method, it allows for more nuanced information to be discussed/experienced within the interview itself.

1.3 How the change(s) affect the project.

It will involve the researcher travelling to various locations. By walking in specific location associated with past counselling sessions it might raise feelings of discomfort for participants (but as the participant can choose which location and if they wish to participate in this way - it is not considered a much greater risk than is associated with speaking about past therapy).

1.4 The effect on the project timetable.

No effect on project timetable

2. Other issues

Are there any other issues that may affect the conduct or course of the project?

If "Yes", please describe these below:

YES	NO
	x



28/1/2016

Signature of researcher:.....

Date:.....

Appendix 10: Study 4 Participant Information



PARTICIPANT INFORMATION SHEET

Client experiences of 'Walk and talk' therapy

Hi, my name is Stephanie Revell. I am a PhD student at Canterbury Christ Church University (CCCU) and I am conducting research that is looking at client experiences of 'walk and talk therapy'. This research project is being supervised by Dr. Joe Hinds (joe.hinds@canterbury.ac.uk).

Background

Interest in 'walking and talking' during a counselling session is growing as therapists expand their range of therapeutic activities. My aim is to develop a greater understanding of the practice of 'walk and talk' therapy. Specifically, I am interested in knowing about past clients' experiences of 'walk and talk' therapy.

What will you be required to do?

I would like to invite you to meet and walk with me either at a location where you have 'walked and talked' in the past or at another outdoor location where it will be possible to 'walk and talk' during the interview. It is anticipated this will take between 1-2 hours.

The questions that will be asked in the interview relate to your own overall experience of taking part in walk and talk therapy sessions. For example, this might include topics such as what you experienced as helpful and/or hindering and what it was like to be outdoors/walking during your therapeutic sessions.

Interview conversations will be audio recorded. You will not be required to disclose any personal or sensitive information relating to your therapy sessions.

To participate in this research you must:

- Be aged 18 years and over
- Have experienced 'walk and talk' therapy as a past client – please note: due to ethical clearance restrictions, I am unable to interview current clients of walk and talk therapy.

Feedback

Copies of the report arising from this research will be available from the researcher at the end of the study upon request.

Confidentiality

All data and personal information will be stored securely within the researcher's premises in accordance with the Data Protection Act 1998 and the University's own data protection requirements. Data can only be accessed by Stephanie Revell and Dr. Joe Hinds. After completion of the study, all data will be made anonymous (i.e. all personal information associated with the data will be removed).

What are the possible disadvantages and risks of taking part?

There is a small risk that through participating in this study, feelings of discomfort may be raised through the process of discussing past experiences related to 'walk and talk' therapy. If you would like support as a result of participating in this research, you can search for a counsellor in your area through the British Association for Counselling and Psychotherapy (BACP) available at: www.bacp.co.uk and select the 'find a therapist' option.

Dissemination of results

Results of this study will be included in my final PhD thesis document and may be used for other publications or studies at some point in the future. Any quotes or comments utilised will be anonymised with all identifying information removed prior to publication.

Deciding whether to participate?

If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact me. Should you decide to participate, you will be free to withdraw at any time without having to give a reason. In addition you will have certain editing rights during the recorded interview, for example if you wish to retract something you have just said it will be wiped from the recording.

Any questions?

Please contact me (Stephanie Revell) via email at: s.revell507@canterbury.ac.uk with any further questions you might have and/or to register your interest in taking part in this study.

Appendix 11: Study 4 Participant Consent

CONSENT FORM

WALK AND TALK THERAPY – CLIENT PERSPECTIVES

Researcher: Stephanie Revell
Email: s.revell507@canterbury.ac.uk

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. I am also under no obligation to answer all questions that are asked and I do not have to give a reason for this.
3. I understand that my responses within this interview will be included in the results, and will therefore be represented in the final report. The results may also be published elsewhere. However, it will not be possible to identify me in any way from these results.
4. I understand that any information that I give that might identify me will be held securely and will not be disclosed to anyone outside of the research team.
5. I consent to the recording of the interview.
6. I agree to take part in the above study.

Name of participant

Date

Signature

Appendix 12. Study 4 Interview Questions

Study 4 - Sample Interview Schedule

- Can you give a general summary of your experiences of walk and talk therapy sessions (i.e. when did you experience them, about how many sessions have you had, how frequent were they?)
- What type of environment/s did your walk and talk sessions take place in? How were these chosen/decided upon?
- How did it come about that you decided to take part in 'walk and talk' sessions as opposed to indoor counselling?
- What made you want to try this therapeutic activity? Did you have any reservations prior to walking and talking? (if so, what were they? If not, why do you think that was?)
- What has taking part in walk and talk therapy sessions been like? How did it feel to be doing it?
- What did you find helpful about walk and talk therapy? (i.e. general aspects, specific events including both what others did and what you did)
- What kinds of things about walk and talk therapy were hindering, unhelpful, negative or disappointing for you? (e.g. specific events, general aspects)
- Were there things that were difficult/painful for you but still Ok or perhaps helpful?
- What changes (if any) have you noticed in yourself since having experienced walk and talk therapy?
- Are there any changes you wanted from walk and talk therapy that hasn't happened?
- Do you have any suggestions about how walk and talk therapy could be offered?
- Is there anything else that seems important to know about your experience of it?