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Therapist's Perceptions of Walk and Talk Therapy: A Grounded Study

A Dissertation

Submitted to the Graduate Faculty of the
University of New Orleans
in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy
in
Counselor Education

by

Bridget L. McKinney

B.S. University of Louisiana at Lafayette, 2002
M.S. University of Louisiana at Lafayette, 2005

December 2011

Copyright page

Dedication

I would like to dedicate this dissertation to the walk and talk therapists who participated in my study. Thank you for taking time from your day to share your experiences with me. To those who invited me to visit in person, you were gracious hosts and I appreciate the time you spent with me. Being able to see the setting of walk and talk therapy enhanced my study. To all, your passion and commitment to walk and talk therapy was inspiring. Thank you for dedicating yourself to the growth of walk and talk therapy.

Acknowledgment

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Abstract

Our society has become less physically active (U.S. Department of Health and Human Services, 2010) and less connected to nature than ever before (Berger & Mcleod, 2006). Spending leisure time indoors, technological advancements, urban living, and car dependent communities have led to these changes (Dustin, Bricker, & Schwab, 2010; Hansen-Ketchum, Marck, & Reutter, 2009; Norman & Mills, 2004). As a result, physical health and mental health is deteriorating (Dustin et al., 2010; Maller, Townsend, Pryor, Brown & Leger, 2005). Physical activity and nature can each produce mental and physical health benefits; some approaches such as adventure-based counseling and wilderness therapy already incorporate these elements. A promising alternative approach using physical activity and nature has received attention in recent years. Walk and talk therapy has been described as an intervention that combines counseling, walking, and the outdoors (Doucette, 2004). Despite, a small number of therapists using the approach (Gontang, 2009), anecdotal research (Hays, 1994), and a description of the approach (Doucette, 2004), little is known about walk and talk therapy. In this qualitative study 11 therapists were interviewed about their experiences with walk and talk therapy. Main themes of the study suggested characteristics, a procedure, reasons walk and talk therapy evolved, limitations, outcomes, and a framework for practice for walk and talk therapy. Therapists believe walk and talk therapy is beneficial for clients as well as therapists. Implications for therapists, researchers, and counselor educators are provided.

Keywords: therapy, walk and talk therapy, alternative therapeutic approaches, physical activity

Chapter One

Introduction

Currently there is an obesity epidemic in the United States (U.S. Department of Health and Human Services, 2010). According to the 2010 *Surgeon General's Report*, two-thirds of adults and nearly one in three children are overweight or obese. Each year, obesity contributes to 112,000 preventable deaths and many other serious health concerns. Obese individuals are at an increased risk for many serious health concerns, such as high blood pressure, high cholesterol, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, and respiratory problems; they have a better chance than others of developing endometrial, breast, prostate, and colon cancers (U.S. Department of Health and Human Services, 2010).

Inactivity is one major factor that contributes to the obesity epidemic. Americans spend over 95 percent of their time indoors (Fletcher & Hinkle, 2002) and leisure time is spent on the computer, watching TV, or playing video games instead of being physically active (U.S. Department of Health and Human Services, 2010). In fact, 47 percent of American adults are not regularly physically active and 25 percent are not active at all (Dubbert, 2002). Car-dependent communities, indoor leisure activities, and technological advancements are responsible for inactivity (Dustin et al., 2010; Hansen-Ketchum et al., 2009; Norman & Mills, 2004), all of which have resulted in a more sedentary society than years ago.

To combat the obesity epidemic, the Surgeon General recommends at least 150 minutes of moderate-intensity activity each week, such as dancing, martial arts, tennis, canoeing, swimming, weight lifting, and walking (U.S. Department of Health and Human Services, 2010). While everyone is at risk for obesity, some are especially vulnerable. Individuals with mental

illnesses already have some risk factors for obesity such as sedentary behavior, stress, and taking weight-gaining prescription medications. Thus, they are more susceptible to the health risks of obesity than others. Furthermore, obese individuals have increased chances of developing mood disorders such as depression and anxiety (Public Health Reports, 2009). Therapists working with mentally ill clients can play an important role in the obesity epidemic (U.S. Department of Health and Human Services, 2010). One way, according to the Surgeon General, is to recommend physical activity as part of client treatment plans. Therapists should, at least, educate clients on the mental and physical health benefits of physical activity as well as linking them to resources in their communities (U.S. Department of Health and Human Services, 2010).

Alternative therapeutic approaches that utilize physical activities are prevalent.

Adventure-based counseling and wilderness therapy incorporate physical activities such as kayaking, hiking, and rock climbing in the therapeutic process (Peel & Richards, 2005). The therapist participates in these physical activities with clients. Although physical activities are an integral part of the approach, the benefits of physical activity are not the focus. The foci of these two approaches are the setting and unfamiliar experiences. Now, there is another alternative approach for therapists to utilize physical activity with clients that focuses on the benefits of physical activity.

Walk and talk therapy, according to Doucette (2004), has been described as an intervention that combines counseling, walking, and the outdoors. Clients can experience the benefits of physical activity, nature, and therapy simultaneously. Despite the potential benefits and occurrence of walk and talk therapy utilized by a small number of therapists (Gontang, 2009; Hays, 1994; Kostrubala & Schuler, 2009; Wright, 2008), research is limited. Presently, one qualitative study and some anecdotal research exist. Furthermore, no established theoretical

framework for this approach is available. However, the benefits and usage of physical activity as well as nature have been well documented.

Physical Activity

Physical activity has been the key to increasing the quality of life and longevity. It has been suggested that physical activity can enhance the physical and mental health of clients (Dixon, Mauzey, & Hall, 2003; Dubbert, 2002; Martinsen, 2008). More specifically, physical health benefits include: reducing the risk of weight gain as well as developing physical conditions such as heart disease, obesity, diabetes, hypertension, and colon cancer (Dubbert, 2002; U.S. Department of Health and Human Services, 2010). With heart disease as the leading cause of death and cancer being second, physical activity is essential to stay healthy and prevent these conditions (Dubbert, 2002).

Mental disorders are a major health problem, with depression and anxiety most common. According to Martinsen (2008), physical activity lowers levels of anxiety and depression symptoms as well as helps reduce the risk of developing depression. Physical activity was identified as one of the many self-care strategies to improve well being; walking, running, and cycling were the most commonly used strategies (Hansson, Hilleras, & Forsell, 2005). Physical activity is an effective, cost-effective, intervention to use in conjunction with treatment of mental health conditions such as depression and anxiety. Additionally, increased social contact, perceived mastery, and distraction from daily stressors from physical activity contribute to the mental health benefits (Dubbert, 2002).

Nature

People are more disconnected from nature than ever (Berger & Mcleod, 2006; Maller et al., 2005). Disconnectedness is caused by technological advancements and urbanization (e.g.,

Hansen-Ketchum et al., 2009; Martin, 2009). Urbanization refers to the amount of people living and working in urban areas opposed to rural ones. According to Dustin et al. (2010), 85 percent of Americans are working and living in urban areas. Urban areas by definition have less nature and green spaces than rural areas.

Recently, much attention has been devoted to physical health consequences of urban living (Dustin et al., 2010; Hansen-Ketchum et al., 2009). Urbanization can have disastrous effects on our health (Dustin et al., 2010; Maller et al., 2005). As a result of modernized Western medicine, we are living longer lives, but new serious diseases have emerged. Research indicated that urban living has led us to stay inside more, work in sedentary ways, and exercise less. Thus, health problems such as heart disease, diabetes, and cancer are becoming increasingly common.

Mental disorders are on the rise; depression is the number one mental condition worldwide (Maller et al., 2005). Several authors have noted the link between disengagement from nature and an increase of mental health conditions (e.g. Dustin et al., 2010; Pretty, Hine, & Peacock, 2006; Maller et al., 2005). According to Pretty et al. (2006), there are fewer natural environments due to an increase in urban living, which results in increased mental stress. Thus, a link between nature and mental health has been suggested.

Maller et al. (2005) reviewed numerous anecdotal, theoretical, and empirical studies supporting the notion that contact with nature promotes health and well being. The research demonstrated: a) natural environments foster recovery from mental fatigue, b) natural environments are restorative, c) established methods of nature-based therapy being utilized, d) when given a choice people prefer natural environments to urban ones, e) people have a more positive outlook on life when in proximity to nature, f) exposure to nature enhances one's ability

to cope and recover from stress and illness, and g) observing nature can restore concentration. Further documented mental health benefits include: increased confidence, increased feelings of tranquility, and increased self-discovery (Fletcher & Hinkle, 2002), a sense of well being and happiness (Berger & Mcleod, 2006; Burls, 2005; Davis & Atkins, 2009) and a heightened sense of presence (Orchin, 2004). Exposure to nature decreased states of aggression, depression, and anxiety (Mayer, Frantz, Bruehlman-Senecal, & Dolliver, 2009; Plante et al., 2007).

In addition to mental health, there are cognitive benefits, which include: increased cognitive capacity (Berman, Jonides, & Kaplan, 2008; Mayer et al., 2009) and an enhanced ability to reflect on life problems (Mayer et al., 2009). According to Berman et al., (2008), interacting with nature and natural settings help individuals reflect on life problems more effectively than does interacting with urban environments. Overall, the benefits of nature consist of mental health and cognitive benefits. Benefits from nature vary from recovery and restorative properties, improved positive mental health states, decreased negative mental health states, and increased cognitive functions.

Alternative Approaches

Alternative approaches to traditional therapy are increasingly common. Numerous approaches utilize physical activity and/or nature. Nature-based approaches are aimed at reconnecting people to nature. Burls (2005) identified many nature-based approaches: ecotherapy, nature therapy, ecopsychology, and horticultural therapy. Nature-based approaches have emerged as a result of our disconnectedness from nature (Berger & Mcleod, 2006; Burls, 2005) and are still in their infancy in research and theory.

Adventure-based counseling and wilderness therapy incorporate physical activity as well as nature. These approaches are well known and utilized more frequently than nature-based

approaches. Adventure-based counseling and wilderness therapy emerged from a need to help behaviorally challenged youth more effectively than traditional talk therapy (Goldenberg, 2001). Now, adventure-based counseling and wilderness therapy are used with a variety of populations.

Ecotherapy and nature therapy. Ecotherapy and nature therapy share the philosophy that people need a connection to nature (Berger & Mcleod, 2006). Ecotherapy is defined as a therapeutic practice that views humans from a systems theory in which all elements in the world are interconnected, and our relationship with nature is reciprocal (Davis & Atkins, 2009). Furthermore, ecotherapy utilizes nature to teach clients about how humans are interconnected with nature and how humans and nature can benefit from one another. Nature can help heal us while we can help heal nature. Through interacting with nature humans gain mental health benefits and thus begin to gain an understanding of the importance of nature. Once we are aware of the importance of nature and the healing effects, we begin to take care of nature. Hence, by focusing on our connection with nature, healing occurs within us (Davis & Atkins, 2009).

Nature therapy encompasses the same philosophy as ecotherapy, but recognizes that elements of nature can influence the therapeutic process (Berger & Mcleod, 2006). Nature, as the setting of nature therapy, is a significant aspect of the approach. According to Berger and Mcleod (2006), nature as the setting is quite different from the indoor setting identified as the therapist's space. Nature is a live and dynamic environment that is not under control of the therapist or the client. Nature therapy utilizes nature as a co-therapist in the therapeutic relationship. Nature is used a way to reconnect the client's mind, body, and spirit. At times, the therapist allows nature to work with the client while observing how the client reacts to nature.

Adventure-based counseling and wilderness therapy. The most well-known alternative approaches, adventure-based counseling and wilderness therapy, have been around

for over two decades. Nature and physical activity are utilized in adventure and wilderness therapy. Peel and Richards (2005) have maintained that experiential learning, novelty, and overcoming challenges are key ingredients of these approaches. Experiential learning allows clients to reflect on what is happening at the present moment and learn through what they are doing and feeling. Clients are placed in novel circumstances: the setting, clothing, and food. Unfamiliar experiences for clients such as hiking, building a fire, camping, and kayaking present challenges for them. Ways in which clients handle and overcome the novel circumstances, unfamiliar experiences, and challenges assist in their growth such as building self-esteem.

Adventure based counseling and wilderness therapy share similar and different characteristics. Adventure-based counseling activities are planned with the intention of teaching clients something through perceived risk activities (Peels & Richards, 2005) whereas wilderness therapy relies on experiences to happen naturally and those experiences teach clients lessons (Russell, 2001). For example, adventure therapy utilizes activities such as kayaking, ropes courses, and rock climbing that have an element of perceived risk. Wilderness therapy utilizes activities such as primitive skills (e.g., camping, building a fire) and reflection to enhance personal growth. Wilderness therapy relies more on the natural consequences of being in the wilderness while adventure therapy relies on planned activities with perceived risk. Both approaches utilize nature as a setting, physical activities, experiential learning, and group interactions as the main components.

Walk and Talk Therapy

Walk and talk therapy has been described as an intervention that combines counseling, walking, and the outdoors (Doucette, 2004). This approach utilizes the benefits of physical activity as well as nature. Although there is only one qualitative study on the walk and talk

therapy, various anecdotal research exist. Anecdotal research has shown that walking and running have been used with psychotherapy for some time. According to Gontang (2009), running was used with therapy before walking. In 1974 running therapy emerged; walk and talk therapy is thought to have evolved from running therapy (Hays, 1994).

Running therapy is defined as running during psychotherapy (Kostrubala & Schuler, 2009). This approach emerged in the 1970s and continued through the mid 1980s. Thaddeus Kostrubala, a psychiatrist, developed running therapy after studying the benefits of physical activity. First, Kostrubala believed running with a client during psychotherapy was more beneficial than psychotherapy alone. In his opinion, a client sits while the therapist fixes problems in traditional therapy, whereas in running therapy the therapist and client are upright together outdoors. Second, Kostrubala contended that running therapy took the mystery out of therapy. Running therapy was outdoors in daylight for everyone to see. He believed it made therapy less intimidating and shameful. Third, therapist and client were both getting the benefits of running during the session. The therapist and client benefited from the numerous mental and physical health benefits of running as opposed to traditional therapy where there are no added benefits.

Kostrubala continued using running therapy and trained therapists until an injury prevented him during the mid-1980s from running. Then, walking with clients became more common than running (Hays, 1994). Considerable anecdotal research has been devoted to why walking with clients is successful. Below are quotes from therapists who are walking with clients:

- When you are out walking, you are working from a position of health, lying on a couch is what we do when we are sick” (Goodman, 2005, p. 112).
- “Vigorous physical activity elicits emotions better than slouching in a chair. It speeds up

therapy” (Goodman, 2005, p. 112).

- “Patients are more talkative and relaxed” (Wright, 2008, webmd.com).
- “Many clients are stuck in the past or future; walking encourages present moment awareness” (Bricklin & Smith, 1996, p. 2).
- “It is often easier to talk honestly with someone while walking because eye contact can be bothersome at times” (Bricklin & Smith, 1996, p. 2).
- “Walking in parallel with visual distractions may allow for easier engagement” (Wright, 2008, webmd.com).
- “Many patients consider the association of being outdoors with recreation and vacation; two positive things that most want to experience more” (Wright, 2008, webmd.com).

Walking with clients during therapy appears to help clients talk more, become more relaxed, and encourages present moment awareness. Therapists utilizing walking with therapy believe clients are more relaxed and talkative due to the orientation of the therapist and client. In traditional therapy, the therapist and client are sitting facing one another. Walking parallel with clients may allow them to become more relaxed and talkative. The act of walking encourages present moment awareness because it is difficult to not concentrate on your steps and surroundings. Although one therapist mentioned the association with the outdoors and recreation, there was little expansion on this idea and how it is beneficial to the therapeutic process. Overall, therapists acknowledged some important aspects of the therapeutic process that may be expedited from walking – relaxation, talking more, engagement, and speeding up therapy.

Despite the occurrence and possible benefits of walking with therapy, few related studies exist. In the only empirical study of walk and talk therapy, Doucette (2004) explored

participants' experiences in a walk and talk approach. Doucette (2004) examined participants' experiences in a phenomenological study of walk and talk therapy. The purpose of her study was to explore the benefits of the walk and talk intervention with behaviorally challenged youths. The objective of the walk and talk intervention was to help the youth feel better, explore alternative behavioral choices, and learn new coping strategies and life skills by engaging in the intervention that has benefits of physical activity and a connection to the outdoors (Doucette, 2004).

Eight students, ages 9 through 13, identified by school professionals as behaviorally challenged (e.g., diagnosed with conduct disorder) were interviewed before and after the six-week walk and talk intervention (Doucette, 2004). During the first interview, participants drew self-portraits, which were examined by an art therapist for insight on their self-esteem. Then, they were asked to list five strengths and five weaknesses. Last, participants wrote a short autobiographical incident about something which had an impression on them, positive or negative. Discussion followed each activity and then the walk and talk intervention was presented to each participant at the end of the interview.

For the walk and talk intervention, therapist and participants met for six consecutive weeks, once per week for 30–45 minutes of walking outdoors on school grounds. Participants were asked what they would like to talk about at the beginning of each session, followed by a discussion of the events of their past week. Strategies taught during sessions included stress management skills such as identifying stressful situations, the importance of positive self-talk, mental imagery, visualization techniques, and focusing skills. Other skills taught included anger management skills, using assertiveness rather than aggressiveness, and using I-statements to convey feelings (Doucette, 2004).

After the intervention, post interviews included the same activities as the pre interviews with the addition of some questions about their experiences in the intervention. Participants drew a self-portrait and listed 5 strengths and weaknesses again. The therapist discussed the differences between the pre and post self-portraits as well as strengths and weaknesses with the youths. Then participants answered these questions: “what has changed since we started;” “what did you like about walk and talk;” and “what didn’t you like about it.”

Data analysis included self-reports from participants, pre and post self-portraits, and pre and post self-reports of strengths and weaknesses. Of the eight participants, one dropped out after one session. Doucette (2004) concluded that one of seven participants had an improved self-image (self-portraits examined by the art therapist), five of seven participants reported more strengths in the post interview, and five of seven participants reported fewer weaknesses in the post interview. When Doucette asked participants about their experiences in the walk and talk intervention, five responses were “I liked talking about my feelings,” “It was helpful,” “It was a positive experience,” “It was a great experience,” “It was good because I got my feelings out.”

From these findings, Doucette (2004) concluded that combining three components of counseling, walking, and the outdoors created a new intervention for behaviorally challenged youth. Furthermore, she found that each youth benefited from the intervention assessed from self-reports. Overall, the walk and talk intervention benefited each youth in terms of learning anger management, creating an opportunity for a physical release, and allowing them to clarify their feelings (Doucette, 2004). Some possible limitations of her study include small sample size, the subjective nature of the self-report findings, and the narrow population utilized.

In sum, urban living has contributed to a more sedentary and indoor society, which many believe has resulted in increased obesity rates, mental health problems, and a disconnect from

nature. Even though urban living continues to rise, our society needs to prevent further physical and mental problems. The benefits of physical activity and nature have been well documented. Thus, physical activity and re-connecting with nature are recommendations to combat physical and mental health problems.

Furthermore, some alternative therapeutic approaches already utilize physical activity and/or nature. Ecotherapy, nature therapy, adventure-based counseling, wilderness therapy, and walk and talk therapy are just a few. All are still in their infancy compared to traditional talk therapy. Overall, physical activity and nature are pathways to better health both physically and mentally.

Statement of the Problem

An alternative approach has emerged- one in which clients benefit from a connection to nature and physical activity (Doucette, 2004). The benefits of nature and physical activity have been suggested. Additionally, therapists are currently utilizing this approach in their practices across the United States. Despite the added benefits and current usage of walk and talk therapy, lack of research and definition remains. Walk and talk therapy has been described by Doucette (2004) as an intervention that combines counseling, walking, and the outdoors. Many questions regarding walk and talk therapy remain: a) how did it evolve? b) why did it evolve? c) what are the benefits? d) how is it defined? e) what is its theoretical framework?

Purpose of the Study

The purpose of this study was to generate a theory for the walk and talk therapy approach. Although therapists are utilizing walk and talk therapy (Hays, 1994), only one empirical study on the approach exists (Doucette, 2004). This study built on the work of Doucette (2004), who interviewed clients participating in walk and talk therapy, by obtaining the

perspective of the therapists. I interviewed therapists about their experiences as walk and talk therapists to generate a general theory of walk and talk therapy. Ultimately, these research findings may help explain walk and talk therapy and provided a framework for future research.

Research Questions

According to Corbin and Strauss (2008), the purpose of the research question is to lead the researcher into the data where the issues and problems under investigation can be explored (p. 25). Questions in qualitative research are broader than questions in quantitative research so researchers have more flexibility and freedom to explore a topic in depth (Corbin & Strauss, 2008). A central research question served as the overarching guide for the research and a small number of subquestions follow the central question (Creswell, 2007).

Central Research Question: What is the theory that explains walk and talk therapy?

Research Subquestions:

1. What is the process of walk and talk therapy?
2. How did walk and talk therapy evolve?
3. What is central (major events or benchmarks) in the process of walk and talk therapy?
4. What influenced or caused walk and talk therapy to develop for you?
5. What are the obstacles in the process of walk and talk therapy?
6. Who are the important participants and how did they participate in the process?
7. What strategies are employed during the process of walk and talk therapy?
8. What effects or outcomes occur from the process of walk and talk therapy?

The answers to these research questions yielded rich descriptions which helped me generate a theory of walk and talk therapy.

Assumptions of the Study

A basic assumption of this research was that the interview questions designed for the study are valid and accurately measure therapist perceptions of walk and talk therapy. Another assumption was that participants were honest and accurate in their answers when participating in interviews. Furthermore, I assumed that participants' perceptions would be valuable and realistic and that their perceptual biases would not interfere with their responses.

Definition of Terms

For the purpose of this study, it was necessary to define key terms utilized within the narrative and within the scope of the research.

Adventure-based counseling: A treatment that utilizes specific activities (i.e., games, initiatives, trust activities), high adventure (e.g. rock climbing, white water), and wilderness (e.g. backpacking, canoeing, etc.), in conjunction with a philosophy that embraces an active exploration of the unknown, in which the challenges encountered are seen as opportunities, and the group is seen as an essential element of individual success (Itin, 2001).

Ecotherapy: The result of integrating ecopsychological principles into psychotherapy, using a multitude of therapeutic approaches to benefit the client and nature (Burls, 2005).

Nature therapy: A postmodern experiential approach based on the integration of elements from art and drama therapy, Gestalt, narrative, eco-psychology, transpersonal psychology, adventure therapy, shamanism, and mind body practices (Berger & Mcleod, 2006).

Outdoors Education: A form of experiential education (Goldenberg, 2001) in which learning occurs through sensory involvement in the outdoors (Priest & Gass, 1997).

Psychotherapy: A primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is

intended by the therapist to be remedial for the client's disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem, or complaint (Wampold, 2001).

Running Therapy: A combination therapy approach in which a therapist and client are running during a psychotherapy session (Kostrubala & Schuler, 2009).

Wilderness therapy: A treatment for troubled adolescents that utilizes outdoor adventure pursuits and other activities such as primitive skills and reflection, to enhance personal and interpersonal growth (Russell, 2001)

Organization of the document

This dissertation is divided into five chapters. Chapter One is an overview of the study, defining the problem, purpose and theoretical base for the investigation. Chapter Two contains the review of literature, which supports the purpose of the study. Chapter Three includes the methodology of the research study. Chapter Four contains the findings of the research including a definition, explanation, and theoretical framework for walk and talk therapy. The last chapter, Chapter Five, includes a discussion of the findings according to themes discovered, as well as a summary of the study, limitations of the study, implications, and future research.

Chapter Two

Literature Review

The purpose of this chapter is to examine the previous research and existing literature related to walk and talk therapy. In grounded theory research, some theorists discourage reviewing prior literature to prevent biases during data collection, while others believe in critically reviewing it (Charmaz, 2006). Research on walk and talk therapy is somewhat limited, therefore I did not believe preconceived ideas would be formed from the literature. Hence, the main concepts of walk and talk therapy, physical activity and nature, were critically reviewed. Additionally, I discuss the current literature on the walk and talk therapy approach.

Physical Activity

Effects of an inactive society. The Surgeon General addressed the public about the current obesity epidemic in the United States (U.S. Department of Health and Human Services, 2010). Every year, obesity contributes to approximately 112,000 preventable deaths in the United States. The rate of obesity is dramatically increasing; it has doubled in adults and tripled in children in recent decades (U.S. Department of Health and Human Services, 2010). As a serious health concern obesity causes increased risks for other health problems such as: high blood pressure, high cholesterol, Type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, as well as endometrial, breast, prostate, and colon cancers (U.S. Department of Health and Human Services, 2010).

Obesity is even more prevalent for individuals with mental illnesses. Eighty-three percent of mentally ill individuals are obese (U.S. Department of Health and Human Services, 2010). Increased social isolation, weight-gaining medication, and sedentary lifestyles are common of this population, which are risk factors for obesity (Crone, 2007; U.S. Department of

Health and Human Services, 2010). In addition to these factors, they are vulnerable to other diseases associated with being overweight, mood instability, and low self-esteem. Furthermore, this population has a shortened life span, living only to approximately age 53 as a result of health problems, not mental health problems.

Many factors influence one's risk for obesity such as diet, physical activity, genetics, metabolism, behavior, environment, and culture (U.S. Department of Health and Human Services, 2010). Modifiable factors, identified by the Surgeon General, consist of diet, physical activity, and sedentary behavior. Dietary choices have become problematic; people are eating out more and choosing foods higher in calories and sugar as well as larger in portion size. Physical activity and sedentary behavior affect one another.

Inactivity has increased over decades (U.S. Department of Health and Human Services, 2010) from car-dependent communities, increased sedentary leisure activities, and technological advancements (Dustin et al., 2010; Hansen-Ketchum et al., 2009; Norman & Mills, 2004). Car-dependent design of communities has made it difficult to walk or bike to and from places. People are choosing more sedentary leisure activities such as watching TV, playing video games, and spending time on the Internet. Even technology that allows us to spend less labor on household tasks creates more inactivity.

Recommendations to help Americans change their diet, physical activity, and sedentary behavior have emerged including: 1) reducing consumption of sugar sweetened foods and drinks, 2) eating more fruits, vegetables, whole grains, and lean proteins, 3) controlling portion sizes, 4) drinking more water, 5) limiting TV viewing time, 6) breastfeeding exclusively to 6 months, and 7) becoming more physically active (U.S. Department of Health and Human Services, 2010).

Becoming more physically active is essential to controlling weight and preventing the risk for obesity and other health concerns. The Surgeon General recommends at least 150 minutes of moderate-intensity physical activity each week, such as dancing, martial arts, tennis, canoeing, swimming, weight lifting, and walking (U.S. Department of Health and Human Services, 2010). In addition to incorporating physical activity into daily lives, reducing sedentary behavior is important. Limiting time spent watching television, playing video games, and on the computer will allow for more time for physical activity.

Physical and mental health benefits. The scientific community has long recognized the positive health benefits of physical activity (e.g., Dubbert, 2002; Hays, 1994; Leer, 1980). Physical activity can decrease risks for numerous health conditions. The risk of heart disease decreases with physical activity, which is important because heart disease is the number-one cause of death in the United States (U. S. Department of Health and Human Services, 2010). In addition to heart disease, physical activity can reduce the risk of obesity, diabetes, some cancers, hypertension, and osteoporosis (Dubbert 2002; U.S. Department of Health and Human Services, 2010). Incorporating physical activity into lives helps control weight, strengthens bones and muscles, and increases one's lifespan (U.S. Department of Health and Human Services, 2010). In older adults, physical activity can assist with retaining functional abilities, preventing falls, and promoting healthy bones and muscles (Dixon et al., 2003).

In addition to the myriad of physical health benefits of physical activity, studies have long indicated that individuals' mental health can be enhanced by physical activity (e.g., Dubbert, 2002; Hays, 1994; Leer, 1980). Mental disorders are major health problems; one in four families is likely to have someone with a mental illness (Hansson et al., 2005). Depression and anxiety are most common (Martinsen, 2008). Depression is the leading cause of disability worldwide,

and it affects more than 340 million people. In the U.S. alone, it affects 16 percent of the population (Rot, Collins, & Fitterling, 2009). Dixon et al. (2003) suggested that physical activity is an effective, successful, and inexpensive method of decreasing depression and anxiety. Moderate physical activity such as walking, running, and playing golf are examples. Furthermore, training on ways to incorporate physical activity into therapy treatment plans as well as the importance of educating clients on the benefits of physical activity is needed (Crone, 2007; Dixon et al., 2003; Graddy & Neimeyer, 2002).

Physical activity utilized in therapy. Using physical activity in therapy is not new and dates back to Anna Freud's development of play therapy (Hays, 1994). Physical activity is used with therapy in three different ways: a) therapeutic (i.e., for the person's well being, b) as an adjunct to therapy, and c) as a medium in which psychotherapy occurs (Hays, 1994). First, relevant literature related to the therapeutic use of physical activity is reviewed. Then, studies supporting physical activity used as an adjunct to therapy are explored. Last, research with physical activity being used as a medium in which psychotherapy occurs is discussed.

Therapeutic use of physical activity. In a study supporting the mental health benefits of using physical activity for therapeutic purposes, physical exercise was the most common type of self-care strategy (Hansson et al., 2005). Self-care strategies have been shown to improve individuals' well being and to help with milder forms of depression. Hansson et al. (2005) interviewed 1093 Swedish citizens, aged 20–64, to explore what kinds of self-care strategies are used for psychological well being. Additionally, a psychological well being assessment was administered to participants to measure whether reports of using self-care strategies were related to individuals' own well being. Participants were first interviewed for 1.5 hours and asked, "What kind of self-care strategies do you use to improve or maintain your psychological well

being?” Then, the participant’s psychological well being was assessed using the *WHO (Ten) Well being Index* (Bech et al., 1996). Ten different self-care strategies emerged from the interviews: physical exercise, physical health, engaging in pleasurable activities, relaxation, plan/set limits, social support, professional contacts, positive thinking, work, and others. Findings suggested that physical exercise was the most common self-care strategy. Participants reported engaging in all manner of activity, including running, cycling, and walking. Additionally, a multiple regression analysis was conducted, and the researchers found that physical exercise, social support, relaxation, and physical health were positively associated with well being; social support (e.g., being with or talking to friends and family) had the strongest association with well being (Hansson et al., 2005).

A series of studies provide more support of physical activity used therapeutically. Plante et al. (2007) conducted two experiments to examine the contextual and social benefits of exercise on mood. In the first experiment, 128 female undergraduate participants ranged in age from 17 to 23. Participants who biked for 20 minutes were randomly assigned to one of three groups: a) biking alone, b) biking with a stranger, or c) biking with a close friend. Prior to the experiment and immediately afterwards, the following instruments were used: *Marlowe-Crowne Social Desirability Scale* (MS-SDS; Crowne & Marlow, 1960) to measure social desirability; *Activation-Deactivation Adjective Check List* (AD-ACL; Thayer, 1978) to measure momentary mood states; and *Physical Activity Enjoyment Scale* (PACES; Kendzierski & DeCarlo, 1991) to measure the amount of enjoyment during the activity.

In their second experiment, 88 female undergraduate participants, ranging in ages 18–22, were asked to walk for 20 minutes. Researchers randomly assigned them to the four following groups: a) walking alone on campus, b) walking on a treadmill alone inside, c) walking on

campus with a friend, or d) walking on a treadmill with a close friend. Prior to the experiment and immediately afterwards, participants completed the *Activation-Deactivation Adjective Check List* (AD-ACL; Thayer, 1978) to measure momentary mood states and the *Physical Activity Enjoyment Scale* (PACES; Kendzierski & DeCarlo, 1991) to assess the amount of enjoyment during the activity.

Plante et al.'s (2007) overall findings of the two experiments suggested that positive mood increased with exercise. When contextual benefits (environment) were analyzed, individuals preferred real-world settings, as opposed to virtual or laboratory settings. When social benefits were assessed, it was found that individuals were more calm when exercising alone than with a friend. When exercising with close friends, individuals were least calm. And finally, the participants reported highest enjoyment levels when they were outdoors, instead of indoors. Findings were consistent with previous research that exercise produces positive mood benefits. Mood may be related to the environment in which individuals exercise and whether they exercise alone or with others.

Physical activity as an adjunct to therapy. Martinsen (2008) reviewed literature related to physical activity preventing depression and anxiety; the first publication about depression and exercise dates back a century and continues to be a topic of much interest. Numerous studies examined the use of physical activity in various ways such as “exercise vs psychotherapy,” “exercise vs medication,” “comparing various forms of exercise” on the treatment of depression (Martinsen, 2008). He concluded that exercise might be an alternative or adjunct to traditional forms of treatment in adults with mild to moderate forms of depression. Various forms of exercise seemed equally effective but the most effective was a daily 30-minute brisk walk.

Martinsen (2008) reviewed two studies concerning the use of physical activity for the

treatment of anxiety. In two studies reviewed, exercise was used “in conjunction with treatment for agoraphobic patients” and “in conjunction with treatment with individuals with generalized anxiety disorders in an inpatient setting.” Although very different studies, exercise used in conjunction with regular treatment was successful in decreasing anxiety symptoms only in the individuals with generalized anxiety disorder. In sum, Martinsen (2008) concluded that depression and anxiety are substantial mental concerns that are often treated inadequately. Integrating regular physical activity as an adjunct to therapy could help prevent depression and anxiety.

Similarly, Dench (2002) showed that physical activity could be used as an adjunct to therapy. Dench utilized a variety of techniques to promote movement and exercise as an adjunct to therapy in an ongoing support group for women with chronic mental illness. Techniques included: a) interviews on sport, exercise, and movement, b) genograms to rate the history of activity level of family members, c) games for throwing and movement, and d) individual walk and talk therapy sessions. These techniques were used in the last six weeks of a 16-week support group with three women. Participants were interviewed, completed genograms, and then participated in games for throwing and movement. These three techniques were used to prepare individuals for the walk and talk therapy sessions. According to Dench (2002), clients experienced more clarity in thinking during and after the walk and talk sessions. Findings suggested that the participants felt more interested in the walk and talk sessions after the interviews and activities that led up to the actual walk sessions. Although the sample was small, and the walk and talk sessions were minimal, Dench’s work still shows that participants experienced clarity in thinking from the walk and talk sessions. Overall, this study provided evidence that physical activity (walking) has been used as an adjunct to therapy.

In a related study, Crone (2007) investigated the perceptions of persons with mental illness participating in walking in adjunct to therapy. Participants included four individuals (between ages 18 and 65), who were referred to the walking project from various mental-health agencies. The walks, which were located on trails in the woods, or around lakes and coastlines in Somerset, UK, included guides giving educational talks about topics, such as wildlife and plants. After the walk, the participants were interviewed with open-ended questions, for up to 45 minutes, about their previous walking experience, the walking project, their attitudes, experiences and, finally, perceived benefits as a result of the walking project. Crone (2007) found the following five themes: a) attitudes regarding the project prior to starting, b) factors affecting their participation, c) attitudes and opinions of the project during the project, d) perceived benefits and outcomes of participation, and e) experiences.

Attitudes regarding the project prior to starting were positive with some apprehension about starting something new. Factors affecting participation consisted of the perceived benefits that participants were expecting to gain from the project. Attitudes and opinions of participants during the project included a) the project is contemporary, b) the project is flexible, and c) the walks were pleasant. Perceived benefits and outcomes of participation consisted of a) enjoyment, b) the opportunity to meet and be with people, c) knowledge and appreciation of plants, d) purposeful activity, and e) help with sleeping. Experiences of participants overall were positive and memorable. Interpretation of the themes concluded that the walking project provided participants with a sense of autonomy, achievement, social interaction, and mental-health benefits (Crone, 2007). Additional benefits reported by participants included: enjoyment of being with nature, enjoyment of being with people (e.g, socializing), increased appreciation of

nature, sense of achievement from completing an activity, and help with sleeping. These findings support using physical activity in conjunction with treatment with mentally ill clients.

Physical activity used as a medium in which therapy occurs. Since the 1970s, running and walking have been used as a medium in which psychotherapy occurs (Hays, 1994). At first, there was more of an emphasis on running, according to Hays (1994), and now walking has become more popular (Gontang, 2009). In the remainder of this section, running therapy is identified and explored. Then, characteristics of running and walking used as a medium in which therapy occurs, are addressed.

Research on running therapy is limited to anecdotal research (Gontang, 2009; Hays, 1994; Kostrubala & Schuler, 2009). Thaddeus Kostrubala, physician and psychiatrist, developed the idea of running with clients in 1974 as an alternative to standard practice of treating clients. At that time and currently, a therapy session is indoors in an office setting, with the client on a chair or couch facing the therapist. Kostrubala felt clients were put in a defenseless position (either on a couch or sitting a chair) and believed the therapist and client should stand upright next to one another (Kostrubala & Schuler, 2009).

Kostrubala's "running therapy" consisted of running with his clients while having a therapeutic conversation. The session ended with time allotted at the office to tie up any loose ends or unfinished business from the session. After seeing successful results with running therapy, Kostrubala began to train others. In 1976, he published his book *The Joy of Running* at a time when professionals were beginning to use running therapy.

Kostrubala's work exposed the need for people to share running experiences with other like-minded people. He saw the need for an organization to establish criteria, monitor progress, and report findings of running therapy. Consequently, he and his colleagues Dr. Teresa Clitsome

and Dr. Mark Shipman formed the International Association of Running Therapists (IART) in 1980. Although Kostrubala did not have a curriculum for the training of running therapists, he developed guidelines. Those who were training to become running therapists were required to participate in weekly running supervision, be active in one of the traditional mental-health fields, and become a marathon runner prior to treating clients. Kostrubala believed completing a marathon was the best way to learn the physiological aspects of running. During the years of 1980 –1983, Kostrubala treated clients while walking, jogging, or running with them. In 1983, Kostrubala sustained an injury and could no longer run with clients; he returned to the traditional method of psychiatry (Kostrubala & Shuler, 2009).

A few years later, in 1988, Dr. Alexander Weber founded the German Center for Running Therapy, at Bad Lippspringe, Germany. The center's purpose was to make running therapy courses available to the public, to continue researching the therapeutic aspects of running, to train running therapists, and to make the therapeutic aspects of running available to the public through interviews, lectures, and seminars. In 1991, the German Center for Running Therapy introduced the first training course for running therapists. The training consisted of an eighteen-month regimen, including one weekend per month of practical and theoretical portions that concluded with a written paper and oral examination. By April of 2008, 387 individuals from Germany, Austria, and Switzerland were trained as running therapists (Kostrubala & Schuler, 2009).

Although no formal definition of running or walking therapy exists, Kostrubala, described it as exercise and verbal therapy conducted simultaneously (Kostrubala & Schuler, 2009). Hays (1994) further described it as being tailored to the client's needs such as readiness for this type of therapy and choice of running or walking. For example, if the therapist notices

cues that the client may benefit from running or walking during session, then the therapist can bring up the option. If the client agrees, then walking or running is their choice. If the client declines, the sessions continue in the office. Furthermore, the sessions vary in length and pace depending on the needs of the client. Running or walking sessions are followed by an allotted time to discuss conclusions, summarize the session, and any issues that arose from the session (Hays, 1994). Time is allotted for discussion at the end of the session just as an end of the session would take place in traditional therapy.

William Glasser, father of reality therapy, used running therapy in the 1970s (Kottler & Carlson, 2003). In his book, *Mummy at the Dinner Table*, Glasser disclosed his skepticism that talk therapy alone has enduring effects. During this time, Glasser was a strong believer of prescribing exercise to his clients for healthy habits. For one particular client, who was eating garbage from trashcans, he felt that sitting in an office would do no good. Therefore, they met twice a week on a Los Angeles street where many people ran, instead of in his office (Kottler & Carlson, 2003). For many months they ran and talked together for 30 minute sessions. After completing a run, they sat down in the parking lot to discuss her life and future goals. Glasser was successful using running therapy to help this client overcome negative behaviors.

Another proponent of running and walking with clients, Hays (1994), identified the characteristics, limitations, and concerns of running/walking therapy. Some characteristics, limitations, and concerns are similar to those of traditional talk therapy, while some are unique to running or walking therapy. Characteristics include: a shared activity, cognitive benefits from running, using metaphors and symbolism, as well as the use of non-verbal communication. Limitations consist of: physical condition of the client, confidentiality, countertransference

issues, and boundary issues. Characteristics as well as limitations and concerns of running/walking with clients are addressed.

First, according to Hays (1994), the therapist and client are sharing the activity of running or walking. Sharing the activity of walking or running creates qualities different from traditional therapy. Hays (1994) and Gontang (2009) both believed there is a more equal balance between the therapist and client due to the shared activity. Specifically, because the therapist is not doing something (e.g., fixing or treating) to the client; the therapist and client are sharing the time, space, and experience. Moreover, since the activity is shared, they are both reaping the benefits of physical activity and nature. As stated previously, numerous benefits are associated with physical activity and nature.

Second, in running therapy, the client and therapist experience clarity of thoughts and the ability to synthesize thoughts in new ways; these changing in thinking patterns occur while running and continue shortly afterwards (Hays, 1994). Clarity in thinking can allow the therapist more clarity in understanding the client, conceptualizing the client, and the interventions used with the client. In addition to having clarity for the current session, therapists can experience clarity with their subsequent client session.

The third characteristic, according to Hays (1994), was the non-verbal communication and body language in running/walking therapy. Non-verbal communication and body language include: changes in breathing, increase or decrease in pace, postural changes, and eye contact. For example, a client's breathing patterns or pace may change while talking about emotional issues; therapists can utilize the non-verbal communication for more understanding.

Running/walking with clients has limitations and concerns, just like traditional therapy. Hays (1994) identified four limitations: a) the physical condition of the therapist and client, b)

confidentiality, which can be compromised by an outdoor setting, c) the possibility of countertransference issues, due to the potential dynamics of competition, sexuality, and friendship that may arise, d) and boundary issues due to the setting change.

Physically, the therapist and client need to be healthy enough to keep the pace during sessions. And, because sessions are outdoors, confidentiality can be a challenge depending on how many people are nearby. Countertransference and boundary issues can arise when sessions change from traditional talk therapy to running/walking therapy. For example, the client may perceive the relationship as more equal as the activity is a shared experience. Or, the client may be a better athlete and some competition may arise. Additionally, according to Hays (1994), the client could confuse boundaries as the safe space of the office is gone. Clients may view the therapist as more of a buddy or friend with whom they spend leisure time, as the office space is not there as a reminder.

Limitations and concerns in running/walking therapy are handled in similar ways to traditional therapy. For instance, if either the therapist or client is not well enough to run or walk, an indoor session can take place. Confidentiality issues related to being outdoors should be discussed prior to onset of running or walking with clients. Countertransference and boundary issues should be treated similarly to traditional therapy sessions. Overall, according to Hays (1994), a responsible therapist assesses the issues in the context of each case, seeks consultation when needed, and reviews issues as necessary with each client.

Nature

People need to have a sense of belonging in the world; a connection to nature allows them to feel a sense of belonging and connectedness (Berger & Mcleod, 2006). Despite the need to be connected, Americans are more disconnected due to the advancements of technology and

urban living (Dustin et al., 2010; Hansen-Ketchum et al., 2009; Martin, 2009). Being connected to nature provides a sense of belonging and connectedness as well as numerous mental health and cognitive benefits (Burls, 2005; Pretty et al., 2006).

Mental health benefits. Exposure to nature can decrease negative behaviors and states such as aggression, anxiety, depression, and illness. It can positively increase affect, general health, and cognitive capacity, (Mayer et al., 2009; Pretty et al., 2006) and improve overall well being (Burls, 2005; Davis & Atkins, 2009). Furthermore, exposure to nature can increase one's sense of belonging, increase the rate of recovery from fatigue and illness, and prevent future stress (Hansen-Ketchum et al., 2009; Mayer et al., 2009; Pretty et al., 2006). Although limited research on engaging with nature is available (Berger & Mcleod, 2006; Hansen-Ketchum et al., 2009; Pretty et al., 2006), benefits are gaining attention. In this section, two studies are presented that support mental health benefits of engaging with nature. Benefits such as improved attentional cognitive capacity, improved ability to reflect on problems, and improved mood will be highlighted.

In a recent study, Berman et al. (2008) conducted two experiments exploring the effects of interacting with nature on cognitive abilities. In the first, 38 participants were administered a mood assessment with the *Positive and Negative Affect Scale* (PANAS; Watson, Clark, & Tellegen, 1988). Then, participants performed a cognitive test of recalling numbers in a backward sequence called "backwards digit-span task." Afterwards, participants were randomly assigned to take a mapped-out, 50–55-minute walk of about 2.8 miles in either a park or downtown area. Upon returning from the walk, participants performed the backwards digit-span task, completed the PANAS, and answered questions about their walks. Two weeks later, the participants repeated the entire procedure in a complementary setting to compare results. The

outcomes suggested that performance on the backwards digit-span improved when participants walked in nature but not downtown. Additionally, scores on the mood assessment were higher when walking took place in nature as compared to downtown.

In the second experiment, the type of cognitive function affected by interacting with nature was explored. The *Attention Network Test* (ANT; Fan et al., 2002) was used to measure three attentional functions: alerting, orienting, and executive attention. Twelve participants were administered the *Positive and Negative Affect Scale* (PANAS) to test their mood; they also completed a backwards digit-span task, and were administered the ANT for a baseline measure. Then, participants viewed either pictures of nature or of urban areas for approximately 10 minutes; there were 50 nature pictures and 50 urban-area pictures. The participants rated the pictures on a scale of 1 to 3 to indicate how much they liked them. After viewing these photos, the participants performed the backwards digit-span task, and completed the PANAS and ANT.

One week later, participants repeated the entire procedure with a complementary set (e.g., similar pictures of nature and urban settings but not the same) of pictures to compare results. The outcomes suggest that only the executive attention on the ANT improved when viewing pictures of nature, versus urban areas. Additionally, performance on the backwards digit-span improved when viewing pictures of nature in contrast to pictures of urban areas. Unlike in experiment 1, mood did not improve when viewing pictures of nature versus urban areas. Improvements on backwards digit-span task, which is a task that relies on directed attention, were consistent in both experiments. In experiment 2, improvements were selective to the executive attention (directed attention) portion of the ANT, meaning that interactions with nature improved only executive cognitive functions such as attention.

Overall, according to (Berman et al., 2008) these two experiments provide support for the restorative value of nature on cognitive functioning. In both experiments, interacting with nature (walking in nature or viewing pictures of nature) improved digit-span tests more than being exposed to urban settings (either walking downtown or viewing pictures of urban settings). And, executive function (directed attention) improved in the second experiment when participants viewed nature pictures but not urban pictures. In addition to the cognitive improvements, mood was improved but only in the first experiment. Mood improved in the first experiment when participants walked in nature but not when walking downtown. Mood was not affected in the second experiment when participants viewed either pictures of nature or of urban settings. This study demonstrated the restorative value of nature on cognitive functioning and mood. Moreover, as little as viewing pictures of nature can improve cognitive functions.

In another study supporting the mental health benefits of nature, Mayer et al. (2009) investigated the relationship of nature to well being. The study was aimed at answering the question, “why does nature produce beneficial effects?” Mayer et al. (2009) postulated that because nature influences mood and cognition in a positive manner, the ability to reflect on one’s life problems (known as “reflection”) could also be improved as a more complex socio-emotional process. Three experiments were conducted to examine the relationship between nature and well being.

In the first, 76 participants completed a 10-minute, timed, memory search task to measure how the environment affected their attentional capabilities. Then, a series of scales were administered to the participants. The PANAS was used to assess their mood; the *Connectedness to Nature Scale* (CNS; Mayer & Frantz, 2004) measured their sense of oneness with nature, sense of kinship with animals and plants, and sense of equality between the self and nature. The

Situational Self-Awareness Scale (SSAS; Goven & Marsch, 2001) was used to measure various dimensions of self-awareness.

After the assessments were administered, participants were randomly arranged into two groups of 15–20 people. Each group was assigned to one of two buses with an experimenter aboard. The buses drove 20 minutes to a nearby town, taking different routes. One bus went to an urban downtown area, and the other went to a nature preserve. Towards the end of the ride, the experimenters asked the participants to reflect silently on a loose end in their life that could be resolved. At the destination, participants were arranged in small groups of 8–10 and were taken on a walk for 10 minutes. When the walk ended, the experimenters asked the participants to answer questions such as: “I feel more prepared to ‘tie up my loose end’ than I did before I began this study.” Participants were then asked how much time they spend outdoors on a typical day and performed the memory search task. Results indicated that those who went to the nature preserve had improved scores on the memory task, showing that interacting with nature significantly affected attentional capacity. In addition to improved cognitive capacity, people’s ability to reflect on their lives increased when the setting was a natural environment.

For the second experiment, the researchers compared virtual experiences with real experiences in nature and psychological effects on individuals. Ninety-two participants completed a memory search task, the PANAS, and the CNS for a baseline measure. Participants were randomly assigned to either nature condition or video condition. While being led into separate testing rooms, participants were asked to reflect on a loose end in their life that needs to be resolved. Participants in the video condition were randomly assigned to either a nature or an urban video group. Then participants watched a 10-minute video of a walk in either nature or an urban area depending on their assignment. Participants in the actual nature condition walked for

10 minutes in a wooded area. Once participants finished watching videos or walking, all completed PANAS, self-awareness measures, and the CNS. Afterwards, participants rated the question “I feel more prepared to ‘tie up my loose end’ than I did before I began this study.” Then, participants performed the memory search task. Findings for experiment 2 suggested similar effects to those of experiment 1. These were: nature led to increase in connectedness to nature, positive affect, ability to reflect, and decrease in public self-awareness. Results also showed support for CNS as a mediator of the exposure to nature/well being effects. The actual nature condition groups produced more positive psychological effects than the virtual nature condition groups, as suspected.

In the third experiment, 64 participants completed a memory search task, the PANAS, and the CNS for a baseline measure. Then, participants were randomly assigned to one of the two conditions (real nature and virtual nature). On the way, participants were asked to reflect on a loose end in their life that needed to be resolved. After participants either walked for 10 minutes in nature or watched a 10-minute video of the same walk, which was videotaped prior to the experiment. Afterwards, all participants completed a memory search task, the PANAS, and the CNS and were asked to rate the question “I feel more prepared to ‘tie up my loose end’ than I did before I began this study.” Results of experiment 3 suggested that people in the real nature group had more positive psychological effects than those in the virtual nature group. Additionally, people were better able to reflect than those in the virtual group, and CNS was found as a mediator of exposure to nature/well being affects meaning that people who rate himself or herself as more connected to nature score higher on mood.

Overall, the three experiments in the study sought to answer three research questions: a) is connectedness to nature a potential mediator of nature/well being effect, b) does exposure to

nature effect our ability to reflect on life problems, and c) is there a difference in psychological benefits of actual versus virtual nature? Findings suggested that the CNS measured consistently for each experiment, showing connectedness to nature is a mediator to nature/well being effect. The ability to reflect on life problems was affected by nature. Being in actual nature gave individuals a better sense of ability to reflect on their life problems. This last finding suggested that being in actual nature produced more positive psychological effects than being in virtual nature settings.

Although only two studies were found that support the mental health benefits of engaging with nature, the benefits for clients could be significant. Improving cognitive clarity, ability to reflect on life's problems, and improved mood are some of therapists' goals in general. If conducting therapy while engaging with nature can provide these benefits, it could be beneficial for therapist and client.

Nature utilized in therapy. Being exposed to nature can have healing effects (Berger & Mcleod, 2006; Peel & Richards, 2005). According to Fletcher and Hinkle (2002), the outdoors has benefits such as increased awareness of the relationship with the natural environment, increased attention to surroundings, increased self-confidence, feelings of tranquility, and self-discovery. Ecotherapy, nature therapy, ecopsychology, and horticultural therapy are therapeutic approaches that use nature as a medium in which psychotherapy occurs (Burls, 2005). Reconnecting people with nature is the commonality amongst all approaches. In this section, ecotherapy and nature therapy are discussed.

Ecotherapy. Ecotherapy is still in the early development including definition, approach, and research (Davis & Atkins, 2009). Because connecting with nature is difficult to measure or observe, empirical evidence is lacking (Davis & Atkins, 2009). Nonetheless, Martin (2009)

defines ecotherapy as a therapeutic practice that uses the healing and psychological benefits of being in natural settings. Martin views ecotherapy as a set of therapeutic practices, a process, and an experiential connection with nature. Furthermore, according to Davis and Atkins (2009), in ecotherapy the health of humans is directly related to the health of the environment. Ecotherapy views humans from a systems theory, wherein all elements in the world are interconnected, and our relationship with nature is reciprocal (Davis & Atkins, 2009).

Ecotherapy strives to reconnect people with themselves, community, and the environment (Burls, 2005). Since the advancement of technology and the industrial revolution, people have more material goods and tend to live comfortably, yet some remain unhappy. Burls (2005) noted that unhappiness comes from the never-ending desire for material needs and disconnection to nature. Ecotherapy has goals to re-connect humans to nature and build environmentally responsible humans (Burls, 2005). Benefits of ecotherapy include positive well being for humans and an increase in environmental awareness of individuals.

Nature therapy. Nature therapy is defined as a nature-informed experiential approach that incorporates the natural environment as a partner in the process of therapy (Berger & Mcleod, 2006). Furthermore, it can be described as an alternative approach to the way traditional therapy is conducted; that is, indoors with the therapist and client relationship as the focus (Berger & Mcleod, 2006). The main concepts of nature therapy consist of: nature as the therapeutic setting, allowing the client to choose the setting, and nature as a co-therapist (Berger & Mcleod, 2006). Nature is neither the client's nor the therapist's space. This, of course, represents a significant departure from traditional therapy, which is typically inside an office that is usually owned and furnished by the therapist (Berger, 2003). Allowing the client to choose the therapeutic space gives the client authority over the individual therapy experience, which can be

powerful (Berger & Mcleod, 2006). Another significant aspect of nature therapy is using the environment (nature) as a partner in the therapeutic process (Berger & Mcleod, 2006). It can be used as a co-therapist in the therapy process by allowing it to influence the entire therapeutic process, not only the setting (Berger & Mcleod, 2006).

Physical Activity, Nature, and Therapy

Currently, there are many therapeutic approaches that incorporate physical activity and nature. Outdoor education programs are experiential approaches that incorporate physical activity and nature. Numerous programs have evolved from Outdoor education; some have therapeutic components while others do not. In this section, outdoor education, adventure-based counseling, and wilderness therapy, all of which utilize physical activity and nature, are addressed.

Outdoor education. Outdoor education is a form of experiential education (Goldenberg, 2001) in which learning occurs through sensory involvement in the outdoors (Priest & Gass, 1997). A key element of experiential learning is the insight individuals gain from the actual experiences of “learning by doing,” as opposed to being taught a lesson (Goldenberg, 2001). Outdoor education can include activities such as fishing, hiking, camping, and boating (Goldenberg, 2001).

According to Goldenberg (2001), outdoor education can take place in controlled environments (outdoor backpacking trip) or uncontrolled experiences (learning how to do things on one’s own). Various venues ranging from the wilderness to artificial obstacle courses can be utilized (Goldenberg, 2001). Outdoor education holds the principles that people learn and change when they are in states of tension brought on by internal conflict; the conflict occurs when there are challenges to a person’s perceived sense of safety and security called “perceived

risk” (Berman & Davis-Berman, 2005). Additionally, outdoor education programs may or may not have personal growth goals (therapeutic elements) for the program. Individuals participating in outdoor education programs without the intent for personal growth may experience growth and change but it may not be intended. Some outdoor education programs are strictly intended to be for recreational purposes and some for personal growth purposes.

Outdoor therapy programs have personal growth goals and come in different forms, such as individual growth, group dynamics, and therapeutic interventions (Goldenberg, 2001). Outward Bound, for example, is considered the leader in outdoor therapy programs (Goldenberg, 2001). In 1962, Outward Bound began in the U.S. and was used as an alternative form of incarceration of adolescents in the U.S. (Russell, 2001). Clients in outward bound programs reach therapeutic goals through exciting and challenging adventure-based group activities held in the outdoors (Marx, 1988).

Outward Bound was founded on quality and safety, true adventure, and making a difference in lives (Goldenberg, 2001). The purpose and goals of Outward Bound are: 1) personal development, 2) interpersonal effectiveness, 3) environmental awareness, 4) learning, and 5) philosophy and values (Goldenberg, 2001). Now, there are 41 Outward Bound centers in 24 countries (Fletcher & Hinkle, 2002). In addition to expanding geographically, Outward Bound’s clientele has grown to include youth, business executives, and substance abusers (Priest & Gass, 1997). From Outward Bound, two notable outdoor therapy programs emerged – adventure-based counseling and wilderness therapy (Peel & Richards, 2005).

Adventure-based counseling. Adventure-based counseling has been around for nearly 40 years and the definition is still a work in progress (Itin, 2001). According to Peel and Richards (2005), adventure-based counseling is an outdoors approach that focuses on clients and

the therapist engaging in adventurous physical activities such as kayaking, rock climbing, or the use of purposeful activities (e.g, ropes courses) as the medium in which psychotherapy occurs. A key element of adventure-based counseling is perceived risk. Clients are placing themselves outside their comfort zones in activities that have perceived danger or risk in a setting of low actual risk.

The setting of adventure-based counseling is a unique feature and can be therapeutic on its own (Fletcher & Hinkle, 2002; Itin, 2001). Adventure-based counselors use the same skills a traditional therapist utilizes with the addition of knowing how to maneuver physical activities, such as rock climbing, hiking, and camping (Fletcher & Hinkle, 2002). Adventure-based counseling can be used with individuals, groups, and families; it can be used as the primary treatment method, in which the counselor plans treatment goals around longer trips in outdoor settings (Fletcher & Hinkle, 2002), or as an adjunct to traditional therapy, an example of which would be a counselor taking a client for a hike.

Wilderness therapy. Similar to adventure-based counseling, the definition of wilderness therapy is still being refined (Russell, 2001). Wilderness therapy is defined as an approach that uses traditional counseling techniques outdoors while incorporating adventure-based physical activities (Hill, 2007). Peel and Richards (2005) add that wilderness therapy deliberately uses the healing effect of the wilderness setting. Hence, the physical activities such as kayaking, rock climbing, or camping may be present but the focus is on experiences with nature throughout the journey. For example, groups of clients are taken on wilderness journeys lasting weeks or months. During this time, they travel, live in tents, and confront natural challenges presented by the environment such as weather, fatigue, or physical objects such as rivers or mountains.

Nature's ability to be unforgiving and punishing as well as inspiring and rewarding provides teaching (Peel & Richards, 2005).

The setting of wilderness therapy is an important aspect of the approach (Hill, 2007) because clients are placed in an unfamiliar environment such as mountains, forests, or near lakes (Peel & Richards, 2005). Wilderness therapy counselors use the same skills a traditional therapist utilizes with additional knowledge of how to maneuver physical activities, such as rock climbing, hiking, and camping (Fletcher & Hinkle, 2002). Wilderness therapy is used primarily with groups but individual counseling sessions can be integrated into the program (Hill, 2007).

Walk and Talk Therapy

To date, one qualitative study (Doucette, 2004) and numerous anecdotal research (e.g., Goodman, 2005; Hays, 1994; Wright, 2008) have provided support for walk and talk therapy. In this section, a definition and current research on walk and talk therapy are provided. The benefits of walk and talk therapy, provided by therapists, are examined. Last, my perspective regarding the theoretical elements in walk and talk therapy is discussed.

Walk and talk therapy has been described in the literature as an intervention of walking outdoors while engaging in counseling (Doucette, 2004). Instead of sitting face-to-face inside an office for 50 minutes of psychotherapy, therapists meet clients at local parks, lakes, or walking paths for 50 minutes of psychotherapy, while walking side by side (Doucette, 2004).

Counseling, physical activity (walking) and being exposed to nature (the outdoors) are the main concepts in walk and talk therapy; the physical activity and nature components distinguish it from traditional therapy approaches.

Doucette (2004) examined participants' experiences in a phenomenological study of walk and talk therapy. The purpose of the study was to explore the benefits of the walk and talk

intervention with behaviorally challenged youths. The objective of the walk and talk intervention was to help the youth feel better, explore alternative behavioral choices, and learn new coping strategies and life skills by engaging in the intervention that has benefits of physical activity and a connection to the outdoors (Doucette, 2004).

Eight students, ages 9 through 13, identified by school professionals as behaviorally challenged (e.g, diagnosed with conduct disorder) were interviewed before and after the six-week walk and talk intervention (Doucette, 2004). During the first interview, participants drew self-portraits, which were examined by an art therapist for insight on their self-esteem. Then, they were asked to list five strengths and five weaknesses. Last, participants wrote a short autobiographical incident about something which had an impression on them, positive or negative. Discussion followed each activity and then the walk and talk intervention was presented to each participant at the end of the interview.

For the walk and talk intervention, therapist and participants met for six consecutive weeks, once per week for 30–45 minutes of walking outdoors on school grounds. Participants were asked what they would like to talk about at the beginning of each session, followed by a discussion of the events of their past week. Strategies taught during sessions included stress management skills such as identifying stressful situations, the importance of positive self-talk, mental imagery, visualization techniques, and focusing skills. Other skills taught included anger management skills, using assertiveness rather than aggressiveness, and using I-statements to convey feelings (Doucette, 2004).

After the intervention, post interviews included the same activities as the pre interviews with the addition of some questions about their experiences in the intervention. Participants drew a self-portrait and listed five strengths and weaknesses again. The therapist discussed the

differences between the pre and post self-portraits as well as strengths and weaknesses with the youths. Then participants answered these questions: “what has changed since we started;” “what did you like about walk and talk;” “what didn’t you like about it.”

Data analysis included self-reports from participants, pre and post self-portraits, and pre and post self-reports of strengths and weaknesses. Of the eight participants, one dropped out after one session. Doucette (2004) concluded that one of seven participants had an improved self-image (self-portraits examined by the art therapist), five of seven participants reported more strengths in the post interview, and five of seven participants reported fewer weaknesses in the post interview. When Doucette asked participants about their experiences in the walk and talk intervention, five responses were “I liked talking about my feelings,” “It was helpful,” “It was a positive experience,” “It was a great experience,” “It was good because I got my feelings out.”

From these findings, Doucette (2004) concluded that combining counseling, physical activity, and nature created a new intervention for behaviorally challenged youth. Furthermore, she found that each youth benefited from the intervention, as assessed from self-reports. Overall, the walk and talk intervention benefited all youths in terms of learning how to deal with their anger management, creating an opportunity for a physical release, and allowing them to clarify their feelings (Doucette, 2004). Some possible limitations of this study include small sample size, the subjective nature of the self-report findings, and the narrow population utilized.

In addition to Doucette, many therapists are utilizing walk and talk therapy as evidenced by anecdotal research. Hays, Kostrubala, Gontang are three therapists have used walking with clients for many years. Kostrubala influenced the work of Hays and Gontang. Kate Hays has been walking and running with clients for more than two decades, since she learned about it in the 1980s from the works of Thaddeus Kostrubala (Wright, 2008). Austin Gontang has been

using walking and running therapy since 1975. Dr. Gontang began his career with running and walking therapy under direction of Thaddeus Kostrubala and was the first trained running therapist. Over the past 30 years, Gontang reported that approximately 75 percent of his clients choose to walk or run during therapy (Gontang, 2009).

In addition to those influenced by Kostrubala, other therapists have offered their perspectives on walk and talk therapy. In recent articles in *Health* magazine and in *WebMD*, therapists offered reasons they provided walking therapy to their clients. The following are important points they have made:

- “When you are out walking, you’re working from a position of health. “Lying on a couch is what we do when we’re sick.” – Geri Dube, licensed mental health therapist (Goodman, 2005, p. 112)
- “When I took them into an adjacent park, I found patients were much more relaxed, and the sessions were much more productive.” – Cathy Brooks-Fincher, licensed clinical social worker (Wright, 2008, p. 1)
- “They are able to figure a problem out better than if they were sitting down with it.” – Kate Hays, psychologist (Goodman, 2005, p. 112)
- “It speeds up therapy”. – Keith Johnsgard, psychologist (Goodman, 2005, p. 112)

Walk and talk therapy could be a beneficial option to offer clients for a number of reasons gathered from the comments above. Walk and talk therapy could be advertised as a more healthful way to participate in therapy which may decrease the stigma associated with therapy. When clients are more relaxed, they may open up faster, which could foster the therapeutic relationship between and therapist and client. And, if walking outdoors helps clients figure out problems better and speeds up therapy, clients could speed less time and money in

therapy. It seems that therapists conducting walk and talk therapy are satisfied and believe this approach is successful with clients.

Although there is no research and little discussion on the theoretical framework of walk and talk therapy, in my opinion elements in walk and talk therapy come from traditional, established counseling and psychotherapy theories as well as non-traditional elements. I make some comparisons to traditional, established counseling theories from the literature on walk and talk therapy regarding view of human nature and the therapeutic alliance. Next, I review the non-traditional elements found in walk and talk therapy.

Traditional theoretical elements in walk and talk therapy. Humanists like Carl Rogers and Fritz Perls viewed people as strong and capable of dealing with challenges, growing, and realizing their own potential (Seligman, 2006). Rogers believed that individuals have the ability to take responsibility for their own actions towards actualization, growth, and health (Rogers, 1992). Similarly, running therapy, which serves as the genesis for walk and talk therapy, views clients as capable and in action-oriented states. In my opinion, walk and talk therapy draws from these two theories to create its own view on human nature; it views its clients from a positive outlook towards good health and a heightened ability to deal with challenges.

From my perspective, walk and talk therapy takes elements from Adlerian therapy to form its outlook on the therapeutic alliance. Adler viewed the therapeutic alliance as cooperative and interactive. Adler believed the therapist and client should have shared goals, mutual respect, and trust (Seligman, 2006). Similarly, in walk and talk therapy, the relationship between the therapist and client is a collaborative one, with shared physical activity (Hays, 1994).

Non-traditional theoretical elements in walk and talk therapy. Some elements in walk and talk therapy not derived from traditional, established counseling theories, I refer to as non-traditional elements in walk and talk therapy. The incorporation of physical activity (walking) and (the outdoors) are the two main non-traditional elements of walk and talk therapy. Two additional non-traditional elements of walk and talk therapy are the orientation of the therapist and client, as well as the setting. In my opinion, these four non-traditional elements are the essence of walk and talk therapy, and each contributes to the effectiveness of this kind of therapy.

The physical and mental health benefits of physical activity are widely recognized (e.g., Dubbert, 2002; Hays, 1994; Leer, 1980). As explained earlier, physical activity has been shown to reduce the risk of developing health conditions such as diabetes, hypertension, and colon cancer (Dubbert, 2002). Living longer, strengthening bones and joints, and controlling weight are some other benefits of incorporating physical activity (Dubbert, 2002; U.S. Department of Health and Human Services, 2010). The most common mental health benefit of physical activity is decreased states of depressed and anxious moods (Dixon et al., 2003). Walking has been shown to provide the same physical and mental-health benefits as more moderate levels of physical activity (Norman & Mills, 2004; Sykes, 2009).

Thus, the physical activity used in walk and talk therapy could increase effectiveness in a number of ways. First, therapists and clients both acquire the benefits of physical activity. According to Hays (1994), clients have more energy, appear less inhibited, loosen up, and are more in touch with their feelings; they also become more aware of their anger and assertive needs. Second, clients and therapists benefit from “centering,” which is defined as clarity of thinking and capacity to synthesize in new way (Hays, 1994). Centering could last longer than

the actual exercising, so the therapist's next client(s) may reap the benefits. The therapist may have a heightened sense of well being and sustain more energy. The therapist may feel less overwhelmed by patient symptoms and feel more focused and relaxed (Hays, 1994).

Furthermore, burnout could be prevented from the restorative and positive mood producing effects of being exposed to nature.

Being exposed to nature can decrease negative behaviors and states such as aggression, anxiety, depression, and illness. It can increase certain important aspects of an individual's well being, such as affect, health, and cognitive capacity (Mayer et al., 2009). Psychological effects can include increased confidence, feelings of tranquility and self-discovery (Fletcher & Hinkle, 2002), as well as decreased negative states of aggression, depression, and anxiety (Mayer et al., 2009). Nature can improve cognitive functioning, specifically cognitive capacity (Berman et al., 2008; Mayer et al., 2009).

The setting in walk and talk therapy is nature. Therapists meet clients at local parks, paths surrounding local lakes, or hiking trails agreed upon in advance. As discussed above, such locales offer a welcome alternative to the traditional office decorated with the therapist's personal belongings. When a client is taken outdoors, out of the therapists' space, the control of the therapist is relinquished (Kostrubala & Schuler, 2009). According to Berger and Mcleod (2006), nature is a dynamic and live environment that is under neither the therapist nor client's control and can, therefore, be considered a neutral space. Although there is no research on the setting as a neutral space, the therapeutic space not belonging to the therapist could allow the client to open up faster. My perspective is that the client may feel less intimidated being in a space that is neither theirs nor the therapist's, which may allow them to open up. Also, if the client has a choice in the meeting place (park, walking path, etc), this may lead to feelings of

empowerment or at least equality for the client. Unfortunately, there are no theories or evidence that support these ideas at this time.

The orientation of the therapist and client in walk and talk therapy is side by side while walking. My perspective is that being side by side with a therapist may be less intimidating for the client than being face-to-face in traditional therapy sessions. In general, clients may feel more comfortable to open up and feel less judged by the therapist. For those clients who have difficulty with eye contact, walk and talk therapy eliminates this problem and may allow them to feel comfortable enough to discuss their situation.

In sum, walk and talk therapy has been introduced in the literature as an intervention using physical activity and nature. Current research, empirical and anecdotal, has been presented. Many therapists have been and are currently utilizing walk and talk therapy, with little theoretical background on the approach. These therapists have shared their perspectives that it is a successful approach (e.g., Doucette, 2004; Goodman, 2005; Hays, 1994). In my opinion, there are theoretical elements that stem from traditional established counseling theories as well as non-traditional elements in the approach.

Utilizing physical activity and nature with therapy may not be new as an approach, but the literature and theoretical framework is in its infancy of development. Therefore, conducting a study which explores the experiences of therapists who are offering walk and talk therapy to gain an understanding of what it is, how it evolved, and the theoretical components will contribute to existing literature.

Chapter Summary

In this chapter, literature related to my research problem was discussed. Since my research problem is the lack of theoretical knowledge on walk and talk therapy, I reviewed

literature on the main concepts of walk and talk therapy - physical activity and nature. Effects of an inactive society were discussed to gain an understanding of how inactivity has occurred and impacted Americans. Numerous physical health and mental health benefits of physical activity were identified. Then, ways in which therapeutic approaches incorporated physical activity were explored. After the concept of physical activity was examined, the other main concept, nature, was discussed. Our needs to be connected as well as the mental health benefits of nature were identified. At the end of the chapter, therapeutic approaches that utilized the main concepts of walk and talk therapy were examined. Ecotherapy and nature therapy, which utilize nature, were discussed first. Then, adventure-based counseling and wilderness therapy, alternative approaches that utilize physical activity and nature, were explored. Last, walk and talk therapy was discussed.

Chapter Three

Methodology

The purpose of this chapter is to describe the methodology utilized in the study. This section includes the following: rationale for the method, research questions, role of researcher, researcher bias, procedures, participant profiles, data collection, data analysis, reliability and validity, and summary.

Rationale for Qualitative and Grounded Theory Design

Previous research related to walk and talk therapy is comprised of one qualitative study (Doucette, 2004) and anecdotal research. Doucette's singular qualitative study (2004) explored client perceptions of walk and talk therapy by interviewing a sample of behaviorally challenged adolescents. Although the study provided information about client perceptions, it did not describe the phenomenon of walk and talk therapy. Therefore, I studied therapist perspectives to explain the evolution and process of walk and talk therapy.

Creswell (2007) identified numerous reasons to conduct qualitative research. The following reasons proffered by Creswell describe why qualitative research was deemed appropriate for this study: 1) to gain a detailed understanding of the issue, 2) to understand the context or settings in which participants address the issue, and 3) to develop theories when partial or inadequate theories exist. In qualitative research, questions are exploratory (Corbin & Strauss, 2008), open-ended (Creswell, 2007; Hesse-Biber & Leavy, 2006), and start with words like "what and how" (Creswell, 2007). Qualitative questions allowed me to explore the issues more deeply than a quantitative method. And one specific type of qualitative research allowed for findings directly related to my research questions.

Grounded theory is a methodology used to generate theory (Glaser & Strauss, 1967). To date, there is no research which expounds a theory for walk and talk therapy. The therapists' perspectives are significant because they will have information on how the phenomenon of walk and talk therapy evolved as a method, an explanation of the process, and their experience as a therapist. By utilizing grounded theory to study therapists' experiences, data can be collected and analyzed to generate a theory to explain and provide a theoretical framework for walk and talk therapy.

Research Questions

According to Corbin and Strauss (2008), the purpose of the research question is to lead the researcher into the data where the issues and problems under investigation can be explored (p. 25). A central research question serves as the overarching guide for the research and a select number of subquestions follow the central question (Creswell, 2007). To explore therapist perceptions of walk and talk therapy and generate a theory for it, the central research question was: What is the theory that explains walk and talk therapy?

The following subquestions were used to generate more discussion from therapists so a detailed understanding of walk and talk therapy could be established.

1. What is the process of walk and talk therapy?
2. How did walk and talk therapy evolve?
3. What is central (major events or benchmarks) in the process of walk and talk therapy?
4. What influenced or caused walk and talk therapy to develop for you?
5. What are the obstacles in the process of walk and talk therapy?
6. Who are the important participants and how did they participate in the process?
7. What strategies are employed during the process of walk and talk therapy?

8. What effects or outcomes occur from the process of walk and talk therapy?

The answers to these research questions yielded rich descriptions that helped me generate a theory of walk and talk therapy.

Role of the Researcher

Researchers are key instruments in qualitative research, meaning the researcher actually gathers all the information in the study. Researchers collect data by reviewing documents, interviewing participants, or observing participant behavior (Creswell, 2007). Sixsmith and Sixsmith (1987) identified several researcher responsibilities during participant interviews. First, throughout the entire research process, researchers build rapport with participants to create an atmosphere of trust. Second, researchers develop a framework for the dialogue in the interviews, which will allow for exploration of pertinent issues. Third, and most important, researchers facilitate participant self-analysis and expression of experiences during the interviews.

My role as the researcher was to generate a theory of walk and talk therapy. My background in qualitative research and conducting interviews allowed me to be the key instrument in gathering information. First, it was essential for me to build rapport and create an environment of trust with each participant for them to open up and speak of their experiences with walk and talk therapy. To build rapport, I utilized my interpersonal skills learned from counselor education training. I made each contact with participants a pleasant one by using a friendly, gracious tone of voice and highlighted commonalities between us such as our interest in walk and talk therapy. To create an environment of trust, I gave each participant a letter of interest/consent form (see Appendix B) to ensure my professionalism. Additionally, I was as accommodating and flexible as possible with scheduling interviews to reinforce my dedication to their participation in the study. I believe these actions helped build rapport and trust.

During the interviews, I continued to build rapport utilizing my interpersonal skills. To engage participants in sharing their experiences with me, I used my clinical and interviewing skills. My clinical and interviewing skills include using active listening and motivational interviewing which allowed the participants to feel at ease and talk about their experiences.

Researcher Bias

According to Shank (2006), researcher bias is considered the greatest threat to reliability in qualitative research and thus, research validity. Researchers are not outside the dialogue, but intertwined within it according to Morriessette (1999); therefore, they must be aware of biases, assumptions, and beliefs about the topic being studied (Corbin & Strauss, 2008).

Let me begin by making my biases known. Originally, I became interested in walk and talk therapy because of a personal experience. In 2005, I found myself walking and talking with an acquaintance and enjoying the interaction. We walked along a walking path at a local park in the New Orleans area. It was a pleasant experience, because as we walked and talked we were enjoying being outdoors. More importantly, it seemed that my acquaintance was opening up to me with ease. The experience gave me the idea that walking with clients would be enjoyable, for me, as a practice.

At that time, I had a master's degree in counseling and was beginning my career as a therapist. While doing Internet research, I found that therapists were offering walk and talk therapy across the nation. After learning that therapists were walking with clients, it led me to search for empirical research. It was then I realized that there was minimal research on this innovative approach to therapy. Conducting a qualitative study on the topic would provide insight into what walk and talk therapy is, how it evolved, and how it is done.

As a result, I am positively biased towards walk and talk therapy because I discovered it on my own and have positive assumptions about it as a method of therapy. My assumptions about walk and talk therapy are twofold. Walk and talk therapy, to me, would be more enjoyable for the therapist and client as well as more effective than traditional talk therapy.

My first assumption that walk and talk therapy is more enjoyable than traditional talk therapy stems from my own experience as a therapist. I have always been an active person who enjoyed spending time outdoors. When I worked in an outpatient clinic setting, I spent the day sitting with client after client alone and indoors. Interactions with co-workers were minimal and only in between clients when time allowed. As I reflect back on that experience, I remember feeling lethargic from sitting as well as isolated from being alone with clients all day. My interest in being active and the outdoors affected my experience as a therapist in an outpatient setting.

Second, I believe walk and talk therapy may be a more effective than traditional therapy because it has the benefits of walking and the outdoors in addition to therapy. Traditional talk therapy has benefits of therapy but is conducted indoors and while seated for 50 minutes. Walk and talk therapy has benefits of therapy with additional benefits of the physical activity of walking and being exposed to the outdoors. Another important reason I believe walk and talk therapy may be more effective than traditional talk therapy is because the therapist is experiencing the benefits of walking and the outdoors as well. The benefits of walking and the outdoors may help the therapist become a better therapist during the session.

My two assumptions are that walk and talk therapy is more enjoyable and effective than traditional talk therapy create my bias regarding walk and talk therapy. I monitored these assumptions and biases to prevent them from affecting my analysis and interpretations during the

research process. To monitor my assumptions and biases, I utilized strategies suggested by Morrow (2005), which are making biases known, bracketing, and consulting with a research team. I have already made my biases known, above. In the remainder of this section, I describe how I utilized bracketing and consulting with a research team.

Bracketing is the process of becoming aware of one's assumptions and setting them aside to avoid influencing the research (Morrow, 2005). Furthermore, bracketing can assist the researcher in taking a fresh perspective towards the phenomenon being studied (Creswell, 2007). To utilize bracketing, I first bring my assumptions regarding walk and talk therapy to my awareness. During the research process, I began each task (e.g., data collection, data analysis, field notes) with bracketing. This allowed me to take a fresh perspective towards walk and talk therapy.

Consulting with peers or a research team was another way of minimizing bias. The researcher can consult with peers who have similar knowledge on a given subject, either as a debriefing process or as a way of gaining input (Morrow, 2005). A research team can serve as a mirror for the researcher's responses or assist with providing alternative viewpoints and interpretations (Morrow, 2005). I consulted with my dissertation chair and fellow doctoral peers throughout the research process to check my biases. My dissertation chair assisted me with reading and discussing the findings while checking my biases throughout the entire research process. My fellow doctoral peers allowed me to check my biases as we discussed my feelings and thoughts related to the research. By speaking to peers aloud about my research I was able to check biases thoroughly. Both processes allowed me to keep my biases in check and prevent them from influencing the findings.

Procedures

Setting. The setting where participants experience the phenomena is often studied in qualitative research (Creswell, 2007). The setting of walk and talk therapy is an important aspect of this study as the setting differentiates it from traditional therapy methods. According to Wright (2008), the setting of walk and talk therapy is characterized by exposure to nature such as local parks as well as some form of walking path. Therapists interviewed about walk and talk therapy depicted the setting as “a local park” or “a paved path that runs along a small river” (Wright, 2008) which can be interpreted in many ways.

The setting was reliant on the therapists who volunteered for the study as they each utilized different settings depending on the location of their practice. Walk and talk therapists practicing in communities with various parks, walking paths, trails, or natural environments have more options than those with few. Three participants chose to be interviewed face-to-face; therefore, I observed three settings of walk and talk therapy. Therapists interviewed face-to-face were eager to share the setting of walk and talk therapy for the purpose of the study.

Each of the three therapists interviewed face-to-face had various settings in which they walked with clients. Each offered their primary setting for my observation. Two of three face-to-face interviews began at the setting of walk and talk therapy and one began at the office. Two participants interviewed face-to-face walked with me for approximately 15 minutes on the walking path they use in their practice. The third participant interviewed face-to-face led me to the setting and I walked alone for 15 minutes.

Approval for study. Before the study began, permission was sought and granted from the University of New Orleans’ Institutional Review Board (IRB) to pursue data collection by completing and filing an IRB application. The application for permission included a project

description, description of data collection, funding source, risks to participants, informed consent, and principal investigator's assurance. Data collection did not commence until approval was obtained on April 7, 2011 via an IRB approval letter (see Appendix A).

Sample. In grounded theory, participants are chosen based on their ability to contribute to the development of a theory (Creswell, 2007). Sampling in grounded theory studies can be people, settings, or relevant materials. Charmaz (2006) has recommended two types of sampling, which have different criteria: initial sampling and theoretical sampling. Initial sampling is where you start, whereas theoretical sampling directs you where to go (Charmaz, 2006).

In initial sampling, sampling criteria for people, places, and situations are established before entering the field. Homogenous sampling was utilized as an initial sampling method, as recommended by Creswell (2007). In a homogenous sample, all participants have experienced the same phenomenon. Choosing a homogenous sample of therapists who have all experienced walk and talk therapy afforded me the opportunity to begin identifying initial categories.

Once initial categories emerged, theoretical sampling was utilized for the duration of the study. The purpose of theoretical sampling is to sample people, information, and settings that will elaborate and refine categories (Charmaz, 2006). Sampling continues until categories have been saturated, which is called theoretical saturation. Theoretical saturation occurs when no new further theoretical insights about the emerging theory are found (Charmaz).

Therefore, according to Charmaz (2006), sample size can be small or large because it depends on how and when the categories are saturated. My sample was a homogenous sample of 11 therapists who offered walk and talk therapy as part of their practice. Approximately 28 individuals were located, via Internet research, who utilize walk and talk therapy as part of their

practice. I estimated a sample size of 8-10 for two reasons. First, the sample size may change depending on the categories that emerge and how quickly the category is saturated. If the category were saturated, I might have to move towards a different sample such as the setting or related materials that emerge through data collection and analysis. Second, approximately 28 individuals were located, via Internet search, who offer walk and talk therapy in the United States. Because only 28 therapists were located, I estimated that 8-10 of those would agree to participate.

Recruitment. To recruit participants, I formulated a list of therapists who provide walk and talk therapy from public domains such as the Internet advertisements and a psychotherapy association listserv. First, I searched for therapists who provide walk and talk therapy in their practice by typing the term “walk and talk therapy” in a Google search on the Internet. I found webpages with contact information (e.g., email and phone) of the therapists. Next, I searched for members of the Association of Experiential Education (AEE) by registering for the AEE listserv and recruiting walk and talk therapists to volunteer via the association member listserv.

Once the potential participant list was formulated, a participant letter of interest/consent form (see Appendix B) was sent via email and mail for oral and/or written agreement allowing for interviews. After one week, a follow up letter of interest/consent was sent via email and mail. I repeated after two weeks when necessary. Once therapists agreed to participate in the study, an interview method (face-to-face, telephone, or Skype™), and interview date were agreed upon via email. At that time, I asked for access to any documents or webpages that would facilitate my understanding of their walk and talk therapy practice.

Informed consent. Once IRB approval (see Appendix A) was granted, a letter of interest/consent form (see Appendix B), which outlined the intent of the research, participant

criteria, the significance of the research study, the rules of confidentiality, as well as the parameters of the study was sent to selected participants. At the onset of each interview, I read the consent form to make sure that each participant understood the study, its purpose, its procedures, and his or her rights as a participant. After I discussed the consent form and my commitment to confidentiality with the participants, I asked whether they fully understood everything we had covered. Their participation in the interview served as consent for participation in the study.

Participant Profiles

In this section, demographic information is presented for each participant. All names used are pseudonyms to protect the identity of the participants.

Kathy. Kathy is a Caucasian female who has a private practice in Minnesota that includes walk and talk therapy as well as in-home counseling. She has a M.Ed. in counseling and was working towards her marriage and family therapy (MFT) licensure. Kathy has been counseling for three years and has six months experience with walk and talk therapy. She is a member of the American Association of Marriage and Family Therapy (AAMFT) and the North American Society of Adlerian Psychology (NASAP). Kathy was the only therapist in my study who did not keep an office; she sees clients in their homes or an agreed location for sessions. Kathy reported that her theoretical orientation is a systems approach. Kathy indicated that her caseload was 15 clients per week; approximately half of her clients are walk and talk clients and the others are in-home counseling clients.

Linda. Linda is a Caucasian female who has a private practice in a holistic health clinic in Illinois. She has been a licensed clinical social worker (LCSW) for 15 years and has 10 years of experience with walk and talk therapy. She is a member of the National Association of Social

Workers (NASW) and Association of Experiential Education (AEE). Linda reported that her theoretical orientation is a systems approach and her caseload is 25 clients per week. She indicated that approximately 4 clients per week are walk and talk therapy clients.

Krystal. Krystal is a Caucasian female who has a private practice in New York. She has been a LCSW for 20 years and has three years experience with walk and talk therapy. At the time of the interview Krystal had several qualifications: emotional freedom techniques-advanced (EFT-ADV) provider, an approved consultant for the Eye Movement Desensitization and Reprocessing International Association (EMDRIA), hypnotherapist, certified sports counselor, and yoga instructor certification. Krystal reported that her theoretical orientation is systems approach. Krystal indicated that the majority of her clients come to her for EMDR and EFT and that she has a caseload of 25. She has had three walk and talk therapy clients in the three years she has offered it.

Christopher. Christopher is a Caucasian male who has a private practice in New York. He has been a LCSW for 19 years and has seven years' experience with walk and talk therapy. He is a member of NASW and his theoretical orientation is solution-focused. Christopher indicated that his caseload was approximately 30 per week and 28 clients were walk and talk clients.

Laura. Laura is a Caucasian female who has a private practice in Northern California. She has been a licensed marriage and family therapist (LMFT) for 10 years and has four years of experience with walk and talk therapy. At the time of the interview Laura was certified eye movement desensitization and reprocessing (EMDR) provider and a member of the California Association of Marriage and Family Therapists (CAMFT). Laura reported that her theoretical orientation is cognitive behavioral therapy (CBT) and person-centered. Laura sees

approximately 25 clients per week. Only four clients have chosen walk and talk therapy in the four years she has offered it.

Mallory. Mallory is a Caucasian female who has a private practice in Texas. She has been a licensed professional counselor (LPC) for eight years and has five years of experience with walk and talk therapy. At the time of the interview Mallory indicated that she was a certified EMDR provider and a member of Texas Counseling Association (TCA). Mallory reported that her theoretical orientation is person-centered. Mallory sees approximately 20 clients per week. Typically four of her 20 weekly clients are walk and talk therapy clients.

Wynona. Wynona is a Caucasian female who has a private practice in Texas. She has masters in counseling and masters in exercise physiology and is working towards licensure for LPC. Wynona reported that she has been in the counseling field for one and half years and has one and half years experience with walk and talk therapy. Wynona is a member of American Counseling Association (ACA) and TCA. Wynona indicated that her theoretical orientation is CBT and rational emotive behavioral therapy (REBT). Wynona sees approximately 20 clients per week and two are walk and talk clients.

Samantha. Samantha is a Caucasian female who has a private practice in Oregon. She has been counseling for three years and has two years experience with walk and talk therapy. Samantha reported that she is a counselor intern and her theoretical orientation is CBT and Systems. Samantha sees approximately 20 clients per week and two are walk and talk therapy clients.

Sally. Sally is a Caucasian female who is primarily an educator and trainer for social workers and teachers in Colorado. She offers therapy on a part time basis. Sally has a master's in social work (MSW) and masters in public administration (MPA). Sally has been a social

worker for 30 years and has 12 years of experience with walk and talk therapy. Sally indicated that she is a continuing education (CE) provider and a member of NASW. Sally stated that her theoretical orientation is a holistic model called “body, mind, heart, and soul model.” Sally sees approximately 10 clients per year and four are walk and talk therapy clients.

Tori. Tori is a Caucasian female who has a part time private practice in Wisconsin. She has a master’s degree in counseling psychology and is working on her dissertation in a PhD psychology program. Tori has been counseling for six years and has six months experience with walk and talk therapy. Tori is an LPC and a nationally certified counselor (NCC). Tori indicated that her theoretical orientation is an eclectic approach. Tori sees 10 clients per week; five are walk and talk therapy clients.

Jamie. Jamie is a Caucasian female who has a private practice in California. She has a master’s degree in counseling and an MFT. Jamie has been counseling for 12 years and has four years experience with walk and talk therapy. Jamie indicated that she is a LMFT and her theoretical orientation is CBT. Jamie sees approximately 20 clients per week and three are walk and talk clients.

Participant demographic data are presented in Table 1 and include the following demographics: (a) sex, (b) ethnicity, (c) education, (d) licensure, (e) years of psychotherapy experience, and (f) walk and talk therapy experience. All 11 participants were Caucasian and had a master’s degree. Ten of eleven participants were female. Eight of eleven participants were licensed in three various disciplines: social work, marriage and family therapy, and counseling. Three were interns working towards their license. Years of experience in the field ranged from 1.5 to 30 years. Walk and talk therapy experience ranged from six months to 12 years.

Table 1

Participant Demographic Data

Name	Sex	Ethnicity	Education	License	Experience	Walk & Talk Experience
Kathy	F	Caucasian	MEd	MFT Intern	3	6 months
Linda	F	Caucasian	MSW	LCSW	15	10
Krystal	F	Caucasian	MSW	LCSW	20	3
Christopher	M	Caucasian	MSW	LCSW	19	7
Laura	F	Caucasian	MA	LMFT	10	4
Mallory	F	Caucasian	MS	LPC	8	5
Wynona	F	Caucasian	MA	LPC Intern	1.5	1.5
Samantha	F	Caucasian	MA	LPC-I, LMFT-I	3	2
Sally	F	Caucasian	MSW	None	30	12
Tori	F	Caucasian	MS	LPC, NCC	6	6 months
Jamie	F	Caucasian	MA	LMFT	12	4

Note. All names are pseudonyms.

Data Collection Methods

In grounded theory, observations, interviews, elicited texts, and extant texts are several ways to gather rich data (Charmaz, 2006). Observations can provide rich data and can be utilized for the participants and setting. Interviews may consist of individual or group single sessions or multiple sessions, depending on the information that emerges throughout the research process (Creswell, 2007). Elicited texts consist of a mailed questionnaire, an Internet survey with open-ended questions or a specific written request by the researcher, whereas extant texts are public records, reports, mass media, and documents (Charmaz, 2006). The type of data collected depends on the topic being explored and access. To study walk and talk therapy, I used observations, interviews, and extant texts.

Observations. Therapists may have many or few choices of settings depending on where they reside and what is available. I observed the setting to learn about what settings are chosen as well as how the settings are chosen by the therapist. Observing the settings provided a greater understanding of the process of walk and talk therapy. Field notes were used to capture the observations.

I observed three sites of walk and talk therapy; only three participants chose the face-to-face method for the interview. The sites I observed were: (a) trails near a river, (b) cement paths in a park near a college, and (c) cement paths adjacent to a lake in a public park. For two face-to-face interviews I met the participants at the settings where they conduct walk and talk therapy. Once we arrived, the participants walked with me and explained their route for walking with the clients and why this location was chosen. We talked about the site as we walked. After walking for approximately 15 minutes, we drove to their office setting and concluded the interview. For one face-to-face interview, we met at the therapist's office then she took me to the setting where she conducted walk and talk therapy. For each setting, observations were captured with field notes taken immediately following the interview.

Interviews. A semi-structured interview protocol with open-ended questions (see Appendix C) was chosen to allow participants the opportunity to provide personal insight about walk and talk therapy. The interview protocol was field-tested within my own peer group, using doctoral-level therapists to examine questions for bias, sequence, clarity, and face-validity. I field tested the interview questions with two doctoral students who had experience walking with clients. To recruit doctoral students with experience walking with clients, I utilized the listserv for the counseling students at the University of New Orleans. I sent an email asking those with experience walking with clients and willing to assist me in my field test to contact me via email for more information. Several students contacted me regarding the field test. To ensure the most accurate field test, I chose the two students who had the most experience walking with clients.

Field-testing the interview instrument provided me with information about: a) the appropriateness of the method to the problem studied, b) administrative convenience, and c) avoidance of ethical or political difficulties in the research process. After completing a field test

of the instrument, I adjusted for a more reliable instrument. The adjustments made were minor such as (a) re-ordering the sequence of the demographic questions for flow of interviewing; (b) adding minor questions such as “how long have you been in the psychotherapy field?” and “what is your theoretical orientation?” and (c) “expanding the last question to ask about the outcomes of walk and talk therapy for the client and the therapist.”

At the beginning of each interview, I thanked participants for their participation, reviewed the consent form, and confirmed permission to be audiotaped. One participant declined audiotaping for no specific reason. Telephone interviews, on average, lasted one hour while face-to-face interviews were two hours on average. More time was spent during face-to-face interviews to ensure adequate time to observe the setting as well as time spent driving to the therapists’ offices. At the end of the interview, I thanked the participants for their time and asked whether they wanted access to the findings of the study upon completion.

If during the interview, a respondent brought up a digression important to the investigation, I followed up with that topic. This technique is called “theoretical sampling” by Corbin and Strauss (2008), whereby researchers become more concerned with new concepts that arise during analysis, and less concerned with asking each participant the same questions. The purpose of theoretical sampling is to collect data from places, people, and events that will maximize opportunities to develop concepts in terms of their properties and dimensions, uncover variations, and identify relationship between concepts (Corbin & Strauss, 2008).

Extant texts. According to Charmaz (2006), extant texts consist of varied documents such as public records, reports, organizational documents, literature, autobiographies, personal correspondence, Internet discussions, and mass media. Furthermore, the researcher does not affect the production of any extant texts. Extant texts are readily available and can be used for

reasons such as background demographic data, spark ideas for theoretical sampling, or provide evidence for hunches.

Webpages contain data related to therapists as well as their walk and talk therapy practice. Access to webpages is public domain and I searched for all therapists with walk and talk therapy webpages during the recruitment phase. All therapists had webpages to analyze as an extant text. Other documents may include marketing flyers, consent forms, and informational handouts that therapists use. To gain access to other documents, I asked each participant upon agreement to participate for pertinent documents such as marketing flyers, consent forms, and informational handouts.

Two therapists supplied documents pertinent to their practice. Wynona and Sally each provided an informed consent and flyer from their walk and talk therapy practices. Analyzing extant texts such as webpages and other documents allowed me another data collection source to gain insights into perspectives, practices, and events related to walk and talk therapy. Additionally, utilizing multiple methods of data collection assisted me in triangulating my findings.

Data Analysis Methods

In grounded theory, the researcher collects and analyzes data simultaneously; data analysis shapes future data collection (Charmaz, 2006). Coding is the link between collecting data and developing an emergent theory to explain these data (Charmaz, 2006, p. 46). Coding is flexible in grounded theory, which allows the researcher to return to the data at any time to make fresh codes.

Grounded theory has three coding phases: initial, focused, and theoretical (Charmaz, 2006). The initial phase entails naming each word, line, or segment of data and the goal is to

remain open to all possible theoretical directions. Focused coding phase utilizes the most frequent or significant initial codes to sort, synthesize, integrate, and organize large amounts of data. Theoretical coding is last and provides theory development. Throughout all coding phases, I utilized the constant comparative approach. Constant comparative method is defined as a method of analysis that generates successively more abstract concepts and theories through inductive processes of comparing data with data, data with category, category with category, and category with concept (Charmaz, 2006, p. 187).

In the remainder of this section, I outline the steps I utilized analyzing the data. Before beginning the process of coding, as suggested by Corbin and Strauss (2008), I read the field notes, extant texts, and transcribed interviews from beginning to end without coding or taking notes. Reading without taking notes or coding allowed me to gain an overall feeling of the data.

Step one. For step one, I initiated the initial coding phase. During initial coding, I examined extant texts (e.g., webpages, documents), interview transcripts, and field notes by utilizing line-by-line coding. Line-by-line coding involves coding each line of written data and allowed me to remain open to the data and see nuances within it (Charmaz, 2006). Charmaz (2006) recommends keeping codes short and simple, and using words and actions of participants. Initial coding assisted me with separating the data into an initial set of categories.

Step two. Focused coding is the next phase in coding which consists of using the most frequent and significant codes from the initial coding phase to synthesize and explain larger segments of data (Charmaz, 2006). In this phase, I made decisions on what initial codes made the most analytic sense to categorize. In focused coding, I utilized constant comparison analysis to compare codes to data as well as codes to codes. I identified themes, subthemes, and related

properties in this coding phase. Themes, subthemes, related properties, and occurrences were represented visually in a diagram as suggested by Charmaz (2006).

Step three. In this final stage, theoretical coding, a framework for practice was generated and research findings were determined. According to Charmaz (2006) theoretical codes specify possible relationships between the categories developed in the focused coding. Furthermore, theoretical codes conceptualize how categories are related which moves the analytic story in a theoretical direction. Once the theoretical scheme was outlined I reviewed my data to refine the theory by filling in gaps and trimming excess (Corbin & Strauss, 2008). I continued to utilize theoretical sampling until saturation occurred. If no new theoretical insights emerge from fresh data, theoretical saturation has been achieved (Charmaz, 2006) and no further data collection and analysis is needed. To accomplish this step, I used two strategies (a) Glaser's theoretical family "Six C's" and (b) theoretical sampling. Glaser's six C's theory of "causes, contexts, contingencies, consequences, covariances, and conditions" was utilized to provide clarity and coherence to the analysis. Theoretical sampling was used to fill in gaps in theory by checking and elaborating properties of focused coding categories as well as specifying relationships among them (Charmaz, 2006). Theoretical sampling was used until no new theoretical insights emerged, which is referred to as "theoretical saturation." Once theoretical saturation was reached, a theory was determined.

Reliability and Validity

Because of the interpretive nature of qualitative research, threats to the reliability and validity of findings exist (Charmaz, 2006). In qualitative studies, reliability refers to the consistency of the research approach to provide reliable findings. Validity is the accuracy of the findings according to the researcher or participant (Creswell, 2009). Procedures to prevent

threats to reliability and validity of findings are utilized in qualitative research. In the remainder of this section, I provide the procedures I utilized to ensure the reliability and validity of my findings.

Reliability. Gibbs (as cited in Creswell, 2009) suggested some procedures to ensure reliability of findings, which I utilized. First, I double-checked all transcriptions for mistakes in transcribing. This step was completed after each initial transcription. Next, I checked all coding for erroneous meanings assigned during the coding process. To check for errors in coding, I utilized the constant comparison method to compare codes to data throughout the entire coding process. Double-checking all transcriptions and coding for mistakes allowed for reliable findings.

Validity. Creswell (2009) recommends multiple strategies to enhance the validity of findings. To increase validity, I utilized strategies suggested by Creswell, which include making biases known and triangulation.

First, I clarified the biases that I brought into the research process. According to Charmaz (2006) researchers are part of what they are studying, not separate from it, and therefore need to check their biases throughout the entire research process. To clarify my biases, I made them known and continued to check them throughout the research process. To check them I utilized bracketing and consulted with my dissertation team, as described earlier. Additionally, I described how the biases affected the interpretation of the findings. Second, I used triangulation to add to the validity of findings. Triangulation consists of using different data sources or different perspectives from participants to justify themes (Creswell, 2009). Themes that emerge from different data sources will enhance validity of findings. Multiple data sources were utilized in this study: participant interviews, extant texts, and observation field notes.

Chapter Summary

The purpose of my qualitative study was to generate a theory for walk and talk therapy to understand its evolution and process. A grounded theory research approach was chosen because a theoretical framework for walk and talk therapy was lacking. Semi-structured interviews were used to allow a deep understanding of the therapists conducting walk and talk therapy. It was necessary to understand the therapists' perspective of walk and talk therapy so a theory could be generated to support the approach. A grounded theory research design approach was used to ultimately provide a theory for walk and talk therapy.

Chapter Four

Research Findings

The purpose of this study was to generate a theory for the walk and talk therapy approach by obtaining the perspectives of the therapists, using a qualitative grounded theory method. Eleven walk and talk therapists were interviewed utilizing the interview protocol (see Appendix C) developed by the researcher for this study. All transcribed interviews, extant texts, and observations were analyzed using the constant comparison analysis of grounded theory design. The research findings gained from the perspectives of walk and talk therapists are reported in this chapter, and include the following: data collection, data analysis, and summary.

Data Collection

Participants were recruited from two sources: (a) a self-generated list formulated from an Internet search, via Google™, of individuals nationwide who provide walk and talk therapy, and (b) a recruitment email sent to the listserv of the Association of Experiential Education (AEE), a professional association dedicated to experiential education and the students, educators, and practitioners who utilize its philosophy. A letter of interest/consent form (see Appendix B) was emailed to both sources; therapists interested in participating in the study were asked to email me directly to schedule an interview. When a mailing address was listed, a letter of interest/consent form (see Appendix B) was mailed in addition to the email.

I generated a list of 27 therapists from the Internet search. One therapist responded from the AEE listserv. Thus, there were 28 potential participants. Initially, I estimated that 8-10 participants would volunteer for this study. I exceeded my estimate; I obtained 11 participants. Of the 28 potential interviews: 11 were interviewed; six therapists responded yes initially, then

never confirmed a date to interview; three therapists never replied; one scheduled then canceled; and seven declined. The therapist who cancelled stated it was no longer a good time to participate. I asked her to reschedule and never received a response. Of the seven therapists who declined: four stated they did not use walk and talk therapy, one was too busy to participate, and two specified no reasons.

After therapists agreed to participate, they were asked to choose an interview method (i.e., face-to-face, telephone or Skype™), date, and time as well as email extant texts to me. Three participants chose face-to-face interviews, eight selected telephone, and none opted for Skype™. Telephone interviews lasted one hour on average, while face-to-face interviews were approximately two hours long. Face-to-face interviews were longer since additional time was allocated to observe the setting. Three settings were observed during three face-to-face interviews.

Extant texts consisted of participant webpages and other documents (i.e., informed consent forms, flyers) participants offered. All 11 participants had webpages but only two therapists supplied other documents. Other documents supplied from participants included four documents: two informed consents documents and two flyers. Thus, data consisted of 11 transcribed interviews, 11 extant texts (webpages), four extant texts (informed consent forms and flyers), and three setting observations. In the remainder of this subsection, participant interviews, extant texts, and observations are summarized. Participant interviews are separated by participant names. All names are pseudonyms to protect the identity of participants.

Kathy. Kathy responded to the first recruitment email. She preferred telephone as the method; the interview was scheduled for May 3, 2011 at 3:00 pm. When I called Kathy, she greeted me warmly and seemed enthusiastic about participating in the study. Before beginning

the interview questions, I thanked Kathy for participating in my study. Then, I read the informed consent, asked for permission to audiotape, and reviewed housekeeping issues (e.g., if the volume of the call was too low, and if we were disconnected, I would call back). Kathy verbally agreed to being audiotaped and reconfirmed her willingness to participate in the study.

Kathy spoke very openly about her perceptions of walk and talk therapy such as why she believed it emerged, how she learned of it, and details pertaining to how it was conducted. Kathy shared her passion for walk and talk therapy and alternative methods in general. She seemed to believe in the value of giving clients options beyond traditional talk therapy. I experienced Kathy as quite talkative; our interview lasted approximately one hour. After the interview concluded, I again thanked Kathy for participating and giving her time to my study. Kathy replied that she was happy to contribute and was looking forward to receiving the findings once completed. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Linda. Linda was the only participant who responded from the recruitment email on the Association of Experiential Education (AEE) listserv. It is possible that not many people on the AEE listserv utilize walk and talk therapy. At the time the recruitment was posted, there were 303 members. Linda responded to the second recruitment email and indicated that she preferred a telephone interview. A date/time was quickly scheduled for May 9, 2011 at 8:30 am. I called Linda promptly at 8:30 am and she greeted me with a warm hello. Before beginning with interview questions, I thanked Linda for participating in my study. Then, I read over the informed consent, asked for permission to audiotape, and reviewed housekeeping issues (e.g., if the volume of the call was too low, and if we were disconnected, I would call back). Linda verbally agreed to being audiotaped and reconfirmed her willingness to participate in the study.

Linda spoke very openly about her perceptions of walk and talk therapy such as why she believed it emerged, how she learned of it, and details pertaining to how it was conducted. Linda had many positive remarks about walk and talk therapy. Linda reported that she used it “as needed” with clients because it made sense to use it with clients who seem stuck. She further indicated that it was not always appropriate for certain clients or certain issues. After 45 minutes, the interview concluded, I again thanked Linda for participating and giving her time to my study. Linda replied that she was happy to contribute and was looking forward to receiving the findings once completed. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Krystal. Krystal responded to the second recruitment email. Krystal preferred a telephone interview; a telephone interview was scheduled for May 9 at 9:00 pm. I called Krystal at 9:00 pm and she greeted me on the phone with a warm voice, yet she seemed preoccupied. It was late in the evening and I could hear background noises. First, I thanked Krystal for agreeing to contribute to my study. Then, I read the consent form, asked for permission to audiotape and reviewed housekeeping issues (e.g., if the volume of the call was too low, and if we were disconnected, I would call back). Krystal verbally declined being audiotaped; she was the only participant who declined being audiotaped. Krystal indicated that she preferred not to be recorded for personal reasons. I assured her that I would not audiotape the phone call and turned off the recorder. Then, she reconfirmed her willingness to participate in the study. During the interview, Krystal spoke very quickly as I took notes on each question. Krystal seemed to be in a rush but was warm and enthusiastic about the research on walk and talk therapy. Krystal shared her perspectives on walk and talk therapy such as what it meant to her, how it emerged, and the benefits and limitations. At the end of the interview, 40 minutes later, I thanked Krystal for her

time. She replied thankfully as well for the opportunity to talk about one of her passions. She stated that she looked forward to seeing the findings and wished me luck. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Christopher. Christopher responded to the third recruitment email. He apologized for taking so long to return my email. I assured him it was no problem and we quickly arranged a telephone interview for May 19, 2011 at 10:30 am. I called him at 10:30 am and was greeted with a very energetic person who seemed excited to speak to me about walk and talk therapy. First, I thanked Christopher for participating in the study. Then, I read the consent form, asked for permission to audiotape, and reviewed housekeeping issues (e.g., if the volume of the call was too low, and if we were disconnected, I would call back). Christopher verbally agreed to being audiotaped and reconfirmed his willingness to participate in the study.

Christopher shared his perspectives on walk and talk therapy and how he and his wife came up with the idea. Christopher reflected on the memory of a client who inspired him to adjust his method to fit his client's needs. The client worked in a very demanding job and was struggling to find time to meet Christopher for therapy sessions. Christopher indicated that his wife suggested he meet the client on his lunch break at a convenient location. Christopher stated, that he first thought, "this cannot be accomplished." Then he decided, "why not?" I enjoyed listening to Christopher share his views on walk and talk therapy. After an hour, the interview concluded and I thanked him for participating. Christopher replied that he was pleased someone was doing research on the topic and he looked forward to receiving the findings once completed. A few days after the interview, I followed up with an email expressing my gratitude for his contribution to the study (see Appendix D).

Laura. Laura responded to the first recruitment email. Laura preferred a telephone interview and we agreed on May 24, 2011 at 3:15 pm. I called Laura and she answered the phone with a friendly hello. First, I asked her if it was still a good time for the interview; she replied “yes.” I thanked Laura for participating in the study. Then, I read the consent form, asked permission to audiotape, and reviewed housekeeping issues (e. g., if the volume of the call was too low, and if we were disconnected, I would call back). Laura verbally agreed to being audiotaped and reconfirmed her willingness to participate in the study.

Laura shared her perspectives on what walk and talk therapy was to her, how it emerged, and specifics on the benefits. Laura seemed happy to share information that she had learned about walk and talk therapy. Laura referred to exercise many times during the interview and how walk and talk therapy kills two birds with one stone. After 35 minutes, the interview concluded and I thanked Laura again for participating in my study. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Mallory. Mallory responded to the first recruitment email and chose the face-to-face method for the interview. As this method entailed more planning, we tentatively scheduled mid-June. I suggested contacting her in mid-May to arrange a date/time for the interview. She agreed to this suggestion. In mid-May, I emailed Mallory to schedule the date/time for the face-to-face interview and after a few email exchanges, we agreed upon June 16, 2011 at 9:00 am. After the date was scheduled we exchanged a few more emails to determine a meeting place, directions, and contact information. Mallory suggested that we meet at her office and then go to the trails where she did walk and talk therapy after the interview concluded. I agreed with this plan.

On June 16, 2011, I arrived at Mallory's office at 9:00 am. I waited in the lobby of a house turned into office spaces. Mallory greeted me with a warm smile and stated she was happy for me to be there. Then, she led me into her office where the interview would take place. I thanked Mallory for participating in my study and gave her a small token of appreciation, a can of local coffee from New Orleans. I chose to give a can of local coffee to those participants who met with me face-to-face because more time and effort was taken to accommodate the interview. Then, I read the consent form and asked permission to audiotape. Mallory verbally agreed to being audiotaped and reconfirmed her willingness to participate.

Mallory shared her perspectives on walk and talk therapy. Mallory was very talkative but was able to get to the point. Mallory reported that she concentrated on what was best for the client. She indicated that because exercise and the outdoors had positive impacts on clients, using it was a viable method. After an hour, we finished the interview questions. Mallory suggested that she drive to the trails and I follow in my car as she was meeting another client for a session at a coffee shop. Upon arrival, she oriented me to the park and trails where she walked with clients. Then, I thanked her again for participating in my study and she left. I walked on the trails for 15 minutes afterwards and observed the setting of the trails, sights of the adjacent river, and sounds of the outdoors environment. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Wynona. Wynona responded to the first recruitment email and chose the face-to-face method for the interview. As this method entailed more planning we tentatively scheduled mid-June. Wynona suggested that she contact me in mid-May to arrange a date/time for the interview. In mid-May, Wynona emailed with June 17, 2011 at 1:00 pm as a suggested date/time. I confirmed and we exchanged a few more emails to determine a meeting place,

directions, and contact information. Wynona suggested we meet at the path she utilized for walk and talk therapy. The path was located at a local college close to her office. She recommended we walk on the path and return to her office to conclude the interview.

On June 17, 2011 I arrived at the college and Wynona was there to greet me with a big smile. Wynona expressed her excitement that I was researching this topic. Then, we walked together on the path. She described typical walk and talk sessions and I observed the setting. Because it was very hot, after 15 minutes we left the park for Wynona's office to conclude the interview. Once settled in the office, I thanked her for participating in my study and gave her a small token of appreciation, a can of New Orleans coffee. I chose to give a can of local coffee to those participants who met with me face-to-face as more time and effort was taken to accommodate the interview. Then, I read the consent form and asked permission to audiotape. Wynona verbally agreed to being audiotaped and reconfirmed her willingness to participate in the study.

Wynona shared her perspectives on walk and talk therapy. Wynona seemed very clear about her perspective on walk and talk therapy. She reported that she had a background in exercise physiology and knew the benefits of exercise. She stated many times that there were many benefits of walking with therapy. After the end of the interview, I again thanked Wynona for participating in the study. Wynona replied that she was excited to be a part of this important research and she looked forward to receiving the findings. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Samantha. Samantha responded to the second recruitment email and indicated that she preferred a telephone interview. After a couple of email exchanges we agreed on June 21, 2011 at 1:00 pm for the interview. When I called, she answered the phone right away and sounded pleased to be speaking with me. I asked her if it was still a good time to talk and she said “yes.” Then, I thanked her for participating in the study and read the consent form, asked permission to audiotape, and reviewed housekeeping issues (e.g., if the volume of the call was too low, and if we were disconnected, I would call back). Samantha verbally agreed to being audiotaped and reconfirmed her willingness to participate in the study.

Samantha shared her perspectives on what walk and talk therapy was to her, how it emerged, and specifics on the benefits. Samantha reported that she had been doing it only for a short time but really enjoyed it. Samantha seemed very calm and at ease as we talked about the topic. About 40 minutes later, the interview questions were answered, and I thanked Samantha again for her time. Samantha thanked me for doing this research and asked for the findings once completed. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Sally. Sally responded to the first recruitment email indicating she preferred a face-to-face interview. We exchanged many emails to arrange the interview date/time. Sally suggested late June, so I proposed June 24, 2011 at 3:00 pm. After the interview was confirmed, we exchanged a few more emails to determine a meeting place, directions, and contact information. Sally recommending meeting at a park located centrally in Colorado where she conducted walk and talk therapy then drive to a nearby coffee shop to conduct the interview.

On June 24, 2011 I arrived at the park at 3:00 pm. We agreed to meet at the main entrance of Washington Park and Sally was there to greet me with a big smile on her face. Sally suggested that it was so hot, we ride together to a nearby coffee shop to conduct the interview then return to the park to observe the setting. Once at the coffee shop, she purchased a cup of tea for each of us. We sat at a table with few seated nearby. Once settled at the table, I thanked her for participating in my study and gave her a small token of appreciation, a can of coffee from New Orleans. I chose to give a can of local coffee to those participants who met with me face-to-face as more time and effort was taken to accommodate the interview. Then, I read the consent form and asked permission to audiotape. Sally verbally agreed to being audiotaped and reconfirmed her willingness to participate in the study.

Sally shared her perspectives on walk and talk therapy. Sally was very talkative, contemplative, and often veered off topic to tell stories of her experiences – which I welcomed. I was pleased that Sally was enthusiastic about the research and willing to contribute. Once the interview questions concluded, we drove back to the park and Sally led me to the path where she walks with clients. As we walked she talked about a typical session on this particular path. I observed my surroundings as we walked and talked. While walking, I observed a small lake adjacent to the walking path, many animals, trees, and people walking or biking in the park. After walking for 15 minutes, we concluded the interview and I again thanked Sally for participating. Sally replied that she was happy to be a part of the study and it helped her conceptualize what walk and talk therapy meant to her and her practice. She thanked me and stated that she looked forward to receiving the findings. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Tori. Tori responded to the first recruitment email and asked that I contact her again in mid-June to arrange an interview. When I emailed her in mid-June we scheduled a telephone interview for June 28, 2011 at 8:30 pm. On the day of the interview, I called her at 8:30 pm and someone else answered the phone. When she picked up, she sounded surprised to hear from me, so I asked if she still had time for the interview. She replied “yes,” and I thanked her for participating in the study. Then, I read the consent form, asked permission to audiotape, and reviewed housekeeping issues (e.g., if the volume of the call was too low, and if we were disconnected, I would call back). Tori verbally agreed to being audiotaped and reconfirmed her willingness to participate in the study. Tori shared with me that she was working on her dissertation as well so she wanted to contribute to my dissertation.

Tori shared her perspectives on what walk and talk therapy was to her, how it emerged, and specifics on the benefits. Tori reported that she had been using the method for only a short time but she sounded pleased with the results to date. Once the interview questions were answered, 35 minutes later, I thanked Tori again for her time. Tori thanked me for doing this research and asked for the findings once completed. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Jamie. Jamie responded to the first recruitment email and preferred a telephone interview. After agreeing on the method, I did not hear from Jamie for two months. In July, Jamie emailed me and stated she had been busy but wanted to arrange an interview for August 1, 2011 at 5:30 pm. On the day of the interview, I called her at 5:30 pm and she answered the phone with an enthusiastic tone. She quickly shared that she was excited to speak to me about my study and would like the findings when completed. I thanked her for participating in the study. Then, I read the consent form, asked permission to audiotape, and reviewed housekeeping

issues (e.g., if the volume of the call was too low, and if we were disconnected, I would call back). Jamie verbally agreed to being audiotaped and reconfirmed her willingness to participate in the study.

Jamie shared her perspectives on what walk and talk therapy was to her, how it emerged, and specifics on the benefits. Jamie reported that she was a firm believer in the benefits of exercise on mental health. Jamie and I spoke for about 35 minutes and she had to end the conversation before all questions were answered, although we covered much without following the protocol. Before we hung up, I thanked Jamie again for her time. A few days after the interview, I followed up with an email expressing my gratitude for her contribution to the study (see Appendix D).

Extant texts. Two types of extant texts were used in this study: participant webpages and documents. All eleven participants had webpages with information related to their practice. Participants webpages were similar to those of individuals with traditional therapeutic practices. Webpages consisted of information related to the therapists, their views on therapy, therapy methods offered (e.g., traditional office sessions, walk and talk therapy sessions, EMDR), policy information such as pay scale and insurance, and frequently asked questions. The only difference from traditional therapy webpages was information on walk and talk therapy. Information regarding walk and talk therapy included descriptions of the approach, how the procedure worked, limits of confidentiality, weather concerns, and what to expect during a session.

Only two participants, Wynona and Sally, provided extant text documents. Each provided me with a consent form and flyer about her practice. Thus, four extant documents were obtained. Wynona gave them to me in person whereas Sally emailed them to me after I

requested them. Both Wynona's and Sally's consent forms were similar to consent forms used in traditional therapy, with additional information on walk and talk therapy. Wynona's informed consent document outlined the benefits of physical activity as well as the risks. The focus of Wynona's consent form was client understanding that the therapist was not liable for any potential risks of physical activity. Sally's informed consent form contained information on her practice, expertise, confidentiality limits, liability concerns, scheduling, and fees. Sally's consent form was similar to a declaration of practices.

Wynona and Sally each gave me a flyer about walk and talk therapy, in addition to the consent forms. Wynona's flyer had frequently asked questions (FAQ) related to her sessions such as where to meet, what to wear, consulting with physician before beginning, weather concerns, and confidentiality risks. Additionally, the flyer included a map with detailed directions to the setting and the therapist's contact information. Wynona's flyer was focused on what clients could expect from the session; she gave them to clients prior to their first walking session. Sally's flyer contained information about what walk and talk therapy was, who could participate, and what types of problems or issues could be worked on during sessions. Additionally, it had a picture of a tree and walking path as well as the therapist's contact information. Sally's flyer was geared toward marketing for her walk and talk therapy practice.

Observations. I observed three settings of walk and talk therapy. Three of eleven interviews were face-to-face. Two settings were in Texas and the third was in Colorado. All the face-to-face therapists introduced me to location and walking path where they conducted walk and talk therapy. I walked with two of three therapists on the walking path for approximately 15 minutes each. The third therapist had an appointment but led me to the location so that I could walk there.

All three settings were observed in June 2011. The weather was extremely warm and it was challenging to walk for a long period of time. Each therapist who walked with me suggested leaving the path after 15 minutes due to the extreme heat. While walking on all three paths, I observed the ease of talking with the therapist, the physical exertion, the weather, and nature.

While walking with two of three therapists, I felt an ease in talking with them. It may have been because they were interested in my study and I was interested in their practice, but there was ease to walking and talking. There was light physical exertion in walking, even for the short period of time. I felt some warmth in my muscles and soreness in my feet. The weather was very noticeable. It was extremely warm and the sun was very strong while I walked at all three settings. At moments I felt a reprieve from the sun in the shaded areas. I experienced the beauty of nature with all my senses. There was much to observe visually - leaves swaying in the wind; water rippling in the lake, river, or stream; wildlife and pets; flowers; children playing; people walking or jogging. I heard many sounds: birds singing; leaves swaying in the wind; water rippling in the lake, river, or stream; children playing, people walking or jogging; and traffic. Additionally, I smelled many scents while walking such as the scent of flowers and grass.

Although each setting was slightly different, I observed many of the same things at all three settings. Mallory's setting was a local community park surrounding a river and included a dirt/gravel trail for the walking path. It was quite large and there were many routes to my understanding. Mallory was unable to walk with me, but she steered me in the right direction and I walked for approximately 15 minutes. There were plenty of trees, wildlife, and people in the area. Wynona's setting was at a local college park and included a narrow stream with a cement walking path that meandered adjacent to the stream. It had many trees for shade throughout the

route. There were wildlife and many flowers to observe while walking. Sally's setting was at a local community park with a cement walking path surrounding a lake. There were many trees for shade as well as wildlife and people walking around. Each setting had some form of water (e.g., lake, river, stream), walking path (cement, gravel, dirt), trees, wildlife, and people.

In sum, 11 participant interviews were conducted. Mallory, Wynona, and Sally were interviewed face-to-face and the remaining eight were interviewed via telephone. All interviews, excluding Krystal's, were audiotaped. All participants had webpages, which were included as extant texts. Wynona and Sally supplied extant texts including informed consent and flyers. Additionally, I documented my observations of the three settings I visited in my field notes. Therefore, data consisted of transcribed interviews, extant texts, and observation field notes.

Data Analysis

In grounded theory, data analysis and data collection occur simultaneously (Charmaz, 2006). Thus, data analysis began after the first interview and continued throughout data collection. Each interview was transcribed verbatim into a Microsoft Word™ document. As extant texts (11 therapist webpages, two informed consent forms, and 2 flyers) were obtained, I copied and pasted the content into Microsoft Word™ documents. After each setting was observed, I typed field notes on Microsoft Word™ documents. Once all data were organized, I read all transcribed interviews, extant texts, and field notes from beginning to end without coding or taking notes, as suggested by Corbin and Strauss (2008), to gain an overall feeling of the data. Then the remainder of the data analysis included three coding phases: initial coding, focused coding, and theoretical coding.

Initial coding. Initial coding was the first step of data analysis in which line-by-line coding was utilized to help establish an initial set of categories. Line-by-line coding entailed

creating a code for each line of written data including all transcribed interviews, extant texts, and field notes. In accordance with procedures suggested by Charmaz (2006), I coded each written line with short, simple action words. As a result of initial coding, the data were separated into an initial set of categories.

The initial set of categories represents the most frequent codes from line-by-line coding of transcribed interviews, extant texts and observation field notes. Categories embody participant perceptions about: (a) what defines walk and talk therapy, (b) how walk and talk therapy evolved, (c) what motivated him or her to utilize walk and talk therapy, (d) limitations of walk and talk therapy, and (e) outcomes and benefits of walk and talk therapy. Initial categories are presented in Table 2 in no particular order of importance or hierarchy.

Table 2

Initial Coding Results

Initial Categories	
Meet at location	Trauma clients are not good fit
Path is important	Running into people you know
Traditional therapy techniques	Safety of client is concern
Client leads pace	Anxiety & depression lowered
Need alternative methods	Wish could do it more
Disconnect from nature	Couples counseling always in office
Interest in self-care	Clients choose to walk
Burnout is a concern	Rapport is built when walking
No support in field	Younger people thinking outside box
Confidentiality has not been issue	Less threatening
Weather is limitation	Client is an active participant
Use consent forms for limitations	Creates responsibility for client
Body awareness is enhanced	May run into someone know
Get to issues faster	Few paths for variety
Less eye contact helps clients open up	Changes happen faster
Clients get unstuck	Physically tiring
Some clients uncomfortable in office	EMDR
Emerged from need	Movement helps move therapy along
Physical limitations may be issue	Exercise is important to me
Personal love for walking	Positive feedback from clients tried it

Table Continued

Initial Coding Results

Initial Categories	
Exercise physiology background	Walking side by side with no eye contact
Combination of physical and mental therapy	Meet clients at office then walk
Walking reduces stress	Release form for safety
Walking promotes better sleep	Screen clients before walking
Walk and talk is efficient	Thought I made it up
Similar to traditional therapy	Well being of therapist
First session at office for intake	Privacy issue is not an issue
As needed	Difficult to go deeper in public
Learned from others doing it	Therapist role is same as traditional therapy
Acceptance for innovative methods	Feel better immediately
Studies related to mind body connection	Eastern concepts coming to America
Studies on benefits of exercise	Helps ground clients with nature
Studies on benefits of nature	Outward bound programs
Nation is sedentary	Match client pace
Promotes physical activity	Love of nature motivated me
Flexibility is important for therapist	Desire to be creative
Easy path to walk	Emerged from nature deficit
Plenty of shade on path	Emerged from disconnect of mind and body
Relaxing atmosphere on path	Meet in café or office for bad weather
Client may develop habit of walking	May see someone they know
Therapist gains health benefits	Safe path and park
Get out of office	Monitor safety outside for client while
Assessment is enhanced	Park was convenient to locate
Teach client healthy coping skill	Beauty of the lake
No training for walk and talk	Benefits of physical activity
Hard to get clients	Saw other therapists were doing it
Harder to get to core affect	Stress reliever for therapist
Clients open up faster	Builds rapport fast with therapist
Wrap up is challenging	Improved mood for therapist and client
Learned about it from NYC therapist	Feels more casual
Movement helps processing	Creates therapeutic relationship
Insights come faster	Misconceptions about it
Less intimate than office	Difficult finding supervision
Harder to conceptualize while walking	Trails by river
Researched the topic	

The initial set of categories is broad categories determined by line-by-line coding. Categories represent the responses of participants as well as data from extant texts and observation field notes. Many categories were related to therapists and clients who participate in walk and talk therapy. The setting of walk and talk therapy was a common category, specifically the location (e.g., park, walking path) and characteristics of the walking path. Nature and physical activity were frequent codes; the benefits of being in nature as well as physical activity more specifically. Limitations and outcomes of walk and talk therapy were recurrent codes. Limitations dealt with clients, procedures, and variables outside the participants' control. Client outcomes, therapist outcomes, and general outcomes of the approach were frequent codes as well. In the following section, the initial set of categories was utilized to establish main themes for walk and talk therapy.

Focused coding. Focused coding consisted of using the most frequent and significant codes from the initial coding phase to synthesize and explain larger segments of data (Charmaz, 2006). To accomplish this step of data analysis, I utilized constant comparison analysis to compare categories to data as well as categories to codes. I determined the following themes in this focused coding phase: (a) Definition, (b) Evolution, (c) Limitations, and (d) Outcomes. In Table 3, themes, subthemes, properties, occurrences are presented. Subthemes help illustrate the boundaries of the themes while properties explicate the subthemes. Occurrence refers to the number of times the property emerged.

Table 3

Themes of Walk and Talk Therapy

Theme	Subthemes	Properties	Occurrences
Definition	Characteristics	Setting	10 of 11
		Roles	9 of 11
		Interventions	9 of 11
		Central components	7 of 11
	Procedure	Session length	10 of 11
		Intake	9 of 11
		Meeting place	9 of 11
		Frequency of usage	7 of 11
Evolution	As an approach	Research	8 of 11
		Need for options	6 of 11
		Physical activity	6 of 11
		Nature	3 of 11
	In therapists' practices	Personal experience	7 of 11
		Other therapists	6 of 11
		Desire to get out of office	4 of 11
		Need for options	3 of 11
Limitations	General	Attaining clientele	6 of 11
		Lack of support	6 of 11
		Populations	4 of 11
	In session	Weather	9 of 11
		Confidentiality	7 of 11
		Safety	5 of 11
		Conceptualization	3 of 11
	Outcomes	Therapeutic benefits	Get to issues faster
Therapeutic relationship			5 of 11
Process differently			5 of 11
Assessment expanded			3 of 11
Client & Therapist benefits		Physical activity benefits	10 of 11
		Self-care	9 of 11
		Mental health benefits	8 of 11
		Nature benefits	4 of 11

Definition. The first theme, Definition, refers to ways in which participants described walk and talk therapy. A definition is important to understand how therapists perceive walk and talk therapy. Two subthemes emerged: (a) characteristics and (b) procedure. The subtheme “characteristics” entailed descriptions that distinguish walk and talk therapy from other therapies.

The subtheme “procedure” consisted of data that explicate how walk and talk therapy is conducted. Each subtheme is examined separately.

Characteristics. The first subtheme “characteristics” represented a description of walk and talk therapy. Walk and talk therapy was depicted in a variety of ways, but each included “walking, nature, and/or therapy.” Some participants compared it to traditional therapy. Kathy responded, “*It’s the same thing as if you were sitting in an office but we get out in fresh air and nature*” and Christopher replied similarly, “*Traditional counseling but the only thing different is that we will be walking instead of sitting in an office.*” Other participants described how it is conducted, such as Wynona who stated, “*It involves walking side-by-side outdoors while discussing life’s issues.*” From participant responses, walk and talk therapy can best be described as traditional therapy conducted while walking outdoors. Properties established for this subtheme are: (a) setting, (b) roles, (c) interventions, and (d) central components.

“Setting” was the most common property of this subtheme. The setting is combined of a location and walking path. Participants identified various locations such as a public park, forest, mountain, college, or downtown area. Walking path refers to the surface the therapist and client are walking on, which has different traits. Traits include width, surface (e.g., cement, gravel, grass), proximity to river or lakes. Participants compared the setting of walk and talk therapy to traditional therapy settings. Tori stated, “*It is more comfortable and relaxing than being in an office.*” Wynona commented about the location of walk and talk therapy. She reported, “*Finding a safe, reliable location that provides adequate and safe parking is important*” and “*I have two parks that are convenient and safe.*” Other participants focused on the amount of paths they used. Sally stated, “*There are three paths that I use. I give them the choices and let them*

choose.” Overall, the setting is comprised of a location and walking path. There may a variety of locations and paths to utilize but all are chosen for their convenience and safety.

“Roles” and “Interventions” were the second most frequent properties, each with nine of eleven occurrences. Participants compared therapist and client roles in walk and talk therapy to roles in traditional therapy. It was clear that clients have the same role in walk and talk therapy as in traditional therapy. However, therapists had one additional role. Sally stated, *“Therapists have a basic safety role – to monitor where we are and if cars are coming up. I have also monitored for health concerns.”* Similarly, Wynona responded, *“Therapists monitor the physical symptoms of the client such as shortness of breath, limping, is that pace too slow or fast.”* Client roles were determined as no different from traditional therapy roles. Linda shared, *“Clients are to participate in the process and be motivated for therapy”* and Christopher added, *“It really is not different from traditional therapy.”*

“Interventions” was the next property and nine of eleven participants responded similarly regarding therapeutic interventions utilized in walk and talk therapy. Kathy indicated, *“Interventions are the same as traditional therapy, I don’t use anything specific to walk and talk therapy.”* Christopher and Linda stated, *“It is the same as traditional therapy.”* Therefore, client and therapist roles are the same as in traditional therapy; however, therapists have an additional role of monitoring and guiding clients while walking. Therapeutic interventions are the same as in traditional therapy; the most commonly used therapeutic interventions were grounded in cognitive behavior therapy, person-centered therapy, and solution-focused therapy.

The next property, “central components,” included: physical activity, nature, and casualness of the approach. Participants’ responses included Samantha’s, *“Physical exercise, being in nature and fresh air”* and Mallory’s, *“Movement and the sensory component of feeling*

the sun, watching the river.” Participants reflected on ways walk and talk therapy stands out from other therapies. Responses included comments about casualness, eye contact, familiarity of walking, and less threatening. Eye contact in walk and talk therapy is minimal compared to traditional talk therapy. In walk and talk therapy, therapist and client are walking side by side with eyes generally focused forward. In traditional therapy, therapist and client are facing one another, thus, eye contact is more frequent. Christopher responded, *“We make eye contact every once in a while, but generally our eyes are focused forward, so it is less threatening.”*

Familiarity of walking side by side with someone contributes to the casualness of the approach according to therapists. Mallory stated, *“There is something about walking with someone that is less threatening.”* Therapists indicated that walk and talk therapy sessions seem less intimidating because walking while talking feels like a familiar experience of walking with a friend as Sally stated, *“It is a familiar feeling because most of us have walked with friends before.”* Thus, the central components of walk and talk therapy are physical activity, nature, and casualness.

Procedure. The second subtheme, “procedure,” represented how walk and talk therapy is conducted. Properties of this subtheme included: (a) session length, (b) intake, (c) meeting place, and (d) frequency of usage. Session length was most frequently cited by ten occurrences; however, intake and meeting place were similar with nine occurrences. “Session length” was most frequently coded and described the length of walk and talk therapy sessions. According to 10 of 11 participants, the length of sessions is 50 minutes. Linda was the only participant who walked for 20 minutes to ensure time to screen clients each session. Linda stated, *“I do a mini-assessment at the beginning of each session to see if sitting or walking is best for them that day.”* All other participants walked for the entire length of the session, 50 minutes.

“Intake” was the next property of this subtheme. According to participants, the intake session was similar to traditional therapy in that the first session was an intake session. The purpose of an intake session is to gather information from the client, offer information to the client about the therapist and his or her practice, and obtain signatures on consent forms. One additional purpose of intake sessions in walk and talk therapy is to screen clients as a safety precaution. Screening clients referred to assessing whether the client is safe to meet with outdoors in public; therapists assess violent behavior and/or legal history that would prevent them from feeling safe outside the office. For example, Christopher replied, *“Meeting with the client at the office first before meeting in the park is good as a precaution,”* and Laura responded similarly, *“I have always met people at my office first to make sure they are a safe person to walk with.”* Thus, utilizing the first session as an intake session is similar to traditional therapy with the additional task of screening the clients as a safety precaution before walking with them.

“Meeting place” was another typical response with nine occurrences. According to participants, the meeting place depends on the location of the walking path. If the walking path is close to the office, then therapists meet the client at the office each time and walk from the office. Linda indicated, *“We just go outside my office and walk.”* If a walking path is not near the office, an agreed upon location is determined beforehand and they meet there for the session. For example, Kathy shared, *“We meet for 50 minutes at an agreed upon location, I have two parks I utilize.”* Some participants have done both such as Samantha, who commented, *“Typically, I meet clients in an office then we hit the streets and go walk. I have a few clients where we have met at walking trails in our area.”* Therapists either meet clients at the office or an agreed upon location for walk and talk therapy sessions.

“Frequency of usage” was the last property of this subtheme with seven occurrences. The frequency of usage was determined by many factors such as the therapists’ preference, the weather, and client’s needs. Two of eleven participants indicated their practice had walk and talk sessions only. The remaining nine indicated that their practice was primarily office sessions with a small portion of walk and talk therapy clients. Additionally, participants indicated how the weather had an effect on walk and talk sessions. According to Wynona, “*Clients don’t want to do walk and talk therapy when the weather is this hot.*” Participants commented on how walk and talk sessions are tailored to client needs. For example, Jamie and Linda shared how they utilize walk and talk therapy as needed. Jamie stated, “*It is used as needed*” and Linda indicated, “*I do a mini assessment in the beginning of the session to see if sitting or walking is best for them that day.*” Additionally, some participants such as Wynona commented on how the office is appropriate at times depending on the issues brought in by the client. Wynona reported, “*There may be instances when meeting in an office may be more appropriate for certain issues.*” Overall, walk and talk therapy can be utilized exclusively but more than likely it is used as needed, as there are many factors such as weather or sensitive client issues that contribute to the frequency of usage. For inclement weather, clients are given the choice to walk or have an office session. If the therapists perceive a client issue is too sensitive for outdoors, an office session may be recommended until further notice. It is up to the therapist to make the decision. For example, sensitive issues could be related to death, trauma, or issues for which being in public may deter client participation in therapy sessions.

Evolution. The researcher asked participants why walk and talk therapy emerged and what motivated them to utilize it. Two subthemes emerged: (a) as an approach, and (b) in therapists’ practices. The subtheme “as an approach” consisted of perceptions explaining why

walk and talk therapy evolved into an approach. “In therapists’ practices” is the second subtheme, which explicated why therapists use walk and talk therapy in their practices. Each subtheme will be examined separately.

As an approach. Participants reflected on why they believed walk and talk therapy emerged as an approach. They were asked, “How did you learn about walk and talk therapy?” and “Describe why you think walk and talk therapy emerged.” Participant responses determined these properties: (a) research, (b) need for options, (c) physical activity, and (d) nature.

“Research” was the most common property of this subtheme, which included eight occurrences. Many therapists believed that walk and talk therapy evolved from an influence of research such as EMDR, recreation therapy, Buddhism, benefits of exercise, and consequences of inactivity. Mallory stated, *“In the same reason that experiential therapies work, I think it gets you out of the left brain such as EMDR.”* Tori agreed, *“The only thing I linked it to was EMDR and recreation therapy.”* Sally agreed with Tori, *“I do think that the youth at risk programs contributed such as outward bound.”* Samantha stated, *“I don’t know, I wonder if it is the new kind of Eastern concepts that are coming into America in terms of yoga, meditation, and all concepts that are very Buddhist.”* Wynona believed research on exercise was a factor. She stated, *“Research on the effects of physical activity have been conducted by the American College of Sports Medicine, Cooper Clinic in Dallas, and the American Council on Exercise.”* Research on the effects of inactivity such as the rise of obesity and increase of sedentary behavior in our society had an influence on the evolution of walk and talk therapy, according to Kathy and Wynona. Kathy shared, *“In my opinion, with obesity issues in America, combining and understanding the connection with the mind and body is vital.”* Wynona added, *“Our nation*

is primarily sedentary and many claim they have not time to exercise.” In summary, many areas of research influenced the evolution of walk and talk therapy as an approach.

“Need for options” was the next most common property of this subtheme. Participant responses indicated walk and talk therapy evolved as an approach because there is a need for options other than traditional therapy. Kathy stated, *“Not all clients benefit from a traditional psychotherapy model.”* Linda reported, *“I would guess it emerged because of the need to move or have a change of scenery or perspective.”* Jamie stated, *“A need for something different.”* Mallory shared, *“Providing other options than traditional therapy is good.* Moreover, some participants believed that the younger therapists in the profession have influenced the evolution of walk and talk therapy. Christopher stated, *“I think that as this profession has more young people that are looking at this from outside the box. They are pushing boundaries of what can be done with talk therapy such as Skype™, Internet, and the outdoors.”* Additionally, Wynona commented on greater acceptance with, *“There is a greater acceptance for innovative ways to provide counseling and coaching.”* Participants believed there is a need to offer options other than traditional therapy. Furthermore, younger professionals are credited with pushing the boundaries of therapy to include alternative options, and the field is more accepting of new methods.

“Physical activity” was the next property of this subtheme. Physical activity has well-known mental and physical health benefits. According to participants, knowledge of these benefits is one reason walk and talk therapy evolved as an approach. According to Laura, *“I think that people can only get so much better with talk therapy alone. I think physical movement is needed which people do not do on their own.”* Wynona offered, *“Numerous studies show the positive benefits of exercise and how it impacts symptoms of depression and mental illness.”* Tori

stated, *“I think you know the research is out there on physical activity and I think people know it is beneficial to get people moving.”* The benefits of physical activity are an important part of walk and talk therapy and are considered one reason it evolved into an approach.

“Nature” is the last property of this subtheme. According to participants, the lack of nature exposure as well as the knowledge of the benefits of nature are two reasons walk and talk therapy evolved as an approach. Sally indicated, *“I think there is an epidemic of nature deficit.”* Wynona shared, *“Research shows there are healing benefits of being in nature.”* The benefits of nature are an important part of walk and talk therapy and are considered one reason it evolved as an approach.

In therapists’ practices. Participants shared motivating factors to utilize walk and talk therapy in their practice. Multiple properties were identified for this subtheme: (a) personal experience, (b) other therapists, (c) desire to get out of office, and (d) need for options.

“Personal experience” was the most common property with seven occurrences. Personal experiences ranged from walking with friends to history of playing sports and/or exercising. Mallory shared, *“I walked with my friends and realized how beneficial it was for me with my girlfriends.”* Likewise, Wynona indicated, *“My own experiences of walking and talking with friends and how my outlook on a certain topic improves exponentially.”* Wynona and Jamie had a personal history of using and valuing exercise. Wynona simply stated, *“Because of my exercise background,”* while Jamie indicated, *“My personal life and interest in exercise and mental health made me want to try it.”* Krystal’s personal experience with sports and running motivated her. She stated, *“I used to run and play sports.”* Overall, personal experiences that motivated participants to utilize walk and talk therapy were related to walking, exercising, and playing sports.

“Other therapists” was the second property of this subtheme. Participants indicated that they were interested in using alternative methods specifically with walking or exercise. As they searched the internet with terms “counseling and walking,” “therapy and walking,” or “counseling and exercise,” webpages of therapists already using walk and talk therapy emerged. Participants reported that seeing others using walk and talk therapy was motivating for them to try it as well. Wynona stated, *“I did some research online and realized many licensed professional counselors and social workers were doing the same thing.”* Four participants cited Clay Cockrell, LCSW, who has a walk and talk therapy practice in NYC as a motivation to begin their own practice. Tori indicated, *“There as a website that was intriguing to me, he is in NYC, and was kind of my inspiration. I may have searched terms ‘walking and counseling’ and his website came up.”* Mallory agreed, *“Clay from NY. He was the first person and has been interviewed and written up.”* Therapists already utilizing walk and talk therapy was motivating for walk and talk therapy to evolve in participants’ practices. Clay Cockrell, LCSW, motivated the majority of participants, as his webpage was first to appear and was in the media most often for his practice.

“Desire to get out of the office” was the third property of this subtheme. Participants indicated their walk and talk therapy practice evolved from a desire to get out of the office. Kathy stated, *“The thought of sitting in an office 8 hours a day is very hard for me. Being able to be around nature was key for me. I also like the idea of being physically active during my workday.”* Krystal stated, *“To be out of the office.”* Wynona observed, *“I wanted to get out of the office environment.”* For participants, getting out of the office meant incorporating nature and physical activity into their day.

“Need for options” was the last property of this subtheme. Participants reported a need to offer options other than traditional therapy to meet the needs of clients. Linda shared, *“I didn’t learn about it, I just did it. I had a 12 year old boy who was uncomfortable in the office, so we just took a walk in the park.”* Christopher reflected similarly, *“Um, I just kind of came up with the idea, actually my wife did. I had a Wall Street broker client who had difficulty getting off work so my wife suggested meeting him at his office and walking with him. At first, I thought, you just don’t do that. Then, as I thought more about it, I realized there were no reasons why we couldn’t do it.”* These participants were motivated by the need to offer clients something different, as traditional therapy was not working for their clients. Participants indicated that traditional therapy may help only certain clients and others may need alternative methods such as walk and talk therapy to help them progress.

Limitations. The researcher asked participants to reflect on limitations of walk and talk therapy. Two subthemes emerged: (a) general, and (b) in session. “General” refers to the general limitations of walk and talk therapy approach. “In session” limitations are obstacles specific to the therapy sessions. Each subtheme is examined separately.

General. The first subtheme, “general,” represents overall limitations of walk and talk therapy. This subtheme is comprised of three properties: (a) attaining clientele, (b) lack of support, and (c) populations. “Attaining clientele” was the most frequent property of this subtheme. According to participants, other therapists are more interested in the approach than are clients. Therapists interested in learning how to start their own walk and talk therapy practices contacted participants more often than did clients interested in participating. Participants reported that they were contacted via email and telephone by other therapists in the field to learn the procedure, limitations, and specifics of walk and talk therapy. Mallory

indicated, *“Getting people on board is an issue. To me, more therapists have been interested in it than clients have been.”* Most participants wish they could utilize walk and talk therapy more than they do. For example, Krystal and Laura each stated, *“I wish I could do it more.”* Overall, participants believed gaining clientele was a challenge and wished they could have more clients in walk and talk therapy. Ten of eleven participants wished they had more clients choose walk and talk therapy. Only one participant was satisfied with the percentage of walk and talk clients.

“Lack of support” was the second property in this subtheme. Lack of support included the lack of leader, trainings, or supervisors in walk and talk therapy. Kathy shared, *“I don’t have anyone for supervision who does walk and talk therapy, so a lot of things, I just make up as we go. It requires a lot of figuring out on my own. There are no leaders.”* Moreover, therapists indicated a sense of judgment from others in the profession, as opposed to support. Jamie indicated, *“There are misconceptions about it, people perceive the therapist is doing it for their own gain.”* Largely, participants have learned how to conduct walk and talk therapy from other therapists already using the approach and/or by making it up as they go.

“Populations” is the last property of this subtheme. Participants reported that certain populations were less appropriate for walk and talk therapy and better suited for office sessions. Couples, families, and individuals with trauma issues were those populations better suited for office sessions. Samantha reflected, *“I think that working with couples and families would be really challenging while walking.”* Participants agreed that working with individuals with trauma issues would be better for the office. Krystal stated, *“Trauma clients may be less inclined because they have panic attacks and flashbacks.”* Mallory felt that it would be more ethical to treat trauma clients in the office, she reported, *“I wouldn’t want to process traumas on the trails, I think sitting in an office in a contained space is more ethical.”* Similarly, Tori

replied, *“I do trauma work and I don’t think I could do it while walking.”* Therefore, certain populations are better suited for office sessions than walk and talk therapy including couples, families, and trauma clients.

In session. The second subtheme, “in session,” is represents limitations of walk and talk therapy specifically in the sessions. This subtheme contains four properties: (a) weather, (b) confidentiality, (c) safety, and (d) conceptualization. “Weather” was the most frequently reported property of this subtheme. Clients were less likely to participate in walk and talk therapy during poor weather conditions such as rain, snow, or extreme heat. When weather was poor, clients typically chose to postpone or have an office session. Sally indicated, *“Most people choose to come to a café or office instead of outside when the weather isn’t favorable. Some choose to postpone.”* Others choose to walk regardless of the weather, according to Christopher, who stated, *“It is always their choice, if they want to walk in bad weather we grab umbrellas or coats and still go walk.”* Although weather conditions are favorable in some regions and less favorable in others, the majority of participants reported that weather was a limitation.

“Confidentiality” was the next property of this subtheme. Confidentiality is an important aspect of traditional therapy; participants indicated that confidentiality was handled the same way as in traditional therapy. Participants stated that although the limitations of confidentiality need to be communicated to clients before walking outdoors with them, it is no more of a limitation than in traditional therapy. Moreover, participants believed that the limitations of confidentiality are more of a concern to professionals in the field not familiar with walk and talk therapy. Sally reported, *“Confidentiality has not been an issue but other professionals in the field think it would be but clients are not concerned with it.”* Other participants responded similarly. According to Linda, Christopher, and Mallory, *“Confidentiality just has not been an*

issue so far.” The risk of others overhearing the therapeutic conversation or running into someone they knew were the confidentiality concerns. Participants acknowledged times when their clients ran into people they knew. Christopher recounted, *“I had a session where a client ran into someone they knew. Either the client ignores it or waves as we pass. They don’t even talk about it or worry about it because there is no way to tell we are in a therapy session.”*

Similarly, Mallory spoke about others overhearing the therapeutic conversation, *“You cannot hear other people’s conversations on the trails. There have been a few times another group has been close but we naturally slow down or speed up.”* Participants indicated that clients running into someone they knew was more likely than others overhearing conversations during walk and talk therapy. Confidentiality limitations are handled the same way they are in traditional therapy – therapists inform clients of the risks involved with confidentiality in walk and talk therapy during the intake session. Clients sign consent forms indicating they understand the parameters of confidentiality. All participants reported that confidentiality was not an issue that deterred clients from participating in walk and talk therapy.

“Safety” was the next property of this subtheme. Safety concerns included ensuring client safety while outdoors walking as well as physical limitations of clients. Ensuring client safety included taking clients to safe parks, walking on paths free of debris or cracks, and guiding clients away from traffic. Kathy stated, *“I choose a walking path that is easy to walk, with shade in a safe park.”* According to Krystal, *“Safety is an issue; someone could hurt themselves or get hit by a car when with you.”* Physical limitations consisted of physical conditions affecting the ability to participate in walk and talk therapy. Samantha responded, *“People that aren’t physically able to go the entire time is a limitation because not everyone can participate.”* Participants utilized medical screenings and release forms to prevent liability

issues in the event someone was injured during a session. Tori said, *“Oh, I give them a health screening for physical limitations,”* and similarly, Mallory stated, *“I always ask about medical problems and I don’t want anyone to get hurt.”* One participant indicated how she handled physical limitations. Linda shared, *“If the client had physical limitations, I would just take them outside to get nature aspect.”* Participants acknowledged client safety was an important aspect of walk and talk therapy. Medical screenings as well as liability consent forms were utilized to prevent liability issues.

“Conceptualization” was the last property of this subtheme. Participants shared concerns related to conceptualization while outdoors and walking. A few concerns included staying present with the client, conceptualizing in the moment, and going into deeper issues. Being outdoors in nature affected therapists’ ability to stay present with the client. As Mallory indicated, *“Being present in the moment is hard because of the sun and water distractions, you know, sensory stuff. It was also difficult to conceptualize while walking,”* according to Mallory. Going more deeply into issues was a concern to participants. Samantha shared, *“There are moments where I want to go deeper with the client and we may be in too much of a public situation to delve into it.”* Overall, nature affected therapists’ ability to stay present, walking created a challenge conceptualizing the client’s problems, and being in public may prevent therapists from going more deeply into client issues.

Outcomes. The researcher asked participants about the outcomes of walk and talk therapy. Two subthemes for this theme: (a) therapeutic benefits, and (b) client and therapist benefits. Therapeutic benefits refer to outcomes of walk and talk therapy as a method. Client and therapist benefits are the individual benefits clients and therapists incur individually from participating walk and talk therapy. Each subtheme is examined separately.

Therapeutic benefits. Therapeutic benefits included four properties: (a) get to issues faster, (b) therapeutic relationship, (c) process differently, and (d) assessment expanded. “Get to issues faster” was the most common property of this subtheme. Seven participants responded that they get to issues faster with walk and talk therapy than traditional therapy. For example, Christopher stated, *“I have seen changes and improvements happen at a more rapid pace.”* Similarly, Linda indicated, *“I think it is a shorted time frame for outcomes and goals.”* Jamie attributed walking for getting to the issues faster with clients. Jamie stated, *“Insights come faster from walking and talking.”* Kathy believed that minimal eye contact helped with getting to issues faster, stating, *“When walking and not looking at you in the eye, it is less intimidating so they spill their guts, we get there faster.”* Therefore, many participants agreed that they get to issues faster in walk and talk therapy than in traditional therapy. Participants attribute the faster rate of getting to issues to the shared activity of walking as well as the minimal eye contact in walk and talk therapy. Furthermore, participants felt the walking aspect and minimal eye contact aspect of walk and talk therapy made therapy less intimidating and therefore clients opened up quickly.

“Therapeutic relationship” was the second property of this subtheme. Participants responded positively about how walk and talk therapy affected the therapeutic relationship between the therapist and client. Some participants such as Krystal and Tori believed rapport is built more easily in walk and talk therapy. Krystal stated, *“It builds rapport easier for the therapist and client.”* Tori agreed, *“I think it is easier to build rapport in walk and talk therapy.”* Christopher and Linda indicated that the rapport is built from walking. Christopher shared, *“When people are walking in rhythm because your steps are aligned and a wonderful rapport is built.”* Linda stated, *“The therapeutic relationship is stronger through walk and talk*

therapy.” Therapeutic relationship in walk and talk therapy is created more easily from rapport building quickly through walking with clients.

“Process differently” is the third property of this subtheme and had the same number of occurrences as the therapeutic relationship. Many participants reflected on how clients processed differently than in office sessions. For example, Laura commented, *“I think walking with clients allows them to process on a different level.”* Specific differences consisted of new insight, more clarity, and ability to problem solve differently. Mallory stated, *“New ideas come up with walking.”* Similarly, Laura shared, *“People get unstuck or have new insights on issues.”* Wynona commented that *“Clients gain more clarity from walk and talk therapy”* and Tori stated, *“Clients have the ability to problem solve and think differently.”* Overall, participants believed clients process differently in walk and talk therapy than in office sessions. Some of the most common and beneficial processing differences included new insights, more clarity, and different problem solving.

“Assessment expanded” was the last property of this subtheme. Participants indicated that assessment was expanded from observing clients in natural settings. According to Jamie, *“Assessment is enhanced because you see them in real life situations.”* Linda agreed, *“Seeing the client in a natural environment, you get more from that experience by observing them outside.”* Additionally, participants reported that observing a client’s walking pace expanded assessment. For example, Christopher stated, *“There is so much I can read from a client because of their pace. Are they walking fast, plodding along, or is there heaviness to their walk?”* Thus, assessment is enhanced in walk and talk therapy via the ability to observe clients in natural settings while walking.

Client and therapists benefits. Many benefits for clients and therapists overlapped, thus all are mentioned in this subsection. Four properties were identified for client and therapist benefits including: (a) physical activity benefits, (b) self-care, (c) mental health benefits, and (d) nature benefits. Physical activity benefits were mentioned most often while self-care and mental health benefits were nearly equal in frequency.

“Physical activity benefits” was the most frequent property of this subtheme. Some participants cited the numerous benefits of physical activity. Wynona stated, *“May lead to better sleep, decreased cholesterol, decreased body fat and risk of heart attack.”* Christopher agreed, *“My blood pressure has gone down, weight has gone down.”* Others reported that walk and talk therapy assisted clients in incorporating physical activity in their lives. Mallory shared, *“Some people have never had movement in their lives so this is tremendously helpful for them.”* Kathy responded similarly, *“There are mild physical benefits for clients; it gets people to use their bodies which is a good start to incorporate movement in their lives.”* Another benefit of physical activity, according to Laura, was *“The ability to be more aware of how emotional problems manifest physically.”* Physical activity benefits of walk and talk therapy for clients and therapist included physical improvements such as better sleep, decreased body fat, decreased cholesterol, and reduced risk of heart attack. Additional benefits for clients consisted of increased movement in their lives as well as awareness of physical symptoms.

“Self-care” was the next property of this subtheme. Self-care was a benefit for both clients and therapists. Participants indicated that clients learn a new skill for self-care from walk and talk therapy. Laura reported, *“I think it helps clients get into healthy lifestyle behaviors to use for self-care. It teaches them a healthy coping behavior.”* Wynona responded similarly, *“Developing a healthy habit of walking for exercise as a coping mechanism for stress.”* For

therapists, walk and talk therapy had self-care benefits as well. Samantha stated, *“Going for a walk even just once a week changes up the routine which is a smart tool for the therapist to stay fresh.”* Likewise, Krystal shared, *“It is refreshing.”* Last, Tori said, *“It can be a stress reliever and self-care for the therapist.”* Thus, walk and talk therapy was considered self-care for the client and therapist.

“Mental health benefits” is the third property of this subtheme. Participants reported mental health benefits for clients as well as therapists. For clients, mental health benefits entailed reduced symptoms of depression and anxiety, reduction in anger, and improved mood. Christopher, Mallory, and Wynona all stated, *“I have noticed a reduction of depressive symptoms.”* Wynona and Christopher also felt that anxiety symptoms were reduced, reporting, *“I have noticed decreased symptoms of anxiety.”* Christopher shared, *“It has been helpful in addressing anger issues.”* Improved mood, according to Krystal and Tori, was another mental health benefit. They each stated, *“It improves client moods.”* The only reported mental health benefit for therapists was improved mood. Tori reported, *“I think one of the biggest outcomes for therapists is improved mood.”* Participants determined many mental health benefits for clients and one for therapists. Mental health benefits for clients consisted of reduced symptoms of depression, anxiety, and anger as well as improved mood. For therapists, improved mood was the only mental health benefit noted.

“Nature benefits” is the last property of this subtheme. The benefits of nature were the same for clients and therapists, according to participants. Benefits included fresh air, change of scenery, and the connection to nature. Wynona reported, *“Benefits of nature such as fresh air and change of scenery, which are invigorating.”* Sally and Wynona stated, *“Feeling more connected to nature while outside walking.”* Only four of eleven participants spoke about the

benefits of nature, which consisted of fresh air, change of scenery, and feeling connected to nature.

In sum, four themes of walk and talk therapy were deduced for this stage: (a) Definition, (b) Evolution, (c) Limitations, and (d) Outcomes. Two subthemes as well as at least three properties were determined for each theme. All were described in detail with direct quotes from participants as well as the occurrence of participant responses. Findings from extant texts such as webpages and documents corroborated some of these findings. Participant webpages included findings that supported the definition, limitations, and outcomes. Informed consent forms and flyers supported findings for the limitations, whereas the participant flyers corroborated findings included in the definition, limitations, and outcomes. Observation field notes backed up the findings for the definition, limitations, and outcomes.

Theoretical coding. According to Charmaz (2006), theoretical codes specify possible relationships between categories developed in focused coding. Further, theoretical codes conceptualize how categories are related, which moves the analytic story in a theoretical direction. To accomplish this step, I used two strategies: (a) Glaser's theoretical family "six C's" and (b) theoretical sampling. Glaser's six C's, "causes, contexts, contingencies, consequences, covariances, and conditions," was utilized to provide clarity and coherence to the analysis (Charmaz, 2006). Theoretical sampling was used to fill in gaps in theory by checking and elaborating properties of focused coding categories as well as specifying relationships among them (Charmaz, 2006). Theoretical sampling was used until no new theoretical insights emerged, which is referred to as "theoretical saturation." Once theoretical saturation was reached, analysis can conclude.

Theoretical sampling was used only to explicate liability concerns of therapists. Because, many therapists did not indicate whether liability was an issue, I used theoretical sampling by sampling extant texts (webpages and flyers) and asking more questions in interviews regarding liability to define the boundaries of the category. Theoretical sampling consisted of going back into the extant texts to refine the category of liability issues. Additionally, as I noticed some participants shared information on liability and others did not, I began to ask questions regarding liability to participants. Each was ways I utilized theoretical sampling in this study. Theoretical sampling is used until no new theoretical insights emerge. The category of liability was saturated quickly since participants perceived liability similarly.

In Figure 1, the results of theoretical coding are presented. The results of theoretical coding are explicated by Glaser's six C's: "causes, contexts, contingencies, consequences, covariances, and conditions." Each of Glaser's six C's was filled with data to explain the theory of walk and talk therapy. The "causes" explicate factors that generated the phenomenon of walk and talk therapy. "Contexts" of the six C's describe circumstances under which walk and talk therapy occurred such as social or environmental factors. The "contingencies" are the direction of the variations in walk and talk therapy. "Consequences" are the outcomes or results of walk and talk therapy. "Covariances" refers to the extent of relationships between variables of walk and talk therapy. Last, "conditions" are circumstances in which walk and talk therapy occurs.

Figure 1

Theoretical Coding Results

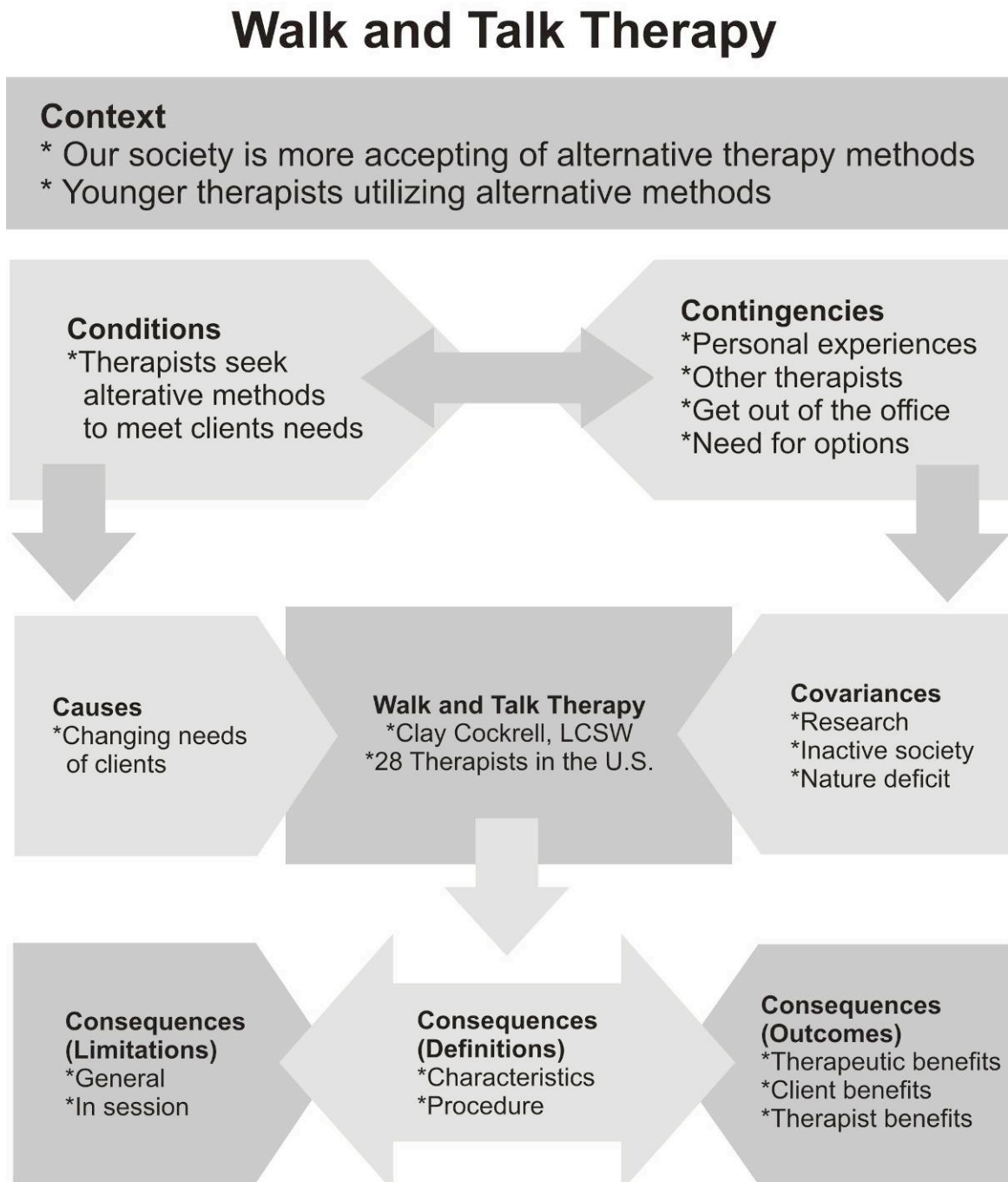


Figure 1. Walk and Talk Therapy flow chart includes boxes that represent Glaser’s six C’s “covariances, contingencies, causes, conditions, contexts, and consequences”

As a result of the theoretical coding phase, a framework for practice was generated for walk and talk therapy. Although the purpose of this study was to generate a theory for walk and talk therapy, findings indicated a framework for practice was best applied to walk and talk therapy. Participants shared perspectives which described how walk and talk therapy emerged, and provides an explanation of the procedure, a definition for the approach, and limitations and outcomes of the approach.

A framework for practice for walk and talk therapy was explicated by Glaser's six C's. The context of walk and talk therapy can be described as our society today. Participants indicated that our society has become more accepting of alternative therapy methods. As a result, younger therapists are utilizing alternative methods. Due to the changing society, the needs of clients changed, which is the cause of walk and talk therapy's evolution, [see Figure 1]. An inactive society, nature deficit, spending more time indoors, car dependent communities, and busy schedules are characteristics of our changing society in the United States. Therefore, client needs are changing as society changes.

Therapists are seeking alternative methods to meet the changing needs of clients. For example, Linda and Christopher changed their therapeutic methods to fit the needs of their clients. Christopher's client had a busy schedule and could not find time to travel to therapy sessions. Christopher decided that traveling to him and walking with him outdoors would meet his needs. Linda's client was not progressing in the office; she felt that movement and a change of scenery would be beneficial for his needs.

Meeting client needs was one factor that determined whether therapists sought alternative methods of therapy. Other contingencies, as referenced in Figure 1, were personal experiences,

learning that other therapists already conducting walk and talk therapy as well as a desire to get out of the office. Personal experiences such as a love for walking, love for outdoors, and walking with friends were noted. Many therapists were motivated from learning that other therapists were already using alternative methods such as walk and talk therapy, while searching for alternative methods on the Internet. Getting out of the office was a motivating factor for therapists because we spend much more time indoors as a society. A need to offer clients an alternative to traditional therapy motivated participants to search for walk and talk therapy.

Clay Cockrell, LCSW, was identified as the first therapist to use walk and talk therapy in the United States, beginning in 2004. Additionally, Cockrell was the first to name the approach “Walk and Talk Therapy,” and to receive media attention for his private practice in New York City. As other therapists learned about walk and talk therapy through Cockrell’s webpage, they were motivated by his success to start their own walk and talk therapy practices. At the time of this study, there were 28 therapists advertising their walk and talk therapy practices on the Internet. Cockrell and 28 therapists subsequently beginning walk and talk therapy practices were the evolution of walk and talk therapy as an approach, as evidenced in Figure 1.

To date, only one study (Doucette, 2004) has been conducted on walk and talk therapy which provided minimal information about the evolution, procedure, or outcomes of the approach. As a result of data analysis, many consequences of walk and talk therapy were determined, as referenced in Figure 1. Consequences consisted of a definition, outcomes, and limitations of walk and talk therapy. A definition of walk and talk therapy consisted of participant descriptions of the characteristics and procedure that make up walk and talk therapy. For example, participants described walk and talk therapy as “therapy while walking” or “exercise and therapy.” In addition to a definition, the limitations and outcomes rounded out the

consequences of walk and talk therapy. Limitations included general limitations, “obtaining clientele is a challenge” and “there is a lack of support in the field” as well as limitations specific to the sessions such as “weather” and “confidentiality.” Outcomes consisted of therapeutic benefits such as “speeds up therapy” and “build rapport in therapeutic relationship.” Client and therapist reaped benefits such as “mental health benefits,” and “nature benefits.”

In addition to the framework for practice, a summary of significant research findings was presented. At least two findings were determined for each subtheme, equaling 14 research findings. All research findings are based on the participants’ perceptions of this study and are presented in Table 4 in no order of importance or hierarchy.

Table 4

Research Findings

Research Findings
1. Walk and talk therapy is therapy conducted walking outdoors.
2. Physical activity, nature, and casualness are the central components of walk and talk therapy.
3. The setting of walk and talk therapy includes the location and a walking path.
4. No training is required to participate in walk and talk therapy.
5. Interventions utilized in walk and talk therapy are traditional therapeutic interventions.
6. The procedure of walk and talk therapy includes an initial intake session indoors then walking outdoors for following sessions.
7. Research, a need for options, lack of physical activity, and a nature deficit caused walk and talk therapy to emerge as an approach.
8. Personal experiences, other therapists, desire to get out of the office, and a need for options motivated therapists to utilize walk and talk therapy in their practices.
9. Clay Cockrell, LCSW was instrumental in the evolution of walk and talk therapy.

Table Continued

Research Findings

Research Findings

10. General limitations of walk and talk therapy include a lack of support, difficulty in obtaining clients, and population concerns.
11. Session limitations of walk and talk therapy consisted of weather, confidentiality, safety, and conceptualization.
12. Therapeutic benefits of walk and talk therapy included getting to issues faster, building therapeutic rapport faster, processing differently, and assessment expanded.
13. Benefits for clients include: physical health benefits, mental health benefits, nature benefits, increased body awareness, and self-care.
14. Benefits for therapists include: physical health benefits, mental health benefits, nature benefits, and self-care.

The 14 research findings in Table 4 highlight significant aspects of walk and talk therapy derived from the theoretical coding results. Research findings are presented here for clarity and emphasize the important findings of the framework for practice of walk and talk therapy in Figure 1. Research findings were outlined in no particular order, yet each represents themes and subthemes of walk and talk therapy. Significant findings such as a definition for walk and talk therapy and central components are presented in Table 4. Other findings, including research findings related to the setting, training, interventions, and the procedure of walk and talk therapy were outlined in Table 4. Findings summarizing facts about the evolution of walk and talk therapy were significant and are included in Table 4. Last, the outcomes of walk and talk therapy were summarized in Table 4, including limitations and benefits of the approach.

Chapter Summary

The findings of this study were presented in this chapter. The researcher utilized a grounded theory qualitative method of data analysis. There were 11 interviews, 11 extant text (webpages), four extant text (documents), and three observation field notes. In the first step of data analysis, line-by-line coding was utilized to establish an initial set of categories. In step two of data analysis, focused coding was utilized to define themes and subthemes of walk and talk therapy. For the third stage, theoretical coding, six C's, and theoretical sampling were utilized to refine the boundaries of themes and generate a theory of walk and talk therapy.

Results were summarized into a framework for practice and 14 research findings of walk and talk therapy. The framework for practice of walk and talk therapy was generated to explain the evolution, definition, procedure, and outcomes of walk and talk therapy. The framework outlined how many factors such as our changing society has led to changing needs of clients, which led therapists to seek new ways to meet client needs. One therapist, Cockrell, was the first to meet the new needs and established his walk and talk therapy practice. The influence of his practice as well as other influences motivated other therapists to begin using walk and talk therapy. As a result, walk and talk therapy is being utilized by at least 28 therapists in the United States. Additionally, a definition, explanation of the procedure, and outcomes are presented.

Chapter Five

Discussion

The purpose of this chapter is to discuss the research findings of this study. Research findings are presented and discussed in relation to the literature. The purpose of the study, summary of procedures, discussion of findings, framework for practice findings, significance of findings, implications for therapists, implications for researchers, implications for counselor educators, limitations of the study, and implications for future research are included in this chapter.

Purpose of the Study

The purpose of this study was to generate a theory for walk and talk therapy. Although therapists are utilizing walk and talk therapy (Hays, 1994), only one empirical study on the approach exists (Doucette, 2004). This study built on the work of Doucette (2004), who interviewed clients participating in walk and talk therapy by obtaining the perspective of the therapists. Therapists were interviewed about their experiences as walk and talk therapists. Instead of a theory for walk and talk therapy, a framework for practice of walk and talk therapy resulted from the research findings.

Summary of Procedures

Therapists who provided walk and talk therapy in their practice were recruited to volunteer for an interview regarding walk and talk therapy. Eleven therapists agreed to participate from a potential list of 28. Three forms of data were analyzed for the purpose of this study: (a) transcribed interviews, (b) extant texts, and (c) observation field notes from settings. Interview transcriptions, extant texts, and field notes from setting observations were organized onto Microsoft Word™ documents for continuity.

First, all data were read without coding to gain an overall feel and understanding of the data. Then, three phases of coding were employed for the remainder of data analysis: (a) initial coding, (b) focused coding, and (c) theoretical coding. Throughout data analysis, the constant comparative analysis was used, consistent with grounded theory design (Glaser & Strauss, 1967). In the initial coding phase, line-by-line coding was utilized to determine an initial set of categories. Next, focused coding was employed to establish the most frequent and significant codes. Main themes, subthemes, properties, and occurrences were concluded in the focused coding phase. Last, in the theoretical coding phase, theoretical sampling and Glaser's six C's (Charmaz, 2006) were utilized to construct a framework for practice of walk and talk therapy.

Discussion of Findings

The purpose of this section is to discuss the findings generated from the research questions and participant interview questions in the context of related research. Previous research on walk and talk therapy consists of one qualitative study (Doucette, 2004) and anecdotal research (e.g., Goodman, 2005; Hays, 1994; Wright, 2008); hence, relating findings to previous literature is a challenge. Many of my findings are new and cannot be compared to previous research. However, comparisons can be made to existing therapy approaches such as traditional therapy and nontraditional outdoors therapy methods (e.g., adventure-based counseling, wilderness therapy, nature therapy, and ecotherapy). Participants often compared walk and talk therapy to traditional therapy without being prompted. Thus, findings reflect these comparisons.

Research questions, participant interview questions, and research findings are summarized in the remainder of this section separated into the four main themes: (a) Definition, (b) Evolution, (c) Limitations, and (d) Outcomes.

Definition. Four of eight research questions were used to generate findings related to the theme “definition.” For each research question, one or two interview questions were employed to understand participants’ perceptions about the definition of walk and talk therapy. Research questions and interview questions are outlined with a discussion of findings.

Table 5

Definition: Research & Interview Questions

Research Questions (RQ):	Participant Interview Questions:
RQ 1: What is the process of walk and talk therapy?	How do you define walk and talk therapy? Describe a typical session.
RQ 3: What is central in the process of walk and talk therapy?	What are the central components of walk and talk therapy? What makes walk and talk therapy stand out from other approaches?
RQ 6: Who are the important participants and how do they participate in the process?	What is the therapist’s role in walk and talk therapy? What is the client’s role in walk and talk therapy?
RQ 7: What strategies are employed during the process of walk and talk therapy?	What strategies or interventions are used in walk and talk therapy?

The research questions and interview questions in Table 5 generated six research findings related to the definition of walk and talk therapy. Findings are summarized by characteristics and the procedure of walk and talk therapy. Characteristics and procedure consisted of the central components, therapist and client roles, as well as interventions in the approach. Each research finding related to the definition of walk and talk therapy is presented in the remainder of this subsection.

Walk and talk therapy is therapy conducted walking outdoors. Findings of this study support the definitions used in literature. Walk and talk therapy, as it is called today, has been

described various ways in the literature. First, Hays (1994) described “running and walking therapy” as exercise and talk therapy simultaneously - a method to use “as needed” based on client needs. In 2004, Doucette defined the “Walk and Talk intervention” as an intervention of walking outdoors while engaging in counseling. Cockrell termed “walk and talk therapy” in 2004 when he began his practice in New York City. Thus, walk and talk therapy is defined as therapy conducted walking outdoors. It is an intervention utilized based on client needs.

Physical activity, nature, and casualness are the central components of walk and talk therapy. Findings of this study support physical activity, nature (Doucette, 2004) and casualness (Kostrubala & Schuler, 2009) as central components of walk and talk therapy. Physical activity, nature, and casualness were three central components identified by participants whereas Doucette (2004) recognized counseling, ecopsychology, and physiological as the three components of walk and talk therapy. The counseling component in Doucette’s walk and talk intervention consisted of strategies for positive life skills and solution-focused brief therapy. The ecological component, same as the nature component, is characterized by the natural connection humans have with nature that being outdoors reinforces (Doucette, 2004). The physiological component, identical to the physical activity component, was described as the aerobic exercise of walking and its effects on well being, mood, and mental illness. According to Doucette (2004), recognizing the importance of exercise and client well being is critical for walk and talk. A third component, casualness, supported Kostrubala and Schuler. Casualness referred to the less threatening and casual spirit of walk and talk therapy is attributed to minimal eye contact and the familiarity of walking with someone.

The setting of walk and talk therapy includes the location and a walking path. Unlike Doucette’s (2004) study, the findings of this study identified a setting for walk and talk therapy.

Previous studies described settings in general terms such as walking on school grounds (Doucette, 2004) and a downtown area (Kottler & Carlson, 2003). The findings of this study recognized a location and path as the setting of walk and talk therapy. The location and path consist of various characteristics, which make the setting unique to therapists' practices. In walk and talk therapy, locations are parks, lakes, forests, or downtown areas with walking paths. Walking paths are sidewalks, trails, and cement or gravel roads. The setting of walk and talk therapy is unique for each therapist's practice as the setting depends on what is available to each therapist; some regions have more outdoor settings to choose from than do others.

No training is required to participate in walk and talk therapy. Training for walk and talk therapy was not addressed in previous research. The findings of this study found that therapists require no additional training to participate in walk and talk therapy. Therapists and clients need to have the ability to walk to participate in walk and talk therapy. Additionally, my findings indicated that therapists have a safety role in walk and talk therapy. Therapists monitor clients for physical and medical safety. Monitoring physical safety included observing for safety hazards such as approaching cars or obstructions. Monitoring medical safety referred to observing clients for physical symptoms such as shortness of breath or limping. Client roles are no different from their role in traditional therapy in that they must be willing and motivated for therapy. Unlike related nontraditional outdoors therapies (i.e., adventure based counseling and wilderness therapy), which require therapists to have knowledge of outdoors activities (e.g., kayaking, hiking, camping) in walk and talk therapy, no training is required.

Interventions utilized in walk and talk therapy are traditional therapeutic interventions. Findings from this study support previous research that interventions or strategies used in walk and talk therapy are traditional therapeutic interventions (Doucette, 2004). Doucette used

solution-focused brief therapy and, similarly, my findings indicated that solution-focused brief therapy, cognitive behavioral therapy, and person-centered therapy are being utilized. Likewise, outdoors therapy methods such as adventure-based counseling, wilderness therapy (Fletcher & Hinkle, 2002) as well as nature therapy and ecotherapy (Berger & Mcleod, 2006; Burls, 2005) utilized interventions from traditional therapy. Moreover, interventions used in walk and talk therapy are the same as traditional office based therapy as well as outdoors approaches (i.e., adventure based counseling and wilderness therapy). It appears that any accepted theoretical approach can be used in walk and talk therapy.

The procedure of walk and talk therapy includes an initial intake session indoors, then walking outdoors for following sessions. Findings of this study described the procedure of walk and talk therapy. My findings support an intake session being conducted indoors as the initial session (Doucette, 2004; Hays 1994). In the intake session, the therapist gathers information about the client's presenting issues, offers information about the therapy practice, and obtains signatures on informed consents. Unlike previous studies, my study found an additional purpose of the intake session in walk and talk therapy - to screen clients as a safety precaution before walking outdoors with them. If the therapist feels the person may be unsafe or too vulnerable to walk outdoors, sessions stay in the office. Once the intake is completed, following sessions are outdoors walking (Doucette, 2004; Hays, 1994). Therapists and client meet either at the office (Doucette, 2004; Hays, 1994) or at an agreed upon location such as local parks, forests, or downtown areas with a walking paths (Kottler & Carlson, 2003). Like previous research, (Doucette, 2004), sessions entailed approximately 50 minutes of therapy while walking outdoors. Others walked or ran for 30 minutes and allotted time at the end of sessions to discuss issues that arose from the session (Hays, 1994; Kottler & Carlson, 2003).

Evolution. Two of eight research questions were related to the theme “evolution.” For each research question, there were two to three interview questions employed to understand participants’ perceptions about the evolution of walk and talk therapy. Research questions and interview questions are outlined with a summary of findings following.

Table 6

Evolution: Research & Interview Questions

Research Questions (RQ):	Participant Interview Questions:
RQ 2: How did walk and talk therapy evolve?	How did you learn about walk and talk therapy? Describe why you think walk and talk therapy emerged? Who has been important in the field for walk and talk therapy?
RQ 4: What influenced or caused walk and talk therapy to develop for you?	What motivated you to start using walk and talk therapy? What changes have you had to make as a therapist to do walk and talk therapy?

Research and interview questions in Table 6 generated three research findings related to the evolution of walk and talk therapy. More specifically, findings suggest why walk and talk therapy evolved as an approach, motivating factors for therapists to begin using walk and talk therapy in their practices, and who was important in its evolution. Each research finding is presented in the remainder of this subsection.

Research, a need for options, lack of physical activity, and a nature deficit caused walk and talk therapy to emerge as an approach. No previous studies have indicated how or why walk and talk therapy evolved. However, anecdotal research (Gontang, 2009; Hays, 1994; Kottler & Carlson, 2003) suggested therapists were walking and running with clients before walk

and talk therapy emerged as an identified approach. Findings of my study suggest many factors have influenced the evolution of walk and talk therapy as an approach including: research, need for options, lack of physical activity, and nature deficit.

Research on topics such as EMDR, Buddhism, recreation therapy, benefits of exercise, and consequences of inactivity had an influence on the evolution of walk and talk therapy, according to participants. Participants believed that EMDR and Buddhism had an impact on the evolution of walk and talk therapy as EMDR and Buddhism share some characteristics with walk and talk therapy. Additionally, recreation therapy programs (Fletcher & Hinkle, 2002; Goldenberg, 2001; Peel & Richards, 2005), benefits of exercise (Dubbert, 2002; Hays, 1994; Leer, 1980), and the consequences of inactivity (U.S. Department of Health and Human Services, 2010) are similar in characteristics as walk and talk therapy. Thus, it seems that walk and talk therapy was influenced by previous research with similarities.

A need to give clients options was another factor that contributed to the evolution of walk and talk therapy. This is consistent with research that posits traditional therapy alone might not have enduring effects for clients (Kottler & Carlson, 2003). According to participants, therapy options are needed for clients who are stuck in their progress and something different needs to be tried to help them progress. Additionally, alternative options are good for clients who struggle with eye contact or sitting for long periods of time. Unrelated to previous research, yet an important finding of my study was that participants think that younger therapists are pushing the boundaries of what is accepted in therapy.

A lack of physical activity has caused walk and talk therapy to evolve as an approach, according to participants. Many previous studies identify a lack of physical activity in the United

States (Dustin et al., 2010; Hansen-Ketchum et al., 2009; Norman & Mills, 2004). According to participants, the increasing amount of inactivity in the United States as well as a disconnect people have with their bodies has led to the evolution of walk and talk therapy. It seems there is a connection between inactivity in our society and the physical activity component of walk and talk therapy.

Nature deficit, a term used to describe the disconnection between humans and nature (Burls, 2005), was considered another reason walk and talk therapy evolved as an approach. Compared to the lack of physical activity, fewer studies are related to nature deficit (Burls, 2005). According to participants, humans are less connected to nature as evidenced by their increased time spent indoors for leisure, working, and car dependent communities. This finding supports previous research that Americans spend 95 percent of their time indoors (Fletcher & Hinkle, 2002). Nature deficit has been attributed to other factors such as an increase in technological advancements and urban living (Burls, 2005). This disconnection between humans and nature has led to the evolution of walk and talk therapy; the nature component of walk and talk therapy assists with nature deficit.

Personal experiences, other therapists, desire to get out of the office, and a need for options motivated therapists to utilize walk and talk therapy in their practices. Doucette's (2004) motivation to use walk and talk therapy was to create positive well being and health for the clients. No other studies identified why therapists were motivated to use walk and talk therapy in their practices. Thus, all findings related to therapists' motivation to begin utilizing the approach are new. Motivating factors for therapists to begin using walk and talk therapy in their practices were personal experiences such as walking with friends, history of playing sports, or a history of exercising. Therapists believed that walking with friends had been therapeutic for

them in the past and thought it could be beneficial for clients. Additionally, therapists were motivated by their personal experiences of playing sports or exercising. Some therapists valued being outdoors and being physically active, which motivated them to use walk and talk therapy in their practices.

Other therapists already utilizing walk and talk therapy motivated participants to use walk and talk therapy in their practices. When participants became interested in incorporating physical activity and/or nature with therapy, they began searching the Internet for ideas. As they searched, participants found webpages of therapists utilizing walk and talk therapy; it motivated them to begin their own walk and talk therapy practices. One therapist, in particular, had media attention surrounding his walk and talk therapy practice. The media attention made therapists aware of walk and talk therapy and motivated them to try walk and talk therapy. Hence, other therapists already conducting walk and talk therapy motivated participants to begin their own practices.

Therapists' desire to get out of the office was a motivating factor to begin using walk and talk therapy. Findings suggested that therapists feared burnout from sitting in an office for eight hours every day. Our society spends much more time indoors including work and leisure time (Fletcher & Hinkle, 2002). Getting out of the office for fresh air and physical activity was appealing to participants who thought being indoors all day would increase the chance of burnout.

The need to give clients options was a motivating factor for therapists to begin using walk and talk therapy in their practices. This finding supported previous studies (Doucette, 2004; Kottler & Carlson, 2003). Participants reported that the traditional office therapy was not

meeting the changing needs of their clients. Clients' needs motivated therapists to find alternative ways to help clients. Therapists are meeting clients' needs by changing the setting of therapy such as taking clients outdoors walking to create progress when office sessions are not effective. Additionally, therapists are meeting the needs of clients' busy schedules by meeting them at convenient locations.

Clay Cockrell, LCSW, was instrumental in the evolution of walk and talk therapy.

Cockrell was cited by most participants as an influence to begin using walk and talk therapy in their practices. Therapists reported locating his webpage when searching for "counseling" and "walking." Additionally, Cockrell is credited as the first person to term the approach "walk and talk therapy" and as the first therapist in the U.S. to gain media attention for his practice. Thus, findings suggested that Cockrell is an important person in the development of walk and talk therapy.

Most findings about the evolution of walk and talk therapy could not be linked to previous research, as only one study has been conducted on walk and talk therapy. Findings from my study shed light on why walk and talk therapy evolved as an approach, in therapists' practices, and who was important in that process. Findings indicated that many factors influenced the evolution of walk and talk therapy as an approach such as research, a need, physical activity, and nature. The evolution of walk and talk therapy in therapists' practices was affected by their personal experiences, other therapists, desire to get out of the office, and a need for options.

Limitations. One of eight research questions was related to the theme “limitations.” For the research question, three interview questions were employed to understand participants’ perceptions about the limitations of walk and talk therapy. Research questions and interview questions are outlined with a summary of findings following.

Table 7

Limitations: Research & Interview Questions

Research Question (RQ):	Participant Interview Questions:
RQ 5: What are the obstacles in the process of walk and talk therapy?	<p>What were the roadblocks in developing walk and talk therapy in your practice?</p> <p>Describe any obstacles or limitations of the walk and talk therapy approach.</p> <p>How do you handle obstacles or limitations of the walk and talk therapy approach?</p>

Research and interview questions in Table 7 generated two research findings related to the limitations of walk and talk therapy. The two research findings addressed limitations in general and in sessions. Lack of support in the profession, obtaining clientele, and population limitations were identified as general limitations of the approach, whereas weather, confidentiality, safety, and case conceptualization were considered session limitations. Each research finding is presented in the remainder of this subsection.

General limitations of walk and talk therapy include a lack of support, difficulty in obtaining clients, and population concerns. General limitation findings do not support previous research, as previous research on walk and talk therapy is scant. Participants identified a lack of support from the profession as a limitation in developing and practicing walk and talk therapy. Lack of support referred to leadership, training opportunities, and supervision. Therapists found

it challenging to develop policies such as price scale, logistics, marketing, liability and confidentiality concerns. A common thread among therapists was “I make it up as I go.” Finding a supervisor and trainings for walk and talk therapy were not available because the method is new and not well supported by the field. Many therapists reported misconceptions and judgment from other professionals in the field. Misconceptions centered primarily on the notion that the therapists are using walk and talk therapy for their own personal gains and not putting the client’s need first.

Obtaining clientele was a limitation not previously mentioned in the literature either. Participants indicated that obtaining clientele for walk and talk therapy is an obstacle. Only two of eleven participants interviewed utilized walk and talk therapy with 80 percent or more of their clients. All therapists wished they could use it more, supporting the finding that obtaining clientele is challenging.

Participants found some populations were better suited for office sessions rather than walk and talk therapy; a finding not identified in previous research. Couples, families, and trauma-related clients are better suited for office sessions, which ultimately limits potential clientele for walk and talk therapy. Walking while talking to couples and families would be difficult logistically. Treating traumatized clients was more appropriate in the office as public spaces could trigger traumatic events.

Session limitations of walk and talk therapy consisted of weather, confidentiality, safety, and conceptualization. This study’s finding that weather is a limitation in walk and talk therapy supports previous research (Doucette, 2004). Participants reported that the majority of clients choose to postpone or move to the office when the weather was unfavorable. The region where a therapist is located determined weather restrictions on the walk and talk therapy

practice. However, clients who walk despite unfavorable weather came prepared with umbrellas and heavy coats.

My study confirmed the findings of Hays (1994) that confidentiality is a limitation of walk and talk therapy due to the setting. However, participants insisted that confidentiality limitations do not hinder clients from participating in walk and talk therapy. In fact, professionals in the field, who do not utilize walk and talk therapy are more concerned with the confidentiality limitations than are clients. Findings indicated that confidentiality in walk and talk therapy was handled in the same way as in traditional office sessions, which supports Hays (1994).

Therapists inform clients of the parameters of confidentiality and ask them to sign a consent form stating their understanding. Because walk and talk therapy is located in public locations, others could recognize clients and/or therapists as well as overhear conversations. Clients seeing people they knew while in public was more common than others overhearing therapeutic conversations. If clients recognize others in public, it is their choice on how to handle those situations. Most clients chose to wave or say a quick hello and continue with their session.

Client safety during sessions is considered a limitation of the approach. Client safety refers to physical limitations of clients as well as potential safety risks while walking. Physical limitations, a finding which supports previous research, included physical symptoms inhibiting from participating in walk and talk therapy safely such as medical problems, obesity, or injuries. According to Hays (1994), both therapist and client need to be healthy enough to participate in sessions; if not, sessions should take place indoors. Safety risks such as client injuries or getting hit by a car was not mentioned in previous literature; yet, participants reported it as a limitation. Additionally, unlike in previous research, participants reported that medical screenings and

consent forms are utilized to ensure therapists are not liable for injuries or medical issues in sessions.

Findings of my study indicated that case conceptualization was a limitation in walk and talk therapy. Participants found it more challenging to conceptualize cases in walk and talk therapy compared to in traditional office sessions. This departed from previous research that walking or running outdoors with clients would help with conceptualizing client issues (Hays, 1994). According to participants, a myriad of factors affected conceptualization in walk and talk therapy. Mainly, staying present with the client, conceptualizing client issues, and going deeper into client issues were challenging in walk and talk therapy as compared to office sessions. Therapists attributed the stimuli of being in nature as well as the physical activity of walking as the culprits for these challenges.

All general limitations such as lack of support, obtaining clientele, and populations were new findings. It is possible that limitations have emerged as a consequence of more therapists using walk and talk therapy. My findings support the finding that weather (Doucette, 2004) and confidentiality (Hays, 1994) are limitations of walk and talk therapy. Physical limitations of therapist and client is a limitation of walk and talk therapy (Hays, 1994). However, the potential of client injuries was a limitation not previously mentioned in research. Another new finding was conceptualization as a limitation. This opposed prior research, which suggested conceptualization was enhanced with walking or running (Hays, 1994). Overall, the findings of this study identified numerous limitations of walk and talk therapy suggested by therapists who are using the approach.

Outcomes. One of eight research questions was related to the theme “outcomes.” For the research question, three interview questions were questions employed to understand participants’

perceptions about outcomes of walk and talk therapy. Research questions and interview questions are outlined with a summary of findings in Table 8.

Table 8

Outcomes: Research & Interview Questions

Research Questions (RQ):	Participant Interview Questions:
RQ 8: What effects or outcomes occur from the process of walk and talk therapy?	<p>What is beneficial about walk and talk therapy?</p> <p>What are some outcomes of doing walk and talk therapy for the client?</p> <p>What are some outcomes of doing walk and talk therapy for the therapist?</p>

Research and interview questions in Table 8 generated three research findings related to the outcomes of walk and talk therapy. Three research findings were concluded for the outcomes of walk and talk therapy: therapeutic benefits, therapist benefits, and client benefits of walk and talk therapy. Each research finding is presented in the remainder of this subsection.

Therapeutic benefits of walk and talk therapy included getting to issues more quickly, building therapeutic rapport more quickly, processing differently, and assessment expanded. Findings of this study support the perceptions that walk and talk therapy speeds up therapy and therapist and clients get to the issues more quickly (Goodman, 2005; Hays, 1994). Participants credited getting to issues faster to the familiarity of walking and minimal eye contact (Bricklin & Smith, 1996) in walk and talk therapy.

This study supports findings that the therapeutic relationship is built more quickly in walk and talk therapy from fast rapport building (Gontang, 2009; Hays, 1994). Findings also support that shared activity of walking created an equal balance between the client and therapist, which builds rapport (Hays, 1994; Gontang, 2009). This study found minimal eye contact helped build rapport which supports previous findings about eye contact (Bricklin & Smith,

1996). Thus, the therapeutic relationship is built fast in walk and talk therapy from shared activity of walking (Hays, 1994) and minimal eye contact (Bricklin & Smith, 1996).

This study also supports the finding that clients process their problems differently in walk and talk therapy than in traditional therapy. Differences in processing problems included: new insights, more clarity, and different problem solving than in traditional therapy. Hays (1994) found that walk and talk therapy helped clients think more clearly, synthesize problems differently, and come up with new ideas. Findings were consistent with Dench (2002) in that clients experience more clarity in thinking in walk and talk therapy. Additionally, findings support previous research of Berman et al. (2008) and Mayer et al. (2009) who found that interacting with nature improved cognitive capacity and one's ability to reflect on life's problems.

This study also supports the finding that the assessments of clients are expanded in walk and talk therapy. According to Hays (1994), there is much non-verbal communication to observe in walk and talk therapy such as changes in breathing, walking pace, and postures. In walk and talk therapy, therapists can observe clients in a natural setting as well as observe walking pace. Observing clients in natural settings gives therapists an expanded assessment of the client. Walking with a client allowed the therapist to assess how issues are affecting the client by assessing the client's walking pace.

Benefits for clients include: physical health benefits, mental health benefits, nature benefits, increased body awareness, and self-care. This study supports the findings that walk and talk therapy has many client benefits. Previous studies support the findings that physical health benefits of physical activity included better sleep (Crone, 2007), decreased body fat,

decreased cholesterol, and reduced risk of heart attack (Dubbert, 2002: U.S. Department of Health and Human Services, 2010).

Likewise, previous studies (Dixon et al., 2003; Martinesen, 2008) have shown that physical activity had mental health benefits for clients such as a reduction in symptoms of depression and anxiety. According to participants, their clients experienced improved mood from walk and talk therapy. Previous studies have shown improved mood from physical activity (Plante et al., 2007) as well as from nature (Berman et al., 2008); thus, it is unknown which is affecting clients' moods in walk and talk therapy, as both physical activity and nature are being experienced.

Participants identified characteristics of nature that benefited clients. This study's outcomes support findings that certain characteristics of nature are beneficial for clients. Participants identified fresh air, change of scenery, and feeling more connected to nature as benefits (Fletcher & Hinkle, 2002). However, previous studies included some benefits not mentioned in this study. Berman et al. (2008) found that cognitive functioning and mood were affected positively from interacting with nature. Mayer et al. (2009) found that interacting with nature improved cognitive capacity and one's ability to reflect on life's problems. Findings of this study did not indicate that nature influenced cognitive functions, yet it seems that clients could be experiencing similar cognitive enhancements from nature.

Self-care refers to clients learning a new skill to utilize as a healthy coping behavior for stress. This finding supports previous research (Hansson et al., 2005) that physical activity is utilized as a self-care strategy. Unlike previous studies, findings showed that clients used walking as a self-care strategy after beginning walk and talk therapy. Thus, walk and talk therapy could help clients begin utilizing physical activity more regularly.

Body awareness, a finding not supported by previous research, referred to clients becoming more aware of how mental health symptoms manifest physically. Participants reported that clients who participated in walk and talk therapy became more aware of their bodies, how symptoms of stress manifest in bodies, as well as mind-body connections.

Benefits for therapists include: physical health benefits, mental health benefits, nature benefits, and self-care. This study supports findings that therapists experience physical health benefits of better sleep (Crone, 2007), decreased body fat, decreased cholesterol, and reduced risk of heart attack (Dubbert, 2002; U.S. Department of Health and Human Services, 2010) from the physical activity of walking in walk and talk therapy.

Participants reported the only mental health benefit of walk and talk therapy for therapists was improved mood. Previous studies have supported the finding that improved mood is caused by physical activity (Plante et al., 2007) as well as nature (Berman et al., 2008); thus, it is unknown whether physical activity or nature is improving mood, as both are being experienced during walk and talk therapy.

Although participants did not identify benefits of nature for therapists in walk and talk therapy, they must be prevalent since therapists are interacting with nature. Benefits of nature for clients were fresh air, change of scenery, and feeling more connected to nature as an outcome of walk and talk therapy. Berman et al. (2008) found that cognitive functioning and mood were affected positively from interacting with nature. Mayer et al. (2009) found that interacting with nature improved cognitive capacity and one's ability to reflect on life's problems. Findings of this study did not indicate improved cognitive functions for therapists, yet it seems that therapists could be experiencing similar cognitive enhancements from nature.

Self-care for the therapist included getting out of the office, keeping sessions fresh, and a change of routine. Participants believed walk and talk therapy is a good tool to prevent burnout. Participants reported that the profession is well known for burnout, vicarious trauma, and compassion fatigue; thus, utilizing walk and talk therapy could have benefits of self-care for the physical activity and nature components. Research on the therapists' professional perspective is limited of walk and talk therapy is limited, therefore no previous research is related to walk and talk therapy and self-care for therapists.

Summary of findings. Numerous research findings were generated from this study; some were supported by previous research while others were new findings. Many characteristics of walk and talk therapy, which were recently unknown, have been exposed and identified. Although there are no definitive reasons why walk and talk therapy evolved, emerging research and a need to give clients options are two main sources. Walk and talk therapy is therapy conducted outdoors walking. It is an approach that is used as needed and is based on client needs. The setting is important to walk and talk therapy and includes a location and walking path, which is unique to each therapist's practice. The procedure consists of, first, an intake session indoors, then walking sessions subsequently. The therapist and client meet either at the office or at an agreed upon location for 50 minute sessions of walking outdoors. Traditional therapeutic interventions are utilized during sessions and client and therapist roles are similar to those in traditional therapy. Therapists have an additional role of monitoring and guiding the client while walking for safety purposes. As is true of any method, there are limitations of walk and talk therapy. General limitations include lack of support, obtaining clientele, and populations. Session limitations include weather, confidentiality, client safety, and confidentiality. Despite the limitations, there are numerous benefits of walk and talk therapy.

Therapeutic benefits include getting to issues more quickly, rapport is built more quickly, processing differently, and the assessment is enhanced. Benefits for clients include physical health benefits, mental health benefits, nature benefits, and body awareness. Last, therapist benefits include physical health benefits, mental health benefits, nature benefits, and self-care.

Framework for Practice Findings

Glaser's six C's theory was utilized in the theoretical coding phase to establish a theory for walk and talk therapy. However, my findings indicated a framework for practice rather than a theory for walk and talk therapy. The six C's, a procedure introduced by Glaser, identified "causes, contexts, contingencies, consequences, covariances, and conditions" for walk and talk therapy (Charmaz, 2006; LaRossa, 2005). Each of Glaser's six C's was filled with data to explain the theory of walk and talk therapy.

The *context* of walk and talk therapy is our society, the United States. More than ever, our society is accepting of alternative concepts (e.g., yoga, outdoors therapy programs, Buddhism) and as a result, therapists are beginning to push the boundaries of therapy to include alternative methods. As a society, we are increasingly inactive due to car-dependent communities, increased sedentary leisure activities, and technological advancements (Dustin et al., 2010; Hansen-Ketchum et al., 2009; Norman & Mills, 2004). As a result, obesity rates are on the rise (U.S. Department of Health and Human Services, 2010) and we spend less time outdoors interacting with nature (Burls, 2005). These changes in our society (i.e., inactive society and nature deficit) have influenced the needs of clients and thus *caused* walk and talk therapy to evolve. Additionally, the research related to inactivity and nature deficits were *covariances* in the evolution of walk and talk therapy, as research brings education and awareness to the public.

A *condition* of walk and talk therapy evolving was the actions of therapists. Therapists recognized the changing needs of clients and sought alternative methods to provide to clients. Some contingencies for therapists included their own personal experiences, other therapists in the field, a desire to get out of the office, and putting needs of their clients as a priority. These conditions and *contingencies* influenced walk and talk therapy's evolution as an approach.

As a *consequence* of walk and talk therapy evolving, therapists began utilizing it in their practices. Cockrell was the first to gain attention for his practice, which he initiated in 2004. To date, 28 therapists are advertising their walk and talk therapy practice on the Internet. Moreover, there are consequences of therapists utilizing walk and talk therapy including the findings of this study to help explicate the approach. Consequences of therapists using it include identifying a definition, characteristics, limitations, and outcomes of the approach.

Significance of Findings

The significance of the findings included: (a) physical activity seems more important than nature, (b) casualness of the approach may motivate clients, (c) self-care for therapists and clients, (d) benefits outweigh limitations. Physical activity and nature are components in walk and talk therapy not found in traditional therapy. Each is beneficial for therapists and clients; however, therapists attributed benefits more often to physical activity than to nature.

Additionally, the setting of walk and talk therapy was not as strong a focus as the physical activity component. It seems that nature was more of a secondary notion in walk and talk therapy. This may be attributed to the widely known health benefits of physical activity (e.g., Dubbert, 2002; Hays, 1994; Leer, 1980) and the less well-known benefits of nature (Burls, 2005; Pretty et al., 2006).

The casualness and non-threatening characteristics of the approach could motivate clients to try therapy. In traditional therapy, therapists and clients sit across from another for 50 minutes indoors. Some clients find this style threatening due to the vulnerability, direct eye contact, and formal qualities. Clients who may fear traditional therapy may be more inclined to try walk and talk therapy as it involves walking side by side with someone outdoors. People are familiar with walking side by side with someone outdoors. Sitting face-to-face with a stranger can be intimidating. Walking outdoors with a stranger could be less intimidating.

Walk and talk therapy is a self-care tool for therapists and clients. In walk and talk therapy, therapists and clients are receiving benefits from participating in physical activity and interacting with nature. Therapists can prevent burnout from utilizing walk and talk therapy in their practice which could lead to a decrease in employee turnover and an increase in job satisfaction. Clients learn a self-care tool from participating in walk and talk therapy. It is a therapy that teaches clients first-hand the benefits of self-care. Thus, clients may begin utilizing physical activity such as walking for self-care which could lead to an increase in mental and physical health.

Last, the benefits outweigh the limitations. Benefits for therapists and clients in walk and talk therapy include mental health benefits, physical health benefits, nature benefits, and self-care. In addition to the benefits of walk and talk therapy, there are no additional requirements for therapists to conduct walk and talk therapy. Therapists who are trained in traditional therapeutic interventions are qualified to conduct walk and talk therapy; no additional training or skills are necessary. Limitations of walk and talk therapy such as confidentiality and liability concerns are present in traditional therapeutic methods. Weather is the only limitation of walk

and talk therapy that is not evident in traditional therapeutic methods. Thus, the benefits outweigh the limitations.

Implications

This study is important to the counseling and psychotherapy profession, in particular to therapists, counselors, social workers, researchers, and counselor educators. Findings from this study contributed to a definition, explanation, and framework for practice of walk and talk therapy. A definition, explanation, and framework for practice of walk and talk therapy can provide counseling professionals with an alternative approach to utilize with clients.

Researchers now have information about walk and talk therapy, which allows further empirical studies to be conducted. Additionally, counselor educators can educate students about this alternative approach to utilize with clients.

Implications for therapists. In this study, various disciplines were represented in the sample: four marriage and family therapists, four social workers, and three counselors. Therapists' years of experience in the profession ranged from 1.5 years to 30 years. Moreover, the years of experience with walk and talk therapy ranged from six months to 12 years. This is a study benefit – it crosses disciplines and age groups. Walk and talk therapy gained media attention in 2006 from Clay Cockrell's NYC practice.

Although some therapists have been utilizing it for many years, public attention is recent. This research will provide more attention and information on walk and talk therapy which has an impact on therapists. Specifically, implications for therapists consist of: (a) another method of therapy to utilize, (b) growth of the profession, and (c) support from the profession.

Research findings could motivate therapists, social workers, and counselors to use walk and talk therapy as another option of therapy either as needed or full time. Some therapists are

currently using walk and talk therapy as a practice or part of their practice. The definition, explanation, and framework for practice could increase the number of therapists that start utilizing walk and talk therapy. Therapists may be motivated by the research to try something new with their clients; once the benefits are noticed, they will continue to use walk and talk therapy either part time or full time.

Research on walk and talk therapy could have a positive impact on the profession, specifically, the longevity of therapists and stigma of therapy. Walk and talk therapy could have an effect on therapist rates of burnout, therefore the longevity of the profession could be impacted. Therapists could get self-care from utilizing walk and talk therapy in their practices either as needed or full time which would prevent burnout. This would impact the amount of experienced therapists in the profession. Additionally, research on walk and talk therapy could cause the public to have a positive view of therapy which decreases the stigma of therapy.

Support from the profession could be impacted from this research. Findings indicated a lack of support from the field, misconceptions, and judgment related to walk and talk therapy. Lack of support from the field included a lack of training, lack of supervision, and lack of therapist support. Lack of training referred to how to conduct walk and talk therapy as well as procedural logistics. Lack of supervision is related to the small number of therapists that conduct walk and talk therapy. Many therapists reported that they wish there was more of a support system for walk and talk therapists to share ideas, provide consultation, and support for one another. Furthermore, therapists reported that other professionals misperceive or place judgment on walk and talk therapists. Since there is little knowledge of what walk and talk therapy is, professionals questioned the legality and ethics of providing therapy outside of the traditional office space.

This research could impact support from the profession because professionals will have more knowledge on walk and talk therapy and the framework for practice for walk and talk therapy. Research will provide a framework to train those beginning to use the approach, increase the number of therapists using the approach which could increase supervisors, provide support to therapists utilizing the approach, and dispel any misconceptions or judgment of others from the profession.

Implications for researchers. Only one empirical study on walk and talk therapy, therefore research implications are great. The findings of this study contribute to the definition, explanation, and theoretical framework of walk and talk therapy, which can be utilized for future empirical studies. Areas to explore related to walk and talk therapy consist of: the effects of nature on walk and talk therapy, the effects of physical activity on walk and talk therapy, and the effectiveness of walk and talk therapy. Overall, research on walk and talk therapy is limited; therefore, research studies are needed.

Implications for counselor educators. The findings of this study provided a definition, explanation, and framework for practice of walk and talk therapy, which impacts counselor educators. Counselor educators are responsible for educating students on counseling theories, approaches, interventions, and research. Counselor educators should teach alternative methods of therapy such as walk and talk therapy in the classroom. Students will have an opportunity to learn alternative methods of therapy, which allows them to stay current and knowledgeable in the profession.

Limitations of the Study

As with all studies, limitations exist. In this study limitations included: participant bias, inflated participant perceptions, and researcher bias. First, there is always a chance of participant

bias when the participants are voluntary. Because those selected for this study have chosen walk and talk therapy as their practice or part of it, their answers may have been positively biased towards walk and talk therapy. Unfortunately, there is no way to prevent this limitation and I assumed that all participants gave an unbiased account of the approach, including the benefits and limitations.

A second limitation is researcher bias; the fact I am positively biased towards walk and talk therapy, as are the participants, may have potentially affected the data collection, analysis, and interpretation of interview answers. To prevent researcher bias affecting my findings, I utilized a journal after each interview to prevent bias from affecting my results. I also consulted with my dissertation chair. I reflected upon my questions as well as the responses from each participant after each interview in a journal. Utilizing a journal to capture my reflections helped me remain as unbiased as possible.

A third potential limitation is the possibility of participants' inflated positive perceptions. My sample included only participants that choose to do walk and talk therapy, so it is possible that their perceptions were inflated positively. To prevent obtaining only inflated positive perceptions, I interviewed all therapists who volunteered even if they conducted walk and talk therapy only once or twice in their careers. Interviewing everyone who volunteered gave me a broad understanding including therapists with successful walk and talk therapy practices as well as those with fewer walk and talk clients.

Implications for Future Research

Many avenues for future research related to walk and talk therapy are possible. Future studies can utilize these preliminary findings and explicate them more specifically. Possible directions for future research include:

- What are client's perceptions of walk and talk therapy?
- Why is obtaining clientele a challenge?
- What are other professional's perceptions of walk and talk therapy?
- Which is more effective, traditional therapy or walk and talk therapy?
- What populations are best suited for walk and talk therapy?
- Are walk and talk therapists less likely to experience burnout/compassion fatigue/vicarious trauma?
- Do walk and talk therapists experience more job satisfaction than traditional therapists?
- What factors are contributing to mental health, physical health, and cognitive improvements - nature, physical activity, therapy, or a combination?
- Can this approach be used for supervision?

Chapter Summary

The findings of this study contributed to a framework for practice for walk and talk therapy. Implications for therapists, researchers, and counselor educators were outlined. Limitations and future research for the study were presented. Overall, a framework for practice for talk therapy provides therapists and clients with another option for therapy. Walk and talk therapy is an alternative therapeutic method that incorporates physical activity and nature into the approach. Physical activity and nature both offer benefits for the therapist and client. With the findings of this study, therapists will have the information needed to begin using walk and talk therapy. Researchers can begin examining walk and talk therapy further to gain more understanding. Counselor educators can educate students on alternative methods of therapy. Although this study had limitations, like all studies, the implications are important and provide a direction for future research related to walk and talk therapy.

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Appendix A
IRB Approval Letter

**University Committee for the Protection
of Human Subjects in Research**

University of New Orleans

Campus Correspondence

Principal Investigator: Louis Paradise
Co-Investigator: Bridget L. McKinney
Date: April 7, 2011
Protocol Title: "Therapist Perceptions of Walk and Talk Therapy: A Grounded Study"
IRB#: 02Apr11

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101 category 2, due to the fact that any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.
Sincerely,

Robert D. Laird, Ph.D., Chair
UNO Committee for the Protection of Human Subjects in Research

Appendix B

Letter of Interest/Consent Form

Appendix B

Letter of Interest/Consent Form

Date

Participant Name

Address of Participant

Dear (Participant's Name),

As a University of New Orleans doctoral student in the Counselor Education program, under direct supervision of Dr. Louis V. Paradise (504-280-6026 or lparadis@uno.edu), I am pursuing a qualitative research study about Walk and Talk therapy. Information from you, as a therapist offering Walk and Talk therapy, will be utilized in my final dissertation entitled, *Therapist perceptions of Walk and Talk Therapy: A Grounded Study*.

I would like to interview you about walk and talk therapy to gain an understanding about the topic. I would like to hold the interviews either face-to-face, Skype™ (online video conferencing) or via telephone. Face-to-face is preferable and I will make arrangements to meet you at your convenience. If neither method will work for you, we can resort to email communications.

I am hoping to complete my research within the months of April 2011 and August 2011. Upon verbal and/or written agreement from you, we can set up the interviews based on your convenience. This is an opportunity of a lifetime for me, and I look forward to conversations with you regarding upcoming times for the interviews.

I am extremely excited to meet with you to learn about walk and talk therapy. This process is not possible without your participation. At the end of the dissertation process, upon request, I will provide you with an executive summary of my research findings.

In agreeing to participate in this study, you understand that:

1. The purpose of this study is to explore your perceptions related to your experiences with walk and talk therapy. Your participation will involve being interviewed on one occasion via face-to-face, telephone, or Skype™ for 60 minutes. You will speak to me and will be (audio or video) taped to make sure that what you say can be typed. Once the study is complete, the tapes will be discarded. Your real name will not be revealed in the study. Anything you say can be used in the study.

2. One risk associated with this study is that you will be asked to share personal information regarding your experiences. You may become tired or have discomfort talking about experiences. You are free to request a break as needed or decline to respond to any question.
3. The benefits of participating in this study for you personally are minimal; however, you will be contributing to the scholarly research about walk and talk therapy.
4. You do not have to participate and are free to stop the interview at any time without consequence. Additionally, you are free to withdraw from this study at any point.
5. The results of this study will be used for my dissertation, publications, and conferences; however, your name and identity will not be revealed. You will be assigned a pseudonym and it will be used in any reporting of your comments. The researcher will only know your name and any transcriptions of this interview will be kept in a locked file cabinet accessible only to the researcher.
6. Your participation in this research study is voluntary and you will not be compensated. Refusal to participate will involve no penalty. You may withdraw from participation in this research study at any time.
7. If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, please contact Dr. Ann O'Hanlon, Institutional Review Board, at the University of New Orleans at 504-280-6501.

If you would like to assist me in the collection of incredibly important information, please feel free to contact me via phone, 504-280-6726 or email bmckinne@uno.edu. I would like to thank you, in advance, for assisting me.

Thank you for your time and attention to this request.

Sincerely,

Bridget L. McKinney, M.S., NCC
Doctoral Candidate
Department of Educational Leadership, Counseling & Foundations
University of New Orleans, New Orleans, LA
bmckinne@uno.edu

Appendix C
Participant Interview Protocol

Appendix C

Participant Interview Protocol

Participant # _____ Date: _____

Demographic Questions:

1. What is your educational background?
2. What certifications or licenses do you hold?
3. What professional association affiliations do you hold?
4. What is your training background related specific to walk and talk therapy?
5. How long (years/months) have you been involved with walk and talk therapy?
6. How many clients that you see, are walk and talk clients?

Central Research Question: What is the theory that explains walk and talk therapy?

Research Sub Questions:

1. What is the process of walk and talk therapy?
2. How did walk and talk therapy evolve?
3. What is central (major events or benchmarks) in the process of walk and talk therapy?
4. What influenced or caused walk and talk therapy to develop for you?
5. What are the obstacles in the process of walk and talk therapy?
6. Who are the important participants and how do they participate in the process?
7. What strategies are employed during the process of walk and talk therapy?
8. What effects or outcomes occur from the process of walk and talk therapy?

Interview Questions:

1. How do you define walk and talk therapy? - RQ1
2. Describe a typical session. - RQ1
3. How did you learn about walk and talk therapy? – RQ2
4. Describe why you think walk and talk therapy emerged? – RQ2
5. Who has been important in the field for walk and talk therapy? – RQ2
6. What are the central components of walk and talk therapy? - RQ3
7. What makes walk and talk therapy stand out from other approaches? – RQ3
8. What motivated you to start using walk and talk therapy? – RQ4
9. What changes have you had to make as a therapist to do walk and talk therapy? – RQ4
10. What were the roadblocks in developing walk and talk therapy in your practice? – RQ5
11. Describe any obstacles or limitations of the walk and talk therapy approach. – RQ5
12. How do you handle obstacles or limitations of the walk and talk therapy approach? - RQ5
13. What is the therapist's role in walk and talk therapy? – RQ6
14. What is the client's role in walk and talk therapy? – RQ6
15. What strategies or interventions are used in walk and talk therapy? – RQ7
16. What is beneficial about walk and talk therapy? – RQ8
17. What are some outcomes of doing walk and talk therapy for the client? – RQ8
18. What are some outcomes of doing walk and talk therapy for the therapist? – RQ8

Appendix D

Participant Thank You Email

Appendix D

Participant Thank You Email

Dear *Participant Name*,

I would like to thank you again for participating in my study. It was a pleasure speaking to you and as requested, I will email the findings of the study once concluded.

Sincerely,

Bridget L. McKinney, M.S., NCC
Doctoral Student
Past President, Alpha Eta, Chi Sigma Iota
University of New Orleans, Counselor Education
bmckinne@uno.edu

Vita

Bridget L. McKinney was born in Metairie, Louisiana. She obtained a bachelor's degree in child and family studies from the University of Louisiana at Lafayette in 2002. She obtained her master's degree in counselor education from the University of Louisiana at Lafayette in 2005. She joined the University of New Orleans graduate program to pursue a PhD in counselor education in 2008.