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Experiences of therapists who integrate walk and talk into their professional practice

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Abstract

Background

There has been increasing interest in recent years in the possibilities arising from conducting psychotherapy in outdoor settings, for example through the use of ‘walk and talk’ sessions.

Aim

This study aimed to explore the experiences of practitioners who use this approach, in terms of helpful and hindering factors.

Method

Eighteen walk and talk practitioners completed an online mixed-methods questionnaire.

Findings

Participants perceived that walking and talking can help shift ‘stuckness’ in clients and facilitate psychological processing. In addition, practitioners indicated that walking side by side can promote a collaborative way of working. Hindering factors included working with uncertainty, issues around maintaining boundaries and the requirement to develop new skills.

Limitations

The sample size and use of an online survey limited the amount and richness of information obtained.

Implications

The results suggest that walk and talk is an emergent psychotherapeutic approach, characterised by a substantial degree of consensus across practitioners regarding the rationale for this type of intervention, and the facilitative processes that are supported by it. It would be valuable to develop research-informed guidelines and training opportunities to support safe practice in this area of work.

Introduction

The use of outdoor spaces in counselling and psychotherapy has been steadily developing in recent years. Practices such as nature therapy (Berger & McLeod, [2006](#)), ecotherapy (Buzzell & Chalquist, [2009](#)), outdoor therapy (Revell, Duncan & Cooper, [2014](#); Jordan, [2015](#)), wilderness therapy (Davis-Berman & Berman, [2008](#)) and adventure therapy (Gass, Gillis & Russell, [2012](#)) have raised awareness of how the outdoor environment can aid both physical and psychological well-being. ‘Walk and talk’ describes a type of counselling where the counsellor and client walk together outdoors during therapy sessions (Doucette, [2004](#); Hays, [1999](#)). Walk and talk offers an accessible means of integrating nature and physical activity

within routine therapy practice and does not attract costs associated with other variants of outdoor-based therapy (such as wilderness and adventure therapy).

General support for the concept of walk and talk can be found in the literature on walking and well-being. There is considerable evidence that walking has numerous benefits, including enhanced psychological processing (Hays, [1999](#)), alleviation of depressive symptoms (Pickett, Yardley & Kendrick, [2012](#)) and improved self-esteem and mood (Barton, Hine & Pretty, [2009](#)). Further support for walk and talk can be identified in research into the inherent benefits that can be gained through spending time in nature (Jordan, [2015](#)).

Spending time in natural environments is linked to positive outcomes such as a decrease in symptoms of depression and anxiety (MIND, [2007](#)), alleviation of stress (Pretty et al., [2007](#)) and increased overall well-being (Mayer, McPherson Frantz, Bruehlman-Senecal & Dolliver, [2009](#)). Furthermore, it is suggested that bodily movement within natural environment settings produces positive impacts on cognitive processes (Corazon, Schilhab & Stigsdotter, [2011](#)).

Walk and talk has received relatively little attention from the research field. In a qualitative study, Doucette ([2004](#)) explored the benefits of walk and talk therapy for behaviourally challenged youths by conducting interviews with clients and found that the impact of therapy was enhanced by being outdoors and engaging in exercise and that the walking component allowed for physical release and aided problem-solving. Studies of professional knowledge, in which practitioners report on their experience in relation to a specific area of work, represent a valuable research strategy in emerging areas of practice (Chartas & Culbreth, [2001](#); Christianson & Everall, [2009](#); Finn & Barak, [2010](#); Fox, [2011](#); Karakurt, Dial, Korkow, Manfield & Banford, [2013](#); van Rooij, Zinn, Schoenmakers & van de Mheen, [2012](#)). To date, one professional knowledge study has been carried out in the area of walk and talk. McKinney ([2011](#)) interviewed 11 walk and talk therapists in the USA. These informants reported a wide range of motivations for using walk and talk methods: client choice, personal beliefs and experience, awareness of research from related fields and the desire to increase physical activity and connection with nature. Positive outcomes observed by these practitioners included equality in the relationship and client experiential processing being enhanced through walking side by side. A number of limitations of walk and talk methods were also described: weather, lack of support from colleagues and perceptions of clients. At the present time, no controlled outcome studies of walk and talk therapy have been published.

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

Method

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

Participants

An objective of the study was to gather the views of all practitioners within the UK who advertised as offering walk and talk therapy sessions to individual clients. As there is currently a lack of recognised terminology associated with outdoor-based therapies, a range of search terms were employed to discover the current provision of walk and talk therapy sessions. The following search terms were used: 'walk and talk therapy UK'; 'outdoor therapy'; 'ecotherapy'; 'nature therapy'; 'outdoor counselling'; 'walking therapy'. Particular attention was paid to the descriptions offered on practitioner websites, to ascertain the type of outdoor therapy experience that was being offered in order to keep the focus of this study centred on walking during the therapeutic session and not branching out into other variants of outdoor therapy practice. Potential participants were emailed directly and invited to take part in the anonymous online questionnaire. A link to access the questionnaire was included within the invitation email. Notices were also placed on relevant online research forums such as BACP and LinkedIn, inviting contact from practitioners who employed this approach.

Data collection

An online questionnaire was constructed and hosted by Bristol Online Surveys (BOS). The questionnaire contained 24 questions that were constructed to enable both qualitative and quantitative responses. The first 12 questions included demographic information, such as professional qualifications, affiliations and participant experience as a counsellor/psychotherapist and of offering walk and talk, reasons for incorporating walk and talk into practice, and length and location of walk and talk sessions. Separate sections of the survey invited respondents to use a 5-point scale to rate a series of statements concerning helpful and hindering aspects of walking and being outdoors. The statements used in these items were compiled from existing literature and from statements on walk and talk practitioner websites. Open-ended items elicited personal accounts of experiences of both the walking and outdoor elements of walk and talk, during therapeutic work with clients. The wording of these items was based on the Helpful Aspects of Therapy form (Elliott, [1993](#); Llewelyn, [1988](#)). A text box was provided for respondents to record their answers. They were then requested to rate how helpful they found these aspects, using a 5-point scale: neutral, slightly helpful, moderately helpful, greatly helpful and extremely helpful.

Pilot

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

Ethical procedure

The study focused on professionals' experiences of offering walk and talk and did not seek sensitive information regarding participants or their clients. All participants were required to read two information pages prior to taking part. Consent was conveyed by participants ticking an 'I agree' option before being able to access the questionnaire. Participants could withdraw at any time. Participants completed the questionnaire anonymously unless they chose to leave their contact details indicating their willingness to be contacted for a follow-up interview. All

participant-identifying information was stored securely for the duration of the research project. Ethical permission was received from the Research Ethics Committee at Glasgow Caledonian University.

Analysis

Quantitative data were analysed with descriptive statistics. Qualitative data were analysed using thematic analysis (Braun & Clarke, [2006](#)). All participants responded to each of the open-ended questions, with responses ranging in length from a brief sentence to a paragraph. Themes were identified by the first author and were agreed upon through discussion with a colleague who read the data independently. Theme analysis was audited by the second author.

Reflexive statement

The first author is a qualified counsellor who holds personal beliefs about the restorative aspects associated with the outdoors and the benefits of walking. She has experience of working therapeutically in outdoor settings and feels there is great scope for the development of this approach that is supported by research incorporating client experiences. The second author is an experienced researcher and therapist with an interest in innovative approaches to therapy, but with no direct experience of outdoor practice.

Results

A total of 32 therapists were located, who described themselves as offering walk and talk therapy sessions. Five practitioners contacted the researcher expressing an interest in the study but stating that they did not feel they fit the criteria for participation due to a lack of client uptake of walk and talk sessions. Nine potential participants who were contacted did not complete the survey, for reasons that are not known. Completed questionnaires were eventually received from 18 participants, 11 (61.1%) female and seven (38.9%) male, the majority aged between 46 and 60 (72.2%, $n = 13$). Respondents tended to be experienced psychotherapeutic practitioners with more than five years of post-qualification experience (61.1%, $n = 11$) and had been integrating walk and talk into their practice for one to two years. The two main psychotherapeutic approaches that were identified as being most utilised in informing the walk and talk practice of participants were person-centred and integrative. Other therapy orientations that were used by participants included CBT, mindfulness-based CBT, Gestalt, psychodynamic, ecopsychology, ecosystemic and humanistic.

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

Characteristics of walk and talk practice

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

Practitioner evaluation of walk and talk practice

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

Participants' perceptions of the relative helpfulness of various elements of walk and talk practice are presented in Tables 1 and 2. Ratings were made using a 5-point scale, with a high score indicating the strongest level of agreement. Participants regarded the outdoor element as slightly more helpful than the walking element within walk and talk sessions. In general, participants indicated no difference between how hindering either the walking or outdoor aspects of walk and talk sessions were, with both elements on average being ranked between the 'not at all and slightly hindering'. Overall, respondents reported that offering walk and talk had been a positive experience for them, with a mean of 7.8 (SD = 1.1): between the points on the scale labelled moderately helpful and greatly helpful on the 9-point scale used in this section of the survey.

Table 1. Perceived benefits of walk and talk therapy for clients

Perceived benefits of walk and talk	Mean	SD
Walking and talking during a therapy session helps clients to get 'unstuck'	4.1	.6
Walk and talk therapy strengthens clients connection between body and mind	4.1	.9
Walking side by side with a clients helps them to open up	4.0	.8
Clients achieve a greater sense of overall well-being through walk and talk therapy	4.0	.8
The process of clients self-discovery is promoted in a more holistic way through walk and talk therapy	4.0	.9
Walking together during walk and talk therapy promotes equality in the therapeutic relationship	3.9	.8
Being outdoors during a therapy session enhances the therapeutic process	3.9	.9
Walk and talk therapy encourages deeper ways of thinking	3.9	.9
Walk and talk therapy is less intimidating for clients compared to indoor seated therapy	3.8	.8
Through walk and talk therapy, the overall counselling process is enhanced	3.7	.8
Lack of eye contact is more comfortable for the client	3.7	.8
Walk and talk therapy improves physical fitness of the client	3.6	.8
Clients resolve issues quicker through walk and talk therapy compared to indoor seated therapy	2.9	.8

Table 2. Therapist experiences of walk and talk

Therapists experiences of walk and talk	Mean	SD
I believe that offering a variety of therapeutic experiences (such as walk and talk) is useful to clients	4.5	.6
I generally feel invigorated when doing walk and talk therapy sessions	4.3	.5
I generally have no trouble being focused on my client during walk and talk therapy sessions	4.3	.8

Therapists experiences of walk and talk	Mean SD	
I generally have clear thought processes during walk and talk sessions	4.1	.8
Offering walk and talk therapy has been beneficial for my professional development	4.1	.7
I believe that walk and talk therapy offers mutual benefits to both client and therapist	4.1	.8
Offering walk and talk therapy has reduced my own stress levels	3.8	1.0
I do some of the best therapeutic work during walk and talk sessions	3.6	.8
I am physically fitter since starting walk and talk sessions with clients	3.4	1.0
I sometimes get distracted by things happening in the environment during walk and talk sessions	2.9	1.0
I find walk and talk mentally demanding to do with my clients	2.7	1.1

The two statements where participants indicated the highest levels of agreement were that walking and talking can shift ‘stuckness’ in clients and that walk and talk strengthens the connection between body and mind. In addition, practitioners indicated that the experience of walking side by side helped clients to open up, enhancing overall well-being, and that walk and talk promoted a holistic approach for client self-discovery. On the whole, respondents did not agree that clients resolved issues quicker through walk and talk compared with indoor therapy.

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

Qualitative thematic analysis

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

Helpful aspects of walk and talk

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

Facilitating collaborative engagement

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

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

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

Encountering different relational embodiment

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

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

Gaining new insights through moving

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

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

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

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

It helps clients that they are in a natural environment, not in an office (as a lot of clients spend a lot of time in an office).

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

Experiencing the outdoor environment

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

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

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

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

Contact with the other-than-human and more-than-human can be transformative in many ways.

Hindering aspects of walk and talk

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

Working with uncertainty

The weather was a main hindering aspect that was identified. This included rain, cold and windy conditions – all affecting the session in some way. Walking on an unfamiliar route was also seen as hindering as this could affect the timing of the session. The potential encountering of other walkers and dogs was also acknowledged as hindering aspects of walk and talk.

Attending to the therapeutic process

The development of new skills to hold the therapeutic process while walking was identified. Aspects such as not having eye contact with clients relied on other ways of making contact with clients within the session. Additionally, the physicality of walking side by side, sometimes resulted in not hearing clients clearly, therefore had the potential to interrupt the therapeutic process. Both clients' and therapists' attention could be affected by the view, and this was seen to raise the potential for the therapeutic process to be interrupted. The outdoor environment was seen as a space and place for reflection, with the potential for this to tap into 'philosophical' mode with clients, and therefore, therapists may need to be more directive of the therapeutic process within the session.

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

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

Maintaining boundaries

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

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

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

Working within certain restrictions

It was acknowledged that while walking and talking offered certain freedom, it also brought with it restrictions. These restrictions related to not being able to engage in additional creative therapeutic exercises during a walk and talk session and that there was no additional information on hand should it be required. For example:

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

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

Discussion

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

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

The findings from this study regarding the characteristics of walk and talk practice (i.e. duration and variation of settings), the importance of therapists' personal beliefs about the outdoors and walking in their decision to offer walk and talk, and the range of psychotherapeutic modalities utilised in walk and talk, generally support the conclusions of the McKinney ([2011](#)) study. The helpful and hindering factors identified by this present study are similar to those reported in previous studies (Doucette, [2004](#); McKinney, [2011](#)). However, as with previous studies, helpful factors relating to client benefits need to be interpreted with caution as clients themselves have not been the participants in these studies.

The findings from this study suggest that walk and talk therapists in the UK tend to be experienced psychotherapeutic practitioners, in contrast to the findings of McKinney's (2011) study in which it appeared that younger and less experienced therapists were more likely to incorporate walk and talk methods in their therapeutic work.

It is important to acknowledge the limitations of the present study. The data reported in the current study reflect the experiences and beliefs of therapy practitioners who can be regarded as public 'advocates' and pioneers in the use of this approach. It seems certain that other practitioners, for example, those who may have tried walk and talk and decided that it was not appropriate to their therapeutic goals or style, would contribute different perceptions and themes. The use of an online questionnaire restricted the richness of information provided by participants. Although the open-ended, qualitative items in the survey questionnaire generated valuable insights, these were derived from a small sample of therapists. On the other hand, the design of the study explicitly sought to identify all relevant informants in the UK. It therefore seems likely that the sample obtained in the present study reflects the limited nature of this community of practice in the UK at this time. A further limitation was that the rating items on the questionnaire were generally framed in a manner that favoured positive aspects of walk and talk therapy. However, qualitative questions explicitly invited participants to highlight hindering factors. We suggest that further research utilising the questionnaire should include hindering statements.

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

The results of the present study can be regarded as having a range of implications for practice. There appear to be a growing number of practitioners who are offering walk and talk despite a lack of 'best practice guidelines'. Given the variety of factors present in walk and talk that can be experienced as either helpful or hindering, consideration by the therapist needs to be given to how these factors might be managed before venturing out with a client. It would be valuable to develop research-informed guidelines and training opportunities to support safe and effective practice in this area of work. Given that practitioners tended to combine walk and talk with a range of office-based therapy models, it is necessary for future research and training to consider not only the issues associated with walk and talk as a stand-alone practice, but to investigate the challenges of combining it with other modes of therapeutic work.