CLIMBING out of the THERAPY ROOM

Andy Cross and **Tessa Tilbe**

write about the development of 'climbing for wellbeing', otherwise known as 'bouldering therapy', at the University of Cumbria

'What am I doing? I'm way out of my depth. No, this is fine, it's well within your ability, you're just scared. Take a breath, it's just a couple of moves and then you'll be fine.'

Failing to reassure myself, I look behind me and judge whether I can climb back to my partner and set up an abseil to retreat off the 30 metres we had just climbed. I feel a familiar tightness in my chest and my legs start to tremor. At this moment, I pause and take a deep breath. Calming myself down, I purposefully lower my shoulders and stand up straight. I notice my heartbeat slowing down, feel the cold rock under my fingertips, and open my eyes. I reach for the next hold and begin climbing again.

It's climbs like this that have both humbled me and helped me grow in equal measure. Climbing provides a visceral response and can present you with abject fear and absolute joy, sometimes all within the same route. Although I'm no longer the obsessive climber I was in the late-1990s, climbing still never ceases to surprise me and I continue to learn so much about myself through the activity.

Having worked as an outdoor education instructor, specialising in youth development, I've always seen the benefits of adventure-based activities. After a career change some 15 years ago, I'm coming full circle with this viewpoint, and re-discovering the role nature and adventure can play within my therapeutic practice.

There is continued evidence to show the increase in demand for student mental health support.[1] As a result, universities continue to diversify their approaches to support students with their mental health and wellbeing.[2,3]

As with all other HEIs, here at the University of Cumbria (UoC), we continue to strive to meet the needs of our student population, and are looking to diversify our wellbeing interventions outside the more traditional face-to-face settings. I have always supported the benefits of group work and as we were aiming to diversify our mental health support, I saw an opportunity to incorporate an adventure-based programme.

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In 2022, I read a *UKClimbing* article by Natalie Berry in which she discussed climbing therapy.[4] This article became a catalyst for the creation of our Climbing for Wellbeing programme, and as I found more academic papers about an approach termed 'bouldering psychotherapy', my initial spark of interest soon became insatiable.

Collaboration

After presenting my idea to the manager of the mental health and wellbeing team, I was advised to speak to the manager of UoC Active. Their team is responsible for promoting the physical health and wellbeing of both staff and students through sports facilities and activities at the university. As it turned out, the team were looking to introduce social prescribing to promote the link between mental and physical health and wellbeing. Viewing this as an opportunity to kickstart their approach, they were keen to fund a pilot project.

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Additionally, the local climbing wall in Carlisle, Eden Rock, were also eager to support the initiative and offered a substantial discount, as well as a regular space for the programme to take place (huge thanks and shout out to them!).

What's bouldering and how does it link to psychotherapy?

There is a long lineage of adventure being used therapeutically which can arguably be dated back to Frederick W. Gunn's organised summer camps in the United States in the mid-1800s,[5] or Millican Dalton, the 'Professor of Adventure' in the 1920s.[6] The term 'climbing therapy' however, albeit seemingly new, can in fact be dated back to the 1980s when Samuel McClung used climbing as an intervention to treat 'chronically mentally ill clients' on a six-week programme.[7]

However, since 2015, there has been an increasing focus on projects using climbing as a clinical intervention, and we are seeing an ever-increasing number of published articles evidencing its benefits in supporting mental health and wellbeing.[8,9,10]

In our project, however, we use bouldering, which is a discipline of rock climbing. The British Mountaineering Council (BMC) defines it as: *'a form of climbing usually practised on small rocks and boulders, or at indoor walls. As the climber doesn't go very high, it is often possible to jump back down. Boulderers usually use padded mats to jump down (or fall).'*[11]

The main reason I chose bouldering over rock climbing is its accessibility; it requires little equipment or experience. Furthermore, as with rock climbing, bouldering offers an array of potential learning for the climber. When climbing, we must navigate emotions such as fear, worry, frustration, to name but a few. This hodge-podge of feelings offers a rich environment for participants to explore how they can manage emotions in a safe but real context.

As the course is climbing-based, there was initial trepidation about the risks involved in delivering such an activity, however, as a qualified rock-climbing instructor (RCI), I was able to manage this and mitigate any health and safety concerns. Unsurprisingly, our biggest hurdle was gaining clarity regarding the university's public liability insurance. But like a dog with a bone, and after some to-ing and fro-ing, we were finally given the green light to go ahead.

Despite being a qualified RCI student psychotherapist, given the nature of delivering a mental health course, it felt appropriate to co-deliver the course with a colleague. Tessa Tilbe is an accredited person-centred counsellor, and despite having no climbing experience, she was passionate about the potential of the programme and keen to get involved. Most participants had little to no climbing experience, so Tessa was able to relate to the students and relieve the power dynamics between the counsellor/instructor/student relationships, which proved to be invaluable.

The course structure was loosely based on work developed by Dr Katharina Luttenberger.[8] Katharina, a psychologist, has studied how bouldering can help manage depression. She is also a co-founder of the manualised bouldering psychotherapeutic approach, BouldApy.[12] Unaware of the BouldApy approach, I created my programme using a range of modalities including compassion-focused therapy (CFT), acceptance and commitment therapy (ACT), cognitive behavioural therapy (CBT) and narrative therapy, all of which I commonly use within my own practice.

Like Katharina's approach, each weekly session was split into two halves: psychoeducation and bouldering. The psychoeducation portion focused on a central theme, such as managing failure, and then the skills taught were used and practised through the bouldering part of the session.

An example of how this appeared in action can be seen in a session where we explored the role of fear-based emotions. The psychoeducation session considered fear from a CFT perspective.[13] We explored human beings as an emergent species with an autonomic nervous system, activating and deactivating emotions to manage potential threat.

The second part of the session linked the learning to the bouldering wall, exploring how climbing situations can evoke various emotional reactions like fear, worry and social comparison. As participants began linking the theory to the felt-sense on the wall, we explored skills to manage these responses in real-time, but also within a safe and contained environment.

> Written feedback from all three cohorts was enthusiastically positive about their experience

By making these connections, students developed a deeper understanding of their emotional responses, and were able to link to experience both on and off the wall. Across the cohorts, participants reported an increase in both their ability and confidence in their climbing skills, and an increasing ability to manage emotional distress.

Student engagement

Having previously worked in NHS substance misuse services and community mental health teams, group work has played a vital role in my practice. When I started at the university, I was surprised to discover that, historically, the number of students attending mental health-based groups was typically low. After persisting, we were rewarded with much higher self-referrals than that of any previous group work delivered by the team.

However, despite my initial excitement, we soon fell from grace, and from the initial 25 self-referrals, 18 couldn't attend due to academic commitments, so only seven spaces were filled. After one student didn't turn up on the day, we were left with a group of six. From a group psychoeducation perspective, eight participants are the optimal number, [14,15] so six people finishing the group felt like a win.

We were pleased to be asked to deliver two additional cohorts the following year, one from Carlisle again, but this time, a second from our Lancaster campus. This time, we took a more focused approach. We advertised the group through social media posts, internal communications, a YouTube intro clip, and distributed posters across both Lancaster and Carlisle campuses. We also ran a 'last chance to attend' campaign running up to the start of the course. However, when discussed at later dates, many students still reported they were unaware the course had been delivered.

After reviewing the first cohort, we decided to shorten the course to a condensed five-day programme, which we held during our two 'enhancement' weeks when there is no formal teaching. However, we did not take into account that most students go home during this time, so this led to fewer referrals compared to the first cohort. As a result, the following two cohorts each had three participants finish the programme.

Moving forward, our groups are meeting on Wednesday afternoons, when most students are free from lectures. We are also rebranding the course as 'climbing for wellbeing', as we feel that 'bouldering psychotherapy' presents as too clinical.

Outcomes

We measured outcomes by using GAD-7, PHQ-9, and The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). The first cohort completed the outcome measure questionnaires at each weekly session, and cohorts two and three completed one at the start of the course (day one), and then again at the end (day five). We also collected verbal feedback at the end of each course, in an attempt to capture the more nuanced aspects of the participants' experience of the programme.

Although the data suggest all three programmes had a positive impact on participants, they indicate that the first programme that we ran had a greater impact and produced better outcomes for the students. Using the statistics and the written feedback, we can begin to identify what contributed to the greater success of cohort one. For example, having the course run over seven weeks allowed participants to reflect on the session and practise the skills learnt. It gave time to digest learning, whereas the week-long courses didn't give participants the opportunity to do this in the same way. We also noticed that during the week-long courses, participants became fatigued around day four, which may have had an impact on their experience of the course and their capacity for learning. However, written feedback from all three cohorts was enthusiastically positive.

Cohort one: Outcomes (Averages)
The below table is based on six participant responses.

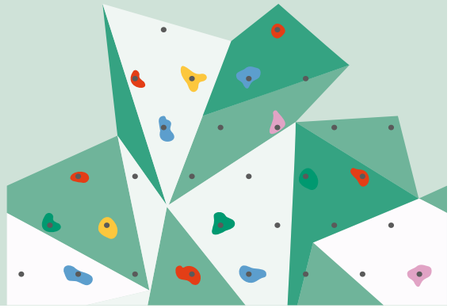
GAD-7	PHQ-9	WEMWBS
Average decrease of 30.95% in anxiety symptoms from first to last session.	Average decrease of 18.25% in symptoms of depression from first to last session.	Average increase of 20% in overall wellbeing from first to last session.

Cohort two: Outcomes (Averages)
The below table is based on three participant responses.

GAD-7	PHQ-9	WEMWBS
Average decrease of 6.35% in anxiety symptoms from first to last session.	Average decrease of 3.17% in symptoms of depression from first to last session.	Average increase of 26.98% in wellbeing from first to last session.

Cohort three: Outcomes (Averages)
The below table is based on two participant responses.

GAD-7	PHQ-9	WEMWBS
Average decrease of 7.14% in anxiety symptoms from first to last session.	Average decrease of 7.14% in symptoms of depression from first to last session.	Average increase of 11.9% in overall wellbeing from first to last session.



We identified key themes within the written feedback, which were:

- Enhancing skills and learning techniques for everyday life, as well as the bouldering wall
- The benefits of having a physical element to a mental health programme
- The benefits of being able to apply theory to practice, particularly in helping participants to remember the theory and skills learnt
- The benefits of trying a new activity, particularly in improving self-esteem and confidence.

Indeed, what was striking in all the feedback received was how participants felt that the bouldering activity was crucial to their positive experience of the course. It also helped with raising confidence and an ability to remain grounded. For example, one participant explained, 'I learnt to trust others more as well as myself. I can be very scared with new things, but this course has taught me to remain calm'.

Another participant highlighted an improvement of their self-awareness, 'I have learnt a lot and [I have] become more self-aware of what bad thinking patterns I may be thinking. There's been lots of application to help me be more positive, confident and calm, on and off the wall'.

By giving the participants the opportunity to practise what was taught in the psychoeducation session, it allowed them to fully understand and use the skills to manage their mental health, not only on the wall, but off the wall too. Thus, the feedback from the participants highlighted how crucial the bouldering element was to the success of the course.

Reflecting on the journey taken and the route ahead

As I write this conclusion and prepare to start our first fully booked cohort, I can't help but reflect on our journey. The last three years have felt like an ongoing pilot project, filled with constant adjustments. This journey has often felt like an emotional rollercoaster. It began with the tentative first steps of approaching my manager, and being pleasantly surprised to receive approval. I felt excitement as interest grew in our initial group, but then experienced disappointment due to low turnout. Nevertheless, I was soon uplifted by the fantastic feedback from the students who did participate, receiving invitations to run a workshop for other university and college therapists at the Advance HE Mental Wellbeing Recharge event in 2024, [16] as well as an opportunity to present a poster about our findings at the 2024 Adventure Mind Conference (www.adventuremind.org/2024).

This experience has been a truly cathartic learning opportunity for me too. So, what have I learned? As cliché as it may sound, the most important lesson has been in how we perceive failure and success. I remember a conversation with the manager of UoC Active, when expressing my disappointment about only three people completing a cohort; she reminded me, 'That's three people who wouldn't have benefitted had you not run the course'. Starting new initiatives takes time and is often filled with setbacks and challenges, making compassionate reflection essential.

Although my role predominantly requires a more traditional talking therapy approach, my experience with this course has shown me that there is a growing need for alternative mental health provision beyond the therapy room. There were times when I felt like giving up, but with a little belief and perseverance, I now feel that we've established what we believe to be a fantastic support group for our students at the University of Cumbria, and we now find ourselves truly climbing out of the therapy room. ■

ABOUT THE AUTHORS

Andy Cross is a registered social worker and mental health case worker at the University of Cumbria. He's passionate about the role of adventure and nature-based therapies. Once he completes the final stages of the PGDip in psychotherapy and person-centred counselling, he aims to develop more of this approach into his clinical practice.

Tessa Tilbe is the Mental Health & Wellbeing Manager at the University of Cumbria and a BACP accredited person-centred counsellor. Tessa also works on a freelance basis for Mind over Mountains charity (https://mindovermountains.org.uk/), which sparked her particular interest in the therapeutic benefits of the outdoors, nature and physical activity.

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