2019

Adult Clients' Experience of Walk-and-Talk Therapy

Denice Crowe Clark
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Denice Crowe Clark

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Review Committee
Dr. Rebecca Stout, Committee Chairperson, Human Services Faculty
Dr. Mary Bold, Committee Member, Human Services Faculty
Dr. Randy Heinrich, University Reviewer, Human Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
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Abstract

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by

Denice Crowe Clark

MFT, Mercer University School of Medicine, 2008

BS, University of South Carolina, 1986

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services

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Abstract

Standards of healthcare exist to promote beneficent treatment; however, treatment approaches are sometimes not supported by research, creating potential ethical issues for clinicians expected to use evidence-based practices. For example, walk-and-talk therapy, where therapy sessions incorporate physical activity in an outdoor setting, is being offered at increasing rates, but research regarding the practice is sparse and primarily reflects the therapists' experiences. Thus, the purpose of this interpretative phenomenological analytic study was to explore the clients' experience of the altered frame of walk-and-talk therapy through the conceptual lenses of therapeutic frame and the biopsychosocial model of well-being. Data were collected through in-depth, semistructured interviews with a sample of three former walk-and-talk therapy clients, and data were analyzed using the modified van Kaam method. Findings included that the clients' experience of walk-and-talk therapy was shaped by prior therapy experiences with participants reporting concerns and benefits related to the altered frame. Clients found walk-and-talk equally or more therapeutic than traditional therapy and felt walk-and-talk could be a less stigmatizing therapeutic alternative for individuals who find traditional, indoor therapy unappealing. Implications for social change include shaping standard practices of walk-and-talk therapy, thus informing the future of training and supervision as well as providing an alternative therapeutic offering for individuals who find traditional, indoor therapy unappealing.

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Dedication

I would like to dedicate this dissertation to all those who have loved and supported me, and cheered me on throughout this process. First, thanks to my husband, Mark, who has put up with my stress and crazy for a lot of years, but particularly these last couple of years of dissertation writing. Thank you for the constant reminders to focus on what is most important and finish! Second, thanks to my youngest daughter, Hope, who lived at home long enough to experience the majority of the same stress and crazy. No wonder you moved out when you did. Thanks to my oldest daughter, Grace for cheering from afar, as well as your daily inquiry towards the end of the dissertation writing, "Are you done yet?" You were certainly brave to move back home while I was in those final stages of writing. Apologies to my son-in-law, Allan, for stressing you out with my writing deadlines, but, thanks for keeping the "pantry" stocked. I would also like to dedicate this to my grandson, Alex, and granddaughters on the way, Evelyn and Iris. Let this serve as an example that persistence pays off. Always follow your passions and live life with purpose. Thanks to my constant canine companion, Beau, who snuggled next to me from the very first course through the last iteration of this dissertation. Last, but certainly not least, this is dedicated to my biggest cheerleader, my Mommy, Annette. You always believed in me and pushed me to excel in whatever endeavors I engaged. I am proud to be a first generation college graduate, and now a first generation PhD! All of you share in my success and I could not have done it without you. I love you all. First round is on me!

Acknowledgments

Many thanks to everyone who held me accountable and guided me through this journey. Thank you to my committee chair, Dr. Rebecca Stout. Even though you were assigned as my chair without a prior conversation or introduction, I could not have selected a more appropriate fit. Thank you for fielding my e-mails and questions so quickly, and for responding to my discouragements along the way with positivity and affirmation. Thanks also, to my second committee member, Dr. Mary Bold, for reminding me to maintain a stance of curiosity, embody the role of researcher, and exercise brevity in my writing. Finally, thank you to my URR and third committee member, Dr. Randy Heinrich, particularly for your recommendation on data analysis method. I had the best dissertation committee in the history of dissertation committees!

Many thanks, also, to my study participants.

I would also like to acknowledge colleagues past and present who served as both friends and mentors: Alan Lyme, for constantly reminding me of the goal I was pursuing while also keeping my ego in check; Bonnie Cole Gifford, for your friendship and inspiring me to find and follow my passion, and to learn it inside-out; Annie Biers, for your ongoing friendship and affirmation. Thank you, Dr. Aaron Johnson, Dr. Paul Seale, and Dr. Sylvia Shellenberger, for all the professional opportunities you afforded me these past several years. And finally, thank you, Deborah Wight-Knight, for holding a safe space for me all those years ago, and helping me realize the path to finding my passion and purpose.

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Chapter 1: Introduction to the Study

Although counselors and therapists have transitioned from a Freud-led, psychoanalytic model of the client reclining on a sofa with therapist sitting out of sight to a model where client and therapist sit face-to-face across the room, therapy generally continues to occur in an enclosed, office space apart from interruption or outside distraction (Hooley, 2016; Jordan & Marshall, 2010). Even though therapists have adapted and changed therapy theories, techniques, and modalities over time, the context is framed by a structure to enforce ground rules and therapeutic boundaries (Hooley, 2016; Jordan & Marshall, 2010; Langs, 1979). However, some therapists have altered the context and frame of therapy by taking therapy outdoors and incorporating activity in the form of *running therapy* (Hays, 1994; Hays, 1999; Kostrubala, 1976; Kostrubala, 2013; Kottler & Carlson, 2003), or interaction with nature during the course of nature therapy, ecotherapy, or wilderness therapy (Jordan, 2013; Jordan, 2015). Many therapists have also begun engaging clients in walk-and-talk therapy as they have discovered the overall health benefits of physical activity and exposure to nature and as they sought to engage clients in a more interactive and dynamic therapeutic experience (Jordan, 2014; Jordan & Marshall, 2010).

In this chapter, I introduce the background of walk-and-talk therapy, including the addressed problem and purpose of this study. In addition, I present the research question and the conceptual framework through which I approached this study. I describe the research tradition and define important terms, as well as outline assumptions, delimitations, and limitations. Finally, I describe the significance of this study.

Background

Physical activity has been correlated with improvements not only in physical health but also overall mood and well-being (Blair, Salis, Hutber, & Archer, 2012; Carek, Laibstain, & Carek, 2011; Smith, 2015). For this reason, mental health professionals frequently prescribe exercise as an adjunct to psychotherapy (Howell, Passmore, & Holder, 2016; Smith, 2015). Exposure to nature via nature therapy, ecotherapy, or wilderness therapy has also been positively correlated with improvements in mood and well-being (Chalquist, 2009; Jordan, 2015; Stigsdotter et al., 2011). The combination of walking in natural settings versus walking in more urban settings has been related to even greater improvements in mood (Bratman, Daily, Levy, & Gross, 2015). Thus, traditional psychotherapy has been combined with walking in an outdoor setting so walk-and-talk therapy may provide additional therapeutic benefits for mood and overall well-being for clients (Greenleaf, Bryant, & Pollack, 2014; Revell & McLeod, 2017).

Walk-and-talk therapy, where therapist and client engage in talk therapy while walking side-by-side in an outdoor setting, has increased in popularity and has caught the attention of the popular press (Abcarian, 2017; Chillag, 2017; English, 2015; Knox, 2017; Magner, 2017; Maher, 2017; Maxted, 2017; Neely, 2017; Packhams, 2015; Wright, 2008). The practice is not entirely new, as Freud was rumored to walk and talk with his clients through the streets of Vienna (Jordan & Marshall, 2010; Karp, 2011), and in the 1970s, Kostrubala (1976) developed a training program for therapists incorporating running with clients to improve mental health diagnoses. In the decades since Kostrubala began running therapy training, a few clinicians have used running or walking with

clients (Gontang, 2009; Hays, 1994; Kottler & Carlson, 2003), and increasingly more therapists are offering walk-and-talk therapy as an alternative to traditional, in office, face-to-face therapy (DeAngelis, 2013).

Research regarding number of therapists incorporating physical activity into their therapy sessions is scarce (DeAngelis, 2013), and the number of therapists offering walk-and-talk therapy is unknown. But there are many media reports referencing the expansion of walk-and-talk therapy and suggest an increase in implementation (Abcarian, 2017; Chillag, 2017; English, 2015; Knox, 2017; Magner, 2017; Maher, 2017; Maxted, 2017; Neely, 2017; Packhams, 2015; Wright, 2008). However, peer-reviewed research and the work of master's and doctoral students specific to walk-and-talk therapy is minimal and is focused on therapists' experiences of the practice rather than clients' experiences (Charbonneau, 2016; Jordan, 2013, 2014; Jordan & Marshall, 2010; King, 2015; McKinney, 2011; Revell, 2016; Revell & McLeod, 2017).

Although some therapists have employed outdoor therapy spaces that mirror indoor spaces in terms of a demarcated *walled* space (Jordan, 2015), most walk-and-talk clinicians believe in the added therapeutic benefit of moderate exercise during the session. Many walk-and-talk counselors are physically active themselves and claim to have personally experienced the overall health benefits afforded by exercise (DeAngelis, 2013; Jordan, 2013, 2015). For this reason, incorporating physical activity in therapy rather than prescribing it as an adjunct to traditional talk therapy sessions felt like a natural fit to these practitioners.

Despite efforts to improve treatment for disorders like depression and anxiety in industrialized nations (Jorm, Patten, Brugha, & Mojtabai, 2016), and increased rates of treatment seeking for psychological issues between 2001-2012, residents of the United States have continued to suffer from increased mental or emotional distress (Mojtabai & Jorm, 2015). Possible explanations include poor quality or low intensity treatments, treatments that were not appropriately targeted to the individual, or inefficient use of treatment options often resulting from disparities in access to services (Mojtabai & Jorm, 2015). Thus, walk-and-talk therapists believe that incorporating physical activity and nature into their traditional therapy offerings is an outgrowth of client needs (McKinney, 2011) and may be a better fit for clients not comfortable in traditional therapy settings (Bell, Foley, Houghton, Maddrell, & Williams, 2018; Houghton & Houghton, 2015), which may close the gap of ill-fitting or poor quality treatment options as well as treatment disparities (Mojtabai & Jorm, 2015). Taking therapy outside the confines of a secure, confidential, walled space, however, may present new challenges. For this reason, it was important to understand how clients experience this change in context of therapy.

Problem Statement

Although therapists who believe in the healing benefits of exercise and nature exposure are conducting their client sessions in more natural settings at increasing rates (Jordan, 2015), there is a lack of research regarding the practice, especially on clients' perspectives. This creates concern for therapists expected to use evidence-based practices and avoid practices that could cause harm to their clients (i.e., maleficence; American Association for Marriage and Family Therapy [AAMFT], 2016; American Psychological

Association [APA], 2010). Taking therapy outside the traditional office space into more natural settings changes not only the physical setting but may also create ethical considerations (Hooley, 2016; Reese, 2016); therefore, it was important to research walk-and-talk therapy further to understand more about the practice and clients' experiences of it. Thus, this study addressed the problem of avoiding treatment that does not help clients and avoiding potential harm to these clients as the result of participation in an invalidated therapeutic practice (i.e., walk-and-talk therapy). Gaining an understanding of clients' perspectives of the practice may establish whether walk-and-talk therapy is as beneficial as traditional talk therapy and may serve to shape future walk-and-talk therapy guidelines for beneficent practice, training, and supervision.

Purpose

Because of the lack of research regarding walk-and-talk therapy, it was important to gain a better understanding of the practice. Although the current literature on walk-and-talk therapy from therapists' perspectives is informed by input from their clients (Jordan, 2015), the lack of research specific to clients' perspectives presents a gap in the current knowledge base. Further, conducting therapy in outdoor settings may alter the experience of the processes and some aspects of therapy like confidentiality, potentially creating ethical issues (Hooley, 2016). Thus, I conducted this qualitative study to gain a better understanding of adult clients' lived experiences (Merriam & Tisdall, 2016; Moustakas, 1994) of walk-and-talk therapy, using an interpretative phenomenological analysis (IPA) approach (Brocki & Wearden, 2006; Reid, Flowers, & Larkin, 2005; Smith, Flowers, & Larkin, 2009). The objectives were to better understand clients'

experiences of walk-and-talk therapy and to determine whether there were any aspects of the altered frame of walk-and-talk therapy that clients found helpful or harmful. In addition, I hoped to determine potential areas of focus for future research regarding efficacy of walk-and-talk therapy and the avoidance of maleficence.

Research Question

The overarching research question for this study was, "How do adult clients experience talk therapy conducted while walking side-by-side with their therapist in an outdoor setting?"

Conceptual Framework

Therapeutic frame is defined as the physical setting, boundaries, roles, and expectations of client and therapist, including the relationship that is built between therapist and client that gives structure and creates expectations regarding power differentials, authority, and expertise wherein the clinician treats the client (Jordan, 2013; Jordan & Marshall, 2010; Langs, 1979). The conceptual framework that guided this study was how the frame of therapy influenced the experience of the client during the therapeutic process (Jordan & Marshall, 2010; Jordan, 2015). The interplay of the physical, mental, and social aspects of walk-and-talk therapy mirror the biopsychosocial model of health (Wade & Halligan, 2017); therefore, I also used the biopsychosocial model as a lens to view the therapeutic frame of walk-and-talk therapy.

Therapy is typically conducted in an enclosed setting in which aspects of the session, such as assurance of privacy and confidentiality, are controlled and monitored by the therapist and ensured by the physical setting (Jordan, 2015). Roles and expectations

are understood given the frame and the enclosed space is considered the territory of and controlled by therapist (Casement, 2014; Milton, 1993; Jordan, 2014). Clients normally go to traditional psychotherapy for therapists' expertise and expect to be treated by the therapist.

Engaging in walk-and-talk therapy in an outdoor setting where some physical boundaries are removed or conditions of the therapy session are unpredictable can both enhance or compromise the therapeutic experience for clients and therapists alike (Jordan, 2015; Jordan & Marshall, 2010; King, 2015; McKinney, 2011; Revell & McLeod, 2016). According to walk-and-talk therapists, walking side-by-side outdoors levels any power differential as neither client nor therapist possess any control over the environment (Jordan, 2015; Jordan & Marshall, 2010). Negotiating the unpredictability of setting, including weather and other people co-occupying the outdoor therapy space, creates additional uncertainties that further alter the context and experience of therapy. Clients conavigating these differences may, therefore, take greater ownership of the therapy session and any power differential normally experienced in indoor therapy may be lessened thereby potentially changing therapy dynamics (Jordan, 2015; King, 2015; McKinney, 2011).

Although primarily aimed at addressing psychological concerns, walk-and-talk therapists approach treatment from a perspective more akin to the biopsychosocial model by incorporating physical activity and nature exposure into their psychotherapy sessions. Changing the setting/context and altering the therapeutic frame may then create a new experience for clients. Introducing the additional physical components of exercise and

nature exposure within the frame of walk-and-talk therapy may alter the clients' perceptions of how these differences contribute to the therapeutic process or to subjective overall well-being. Therefore, with a qualitative, IPA approach, I explored the clients' overall experience of walk-and-talk therapy through a conceptual framework of therapeutic frame and biopsychosocial well-being.

Nature of the Study

Qualitative inquiry is designed to gain an in-depth understanding of a phenomenon, event, process, or the lived experience of individuals (Maxwell, 2005; Merriam & Tisdell, 2016; Moustakas, 2014). This study was conducted to understand in-depth adult clients' lived experiences of the phenomenon of the altered frame of walk-and-talk therapy. Because walk-and-talk therapy is a novel approach to psychotherapy, and the research that I was able to locate was limited and specific to therapists' perspectives, I chose a qualitative approach for a better understanding of adult clients' experiences of the frame of walk-and-talk therapy (Maxwell, 2005; Moustakas, 2014; Patton, 2015). A qualitative, IPA inquiry allowed for in-depth exploration of their experiences, including exploration of the context of the outdoor setting coupled with physical activity (Maxwell, 2005; Patton, 2015). Further information regarding the IPA approach is provided in Chapter 3.

Operational Definitions

Frame of therapy: The context, setting, and/or physical boundaries of the therapy session that establish the rules of engagement for therapy to include the relationship between client and therapist (Jordan, 2013; Jordan & Marshall, 2010; Langs, 1979).

Nature therapy: Exposure to nature/natural settings intended to decrease stress, improve relaxation, as well as reduce the toll of artificial and/or toxic physical stimuli (Li, 2018; Miyazaki, Park, & Lee, 2013).

Therapist: A licensed counselor, therapist, psychologist, social worker, or other licensed mental health provider (Hunter & Goodie, 2010; Smith, 2017).

Therapy: Treatment conducted by a licensed clinician typically involving conversational sessions (e.g., "talk therapy") between client and therapist for helping clients navigate and ideally realize improvement in mental, emotional, and/or behavioral issues (Smith, 2017). Additionally, it is called counseling or psychotherapy.

Walk-and-talk therapy: Therapy sessions conducted in an outdoor/natural setting where client and therapist walk side-by-side during the encounter (Jordan, 2015; King, 2015; McKinney, 2011).

Assumptions

I expected that study participants would be volunteers, participating of their own free will and that they would give accurate and honest descriptions of their participation in walk-and-talk therapy. Furthermore, I assumed that these participants' experiences, input, and responses would be genuine and valuable toward understanding in greater depth the practice of walk-and-talk therapy. I also assumed that the research question would elicit an accurate understanding of clients' experiences of the frame of walk-and-talk therapy and that study participants would be able to accurately articulate their understanding of the frame of walk-and-talk therapy sessions and its impact on their overall experience of therapy.

Delimitations

The focus of this study was limited to gaining a general understanding of clients' experiences of walk-and-talk therapy defined as talk therapy occurring in a natural setting while therapist and client walk side-by-side. This investigation did not include examination of the therapeutic frame of other types of nature-based or ecotherapy that include more intense interaction with nature and/or overcoming challenges or obstacles presented by intensive nature outings as is often encountered in wilderness therapy (Hoag, Combs, Roberts, & Logan, 2016; Tucker, Norton, DeMille, & Hobson, 2016). Rather, the focus was how clients experienced the unbounded outdoor environment combined with moderate physical activity by walking while also participating in traditional talk therapy. I did not delve into nor compare therapeutic modality (i.e., cognitive behavioral therapy versus psychoanalytic) used by the walk-and-talk therapists; the focus was on clients' perspectives of the frame regardless of therapeutic modality. Furthermore, findings were bounded by the characteristics of a small number of former walk-and-talk client participants who participated in therapy for mild to moderate psychological issues (e.g., depression, stress, anxiety, grief). These clients' symptoms may have met criteria for diagnosis, but symptoms were manageable with limited impairment in daily functioning and clients did not pose a danger to themselves or others at the time of therapy nor at the time of participation in this study (American Psychiatric Association [APA], 2013). Participants also resided in the United States and in areas with milder weather conditions. As a result of these delimitations, findings regarding clients' perspectives of the frame of therapy may differ from walk-and-talk therapy clients with

either more severe issues and/or those who participate in walk-and-talk therapy in areas with more severe weather conditions.

Limitations

There are risks associated with conducting qualitative inquiry related to validity because of generalizability (Maxwell, 2005). Internal generalizability may be problematic if the researcher only focuses on similarities between participant interview responses and is not attuned to any variations that arise between them. To increase the validity of this IPA, it was important for me to be mindful of and note any differences that surfaced from different client perspectives and between clients who participate in walk-and-talk therapy with different therapists and/or at different locations. In addition, qualitative research does not typically lend itself to external generalizability; however, IPA may serve as a launching point for later theory development (Reid et al., 2005; Smith et al., 2009).

Therapists and clients often have different experiences of therapy (Timulak, 2010). As a walk-and-talk therapist who believes there are synergistic benefits from combining traditional psychotherapy with walking outdoors, I acknowledged and managed this known personal bias (see Miles, Huberman, & Saldaña, 2014; Smith et al., 2009) when collecting and analyzing the data and reporting findings. Managing this personal bias began at the outset in forming quality, non-leading, open-ended questions (Smith et al., 2009; Yin, 2014) that allowed for various perspectives and rich descriptions of the clients' experience of walk-and-talk therapy. I also listened while avoiding preconceived ideas of where the research process and questions might lead. As new or unexpected ideas arose during the data collection and/or analysis phases, I was flexible

and followed these threads where they led. I overtly stated any biases I had, bracketed them, and was willing to entertain new thoughts and themes (Cooper & McLeod, 2015) being mindful that some biases would not arise until the data collection and analysis phases (Smith et al., 2009). I also journaled personal expectations and made notes during the process of personal perceptions, thoughts, and/or feelings regarding the process and the content (see Cooper & McLeod, 2015).

Significance

Therapeutic techniques have evolved over time through practice and study. Although sometimes research precedes practice, many new therapy modalities and practices are implemented based on therapist and/or client preferences and adjusted over the course of therapy based on experience and/or research findings (Casement, 2014; Harvey, 2016). Therapists' practices are more often informed by supervision feedback versus research (Gyani, Shafran, Myles, & Rose, 2014); however, supervision for walk-and-talk therapy does not currently exist because the practice is relatively new and there are no standards for it (Charbonneau, 2014). Walk-and-talk therapy has evolved over time as therapists and counselors have believed that adding exercise in a more natural outdoor setting to their therapy sessions would benefit their clients (Jordan, 2015). For instance, research has supported the therapeutic benefits of both exercise (Blair et al., 2012; Carek et al., 2011; Smith, 2015) and nature exposure (Chalquist, 2009; Jordan, 2015; Stigsdotter et al., 2011) separately and synergistically (Bratman et al., 2015; Shanahan, Fuller, Bush, Lin, & Gaston, 2015). It is important to use evidence-based

practices (AAMFT, 2016; APA, 2010; Gyani et al., 2014) because of standards of care that are regulated and on which insurance payments are often based (Mechanic, 2012).

Researching clients' experiences of the frame of walk-and-talk therapy helped give further understanding and may further define the practice, ensuring that therapists are providing evidence-based practices and demonstrating sufficient standards of ethical care. In addition, qualitative inquiry helps shape theory that, in turn, may be tested through future quantitative inquiry to hone and refine clinical practice (Sofaer, 1999). If walk-and-talk therapy is later found to be as effective, or more effective as talk therapy alone, clients may not only experience added psychological benefits by participating in the practice but also the added physical benefits of physical activity. It may also provide additional treatment options for clients who may not prefer traditional therapy in an office setting. Finally, once more is understood about how clients experience the frame of walk-and-talk therapy including what is helpful or hindering in the experience, adjustments may be made to maximize therapeutic benefit for the clients.

Summary

This first chapter provided background, and outlined the problem being addressed and the purpose of the study of walk-and-talk therapy. The research question, research objectives, and framework were also introduced as part of a qualitative research approach. Operational definitions were provided for important concepts and terms. Assumptions, limitations, and delimitations were also described. Finally, the significance of this study was discussed. The next chapter details findings from the literature review conducted to determine the gaps in the knowledge base regarding the topic of this study.

Chapter 2: Literature Review

Introduction

According to the National Institute of Mental Health [NIMH] (2018), talk therapy is a primary treatment for psychological conditions either in combination with psychotropic medications or as a stand-alone treatment. However, professionals may also recommend therapeutic lifestyle changes, such as physical activity, for psychological conditions such as depression or anxiety (Howell et al., 2016; Walsh, 2011). Physical activity is associated with physiological health benefits (Reiner, Niermann, Jekauc, & Woll, 2013; Soroush et al., 2013; Sykes, 2009; Warburton, Nicol, & Bredin, 2006) as well as improvements in psychological well-being (Rot, Collins, & Fitterling, 2009; Sykes, 2009), especially when physical activity is conducted in a more natural setting (Mackay & Neill, 2010; Stigsdotter et al., 2011; Wright, 2008). Many therapists who believe in the benefits of talk therapy and physical activity and nature exposure for overall well-being are now offering walk-and-talk therapy sessions outdoors as an alternative to traditional, in-office therapy (Jordan & Marshall, 2010; King, 2015; McKinney, 2011). These therapists are supporting the idea that well-being comes from connections to people as well as connections between people and places during particular times (Rybråten, Skår, & Nordh, 2017, p. 24) and during specific activities (Hays, 1994; Hays & Sime, 2014; Rahman, El Werfalli, & Lehmann-Waldau, 2017; Vincent 2017). For the most part, the content and process of walk-and-talk therapy remains the same as traditional therapy sessions conducted indoors; however, taking therapy outside while

walking together alters the context and frame of therapy (Jordan, 2015; Jordan & Marshall, 2010).

The practice of taking therapy outside the traditional office space into more natural settings changes not only the physical setting and therapeutic frame but may also create ethical considerations (Hooley, 2016; Reese, 2016). Per their professional codes of ethics, therapists should attempt to abide by the principles of beneficence and avoid maleficence while providing evidence-based services (AAMFT, 2016; APA, 2010) and provide services in which they have adequate understanding and training (Duros & Crowley, 2014). But despite its increasing popularity and use, there is little research regarding walk-and-talk therapy aside from an older study addressing adolescent client experiences with walk-and-talk therapy (Doucette, 2004) and a case study involving incorporating walk-and-talk with a client suffering with complex trauma whose progress had stagnated with other therapeutic modalities (Wessan, 2018). The remainder of the research regarding walk-and-talk therapy has been focused on therapists' perspectives of the practice. Therefore, the purpose of this study was to gain an understanding of the clients' perspective of the practice, which can establish aspects of walk-and-talk therapy that clients find helpful or hindering and whether the change of therapeutic frame might create potential harm to the client.

In this chapter I describe the literature search strategy including search terms and databases used. I describe the conceptual framework of therapy frame and biopsychosocial model of well-being. I also present literature that addresses the individual components of physical activity, nature exposure, and psychotherapy, as well

as the literature specific to walk-and-talk therapy. Finally, I discuss the gap in the knowledge base regarding walk-and-talk therapy including lack of information regarding the experience of walk-and-talk therapy from the clients' perspectives.

Literature Search Strategy

This literature review was conducted to examine the current knowledge base regarding walk-and-talk therapy and the individual components that comprise walk-and-talk therapy (i.e., physical activity/walking, nature exposure, and psychotherapy) in addition to determining what aspects of walk-and-talk therapy need further study. Psychology databases searched included PsycINFO, PsycARTICLES, PsychEXTRA, and SocINDEX using search terms "walk-and-talk therapy," "walk and talk therapy," "walk talk therapy," "walk talk counseling," "walk and talk counseling," "walking counseling," "walking therapy," "nature therapy," "outdoor therapy," "exercise and mental well-being," "nature and mental well-being." An iterative process was used as well in which reference lists of found articles and dissertations were used to uncover further resources pertaining to desired subject matter. In addition, U.S. Government and other academically recognized websites were used for gathering current information, statistics, and references for the most current research regarding physical and psychological health and well-being.

Conceptual Framework

The World Health Organization (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948, preamble, bullet 1). Thus, health encompasses not only aspects

that contribute to physical health but also psychological and relational health. In the United States, however, treatment is usually divided between physical versus psychological issues (Vanderbilt, Dail, & Jaberi, 2015), despite evidence that an integrated or biopsychosocial approach is useful for a myriad of healthcare outcomes (Wade & Halligan, 2017). This segmented health approach was described as a "dualistic separation of body and mind, nature and culture" (Rybråten et al., 2017, p. 4). Health and well-being are not experienced apart from environment but rather within and in dynamic relationship with environment and landscape (Rybråten et al., 2017). Further, there is a relationship between psychological and physical health wherein stress can create or compound mental and physical illnesses (Corazon, Nyed, Sidenius, Poulsen, & Stigsdotter, 2018). Thus, well-being may be understood as a synergistic interplay of physical, mental, emotional, relational, and environmental factors (Adams & Morgan, 2018; Rybråten et al., 2017) and approaches to health and well-being should address these aspects; however, Western medicine often has a different approach.

Western physicians typically treat physical ailments with physical interventions such as alterations in diet, recommendations for regular physical activity, or prescriptions for medications without addressing underlying or comorbid mental or emotional contributing factors (Vanderbilt et al., 2015). Clinicians generally treat mental and emotional issues with psychotherapy and/or psychotropic medications, as there is evidence for biological processes for these conditions (NIMH, 2018). On occasion, clinicians may recommend therapeutic lifestyle changes, such as physical activity, as an adjunct to therapy or medication (Kerling et al., 2015; Kyam, Kleppe, Nordhus, &

Hovland, 2016; Legrand & Neff, 2016), but incorporating physical activity into therapy sessions was not the norm until more recently.

Evidence supports the healing value of nature and natural surroundings for physical and mental health (Corazon et al., 2018; Feugen & Breitenbecher, 2018; Iwata et al., 2016; Korpela, Stengård, & Jussila, 2016), including incorporation of more natural elements in indoor treatment settings (Gessler, 1992; Ulrich, 1979) and the creation of outdoor intervention therapeutic programming (Bratman et al., 2015; Ulrich, 1979). Walk-and-talk therapy combines aspects of these dynamics—physical activity, traditional psychotherapy, natural setting, and relational interaction between therapist and client—in a way that may create a new dynamic and a different way in which clients' perceive their therapy experience and the altered frame of such (Jordan, 2015; Jordan & Marshall, 2010).

Approaches to health and well-being might be done via multiple means that include the various biopsychosocial processes as well as considering contextual components such as environment or the contribution of nature exposure. Therefore, the conceptual lenses that shaped this study included the biopsychosocial model of well-being and the frame of psychotherapy, in particular clients' experiences of the frame when therapy is conducted outdoors while client and therapist walk side-by-side. I examined what researchers discovered regarding the components of walk-and-talk therapy and the overlap of some of these various components and summarized in the following sections. This helped determine what was known and not known regarding the dynamic interplay of physical activity, psychotherapy, client and therapist relational

interactions, and nature exposure as it related to overall well-being, including mental and emotional well-being. Additionally, I reviewed the literature to date regarding the frame of therapy as well as the practice of walk-and-talk therapy.

Physical Activity

Physical activity has been correlated with many benefits to health and well-being. Beyond physiological benefits, other benefits of physical activity include increases in mood and cognition and increased creativity. These benefits, however, may be mediated by several factors such as level of enjoyment, characteristics of the location or environment where activity occurred, and social aspects and interactions during physical activity.

Benefits of Physical Activity

In the United States, efforts to promote public health have included the Surgeon General's 2015 Call to Action aimed at promoting disease prevention, encouraging a healthy lifestyle at every age and across demographics, and establishing healthy, walkable communities (Murthy, 2017; U.S. Department of Health and Human Services [HHS], 2015). Lack of physical activity is a public health crisis, and physical activity is important not only for physical health but for overall well-being (Blair et al., 2012; Febbraio, 2017; Hanson & Jones, 2015). Lifestyle factors including physical inactivity have contributed to rising noncommunicable disease rates such as cancer, diabetes, and cardiovascular disease (Reiner et al., 2013; WHO, 2018) as well as osteoporosis and osteoarthritis and gender-specific issues such as erectile dysfunction and polycystic ovary syndrome (Febbraio, 2017). WHO (2018) also described physical inactivity as

contributing to increased early mortality risk with 25% of adults lacking sufficient healthy activity levels globally. Age-related diseases as well as depression and other mental health conditions also correlate with level of physical activity (Carrera-Bastos et al., 2011; Reiner et al., 2013; Rot et al., 2009).

Regular physical activity lowers risk of early death by 30% (HHS, 2015). Adults meeting regular physical activity recommendations have also experienced better cardiorespiratory and muscular fitness as well as a lowered risk of a number of specific conditions including cardiovascular disease and metabolic syndrome (HHS, 2015). Generally, a minimum of 150 minutes per week of moderately intense physical activity, or 75 minutes per week of vigorous activity, has been recommended for minimal health benefits, with 300 minutes per week of moderately intense activity recommended for maximal health benefits (HHS, 2015; WHO, 2018).

In addition to physical activity recommendations, walking is one of the oldest forms of physical activity (Solnit, 2014) deemed generally safe and easy for most individuals (Murthy, 2017; HHS, 2015) and does not require any special equipment or training (Murthy, 2017; Sykes, 2009). As early as approximately 450 BC, Hippocrates attributed level of physical activity to physical well-being, likening walking to medicine (Febbraio, 2017). In the 1960s, a 10,000 steps per day benchmark was established for adults based on Japanese walking group research outcomes coupled with an advertising campaign for pedometers (Tudor-Locke, & Bassett, 2004). This 10,000 per day step measure also correlated with meeting recommended WHO time-based physical activity guidelines (Wattanapisit & Thanamee, 2017). A review of English-language articles

between 2000–2016 on benefits of adults meeting the recommended 10,000 per day step goal revealed benefits for health issues including body composition measured by weight and body fat, bone density, blood pressure, and cholesterol (Wattanapisit & Thanamee, 2017). Interventions aimed at reaching and maintaining the 10,000 step daily goal have included reinforcement via prizes, gift cards, and other items of value as well as pedometer-based interventions including those with individualized motivation and feedback (Wattanapisit & Thanamee, 2017). Additionally, family- and community-based campaigns with community-based interventions over a 1-year period have resulted in an 8% increase in individuals reaching the targeted 10,000 per day step goal (Wattanapisit & Thanamee, 2017). Participants across studies have reported walking as an accessible and popular way in which to achieve physical activity guidelines with little risk of injury (Wattanapisit & Thanamee, 2017).

Further research has also supported the benefits of walking. In the United Kingdom, focus group interviews were conducted with three walking groups and their leaders to determine perceived benefits and sustainability of these groups (Raine, Roberts, Callaghna, Sydenham, & Bannigan, 2017). Participants reported many subjective benefits including immediate and longer-term improvement in feelings of well-being. Participants also reported making additional healthy behavior changes, such as changes in their diet, because of their engagement in the walking groups (Raine et al., 2017). Being outdoors and making social connections with others served as added benefits to well-being as well as reasons participants cited for continued walking group attendance (Rain et al., 2017). Some walking group participants reported that they also

began incorporating walking and other healthy behaviors with partners, family members, or friends (Raine et al., 2017). Participants reported that they wished primary care providers would consider offering walking groups as an alternative to their general recommendation of a gym membership (Raine et al., 2017). Walking is cost-effective compared to other types of physical activity, is considered beneficial for overall well-being, and participants sustained this activity through social interactions and nature exposure (Raine et al., 2017).

Despite the ease in which individuals can incorporate walking as physical activity and despite an abundance of knowledge regarding the benefits, Americans walk far less than in generations past in industrialized nations (Vanderbilt, 2012). For example, a Canadian Amish group whose labor-intensive, farming lifestyle has remained largely unchanged was observed in a study using pedometers, and participants averaged step rates of 18,000 per day (Bassett, Schneider, & Huntington, 2004) versus current average daily rates for Americans of 5,117 steps (Vanderbilt, 2012). In another study of physical activity levels of persons participating in a simulated historical lifestyle activity in Australia, participants averaged walking an estimated 16 kilometers per day, equating to more than twice that of modern levels of physical activity (Egger, Vogels, & Westerterp, 2001). As adults are less physically active and subsequently suffer from lower overall fitness, their risk for physical illness rises, but physical activity and fitness can improve physical health as well as mental and emotional well-being.

Mental/Emotional Benefits of Physical Activity

Physical activity is a beneficial treatment for many noncommunicable diseases and age-related diseases, and it serves as a preventative measure for mental conditions (Reiner et al., 2013). Physical activity has been efficacious as a treatment for psychological issues such as depression (Rot et al., 2009), anxiety (Mackay & Neill, 2010), age-related dementia, and Alzheimer's disease (Reiner et al., 2013). Exercise has been positively correlated to mood and cognition improvements with even greater improvements in mood related to walking/exercising in a more natural setting versus walking in a more urban setting (Bratman et al., 2015). Physical activity has also been positively correlated to improvements in symptoms of mild to moderate depression similar to medication and as an adjunct to psychotropic medications (Carek et al., 2011). In addition, cardiorespiratory physical fitness has been associated with lower occurrences of more severe depression or anxiety in a population of adults aged 25-83 regardless of type of physical activity in which they engaged (e.g., leisure, occupational, or sport; Baumeister et al., 2017). Individuals who have walked with others versus those who have not have also experienced improvements in quality of life (Meads & Exley, 2018).

Physical activity has also been associated with hedonic well-being (i.e., positive affect and avoidance of negative feelings) and eudaimonic well-being (i.e., self-realization and meaning making; Ettema & Smajic, 2015). Based on research from the mid-1990s through the middle of the first decade of the 2000s regarding the association between physical activity and mental/emotional health, physical activity for various age and gender groups was linked to increases in psychological well-being including

improvements in symptoms of depression similar to improvements with treatment with antidepressant medication (Carek et al., 2011). Physically inactive individuals were more likely to develop psychiatric symptoms (Carek et al., 2011). Individuals who participated in physical activity have reduced use of medications for depression and anxiety, which reduces the expense associated with medication in addition to reducing severe side effects associated with psychotropic medications (Carek et al., 2011). Furthermore, trauma interventionists have often involved physical activity to encourage change in limbic responses because trauma frequently manifests in physical symptoms (Duros & Crowley, 2014). The literature has thus supported the benefits of physical activity for a variety of psychological issues as well as overall well-being. Researchers have also identified additional benefits of physical activity likely of further interest to therapists.

Other Benefits of Physical Activity

Other benefits of physical activity have been discovered, including those reported from a study designed to test creativity effects of walking versus sitting, and walking indoors versus outdoors, as well as controlling for exposure to nature (Oppezzo & Schwartz, 2014). Creativity increased after walking whether indoors or outdoors; however, participants experienced increased novel thoughts when outdoors and talked more when walking outside (Oppezzo & Schwartz, 2014). Although focused on business, work, or school settings (Oppezzo & Schwartz, 2014), the results of this study are important as clients are often in need of new approaches to their issues. For this reason, these findings were also important when considering how walk-and-talk therapy might influence ideas and progress in therapy.

In another phenomenological study on walking, 73 residents of a mid-sized town in southeastern Norway were interviewed (Rybråten et al., 2017). Participants described walking as a dynamic experience offering multiple benefits including the opportunity to experience their surroundings, lose themselves in thought and contemplation, socialize with others along the way, as well as being a form of transportation from one place to another (Rybråten et al., 2017). Although walking was a form of exercise, many of the study participants also mentioned walking at a slower pace was a form of relaxation (Rybråten et al., 2017). Participants described an experience of *place making* as they integrated their surroundings, senses, and subjective experience with the physical activity of walking (Rybråten et al., 2017).

These findings reflect some of the change clients may experience through adding physical activity to therapy, such as feeling differently about the efficacy of their therapy experience and how it influences their overall well-being. They may also feel more open and creative in exploring and addressing their concerns. There are additional mediating factors related to individuals' enjoyment of physical activity.

Mediating Factors Related to Benefits of Physical Activity

Duration and intensity are some of the many mediating factors that appear to influence the benefits of physical activity (Soroush et al., 2013). Participant level of enjoyment of the activity influenced participation, long-term follow-through, and short- and long-term benefits (Ettema & Smajic, 2015; Raine et al., 2017). Other mediating factors included having safe spaces for physical activity (Ettema & Smajic, 2015; Grant, Pollard, Allmark, Machaczek, & Ramcharan, 2017; Rybråten et al, 2017), having

stimulating environments (Ettema & Smajic, 2015; Grant et al., 2017), as well as having sufficient level of *greenness* or natural surroundings (Ettema & Smajic, 2015; Raine et al., 2017). Social context was also important as individuals reported greater enjoyment and well-being (Grant et al., 2017; Meads & Exley, 2018; Rybråten et al., 2017), as well as sustained participation when being physically active with others (Raine et al., 2017). Although older individuals cited health as the main reason to join a walking group, social relationships built during group walks influenced continued participation (Grant et al., 2017).

Individuals often walk alone by choice but sometimes out of necessity (Rybråten et al., 2017). Loneliness is considered a current public health dilemma and walking solo was viewed as a lonely endeavor (Rybråten et al., 2017). To counter the loneliness, individuals assigned a specific purpose to their walks (Rybråten et al., 2017). Participants viewed walking solo positively when it was for reflection and restoration within the context of and in dynamic relationship with the landscape and surroundings (Rybråten et al., 2017). Frequently individuals preferred walking with others for companionship while simultaneously processing life and meaning (Rybråten et al., 2017). Males aged 40-50 felt less positively about walking when there were other transportation options, and desired to walk with others only if there was an associated purpose or destination (Rybråten et al., 2017). However, as men aged they considered walking with others important for health and social connection (Rybråten et al., 2017).

The literature thus supported physical activity for overall well-being, including physical, psychological, and social enhancement as benefits and reasons for sustained

participation. In addition, incorporating physical activity in an outdoor setting was restorative and enhanced the benefits of solo physical activity. Though helpful in understanding the benefits of exercise outdoors, including exercising with others, these studies were not specifically aimed at gaining understanding of walk-and-talk therapy, or the benefits for individuals psychological distress. As previously mentioned, traditional therapy has been conducted within the frame of an office to support confidentiality and set the tone of the therapeutic encounter. The following section addresses traditional talk therapy and frame.

Traditional Therapy

Therapeutic lifestyle changes such as physical activity are considered beneficial for physical and mental health, for proactively promoting general well-being, and for treatment of mental health diagnoses (Howell et al., 2016; Walsh, 2011). Although clinicians may be familiar with the overall benefits of therapeutic lifestyle changes, physical activity is often categorized as a treatment for physical health or is considered an adjunct to talk therapy for mental health (Walsh, 2011). Most therapy continues to occur in a safe (Duros & Crowley, 2014), enclosed space, free from distraction (Jordan, 2015; Jordan & Marshall, 2010; Langs, 1979), Though therapeutic approach or treatment modality might differ among therapists, traditional psychotherapy has remained focused on talking therapies (Chalquist, 2009), and the efficacy of traditional talk therapy is supported by research.

Benefits of Therapy

Talk therapy as a treatment for psychological well-being has been well researched with correlations between psychotherapy and improvements in mental health similar to treatment with psychotropic medications alone (Hollon & Ponniah, 2010; NIMH, 2018; Substance Abuse and Mental Health Services Administration [SAMHSA], 2017), or increased benefit in mental health when therapy was combined with medication (Hollon & Ponniah, 2010; NIMH, 2018; SAMHSA, 2017). Many specific talk therapy interventions are regarded evidence-based practices and deemed better for specific mental disorders, such as mild to moderate depression or anxiety (NIMH, 2018; SAMHSA, 2017). With psychotherapy, individuals may experience the added benefits of circumventing or managing future psychological symptoms even after therapy has ceased whereas symptoms could return when medication is discontinued (Hollon & Ponniah, 2010). In addition, some individuals are unable to tolerate specific medications or are unable to obtain sufficient symptom relief from medication alone (Hollon & Ponniah, 2010). Walk-and-talk therapists reported their outdoor therapy sessions were informed by the same theories (Jordan, 2014) and treatments they used during indoor sessions (Revell & McLeod, 2016). Therefore, this literature review focused more specifically on aspects common to most indoor therapy experiences including the therapeutic frame rather than treatment modalities.

Frame of Traditional Therapy

Physical setting. In the early stages of psychoanalysis, Freud organized the physical setting of the therapy room with therapist sitting out of client's sight to create a

space he believed conducive to his psychoanalytic model (Freud, 1913; Laws, 2009). During the 1960s, counselors such as Rogers altered the therapeutic space so client and therapist faced each other to facilitate the empathy and genuineness believed crucial to the processes of therapy (Laws, 2009; Rogers, 1961). This face-to-face arrangement remained the standard for therapeutic frame (Laws, 2009) with a few exceptions.

The *Freudian couch* was revisited to investigate how Jungian therapists have evolved in their use of chair or couch in the therapy space (Connolly, 2015; Wiener, 2015). A number of prominent therapists' beliefs were explored regarding whether a couch for reclining, or a chair for sitting face-to-face was more conducive to the therapeutic process, specifically when using the psychoanalytic approach (Connolly, 2015). A lack of research existed that demonstrated either couch or chair was better or preferred by clients or therapists (Connolly, 2015). Having an office setting with a *proper* couch that may be used by clients to sit or recline facing toward or away from the therapist allowed the client to choose what was most comfortable with the option to change position at any time, and was considered informative to the therapeutic process (Connolly, 2015). Therapists may have offices containing a chair that clients may chose if they feel uncertain or unable to participate in the depth of work they believe they must do if using the couch; however, the office setting reflects the person of the therapist and their approach to therapy (Connolly, 2015; Wiener, 2015). Although therapists expressed differences of opinion and practices regarding couch versus chair for specific therapeutic modalities, therapists reinforced a model with an indoor setting and comfortable furniture where client had the option to recline or sit and to opt for or against eye contact

(Connolly, 2015; Wiener, 2015). Despite allowing clients these choices, therapists continued to maintain power in choice of furnishings and arrangement that set the tone and implied expectations for therapy (Connolly, 2015; Wiener, 2015). This further reinforced clients' perception that indoor therapy offices create a space, frame, and power differential in favor of therapists (Jordan, 2013).

Therapeutic frame. Two prominent voices in the field of psychodynamic therapy regarding what aspects of the therapeutic frame are secure versus deviant, or necessary versus flexible are Langs and Casement (Milton, 1993). Langs (1979) considered a number of items important to create a secure frame of therapy in order that a basic sense of trust was established between client and therapist, interpersonal boundaries were clearly articulated and understood, and healthy, balanced therapeutic work focused on the client's issues was conducted (Milton, 1993). This secure frame required a private, soundproof office space; sessions with set time, length, and fee; and set places for client and therapist with no physical contact occurring between them (Langs, 1979; Milton, 1993). Therapist attention to these fixed, steady aspects of therapy created a secure space in which client trust of therapist as competent and sane professional was established and where psychodynamic therapy could be conducted in a fluid and dynamic manner for the purpose of symptom resolution (Langs, 1979; Milton, 1993). Langs viewed any change in the frame that altered any secure aspect less than optimal and a threat to the quality of therapy (Milton, 1993).

Casement (2014; Milton, 1993) agreed with Langs regarding many aspects of therapeutic frame including a confidential and private meeting space with set

appointment times, and no physical contact; however, Casement indicated a willingness to consider some flexibility that met client needs (Casement, 2014; Milton, 1993). Specifically, client should determine what positions client and therapist assumed during the therapeutic encounter (i.e., face-to-face or some other positioning) and use of the therapeutic space based on what the client found comfortable and therapeutic (Casement, 2014; Milton, 1993). The frame of walk-and-talk therapy would be considered radically deviant given an outdoor setting where other individuals might be encountered or might overhear the content of therapy (Jordan & Marshall, 2010); however, it provides another option for clients who might not find indoor office spaces therapeutic. Beyond setting the stage for the work of therapy, the frame of therapy assists therapists in other ethical obligations to their clients.

Ethical considerations. Mental health clinicians' professional codes of ethics help ensure client beneficence and avoidance of maleficence (AAMFT, 2016; APA, 2010). Professional ethics cover a variety of aspects that help establish therapeutic frame including client confidentiality and safety. In addition, clinicians are expected to be trustworthy, and to provide interventions backed by research in which they have adequate training and experience (AAFMT, 2016; APA, 2010; Duros & Crowley, 2014), as well as providing cost-effective services that meet client needs (Anderson & Brownlie, 2011).

Confidentiality and safety. The types of topics discussed in therapy sessions are often quite sensitive and likely to evoke strong emotions (McLeod, 2013). An indoor, enclosed office space ensures these conversations are not overheard, as well as creating a space in which client and therapist have a measure of safety from outside influences

(Jordan, 2015; McLeod, 2013). In addition, it is important therapists only practice interventions in which they are sufficiently educated and their licensing boards recognize (Duros & Crowley, 2014). Beyond a safe, secure meeting space, and the assurance of confidentiality, researchers declared the importance of the relationship between client and therapist was key as well.

Therapeutic alliance/relationship. The relationship between therapist and client is a common factor determined important to the success of therapy outcomes (Laska, Gurman, & Wampold, 2014; Wampold, 2015). Clients need to be able to trust their therapist; know the therapist has the necessary qualifications and expertise to manage their particular issue; and know the therapist is willing to engage in a genuine, empathic relationship (Wampold, 2015). This relationship creates human connection, or attachment, important to the success of therapy (Wampold, 2015). Human connection in the context of psychotherapy creates a supportive environment to explore difficult circumstances and emotions thus adding to the aspect of safety (Wampold, 2015). Beyond relationship and support, the therapeutic alliance consists of agreement about the goals and tasks of therapy (Wampold, 2015). Therapeutic alliance is generally solidified early in the therapy process—usually by the third or fourth session—and is highly predictive of outcome (McLeod, 2013; Wampold, 2015). Thus, the frame of therapy includes a relational component built on trust and agreement regarding goals and tasks of therapy. Despite efforts of therapists to create a confidential and safe space, as well as a trusting relationship conducive to therapy, some individuals continue to experience barriers seeking therapy.

Barriers to Seeking Psychotherapy

Despite benefits and successful therapy outcomes, barriers to seeking psychological treatment continue to exist. Because of the stigma associated with mental health, many individuals do not seek help until they have endured tremendous mental, emotional, or relational distress (Charbonneau, 2016). In addition to this stigma, cost of treatment prevents people from seeking psychological intervention (Anderson & Brownlie, 2011). Barriers are often associated with client demographics, such as socioeconomic status, age, gender, race, or level of education (Anderson & Brownlie, 2011), as well as attitudes about perceived need for treatment, or issues related to cost or availability of treatment (Andrade et al., 2014). Older people, males, and those with less education are less likely to seek emotional support thus prompting the question of whether less formal and less stigmatizing approaches might be more beneficial (Anderson & Brownlie, 2011). Poorer and lower educated individuals are less likely to seek out therapy yet most likely to be prescribed medication for psychological issues (Anderson & Brownlie, 2011) despite evidence that therapy may be as beneficial as medication with less chance of relapse over time (Hollon & Ponniah, 2010). Furthermore, not everyone finds the traditional frame therapeutic (Laws, 2009). Cockrell echoed this with his belief that walk-and-talk therapy was well suited for men because walking side-by-side avoided the intimate and potentially intimidating face-to-face posturing in traditional therapy (Wright, 2008).

An ethnographic study was conducted with a group of 23 individuals who organized their own *psychiatric survivor* support group upon discharge from a psychiatric

facility in Northern England and themes of therapeutic spaces and places emerged from their responses (Laws, 2009). Participants purposely chose meeting spaces others deemed dissident but that aligned with their identity and needs because traditional therapy spaces and methods were not meaningful or therapeutic for them (Laws, 2009). Participants viewed therapeutic spaces, places, and methods subjectively, and felt that traditional spaces and rules regarding session length and processes created an atmosphere where therapist maintained control (Casement, 2014; Milton, 1993; Jordan, 2014) and power, and client was passive (Laws, 2009). The members of the *survivor* group "appropriated" (Laws, 2009, p. 10) spaces for themselves outside of the norm thus mirroring taking control of their lives, health, and therapeutic processes. Conversely, for others the confinement of a walled therapy space was preferred and more therapeutic (Laws, 2009). Participants demonstrated activism and action in their recovery process through their appropriation of space and in the manner in which they sought change for themselves and others (Laws, 2009). These individuals were able to externalize their mental turmoil by meeting outdoors and maintaining an outward focus (Laws, 2009). This study was important because the concept of *therapeutic* can be subjective. Weaknesses of this study were its inability to be applied or generalized broadly because the participant group was quite narrowly defined and unique as members either partially or totally rejected traditional psychotherapy or psychiatric treatment.

Thus there are a myriad of considerations regarding what is therapeutic for clients and also meets professional ethical standards. Although talk therapy has been one of the primary treatments for psychological distress, a number of individuals have challenged its

focus on cognitions and insisted that interventions should attend to bodily processes because psychological distress manifests in the body (Young, 2008). Approaches have ranged from attending to body language or nonverbal cues in talk therapy or incorporating physical activity as an adjunct to or within talk therapy, to incorporating specific movements, dance, or yoga in therapy sessions. The next section addresses incorporation of the body in psychotherapy.

Physical Activity, the Body, and Therapy

Despite early theorists and practitioners believing in a mind-body connection (Janet, 1905; Janet, 1906; Young, 2008) and treating individuals with "psychoorganismic totality" (Brown, 1973, p. 100), psychotherapy in its current form has separated mind and body and focused mostly on cognitions (Young, 2008) with some focus on interpretation of body language or nonverbal communication (Watchel, 1967). Freud incorporated integration of physical aspects into treatment considerations with his early focus on libido; however, he later focused on unconscious mental states to the exclusion of any form of physical components in his psychoanalytic treatment modality (Young, 2008). Reich practiced psychoanalysis with a focus on the interconnectivity of mind and body, but was expelled from the Psychoanalytical Association in 1934 thereby ushering in the *un-embodied*, cognitive approach to psychotherapy (Young, 2008). Nevertheless, Reich and others continued to champion the interconnectedness of body and mind. A resurgence of body therapies, including Gestalt, Reichian, Lowenian Bio-energetics, and Janov's primal therapy, occurred in America when a new wave of psychologists and mental health clinicians embraced the "wisdom of the body" (Brown, 1973, p. 98). These

iterations of combining body and mind in psychotherapy continue to exist in therapeutic practice; however, the approach to the importance of body in therapy has taken different forms in more recent years.

Physical Activity as an Adjunct to Therapy/Counseling

The benefits of physical activity for overall well-being have been well established and many providers recommend physical activity for psychological distress; however, this recommendation is often as an adjunct to psychotherapy or pharmacologic treatments (Howell et al., 2016; Walsh, 2011) because research supports physical activity as an adjunct to psychotherapy.

In the 1970s, Kostrubala (1976; 2013) was an early adopter of combining psychotherapy with outdoor exercise. Having participated in a cardiac rehabilitation group, Kostrubala (2013) experienced health benefits that he believed would translate well to his psychiatry practice. Over time, his clients participated in running therapy in which they ran and walked at their own pace in order to maintain target heart rates for a designated period of time, after which they participated in a group therapy session (Kostrubala, 2013). Running therapy correlated not only with physical health benefits, but also benefits for depression and schizophrenia (Kostrubala, 1976; Kostrubala, 2013). Similarly, Gontang (2009) and Hays (1994) used running or walking with some of their clients because of their belief in the added psychological benefits, as did Glasser (1989) because of his belief in a need for an alternative approach to address the needs of one of his adolescent female clients.

A feasibility study was conducted to examine whether combining aerobic exercise as an adjunct to cognitive behavior therapy would be beneficial for posttraumatic stress disorder (PTSD) for survivors of sexual assault. Results related to improvement in PTSD symptoms were not measured; however, retention and satisfaction with cognitive behavior therapy plus exercise was extremely high (Smith, 2015). This finding could be of importance when examining the combination of talk therapy with exercise outdoors as retention and satisfaction with therapy may be predictive of better outcomes. These findings are also important because of the added benefit of exercise with traditional talk therapy for psychological symptoms. Using physical activity as an adjunct to psychotherapy, naturally led the abovementioned therapists to incorporate physical activity into their therapy sessions.

Including Physical Activity in Therapy

A number of therapies exist where clinicians use physical movements, stimuli, and body-mind approaches to treat specific psychological issues and stress. Mind-body theories are based on the belief that environmental and psychological stressors create a physical stress response and by attending to the physical manifestations these effects may be lessened or reversed (Payne & Crane-Godreau, 2015). Reich believed that individuals developed somatic symptoms for psychological distress through *body armoring* and that therapeutic interventions needed to be physical as well as psychological (Young, 2008). Increasingly therapists have used body movement such as dance (Burns, 2011), yoga (Gangadhar & Varambally, 2015), and mindfulness practices (Gu, Strauss, Bond, &

Cavanagh, 2015) to attend to bodily sensations and create self-reflective practices for relief of mental and emotional distress.

As indicated by media reports, a number of therapists have introduced physical activity into their therapy sessions in the form of walking or running (Abcarian, 2017; Chillag, 2017; Knox, 2017; Magner, 2017: Maher, 2017; Maxted, 2017; Neely, 2017: Packhams, 2015) including introducing walking in support groups (Barton, 2011), yet it is not an entirely new practice. A number of clinicians have included walking or running as part of their therapeutic repertoire, with Freud rumored to have walked with his clients through the streets of Vienna (Jordan & Marshall, 2010; Karp, 2011) prior to settling on an enclosed office model of therapy.

In the 1960s, Glasser, a psychiatrist, and the creator of Reality Therapy (Glasser, 1989) worked with young, delinquent females in a residential setting at the Ventura School for Girls in California. Glasser also focused on addictive behaviors, believing in a principle of "positive addiction" (Kottler & Carlson, p. 57) where individuals could replace unhealthy behaviors with healthy behaviors. Doubting the lasting effects of talk therapy alone, Glasser decided to prescribe physical activity in the form of running for one patient (Kottler & Carlson, 2003). Being a runner who frequently recommended physical activity as an adjunct to therapy for other patients, Glasser decided to run with this young woman twice a week while simultaneously conducting their therapy sessions (Kottler & Carlson, 2003). This young woman experienced success with these running sessions, and experienced improvements in well-being as she transitioned from

controlling her unhealthy food intake to controlling her physical activity in a healthier manner (Kottler & Carlson, 2003).

Hays (1994; 1999) also championed physical activity as therapeutic for psychological issues by itself, as an adjunct to therapy, as well as conducted simultaneously with talk therapy. Clients experienced cognitive benefits during and after physical activity, and they were able to use symbolism and metaphor, as well as use nonverbal communication during sessions where exercise was incorporated (Hays, 1994). Therapists who engage in physical activity may also serve as example and role model for clients (Hays, 1999); however, engaging in physical activity alongside clients is not without potential consequences (Hays, 1994; Hays, 1999). For instance, clients may have concerns about their level of fitness compared to their therapist or running alongside their therapist may develop into a competition or power struggle (Hays, 1999). Overall, however, clients enjoyed synergistic benefits when their therapist joined them in physical activity as a part of their therapy process including shifting control and responsibility for outcomes from therapist to client (Hays, 1999). Additionally, therapists were cautioned to consider the changes in boundaries and power (i.e., frame), as well as issues of confidentiality when conducting therapy sessions outdoors while engaging in running or walking (Hays, 1999).

Thus, for quite some time therapists have believed in the benefits of physical activity for overall well-being, including psychological well-being. Incorporating physical activity for psychological benefit is not a new phenomenon; however, there are numerous considerations for therapists opting to include physical activity in therapy

sessions. Duros and Crowley (2014) described how trauma impacts clients' bodies in addition to their emotions thus there has often been a need to incorporate alternative interventions beyond talk therapy; however, in doing so there was also a need to ensure client safety and comfort. Running or walking has typically been the easiest way in which to incorporate physical activity into a therapy session (Hays, 1999) with walking being a much less strenuous activity in which most individuals can engage easily and safely (Murthy, 2017; HHS, 2015, Vanderbilt, 2012); however, therapists did not begin incorporating walking in therapy sessions in a more mainstream manner until the early 21st century.

The experiences of the professionals mentioned earlier are important because these clinicians reported benefits for overall well-being, as well as specific psychological benefit (Hays, 1994; Hays, 1999; Kostrubala, 1976; Kostrubala, 2013; Kottler & Carlson, 2003); however, other than Hays, these clinicians failed to address issues that may arise when combining physical activity in a therapy session. In addition, Kostrubala typically engaged clients in running in a group setting at a track where clients could run at their own pace with group therapy sessions occurring after their running sessions (Kostrubala, 1976; Kostrubala, 2013). Thus, these clients did not truly experience the phenomenon of simultaneous physical activity and talk therapy. In addition, these accounts of incorporating exercise as an adjunct or as part of the therapy session were not from the clients' perspectives. Furthermore, because of the location of their sessions, the participants' experiences may have differed from clients whose therapist engaged them in walk-and-talk therapy in a park or forest setting. It is unclear in what setting Glasser

incorporated running therapy with his client suffering with an eating disorder. As mentioned earlier, the settings in which physical activity occur are a mediating factor influencing participant experiences with physical activity in more natural settings being correlated with greater improvements in mood than physical activity in more urban settings (Bratman et al., 2015; Shanahan et al., 2015). Thus it is important to examine the importance of nature exposure to well-being.

Nature Exposure

As early as the 1980s, those living in more industrialized nations spent greater than 90% of their time indoors (Chalquist, 2009). This increased time indoors, in built environments, particularly in crowded urban settings is often associated with increased stress and decreased well-being (Chalquist, 2009). Nature exposure has been found to be a mitigating factor for psychological health as individuals were able to reconnect with nature (Burns, 2011; Chalquist, 2009). Exposure to outdoor settings, particularly green spaces, and those located close to water such as a lake or ocean, correlated with restorative properties (Ulrich, 1979; Jordan, 2015). *Shinrin-yoku*, or forest bathing, was also deemed beneficial for physical and psychological health (Li, 2018). Adolescents participating in wilderness therapy also experienced improvements in psychological health (Hoag et al., 2016). It is important to consider the healing power of exposure to natural environments given the increasing trend toward urban living and subsequent negative health effects (Shanahan et al., 2015). Individuals experiencing emotional stress exacerbated by urban environments might benefit from nature exposure resulting in emotional and physical health improvements (Stigsdotter et al., 2011). Similar to

traditional talk therapy and physical activity, there is evidence supporting nature exposure for psychological and overall well-being, as well as in combination with either talk therapy or physical activity.

Benefits of Nature Exposure

The benefits of nature exposure have been studied extensively from a variety of perspectives ranging from viewing natural settings (Ulrich, 1979; Ulrich, 1984) and incorporating natural elements into indoor environments (Gessler, 1992) to immersive experiences in nature (Hoag et al., 2016; Li, 2018). Ulrich (1979; 1984) examined the effects of nature exposure on physical and psychological health. Individuals recovering from surgery had a quicker recovery and better relationship with hospital staff when they recovered in a room with a window view of a more natural setting (Ulrich, 1984). In addition, individuals who viewed natural versus urban landscapes reported higher subjective psychological well-being (Ulrich, 1979). Differences exist between passive versus active interaction with natural versus built settings as well .

In a study in which 60 participants were randomly assigned to two groups, participants who walked in more natural settings versus urban setting had greater affective and cognitive benefits (Bratman et al., 2015). The contribution of nature exposure to better cognition and affect may be explained by stress reduction theory and attention restoration theory; however, further examination of different types of natural environments and different lengths of time spent in them, as well as assessment of affect and cognition at various times during the walks as opposed to only at the conclusion of the walks was recommended (Bratman et al., 2015). In this study psychological

differences between walking in urban versus natural settings were highlighted the effects of walking were controlled, thus reinforcing the therapeutic benefit of nature, allowing for further examination of the talk therapy component, and highlighting a need for further study of the influence of different environments and lengths of time spent walking.

The influence of exercise versus rest indoors and outdoors were compared through an experimental study and findings of increased positive affect and energy through exercise and nature exposure were discovered (Fuegen & Breitenbecher, 2018); however, in contrast to Bratman et al. (2015), no significant improvement in attention was reported as a result of exercise or nature exposure (Fuegen & Breitenbecher, 2018). Activity conducted either indoors or outdoors was found better than no activity for a boost in energy (Fuegen & Breitenbecher, 2018). Improvements in affect occurred with either activity indoors or outdoors, or resting outdoors, with greatest gains in positive affect from exercise outdoors (Fuegen & Breitenbecher, 2018). Thus, therapists working with individuals with mood disorders may want to consider incorporating physical activity and nature exposure during, or as an adjunct to therapy sessions.

In a randomized control trial comparing nature-based therapy to a cognitive behavioral approach for stress management, nature-based therapy was associated with similar results in improvement in mental and physical health symptoms at the conclusion of the intervention, but also a year post intervention (Corazon et al., 2018). In addition, participants in both treatment groups experienced long-term reductions in healthcare utilization thus further supporting the efficacy of nature-based therapies for psychological

and physical well-being (Corazon et al., 2018), a finding likely of importance to policy makers, healthcare organization leaders, and insurance payers.

In another pilot study investigating the correlation between mental well-being, depressive symptoms, and restorative benefits from a treatment intervention including nature walks at alternating treatment sessions, participants experienced increases in mental well-being and decreases in depression over the course of the eight-week intervention continuing through the 3-month follow-up (Korpela et al., 2016). In addition, the nature walks versus the indoor treatment experiences appeared to mediate the increases in positive mental well-being from baseline through follow-up (Korpela et al., 2016). This study was significant because of its focus on individuals with a diagnosis of depression because most research on the relationship between nature exposure and well-being has been done with the general population (Korpela et al., 2016).

Although research has supported ties between exposure to nature and overall well-being including physical health benefits and subjective overall well-being, there was need for further study of how much of a *dose* (i.e, frequency and duration of exposure) of nature was required to obtain and/or sustain health benefits (Shanahan et al., 2015). This was important in light of urbanization and increased proportions of the population living within urban environments with less nature or green spaces (Shanahan et al., 2015). Moderating factors that could influence dose included culture, socioeconomic status/advantage, personal preferences, and/or demographics (Shanahan et al., 2015). This is of interest because of the connection between health and nature, as well as the importance of measuring how often or for how long people need to experience nature

before they experience benefit. Although individuals exercising alone or in natural settings may experience gains, and individuals experiencing nature exposure alone may also experience benefit to well-being, it would be important to know how much clients benefit from a single, weekly, 45-minute walk-and-talk therapy session.

These studies demonstrated evidence that nature exposure was beneficial for overall well-being, including a decrease in depressive symptoms for those carrying a diagnosis of depression (Korpela et al., 2016) and nature-based therapy should be formatted to meet client needs (Stigsdotter et al., 2011). Thus, a variety of nature-based therapies exist that have paved the way for walk-and-talk therapy, including ecotherapy, nature therapy, horticulture therapy, animal-assisted therapy, adventure, and wilderness therapy.

Types of Nature-Based Therapies

The field of nature or outdoor therapy has expanded in recent years. Ecotherapy, or the application of ecopsychology, is a broad term referring to numerous treatment approaches involving nature exposure or activities incorporating interaction with nature to enhance psychological well-being (Chalquist, 2009; McLeod, 2013). Various modalities include, but are not limited to, nature therapy (Berger & McLeod, 2006), horticulture therapy (Soderback, Soderstrom, & Schalander, 2004), animal-assisted therapy (Kamioka et al., 2014; Maujean, Pepping, & Kendall, 2015), and wilderness or adventure therapy (Chalquist, 2009; McLeod, 2013). Clinicians frequently use wilderness and adventure therapy with younger populations, whereas older populations might find less intense ecotherapy interventions such as gardening or nature-based walking groups

more appealing. Though the manner varies in which therapists conduct nature-based therapies and interventions, as do the amount of focus therapists direct toward interaction with nature, these therapies have the common elements of a natural setting, greenspace, or incorporation of natural components (Stigsdotter et al., 2011). Therapists who conduct nature-based therapies often do so out of personal belief in the benefits of nature exposure for well-being (Jordan, 2014).

Walk-and-talk therapy is another emerging type of nature-based therapy where therapists often conduct their therapy sessions outdoors in a more natural setting; however, in walk-and-talk therapy the outdoor, natural setting is more often a backdrop rather than an active component of the therapy session. Walk-and-talk therapists have, however, eluded to their belief in the restorative power of the nature component of walk-and-talk therapy (Jordan, 2015; King, 2015; McKinney, 2011). Walk-and-talk therapy will be discussed further in a separate, dedicated section.

Ecotherapy. Ecotherapy was defined as treatments that incorporate elements of nature toward growth and healing (Chalquist, 2009). Although there are a variety of ecotherapy modalities ranging from incorporating natural pictures or fragrances, to hands-on interaction such as gardening, ecotherapists promote connection between humans and the natural world (Jordan, 2015; McLeod, 2013). Previous studies on ecotherapy linked increased psychological symptoms with disconnection from nature and improvement in these symptoms with reconnection with nature (Chalquist, 2009). This was an important consideration for this study as I examined how walk-and-talk therapy

might influence clients' perceptions of connection/reconnection with nature that might thus inform their experience of therapy or their psychological symptoms.

Nature therapy. Nature therapy is therapy conducted in an outdoor space wherein nature is not merely a backdrop to the therapy process but a "partner in the process" (Berger & McLeod, 2006, p. 80). Participants viewed nature as a living and dynamic partner, yet neutral and not under the control of the therapist; therefore, it allowed clients to take more ownership of the therapeutic frame and processes (Berger & McLeod, 2006). Nature therapy might involve a single client and therapist, or multiple clients and therapist or group leader.

Horticulture therapy. Horticulture therapy ranged from participants viewing natural spaces, such as gardens, to sitting or walking in gardens (McCaffrey & Liehr, 2016), to actual hands-on gardening (Soderback et al., 2004). People of all ages and abilities found it useful, and it may be done in a variety of settings from inpatient, outpatient, community, and independent home settings (McCaffrey & Liehr, 2016; Soderback et al., 2004). Participants reported improved affect, relaxation, and improvements in overall well-being, as well as increases in self-esteem (Soderback et al., 2004) and reductions in psychological stress (McCaffrey & Liehr, 2016). The improvements experienced by participants reflected the benefits of interaction with nature; however, walk-and-talk therapists use nature as backdrop rather than an entity with which participants actively engage through gardening or landscaping.

Wilderness and adventure therapy. Wilderness and adventure therapies have in common components of challenge and overcoming circumstances in outdoor settings

(Gelkopf, Hasson-Ohayon, Bikman, & Kravetz, 2013; McLeod, 2013). Adventure therapists often incorporate man-made obstacles in addition to natural ones, whereas wilderness therapists mainly incorporate overcoming natural obstacles or challenges such as weather or navigating a difficult terrain (McLeod, 2013). Participants are challenged in how they relate to others as wilderness and adventure therapy frequently require working with others (Bettmann, & Jasperson, 2008; Gelkopf et al., 2013; McLeod, 2013). In wilderness programs, participants are typically separated from their daily routines and interactions in order to establish healthier attachment (Bettman & Jasperson, 2008), and improvement in mental well-being (Hoag et al., 2016). Critics of wilderness therapy suggested that some of the interventions could be easily adapted to indoor or urban settings and were not dependent upon a nature-based setting (Rutko & Gillespie, 2013). Those opposed to traditional therapy, including combat veterans with PTSD, may find adventure therapy a suitable alternative (Gelkopf et al., 2013). Participants reported relationships with other participants as mediating treatment factors in adventure and wildnerness therapy (Gelkopf et al., 2013; Bettman & Jasperson, 2008). Although the intensity of these types of therapies far exceed walk-and-talk therapy, including the level of interaction with nature, participant experiences with these therapies inform the frame of nature-based therapy, particularly with regard to how participants relate to the outdoor environment, as well as the relational components of these therapies.

Animal-assisted therapy. Animal-assisted therapy is another possible nature-based therapy (McLeod, 2013), although animal-assisted therapy also involves care for a pet indoors or at home (Maujean et al., 2015). Therapy incorporating animals may also be

divided into animal-assisted therapy where an animal is used to assist in achieving a specific goal; versus animal-assisted activities, such as caring for animals in order to bring about improvement in well-being (Maujean et al., 2015; Kamioka et al., 2014). Although some walk-and-talk therapists may allow clients to bring their pets along for sessions, walk-and-talk therapy generally does not incorporate animal-assisted therapy or animal assisted activities.

The aforementioned nature-based therapies have in common an altered frame of therapy, particularly those involving immersion in natural environments. Thus it was important to consider this altered frame and clients' perspectives of it.

Frame of Nature Therapy

When therapists take therapy outdoors into a garden, greenspace, nearby park, or rural setting, they remove the rigid office boundaries and alter the frame of therapy (Jordan, 2015). As also previously mentioned, some therapists believe nature may shape outdoor therapy in a dynamic way as participants interact or connect with their surroundings (Berger & McLeod, 2006; Chalquist, 2009; Jordan & Marshall, 2010), or as participants engage with their therapist or other clients in a new way (McLeod, 2013; Adams & Morgan, 2018). In addition, outdoor settings, especially more public or rural ones, are no longer under the control of the therapist and may create a new therapist-client power differential (Jordan & Marshall, 2010; McLeod, 2013). Researchers have discovered additional processes in nature-based therapies that also have bearing on therapeutic frame.

Over the period of three years, individuals participated in a nature-based program for psychological distress (Adams & Morgan, 2018). Participants attended eight-week seasonal sessions that involved various group activities in an outdoor setting in southern England. Believing that a solid evidence base was already established regarding the benefits of nature exposure for well-being, the authors sought to understand the added psychosocial dynamic of social interaction during these outdoor interventions (Adams & Morgan, 2018). Study participants described themes of escape, being present, social contact, and personal growth related to the outdoor setting and social interaction (Adams & Morgan, 2018). Participants described escape from their everyday circumstances and settings, and their own internal processes, as well as into a setting that provided a safe backdrop conducive to being present in the moment and with others (Adams & Morgan, 2018). Individuals reported social contact was correlated with the benefit of immediate social connection, as well as laying a foundation for future social interactions (Adams & Morgan, 2018). Finally, participants described ways in which the natural setting and social interaction created opportunities for personal growth through self-reflection leading to self-acceptance, and a focus on an optimistic future (Adams & Morgan, 2018). Participant responses mirrored recovery processes posited by Leamy (2011) of connectedness, future orientation, empowerment, identity, and meaning of life (Adams & Morgan, 2018). It is therefore important to consider the overlap of setting and social interaction for psychological and general well-being (Adams & Morgan, 2018). Although not specifically examining walk-and-talk therapy, this study was important because it highlighted the overlap of contextual and relational factors, described the clients'

perspectives and noted that some participants found the outdoor, natural environment a safe space (Adams & Morgan, 2018).

Inpatients being treated for significant mental illness (i.e., depression, bipolar, or anxiety disorders) were recruited to participate in a mixed methods study to determine what participants found beneficial regarding group forest walks (Iwata et al., 2016). Patients participated in the group forest walks as an adjunct to their treatment as usual and no other therapeutic intervention was imparted during the walks; rather, participants were free to walk or talk with other participants (Iwata et al., 2016). Participants demonstrated significant short-term improvement in positive affect and reduction in negative affect, as well as longer-term sustained benefits (Iwata et al., 2016). Participants indicated that being in a quiet setting away from others contributed to a peaceful and calming effect, and some indicated the change of setting to a more beautiful and interesting context was helpful (Iwata et al., 2016).

In these nature-based group therapy interventions the frame of therapy differed from that of indoor therapy not only through the difference in setting, but also in terms of how participants engaged in the therapeutic process and with one another. Participants in these studies reported a safe, calm environment that was conducive to improvements in well-being. Similar to incorporating physical activity into therapy, mediating factors existed for nature-based therapies as well.

Mediating Factors of Nature-Based Therapy

A number of studies have been conducted to explore the phenomena of nature exposure and well-being, and included a combination of a physical activity or a social

component or both. Individuals with significant mental illness who participated in a group forest-walking program experienced short-term increased positive affect and decreased negative affect (Iwata et al., 2016). In addition, longer-term outcomes for some participants included medication reduction, fewer hospitalizations over the course of the program, with one participant able to return to work (Iwata et al., 2016). Participants reported the social interaction, as well as the nature exposure, were impactful in these outcomes and the role of regular physical activity could not be ignored (Iwata et al., 2016).

Participants in a mixed-methods study investigating perspectives of primarily outdoor group therapy experiences reported helpful aspects that included being outside, connection with nature, ability to reflect, and interaction with others (Revell, Duncan, & Cooper, 2014). Participants further reported the majority of interpersonal benefits were with other participants rather than the therapist. The perceived benefits of the combination of therapy in an outdoor setting was from the perspective of the participant; however, walk-and-talk therapy was not specifically addressed as an outdoor therapy. More specifically, in the aforementioned studies, a one-to-one client-therapist relationship was not examined (Iwata et al., 2016; Revell et al., 2014) thus revealing another gap in the knowledge base.

Thus far in the literature reviewed, positive associations existed between talk therapy for overall well-being, as well as for physical activity and nature exposure. In addition, physical activity as an adjunct or in combination with talk therapy was found beneficial for well-being, as were a number of nature therapies. Participants cited social

interaction in the form of the client-therapist relationship, as well as connection with others and with nature, as important factors for participating in exercise and nature therapies, as well as reasons to continue participation. Walk-and-talk therapy is a combination of aspects related to physical activity, nature exposure, and social interaction, and the next section includes research specific to the practice of walk-and-talk therapy.

Walk-and-Talk Therapy

A number of therapists have incorporated walk-and-talk therapy in its current form through the years. This may be inferred as Freud was rumored to have walked with his clients (Jordan & Marshall, 2010; Karp, 2011), and as other therapists throughout the 20th century experimented with running and walking with their clients (Glasser, 1989; Hays, 1994; Kostrubala, 1976; Kostrubala, 2013; Pullen, 2017). Its mainstream use, however, appears to be a more recent development with increasing media exposure. Media coverage of the practice has blossomed during the early 21st century as a new approach to treating psychological issues and stress (Abcarian, 2017; Chillag, 2017; Knox, 2017; Magner, 2017: Maher, 2017; Maxted, 2017; Neely, 2017: Packhams, 2015). Although the practice has been described as taking "ordinary counselling" (McLeod, 2013; p. 350) into an outdoor setting, clinicians and researchers familiar with the practice expressed the importance of considering the change in the frame of therapy and experience that occurs for therapists and clients when taking it into open, outdoor, public spaces (Jordan & Marshall, 2010; McLeod, 2013). Despite concerns over this change in

frame, those therapists who have embraced the practice believe it to be an intuitive treatment.

Early Adopters

As mentioned previously, Kostrubala (1976), Glasser (1989), and Hays (1994) were pioneers in combining outdoor physical activity in the form of running or walking with clients with an ordinary therapy session. In addition to the influence of these clinicians, the advent of the current iteration of walk-and-talk therapy in the United States appears to stem from the example of Clay Cockrell, a New York social worker who began offering walk-and-talk sessions to his busy clients in 2004, and received a great deal of media attention ranging from *Good Morning America* to *The Wall Street Journal* (Charbonneau, 2016; Cockrell, 2013). A number of therapists interviewed in subsequent media coverage cited Cockrell as their inspiration (Chillag, 2017; Maher, 2017; Neely, 2017). Similarly, William Pullen (2017), a psychotherapist in the United Kingdom who practices Integrative Psychotherapy and founded Dynamic Running Therapy, has been the inspiration for other walk-and-talk or running therapists (Maxted, 2017; Packhams, 2015) in the United States and the United Kingdom.

Current Practice

Some walk-and-talk therapists, such as Cockrell, conduct their sessions in urban parks (Chillag, 2017; Cockrell, 2013), while other therapists choose more secluded or rural settings such as hiking trails (English, 2015; Neely, 2017) or beaches (Revell & McLeod, 2016). Some therapists abide by a traditional *therapy hour* whereas others opt for longer sessions depending on setting, client issues, or client or therapist preference

(Blue Cloud Walking, n.d.; English, 2015). Some offer initial sessions indoors (Chillag, 2017; English, 2015) as well as bring sessions indoors for inclement weather or if the client expresses a desire to be inside because of the sensitivity of the session's content (Chillag, 2017; Cockrell, 2013). Most incorporate the same treatment modalities they use in traditional indoor, office therapy sessions (Revell & McLeod, 2016) and the cost of sessions are roughly the same as office sessions (Cockrell, 2013). The main difference in walk-and-talk therapy is the format where client and therapist walk side-by-side outdoors in a natural setting.

Therapists' Perspective of Practice

In a mixed-methods study of therapists' perspectives of what they found helpful or hindering aspects of walk-and-talk therapy, participants reported that walk-and-talk therapy was more casual, collaborative, and facilitated a better therapeutic alliance (Revell & McLeod, 2016). Therapists also believed walk-and-talk therapy helped clients who were feeling stuck move forward in their journey more quickly (Revell & McLeod, 2016). On the other hand, therapists reported concerns with weather and maintaining proper boundaries in therapy, as well as struggling to attend to therapeutic content and process while walking outdoors (Revell & McLeod, 2016). Further research from the clients' perspectives, as well as further research to help create standard practices for those clinicians engaging in walk-and-talk therapy practice were recommended (Revell & McLeod, 2016). This aligned with others' caution against assuming any particular setting holds therapeutic value, as well as encouragement to explore individuals' subjective

perspective of what they deem intrinsically therapeutic (Bell et al., 2018; Houghton & Houghton, 2015).

In a doctoral study on therapists' perceptions of walk-and-talk therapy 11 walk-and-talk therapists were interviewed to generate a theory and framework of walk-and-talk therapy based on Glaser's six Cs (McKinney, 2011). The context of therapy was our overall society in which younger therapists are more open to using alternative therapy interventions and methods and therapists abided by the conditions that therapy interventions arose out of client needs, based on contingencies of the therapists' personal experiences, the example set by other therapists, and the need for other options, including their desire to get out of the office (McKinney, 2011). The causes that led to the development of walk-and-talk therapy included changing client needs coupled with covariance of research supporting an increasingly inactive society that was also experiencing a deficit of nature exposure (McKinney, 2011). Through the example of Cockrell the practice was born resulting in consequences of benefits to clients and therapists alike with some limitations specific to the outdoor, walking framework including confidentiality, and challenges and speed in building therapeutic relationship, among others (McKinney, 2011). No special training was identified to conduct walk-and-talk therapy beyond minimal requirements for clinical licensure and a walking path outdoors, and traditional therapeutic interventions were the norm among walk-and-talk therapists (McKinney, 2011). Practitioners described limitations of walk-and-talk therapy including lack of support among other clinicians and leaders, difficulty obtaining clients, and the perception that some client populations were better suited to walk-and-talk

therapy than others (i.e., individuals, and those with less severe symptoms; McKinney, 2011). Limitations to the logistics of walk-and-talk therapy included weather, confidentiality, and safety (McKinney, 2011). In addition, walk-and-talk therapists reported difficult *conceptualizing* therapy, meaning it was more difficult attending to client issues and remaining present with the client versus in-office sessions (McKinney, 2011).

The contribution of this research was important as McKinney (2011) explored the evolution of walk-and-talk therapy, including the influence of Cockrell in shaping the practice, and other walk-and-talk therapists' experiences and thoughts. Emergent themes from participant interviews touched on aspects of therapeutic frame from the therapists' perspectives as well, including confidentiality, safety, and therapeutic alliance (McKinney, 2011). These same walk-and-talk therapists believed the practice beneficial to therapist and client alike indicating the casualness of the practice may be appealing to clients; however, lacking was the clients' perspectives of the practice, specifically the altered frame of being outdoors in nature, walking side-by-side versus sitting face-to-face in an office space (McKinney, 2011). Finally, therapist participants in this study were self-selected volunteers and likely had a positive view of the practice as they were among some of the early adopters largely based on their personal beliefs in the benefits of physical activity and nature exposure (McKinney, 2011). In light of these findings and limitations, further research was recommended to inform perceptions across the field of mental health and to inform training, supervision, and practice, as well as to determine clients' perceptions of walk-and-talk therapy (McKinney, 2011).

Another immersive, narrative, doctoral dissertation inquiry of four practitioners allowed for rich description of the lived experiences of other walk-and-talk therapists through shared stories (Charbonneau, 2016). This study was conducted, "(a) to explore the psychological understanding of place, (b) to question the idea that therapy needs to be conducted only in small rooms indoors, (c) to present experience that highlighted the benefits of going outside, and (d) to evoke the challenges and therapeutic outcomes of [walk-and-talk therapy]" (Charbonneau, 2016, p. 61).

Four narrative threads emerged from conversations with four walk-and-talk therapists: social complexities, connecting to a greater sense of the world, acknowledging the therapist, and innovation and creativity (Charbonneau, 2016). Therapists mentioned complexities that arose during the course of taking therapy outside that included issues of confidentiality, emotional regulation for the client (i.e., what happens if they become emotional or cry in public), and issues of standard of care and ethical practices (Charbonneau, 2016). Therapists reported that clients were far less worried about these issues than therapists, and the therapists began walk-and-talk therapy with informed consent (Charbonneau, 2016). In addition, therapists agreed that walk-and-talk may not be appropriate for every client, but it was an option for those for whom it felt like a good fit (Charbonneau, 2016). According to these four therapists, conducting walk-and-talk sessions outdoors also provided a space that was not controlled or owned by the therapist, but rather co-navigated by therapist and client creating a collaborative relationship (Charbonneau, 2016). In addition, therapists related the ways in which they were able to incorporate nature and the unpredictability of navigating public spaces into therapy

content (Charbonneau, 2016). Therapists also reported the practice of walk-and-talk therapy was a good fit for their subjective identities as they enjoyed physical activity and nature (Charbonneau, 2016). All four believed they received personal benefit from conducting outdoor walking sessions; however, they warned about the need for therapist self-care outside of these sessions and that therapy sessions were to focus on the clients (Charbonneau, 2016). The therapists embraced innovation and creativity and felt that these were to be valued in approaching therapy of any sort (Charbonneau, 2016). They agreed that walk-and-talk therapy could be viewed as a specialty niche more appropriate for some clients than others, but that this provided variety and options for clients and may reduce some of the stigma associated with seeking therapy (Charbonneau, 2016). Finally, there was agreement that walk-and-talk therapy was simple and could be conceptualized as normal therapy outside; however, there was also belief that there was more to it as clients and therapists navigated dynamic, ever-changing environments together, and there was a shared belief that further research was important (Charbonneau, 2016). The need for clients' perspectives of the practice was also highlighted confirming one of the current gaps in the literature (Charbonneau, 2016).

Additional studies were conducted examining aspects of working with clients outdoors (Harris, 2014; King, 2015). Four therapists who practice outdoors were interviewed as part of an IPA study to discover how working with clients outdoors might influence the therapeutic relationship (Harris, 2014). The role of nature in outdoor therapy sessions ranged from backdrop to dynamic third participant, and therapists described the ways in which they alternated between being active facilitator of the

therapeutic process within a natural setting, to being a more passive "witness, container, and mediator" (Berger & McLeod, 2006, as cited by Harris, 2014, p. 15). Three themes emerged from interviews with four therapists with different backgrounds and theoretical approaches: the process, indoors/outdoors, and culture; however, it was difficult to determine agreement of what constitutes therapeutic relationship through the literature review, and the variation in treatment approaches and interventions conducted by this study's participants did not add any clarity (Harris, 2014). The choice of interpretive phenomenological analysis, however, was appropriate as Harris sought to understand what his therapist participants believed about the therapeutic relationship in the context of outdoor therapy. Because this study was yet another from the perspective of outdoor therapists, it was not appropriate for further understanding of clients' perspectives thus further exposing the gap in the knowledge base. In addition, it was not specific to walk-and-talk therapy.

Another phenomenological study focused on the shared lived experiences of outdoor therapists and findings mirrored those later discovered by Charbonneau (2016), including concerns with training, supervision, and ethics; therapists' beliefs about the benefits to clients, including connection with nature; and the therapists' collaborative role (King, 2015). Additionally, therapists believed there was a spiritual component to conducting therapy outdoors (King, 2015). A strength of this study was the phenomenological approach to gain depth of understanding of the lived experience of the therapists, however, this study was also from the perspective of the therapists conducting the outdoor therapy rather than clients, and it was not specific to walk-and-talk therapy.

Wessan (2018) published a case study describing one of her client's experiences with walk-and-talk therapy. This client suffered from complex trauma and her therapeutic progress had slowed (Wessan, 2018). Upon engaging in walk-and-talk therapy the client experienced a break-through described as "astonishing" (Wessan, 2018, p. 17), and was able to move past one particularly crippling traumatic experience. Wessan (2018) hypothesized the mind-body connection experienced through walk-and-talk allowed her client to access this trauma in a new way, process, and release it. This case study is useful for beginning to understand potential benefits of adding physical activity in a natural environment to traditional psychotherapy modalities (i.e., dialectical behavior therapy); however, it is also from the perspective of the therapist rather than the client.

Prior to his untimely death (Marshall & Hinds, 2017), Martin Jordan (2013, 2015; Jordan & Marshall, 2010) was an emerging expert on the European equivalent of walk-and-talk therapy. Jordan's focused his work on the therapists' perspective of the frame of outdoor therapy and his work will be discussed in the section on frame of walk-and-talk therapy.

Clients' Perspective of Practice

Although researchers have been studying walk-and-talk therapy more during the early 21st century, the research has been largely from the perspective of the therapists. I was only able to locate a single study framed from the perspective of walk-and-talk therapy clients. In a phenomenological study in which adolescents participated in outdoor, walk-and-talk therapy sessions, the benefit of these sessions were evaluated by the adolescents, the counselor/researcher, parents, and teachers (Doucette, 2004).

Although positive results were reported, including "solutions to problems" (Doucette, 2004, p. 386), the exercise and outdoor components of the walk-and-talk intervention were more peripheral to the therapeutic approach (e.g., solution focused) and incorporation of attachment theory (Doucette, 2004). Though the walk-and-talk therapy intervention was introduced from the participating adolescents' perspectives (Doucette, 2004), there was room for further, objective study from adult walk-and-talk therapy perspectives particularly regarding adult walk-and-talk therapy participants' beliefs about the shift in therapeutic frame.

Frame of Walk-and-Talk Therapy

Walk-and-talk therapy in may range from walking/hiking to camping expeditions (Jordan & Marshall, 2010). Through specific case examples, challenges and opportunities of outdoor therapy experiences were explored including having to redefine the frame and boundaries of therapy and the therapeutic spaces, but also addressing clients' issues in a more fluid and emergent manner (Jordan & Marshall, 2010). Some of the risks of outdoor therapy sessions included the need to address confidentiality when the physical boundaries of a walled office are no longer present (Chalquist, 2009; Jordan & Marshall, 2010), and when outdoor spaces became therapy and social spaces (Jordan & Marshall, 2010). Issues of geography and power that are not normally of concern within traditional, indoor therapy sessions were highlighted (Jordan & Marshall, 2010). Therapists' and clients' perspectives of the outdoor therapy experience were explored, though clients' experiences were reported by the therapist participants.

Subsequently, Jordan (2013) later conducted a narrative doctoral study on the practice of outdoor therapy, with focus on the frame of therapy, again from the therapists' perspectives. Themes of confidentiality and client safety surfaced yet again, as well as potential boundary issues, and the distractions that naturally occur in outdoor or public spaces (Jordan, 2013). Therapists must work hard to maintain the frame of therapy in outdoor settings, but it is possible with flexibility and with client understanding (Jordan, 2013). When therapy was taken outside of an enclosed office the therapist became the holder of the therapeutic frame meaning the therapist had to be comfortable with maintaining appropriate, yet fluid boundaries (Jordan, 2013). Similar to other findings, therapists believed outdoor therapy results in an equal distribution of power in the session and more collaboration (Jordan, 2013). Finally, therapists believed outdoor therapy was more multidimensional and allowed for a more holistic approach to well-being (Jordan, 2013). The recommendation to inquire of outdoor therapy clients for their perspectives of outdoor, or walk-and-talk therapy practices was made yet again (Jordan, 2013).

Literature Analysis

As evidenced by the literature reviewed thus far, talk therapy was well established as an efficacious treatment for psychological distress (i.e., stress, depression, or anxiety), either alone or in combination with psychotropic medication (Hollon & Ponniah, 2010; NIMH, 2018; SAMHSA, 2017). Physical activity as a therapeutic lifestyle change, as an adjunct to traditional talk therapy or in conjunction with therapy, was also found beneficial for mental well-being (Blair et al., 2012; Febbraio, 2017; Reiner et al., 2013; Rot et al., 2009). Evidence gathered from this literature review also supported the

efficacy of nature exposure for overall well-being, as a standalone intervention (Bratman et al., 2015; Feugen & Breitenbecher, 2018; Korpela et al., 2016); in conjunction with therapy in the form of ecotherapy, horticulture therapy (McLeod, 2013; Soderback et al., 2004), forest bathing (Li, 2018), or other forms of nature-based therapy interventions (Gelkopf et al., 2013; Jordan, 2015; Tucker et al., 2016); or in combination with physical activity (Bratman et al., 2015). Finally, relationships, including the relationship between client and therapist highlighted as a common factor influencing therapy outcomes, were deemed important factors contributing to well-being (Laska et al., 2014; Wampold, 2015). Walk-and-talk therapy exists at the intersection of these components.

There is a need to attend to client comfort and safety in therapy (Duros & Crowley, 2014; Jordan, 2015) as well as to provide a space conducive to therapeutic gains (Langs, 1979; Laws, 2009) that is appropriate for the client's presenting issue (Duros & Crowley, 2014). Attention must also be given to whether the therapy setting is therapeutic to individuals participating in therapy (Adams & Morgan, 2018; Houghton & Houghton, 2015; Laws, 2009). Therapeutic interventions should also be supported by scholarly research and therapists should be adequately trained in any intervention they deliver (AAMFT, 2016; APA, 2010; Duros & Crowley, 2014).

Although natural outdoor settings are viewed as therapeutic landscapes (Gesler, 1992; Laws, 2009) that contribute to improvements in mood and well-being (Chalquist, 2009; Stigsdotter et al., 2011), individuals may find different settings more therapeutic depending on accessibility, perceived safety, or level of activity or stimulation (Grant et al., 2017; Laws, 2009). Though critics of outdoor, nature-based therapies, such as walk-

and-talk therapy, cited concerns over client confidentiality and safety (Charbonneau, 2016; Jordan, 2015; Wright, 2008), some participants in outdoor therapy programs felt outdoor spaces were safe and relaxing (Adams & Morgan, 2018; Iwata et al., 2016). Nontraditional outdoor spaces were more comfortable for some individuals than traditional, inpatient or office settings, thus there is a need to attend to the influence of spaces and places in therapy (Laws, 2009) in addition to therapeutic treatment modality.

Although research exists on walk-and-talk and outdoor therapy from the therapists' perspective (Charbonneau, 2016; Jordan, 2013; King, 2015; McKinney, 2011; Revell & McLeod, 2016), I was unable to find research of walk-and-talk therapy from the clients' perspectives aside from a single, older study about adolescent clients' experiences (Doucette, 2004), and anecdotal information from therapists' points of view regarding their clients' experiences. Although the current literature on walk-and-talk therapy from the therapists' perspectives was informed by input from these same therapists' clients (Jordan, 2015), I identified the lack of research specific to the clients' perspective of walk-and-talk therapy as a gap in the current knowledge base. Furthermore, therapists conducting therapy in outdoor settings believed the frame and/or boundaries of outdoor therapy are different than in-office therapy and thus may alter the experience of therapy for walk-and-talk clinicians and clients alike (Jordan & Marshall, 2010; Jordan, 2015). This creates unique challenges (Jordan, 2015), and may alter the experience of the processes and some aspects of therapy, such as confidentiality, potentially creating ethical issues (Hooley, 2016). Although therapists' perspectives of what they deem helpful or hindrances of walk-and-talk therapy and why they believed it a

beneficial, therapeutic alternative to traditional office talk therapy were presented (Revell et al., 2014), little was known of what clients found helpful or hindering regarding walk-and-talk therapy. Thus, I investigated clients' perspectives of walk-and-talk therapy and the subsequent change in traditional therapeutic frame through a qualitative, phenomenological study.

Summary

Through this literature review, I documented the supporting literature for the components that make up the practice of walk-and-talk therapy. I presented the existing literature specific to walk-and-talk therapy, including limitations and recommendations for future research. Finally, I established a noteworthy gap in the knowledge base supporting the importance of this study. In Chapter 3 I describe the chosen research methodology for this research study focused on walk-and-talk clients' perspective of the altered frame of walk-and-talk therapy.

Chapter 3: Research Method

Introduction

Because of the lack of research regarding walk-and-talk therapy despite its expanding use, it was important to gain a better understanding of the practice, especially from clients' perspectives because research has been largely from the therapists' perspectives (Charbonneau, 2014; Jordan & Marshall, 2010; King, 2015; McKinney, 2011). Thus, I conducted a qualitative study for the purpose of gaining a better understanding of adult clients' lived experience of walk-and-talk therapy. I chose a phenomenological approach to understand walk-and-talk therapy clients' lived experience (Merriam & Tisdell, 2016; Moustakas, 1994) of the altered frame of walk-and-talk therapy where therapy sessions occur outdoors while client and therapist walk side-by-side.

In this chapter, I present the research design and why it was appropriate for studying the phenomenon of interest. I further outline the role of the researcher and provide a detailed description of the specific methodology including participant selection criteria and protocol, data collection, and analysis. Finally, I address issues of trustworthiness, including validity and reliability, and ethical considerations.

Research Design and Rationale

Research Question

How do adult clients experience talk therapy conducted while walking side-by-side with their therapist in an outdoor setting?

Research Tradition

The research tradition I chose for this study was a qualitative, phenomenological approach. Qualitative inquiry is designed to gain an in-depth understanding of a phenomenon, event, or process, or the lived experience of individuals (Moustakas, 1994; Smith et al., 2009). This study was conducted to understand adult clients' lived experience of the practice of walk-and-talk therapy. Because walk-and-talk therapy is a fairly new approach to psychotherapy, and the research that I was able to locate was limited to therapists' perspectives, I determined that a qualitative approach was appropriate for gaining a better understanding of adult clients' experience of the frame of walk-and-talk therapy (Maxwell, 2005; Moustakas, 1994; Patton, 2015). A phenomenological inquiry allowed for in-depth exploration of clients' experiences, including the context of the outdoor setting coupled with physical activity and the shift from sitting face-to-face to walking side-by-side.

The type of qualitative inquiry that I chose was the IPA approach, which is informed by three philosophic traditions: phenomenology, hermeneutics, and idiography (Smith et al., 2009). As a phenomenological and hermeneutic approach, IPA researchers focus on the meaning and sense individuals make out of their experiences, particularly because they are unique to the individuals (Smith et al., 2009). In addition, IPA researchers employ an idiographic approach with focus on the particular (Smith et al., 2009). Small, homogenous samples allow for detailed data collection and systematic depth of analysis to create a greater understanding of a specific phenomenon (Smith et al., 2009).

IPA is useful for gaining an understanding of participants' perceptions of their lived experiences while also seeking to understand how they make sense of these perceptions (Brocki & Wearden, 2006). Because therapists use the frame of therapy to lay the foundation for the work of therapy, a change in context, setting, and boundaries may create a different experience for therapy clients (Jordan & Marshall, 2010; Jordan, 2015). IPA can also be useful for exploring an overall phenomenon through recollection of parts of the experience and the meaning individuals assign to each (Smith et al., 2009). In this manner, IPA helped to understand how former walk-and-talk clients make meaning of the parts (i.e., talk therapy, physical activity, nature exposure, and shift from sitting face-to-face to a side-by-side arrangement) as they relate to the overall experience, encompassing the components of the biopsychosocial conceptual framework that also informed this study. Thus, an IPA approach allowed for examination of the significance of this altered frame through the lens of the clients' perception of their lived experience of participating in walk-and-talk therapy (Smith et al., 2009) and how they make sense of the altered frame (Brocki & Wearden, 2006).

I considered other qualitative research methodologies for this study; however, I chose IPA as a phenomenological design that was the most appropriate because my focus was understanding the essence of the participants' lived experience of a unique phenomenon (Moustakas, 1994) through a small, homogenous sample (Smith et al., 2009). I did not choose grounded theory because it is intended for developing nomothetic theory that may be later tested and more generally applied to a population (Merriam & Tisdell, 2016; Sofaer, 1999), and my focus was on a specific phenomenon that may not

extend beyond the experiences of participants. Additionally, I did not choose case study methodology because it involves multiple data points (Maxwell, 2005; Merriam & Tisdell, 2016; Yin, 2014) and does not focus on the meaning making or essence of the participants' experience of a phenomenon (Moustakas, 1994). I also did not consider ethnography as an appropriate methodology because of its focus on understanding and describing a shared culture through immersion in and observation of it over time (Lincoln & Guba, 1985; Maxwell, 2005; Merriam & Tisdell, 2016). The focus of this study was on understanding how the clients made sense of their experience of the frame of therapy rather than the overall culture of walk-and-talk therapy. Finally, narrative inquiry is focused on understanding and communicating an individual's unique story (Maxwell, 2005; Merriam & Tisdell, 2016), but IPA still allowed me to present the stories of how participants make sense of their experiences informed by the narrative tradition and supported by participant utterances (Bruner, 1991; Smith et al., 2009). As a phenomenological approach, IPA incorporates aspects of some of the other qualitative traditions, with a focus on understanding the underlying essence and how participants make meaning of a phenomenon, making it suited to this study.

Role of Researcher

In qualitative inquiry, the researcher serves as primary instrument of data collection (Merriam & Tisdell, 2016). In IPA inquiry, the researcher also embodies a dual hermeneutic role in inquiry and analysis (Smith et al., 2009). First, the researcher acts as the interviewer (Smith et al., 2009), attending to and documenting participants' descriptions of their experience while these participants are attempting to make sense of

and communicate their experience. Second, the researcher attempts to understand and interpret the meaning the participants are communicating about their experiences, facilitating responses while interpreting them (Smith et al., 2009). Thus, my role in this study was as interviewer for data collection and interpreter for data analysis. I did not serve as either observer or participant, as I interviewed former walk-and-talk clients of other therapists rather than my own clients. I also did not observe actual walk-and-talk therapy sessions with current clients. Both of these stipulations acted as safeguards to avoid ethical concerns of confidentiality and power differentials between therapist and client (AAMFT, 2016; APA, 2010).

In any qualitative inquiry it is important to address potential researcher bias—both known and unknown (Moustakas, 1994). As a walk-and-talk therapist, I brought known personal bias into this study that I managed by acknowledging it through reflexivity, and controlling for it through epoche (Moustakas, 1994). Epoche involves suspending judgment by examining personal beliefs regarding the phenomenon of interest followed by setting aside, or bracketing, any prior assumptions to focus on the essence of what is being communicated by study participants (Merriam & Tisdell, 2016). Further, data collection and analysis should be approached with doubt of prior knowledge in favor of seeking new knowledge (Moutsakas, 1994). From the outset of this study, I acknowledged and documented my preconceived understanding of clients' experiences of walk-and-talk therapy based on my own experiences as a walk-and-talk therapist. I also set aside these assumptions in order to be present with the participants, the data, and the essence what the participants communicated regarding their experiences. Furthermore, I

employed the technique of *free imaginative variation*, a form of *eidetic reduction*, wherein I attempted to imagine different possibilities or explanations for the essence of walk-and-talk therapy participants' experiences (Smith et al., 2009).

Despite my efforts to bracket experiences, attempts to completely bracket preconceptions are not possible, and sometimes knowledge of bias arises through the analytical process (Smith et al., 2009). As I noticed my personal biases surface, I further managed these through acknowledging and documenting them through journaling, followed by bracketing and focusing on the subjective experiences detailed by the study participants. Finally, it was important to acknowledge limitations to the study that arose out of the inability to remove my prior understanding in this IPA study and to allow for the possibility that there could be other interpretations (Smith et al., 2009).

Methodology

Participant Selection Logic

Qualitative study participation is different from quantitative study participation in that data collection often involves intense interaction resulting in rich, descriptive, written data (Merriam & Tisdell, 2016). For this reason, qualitative researchers often employ the use of in-depth, semistructured interviews for phenomenological inquiry (Merriam & Tisdell, 2016; Moustakas, 1994; Smith et al., 2009). Interviews are more personal, intense interactions providing detailed and descriptive data, and thus recruitment procedures for qualitative inquiry must be specific while planning for participant safety and anonymity (Smith et al., 2009).

Population. Although qualitative study results are not generalizable to a population because of the nature of qualitative research, including small sample sizes (Moustakas, 1994; Patton, 2015; Smith et al., 2009), it is still important to identify the population from which participants will be recruited and are thus representative. The population that was represented by this study was adult walk-and-talk therapy clients.

Sampling strategy. Through IPA inquiry, researchers use purposeful, convenience sampling to obtain a small and homogenous sample for providing detail and depth (Smith et al., 2009). Frequently participants are recruited by referral or through snowball sampling (Smith et al., 2009). Although walk-and-talk therapy is gaining in popularity, the number of walk-and-talk therapy clients is still a small percentage of therapy clients in general. Thus, to reach former walk-and-talk therapy clients, referrals for participants were obtained from walk-and-talk therapists who acted as gatekeepers to accessing these individuals. Walk-and-talk therapists identified via Internet searches and social media such as Facebook, Instagram, Twitter, or LinkedIn were contacted via e-mail and asked to forward study information to their former walk-and-talk therapy clients. Snowball sampling (Merriam & Tisdell, 2016; Smith et al., 2009) was also used by asking walk-and-talk therapists as well other therapists and colleagues to forward to me the information for other walk-and-talk therapists they may know or to forward study information to other individuals they may know that may have also participated in walk-and-talk therapy sessions.

Participant selection criteria. Therapy clients are considered a more vulnerable population and involving them in research created potential ethical issues (AAMFT,

2016; APA, 2010; Walden, 2015). Walden's Institutional Review Board (IRB) allows for recruiting individuals who have completed treatment for phenomenological analysis of their past experience, but I also took precautions to ensure participant safety of former walk-and-talk therapy clients (Walden, 2015). Other precautions included having voluntary participation, not involving participants where I held any authority or maintained any level of familiarity with them, and distinguishing the study as research and not a therapeutic intervention (Walden, 2015). I did not recruit any of my own past or present therapy clients, thus avoiding familiarity or undue influence. Additionally, only adults over the age of 18 were eligible to participate.

To promote ethical recruitment and treatment of study participants, I implemented a screening protocol. First, all potential participants were adult volunteers recruited primarily per invitation forwarded by e-mail from their former therapist. Participants also responded affirmatively to recruitment protocol and contacted me voluntarily. I further screened these volunteers for study suitability, including a review of inclusion criteria. Protocol required treating potential or actual study participants in immediate danger of harm to self or others as any other individual in crisis, and attempts, to keep this individual safe were planned per researcher's professional licensure protocol (AAMFT, 2016). This was not an issue and no crisis interventions were necessary. Upon verification that the individuals met inclusion criteria and receipt of their signed consent, participant interviews were scheduled.

Number of participants. By their nature, qualitative, phenomenological studies are designed to use small sample sizes because of the desire to obtain quality, detailed,

rich, descriptive accounts of lived experiences (Moustakas, 1994; Smith et al., 2009). IPA researchers similarly use small sample sizes ranging from as small as a single case (Smith et al., 2009). Though single case IPA studies have become more popular as the method has gained popularity, single cases are usually saved for distinct cases likely to have a powerful impact on the phenomenon of interest (Smith et al., 2009). The minimum recommendation was for a range of three to six cases to provide meaningful representation without creating an undue burden of an overwhelming amount of data (Smith et al., 2009). A small number of cases also allows for a homogenous sample, a hallmark of IPA (Smith et al., 2009). Given these considerations, as well as the potential difficulty I might have encountered when attempting to recruit participants who met the criteria, I planned to recruit a minimum of four participants. I understood that I might need to recruit more as the study progressed to reach data saturation (Merriam & Tisdell, 2016; Patton, 2015). However, despite recruiting efforts, I was only able to recruit three study participants. Explanation of recruitment efforts and subsequent difficulties are outlined in the next section and in Chapter 4.

Recruitment procedures. Recruiting therapy clients was challenging for a number of reasons. Although walk-and-talk therapy is being more widely practiced, it is still not standard practice, and locating walk-and-talk therapy clients through more traditional recruiting methods such as advertisements would have been difficult. Therefore, I chose to locate walk-and-talk therapists first for the intention of purposeful and convenience sampling. Therapists who agreed to pass along information were not asked to target specific former clients but were asked to pass along information to all

former clients to avoid identifying study participants. I also asked whether these therapists knew of other walk-and-talk therapists who might also be willing to pass along the opportunity to their clients in a snowball-sampling manner. When recruitment protocol was not sufficient to recruit the minimum number of participants, I attempted a broader dissemination of study information by forwarding study information to colleagues and other mental health professional organizations, including the Metro-Atlanta Therapists Network, as general mental health practitioners may have former clients who have also participated in walk-and-talk therapy sessions. Potential former walk-and-talk client participants who did respond were screened for suitability for participation in the study as previously described, including being mentally and emotionally stable enough to participate in research to avoid maleficence (AAMFT, 2016; APA, 2010).

Saturation. Saturation occurs when similar patterns develop during data analysis and there is minimal likelihood that any new insights will be gained from any additional data collection (Fusch & Ness, 2015; Merriam & Tisdell, 2016). It was important to have a sufficient sample size for replication and saturation as well as to provide information that supported the observed phenomenon (Merriam & Tisdell, 2016). Adding further cases over time if replication or saturation did not occur with the initial sample size was recommended (Merriam & Tisdell, 2016; Smith et al., 2009). As described, I began with the intent of recruiting a minimum sample of four participants, resulting in a minimum of four interviews while allowing for recruitment of additional participants over time until saturation was apparent and the likelihood that additional significant insights would not

occur with the addition of more cases. However, I was only able to recruit three participants, which will be addressed again as a limitation in Chapter 5.

Instrumentation

Semistructured interviews. Data collection was through in-depth, semistructured interviews that "invite[d] participants to offer a rich, detailed, first-person account of their experiences" (Smith et al., 2009, p. 56). Through in-depth interviews, participants could more fully convey their thoughts and feelings regarding their experience of the phenomenon of interest (Smith et al., 2009). IPA interviews are typically approached as a purposeful conversation guided by the research question (Smith et al., 2009). I composed interview questions in open-ended fashion, and designed them to allow participants to respond with as much detail or description as they felt comfortable (Smith et al., 2009). Additional, open-ended questions were included as prompts to encourage participants to reflect on and describe their experience of the various biopsychosocial components of walk-and-talk therapy individually and together. The semistructured interview schedule may be found in Appendix A.

The following interview questions were proposed for conducting a semistructured interview to answer the overarching research question, "How do adult clients experience talk therapy conducted while walking side-by-side with their therapist in an outdoor setting?"

1. How did you decide to participate in walk-and-talk therapy instead of traditional in-office therapy?

This question was posed to gain an understanding of whether clients self-selected to participate in walk-and-talk therapy or whether it was at their therapists' recommendation as this could influence a client's experience of their therapy (Jordan & Marshall, 2010; Langs, 1979; Laws, 2009). In addition, this question was posed to begin building rapport and facilitate the interview process (Smith et al., 2009).

2. Tell me what it was like for you to participate in therapy sessions outdoors while walking with your therapist.

Per IPA interview protocol, this was an open-ended, non-leading question aimed at gaining an understanding of participants' experience of the phenomenon (Smith et al., 2009). In addition, this question contained elements that addressed the biopsychosocial components contained in the conceptual framework that shapes the frame of therapy, and are the lenses through which this study was approached.

The following prompts were used as needed, and to elicit more detailed information about the participants' experience of the biopsychosocial components that shape the phenomenon of walk-and-talk therapy:

- How did being outdoors influence your experience of your therapy sessions?
- How did walking influence your experience of your therapy sessions?
- In walk-and-talk therapy you are side-by-side with your therapist rather than face-to-face. How did that influence your experience of your therapy sessions?
- Tell me more about _____.

This prompt was used as needed to elicit more detailed information regarding any prior question or any unanticipated information participants divulged that may have been useful in understanding their experience of the frame of therapy, particularly as it related to the whole as well as its parts (Smith et al., 2009).

- What else do you think it is important for me to know about your experience of walk-and-talk therapy?

This question allowed for the participants to relay any additional information they felt was important about their experiences of the phenomenon of walk-and-talk therapy that I did not explicitly ask. In addition, I asked this question during member checking to elicit additional feedback and insights that might have arisen as participants reviewed their transcripts (Merriam & Tisdell, 2016; Moustakas, 1994). Finally, this question helped balance researcher bias (Smith et al., 2009). Participants were allowed to raise additional insights that challenged researcher's personal experience and bias as a walk-and-talk therapist.

Audio recordings. Qualitative researchers frequently use audio recordings of interviews and transcribe them to reference for accuracy and to use in the data analysis process (Merriam & Tisdell, 2016). IPA inquiry specifically calls for verbatim transcription of any interactions (Smith et al., 2009). By recording and transcribing interviews I was able to keep data organized and facilitate data analysis (Smith et al., 2009). Interviews were conducted via Internet video chat, and recordings were made through the Zoom video-conference platform. In addition, backup audio recordings were made using a digital hand-held recorder and a Livescribe smart pen. Listening and re-

listening to the recordings, as well as using the transcriptions during the analysis process allowed for additional opportunities for new insight (Smith et al., 2009).

Procedures for Recruitment, Participation, and Data Collection

Walk-and-talk therapists' e-mail. I began recruiting participants by contacting walk-and-talk therapists. I located these therapists via Internet search and social media platforms as well as through my professional affiliations. I contacted these therapists by e-mail explaining the study and asking that they forward information to their former walk-and-talk therapy clients within a week. In snowball sampling fashion, I asked these same therapists to forward information for other therapists they may know who might also be willing to forward study information to their former walk-and-talk therapy clients.

Former walk-and-talk clients' e-mail invitation. Former walk-and-talk therapy clients who received the e-mail invitation forwarded from their therapists were asked to contact me via e-mail within seven days. I responded to potential study participants' e-mails of interest within 24 hours and scheduled a brief phone call to review study criteria and informed consent. If the volunteer remained interested, the informed consent was e-mailed. Once a participant returned the signed informed consent their interview was scheduled

Had more than the minimum of four participants responded with interest and met screening qualifications, I would have added these extra participants to a waiting list for future interviews should additional cases be needed to accomplish saturation; however, as previously mentioned, I only recruited three participants. Because recruitment lagged behind the minimum four, I continued to contact additional walk-and-talk therapists;

however, despite my efforts and follow through, I exhausted my resources and settled for three interviews.

Interviews. I conducted interviews by Zoom video-conference platform. I scheduled these interviews for two hours to allow plenty of time for thick, rich description of the phenomenon; however, each interview lasted slightly less than one hour. I audio recorded the interviews using a combination of the video-conference recording feature, a handheld digital recorder, and a Livescribe smartpen as described earlier as well as kept written notes. I debriefed participants at the end of the interview. and reminded them I would send a follow-up e-mail with a summary of their responses for verification through member-checking.

Data Analysis Plan

As previously described, I collected data through semistructured interviews conducted by me and audio recorded. I conducted these interviews to gain an understanding of how former walk-and-talk therapy clients experienced and made meaning of the altered frame of their therapy and to answer the following overarching research question: How do adult clients experience talk therapy conducted while walking side-by-side with their therapist in an outdoor setting? I transcribed the interviews and manually coded and analyzed the data.

In IPA, as in general qualitative inquiry, there is no absolute perfect formula for qualitative data analysis (Patton, 2015; Smith et al., 2009). During the data analysis process, however, it was important to focus on how participants tried to make sense of their experiences (Smith et al., 2009). One manner of attending to participant sense-

making was by incorporating the seven-step, modified van Kaam phenomenological data analysis methodology aimed at helping participants with *feeling understood* (Moustakas, 1994; Polkinghorne, 1989).

Starting with the first interview transcript, I began with horizontalization and listed "every expression relevant to the experience" (Moustakas, 1994, p. 120) detailed through participant utterances. Next, through reduction and elimination I examined these utterances to determine whether they were necessary for understanding the phenomenon and could be abstracted and labeled (Moustakas, 1994). I eliminated participant statements that did not meet these two requirements as well as overlapping or redundant statements and the remaining statements were considered the *invariant constituents* (Moustakas, 1994). Third, I grouped these invariant constituents according to theme via clustering and thematizing (Moustakas, 1994). During the fourth step I validated that the remaining invariant constituents and themes aligned with the overall transcript by either being explicitly addressed or compatible. Remaining invariant constituents that did not align at this stage were subsequently deleted. During the last three steps I composed an individual textural description of the phenomenon, followed by an individual structural description, and concluded with an individual textural-structural description. I followed these steps with each subsequent interview. Finally, I composed a composite textural-structural description of the phenomenon yielding a thick, rich description of the clients' lived experiences of the phenomenon of walk-and-talk therapy.

Unique to IPA is the manner in which cases are carefully analyzed one at a time before moving onto the next (Smith et al., 2009). The van Kaam data analysis

methodology aligned with the IPA approach. Once I completed a detailed analysis of the first case, I repeated the same processes for subsequent cases, considering each as stand-alone entities (Smith et al., 2009); however, because of the hermeneutic nature of IPA, prior cases are likely to influence subsequent analysis (Smith et al, 2009). For this reason, it was important I was mindful of this tendency while being open to new emerging themes. After I analyzed cases individually, it was possible to conduct a cross-case analysis to determine similarities and differences (Smith et al., 2009). Finally, I conducted a deeper micro-analysis to tease out levels of interpretation for the purpose of comparing, then contrasting these various interpretations (Smith et al., 2009).

Issues of Trustworthiness

Although trustworthiness and study rigor may be judged in various ways to ensure the qualitative study quality, one set of criteria included credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985; Merriam & Tisdell, 2016). Qualitative researchers must be proactive and address these criteria throughout the process of data collection and analysis (Merriam & Tisdell, 2016). It is important to match techniques for trustworthiness to the potential threats that might arise out of the specific type of qualitative study conducted (Maxwell, 2005). Thus, I address how I approached trustworthiness for this IPA study in the following sections.

Credibility

Credibility, also known as internal validity in qualitative studies, refers to whether the findings and interpretations are truly reflective of the phenomenon being studied (Merriam & Tisdell, 2016; Moustakas, 1994). Credibility may be established in a variety

of ways, including prolonged contact, triangulation, member checks, saturation, and reflexivity (Moustakas, 1994; Peat, Rodriguez, & Smith, 2019). I used in-depth, semistructured interviews of a small, homogenous sample size to create prolonged contact that resulted in a rich and descriptive data set (Smith et al., 2009). I created additional opportunity for prolonged contact by following up with participants through e-mail for clarification of their interviews. Triangulation is the use of multiple and diverse sources of data collection (Maxwell, 2005; Merriam & Tisdell, 2016). Although IPA uses a small, homogenous sample, I accomplished triangulation through member checking (Merriam & Tisdell, 2016) and second tier triangulation by comparing analysis results with professional knowledge and extant literature (Smith et al., 2009). After initial data analysis, I contacted participants to review their accounts (Moustakas, 1994) of their experiences in a process called member-checking (Merriam & Tisdell, 2016). This process also helped to reveal any unchecked personal bias (Merriam & Tisdell, 2016; Moustakas, 1994) while assessing whether the researcher's attempts to understand the participants' attempts to make meaning of their experience was accurate (Smith et al., 2009). Saturation also helps establish credibility and involves collecting a sufficient amount of data that the likelihood of discovering any new information or themes is doubtful despite adding any more cases or interviews (Merriam & Tisdell, 2016). My initial intent was to recruit additional participants as needed to meet the criteria of saturation; however, I was unable to recruit the desired minimum participants and thus this was a limitation of this study.

I also needed to avoid formulating conclusions too early and remained mindful of alternative explanations to what I interpreted (Moustakas, 1994). This was of particular importance as researcher because I am also a therapist who practices walk-and-talk therapy. For this reason, it was important that I exercised reflexivity (Merriam & Tisdell, 2016; Moustakas, 1994) by tending to how my own bias and the data collection and analysis processes may have influenced my interpretation of the data (Smith et al., 2009). Exercising epoche early by bracketing known bias, as well as practicing *imaginative variation* by attempting to see things from several angles (Moustakas, 1994), also added to credibility. Therapists and clients frequently view their experiences of therapy differently (Timulak, 2010). Thus, interview questions were open-ended and non-leading, to allow clients many opportunities to articulate their specific perspectives that might have differed from mine as a walk-and-talk therapist (see Miles et al., 2014; Patton, 2015; Smith et al., 2009). Attending to differences that surfaced between client accounts was as important as attending to similarities for the purpose of credibility.

Transferability

Transferability, or external validity, is the ability to generalize findings of the study to other situations or populations (Merriam & Tisdell, 2016). Qualitative inquiry does not lend itself to external generalizability; however, qualitative inquiry may serve as a launching point for theory development (Reid et al., 2005; Smith et al., 2009). Because of the small, homogenous sample sizes used in IPA inquiry, generalizations to the larger population may not be made; however, IPA may support theoretical transferability through rich analysis making connections between detailed participant accounts, the

researcher's own personal and professional experience, and the existing literature (Smith et al., 2009) through second tier triangulation of resources and theories (Leung, 2015). Thus transferability is a limitation of IPA that must be acknowledged, but it may be increased through contextualizing the experiences of participants so that application may be made to other similar populations (Merriam & Tisdell, 2016; Smith et al., 2009).

Dependability

In qualitative research, the concept of reliability is often referred to as dependability. Dependability is the degree to which a research study may be replicated (Merriam & Tisdell, 2016). In qualitative inquiry, dependability can be a difficult to promote. To increase dependability it was important to use triangulation and include an audit trail. As mentioned previously, triangulation allows the researcher to confirm that the data analysis and interpretation were representative of the participants' true experience (Leung, 2015), or their attempts to make sense of their experience (Moustakas, 1994; Smith et al., 2009). Researchers use audit trails as a detailed roadmap regarding the research process and methodology from inception to conclusion (Merriam & Tisdell; 2016). Replication of a study does not imply that the same results will be obtained as there could be multiple ways to interpret data (Merriam & Tisdell, 2016). This does not mean a study is not valuable or trustworthy; rather, it is important the results and interpretations are consistent with participant accounts (Merriam & Tisdell, 2016) and reflect the essence (Moustakas, 1994) and meaning (Smith et al., 2009) participants attempted to convey.

Because I interviewed multiple participants regarding the same phenomenon, it was important to document methods and procedures and follow them accurately across individual interviews (Merriam & Tisdell, 2016; Smith et al., 2009). One way I promoted dependability was to record and transcribe interactions and have participants verify these transcripts before data analysis began through member checking (Merriam & Tisdell, 2016; Moustakas, 1994) to make sure I captured the essence of what the study participants were attempting to communicate (Merriam & Tisdell, 2016; Moustakas, 1994).

Confirmability

Confirmability is comparable to the quantitative imperative of objectivity. Researchers should strive for objectivity; however, it is not possible to conduct research in a sterile environment apart from personal bias. For this reason, to control for bias to increase confirmability of study results, I exercised reflexivity through acknowledging and bracketing known bias at the outset (Maxwell, 2005; Smith et al., 2009). In addition, as I conducted data collection and analysis, I maintained a position of curiosity and allowed for alternate explanations beyond my personal bias (Merriam & Tisdell, 2016; Moustakas, 1994; Smith et al., 2009). Finally, in hermeneutic fashion that informs IPA, I was mindful that each step of the data collection and data analysis process had the potential to influence interpretation. A continued attention toward potential bias and watching for evidence of unknown biases as they surfaced was important (Smith et al., 2009). I bolstered confirmability by journaling throughout the process of data collection and analysis.

Ethical Procedures

The manner in which researchers recruit participants, manage the interview process, and handle data analysis may bring about numerous ethical considerations (Merriam & Tisdell, 2016). I addressed some of these issues previously in this chapter and will also review these in the following sections, as well as address some additional ethical concerns.

When participants are recruited from vulnerable populations, a number of ethical considerations may arise. Although not all therapy participants qualify for mental health diagnoses, research participants who have previously attended therapy are treated with more caution. Recruiting individuals who have engaged in therapy was not forbidden by Walden IRB (Walden, 2015), but a number of precautions were recommended, such as recruiting former clients who have completed treatment to interview them about their past experience. Having a licensed clinician conduct interviews was also cited as important to ensure participant comfort and safety (Cooper & McLeod, 2015). Brief screening interviews with potential study participants to assess suitability for participation and counseling clients' comfort with the study were recommended as well (Chandler, Fernando, Barrio Minton, & Portrie-Bethke, 2015). As a licensed marriage and family therapist with over 10 years of experience, I believe I was qualified to screen for client suitability and/or suspend study participation should I deem the process potentially harmful to the participant. Combining my own clinical judgment with brief screening helped ensure ethical client participant recruitment.

Throughout study recruitment, I reminded participants that their identity would be protected, and during a process of informed consent, I notified participants of the measures that would be enacted to protect their identity, including de-identification and use of pseudonyms rather than their actual names. I took additional measures to ensure participant safety, including identifying crisis resources, should any urgent situation arise during the course of data collection that might require immediate attention or therapeutic intervention. During informed consent, I followed Walden IRB guidelines (Walden, 2015), detailing the nature of the study, and informing interviewees that their participation was for research purposes only and the interview would not be a therapeutic interaction or intervention. An added precaution of the Walden IRB (2015) was ensuring researchers possessed the appropriate qualifications for working with vulnerable populations. I detailed these qualifications and other information regarding ethical management of participant recruitment earlier in the methodology section.

When involving other agencies or institutions, institutional permissions are often required including letters of cooperation and IRB approval from the other organization. According to Walden IRB guidelines, however, a letter of cooperation was not necessary for this study because the therapists who were contacted had no other role than forwarding information to their former walk-and-talk clients and former client participation was voluntary and unknown to these therapists (Walden, 2015).

I addressed ethical concerns related to recruitment materials and processes in the prior sections outlining recruitment. Forwarding the study invitation was voluntary as was participation. I included a copy of the informed consent with the therapist e-mail, as

well as my contact information should there have been any questions about the study. I also outlined processes to secure assistance for anyone deemed in acute emotional distress at any point in the process. Participants were able to withdraw from the study at any time. If a participant had withdrawn I would have implemented the debriefing protocol; however, this was not a cause for concern.

Data storage and handling included de-identifying data through coded file names and pseudonyms. I stored files on a secure, password protected laptop or encrypted hard drive only accessible to me and stored in a locked file cabinet in my home office. After dissertation completion, I will maintain the data on the encrypted hard drive for a period of 5 years, at which time I will reformat the hard drive and erase the data.

I did not involve any of my clients in this study, nor anyone in my work environment. The walk-and-talk therapists I contacted were unknown to me prior to the study outside of minimal professional interaction via social media. There was no undue influence or pressure by me towards the therapists or participants and I attended to the researcher-participant power differential through respectful acknowledgement throughout that the participant was the *experiential expert* (Smith et al., 2009). No incentive was provided to participants. I sought and obtained approval from Walden's IRB with approval number 09-27-18-0383087 and an expiration of September 26, 2019.

Summary

In this chapter I addressed the chosen research methodology and related protocols. For the purpose of this study, I chose a qualitative, IPA approach well suited to understanding the essence of clients' lived experiences of the altered frame of walk-and-

talk therapy sessions. I recruited three former walk-and-talk therapy clients and interviewed them using a semistructured, in-depth interview protocol. The primary recruitment approach was e-mails forwarded to former clients by their walk-and-talk therapists. I conducted coding and data analysis manually. Data collection and analysis were done from a combined IPA approach attending to my own interpretation of participants' meaning-making of their lived experience of walk-and-talk therapy using the seven-step modified van Kaam phenomenological data analysis approach, while also addressing issues of trustworthiness through practices such as epoche, triangulation, and member-checking. In Chapter 4 I will address study results gathered and analyzed through the proposed IPA methodology.

Chapter 4: Results

Introduction

This IPA study was conducted to better understand clients' lived experience of walk-and-talk therapy. In traditional therapy, sessions occur in an enclosed office space for a confidential and safe therapeutic encounter (Jordan & Marshall, 2010; Langs, 1979), both to meet clinicians' ethical requirements to do no harm and to promote therapeutic benefits for clients (AAMFT, 2016; APA, 2010). Taking therapy sessions outside in an open, more natural space, and incorporating physical activity by walking side-by-side creates a different therapeutic encounter and alters the therapeutic frame (Jordan & Marshall, 2010). Despite recent studies on therapists' perspectives of walk-and-talk therapy (Charbonneau, 2016; Jordan, 2013; Jordan & Marshall, 2010; King, 2015; McKinney, 2011; Revell & McLeod, 2016, 2017), not much is known about clients' perspectives of the practice. Thus, I conducted this phenomenological study to address the following research question: How do adult clients experience talk therapy conducted while walking side-by-side with their therapist in an outdoor setting?

In this chapter, I describe the setting of the study, and the demographics of study participants. I also outline the data collection and data analysis processes as well as address trustworthiness based on criteria of credibility, transferability, dependability, and confirmability, as proposed in Chapter 3. I also delineate any adjustments that arose during data collection and analysis and conclude with a summary of my study findings.

Setting

Participants were recruited through protocol outlined in Chapter 3, beginning with identifying walk-and-talk therapists in the United States through Internet searches (Google and social media). I then e-mailed these therapists and asked them to forward study information, in the form of a participant invitation e-mail, to their former adult walk-and-talk therapy clients. These former clients had the option to self-select to participate in a semistructured interview via online video conferencing using the Zoom video-conference platform.

I was able to identify 135 therapists across the United States whose websites or social media accounts indicated that they offered walk-and-talk therapy. Despite multiple e-mails and phone calls, 56 responded indicating they were unable or unwilling to forward, and 50 of the therapists never responded to any attempts to contact them. A total of 29 therapists agreed to forward my study information to their former clients and from those forwarded e-mail invitations, four participants volunteered and e-mailed me indicating their interest to participate; however, only three consented and participated in the interview process, and the fourth did not respond to multiple follow-up e-mails asking for appropriate times for a brief phone conversation to discuss the study and consent form.

I had originally intended participants would have terminated their participation in walk-and-talk therapy within the last 6 months; however, the first volunteer's past therapy experience was outside of this 6-month window. In addition, after speaking with some of the therapists who were willing to forward study information, it became apparent

that this 6-month window was too limited. Thus, I sought and received an IRB amendment to expand inclusion criteria to include any former walk-and-talk therapy client regardless of how far in the past their sessions occurred.

I outlined that I was asking therapists to forward the study information to all their former clients. I did this to broaden the pool of participants, to avoid the perception of coercion, and to lessen the chance of participants being identified in the final study description. Despite these efforts, therapist responses suggested that they possibly hand-chose former clients they felt would be a good fit for this study and believed would likely respond. These limitations will be discussed further in Chapter 5.

Demographics

Three participants voluntarily self-selected to participate in this study. Per study protocol, participants were adults over age 18, had previously participated in a minimum of three walk-and-talk therapy sessions, and were no longer actively participating in any form of psychotherapy. Finally, participants said that they felt no emotional distress that would place them at risk of harm to self or others at the time of their participation, and they provided consent to participate. Participants were females, ranged in age from early 20s to early 50s, and had engaged in traditional, in-office therapy before participating in walk-and-talk therapy. Two of the three indicated having in-office sessions interspersed with their walk-and-talk sessions, whereas the third reported that once she began walk-and-talk therapy she never returned to office-based therapy. Participants described walk-and-talk settings that included natural elements (i.e., grass, trees, water) and ranged from urban parks to multi-use trails and a multifunction sports complex. Participants were in

the United States, with each located in a different geographical region. The participants were assigned pseudonyms (i.e., Participant A, Participant B, and Participant C) to mask their identity, which are used throughout the remainder of this study when referring to participant responses. Specific information related to participants' therapists, including therapist demographics and locations where therapy occurred are also vaguely described to mask participant identity.

Data Collection

Data collection consisted of semistructured interviews. I scheduled a single interview with each participant at the participants' convenience with 2 hours planned to allow time for an in-depth interview; however, interviews were completed in approximately 40-45 minutes. None of the participants were located in my geographical area, so I did not conduct any interviews in person. I conducted interviews via the Zoom online videoconference platform. I used the Zoom platform to record video and audio, and I also used alternate audio recording devices consisting of a digital recorder and a LiveScribe pen. I used these recordings to transcribe the audio interviews into written transcripts. After transcribing these interviews that had been edited to remove excessive verbal fillers (i.e., "um," "like," "you know"), and brief side discussions not pertinent to walk-and-talk, I forwarded copies of the individual transcripts to participants to review for accuracy and to add additional insights they might have regarding their walk-and-talk therapy experiences. Participants approved their transcripts with no additional comments. I conducted the interviews without incident and participants expressed their enthusiasm for the opportunity to participate.

Data Analysis

Data analysis was conducted using the seven-step, modified van Kaam approach for phenomenological research (Moustakas, 1994). Data analysis was informed by IPA traditions of phenomenology, hermeneutics, and idiography (Smith et al., 2009), wherein I focused on how the participants, or coresearchers (Moutstakas, 1994), attempted to make sense of their experience with walk-and-talk therapy from their individual frames of reference, while also focusing on a specific phenomenon through a small, homogenous sample (Smith et al., 2009). In addition, I considered how these participants recalled and made meaning of the separate aspects that comprise the whole experience of walk-and-talk therapy. Finally, during the process of data analysis, I also gave attention to the informing conceptual lenses of this study including the therapeutic frame (Jordan, 2013; Jordan & Marshall, 2010; Langs, 1979) and biopsychosocial model of health (Wade & Halligan, 2017). In accordance with both IPA and modified van Kaam protocol, I analyzed individual participant data separately before combining and synthesizing results (Moustakas, 1994; Smith et al., 2009). I used Excel spreadsheets and manual coding to list and categorize participant responses for the first four steps of the modified van Kaam method of analysis. In addition, in accordance with IPA principles, I was mindful during these and subsequent processes that, as researcher, I was attempting to make sense of the coresearchers making sense of their experience (Brocki & Wearden, 2006) of the frame of walk-and-talk therapy. Descriptions and results from the analysis steps, including a composite textural-structural description of the phenomenon of the frame of walk-and-talk therapy from the clients' perspective are addressed in the Results section.

Evidence of Trustworthiness

Credibility

To establish credibility, or internal validity, and ensure the findings and interpretations of this study were reflective of the phenomenon of interest (Merriam & Tisdell, 2016; Moustakas, 1994), I used various methods such as prolonged contact, triangulation, member checks, and reflexivity. I accomplished prolonged contact (Smith et al., 2009) through in-depth, semistructured interviews of a small, homogenous sample, and I encouraged participants to e-mail or call with additional insights later. I accomplished triangulation through member checking (Maxwell, 2005; Merriam & Tisdell, 2016) by having participants verify the content of their transcripts for accuracy and asking for further clarification or insights. Participants confirmed that the transcripts were accurate descriptions of their experience of walk-and-talk. I also used second tier triangulation by cross-referencing the current knowledge base and my professional experience during the structural description and synthesis phases (see Smith et al., 2009). Throughout the data collection and analysis phases I exercised reflexivity by attending to my bias as a walk-and-talk therapist and considering other possible explanations of the observed phenomena (see Merriam & Tisdell, 2016; Moustakas, 1994). Interview questions were open-ended and non-leading, and I asked clarifying questions to allow participants to communicate their perspectives (see Miles et al., 2014; Patton, 2015; Smith et al., 2009). I also noted differences between client accounts of their experiences of walk-and-talk to increase credibility of findings.

Transferability

Transferability, or external validity, is a limitation in IPA studies because the sample is typically small and homogenous (Smith et al., 2009). This study had a small sample size, so it is not possible to generalize findings to larger groups or populations (Merriam & Tisdell, 2016). However, I used second tier triangulation to synthesize participants accounts with my professional experience and the current literature from the therapists' perspectives (Leung, 2015), thereby contextualizing participant experiences (Merriam & Tisdell, 2016; Smith et al., 2009) and increasing the possibility of application to similar populations.

Dependability

Dependability was accomplished both by the triangulation processes (Leung, 2015) and by maintaining an audit trail (Merriam & Tisdell, 2016). Throughout the recruitment process, I maintained an Excel spreadsheet containing dates of contact attempts with walk-and-talk therapists, follow-up e-mails and phone calls, and therapist responses. I also maintained a record of participant contacts and responses, dates of consent, and interview dates. During the data collection process, I adhered to the protocol regarding semistructured interview format, allowing for participants to elaborate on aspects of their experience they deemed important as they attempted to make sense of their experience while making sure to prompt them to further describe specific components of walk-and-talk therapy and specific aspects of their experiences. I further promoted dependability through member checking (see Merriam & Tisdell, 2016; Moustakas, 1994).

Confirmability

To increase confirmability and maintain objectivity, I exercised reflexivity throughout the data collection and analysis process, bracketing known bias from the start and attending to additional bias as it arose (see Maxwell, 2005; Smith et al., 2009). I maintained a curious stance and asked participants to elaborate on their answers, being mindful of alternate explanations (Merriam & Tisdell, 2016; Moustakas, 1994; Smith et al., 2009). I was mindful that I was attempting to make sense of the clients' experience as they were also attempting to make sense of their experience (Smith et al., 2009), and I noted and addressed personal bias as it surfaced. I also exercised imaginative variation during the analysis phase (Moustakas, 1994), considering alternate explanations apart from my bias influenced by my professional experience and knowledge.

Results

The seven steps of the modified van Kaam method were used for data analysis. See Appendix B for samples of the horizontalization outcomes for each of the participants. Overarching themes and invariant constituents are presented in Table 1. Individual textural descriptions are detailed in the following sections, as are highlights of the individual structural descriptions.

Table 1

Invariant Constituents

	Participant A	Participant B	Participant C
Invariant constituents/themes			
Prior experience in traditional therapy	X	X	X
Unfamiliarity with walk-and-talk	X	X	X
Self-selection to participate			X
Invitation to participate in walk-and-talk	X	X	
Initial reluctance	X	X	
Initial awkwardness	X		
Concerns	X	X	X
Characteristics of setting:	X	X	X
Therapeutic relationship/engagement	X	X	X
Client agency	X	X	X
Informed consent			X
Mind-body experience	X	X	X
Comparison to traditional	X	X	X
Enjoyment/therapeutic benefit	X	X	X
Walk-and-talk as alternative	X	X	X

Participant A Textural Description

Having previously participated in traditional, in-office therapy, Participant A learned about walk-and-talk therapy from her therapist. She was not knowledgeable about walk-and-talk before her therapist's invitation, and she did not self-select to participate. Her therapist "was doing walk-and-talk, so it was sort of random." Participant A's relationship with her therapist was a mitigating factor influencing her decision to participate. "I clearly wouldn't have even considered doing the walk-and-talk originally unless I really got a lot from her and enjoyed working with her. If it was someone else, I probably would have said, *forget it. I'll just find somebody else.*" In addition to this therapeutic alliance, scheduling concerns dictated her decision to participate. "I really liked my therapist, so, if I wanted to keep seeing her, in the time that was convenient for me I basically had to do the walk-and-talk."

Participant A described the setting of her walk-and-talk experience as a trail "that got a little crowded depending on the time of day" with early mornings being especially popular for joggers and commuting bikers she described as "aggressive." Appointment scheduling depended on weather and temperature with most scheduled for early morning to accommodate her work schedule and to avoid extreme heat or cold because "it would stress [her] out if it was very cold or very hot." She was averse to rainy conditions as well "because it's bad for [her] hair." Participant A cited additional logistical challenges including scheduling around having to "change, shower, or whatever before or after" and figuring out how to carry "a water bottle and then your phone," but she reported these challenges were "manageable."

Participant A had some initial reluctance. “I work out sometimes, but it’s only because I have to, so I wasn’t super excited about walking and being outside.” Other reasons for this reluctance included “having to get to work and shower.” She also described awkwardness with walking side-by-side instead of sitting face-to-face. “At first it was kind of weird for me ’cause I felt like I should be looking at her and talking.” Other concerns Participant A had included concerns about seeing people she knew and fearing “they would somehow know all of [her] problems.”

Working through scheduling and logistical challenges provided opportunity for Participant A to work collaboratively with her therapist. “I do know if it was raining I didn’t like to go and walk in the rain so we would change and just talk inside.” Participant A’s therapist allowed her to set the walking pace that she defined as “not jogging, but just walking very fast.” In addition, Participant A indicated she had input in the location of her outdoor therapy sessions as the walking path was “mutually agreed upon . . . because it was convenient” for the both of them and “equidistant” between work and home.

Participant A reported that talking while walking side-by-side became “perfectly comfortable.” She also expressed that she never did see anyone she knew, but even if she had it likely would not have mattered because “everybody who is walking out there is going about their own business anyway.” She came to understand that others would likely view her outdoor session as “friends” out for a walk. She realized that others could see her walk into the office building where her indoor appointments occurred, therefore,

"there's no difference," and her concerns about others seeing her out with her therapist were unfounded. "That was stupid. So, I got over that right away, too."

Participant A described her experience as a whole-body, multi-sensory experience where her "brain was moving faster with the rest of [her] body that was moving," and incorporated her "whole body involved in what [she was] trying to solve." She described how participating in therapy outdoors while walking helped solidify the content of her therapy sessions:

> I think it just made it stick. You know, you can talk, and talk, and talk about something, but when you're walking and talking . . . I felt like, for me at least, it made my ideas a little better, and my commitment to go out and do the things we talked about stick. I would go out and do it because it's baked into my muscle memory. And when I would go out, and I'd have images in my mind of where we were walking when we were talking about something, and how things smelled, or the sound of the train going by, or the bird or something, and that those would be kind of like very positive triggers for me to remember the point of the therapy and what I wanted to get out of it.

She further commented that, "sometimes, when I walk the dog, or whenever I have occasion to just go out walking by myself . . . I kind of default back to the walking therapy and some of the advice she's given me to kind of think through problems I might be having."

Although she described the natural component of her outdoor therapy as merely "backdrop," she mentioned that it reinforced some of the content of her therapy sessions

as well. “I don’t know that this was intentional, but, even today . . . it’s been years since I started doing it . . . I can still remember exactly where I was when we talked about certain things…I can close my eyes and remember that and there’s comfort to that.” She also expressed belief that office spaces are “artificial” and being outside allowed for more freedom of expression. “As comfortable as you try, people try and make their offices, it’s still an office. And when you’re outside, I think that the unlimited-ness of outside . . . you can see the sky, you can see the trees, you can see forever . . . I think kind of frees your mind a little bit, too.”

Participant A described that physical activity during walk-and-talk therapy provided numerous benefits including improved mood. “It was nice to get a workout in as well. It felt good after that.” She also reported increased energy evidenced by “that kind of high feeling . . . just ready to go do more stuff.” Finally, she described improved cognition. “I don’t know if it’s, like, hormonal or chemical when you’re walking around, but, I just feel like I could think more clearly as I was moving.”

Participant A appeared to try to make sense of her walk-and-talk experience by comparing it to her prior indoor therapy experience. She described her walk-and-talk sessions as “more natural, less forced being outside and walking instead of just having to sit there.” Returning to the office on occasion “just wasn’t as dynamic. It almost gets kind of boring just sitting there.” She described subsequent indoor sessions sitting face-to-face as “harder.” She described walk-and-talk sessions as less formal “because you’re not dressed up or sitting in a chair and there’s not a box of Kleenex nearby. You’re just walking which is something everybody does. There’s nothing unnatural about it.” She

concluded this informality made talking "easier" and reflected on how it increased her honesty and vulnerability. "It just made me feel like my armor was off 'cause I wasn't wearing my work clothes. So, I felt like I was going in a little more vulnerable . . . in a good way . . . than I had been before." She described making the change to walk-and-talk therapy "mentally helped me express myself . . . be a little more honest and vulnerable having stripped down to just like wearing workout clothes . . . and knowing I was going to get hot and sweaty, and not caring what I looked like."

She also mused about not remembering crying while outside. "I don't know what I did, which is weird, because I did a lot of crying when we were in, and the same things were in effect so maybe there was like no crying outside?" She further pondered how the movement may have influenced this phenomenon. "Like I said before, when your whole body is in motion . . . you can't crawl into yourself and your sadness, you know? You can still be sad and emotional, but . . . I just didn't have to cry anymore." However, she did conclude, "maybe I did cry. Maybe it just wasn't sobbing where I needed a box of Kleenex."

Responding to whether walk-and-talk affected her relationship with her therapist Participant A reflected, "I liked her a lot before and then liked her a lot after. I don't know that it changed." Overall, Participant A described her walk-and-talk experience as pleasant, something she "enjoyed," and to which she "looked forward." Despite initial reluctance she indicated, "the first time I did it I was a convert." Finally, Participant A pondered whether walk-and-talk might be a worthwhile therapeutic option for individuals who are more active and would "have trouble just sitting still and talking."

Participant B Textural Description

Participant B had many years of experience with traditional therapy in an indoor setting before learning about walk-and-talk, and at that point she was in a new location with a fairly new therapist. She did not self-select to participate and was surprised to learn about it, responding to her therapist's invitation with, "Oh, that's cool. I didn't even know it was a thing." Participant B's therapist had recently begun offering walk-and-talk therapy and "messaged [her] one day before a session and said, *Do you want to meet in the park today?*" Having not heard of walk-and-talk before, she found the idea of it "fascinating," but "also a little bit of an eyebrow raise. Like, *Really? We're going to go walk around in the park and have therapy? Is this really a thing?*" Her initial response was twofold—on the one hand, she had reservations. She had recently relocated from a more "staid, pragmatic environment" to a city she referred to as "woo woo" with various "different modalities" that she appreciated, but to which she was not accustomed. On the other hand, her self-proclaimed sense of adventure helped spur her to participate. "I'm an experimenter, and I like to try new things . . . and I like to be outside. I'm an outdoorsy type. I didn't feel like it hurt . . . and so it just was kind of, *Why not?*"

Despite her willingness to engage in walk-and-talk therapy, Participant B did continue to have concerns about whether it would be "super therapeutic." She also worried about addressing more serious topics. "I was concerned at first that it wouldn't be therapeutic or that I wouldn't feel like talking about serious . . . getting into the nuts and bolts of things because I'm out in public. And I don't want to cry in public." Her initial concerns were based on what she deemed "some sort of old-school ideas about

what [she] expected." Another similar concern was related to worry over being able to be "authentic" during walk-and-talk sessions. "I guess I just want to be in an environment where I can be authentic with my reactions, and I don't know if I can do that when we're outside in public walking around."

Over the course of her outdoor sessions Participant B developed further concerns about being distracted from the content of her sessions and losing her train of thought. "I feel like I'm on a good run and then we get distracted by a dog or a bicyclist, or whatever, and I lose my train of thought. I may or may not pick it up again. I guess I would not want to lose that train of thought even for something as adorable as a dog." She also expressed a concern about running into others she knew because she did not want to have to stop and talk and take time away from her sessions. "It was in the back of my mind, like, *oh my God, the clock is ticking. This is my hour and I don't want to waste it.* I feel like every minute with my therapist is precious." Upon running into people she knew a couple of times during outdoor sessions she reported being concerned about "how quickly can I extricate myself from this situation so that I can go on with my session?"

Some of Participant B's concerns were addressed as her therapist gave her voice and agency in decision-making around her sessions. Although she quickly came to realize her therapist was "always up for walking. It [didn't] matter the weather. She's always up for it, no matter what," her therapist left the decision about being indoors or outdoors up to her. "Most of the time it was a game-day decision. She'd text me in the morning to confirm the appointment . . . and I'd just respond with whatever I wanted . . . with my choice. So, it was kind of nice I got to make the decision on that day." Her reasons for

occasional preference for being indoors included feeling like it might be a "heavy-duty session" and she might cry. She also mentioned a desire to take notes. "Sometimes I wanted to be in the office because I can write down what we're talking about or give myself homework or something. You can't do that when we're walking." Otherwise she would "opt outside weather permitting, and as long as [she] didn't have anything earth-shattering that [she] needed to talk about . . . which was most of the time."

Participant B's therapist also gave her agency in choosing where her outdoor sessions occurred. The location was one of two parks located conveniently to her home and work. She described the settings as "beautiful parks with walking paths, and one of them [had] lakes and ducks, and one [didn't] . . . but just beautiful, green, grassy, trees." Although she initially expressed equal satisfaction with both parks, she later described a preference for the one that was "just a little bit farther away" from her home because she was "not as concerned about running into neighbors."

Participant B was attentive to the relationship she had with her therapist. She found it easy to engage and had a good rapport with her therapist "by the end of [their] first session" that she also attributed to voluntarily "putting [herself] in therapy." She felt her therapist demonstrated engagement and attention to the relationship indoors and outdoors, but she felt her therapist had to work harder at demonstrating that engagement during walk-and-talk sessions. "She's awesome, but when we were walking, I guess I realized that it probably takes more effort for her to stay, to appear to be engaged in what I need, or to help me feel that she's engaged because we're multitasking . . . navigating the trails, and keeping track of the time, and watching out for dog-walkers and bicyclers,

and things like that. I always felt like she was still, really with me." She commented feeling like her therapist was "more engaged because we were walking" despite lack of eye contact while walking side-by-side. "It's obvious when you're sitting in an office and she's making eye contact. She's paying attention and she's taking notes. That's obvious that she's there for me, but I still felt that way when we were out walking, even though we would barely make any eye contact at all." Participant B questioned whether walk-and-talk might be "a great entre for someone who is not especially motivated for therapy?"

Participant B repeatedly referenced her indoor therapy sessions when describing her walk-and-talk therapy experience. She indicated having been "in and out of therapy" for a number of decades, that she would "always return to it," and reported that this last return to therapy was just for "emotional tune-ups." The lesser severity of her concerns for which she returned to therapy this time influenced her willingness to participate in walk-and-talk. "If I had been going for anything other than just emotional tune-ups . . . I would probably prefer to stay in office just because less distraction." Although Participant B requested to be in the office on days she felt she might need to cry, she recognized, "it didn't always happen. I could never predict it." Despite being cautious about being outside when she believed her session content would be more intense or emotional, Participant B indicated, "I never cried when we were out walking around." Continuing to compare with her indoor experience she reported, "There were times in the office when I would lose it and be crying, but I didn't ever have that experience outside." Trying to make sense of this phenomenon she commented, "I didn't ever have to try and

stop myself crying when we were outside. It just never came up when we were out there, and so I don't know if it didn't come up because we were walking, or if it didn't come up just because it doesn't always." She also recounted that, "If I wanted to stay in the office 'cause I thought it was going to be a heavy day, usually it just was in my head."

In addition to noticing that she did not cry outdoors, Participant B reflected on ways in which she experienced a mind-body connection during her walk-and-talk therapy experience, indicating she never felt "stifled when we were out walking around, like [she] couldn't do or say whatever [she] wanted." She also reported she was never "at a loss really for things to say when we were walking." She indicated that outdoor sessions were somewhat easier "because you're not just sitting there staring at each other across the room" and "sometimes in the office maybe I would feel pressured to come up with something." She pondered whether "other things came up to talk about because [they] were moving and being active." She recalled that she and her therapist "could have just sat outside instead of walking around." She commented, "I don't know if that's the physical activity that kept . . . my thoughts flowing better. I don't know."

Participant B appreciated the ability to combine therapy with physical activity. She opted for taking her sessions outdoors on days when she also wanted to "get a little exercise and some fresh air" and when "the sidewalks were clear and we didn't have to slop through any muck." She even attempted to combine one therapy session with walking her dog, but quickly decided that was a bad idea as it was "distracting" because others "were coming up and constantly commenting on the dog." In addition, Participant B lamented other outside distractions. She had concerns about running into others she

knew and chose the location where this was less likely to happen. Although her therapist addressed this possibility prior to it happening, and asked her about how she would like to handle it, Participant B still worried that keeping her responses with others brief in order to get back to therapy may have appeared "rude." She indicated that she was not afraid for others to know she was in therapy, but introduced her therapist as her "friend" in order to lessen awkwardness for others.

Overall, Participant B concluded that her walk-and-talk sessions felt very "natural" and "normal." Addressing her initial reluctance with walking-and-talk, Participant B reflected, "I didn't feel like it hurt . . . it didn't really take away from the therapeutic value of the session." Although she did counter with, "but some of our best work was done in the office."

Participant C Textural Description

Participant C enthusiastically embraced walk-and-talk therapy upon learning about it from a friend. She had prior experience with "traditional, in-office therapy" she described as "your classic, office, couch scenario," but felt she "got off on a bad foot with the office setting to begin with." She described one indoor setting where the therapist "had essential oils going with a diffuser, and playing classical music, and the lights were dimmed," indicating it was like "stepping into a movie . . . very strange, and not at all casual and comfortable to talk about my feelings." For this reason, she felt like walk-and-talk was "just a brilliant idea" and self-selected to participate. She recalled that if she did not "feel comfortable in a room setting maybe something more natural would be better for talking. That was on purpose. It just seemed like a better option."

Participant C's walk-and-talk therapist conducted their sessions at a multi-function sports complex with a walking pathway around a park with "a big grassy area with lots of trees." Although there were some "patches where there was mostly asphalt," there were plenty of natural components. With the exception of one brief phone session all of her sessions with this therapist were "meeting and walking outside." Participant C noted that this setting was often "a very busy place" with "a lot of people using the loop as well . . . to get in a work out." She commented that it was not an "overwhelming amount of people," but that they "always had people in sight" and were "constantly walking by people." She mentioned that at times when they were "walking at the same pace as someone" they would "jog for a little bit to get past them and then start walking again." Despite the number of people they encountered during their sessions, Participant C reported that it "wasn't really a hassle" and the "hustle and bustle . . . felt very natural."

From the beginning, Participant C compared her prior therapy experience with walk-and-talk therapy. She indicated that she did not "personally agree with the stigma behind therapy" but knew that it existed. In the past she noted that she was "very nervous about it, 'cause what if people see me walking up here? I don't know what they're going to think." She felt that participating in walk-and-talk helped "take that sort of stigma away," because the setting was "very natural to go there" and she would not "stand out by being there." She mentioned that there were "tons of other people there, chatting with their friends, or walking, or on a run, or with their dogs. People were there for all sort of reasons, so I felt normal going there."

Participant C described initial awkwardness "getting to know" her therapist, because "meeting anyone for the first time is a little bit awkward;" however, she did feel like "connection with [her] therapist" happened more quickly with her walk-and-talk experience. The conversations she had with her therapist "getting out of the car and parking, and getting into the car" felt "very normal" and helped her get to know her therapist better than she had known any of her prior therapists. She knew their relationship "was built around the help that [she] was seeking," and that her therapist "genuinely cared about [her] as a client, but as a person as well. And that's not something that [she] felt with any other experience." Participant C commented, "I didn't feel like it was super easy for me to talk to my [previous] counselor just because it was kind of a forced setting." She iterated that "walking side-by-side really helped me get what I wanted out of the experience faster by kind of making me feel more comfortable so that we could progress together faster." She felt comfortable with her therapist more quickly because their relationship was not "just associated with this professional, doctor/service type thing."

Although Participant C purposefully self-selected walk-and-talk therapy, she still had some concerns. Weather and temperature were a concern because it could get "pretty hot sometimes," but she "would always dress in workout clothes" and "was prepared to probably sweat a little bit." She did not recall rain ever being an issue, and she wondered how they might have handled things if it had rained. Participant C recalled being "strategic" about scheduling "before the sun would come out, or after it would go down" to avoid the heat of the day. Her therapist handled other potential concerns with a detailed

informed consent and allowed Participant C agency in many of the decisions regarding her therapy experience. She recalled signing a document "that [she] agreed to what [she was] doing in terms of the exercise, and that it was a walk, and there was [sic] accommodations to be made if that was needed." She also described her therapist reviewing risks and benefits of walk-and-talk including "there could be unexpected things that happened." She likened this informed consent process to "commercials where they list all of the side effects." She also had a choice in whether she "wanted to just be outside in nature" or if she wanted to include physical activity. She also had a choice in "which pace [she] thought would fit [her] best" and expressed preference for the outdoors because "just physically getting outside, even if it's not for walk-and-talk therapy, is a good thing by itself." She also mentioned scheduling sessions late in the week as a way to "sort things out and have a debrief at the end of the week."

Participant C's therapist's informed consent also addressed encountering others they might know in the busy environment where her sessions occurred. She recalled she "never really had a concern" with being around others in public because her therapist had "never had an issue" with it, telling her, "everybody here is basically just here to either enjoy the park or workout." Because her therapist was up front about this, she recalled not feeling "super freaked out when we saw people." Upon encountering others, they knew they "stopped and said, *Hello*," but it was not bothersome. "I could have been with anyone. There was no association behind what I was doing or what they were doing, and they were just really quick interactions." These brief encounters did not disrupt her therapy sessions. "It wasn't really an interruption. It was super easy to pick back up

where we left off." She mentioned, "It was very natural. We kind of just kept walking . . . and then it was just a pause."

Participant C articulated a number of benefits of her walk-and-talk experience. She iterated that it was more "personable" and that walking side-by-side helped her feel "more comfortable to actually articulate and think about what [she] was going to say." She described the frame as providing her time to think, "because it wasn't forced." She described her sessions as "casual," and feeling "like two friends going to a park to catch up." She even described feeling more "equal" and like she was "on the same playing field" as her therapist. She felt the setting allowed her to "connect" with, and get to know her therapist more quickly, calling her experience "easy" and more "conversational." Specifically, Participant C described walking side-by-side as less "awkward" allowing her freedom to not "overthink" what she was going to say, or to feel less pressure if she needed to "take a break from talking." She even mentioned, "If I needed a second to grab my thoughts, we'd just look around and see cute dogs."

Participant C described other benefits including feeling "productive" while combining her weekly therapy session with a "pretty fast" walk. She described feeling "satisfied" with the content of her sessions, and feeling "happy at the end" knowing she was "learning tools to deal with stress" and making "progress" that also served to boost her confidence. She especially appreciated the combination of physical activity and being outside because of the sedentary nature of the rest of her weekly activities and "being stuck inside." Participant C made a connection between the physical activity and her thoughts and mood. "You are also exercising and stimulating your body and stimulating

your mind by being outside." She commented, "Exercise in general stimulates your brain in a different way. It like sends different hormones and endorphins and things throughout your body" and provides "a different way to get your brain thinking." She recognized the ways in which walk-and-talk was "relaxing," "calm," and "refreshing" in the natural surroundings, as well as leaving her with a "good kind of afterglow feeling" post session. Although Participant C described the natural setting of her sessions as backdrop, she did feel that it "subconsciously helped with the relaxing part." She mentioned that although clinicians often attempt to decorate their offices with artwork reflective of nature, "nothing beats the real thing." More than once she commented on the importance of the natural, outdoor setting saying, "it would have been a completely different experience if we were walking inside a track at a gym or something. It would have been very different to have been doing the same intensity walking in a different setting." Participant C also felt walk-and-talk therapy helped her internalize the content of her therapy sessions. "I think the movement part kind of made me more aware of my actions . . . which kind of helped me to keep what we talked about during the sessions something that was easy to remember, and to bring with me after that and apply what we had actually talked about."

Whereas, Participant C would often dread her traditional, indoor therapy sessions, "because it was a big ordeal," she enjoyed and anticipated her walk-and-talk sessions. "This was something that I really looked forward to, and I remembered, and it was a really, really great way to kind of change my counseling experience." She recalled that walk-and-talk was "definitely just an easier experience than any office setting I think could ever provide." Although she recognized that walk-and-talk might not be suited for

everyone, she believed it to be one of "many different options" for others. She indicated walk-and-talk was now her "go-to thing to recommend."

Participant A Structural Description

Participant A described synergistic benefits of engaging her mind, body, and senses in the walk-and-talk therapeutic process. She became aware of improved cognition evidenced by clarity of thought during sessions, and improved mood and increased energy at the conclusion of her therapy sessions. She found it puzzling that she did not remember crying during outdoor, walking sessions, further supporting her belief in the mood boosting effects of adding physical activity and nature exposure to her therapy experience. In addition to the immediate benefits experienced during and after her therapy sessions, Participant A felt the physical activity and natural surroundings heightened and coalesced her therapeutic experience, and even now she remembers content of her therapy sessions and the sensory stimuli she experienced at the time. Though she engaged with hesitation, the essence of Participant A's lived experience of walk-and-talk therapy was that it was challenging yet transformative. She developed a preference for walk-and-talk and enjoyed and anticipated her sessions.

Participant B Structural Description

Participant B's experience with walk-and-talk therapy was peppered with ambivalence. On the one hand, she expressed appreciation for the experience and some of its benefits, in particular the relationship with her therapist. On the other hand, she preferred being indoors, especially when and if her sessions might be intense or emotional. She equated her enjoyment of walk-and-talk with having volunteered for

therapy for emotional maintenance. She appreciated being outdoors and being able to combine her therapy session with physical activity; however, real or potential distractions prevented her from always enjoying a safe and secure outdoor therapy frame. She indicated her walk-and-talk therapy experience was as therapeutic as her indoor experience, although she repeated her reasons for therapy this time around were less severe. She also referenced having recently moved from a more traditional and conventional environment. Cultural norms and the extended length of time Participant B had been in therapy off and on over many years may have contributed to an expectation of traditional therapy norms.

Participant C Structural Description

Overall, Participant C enjoyed her walk-and-talk experience and anticipated her sessions. She believed the benefits she gained from walk-and-talk were far greater than what she experienced with past therapy experiences. Although her positive walk-and-talk experience may have been predicated by her expectations based on her awkward past therapy experiences, Participant C did report that the outdoor frame was more comfortable, safe, and therapeutic for her. Her youth and recognition of the importance of including physical activity and elements of nature in her everyday life may have also predisposed her to a preference for an outdoor frame. Participant C is now a proponent of walk-and-talk therapy and recommends it to others reluctant to engage in indoor therapy, or for those who, like her, have not had positive traditional therapy experiences.

Composite Textural-Structural Description

After completing individual textural-structural descriptions for each participant, I composed a composite textural-structural description as the final step of the van Kaam data analysis process. In this composite, I describe the essence of the coresearchers' walk-and-talk therapy experience.

Prior therapy experience. The essence of the frame of walk-and-talk therapy may be better understood from the perspective of the clients who have engaged in the practice. Clients are likely to make sense of walk-and-talk through the lens of their prior traditional therapy experience. The coresearchers in this study had participated in traditional, therapy and described the essence of their experience of walk-and-talk therapy through the lens of these past experiences. In addition, participants framed their walk-and-talk experience by amount of time they previously spent in therapy, their relationship with their therapist, and whether their earlier experiences in therapy were positive or not.

Unfamiliarity with walk-and-talk. Two study participants had not heard about walk-and-talk therapy until their therapists invited them to participate. These clients were content with their prior indoor therapy arrangement, had no knowledge of walk-and-talk to date, and were not seeking a new therapy experience. The third participant was informed of walk-and-talk by a friend.

Invitation versus self-selection. For the two clients who were invited to participate by their current therapist, the impetus to participate varied. One expressed a sense of adventure and willingness to try something new, whereas the other valued her

relationship with her therapist, and knew that she had to agree to walk-and-talk or find another therapist that could meet with her within the confines of her work schedule. Both had a strong therapeutic alliance and therefore felt more inclined to accept the walk-and-talk invitation; however, inherent in this was the possibility that the therapist-client power differential may have produced some influence. Although neither overtly expressed coercion to participate, the initial reluctance they both felt coupled with their relationship with their therapists suggested an underlying fear that if they opted against walk-and-talk they would either have find a new therapist, or they risked harm to their current therapeutic alliance.

Conversely, the youngest study participant was encouraged by a friend to try walk-and-talk. Having prior traditional therapy experiences she considered strange and uncomfortable, she enthusiastically self-selected to participate in walk-and-talk, and expected it to be a better fit for her. She may have also been more inclined to participate in a new and novel experience because of her youth.

Initial reluctance. Two participants responded to walk-and-talk with ambivalence and initial reluctance. These two participants had concerns about whether it would be therapeutic, concerns about being outdoors in the elements, and concerns about running into others they might know. Yet they agreed to participate with minimal enthusiasm. Some of their ambivalence may have also stemmed from being unfamiliar with the practice and not self-selecting to participate. The third participant who self-selected walk-and-talk did so without hesitation.

Characteristics of setting. Although the outdoor settings varied, including multiuse trails, a multi-function sports complex, and urban park settings, the settings had natural components, and other pedestrians and commuters (i.e., bicyclers) used the spaces at the same times as therapy sessions occurred. Therapy settings were conveniently located to participants' home, work, or other activities. Participants agreed that the natural components of their walk-and-talk therapy settings were backdrop and their therapists did not actively incorporate the natural elements into the work of therapy; however, two of the participants expressed that those natural components enhanced their outdoor therapy experience.

Therapeutic relationship. Coresearchers described good rapport with their therapist before being invited to participate in walk-and-talk therapy, or they rapidly developed rapport after self-selecting to participate. Study participants also described engagement with their therapists throughout the process, whether they returned indoors, or remained outdoors for their therapy sessions. The therapeutic alliance may have enhanced the walk-and-talk experience and lessened the impact of deviations in the altered outdoor frame.

Initial concerns. Participants approached walk-and-talk therapy with various concerns, including logistical concerns such as scheduling around work and other activities. Weather and temperature were also considerations for participants that dictated session location and timing. Participants also vocalized concern over the presence of others in their walk-and-talk therapy environment. Participants alluded to a concern for confidentiality and an understanding of the stigma associated with therapy. For one

participant, however, encountering others she knew was more of a concern because it infringed upon her therapy hour. Although she felt comfortable introducing her therapist as a friend, she wanted to quickly return to her session without appearing rude. This participant also expressed frustration with other distractions because they would derail her thought process. An additional concern was fear of becoming emotional during an outdoor session. One participant also desired authenticity in her reactions in session and feared losing control in public. This participant indicated a preference for being indoors on days she believed her session content would be more intense or she felt she might cry. This speaks to clients' desire to have a safe space to explore and experience the full spectrum of their emotions without others witnessing or judging. Each of these concerns were issues related to the altered, and often unpredictable nature, of the frame of being outdoors, with the potential for detracting from the therapeutic value of walk-and-talk.

Informed consent and client agency. Therapists addressed client concerns both through an informed consent process and by allowing client agency. Participants scheduled their appointments strategically to avoid extreme hot or cold, or sessions were conducted indoors if it was raining. Although clients realized their therapists preferred to be outdoors regardless of weather conditions, they indicated their therapists deferred to them in determining an indoor or outdoor location. Clients also adapted and dressed for the weather conditions. The outdoor frame created conditions of physical discomfort for these clients that might have been detrimental to their walk-and-talk experience. Allowing for personal agency and having alternate schedule and location options helped

ease participant concerns regarding logistical issues, and helped them prepare for and manage potential discomfort.

Walk-and-talk therapists managed concerns for confidentiality and lessened the clients' worry over implied stigma in a few ways. The first was through a formal informed consent process and by informally asking how clients preferred to handle chance encounters. One therapist normalized the setting and activity level, assuring her client that it had not been an issue because others were immersed in their own activities. Over the course of walk-and-talk therapy participants realized that others were not paying attention to their therapy sessions or the content. They also realized that others could also witness them walking into their therapist's office. The participants expressed understanding that others would view their walk-and-talk sessions as friends out for a walk, and introduced their therapist as a friend when they encountered others they knew.

Matters of confidentiality and the remaining stigma regarding seeking counseling are typically nonissues in traditional therapy settings; however, coresearchers recognized that being seen walking into an indoor therapy office is not without risk. Participants' concerns were eased when their therapists addressed these issues before their first outdoor session. In addition, after experiencing walk-and-talk, clients realized others were attending to their own pursuits and not mindful that they were engaging in a therapy session. One coresearcher even felt the presence of others in the busy setting helped reduce felt stigma because the setting and surrounding activity felt very normal.

One client opted for indoor sessions on days when she felt her session content would be more intense or she would choose the outdoor location that was farther from

her home to lessen the probability of chance encounters and other distractions. This client's experience is important as it highlights other concerns arising from and outdoor therapy frame. Indoor therapy settings prevent interruption and protect therapy time. Opting inside solved those issues on occasion, but this was still a very real concern for this client on the days therapy sessions were outside. Having extensive therapy experience over a few decades may also have factored into this client's expectations for a more strict and protected frame. Her therapist respected her concerns and choice about the location of her therapy sessions on the day of her appointments.

Initial awkwardness. Another issue mentioned by participants was the initial awkwardness of walking side-by-side with their therapist. Eye contact is acceptable etiquette while communicating; thus, clients initially felt strange not looking at their therapist during outdoor sessions. Yet, the consensus was that talking while walking side-by-side was easier, more comfortable, less forced, and less pressured. They also experienced a newfound freedom of expression. While one participant opted outside for all her sessions save one brief phone conversation, the other two had indoor sessions interspersed with their walk-and-talk sessions, and therefore, experienced the face-to-face, static office setting anew. Both felt this reinforced the benefits of walking side-by-side as they experienced awkwardness returning to a face-to-face setting. The participant who had self-selected walk-and-talk therapy, and thus only had outdoor sessions with this therapist indicated that walking side-by-side helped facilitate engagement. Although walking side-by-side was a deviation from the traditional frame, participants enjoyed it

and realized benefits including finding it easier to talk and express themselves when not having to make eye contact with their therapist.

Mind-body benefits. Coresearchers described benefits of the different components of walk-and-talk therapy including feeling refreshed, relaxed, and calmed by the outdoor setting. Adding physical activity helped boost and aided with clearer and improved cognition. Participants reported improved communication with their therapist and issues surfaced they likely would not have discussed in an indoor setting. Incorporating physical activity into the therapy session also created increased satisfaction as participants felt their sessions were more productive as they multitasked therapy with workouts. One participant also indicated multitasking afforded her a boost in confidence. Coresearchers expressed a belief in a mind-body, or multi-sensory experience as they described how walk-and-talk sessions helped solidify the content of their sessions. They believed features of their therapy settings and the movement helped them internalize and act upon therapy content at later dates.

Participants noticed that they did not remember crying while out walking. A secure, indoor therapy space provides privacy and helps reduce client worry about whether or not they might cry; however, participants pondered that something about the outdoor therapy experience may have prevented their need to cry. Thus walk-and-talk may influence a boost in mood; however, one participant mentioned an alternate explanation that emotional responses are sometimes difficult to predict. Regardless, the possibility of becoming emotional while participating in a walk-and-talk session in public is a very real possibility and concern brought about by the altered therapeutic frame.

Comparison to traditional therapy. Coresearchers compared the frame of walk-and-talk to the frame of their prior traditional therapy experiences. Participants described walk-and-talk as less formal and pressured, more comfortable, casual, dynamic, and natural. They felt it enhanced communication and was equally or more therapeutic than indoor sessions. One participant believed that her walk-and-talk experience allowed her to feel more equal to her therapist alluding to a more collaborative therapeutic alliance. Another noticed that the informality helped her be more honest and vulnerable in her sessions. Despite significant differences between the frames of indoor and outdoor therapy, these clients recognized benefits during their outdoor sessions they had not experienced to the same degree indoors. Removing the trappings of the office space decorated and controlled by the therapist, reduced the formality of the setting, and brought about a shift in the therapy relationship and dynamics participants felt more conducive to the therapeutic process.

Enjoyment of walk-and-talk. The study participants indicated they enjoyed their walk-and-talk therapy experience and believed it to be as therapeutic, or more therapeutic than their indoor therapy sessions, although one expressed a belief that indoor sessions would be more appropriate for more severe presenting issues.

Walk-and-talk as an alternative offering. Study participants expressed belief that walk-and-talk therapy is an appropriate alternative therapeutic offering for individuals who may not find traditional, indoor therapy appealing for various reasons.

Composite summary, The walled space and ground rules of traditional indoor therapy is designed to ensure confidentiality and safety, and facilitate a positive and

productive therapy experience; however, walk-and-talk clients reported that walk-and-talk therapy, even with its challenges and deviant frame, provided a more holistic, synergistic therapy experience comparable to, or better than their traditional therapy experience. The ways in which their therapists addressed the altered outdoor frame, including prior informed consent, and working collaboratively with clients to facilitate personal agency, eased client concerns regarding the deviations in the frame. The coresearchers reported numerous synergistic, mind-body benefits incurred during their walk-and-talk therapy journeys, and when compared to their prior traditional therapy they believed walk-and-talk superior in many ways.

Summary

In this chapter I described the data collection and modified van Kaam data analysis processes I used that resulted in a description of the essence of clients' experience of walk-and-talk therapy. I presented the themes and invariant constituents that emerged, and possible explanations for them, using imaginative variation. Themes that arose addressing how clients experienced the walk-and-talk frame included participant experience with traditional therapy, unfamiliarity with walk-and-talk, invitation versus self-selection, initial reluctance, characteristics of setting, therapeutic relationship, initial awkwardness, initial concerns, informed consent, client agency, mind-body experience, comparison to traditional therapy, enjoyment and therapeutic value, and walk-and-talk as an alternative. I also addressed trustworthiness of the data collection and analysis process through credibility, transferability, dependability, and confirmability. In the following chapter I will interpret the findings, address limitations, and implications.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In recent years, more therapists have added walk-and-talk therapy to their therapeutic repertoire (DeAngelis, 2013); however, research regarding the practice is behind its increasing popularity. Although some research exists regarding the practice from the perspective of walk-and-talk therapists (Charbonneau, 2014; Jordan, 2015; Jordan & Marshall, 2010; King, 2015; McKinney, 2011), there has not been as much about clients' perspectives (Jordan, 2015; Jordan & Marshall, 2010). The purpose of this qualitative, IPA study was to better understand walk-and-talk clients' experience of the altered frame of psychotherapy that occurred outdoors while walking side-by-side. The results showed that clients were largely unfamiliar with the practice before engaging in it, and their experiences of it were shaped by prior experience they had with traditional therapy. Clients experienced initial reluctance, awkwardness, and had concerns related to logistics, weather, and confidentiality. Their engagement with their therapist, how their therapist handled informed consent, and how their therapists allowed for personal agency regarding their concerns about the altered frame helped mitigate many of these concerns. Clients reported an experience that integrated mind and body, with synergistic therapeutic benefits equal or better than what they experienced with an indoor frame. They reported overall enjoyment of walk-and-talk therapy and believed it to be a viable alternative for others who do not find traditional indoor therapy appealing for various reasons.

Interpretation of the Findings

Participants in this study, consisting of three former walk-and-talk therapy clients, described their lived experiences of walk-and-talk therapy and echoed some of the same benefits and themes previously reported in the literature from therapists' perspectives. Participants and walk-and-talk therapists alike referenced their perspectives of the practice based on their prior experience with traditional indoor therapy. Participants also provided additional insights based on their subjective experiences of the altered frame of walk-and-talk therapy.

Walk-and-talk therapy may be conceptualized as merely taking normal therapy outside (McKinney, 2011); however, some therapists have suggested that there is a larger dynamic occurring during walk-and-talk (Charbonneau, 2016; Wessan, 2018) like a spiritual component (King, 2015). Participants alluded to this altered energy with one calling walk-and-talk "more dynamic," but participants reported mind–body connections and increased internalization of therapy content they attributed to the convergence of therapy, physical activity, and the natural setting. Being outdoors and walking side-by-side also seemed to create a different therapist-client dynamic. For instance, therapists have recognized that nature adds another dimension to the relationship, creating a triadic versus a dyadic relationship, with nature ranging from backdrop to active participant as well as influencing the process of therapy (Harris, 2014). In addition, therapists sometimes have a preference for working outdoors (Harris, 2014). Clients in this study echoed the sentiment that their outdoor sessions were easier, more comfortable, and more natural, with one client reporting better rapport and a better working relationship than she

had with her prior therapists. None of this study's participants alluded to a spiritual component to their walk-and-talk therapy experience.

Increased use of walk-and-talk therapy may be rooted in younger therapists' willingness to embrace alternative methods and interventions as well as belief that client needs shape interventions (McKinney, 2011). In addition, the decision to incorporate walk-and-talk into a therapeutic practice is often born of the therapist's desire to be outside (McKinney, 2011). Though the age of the therapists for the participants was unclear, two of the coresearchers indicated that walk-and-talk was initiated by their therapist and not themselves. It is also unclear whether their therapists felt that being outside and walking was a better therapeutic intervention for these clients or whether it was therapist preference to be outside; however, therapists allowed for client agency in making the decision whether to be indoors or outdoors.

Researchers have also highlighted therapists' perspectives regarding a number of aspects of walk-and-talk therapy as compared to indoor therapy. Findings included that therapists believe walk-and-talk therapy to be more casual (McKinney, 2011; Revell & McLeod, 2016), collaborative (Charbonneau, 2016; King, 2015; McKinney, 2011; Revell & McLeod, 2016), and helped with engagement and therapeutic alliance (McKinney, 2011; Revell & McLeod, 2016). This information was confirmed by this study's participants, who described feeling that their experience was more casual, informal, comfortable, and normal. Although two clients already had a relationship with their therapists before embarking upon walk-and-talk, the one client who did not know her therapist before participating reported feeling as if she built that therapeutic alliance with

her walk-and-talk therapist more quickly, citing walking side-by-side as being a catalyst to this process and indicating that she felt more equal with her therapist. It is also possible that her self-selection and prior excitement about the practice, shaped by her uncomfortable earlier traditional therapy experiences, may have also fueled quicker engagement with her therapist. Although participants did not overtly mention feeling as though their walk-and-talk therapy felt more collaborative, the coresearchers did express ways in which their therapists involved them in decision making around aspects of their walk-and-talk therapy experiences including setting, scheduling, and whether to stay outside or go back indoors based on weather or session content and intensity. In these ways, participants implied collaboration, at least with regard to planning and logistical concerns. It is not known whether this same collaboration carried over into session content, processes, or outcomes.

Because walk-and-talk therapy occurs in a space not controlled by the therapist, it lays the foundation for a more collaborative relationship and allows opportunities for therapists and clients to co-navigate the space as well as to incorporate aspects of nature into sessions. Participants in this study experienced opportunities to collaborate with their therapists regarding session logistics. Participants also expressed the formality and discomfort they experienced being in a space designed by and controlled by a therapist, reporting that being outdoors was more therapeutic and less stigmatizing, also supporting Charbonneau's (2016) findings. Clients in this study indicated the natural aspects of their outdoor therapy setting was backdrop and not actively incorporated into their sessions;

however, two of them mentioned the ways in which the setting enhanced and solidified session content.

Despite the client-stated benefits of walk-and-talk therapy, there are some noted concerns. For example, participants echoed researchers' concerns about weather (McKinney, 2011; Revel & McLeod, 2016). Engaging in outdoor therapy leads to concerns not encountered in indoor therapy spaces such as weather and temperature. In addition, weather and temperature concerns are likely to vary with the particular region and session in which a client participates in outdoor therapy; however, clients felt as if their therapists respected their wishes regarding this matter.

There are also concerns about maintaining proper boundaries during walk-and-talk (Revell & McLeod, 2016). Participants referenced feeling as if they were walking with a friend, and others might view them as walking with a friend or they introduced their therapist as a friend, but they also vocalized understanding that their relationship with their walk-and-talk therapist was a professional one. Another concern mentioned by walk-and-talk therapists and pointed out by one participant was difficulty in attending to therapy content and processes during walk-and-talk sessions (McKinney, 2011; Revell & McLeod, 2016). One participant mentioned feeling as though her therapist had to work harder to engage while walking and talking. In making further recommendations for research, Revell and McLeod (2016) warned against assuming one setting was more therapeutic than another. Participants' responses confirmed this as one indicated being in an outdoor space with plenty of activity felt more normal, whereas another felt it more distracting. Thus, the therapeutic value of a space and level of activity is subjective,

which was also mirrored in the literature (Bell et al., 2018; Houghton & Houghton, 2015).

Therapists have further mentioned concern for safety (McKinney, 2011). Although one participant did mention that her therapist's informed consent included reference to possible unexpected occurrences, none of the participants overtly mentioned nor implied concern for their physical safety. There was also agreement between therapists (Charbonneau, 2016; McKinney, 2011) and participants regarding whether walk-and-talk might be better suited for specific individuals, particularly those who have less severe presenting issues.

In addition to concerns about confidentiality, therapists mentioned challenges related to emotional regulation (i.e., crying in public) and appropriate ethical practices (Charbonneau, 2016). However, therapists have suggested that clients worried less about these issues than therapists did (Charbonneau, 2016). Though participants in this study reported not crying, or not remembering crying, in outdoor sessions it was a real concern for them, and one reported preference for being indoors on days she felt she might become emotional. In contrast, Wessan (2018) reported the client in her case study released a "tsunami of tears" (p. 17) during her first outdoor session. For participants in this study, reasons for crying or not crying were likely related to intensity of presenting issues. Study participants may not have sought therapy for complex traumas and thus the physical activity or nature exposure incorporated during session was a sufficient dose for improvement in mood (Carek et al., 2011; Ettema & Smajic, 2015; Shanahan et al., 2015) at the moment. Concern for emotionality, however, may be client specific, as well as

setting specific. Being in a more secluded, rural setting may ease clients' concerns about becoming emotional in public. The process of completing the informed consent process, including risks and benefits, may also mitigate client concerns about confidentiality and emotionality (Charbonneau, 2016). This appeared to be the case for one participant as well, as did having the agency to opt indoors for the other two participants.

Findings in Relation to Conceptual Lens

Concerns reported by therapists in earlier research related to the conceptual lens of the frame of therapy (Chalquist, 2009; Jordan & Marshall, 2010; Jordan, 2013), were echoed by participants in this study. Participants noted diverse ways in which the frame of walk-and-talk therapy deviated from their indoor sessions including concerns about confidentiality, stigma, distractions, and worry over emotionality. Although participants quickly became comfortable with the activity and presence of others, these were very real initial and sometimes ongoing concerns. In addition, one client pointed out more concern for session flow and infringement upon her therapy hour. Informed consent and client agency helped clients adjust and adapt to the altered frame, as did immersion in the experience over time. However, the deviant frame created opportunity for more intense therapeutic work as one client described that walk-and-talk allowed her to be more honest and vulnerable in her therapeutic encounters.

In the absence of walls, issues of boundaries and safety were considered important considerations for the altered outdoor therapy frame (Jordan, 2013: McKinney, 2011; Revell & McLeod, 2016). The therapist is holder of the therapeutic frame when conducting therapy outdoors and it is important to be able to maintain fluid, yet

appropriate boundaries (Jordan, 2013). Participants appeared to understand the client–therapist boundaries and did not seem concerned for their physical safety, although concerns over emotionality and confidentiality may have been their way of communicating concern for emotional safety. One client also noticed the ways in which her therapist appeared to work harder at engagement through attending to the various distractions in the outdoor therapy environment, thus alluding to understanding that the therapist was also working harder at maintaining appropriate boundaries and ensuring a safe environment for therapy. The belief that the altered frame creates an equal power distribution (Jordan, 2013) was further supported by this study's clients.

Clients' descriptions of the essence of their experiences with walk-and-talk therapy also supported the second conceptual lens for this study, the biopsychosocial model of well-being. The altered frame of walk-and-talk therapy potentially facilitates a more holistic therapy experience (Jordan, 2013), consistent with the biopsychosocial model of well-being. Clients described the ways in which the combination of physical activity and nature exposure, along with the content of their therapy and their client-therapist relationship created a better therapy experience for them. They appreciated the opportunity to multitask, recognizing the importance of physical activity for their physical well-being, but also noticed improvements in overall well-being evidenced by improvements in mood, cognition, energy, and confidence. They further described the experience as refreshing, calming, relaxing, and providing them with ingrained memories of their therapy sessions they could access in the future.

Summary of Findings

In conclusion, findings from this study confirmed walk-and-talk therapists' beliefs that there are challenges to be addressed when taking therapy into an altered outdoor frame, but also additional benefits not realized indoors. While clients believed walk-and-talk therapy equally or more therapeutic than their prior, indoor experiences, they agreed that walk-and-talk may be better suited for specific clients, particularly those with less severe presenting issues. Some of the findings of this study that differed from those from the therapists' perspective include therapists' belief that clients are far less concerned with confidentiality, stigma, emotionality, and ethical considerations. This may be because therapists are referencing their clients' experiences retroactively after clients have become comfortable with the altered frame.

Limitations of the Study

As expected with a small, homogenous sample typical of an IPA study, this study's mere three participants prevent generalization to the larger population (Smith et al., 2009). Specifically, because participants were Caucasian females, the results of this study may not be generalized to minority populations or to males, or to broader cultural contexts outside of the United States. Other limitations include focus on the frame of walk-and-talk in more urban settings, as well as more remote versus recent walk-and-talk experiences. Finally, participants contacted by their former therapist and provided with information to participate may have felt obligation or coercion and therefore provided a more positive description of their experience.

Recommendations for Future Research

Recommendations for future research include, but are not limited to, examining the experiences of a more diverse sample, including males and ethnic minorities, current walk-and-talk therapy clients, or those with more recent walk-and-talk therapy experience, as well as examining client experiences of walk-and-talk therapy in more secluded, natural settings where concerns over stigma, confidentiality, or distractions may be of less concern. Other recommendations for future research of walk-and-talk therapy include quantitative inquiry such as correlational studies and multiple regression analysis controlling for various aspects related specifically to the walk-and-talk therapy frame (i.e., physical activity, natural setting), as well as client and therapist characteristics and demographics, client presenting issue, or therapist treatment modality. Other variables for consideration include informed consent, self-selection to participate, and prior versus no experience in traditional therapy.

Implications

Positive Social Change

Clinicians are expected to abide by their professions' standard practices and ethical codes (AAMFT, 2016; APA, 2010). As such, clinicians should also be trained in their therapeutic offerings and received adequate supervision (Duros & Crowley, 2014). Because research regarding the practice of walk-and-talk lags behind its rapidly growing use, training, supervision, and standard practices are virtually nonexistent (Charbonneau, 2016). This study highlighted some of the issues and concerns clients had with their walk-and-talk therapy experience as well as some of the ways in which their therapists

did, or did not address them. Shedding light on these client concerns provides opportunity for clinicians to consider ethical and practical implications, and to establish protocols and appropriate informed consent for client comfort and safety for walk-and-talk therapy. Another potential implication for social change resulting from this study is that walk-and-talk may be a viable alternate offering for clients that do not find traditional therapy settings appealing or comfortable. Walk-and-talk may also be a way to engage clients who would otherwise avoid traditional therapy because of the continued stigma associated with it.

Theoretical Implications

No theory was generated as a result of this study; however, IPA studies may serve as a launching point for theory generation (Reid et al., 2005; Smith et al., 2009) and future studies. Participants in this study alluded to an increase in cognitive and emotional benefits when physical activity and nature were combined with their talk therapy sessions. These participants also highlighted benefits and improvements in their physical and overall well-being. Thus, it could be postulated that the combination of physical activity, nature exposure, and psychotherapy work synergistically for increased benefits to well-being than incorporating these components separately. This would be an appropriate consideration for future research.

Recommendations for Practice

Based on participant input from this study, numerous recommendations for the practice of walk-and-talk therapy emerged. Walk-and-talk clinicians should avoid coercing clients into participating in walk-and-talk therapy. They should also conduct a

detailed informed consent prior to engaging in walk-and-talk covering potential risks and benefits, as well as addressing client concerns before the onset of outdoor therapy sessions. Therapists should respect and encourage personal agency for client preferences related to their walk-and-talk experience including having an alternative space, including a phone or online option, for sessions in which client does not feel like engaging in walk-and-talk therapy. Clinicians should address issues of confidentiality and the presence of others in the outdoor space and work collaboratively with the client on how to manage these scenarios. Finally, therapists should assess client suitability and preference for outdoor sessions, including assessing for severity of client issues or client's sensitivity to sensory stimuli they may find distracting from their therapy experience.

Conclusion

Many therapists have championed walk-and-talk therapy based on their belief in the benefits of physical activity and exposure to natural outdoor settings, in combination with talk therapy. This study confirmed some of these therapists' beliefs about the practice, as well as bringing to light some new considerations regarding the altered frame of the practice. Walk-and-talk therapy may be a viable alternative for clinicians to add to their therapeutic repertoire, particularly for clients who may struggle with the intensity of sitting face-to-face in a traditional office setting. Walk-and-talk may also be a way to normalize the experience of therapy for some and reduce the stigma associated with seeking help for mental and emotional issues.

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Appendix A: Interview Schedule

The following interview questions are proposed for conducting a semistructured interview in order to answer the overarching research question, "How do adult clients experience talk therapy conducted while walking side-by-side with their therapist in an outdoor setting?"

1. How did you decide to participate in walk-and-talk therapy instead of traditional in-office therapy?
2. Tell me what it was like for you to participate in therapy sessions outdoors while walking with your therapist.

The following prompts will be used as needed to elicit more detailed information about the participants' experience of the biopsychosocial components that shape the phenomenon of walk-and-talk therapy.

- How did being outdoors influence your experience of your therapy sessions?
- How did walking influence your experience of your therapy sessions?
- In walk-and-talk therapy you are side-by-side with your therapist rather than face-to-face. How did that influence your experience of your therapy sessions?
- Tell me more about _____.
- What else do you think is important for me to know about your experience of walk-and-talk therapy?

Appendix B: Horizontalization Samples

Participant A Horizontalization Samples

- I was actually doing the traditional face-to-face therapy when she said she was cutting back her office time and doing more walk and talk therapy and would I be interested in doing that. And I said that I would, and it was the days that I could do it.
- She was doing walk-and-talk, so it was sort of random.
- . . . my brain was moving faster with the rest of my body that was moving. It felt more natural, less forced being outside and walking instead of just having to sit there.
- I don't know if it's, like, hormonal or chemical when you're walking around, but I just feel like I could think more clearly as I was moving.
- It was nice to get a workout in as well. It felt good after that.

Participant B Horizontalization Samples

- My therapist invited me. She texted one day before a session. It was fairly new to her. And she just messaged me one day before a session and said, "Do you want to meet in the park today?" And I was like, "Oh, that's cool." I didn't even know it was a thing.
- I was a little . . . I wasn't exactly sure how I felt about it. Like, "Is it going to be super therapeutic?" That's how I got introduced to it.
- I got to know that she's always up for walking. It doesn't matter the weather. She's always up for it, no matter what. She's great, but she will also do whatever I

want too. So, I would decide whether to do walk-and-talk depending on if I felt like it was going to be a heavy-duty session, and if I felt like I needed to cry I would say, "We need to be in the office today." It didn't always happen. I could never predict it.

Participant C Horizontalization Samples

- I had that experience here, which was your classic, office, couch scenario, but I didn't feel like it was super easy for me to talk to my counselor just because it was a kind of forced setting.
- I think that while I don't personally agree with the stigma behind therapy, there definitely is a stigma. And while it's getting better, I was super nervous about going in the first place.
- It just felt like two friends going to a park to catch up. And while our talks were very focused it was very natural. I think meeting anyone for the first time is a little bit awkward, so I think at first I was a little bit reserved, but it's just because I was still getting to know her . . . but as time went, that kind of break down period moved and progressed much faster and it was a lot easier for me to feel comfortable with her faster because our relationship wasn't for me just associated with this professional, doctor/service type thing. It was more of a way for me to sort things out and have a debrief at the end of the week.