WALK AND TALK THERAPY: POTENTIAL CLIENT PERCEPTIONS

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INTRODUCTION

Walk and talk is an emergent therapeutic activity within counselling/psychotherapy practice. The activity of 'walk and talk' is pan-theoretical and can be utilised as the foundation for all therapeutic work, or as a periodic activity in conjunction with office based sessions. Research exploring the benefits and utility of walk and talk is in its infancy despite the growing number of therapists choosing to integrate this activity into their professional practice. This study explored general perceptions of walk and talk as a therapeutic activity, generating qualitative data gained from short answer responses that sought to elicit perceptions of appealing and least appealing aspects of walk and talk therapy. Thematic analysis identified the following three themes: 'being outdoors'; 'engaging in movement' and the 'aspects affecting the context of therapy'. Taking therapy into an outdoor context and walking while talking was perceived to both support and hinder the therapeutic intent. This highlights complex and multi-layered relationships people have with 'place' as well as the importance of the provision of a professional framework in offering this therapeutic activity. Understanding potential clients' perceptions of therapeutic interventions, can serve to inform professional practice, leading to a client led and informed approach.

Background

'Walk and talk' is a general term that is used to describe a therapeutic activity where the counsellor and client walk together in outdoor settings during therapy sessions (Revell & McLeod, 2016; Doucette, 2004; Hays, 1999). The activity of 'walk and talk' is pan theoretical and can be utilised as the foundation for all therapeutic work, or as a periodic activity in conjunction with office based sessions (Revell & McLeod, 2017). Research exploring the benefits of walk and talk is in its infancy despite the growing popularity of integrating this activity into therapeutic encounters (Revell & McLeod, 2017, 2016; McKinney, 2011).

Previous research has highlighted a discrepancy between therapists seeking to accommodate walk and talk within their professional practice and the number of clients who wish to try it (Revell & McLeod, 2017; McKinney, 2011). 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 (McLeod, 2012; Sandell et al., 2011; Bragesjö, Clinton & Sandell, 2004; Iselin & Addis, 2003; Duncan & Miller, 2000; Joyce & Piper, 1998; Kazdin, 1980).

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 (Sandell et al., 2011; Frovenholt et al., 2007). 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.

Historically, the physical setting in counselling/psychotherapy has received relatively scant attention in psychotherapeutic literature (Fenner, 2011; Backhaus, 2008; Berger, 2007). 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 (Jordan, 2015; 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 (Pressly & Heesacker, 2001; Gross et al., 1998). 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 (Jordan, 2015; 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 argue that human experience of place is influenced by a conscious relationship between the self and the world (Creswell, 2004).

Health geographers have examined the ways certain places and wellbeing are connected (Philips, 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.

Therefore, situating wellbeing within the broader context of relationships between people and places, as something fluid and subject to change over time and 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 (Philips, 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.

The focus of this study was to explore potential client's perceptions of walk and talk as a therapeutic activity. The full survey utilised a mixed methods approach (Hanson et al., 2005). Only data from the qualitative short answer questions will be presented in this current article.

METHOD

The full survey contained both qualitative and quantitative items, thus employing a mixed methods approach (Hanson et al., 2005). Quantitative measures sought to identify predictive factors associated with the likelihood of choosing to participate in walk and talk. Qualitative data reported in this present article relates to 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. An on-line survey was considered the most effective way of accessing a large number of potential respondents from various locations throughout the UK.

A convenience sampling approach was employed. Participation was sought from current students aged 18 years and over who were students at UK based Universities/Colleges. An email introducing the study and inviting participation was sent to academic staff known to the first author, requesting distribution of the survey link to their students. Additionally, information was placed on research forums and other informal networks.

Ethical permission was granted by Canterbury Christ Church University (UK) research ethics committee. All participants were requested to read the information pages prior to gaining access to the survey. Participants indicated their explicit consent by selecting the 'I agree' option, which once ticked, would grant access to the survey. No sensitive information was sought and all responses were anonymous. 147 participants responded to the qualitative questions with 79% (n=117) female and 21% (n=29) male. 74% (n=109) of participants were aged between 18-35 years old, with the majority (n=80) aged 18-25. The majority of participants indicated they were studying Psychology or Counselling related courses with both undergraduate and postgraduate levels represented. In line with other studies seeking perceptions of counselling/psychotherapy interventions (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 described in Figure 1.

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.

Figure 1. A description of walk and talk
Source: Author

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. 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 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.

FINDINGS

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. Figure 2 shows the overall analysis.

BEING OUTDOORS		**ENGAGING IN MOVEMENT**		**ASPECTS AFFECTING THE CONTEXT OF THERAPY**	
The open space	Lacks therapeutic containment	***Being in motion***	Supports engagement with therapeutic process	***Effects on therapy processes***	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		
Varying weather conditions	Negatively impacting upon mood	***Walking side by side***	Lowering intensity of therapy session	***Having distractions***	As a helpful therapeutic tool
	Disruptive to focus of session		Creating barriers to developing therapeutic connection		As something that gets in the way
	Invigorating				
A different setting	Offers contrast to being indoors				
	Allows for different connections				

Figure 2. Thematic Analysis
Source: Author

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"*.

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, and 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' 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

Findings from this study show that 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 (Iselin & Addis, 2003; Duncan & Millar, 2000).

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).

It is important to acknowledge the limitations of this study. Firstly, the perceptions of walk and talk as a therapeutic activity were not from actual clients of therapy. Therefore, it is possible that perceptions might be different for individuals at the point of accessing therapy, when experiencing a level of distress or seeking particular things from their therapy. Clients of therapy (who are not studying counselling/psychology related courses) may also have different reactions to walk and talk and fewer concerns related to the maintenance of the therapeutic relationship. The majority of participants were young adults, and therefore findings are not generalizable to all age groups.

Short answer responses limit the depth and richness of the data. However, as the practice of walk and talk therapy has not been widely investigated, the findings from this study offer a useful platform from which to base further in-depth qualitative investigations upon. Research exploring client experience of participating in walk and talk is needed in order to broaden understanding of how this therapeutic activity can enhance existing therapy provision for some clients.

CONCLUSION

In conclusion, the findings from this study offer general support for the provision of walk and talk as a therapeutic activity. 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. Therapists wishing to integrate walk and talk into their therapeutic practice can be informed of various practical aspects that require careful consideration and collaboration with clients that could enhance uptake of this therapeutic activity.

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