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ORIGINAL ARTICLE

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Walking and talking for well-being: Exploring the effectiveness of walk and talk therapy

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Abstract

Despite the rising trend of integrating nature and movement into talking therapy, the extent of empirical support remains limited. This study explored the effects of a walk and talk intervention on adult mood and well-being using a multiple baseline design with pre, post and follow-up assessments. Five adults (3 males and 2 females) from a technology company took part in a walk and talk intervention lasting approximately 6–8 sessions. They completed self-report measures at baseline, post-intervention and follow-up, with semi-structured interviews conducted at follow-up. Results showed a reduction in psychological distress and an increase in well-being for all participants from baseline to follow-up. Qualitative data from a thematic analysis supported these findings: participants found the natural, calming effect of the outdoors, combined with the movement of walking, facilitated a sense of freedom to express themselves and, in doing so, maximise the benefits of the therapeutic space. These included gaining a broader perspective, heightened self-awareness and greater acceptance of oneself, others and life's challenges. This study offers real-world evidence supporting walk and talk therapy as an effective intervention for adult well-being and mood.

KEYWORDS
nature, outdoor therapy, walk and talk therapy, walking, well-being

1 | INTRODUCTION

As mental health professionals acknowledge the vital connection between the mind and body for well-being, an integrative approach that combines movement and traditional talking therapy, often in outdoor environments, is becoming increasingly prevalent (Petri, 2015). This approach, known as *outdoor therapy*, involves 'an intentional psychotherapeutic relationship through which all of the programme/sessions take place in an outdoor setting' (Revell et al., 2014, p. 282). The interaction with nature in outdoor therapy varies from low (e.g. sitting, walking or passive experiences in the outdoors), moderate (e.g. gardening, outdoor pursuits and problem-solving), to high (e.g. one-off wilderness expeditions in remote locations in groups, which can last days or weeks; Cooley & Robertson, 2020). Therapy can either occur simultaneously with movement (e.g. walk and talk therapy [WATT]) or before or after movement (e.g. high ropes course) as a mechanism to support personal resilience, confidence and growth. Outdoor therapy therefore includes a wide range of activities and is referred to in the literature by various terms, such as nature therapy, adventure therapy, ecotherapy, wilderness therapy, horticultural therapy, adventure-based counselling and walking therapy. Cooley and Robertson (2020) conducted a meta-synthesis of existing outdoor talking therapy research, drawing on 38 largely qualitative studies that reflected the

experiences of 322 mental health practitioners and 163 clients in the UK. Their review highlighted several advantages, such as a more mutual therapeutic space, greater freedom for clients in terms of movement and expression, stronger connections with nature, holistic health benefits for both clients and therapists, and improved access to care for those who find indoor or digital therapy challenging. Whilst empirical evidence exploring the mechanisms for change is limited, anecdotal evidence points towards the restorative effect of nature on mental health, as well as the integration of movement in outdoor therapy (e.g. Kim et al., 2009).

Walk and talk therapy is one example of outdoor therapy, in which practitioner and client walk side by side in a natural setting. Walking outdoors has shown to reduce negative emotions and enhance positive emotions (Berman et al., 2012; Thompson-Coon et al., 2011), whilst also providing a greater boost to self-esteem and mood than walking indoors (Barton et al., 2009; MIND, 2007). In addition, compared with sitting, walking boosts cerebral blood flow and fosters psychological flexibility (Carter et al., 2018), which has been identified as a critical component of effective therapy (Brandon et al., 2021). Walking requires no specialised equipment, poses minimal injury risks and promotes inclusivity across genders and sociopolitical statuses (Ettema & Smajic, 2015; Soroush et al., 2013). Descriptive research exploring therapist and client experiences of WATT suggests that it offers a relaxed, enjoyable and collaborative experience, which is beneficial for client and therapist well-being (Charbonneau, 2016; McKinney, 2011; Revell & McLeod, 2016). WATT has also been suggested to enhance the therapeutic relationship because walking side by side allows for a more balanced ownership over the natural environment (Jordan, 2015; Jordan & Marshall, 2010). Findings from Clark (2019) indicated that adult clients experienced WATT as equally or more therapeutic than traditional therapy, with less stigma attached. Beyond this example, we only found two other relevant studies. First, Doucette (2004) assessed a 6 weeks walk and talk (WAT) intervention for behaviourally challenged youths. Sessions lasted 35–40 min, and an unidentified practitioner using a person-centred approach facilitated the sessions. Post-intervention interviews revealed a range of positive outcomes, such as increased self-awareness, self-esteem, self-efficacy and well-being. Participants reported that the movement of walking facilitated problem-solving and allowed a physical release. A more recent mixed-method study explored the effect of WAT on individuals experiencing stress and burnout (Van den Berg & Beute, 2021). Individuals assigned to the WAT group engaged in four country estate walks, over the course of 12–18 weeks. Each walk lasted 1.5 h, in which the psychologist used nature as a backdrop and catalyst for the conversation. Compared with the control group, who received no therapy, individuals who experienced WAT reported improvements in burnout, stress, well-being and mental health post-intervention. They also experienced nature as relaxing and contemplative and disclosed that they felt more optimistic and self-aware after the intervention.

The rising popularity of WATT, calls for additional research to confirm its effectiveness for adult well-being. Therefore, the aims of this study were to (i) explore the feasibility of a WAT intervention on adults' mood and well-being and (ii) develop a deep understanding of the client's experience of the WAT intervention.

Implications for Practice and Policy

- This study highlights the beneficial effects of WATT on adult well-being.
- It also highlights the facilitative effects of walking outdoors for client freedom of thought and expression.
- Furthermore, the study raises awareness for WAT as an appealing alternative for clients who find therapy in a room to be too intimidating.
- Finally, the findings suggest that clients need to prepare for and decompress from WATT sessions when occurring in the working day.

2 | METHOD

2.1 | Participants

Following ethics approval from the university ethics committee, individuals were recruited from a technology company in the UK through their internal communications systems (e.g. posting an advertisement in Slack channels). As the company had remote employees, they wanted to make this opportunity accessible for all, so WAT was offered in person or virtually over the phone. Initial reasons for signing up for WAT included a mixture of (i) curiosity to experience therapy for the first time, and for free, and (ii) a desire to be in and benefit from being outdoors during the working day. The therapeutic aims of participants varied from person to person; some examples included the following: addressing an unhealthy relationship with exercise and/or food; getting back to exercising again; improving self-confidence at work and working through imposter phenomenon; improving emotion regulation and expression; improving relationships with others; and improving productivity and mood. Given that in a single-case study design, the number of recommended participants varies from two (Yin, 2014) to five (Creswell et al., 2007), this study included five Caucasian participants (2—female; 3—male) aged between 25 and 40 years. All participants disclosed no mental health conditions, or priori experience of therapy, and could walk comfortably.

2.2 | Design

We used a multiple baseline design with pre, post and follow-up assessments to explore the feasibility of a WATT intervention in a naturalistic setting. A multiple baseline design is a research method used to evaluate the effectiveness of an intervention across

different contexts, subjects or behaviours. Here, we used an A-B design, which involved two phases:

1. A (baseline phase): In this initial phase, we collected data before introducing the WATT intervention. The goal was to observe the natural state or behaviour of interest (psychological distress and well-being) with no influence.
2. B (intervention phase): In this phase, we introduced the WATT intervention and collected data again to see whether there was any noticeable change compared with the baseline.

Unlike other designs, such as reversal (A-B-A) designs, a multiple baseline design does not require the removal of the intervention. This was particularly beneficial here as withdrawing the potentially effective intervention would have been unethical and impractical. For the follow-up semi-structured interviews, we adopted a critical realist perspective, which assumes that the world exists independently of our knowledge of it (ontological realism). However, this perspective also acknowledges that our understanding is shaped by language, methods and the politics of science, aligning with epistemological constructivism (Sayer, 1992). As such, we acknowledge that the researcher–psychologist status played a role in influencing both the process and outcomes of this study.

2.3 | Measures

Because we used measures within the therapeutic context, we adhered to the British Psychological Society's (BPS, 2017) psychological testing guidelines throughout. The measures were used to develop a shared understanding of participants' internal landscapes and determine individual, meaningful change post-intervention (Van Scoyoc, 2010). During the assessment phase, their experiences of completing the questionnaires and their responses were explored collaboratively, allowing them to confirm or challenge the interpretation of the data. This approach aimed to strengthen the therapeutic alliance and address the power imbalance that can often occur when formal measures are introduced (Hilsenroth et al., 2004). The following measures were chosen because they were brief, easy to administer and relevant to the research aims.

2.3.1 | Psychological distress

We used the Clinical Outcomes in Routine Evaluation—Ten (CORE-10) to assess levels of psychological distress. Participants responded to 10 statements, reporting their frequency over the past week, from 0 (not at all) to 4 (most, or all the time). The measure has adequate internal reliability, with a Cronbach's alpha coefficient of 0.9 ([CI] 0.84–0.92) and 0.89 (CI 0.80–0.94) reported for female and male samples, respectively (Barkham et al., 2013).

2.3.2 | Psychological Well-being

We used the Warwick–Edinburgh Mental Well-being Scale (WEMWBS; Tennant et al., 2007) to assess well-being via 14 positively worded items relating to subjective well-being and psychological functioning. Participants responded to each item on a 5-point Likert scale, generating a corresponding score per item from 1 (none of the time) to 5 (all the time). The measure has shown high levels of validity (Cronbach's alpha .90), adequate test–retest reliability (.83) and high correlation with other mental health and well-being measures, and lower correlations with measures of overall health (Tennant et al., 2007).

2.4 | Data collection procedures

We collected self-report data at four time points (Figure 1) and conducted semi-structured online interviews lasting 45–60 min at follow-up to explore participants' experiences of WATT. Participants were invited to a voluntary 60 min online meeting, which took place through Microsoft Teams and was recorded with their consent.

As a trainee psychologist conducting the WATT study, I balanced dual roles as both practitioner providing therapeutic support and researcher responsible for data collection and analysis. To minimise potential bias, I employed several strategies to uphold the integrity of the research. First, I collaborated with my supervisor to develop an open-ended, non-leading, semi-structured interview guide (Smith et al., 2009). Example questions included, 'How did being outdoors influence your experience?' and 'Did you

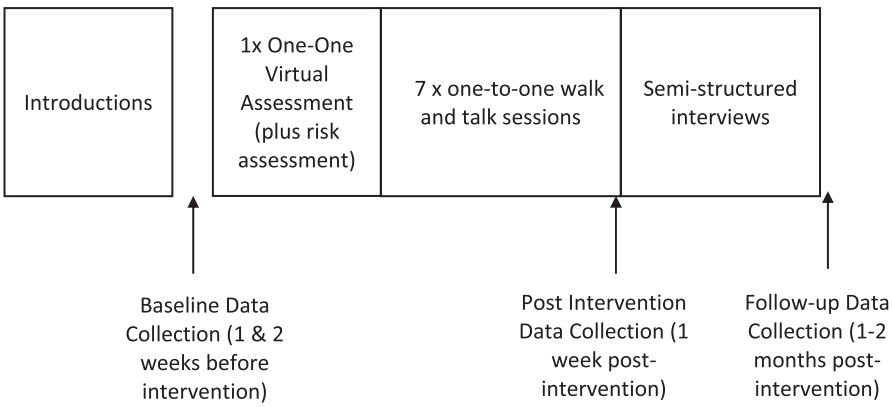

FIGURE 1 Collection of quantitative measures (CORE-10 and WEMWBS) across time points for all five participants.

face any challenges during the walk and talk sessions?' Second, I maintained a reflective journal throughout the study, documenting both personal and epistemological reflexivity (Willig, 2008), as well as my experiences, aspirations and reflections after each session (Cooper et al., 2015). This practice aimed to bracket my biases, as much as possible, in line with professional guidelines (BPS, 2018). Lastly, I sought role fluency by managing my dual responsibilities ethically, raising challenges in supervision and providing clear information about client withdrawal rights and confidentiality. Whilst acknowledging the inherent subjectivity of qualitative research (Smith et al., 2009), these strategies aimed to minimise bias and enhance the credibility of the findings.

2.5 | Walk and talk intervention

Initially, participants attended an online session to establish rapport, assess WATT suitability and conduct a risk assessment, covering confidentiality, weather and logistics.

After giving written consent, individuals completed a virtual assessment session, which involved taking history of the client's presenting problem, their background and any factors leading to their presenting concerns. Assessment also sought to determine their preferred psychological support and develop goals for the remaining sessions. For four individuals, the subsequent seven sessions took place at a Botanic Gardens, chosen for its accessibility and tranquillity. I conducted a risk assessment to comply with best practice for safety (BPS, 2020). The fifth participant engaged in WATT over the phone, choosing their own quiet, rural route to walk whilst I stayed at my desk, a mode referred to as virtual WAT.

As a trainee practitioner psychologist, I, the first author, was in the final year of my doctoral training programme in sport and exercise psychology. I therefore had training in person-centred and cognitive behavioural therapeutic approaches, and was developing as an integrative practitioner. As such, I aimed to provide the core conditions of empathy, congruence and unconditional positive regard, to develop a strong therapeutic relationship, from which client change could occur. Sessions followed a cognitive behavioural therapy (CBT) format (e.g. Beck, 2020) and included the following: (i) a brief check-in with a measure appropriate to the individual; (ii) the bridge, in which the client shared anything important that happened between sessions; and (iii) an aim for the session agreed and worked through. The final 10 min were used to review the session and discuss any homework. This was the ideal; however, given the naturalistic setting, this was not strictly adhered to. In line with my developing pluralistic philosophy of practice, I accommodated sessions depending on client preference and presenting needs.

2.6 | Analytic strategy of quantitative data

Because of the insufficient number of participants required to conduct parametric tests, we implemented visual inspection (Parsonson & Baer, 1978), using guidelines from Hrycaiko and Martin (1996) to evaluate the effectiveness of the intervention. In addition, we calculated percentage scores between data collection phases to determine the magnitude of change (Davis & Turner, 2020).

2.7 | Qualitative approach

We used inductive thematic analysis to identify themes and concepts from the data (Liamputtong & Ezzy, 2005). We chose this method as it is widely used to analyse textual data sets and reveal relevant themes that align with the research objectives. Thematic identification is an active process in which researchers interpret participants' words and decide what to include or exclude (King & Horrocks, 2010). Themes can typically not only reflect recurring ideas or topics across cases but also reveal insights from individual participants. They represent meaningful patterns in the data, whether they permeate the data set or stand out due to their emotional or factual impact (Ely et al., 1997). To ensure consistency and reliability, we followed the guidelines outlined by King and Horrocks (2010), which were derived from earlier works by Langdridge and Butt (2004) and Braun and Clarke (2006). We moved in a cyclical manner between various stages, including becoming more familiar with the data, descriptive coding, interpretative coding, the development of overarching themes and research write-up, which included creating a diagram to represent theme organisation.

3 | RESULTS

3.1 | Quantitative results

Scores on the questionnaires represented a reflection of the individual's experience at that moment in time. The CORE-10 measures psychological distress within the following ranges: ≤10—non-clinical range; 11–14—mild; 15–19—moderate; 20–24—moderate-to-severe; and ≥25—severe (Barkham et al., 2013). The WEMWBS scores range from 14 to 70. Typically, higher scores show greater mental well-being, with the UK population averaging around 48.6 (The Scottish Health Survey, 2021). Some benchmarks suggest that scores of 60–70 represent high well-being, whilst scores below 42 may reflect lower well-being. We used these as a guide to interpret the scores in the following section.

3.2 | Participant 1

Visual inspection of the data showed a reduction in psychological distress from baseline (5) to post-intervention (4), and this reduced further from post-intervention to follow-up (3). Scores fell within the non-clinical range (≤10) and continued to reduce at follow-up, suggesting that the positive effect of the intervention continued one month post-intervention Figure 2.

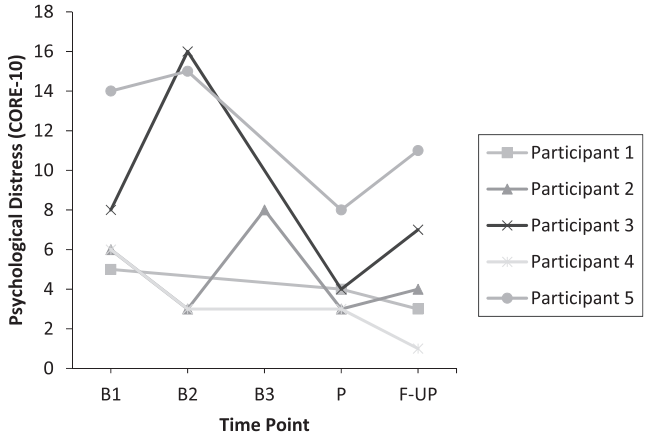

FIGURE 2 Changes in psychological distress for all participants. B1, B2 and B3 refer to baseline measures (1–3 weeks of pre-WATT intervention); P refers to post-intervention (within 1 week post-final WATT); and F-UP refers to follow-up (1–2 months of post-final WATT). CORE-10; Clinical Outcomes in Routine Evaluation—Ten.

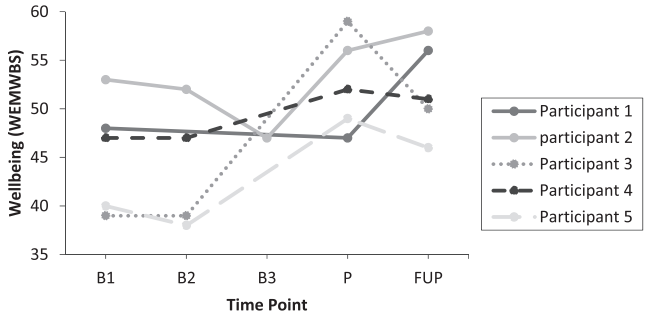

FIGURE 3 Changes in well-being for all participants. B1, B2 and B3 refer to baseline measures (1–3 weeks of pre-WATT intervention); P refers to post-intervention (within 1 week post-final WATT); and F-UP refers to follow-up (1–2 months of post-final WATT). WEMWBS, The Warwick–Edinburgh Mental Well-being Scale.

Well-being scores increased from baseline (48) to follow-up (56). However, scores decreased from baseline (48) to post-intervention (47) and increased from post-intervention to follow-up (48) (Figure 3). This may suggest that something other than the intervention influenced this participant's well-being, or perhaps, the positive effects of the intervention were delayed.

3.3 | Participant 2

Psychological distress decreased from baseline (5.7) to follow-up (4). Whilst a reduction was observed from baseline (5.7) to post-intervention (3), psychological distress increased from post-intervention (3) to follow-up (4), suggesting that although psychological distress decreased overall, the effect decreased over time.

Well-being increased from baseline (50.67) to follow-up (58), with scores increasing from baseline (50.67) to post-intervention (56) and from post-intervention (56) to follow-up phases (58). This suggests WATT had a positive effect on this participant's well-being, which continued 1 month after the intervention.

3.4 | Participant 3

Visual inspection of the data showed that psychological distress decreased from baseline (12) to follow-up (7); this reflects a change in scores representing mild psychological distress to non-clinical levels. Note that as scores dropped to 4 at the post-intervention phase, a 75% increase in psychological distress from the post-intervention to follow-up phase was observed, suggesting that the effects of the intervention were not maintained.

Well-being increased from baseline (39) to follow-up (50), and an upward trend was observed from baseline (39) to post-intervention (59); however, well-being reduced from post-intervention (59) to follow-up (50). This finding may suggest that the positive effects of the WATT on well-being could not be sustained.

3.5 | Participant 4

Visual inspection shows that psychological distress decreased from baseline (4.5) to follow-up (1), and a downward trend was observed from baseline (4.5) to post-intervention (3) and post-intervention (3) to follow-up phases (1). Scores remained in the non-clinical range throughout, suggesting that the intervention was effective at decreasing psychological distress for this participant.

Well-being increased from baseline (47) to follow-up (51), and whilst it increased from baseline (47) to post-intervention (52), it then decreased at follow-up (51). This may suggest that the intervention's effects on well-being may have decreased over time for this participant.

3.6 | Participant 5

Psychological distress decreased from baseline (14.5) to follow-up (11). Initially sitting on the cusp of moderate psychological distress (14.5); it decreased to within a non-clinical range at post-intervention (8); however, it then increased to reflect mild levels of psychological distress at follow-up (11), suggesting that the effects of the WATT intervention on psychological distress were not sustained. Well-being increased from baseline (39) to follow-up (46). However, well-being decreased from post-intervention (49) to follow-up (46), suggesting that the intervention effects could not be maintained.

In summary, psychological distress decreased, and well-being increased for all participants from baseline to follow-up phases. Despite these findings, there were slight increases in psychological

distress from post-intervention to follow-up phases ($n = 3$) although they remained lower than baseline levels. In addition, well-being decreased for one participant from baseline to post-intervention, and it decreased from post-intervention to follow-up for three participants. This may suggest that the intervention effects were not sustained over time.

3.7 | Qualitative results

These data aimed to answer the question: *How do individuals experience walk and talk?* Please see a graphic representation of the six themes in the thematic map (Figure 4). Walk and talk = freedom to express oneself is a higher order theme, which comprises three subthemes: the outdoors is freeing; free from judgement, free to feel; and walking liberates the mind and the conversation. The three remaining themes included the following: warming up and cooling down for WAT; therapy transformed, from couch to conversations; and WAT was transformational. All names used are pseudonyms to protect client confidentiality.

3.8 | The outdoors is freeing

Individuals referred to the environment (indoor versus outdoor) as influential on their ability to think, feel and share in therapy. The outdoors was constructed as a calming, peaceful and relaxing place where individuals could breathe more deeply, feel more energised and express themselves more freely. This was due, in part, to the stimulation in the natural environment, which supported a deeper reach into the mind and comfort of being open. The limited eye contact in WATT also facilitated the sense of freedom. Walking side by side, individuals felt at ease to observe their surroundings and reflect, reducing the pressure to conform to expectations in their responses. This minimal eye contact, amidst nature's tranquillity, accelerated client openness and depth. In contrast, despite individuals having no prior experience of therapy, they tended to view psychological support that occurred in a room as clinical, formal and forced, and associated it with feelings of claustrophobia, stuffiness, grogginess and fatigue. These views, informed by the media and people in their lives, were enough to put some off from seeking therapy. In addition, being confined to a room prevented one from freely expressing oneself, and also, as George explained, kept one feeling stuck in a particular way of thinking:

> ...there's an element of perspective that it helped with ..... when you're sat in a room...and you don't have a window view you get very closed in on your thought process and how you're interpreting things; being out walking in nature helps that little bit of perspective in terms of, more open space, more greenery around.

Maybe the open space of the outdoors is mirrored internally, in which individuals experience expansion, and therefore, a greater perspective.

3.9 | Walking liberates the mind and frees the conversation

Walking was experienced as a simple, natural and easy form of exercise, which goes hand in hand with talking. As a familiar activity, walking created feelings of comfort, which supported an open and free-flowing conversation. The natural and automatic nature of walking provided an outlet for dispositional fidgetiness and eased potential self-consciousness that would occur in a face-to-face context. In doing so, it enabled a greater depth of thought and focus on what was important. Walking provided an alternative purpose to the session which, as Steven shared, enabled individuals to express themselves more fluently:

> [in WATT] The purpose is walking and the secondary thing is speaking... that's not necessarily the case, the purpose is speaking and the secondary thing is walking...that's quite a stark contrast to going into a room and sitting down and speaking with somebody,

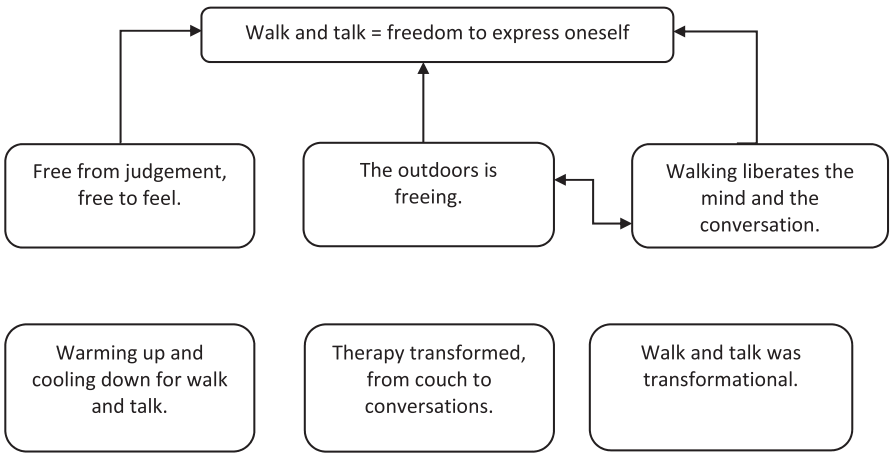

FIGURE 4 Thematic map of qualitative themes.

> because you're just sitting there, there's nothing else to achieve, you're in the one room the whole time, you've got the same things to look at, you're making eye contact. and that places pressure on the conversation…I'd like to think that I spoke a bit more fluently when we were out walking than I do in this sort of [indoor] environment, it just seems to….take the pressure off the conversation.

Steven also suggested that walking provided a sense of purpose, and achievement in a way that sitting down did not. One individual found that meaningful conversation during WATT made walking more enjoyable, and they experienced positive side effects, such as increased energy returning to work and increased daily step count.

3.10 | Free from judgement, free to feel

Getting accustomed to talking therapy and going deeper than surface-level conversation took longer for some than others. Given that none of the participants had engaged in any psychological support previously, trust in the psychologist was key to support this process of openness and depth.

> Sarah: I was waiting to make sure there was no judgment ….that there wasn't [psychologists name] perception of what I was saying…that only came by you asking the questions that you asked and the responses that you had…so I think I was just waiting to build that trust and particularly the zero judgment environment.

As Sarah and others alluded to, trust was built through the non-judgemental and non-directive yet guiding qualities of the psychologist. Overall, individuals found greater value and meaning from the deeper sessions which, although challenging and more emotional, led to increased introspection and subsequent self-discovery.

Individuals highlighted how this confidential and trusting space was not present anywhere else in life, as others often give their opinion, advise or are judgemental. The absence of the psychologist sharing their opinion conveyed a level of understanding, validation and permission for the individual to feel as they were.

3.11 | Warming up and cooling down for WATT

Given that WATT was conducted in a business setting and occurred throughout the working day, unsurprisingly, individuals required separation from work and sessions. This included preparation time and a specific activity, such as cycling or a cup of tea, as John shared:

> … if I was answering emails until five minutes before…I would mentally still be somewhere else…and it wouldn't allow me the space to focus on what I wanted to talk about. So there needs to be some time to come into, it's not like you can come into it completely cold…even if I didn't cycle I would probably want to be away from my desk and have a cup of tea first just to have that separation.

As John suggested, for WATT to be effective, time was needed to allow the mind to leave work behind, become present and focussed. This allowed for the mind to warm up much like the muscles do before exercise. Time was also required post-session to reflect and decompress. Individuals managed this in different ways, from note-taking, to walking alone, to thinking on the bus journey home. Regardless, this process needed to be intentional and proactive, to ensure the finer detail of sessions was processed, remembered and acted upon if needed.

3.12 | Therapy transformed: From couch to conversations

Informed by the media, society and family, psychological support was initially viewed through the traditional medical lens as something that is done to you when you are in a very dark place or there is something seriously wrong with you. Indeed, one individual had imaginations of a couch with the psychologist staring at them, waiting for them to answer difficult and obtrusive questions. Overall, individuals entered WATT thinking it would be more formal, as Steven shared:

> …I came in a with a little bit of those [societal] preconceptions, thinking it might be more formal… I knew what I signed up for, but despite that, I still had this preconception of there's a waiting room, you go in as if you're going to see a doctor… and it just wasn't like that at all…ultimately it turned into a very nice open discussion with you that I wasn't necessarily expecting …a conversation that encouraged me to think about various things and look at things in different ways.

This reflects a common experience, that their experience of WATT was far more relaxed and enjoyable. As a result, their meaning of therapy shifted from being formal and traditional, to having open, informal and honest conversations. It also shifted from being a one-time cure to a way of gaining outside perspective during certain periods of life. The appetite for more WATT was clear, with calls for more availability locally with flexibility in location and time. Individuals also made the argument for WATT to be treated like any other health appointment, as something that we all might benefit from at different stages of our lives.

3.13 | WATT was transformational

Although unique to each individual, overall, individuals felt more accepting of themselves, others, challenges in life and their state in life. Accompanied by that was an increased sense of happiness and peace. Central to this process was an increased awareness of thoughts, feelings and behaviours. Increased awareness of thoughts, such as cognitive distortions, supported individuals to challenge thoughts, gain perspective or reduce the tendency to catastrophise. For George, awareness of thoughts and core beliefs was far-reaching:

> I'm more aware of how much the way I think about things influences all areas of my life… of how much my lack of self-awareness has led to situations being the way they are….in a professional sense not making as much progress as I could and in a personal sense not pursuing hobbies for different reasons, so I've become more aware of that and my interactions with the world, how I think influences that.

Increased awareness of behaviours, such as getting stuck in a self-critical cycle, helped individuals to understand their root cause and facilitated a more self-compassionate and accepting response when they occurred. In addition, increased awareness of self-sacrificing behaviours led to a better awareness and, therefore, prioritisation of one's own needs. For others, increased awareness of emotions supported them to be more mindful of their emotions, being curious about their presence and communicating emotions more easily. Finally, WATT reaffirmed the benefits of being in nature and walking, which led to increased walking in their own time. One individual ordered a standing desk after WATT to help look after their body and ensure they have the energy to enjoy the benefits of being in nature at the end of the working day.

3.14 | Integrating findings

Taken together, the results show that WATT positively affected individuals' mood and well-being. Qualitative data suggest that the natural, calming effect of the outdoors, combined with the movement of walking, facilitated a sense of freedom to express themselves and, in doing so, maximise the benefits of the therapeutic space. Such benefits included a greater perspective, increased self-awareness and acceptance of self, others and the ups and downs of life.

4 | DISCUSSION

This study employed a multiple baseline design with pre, post and follow-up assessments, to explore the effects of a WATT intervention on the mental well-being and levels of psychological distress of five adults. Visual inspection of the data showed a reduction in psychological distress and an increase in well-being from baseline to follow-up for all individuals. We adhered to the inspection criteria to assess significant changes (Hrycaiko & Martin, 1996). For example, there were no overlapping data points; all but one individual reported significant reductions in targeted variables immediately post-intervention. A reduction in well-being for one individual from baseline to post-intervention was tiny (from 48 to 47) given that scores range from 0 to 70 on the WEMWBS. The participants also expressed their improved well-being qualitatively in increased happiness, acceptance and peace. They experienced benefits such as a greater self-awareness and perspective, as well as understanding and communicating emotions more easily. Therefore, taken together, the intervention produced meaningful change for individuals. This could be because walking, as a form of physical activity, has been shown to have a positive impact on a range of psychological outcomes, such as depressive symptoms, mood and self-esteem (Barton et al., 2009; Berman et al., 2012; Thompson-Coon et al., 2011). In addition, CBT has also been found to have positive effects on mental health across a range of psychological outcomes, such as stress, anxiety and depression (Butler et al., 2006; Stigsdotter et al., 2018). Together, the movement of walking combined with the main aims of CBT, such as focussing on thinking patterns and addressing distortive thinking, could bring the benefits witnessed in the study.

Overall, individuals described their experience of WATT as enjoyable, relaxing and calming. They noted feeling more energised, able to breathe more deeply and feeling more comfortable disclosing personal thoughts and feelings. This echoes previous research about the healing and restorative properties of natural settings, which are thought to stem from either cognitive or emotional restoration in nature (Ottosson & Grahn, 2008; Ulrich, 1981, 1993). In addition, in line with previous studies (e.g. Boutcher, 2000; Carter et al., 2018), participants found that walking improved their cognitive functioning and internal focus, which facilitated more effective and smoother conversations. The Theory of Embodied Cognition (Wilson, 2002) assumes that the mind is intricately connected to the physical body and its interactions with the world. As such, bodily movement, such as walking, plays a role in the formulation and understanding of abstract concepts. Furthermore, walking stimulates and expands cognitive processes, helping individuals shift from rigid to more flexible thought patterns (Barsalou, 2008; Niedenthal et al., 2005). This study provides further evidence that walking during therapeutic conversations can promote an open and adaptable mindset. This effect aligns with CBT, which focusses on modifying cognitive patterns to create more rational and balanced thoughts and beliefs, highlighting the potential synergy between walking and cognitive restructuring in CBT interventions.

Walking also relieved the pressure on the conversation, making it more enjoyable than speaking in an office with constant eye contact. Walking with company increased the enjoyment of walking for individuals (Darker et al., 2007). Thus, by default, the positive effects of walking outdoors were experienced and reinforced in such a way that walking became a habit for some. Walking was also perceived to be effortless. The literature infers that this may be because of the pleasant natural stimuli acting as a distraction from physiologic sensations and therefore minimising the perception of effort (Akers et al., 2012; Hampson et al., 2001).

The therapeutic relationship is central to successful therapeutic outcomes, with trust being a key component (Laska et al., 2014; Wampold, 2015). Individuals trusted the psychologist and appreciated their non-judgemental approach, which encouraged more open sharing during sessions. Interestingly, previous research suggests that physical attending cues, such as eye contact and facing clients, are key to building client trust (Duff & Bedi, 2010). However, in this study, clients found limited eye contact liberating, as it reduced feelings of self-consciousness and allowed for more authentic and in-depth responses. This mirrors findings by McKinney (2011), in which therapists noted that walking side by side, with reduced eye contact, fostered a more informal and open way of relating to their clients. In the current study, participants also appreciated the opportunity to observe the natural environment, finding it more stimulating than a traditional indoor setting. Whilst this study makes no claims that outdoor therapy is universally superior, it supports previous findings that, for some individuals, outdoor spaces offer a more comfortable environment compared with traditional therapy rooms (Laws, 2009). Indeed, some research implies that WATT might be especially suited to men as it avoids intimate eye contact (Wright, 2008) as well as for those with less severe presenting issues (Clark, 2019). Individuals in the current study had not previously engaged in psychological support as they found the traditional therapeutic frame too intimidating; however, WATT was much more enjoyable and relaxed than they thought. Additional research suggests that natural environments can enhance the therapeutic relationship by creating a shared, neutral space that encourages a more balanced power dynamic (Cooley & Robertson, 2020). This increased sense of autonomy over the space may have contributed to the openness participants experienced.

4.1 | Limitations

Given that participants had received no therapeutic intervention before, the results could be because of a placebo effect. The placebo effect refers to a phenomenon in which a person experiences a perceived improvement in their condition after receiving a treatment that has no therapeutic effect. This improvement is not because of the treatment itself but emerges because of the individual's belief or expectation that the treatment will work. It is also worth highlighting that, as this was a case study, it limits the generalisability of the findings. Generalisability refers to the extent to which the findings or results of a study can apply to broader populations, settings or situations beyond the specific conditions of this study.

4.2 | Applied implications

The outdoor setting offers a conducive setting to explore non-clinical difficulties, and space for individual reflection and deepening awareness, which together promote client change in several areas. Walking in nature whilst engaging in meaningful conversation with a psychologist offers an alternative frame of reference for providing psychological support. Such support could be perceived as more accessible for those with a preference for the outdoors and reduced eye contact, and less severe mental health difficulties.

5 | CONCLUSION

In the first of its kind, this study shows WATT to be a promising intervention for reducing psychological distress and increasing well-being for adults with non-clinical presentations. The dual role adopted by the psychologist supported the generation of 'knowledge in context' needed to understand best practice in action (McLeod, 2010, p. 7). In doing so, it supports practitioners to implement research-informed practice, especially given the increasing popularity of WATT.

Future research could build on the findings here, and from van den Berg and Beute (2021), by developing a WATT intervention for a specific problem or purpose, such as the prevention of workplace anxiety or burnout, and use measures accordingly to assess meaningful change over time. This could then be used to support adult well-being, in a preventative manner.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, Hannah Prince, upon reasonable request.

ETHICS STATEMENT

This study was approved by the School of Health and Life Sciences Psychology, Social Work and Allied Health Sciences departmental committee at Glasgow Caledonian University (code: HLS/PSWAHS/21/257).

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